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Cultural Capital and Power Politics in Health Policy: The Case of HIV/AIDS in Uganda

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Abstract: This thesis set out to understand the seemingly contradictory nature of developments in Uganda's HIV/AIDS policy, such as the recent anti-LGBT law. Using an interdisciplinary approach drawing on insights from international relations theory, primary historical sources and the global health domain, it argues that health policy decisions are driven by political and historical factors, and that the latest developments should be seen as an expression of international relations tensions.

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Introduction

In the early 1990s Uganda was severely hit by the HIV/AIDS epidemic with prevalence rates of over 15%.[1] Since that time, Uganda has received a significant amount of financial aid through global health initiatives such as the Global Fund and PEPFAR, resulting in a reduction of HIV rates in Uganda in the early 2000s.[2] Based on these (relatively) short-term observations it would seem that the relationship between global health initiatives and public health is a simple one: more foreign funding is clearly instrumental to the implementation of successful health policy and the decline of a disease. However, recent developments in domestic social policy indicate that this may not always be the case.

In March of this year, a new law was adopted by the government of Uganda, which puts a restriction on LGBT rights that is unseen in recent years.[3] Those who do not comply with the new law risk a lifelong prison sentence and in extreme cases even the death penalty. While this decision was widely criticized by European policy-makers for its violation of basic human rights, UNAIDS also points out the negative ways in which this law might affect public health, as it includes a duty to report any 'offences', with individuals who fail to do so even risking a six month prison sentence, making it much more difficult for healthcare professionals to provide aid to LGBT people.[4] This fear was proven accurate several weeks ago, when HIV clinics in the capital Kampala saw their admission numbers run back drastically.[5]

A possible explanation for this new bill is found in a recent policy brief by the Egmont Institute in Brussels. In this paper, authors point out the difficult relationship between the European Union (EU) and Uganda in recent years.[6] The latter's president Museveni has repeatedly proclaimed his discontent with European interference in Ugandan affairs, specifically relating to human rights and domestic politics. Furthermore, a recent liberalization of the Anglican Church's policy on homosexuality was met with dissent from Church leaders in several countries in the Global South, including Uganda, where the Church continues to be a very influential force in society.[7] Despite comments referring to Western policy-makers as fools and hypocrites, European countries continue to be amongst the largest donors of financial development aid to Uganda, as they have been for decades.[8] The continuation of foreign funding in spite of such negative developments begs the

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[1] World Bank, 'Prevalence of HIV, total (% of population ages 15-49) – Uganda,' https://data.worldbank.org/indicator/SH.DYN.AIDS.ZS?locations=UG. Accessed April 10, 2023.
[2] World Bank, 'Prevalence of HIV'.
[3] United Nations Human Rights, 'Uganda: UN experts condemn egregious anti-LGBT legislation,' https://www.ohchr.org/en/press-releases/2023/03/uganda-un-experts-condemn-egregious-anti-lgbt-legislation. Accessed on May 20, 2023.
[4] Joint United Nations Program on HIV/AIDS, 'UNAIDS urges the Government of Uganda to not enact harmful law that threatens public health,' https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2023/march/20230322_Anti-Homosexuality_Bill_Uganda. Accessed on June 10, 2023.
[5] Rédaction Africanews, 'Effects of Ugandan Anti-LGBT Law: Emptying HIV clinics,' https://www.africanews.com/2023/06/12/effects-of-ugandan-anti-lgbt-law-emptying-hiv-clinics/. Accessed on June 24, 2023.
[6] Egmont Institute, 'EU-Uganda Relations: Friction, Change or Business as usual?' https://www.egmontinstitute.be/eu-uganda-relations-friction-change-or-business-as-usual/. Accessed on April 10, 2023.
[7] Harriet Sherwood, 'Anglicans reject Justin Welby as head of global church amid anger at same-sex blessings', https://www.theguardian.com/world/2023/feb/20/anglicans-reject-justin-welby-as-head-of-global-church-amid-anger-at-same-sex-blessings. Accessed on June 10, 2023.
[8] Egmont Institute, 'EU-Uganda Relations,' 1.

question to what extend an improvement in public well-being is the primary objective, and or whether there are other motives at play here. The goal of this thesis is to understand the political and historical factors influencing such seemingly contradictory policy-decisions and to argue that health policy is driven by political motives. Therefore, this thesis will attempt to answer the following research question: How are health policies used as political instruments in the case of HIV/AIDS in Uganda?

Methodology

The complexity of global health issues is best voiced by medical anthropologist Paul Farmer, who argues that "global health is not yet a discipline, but rather a collection of problems."[9] Such complicated problems thus call for an interdisciplinary approach like the one that will be employed in this research. This thesis expands on the challenge socio-economically determined health issues by adding the political dimension. Recent research has shown how the socio-economic determinants of health are not a given, rather they are shaped by policy-decisions made by politicians.[10] Therefore, these issues require insights from the field of political science and, since this particular study deals with an international health issue, insights from the sub-field of international relations. The limited use of political science and international relations theory in the study of global health practice is currently considered insufficient by academics, as has been pointed out by the authors of the Lancet Series *Political Science and Health*, which was published last year.[11] For that reason, this study will first examine international relations theory to establish a theoretical framework that will be used throughout the thesis.

The above-mentioned political determinants are shaped by historical factors themselves, which includes certain socio-cultural factors. A historical perspective on its own cannot be used as a direct solution to any problem. What it can do is help us understand how these problems were shaped. Understanding is an indispensable factor when it comes to solving any issue, which is why part of this research will consist of a historical analysis of colonial policy in Uganda.

The historical part of this thesis will use a variety of primary sources including: historical government records from British colonial administrators in the late nineteenth and early twentieth centuries, missionary monographs and medical articles by British doctors in Uganda. The goal is to show how colonial health policy led to the construction of a new type of what sociologists call 'moral context' in Uganda.[12] Factors influencing the way in which this context was shaped can range from medical intervention to religion, and of course the socio-cultural context that predates colonial influence plays an important role as well. This section will show how the goals and effects of foreign health programs are historically not limited to health itself.

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[9] Paul Farmer, et al., *Reimagining Global Health: an Introduction*, (Berkeley: University of California Press, 2013): 2.

[10] On the political determinants of health: Johan P. Mackenbach, 'Political determinants of health,' *European Journal of Public Health* 24 no.1 (2014): 2. https://doi-org.proxy.library.uu.nl/10.1093/eurpub/ckt183

[11] The Lancet Series on 'Political Science and Health' (2022) argues in favor of the importance of political science and international relations theory in global health policy. https://www.thelancet.com/series/political-science-and-health. Accessed on April 10, 2023.

[12] Arthur Kleinman, 'Four Social Theories for Global Health'. *The Lancet* 375, no. 9725 (2010): 1518–1519. https://doi.org/10.1016/S0140-6736(10)60646-0

Finally, this thesis will examine Ugandan HIV/AIDS policy from the start of the epidemic in the late 1980s until today. The goal of this section is to show how the historical legacy of British colonial rule still shapes health policy made by Ugandan politicians today.

Theoretical Framework: International Relations Theory in Global Health

First, this thesis will draw on theory from the fields of international relations and social science in order to explain any potential underlying political motivations of engagement in global health initiatives throughout the history of Uganda. Plentiful literature exists on the international institutional aspects of global health, which is often called global health governance.[13] While the exact definition of the term is up to debate, its focus on institutions means that it mainly deals with the 'how's of the political dimensions of global health.[14] In this way, it does not adequately address the questions of why these institutions exist in the first place, and, what the ideological or political motivations are of its actors, which is where international relations theory can be of value. Examining different theoretical approaches to international relations, the goal is to identify a singular theoretical motivation for both state and non-state actors to engage in global health initiatives.

In order to observe global health initiatives from an international relations perspective, it is necessary to identify these actors, something that becomes more complicated (abstract) the further we zoom out. As a sub-field of political science, international relations concerns itself with the (inter-)actions of political entities, and primarily, the actions of nation-states on an international level. Different theoretical explanations exist for the ways in which these states interact with each other, but what defines this 'state'? A classic definition is given by Max Weber in his famous essay *Politik als Beruf*, in which he argues that a state is a political entity that is not defined by its ends, but by the means through which it is able to achieve those ends.[15] Among these means of the state are the existence of a geographically defined territory within which the state has a monopoly on the legitimized use of violence. Problems arise however, when we take into account the fact that the borders of these geographical territories are man-made fabrications, and the reality that health emergencies often transcend national borders. Authority and responsibility are difficult to pin-down in a global world, considering there is no supreme political entity above the state-level.

Liberal Internationalism: Cooperation through Institutions

One of the most prominent schools of thought in the field of international relations is liberalism (which is not dissimilar from the political ideology that shares the same name). It came into existence in the early twentieth century, following the establishment of international organizations like the United Nations, and related organizations such as the World Health Organization and the World Bank. It is praised for being one of the most optimistic theories within the field of international relations study, but this view has also been criticized for being too naïve.[16]

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[13]Ilona Kickbusch, et al., *Global Health Diplomacy: Concepts, Issues, Actors, Instruments, Fora and Cases* (New York: Springer, 2013), 18.

[14]Kelley Lee & Adam Kamradt-Scott, 'The Multiple Meanings of Global Health Governance: A Call for Conceptual Clarity,' *Globalization and Health* 10, no. 1 (2014): 28. https://doi.org/10.1186/1744-8603-10-28

[15] Max Weber, Politik Als Beruf (1919); English translation: 'Politics as a Vocation', in *Max Weber: Essays in Sociology*, edited and translated by HH Gerth and C. Wright Mills (New York: Oxford University Press), 1946, 77-128: Selected Topics, 1.

[16] Haro L Karkour. 'Liberal Modernity and the Classical Realist Critique of the (Present) International Order'. *International Affairs* 92, no.2 (2022): 569-586. https://doi-org.proxy.library.uu.nl/10.1093/ia/iiac006

A more fundamental point of criticism is aimed at the international system of institutions that liberalism argues to be one of the central drivers in global affairs. These institutions and the fact that they are primarily based on Western values and ideals mean that they are inherently exclusive to states and peoples where liberalism is not the dominant political ideology. Cooperation within this liberal system can only be pursued by those who are actually a part of it, which means that there is a problem when dealing with issues that are not bound by borders or ideology, such as global health.

Structural Realism: Anarchy and Power Politics

The realist school of thought argues that states are the primary actors in international relations and it does not believe cooperation based on liberal values to be rooted in reality. Rather, it makes the argument that secularization in the West resulted in the emergence of a moral vacuum and a sense of insecurity among individuals.[17] This insecurity ranges across all levels of society to include high-level policymakers. In order to deal with this sense of insecurity and lack of morality, political ideologies (such as liberalism) now take the place that religion previously had, as a moral guideline through life, including global affairs.[18] International cooperation based on liberal values it argues, is simply one way of dealing with this insecurity in a 'global state of anarchy', as there is no supreme political authority on an international level.[19] Ultimately, states act within their own best interests, which might take the form of cooperation when deemed beneficial or necessary. Power dynamics play an important role here, as friendly relations with powerful actors might increase one's own sense of security.

As states are mainly driven by their own national interests and power in the global political arena, the realist perspective argues against the role of humanitarian or philanthropic interests when engaging in global health initiatives. Strategic interests are likely to outweigh foreign public health concerns when conducting foreign affairs.

Traditionally, realism has viewed international politics and power from a coercive point of view: security is pursued either by engaging in warfare, or by refraining from it, this use of military force to force other states has also been described as 'hard power'. Thus, while this theory is able to make sense of some of the selfishness that has been observed in international policy decisions with regards to global health, its focus on this type of power means that it requires further attention to be properly applicable to state's responses to international health emergencies.

Soft Power and Global Health

The concept of soft power has already been briefly mentioned in the introduction, but no proper definition has yet been given. Joseph Nye described the concept as 'The ability of a country to structure a situation so that other countries develop preferences or define their interests in ways consistent with its own. This power tends to arise from such resources as cultural and ideological attraction as well as rules and institutions of international regimes.'[20] This concepts allows us to more accurately apply the realist theory to the topic of global health initiatives, as such health programs, and the liberal international institutions through which they are being transported, might be seen as cultural products themselves.

[17] Karkour, 'Liberal Modernity,' 570.
[18] Karkour, 'Liberal Modernity,' 571.
[19] David P. Fidler, 'Disease and Globalized Anarchy: Theoretical Perspectives on the Pursuit of Global Health,' *Social Theory & Health* 1, no. 1 (2003): 21–41. https://doi.org/10.1057/palgrave.sth.8700003.
[20] Joseph Nye, 'Soft Power,' *Foreign Policy* no.80 (1990): 153-171. https://doi.org/10.2307/1148580

States may decide to engage in global health initiatives for a variety of different reasons. First, health issues abroad may be targeted because they form a potential risk to domestic health and security, as is might be case with certain infectious diseases. Simultaneously, states might expect to obtain international prestige or to positively affect bilateral relations between itself and the donor country. In a world where non-communicable diseases (NCDs) make up the vast majority of the disease burden (both in the Global North, and in the Global South), the fact that over 75 per cent of international health programs target infectious diseases might be an indication of the role of soft power in this case.[21] Secondly, geopolitical interests might also play a role in a state's decision to engage in global health initiatives. The European Global Health Strategy might again serve as an example here. Critics have pointed out how the language used in the Strategy might be read as too 'strategic'.[22] The example posed is: '[the] need to enhance strategic resilience through diversifying and building EU capacity of supply chain, for critical equipment, countermeasures, diagnostics, and therapeutics', which seems to emphasize the strengthening of global health infrastructure and cooperation within Europe itself, rather than abroad.[23]

This idea is not that farfetched if we take into account certain major geopolitical developments that have taken place in recent years. First, the transatlantic relationship between Europe and the United States that characterized much of the second half of the twentieth century continued to weaken during the Trump administration.[24] Secondly, the rise of China and other middle-income countries as future economic competitors and the Chinese partnerships with Africa might explain why the EU Strategy emphasis EU-AU (African Union) partnerships.[25] Furthermore, the lack of uniformity in public health measures taken during the COVID-19 pandemic has highlighted political differences between the different EU member-states. Coupling these developments with the acute security risk following the outbreak of the first war in the region in decades, it makes sense that a more strategic and coordinated approach to global health might seem attractive to European policy-makers. Clearly, the global spread of liberal democracy and the subsequent 'end of history' that was propagated by Francis Fukuyama in the 1990s is not in sight.[26] Furthermore, a perceived challenge to the liberal values that characterize contemporary European society (for example, the newly adopted anti-LGBT law in Uganda) might be reciprocated by threats of financial repercussions, such as cuts in development aid funding, as was proposed by some members of the European Parliament.[27]

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[21] Arne Ruckert & Ronald Labonté, 'Public–private partnerships (ppp's) in global health: the good, the bad and the ugly', *Third World Quarterly* 35:9 (2014), 1604. https://doi-org.proxy.library.uu.nl/10.1080/01436597.2014.970870

[22] The Centre for Africa-Europe Relations. 'The EU Global Health Strategy: How to Make it Work' https://ecdpm.org/work/eu-global-health-strategy-how-make-it-work. Accessed on May 10, 2023.

[23] European Commission, *EU Global Health Strategy*, 15.

[24]Timothy Garton Ash, 'It's not just Trump. Much of America has turned its back on Europe,' https://www.theguardian.com/commentisfree/2018/sep/28/trump-america-europe-united-states. Accessed on May 10, 2023.

[25] Robert A. Blair, et al. 'Foreign Aid and Soft Power: Great Power Competition in Africa in the Early Twenty-First Century'. *British Journal of Political Science* 52, no. 3 (2022): 1355–1376. https://doi.org/10.1017/S0007123421000193

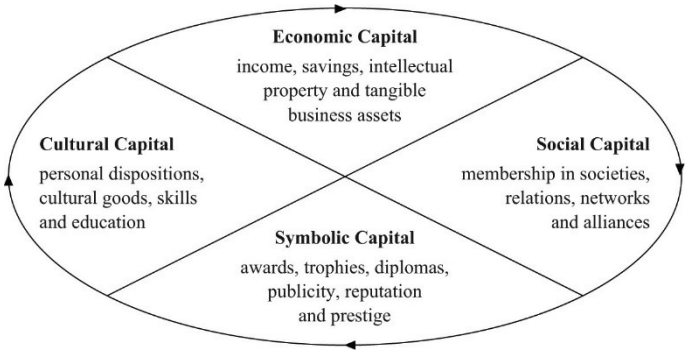
[26] Francis Fukuyama, *The End of History and the Last Man*, (New York City: Free Press, 1992).

[27] European Parliament, 'Uganda's anti-homosexuality bill,' https://www.europarl.europa.eu/doceo/document/P-9-2023-001272_EN.html. Accessed on May 15, 2023.

Non-State Actors and 'Capital' as Soft Power

So far, the emphasis in this article has been on the motivations of state actors when engaging in global health initiatives. To an extent, this is a logical consequence from the way in which international relations theorists have identified political actors, non-government actors such as philanthropists also play a role in global health. While individuals or private organizations are not driven by political power in the same sense as state might be, the concept does play a role, albeit in a slightly different form. Hanefeld and Walt use Pierre Bourdieu's different forms of *capital* to explain why private actors might engage in global health.[28] Bourdieu argued that power in society is primarily derived from different forms of *capital* (economic, cultural, social and symbolic) which are to an extend transferrable to each other.[29] This allows individuals who possess a large quantity of one type of *capital* to extend their influence to other societal aspects within their community.[30]

The example posed by Hanefeld and Walt is the Bill and Melinda Gates Foundation, a philanthropic organization that invests heavily in the global health sector, both in terms of interventions (primarily targeting infectious diseases in the Global South) and in scientific research. Through these investments, the organization is able to exchange its *economic capital* (financial means) for *cultural capital*, as its investments might lead to it becoming a cultural and intellectual authority in the global health field.[31] This, combined with the humanitarian prestige it might derive by investing in fighting infectious diseases, (which is arguably a more easily achievable goal than building health infrastructure or reducing the prominence of NCDs) might increase the Foundation's *symbolic capital*.



The different types of capital as described by Pierre Bourdieu.[32]

In the historical case-study of Uganda, an especially important factor that bridges the notions of symbolic and cultural capital is religion. This specific type of capital sometimes referred to as *sacred capital* has recently been used in the study of international relations by Gregorio Bettiza, who argues that some countries possess a high amount of sacred capital due to the presence of locations or

[28] Johanna Hanefeld & Gill Walt, 'Knowledge and Networks: Key Sources of Power in Global Health: Comment on "Knowledge, Moral Claims and the Exercise of Power in Global Health",' *International Journal of Health Management and Policy* 4, no. 2 (2015): 119-121. doi: 10.15171/ijhpm.2015.25
[29] Pierre Bourdieu, 'The Forms of Capital'. *Handbook of Theory and Research for the Sociology of Capital*. J. G. Richardson. New York, Greenwood Press: 241-258.
https://home.iitk.ac.in/~amman/soc748/bourdieu_forms_of_capital.pdf
[30] Bourdieu, 'The Forms of Capital,' 24.
[31] Hanefeld, 'Knowledge and Networks,' 121.
[32] Tobias Pret, et al., 'Painting the Full Picture: The Conversion of Economic, Cultural, Social and Symbolic Capital,' *International Small Business Journal: Researching Entrepreneurship* 34, no.8 (2016): 1004-1027. https://doi-org.proxy.library.uu.nl/10.1177/0266242615595450

institutions that are of great religious significance.[33] Examples include the Vatican, Jerusalem, and, in the case of Britain and Uganda: the former one's primacy in the global Anglican Church communion, which, as this thesis will show, played a significant role in the spread and implementation of Western medicine and health policy in Uganda.

Bourdieu's *capital* shares similarities with Nye's *soft power*, as both rely on appeal rather than coercion in their efforts to persuade other actors. This section has showed how such soft power tools (which might range from investments in healthcare interventions to the liberal institutions that make up global health governance) fit within the realist framework, within which national or personal interests are the dominant factor in conducting international affairs. The next step is to apply this framework to the case-study of Uganda under British rule.

Missionary Medicine and the Establishment of British Imperial Rule in Uganda

This section will deal with the historical roots of foreign intervention and the introduction of Western medicine in Uganda. It will try to explain how, the British empire attempted to establish *cultural capital* in Uganda through its collaboration with the Anglican missions of the Church Missionary Society and how this enabled British administrators to use religion as a soft power tool for establishing colonial rule in the following decades. I will show how the provision of medical aid in the context of missionary work was used by British imperialists to further their evangelizing mission and assert hegemony in the region.

In 1874, a decade after British explorer John Speke had been the first European set foot in Uganda on his search for the source of the Nile, Henry Morton Stanley visited Mtesa, the *kabaka* (king) of Buganda (a kingdom in the south of Uganda) on his journey through Africa. After returning to Britain he published an article in the *Daily Telegraph* in which he urged Christian missionaries to direct their evangelical endeavors toward the native population of this 'pearl' of East Africa.[34] His call was answered shortly after by engineer Alexander Murdoch Mackay (1849-1890) and other members of the Church Missionary Society (CMS), who launched their first mission to Uganda in 1878.[35] While its primary mission was one of evangelization, the activities of the CMS would be instrumental in paving the way for British imperial rule in the country.[36] Furthermore, as this chapter will show, the introduction of Western medicine in early-colonial Uganda was intimately connected to the establishment of Christianity as the dominant religion by European missionaries.

Missionaries of the CMS largely based their knowledge of the region on reports of Stanley and other British explorers, and therefore settled in Buganda, a region that, unlike some contemporary accounts, was not 'left severely alone… like some haunted chamber in a great mansion…'.[37] On the contrary, it was one of multiple states in the south of Uganda and had developed its own centralized

[33] Gregorio Bettiza, 'States, Religions, and Power: Highlighting the Role of Sacred Capital in World Politics,' Berkley Center, 2020. https://s3.amazonaws.com/berkley-center/200330BettizaStatesReligionsPowerHighlightingRoleSacredCapitalWorldPoliticsWorkingPaper.pdf

[34] Henry Morton Stanley, 'Letters of Mr. H. M. Stanley on His Journey to Victoria Nyanza, and Circumnavigation of the Lake,' *Proceedings of the Royal Geographical Society of London* 20, no. 2 (1875): 149. https://doi.org/10.2307/1799875.

[35] Herbert Gresford Jones, *Uganda in Transformation 1876-1926* (London: The Camelot Press Limited, 1926), 19-20.

[36] Kathleen Vongsathorn, 'First and Foremost the Evangelist? Mission and Government Priorities for the Treatment of Leprosy in Uganda, 1927-1948,' *Journal of East African Studies* 6, no.3 (2012): 544. doi: 10.1080/17531055.2012.696906.

[37] Gresford Jones, *Uganda in Transformation*, 1.

and hierarchical administrative structure over the course of its centuries-long existence.[38] Furthermore, the Baganda (the people of Buganda) had established contact with Arab traders, which would prove to be crucial to the early successes of Christian missionaries who came to the country, as they relied on pre-established trade routes from Zanzibar.[39] Additionally, knowledge of Islam is believed to have made the Baganda people more open to the introduction of other monotheistic faiths such as Christianity.[40]

Nevertheless, traditional belief-systems and culture had also been well-preserved, and some indigenous medical practices were considered to be fairly advanced by Europeans.[41] This claim is largely based on a lecture given to the Edinburgh Obstetrical Society by missionary and medical doctor Robert Felkin (1853-1926) on the use of caesarean sections in childbirth in Uganda in 1884. In 1878 Felkin (while still a medical student at the University of Edinburgh) travelled to Uganda on the first CMS mission, after which he soon became the personal physician of king Mtesa.[42] On one of his travels, he wrote a detailed report describing the way in which a caesarean section was performed by a team of traditional medical practitioners using alcohol ('banana wine') as an anesthetic.[43] He notes that both the mother and her new-born child suffered only minor injuries from the procedure which healed within eleven and four days, respectively.[44] While the one success-story that Felkin observed might have been a lucky coincidence, his statement that Uganda was the only place in central Africa where such advanced healthcare was practiced is in line with the British perception of Bugandan society as 'more advanced' than other peoples in the Central and East Africa regions. A view that would contribute to the dominant position of Buganda in the later Uganda Protectorate. In a similar vein of thought, Christian missionaries considered the Baganda people to be more 'ready for civilization' and thus more receptive to their evangelizing message.[45]

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[38] Aidan Stonehouse, *Peripheral Identities in an African State: A History of Ethnicity in the Kingdom of Buganda since 1884*, (Leeds: University of Leeds, 2012), 19.
[39] Gresford Jones, *Uganda in Transformation,* 14.
[40] N.Q. King, et al., *Islam and the Confluence of Religions in Uganda 1840-1966* (Tallahassee: American Academy of Religion, 1973), 14.
[41] Seggane Musisi, 'Afrocentrism and Healthcare: The Legacy of Colonial Medicine in Uganda,' https://www.afyanahaki.org/download/afrocentrism-and-healthcare-the-legacy-of-colonial-medicine-in-uganda/. Accessed on May 15, 2023.
[42] Peter Dunn, 'Robert Felkin MD (1853-1926) and Caesarean Delivery in Central Africa (1879)'. *Archives of Disease in Childhood - Fetal and Neonatal Edition* 80, nr. 3 (1999): 250–251. http://dx.doi.org/10.1136/fn.80.3.F250
[43] Dunn, 'Robert Felkin MD,' 250-251.
[44] Dunn, 'Robert Felkin MD,' 250-251.
[45] Yolana Pringle, 'Crossing the Divide: Medical Missionaries and Government Services in Uganda, 1897-1940,' in *Beyond the State: The Colonial Medical Service in British Africa* (Manchester: Manchester University Press, 2016). https://doi-org.proxy.library.uu.nl/10.7228/manchester/9780719089671.001.0001

Drawing of a traditional Bugandan c-section from the report of Robert Felkin.[46]

Little confusion is possible on what missionaries considered to be the primary aim of their works in Uganda. Alfred Robert Tucker (1849-1914), who served as Anglican bishop of Kampala in the early twentieth century, summarized this goal as "a knowledge of Christ, the Way, the Truth, and the Life".[47] This reaffirms the view of some authors, that medical practices by missionary doctors were primarily a tool to further the spread Christianity amongst the Ugandan population.[48] The fact that both medicine and religion were strongly intertwined is also reflected in the writings of doctor Albert Cook (1870-1951), who stated that "no fame or pleasure or wealth or power can compare with the joy of tending these sick ones or of trying to bring them to the Savior of sinners and the loving Friend of the sick".[49] While some medical practitioners might have hoped that physical healing would increase the appeal of Christianity among potential converts, sub-par medical care was sometimes justified based on the belief that spiritually saving a larger number of patients was more important than providing the best possible care to a smaller number of patients.[50] Apart from such religious motives, missionary societies also had a financial interest in providing medical care, as they relied on patient fees for a large portion of their income during this time period.[51]

Acceptance of Christianity seems to have been fairly positive and rapid based on contemporary accounts. Herbert Gresford Jones (1870-1958) notes of missionary and engineer Alexander Mackay that "It was he [Mackay] more than any other who so implanted a living devotion to Christ in the African breast that within eight years of the advent of His Gospel, Africans were prepared to die for Him [God]." [52] Over the course of his stay, Mackay became an influential figure at the royal court in Buganda.[53] Part of Mackay's success can be attributed to the fact that local elites saw in Christianity a

[46] Dunn, 'Robert Felkin MD,' 250-251.
[47] Gresford Jones, *Uganda in Transformation*, 191.
[48] Shane Doyle, 'The Blessings of Medicine? Patient Characteristics and Health Outcomes in a Ugandan Mission Hospital, 1908-1970,' *Social History of Medicine* 33, no.3 (2019), 947. https://doi.org/10.1093/shm/hky125
[49] Gresford Jones, *Uganda in Transformation*, 170-171.
[50] Charles Good, *The Steamer Parish: The Rise and Fall of Missionary Medicine on an African Frontier* (Chicago: University of Chicago Press, 2004), 407.
[51] Shane Doyle, "Missionary Medicine and Primary Health Care in Uganda: Implications for Universal Health Care in Africa," In: Medcalf A, Bhattacharya S, Momen H, et al., editors. *Health For All: The Journey of Universal Health Coverage*, (Orient Blackswan, 2015), 73-81. https://www.ncbi.nlm.nih.gov/books/NBK316272/
[52] Gresford Jones, *Uganda in Transformation*, 25.
[53] Gresford Jones, *Uganda in Transformation*, 31.

way to reassert their own dominant position within Bugandan society.[54] This was essentially made possible by the functioning of local political culture: It was customary in Bugandan society for the kingdom's laws and traditions to be essentially remade in the first year after a new *kabaka*'s success.[55] Local chiefs thus sought to use this short timeframe to imbed their version of Christianity into the existing (political) culture. Due to its prominence amongst these local elites and the popularity of British CMS missionaries like Mackay, Anglicanism eventually became the dominant Christian denomination within the Kingdom of Buganda.[56]

This was instrumental to the British colonial enterprise which was primarily based on indirect rule, and thus relied on the willingness of local rulers to cooperate with British administrators.[57] This can be explained by expanding upon the previously established framework of soft power and capital. International Relations scholar Gregorio Bettiza argues that some countries possess a large quantity of a specific type of *cultural capital* that he calls *sacred capital*, which they derive from the presence of locations or institutions that are of spiritual significance.[58] Examples of this include the Vatican in Italy, Jerusalem in Israel and more recently, the United States as a self-proclaimed champion of Christianity. The Anglican Church can, through the supremacy of the Archbishop of Canterbury, be seen as essentially a British imperial institution, a view that is also reflected in missionary statements such as 'To the Anglican all fields which lie beneath the British flag are presumably him to occupy'.[59] Similarly to the above-mentioned examples, this means that Anglicanism as an institution could be used as a 'soft power' tool by British administrators in establishing their collaborative relationships with local rulers.

Missionary activities also more directly contributed to the establishment of British rule through their collaboration with the Imperial British East Africa Company. The Company, which had threatened to leave Uganda due to a lack of commercial potential, was eventually persuaded to stay by bishop Alfred Tucker in 1891.[60] The claim for British presence was further strengthened by the international legitimacy Britain could derive from the 1884-1885 Berlin Conference, which opened the way for Britain to expand its sphere of influence in East Africa.[61] These developments paved the way for the establishment of Uganda as a British Protectorate in 1893, of which the Kingdom of Buganda would become the administrative center.

The institutionalization of British rule and Western medicine

Throughout the colonial period and across the British empire, healthcare was provided by two sources: the medical services provided by the Christian missionary societies, and the public health service of the British colonial administration. However, the exact degree to which these two types of medical service in late nineteenth and early twentieth century Uganda differed has been up to debate by historians. Some have argued that both types of medicine served different groups of people:

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[54] Neil Kodesh, 'Renovating Tradition: The Discourse of Succession in Colonial Buganda,' *International Journal of African Historical Studies* 34, no.3 (2001), 512. https://doi-org.proxy.library.uu.nl/10.2307/3097552
[55] Kodesh, 'Renovating Tradition,' 512.
[56] Stonehouse, *Peripheral Identities*, 193.
[57] Stonehouse, *Peripheral Identities*, 10.
[58] Bettiza, 'Sacred Capital,' 2-3.
[59] Gresford Jones, *Uganda in Transformation*, 223.
[60] Gresford Jones, *Uganda in Transformation*, 42
[61]The Berlin Conference is generally regarded as the formalization of what historians call the 'Scramble for Africa', during which European powers claimed large parts of the African continent as part of their imperialist project.

missionary medicine would primarily have been concerned with the health of the native population on an individual level.[62] On the other hand, the public health services of the colonial government would see the health of the overall population as a necessity for the economic prosperity of the protectorate and its contribution to the empire.[63] As has been pointed out by Yolana Pringle however, a clear division between missionary and government healthcare is nearly impossible, as doctors would often fulfill a 'dual role' as medical officer and missionary, and collaboration between the two types of health works was fairly common throughout much of the colonial period.[64] Through the way in which Western healthcare was implemented in Ugandan society, the British tempted to create a culture in which Western medicine held hegemony over traditional practices.

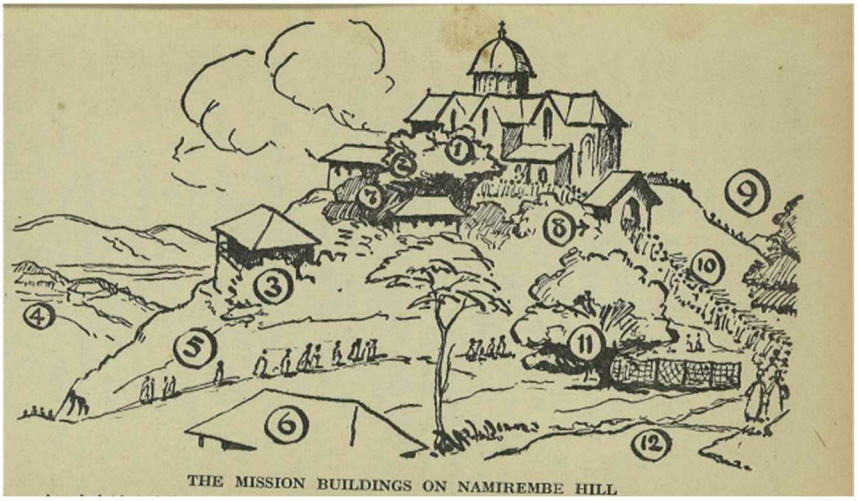
As British rule started to become institutionalized in Uganda following the establishment of the Protectorate, so did the medical missions of the CMS, which had remained rather informal for the first two decades of its presence. In 1897 the Mengo Hospital, the first European hospital in the country, was opened by Dr. Albert Cook in the capital Kampala.[65] The hospital was located on the eponymous hill, which was also home to the local cathedral, missionary school, and the bishop's home, reflecting the centrality of Christian conversion to the medical works of missionary doctors. Aside from being the first hospital to open in Uganda (and the only hospital to own an X-ray machine in the country for most of the colonial period) the significance of this hospital was two-fold. First, it showed the continuation of the evangelical mission as contemporaries noted that "[the hospital] has done a service to the cause of Missions and the cause of Christ for which we cannot be too thankful."[66] The larger number of patients that could be treated in the Mengo hospital and its location in a completely Christian surrounding helped to stimulate native conversion.[67] Secondly, due to its relatively high patient rates and advanced technology, the mission hospital would come to play an important advisory role in the making of colonial healthcare policy in Uganda.[68]

Annual British colonial reports on Uganda from the first decades of the twentieth century reveal that British imperial health policy was primarily concerned with epidemics of infectious diseases such as plague, malaria, venereal disease and sleeping sickness.[69] An epidemic of sleeping sickness which had started in 1901 would prove a particularly problematic disease to the British rulers, as it wiped out a significant portion of the population of the region of Busoga in western Uganda.[70] As Dr. Cook himself would put it in 1907, this was problematic to the colonial administrators for two reasons: "In the first place, they were for the most part men in the prime of life, paying hut-tax etc. and thus directly profitable to the Administration, as well as forming no inconsiderable part of the wage-earning members of the community, and their deaths also directly decrease the by no means large population."[71] With the profitability of the colony at risk the British resorted to untested interventions

[62] Doyle, 'Missionary Medicine and Primary Health Care,' 73.
[63] Doyle, 'Missionary Medicine and Primary Health Care,' 74.
[64] Pringle, 'Crossing the Divide,' 21.
[65] Pringle, 'Crossing the Divide,' 21.
[66] John Jamieson Willis, *The Church in Uganda: A Charge to Missionaries of the Uganda Mission 1913*, (London: Longmans, 1914), 8.
[67] Pringle, 'Crossing the Divide, 22.
[68] Pringle, 'Crossing the Divide,' 21-22.
[69] Annual Reports on the Colonies – Uganda (1904-1920). http://hdl.handle.net/10111/UIUCAFRICANA:Serial/466563
[70] Gresford Jones, *Uganda in Transformation*, 89.
[71] Albert R. Cook, 'On Sleeping Sickness as Met with in Uganda, Especially with Regard to Its Treatment'. *Transactions of the Royal Society of Tropical Medicine and Hygiene* 1 (1907): 25. https://doi.org/10.1016/S0035-9203(07)90008-5.

to try and halt the disease. Famed biologist Robert Koch visited German East Africa (Tanzania) in the early twentieth century to experiment with the drug Atoxyl as a possible cure for the disease.[72] Despite its name, the drug proved highly dangerous for human use, as it caused varying levels of blindness in up to 20% of injected people. Furthermore, later research showed that the minimal effective dose of the drug and the maximal tolerated dose were almost identical, meaning that there was a very thin line between (potential) cure and death.[73] Given the drug's limited effectiveness, Koch proposed the usage of internment camps to isolate infected people and halt the spread of the disease in the region, a method that would also be employed by British administrators in Uganda.[74]

The early fascination with traditional medicine practices that we see in the case of Felkin's lecture on obstetrics quickly dissipated in the first decades of colonial rule. One early twentieth century drawing of Mengo Hill in Kampala illustrates this even more clearly: the cathedral is front and center with a long procession of people entering the church, presumably going to mass. Mengo Hospital itself is located on the backside of the hill and sees a similarly impressive line of people entering the building. In his attempt to show off this hill as the new and Christian center of Uganda (presumably), the *kabaka*'s hill and palace are sort of discarded to the background (drawn with less detail etc). This illustrates the way in which traditional (a difficult term to use in the case of Buganda given the aforementioned way in which new kings could 'recreate' society) culture had become a thing of the past in British eyes, something that is reflected by colonial healthcare policy that sought to reform it.



'The Mission Buildings on Namirembe Hill.'[75]

An important part of pre-colonial healthcare were the *balerwa*, traditional midwives that used massage techniques and herbal medicine to aid women in giving birth.[76] These healers had traditionally held a prominent role in local society, as their work was instrumental to what is arguably the most fundamental type of healthcare. This powerful position in society was based on the knowledge (*cultural capital*) they possessed of specific approaches to healing and pain relief. Evidently, the British saw this as a threat to their colonial effort.

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[72] Daniel R. Headrick, "Sleeping Sickness Epidemics and Colonial Responses in East and Central Africa, 1900-1940," *PLOS Neglected Tropical Diseases* 8, no.4 (2014): 1-8. doi: 10.1371/journal.pntd.0002772.
[73] Headrick, 'Sleeping Sickness Epidemics,' 3-4.
[74] Headrick, 'Sleeping Sickness Epidemics,' 4.
[75] Gresford Jones, *Uganda in Transformation.*
[76] Alexander Paul Isiko, *Gender Roles in Traditional Healing Practices in Busoga*, (Leiden: Leiden University, 2018): 125. https://scholarlypublications.universiteitleiden.nl/access/item%3A2904502/view

The institutionalization of Western obstetrics began with the requirement for midwives to own a certificate in the early twentieth century, an inherently Western notion of knowledge qualification.[77] This was followed several years later by the prohibition of traditional practices under the Witchcraft Ordinance of 1912 (and the later Witchcraft Act of 1957).[78] By outlawing these *balerwa* the British attempted to deprive them of the cultural capital that traditional healers had enjoyed in society. Furthermore, the reshaping of local laws, combined with the increasing number of hospitals and public health interventions can be seen as an attempt by the British to reframe their own *cultural capital*, which up to that point had been based on religious beliefs. An attempt that would not remain unchallenged by locals.

In 1914 a religious group colloquially known as the 'Malakites' (followers of Malaki) emerged in Uganda.[79] As a countermovement to the dominant Anglican denomination of the British rulers, the group (which included prominent members of the Buganda elite) believed the Europeans to have become too far removed from the teachings of the Bible that they themselves had introduced to the country. Their critique was primarily aimed at the biomedical approach to healthcare, which they believed to be similarly akin to witchcraft as the traditional healing methods that the British had outlawed just two years prior. As part of their protest the Malakites refused to take any Western medicine, which they considered to be a form of 'colluding with the forces of evil'.[80]

What makes this case interesting is the above-mentioned fact concerning the *kabaka*'s ability to 'remake' pre-colonial traditions in Ugandan society and its contradiction to the Western notion of traditions as being inseparable from an ancient past. After only several decades of Western political and cultural intervention, these Malakites were now advocating a form of Christianity that they considered to be more traditional (closer to the Bible) than the people who brought them into contact with that tradition in the first place. In doing so, native people were now not merely challenging the authority of the British imperial authority, rather their criticism was more fundamental, and aimed at the religious institutions and thereby, the *cultural capital* that the British had attempted to base their rule on. Moreover, their critique was an indication of the growing incompatibility between local and foreign cultural values. This compatibility had been crucial in the interaction between British missionaries and Buganda elites in the 1870s and 80s and continues to play an important part in Ugandan health policy today. Furthermore, the above-mentioned conservative Christian beliefs did not disappear with the Malakites after the Second World War and are leading in many HIV policy decisions.

[77] Isiko, *Gender Roles*, 125.
[78] Isiko, *Gender Roles,* 125.
[79] Jason Bruner, "What is a European Hospital but a Pagan Shrine? Missionaries, Progress, and the Problem of Materiality in Colonial Uganda," *Material Religion* 14, no. 3 (2018): 314-338. https://doi-org.proxy.library.uu.nl/10.1080/17432200.2018.1485429
[80] Bruner, 'What is a European Hospital,' 320.

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The Cultural Legacy of Colonialism in Ugandan HIV/AIDS Policy

Human suffering can be caused or intensified by social and political factors.[81] While studies on the social determinants of health exist in plenty, the argument that these social determinants are importantly shaped by political factors has only really gained prominence in the last fifteen years.[82] In the case of Uganda, the interplay between political circumstances and social determinants of health is starkly visible in the country's responses to the HIV/AIDS epidemic, which has been importantly shaped by a colonial legacy of foreign interference.

Christianity continues to be the largest religion in Uganda. Both in the country as a whole and across its different regions the vast majority of people adhere to either the Anglican or the Catholic denomination.[83] Furthermore, the amount of people actively practicing their religious beliefs is similarly high, with attendance at religious events such as mass estimated to be around eighty per cent.[84] This makes religious organizations such as the Church of Uganda very influential cultural actors in society. In the field of healthcare in particular, the continuing influence of religious or fate-based organizations (FBOs) as providers of healthcare is fairly high, with thirty per cent of all healthcare facilities (such as hospitals and personnel) in the country being run by these organizations.[85] As a result, many scholars have tried examined the relationship between the dominance of religion-based healthcare providers and the HIV epidemic in Uganda.

In a case-control study of about 500 people in central Uganda, researchers found a higher level of religiosity, expressed by practices such as prayer, church attendance and other religious activities and experiences to be associated with a lower HIV infection rate among Ugandan youths.[86] Another study found that in areas that are nearer to historical missionary stations HIV rates are actually higher than in more remote regions, which it blames on the negative perceptions of condom use and contraception that a religious organization might advocate.[87] Despite their conflicting results, both cases highlight the profound influence of religious organizations in shaping cultural and moral values within their community and in Ugandan society as a whole.

The prominence of religious healthcare providers is closely tied to broader political developments in Uganda as after the colonial period, these healthcare providers continued to emerge in places and times of a (power) vacuum as a result of political turmoil. [88] Not surprisingly then, many people in

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[81] On the social and political dimensions of human suffering, see, for instance: Arthur Kleinman, et al. *Social Suffering.* Berkeley: University of California Press, 1997.
[82] For example: Daniel E. Dawes, *The Political Determinants of Health*. Baltimore: Johns Hopkins University Press, 2020.
[83] Robert Lloyd et al., *Religion and Healthcare in East Africa: Lessons from Uganda, Mozambique and Ethiopia*, (Bristol: Policy Press, 2019): 44.
[84] Lloyd, *Religion and Healthcare in East Arica*, 49.
[85] Lloyd, *Religion and Healthcare in East Africa*, 51.
[86] M. Kagimu et al., 'Religiosity for HIV prevention in Uganda: a case study among Christian Youth in Wakiso District,' *African Health Sciences* 12, no. 1 (2012): 17-25.
[87] Center for Economic and Policy Research, 'The devil is in the detail: Christian missions' heterogeneous effects on development in sub-Saharan Africa,' 2017. https://cepr.org/voxeu/columns/devil-detail-christian-missions-heterogeneous-effects-development-sub-saharan-africa. Accessed on June 10, 2023.
[88] Sam Orochi Orach et al*., Is Religion Relevant in Health Care in Africa in the 21st Century? – The Uganda Experience*, 3. https://s3.amazonaws.com/berkley-center/09ARHAPReligionRelevantAfrica.pdf

Uganda are more inclined to trust religious organizations than government officials, whose public services are often found to be inefficient, lacking or corrupt.[89]

Early HIV/AIDS Policy: International Collaboration

When the HIV/AIDS epidemic first came to Uganda in the late 1980s, the country had just witnessed years of political turmoil. A war with Tanzania in the late 1970s and the civil war that followed had effectively dismantled the existing political system. As a result healthcare infrastructure was virtually non-existent when the epidemic hit. To the new president Museveni, this was not simply a threat to public health, rather it jeopardized his ideal view of Ugandan society, which he believed was witnessing 'the erosion of [Christian] cultural attitude and practices to sex'.[90] This conservative religious attitude helped him win over local religious authorities in support of his moralistic HIV agenda, many of whom were directly confronted by the epidemic through members of their congregations. This was also an important political move for Museveni, given the aforementioned fact that the general public was more inclined to trust faith-based organizations than political institutions.

Apart from this goal of preserving his moral values, Museveni seemingly recognized in the epidemic an opportunity to rebuild the Ugandan state and for it to gain a prominent position in global affairs. The president initiated a policy of openness on the disease and was very successful in his diplomatic ability to persuade foreign governments and organizations into investing in his country, who praised the president for his personal commitment in curbing the spread of the disease.[91] Internally, the primary goal of his HIV policy was to change people's behavior in accordance with his own conservative Christian moral beliefs and primarily focused on the promotion of abstinence and faithfulness.[92] Little investment was made with regards to syndromic management or with the building of healthcare infrastructure, which limited the implementation of health initiatives such as a World Bank-funded HIV/AIDS program in the mid-1990s.[93]

Nevertheless, Museveni's efforts proved successful in raising the international position of Uganda, as the country would come to be known as 'Africa's success story' and became an international authority in combatting the HIV/AIDS epidemic in the early 2000s. As a result, Ugandan HIV/AIDS policy-makers rose to international prominence with people such as former Minister of Health Chrispus Kiyonga being appointed as the first head of the Global Fund in 2002.[94] The 'success story' rhetoric was also used by US president George W. Bush when the President's Emergency Plan for Aids Relief (PEPFAR) was first introduced by his government in 2003.[95] Since then, this global health initiative has been a large funder of HIV/AIDS-related research, treatment and prevention programs. In both cases, Uganda received the majority of financial funds from these global health initiatives. An important factor in the success of Museveni's international success was the compatibility of his

[89] Erasmus Otolok-Tanga, et al., 'Examining the actions of faith-based organizations and their influence on HIV/AIDS-related stigma: A case study of Uganda,' *African Health Sciences* 7, no. 1 (2007): 55-60. doi: 10.5555/afhs.2007.7.1.55.
[90] Shane Doyle, 'Pandemics and Soft Power: HIV/AIDS and Uganda on the Global Stage,' *Journal of Global Health* 15, (2020) no. 3: 483. doi:10.1017/S1740022820000248.
[91] Doyle, 'Pandemics,' 484.
[92] Doyle, 'Pandemics,' 484.
[93] Justin O. Parkhurst & Louisiana Lush, 'The Political Environment of HIV: lessons from a comparison of Uganda and South Africa,' *Social Science & Medicine* 59 (2004): 1913-1924. doi: 10.1016/j.socscimed.2004.02.026.
[94] Doyle, 'Pandemics,' 487.
[95] Doyle, 'Pandemics,' 488.

traditional Christian values with the views of the US government at the time.[96] Furthermore, the emphasis Museveni placed on behavioral change as a means of fighting the epidemic was in line with the neoliberal approach to development aid and health initiatives that became dominant during the 1990s and early 2000s, as it similarly focused on the responsibility of the individual in health issues. This shows how both parties' political and cultural interests were compatible with each other, similar to what we observed with early missionaries in the late nineteenth century.

The Global North-South Schism

The moral-cultural compatibility between Uganda and other international actors has started to erode in recent years, not least so between Museveni and the overarching organization of his own church, which has witnessed the growing of a schism over the conflict of homosexuality since the late 1990s.[97] This is an important development for understanding Ugandan policy-making, given the long-standing position of both interior and exterior religious organizations as important possessors of *cultural capital* in society. While political decolonization in Uganda occurred in the 1960s, the Church of England and the Archbishop of Canterbury continued to be the primary holders of *cultural capital* within the global Anglican Communion.[98] The current schism therefore largely takes the form of a cultural drift between the Global North and the Global South. This can be explained by the fact that Western liberalism is often seen as a 'foreign ideology' that is not necessarily compatible with local cultural and religious values.[99] This is reflected by the rise of religiosity in many developing countries in opposition to secular ideologies.[100] As a result of this and the growing population in many African countries, the Anglican Communion primarily continues to grow in the Global South, where it takes a more conservative character than in the North.[101]

As the conservative form of Anglicanism becomes more widespread than the progressive one, *capital* and power shifts away from its original source in what has been called a decolonization of the Anglican Church. One example of this is the ordaining of African bishops to church dioceses in the US that were deemed to be too progressive for the Anglican Communion.[102] This schism and the shift of *cultural capital* within the Anglican Communion is also reflected by the response of Anglican Church leaders to the new anti-LGBT law. The Archbishop of Canterbury responded critically and urged Ugandan Anglicans to reject the anti-gay law.[103] The domestic church gave the exact opposite response, with Archbishop Mugalu of the Church of Uganda praising the president for adopting this law.[104]

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[96] Doyle, 'Pandemics,' 490.
[97] Andrew McKinnon, et al., 'Bourdieu, Capital, and Conflict in a Religious Field: The Case of the 'Homosexuality' Conflict in the Anglican Communion,' *Journal of Contemporary Religion* (2011). doi:10.1080/13537903.2011.616033.
[98] McKinnon, 'Bourdieu,' 20.
[99] Fabian Winiger & Simon Peng-Keller, 'Religion and the World Health Organization: an Evolving Relationship,' *BMJ Global Health* 6 (2021), 7. http://dx.doi.org/10.1136/bmjgh-2020-004073.
[100] Lloyd, *Religion and Healthcare in East Africa*, 49.
[101] McKinnon, 'Bourdieu,' 16.
[102] McKinnon, 'Bourdieu,' 15.
[103] Reuters, 'Archbishop of Canterbury urges Ugandan Anglicans to reject anti-gay law,' https://www.reuters.com/world/africa/archbishop-canterbury-urges-ugandan-anglicans-reject-anti-gay-law-2023-06-09/. Accessed June 10, 2023.
[104] John Sandeman, 'New anti-lgbt law welcomed by Church of Uganda,' https://theothercheek.com.au/new-anti-lgbt-law-welcomed-by-church-of-uganda/. Accessed June 10, 2023.

The drifting apart between Uganda and Western actors is also reflected by the changing nature of certain global health initiatives. PEPFAR, which had initially been a neoliberal and conservative program emphasizing individual agency and responsibility for prevention, became more progressive in 2009 under the Obama administration, who reduced the amount of aid funding that could be allocated to prevention programs emphasizing abstinence. This was received by Christian parties in Uganda as a form of betrayal.[105]

As a result of these developments, the Ugandan government has taken increasingly hostile actions towards the international community and Western nations in particular. In 2021 the president temporarily forced the Democratic Governance Facility to suspend its activities, an action that should primarily be perceived as a symbolic display of power over international actors.[106] Another example is the introduction of new legislation in 2022, which dictates that all foreign aid funding must go through government agencies which, given the highly consolidated nature of Ugandan political power at the moment, allows Museveni to directly assert his influence over development aid.[107]

In recent years, Museveni's rule has increasingly been characterized by authoritarian inclinations. The number of high-level state officials with any meaningful influence is severely limited, and formal institutions are often bypassed by informal relations.[108] One thing that authoritarian leaders have in common is that the duration of their reign is an ongoing uncertainty, as their regimes are generally not dependent on public approval. Furthermore, as we saw in the case of the Malakites' cultural religious resistance to British medical practices, political power does not necessarily translate to *cultural capital*. This is also reflected by the persistence of traditional medical services and the lack of trust in government services.

An interview-based study into the prevalence of traditional medicine among HIV patients who were receiving antiretroviral therapy found that around 33.7% were also using traditional healing methods as part of their treatment.[109] Another study found a fairly similar rate in hospital patients, with 32.8% of people using traditional herbal medicine in combination with their prescribed medicine.[110] One reason for the prominence of traditional healers was already mentioned in the previous paragraph, and has to do with the lack of public health services. Most communities have at least one traditional healer, whereas formal hospitals might be far removed. Furthermore, the ratio of traditional healers to the population is significantly higher than the ratio of formal health workers to the population.[111] The use of traditional healers is also reinforced by cultural beliefs that HIV is a result of witchcraft, or a curse from God. The social stigma that results being infected might make religious facilities a less

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[105] Lydia Boyd, *Preaching Prevention: Born-Again Christianity and the Moral Politics of AIDS in Uganda (Perspectives on Global Health)*, (Columbus: Ohio University Press, 2015): 4.
[106] Bram Dijkstra, *Uganda's Future: Navigating a Precarious Transition – The Role of the International Community*, (New York: Open Society Foundations, 2022): 21. https://www.opensocietyfoundations.org/uploads/b7e2f972-c1a9-4455-bd8d-bce660a450ae/uganda's-future-navigating-a-precarious-transition-20220704.pdf.
[107] Dijkstra, *Uganda's Future*, 24.
[108] Dijkstra, *Uganda's* Future, 9.
[109] Betty Namuddu et al., 'Prevalence and Factors Associated with Traditional Herbal Medicine use among patients on highly active antiretroviral therapy in Uganda,' *BMC Public Health* 11 (2011). https://doi.org/10.1186/1471-2458-11-855.
[110] Deanne Langlois-Klassen et al., 'Use of Traditional Medicine by AIDS Patients in Kabarole District, Western Uganda,' *American Journal of Tropical Medicine and Hygiene* 77 (2007) no. 4: 757-763. http://dx.doi.org/10.4269/ajtmh.2007.77.757.
[111] Orach*, Is Religion Relevant,* 5.

attractive option.[112] These beliefs are criticized by president Museveni, an ardent defender of scientific expertise who (similarly to British colonizers) has sought to regulate and imbed these practices into his own religious views.[113]

Adding the persistence of traditional practices to the dwindling relationship between Uganda and Western countries and the subsequent cutback of Uganda's international prestige, we can see how Museveni might fear that his almost four-decade long reign is coming to an end.[114]

One way in which authoritarian governments tend to deal with this is by keeping their allies as close as possible in an attempt to protect his own security.[115] In Uganda, this is reflected by the steady increase in military spending and a relative financial neglect of public services such as healthcare and education over the course of the past twenty years.[116] Another party that has received substantial funding in recent years are the religious authorities that Museveni also relied on during his early HIV/AIDS campaign. One example is the donation of 50 million Ugandan Shillings for the construction of the Nakasero Cathedral (the seat of the archbishop of Uganda) in Kampala in 2018.[117] Another (somewhat anecdotal) example is his close relationship with local Anglican bishops, many of whom he gifted cars after they were ordained.[118] The controversial anti-LGBT law should thus also be seen as an attempt to enhance the cultural compatibility of Museveni and his religious allies in what he might perceive as an increasingly hostile global environment.

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[112] P. Baguma, 'The traditional treatment of AIDS in Uganda: benefits and problems. Key issues and debates: traditional healers,' *Soc Afr SIDA* 13 (1996): 4-6. https://pubmed.ncbi.nlm.nih.gov/12179373/.
[113] James Putzel, 'The Politics of Action on AIDS: A Case Study of Uganda,' *Public Administration and Development* 24 (2004): 19-30. doi: 10.1002/pad.306.
[114] Christine Hackenesch, 'It's Domestic Politics, Stupid! EU Democracy Promotion Strategies Meet African Dominant Party Regimes,' *World Development* 75 (2015): 85-96. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2971437.
[115] Hackenesch, 'It's Domestic Politics,' 85-96.
[116] Dijkstra, *Uganda's Future*, 17.
[117] The Independent, 'Museveni gives Nakasero Cathedral a sh500m Boost,' https://www.independent.co.ug/museveni-gives-nakasero-cathedral-construction-a-sh500m-boost/
[118] The Diplomatic Service of the European Union, 'Religion and Democracy in Uganda: A historical perspective,' https://www.eeas.europa.eu/sites/default/files/documents/Keynote%20address%20by%20Dr%20Jimmy%20Spire%20Ssentongo--Religion%20and%20democracy%20in%20Uganda.pdf.

Conclusion

Using insights from both political science and history, this thesis has shown how health policy might be used as a political instrument by both local and foreign actors to increase their own influence (*capital*) in the case of Uganda.

In the historical section it was found that early British missionaries were successful in their use of Western medical practices as a tool to further their own evangelizing mission and the establishment of British colonial rule. Furthermore, their success was largely thanks to the willingness of local elites to adopt Western culture, as they recognized it as a way to reaffirm their own positions of power in society, and the success of British colonial healthcare policy halted when these compatible interests drifted apart.

A similar trend was observed in the case of HIV/AIDS policy from the 1980s onwards. While early policy was successful in halting the disease, this was primarily made possible by the compatibility of Ugandan and Western (primarily American) cultural values at the time. As we have seen in recent years (and weeks even), the drifting apart between Uganda and countries in the Global North has led the Ugandan president Museveni to adopt a policy that is more firmly in line with his own religious beliefs and that of his close allies. Policies such as the anti-LGBT law should thus be seen as an expression of international political tensions.

Discussion: Strengths, Shortcomings, Implications and Suggestions for Future Research

An interesting observation from this study is the importance of the agency of local actors in accepting or rejecting cultural products such as religious, ideological and scientific beliefs. This somewhat challenges the common notion that colonialism and present-day North-South interactions should simply be seen as a one-way street, where countries in the Global South are merely passive recipients of Western culture.

While this study has attempted to use a variety of primary source materials (e.g. books, government reports and medical articles), it should be noted that that these are all written from a British perspective. Furthermore, all sources seemed to reflect the same views, namely that the British imperial project was the primary objective of medical practices and policy in Uganda. An attempt was made to take into account the local perspective but this had to be based on secondary literature given the limited availability of such sources online. For a stronger historical analysis of the interaction between local and foreign actors in colonial Uganda, it is recommended that the study be performed with access to the Ugandan National Records Centre and Archives in Kampala due to the larger availability of primary source material at these local undigitized archives.

Initially, the intention of this thesis was to compare the case of Uganda with Botswana, given the two country's contrasting approaches to HIV/AIDS policy. Such a comparison would still be interesting, particularly to see if the early interaction between British colonizers and local people is similarly driven by shared and conflicting interests.

It is difficult to make any concrete recommendations based on the findings of this study. One important implication however is the need for policy-makers to find common ground with local actors in pursuing cooperative relationships to prevent further escalation. Furthermore, as an important part of this study concerned current events, it is important for continuing research to be conducted in order to keep up with ongoing developments and try to understand the decisions made in global and public health policy.

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Bibliography

Annual Reports on the Colonies – Uganda. London: Darling & Son Ltd, 1921. http://hdl.handle.net/10111/UIUCAFRICANA:Serial/466563. Accessed on April 10, 2023.

Ash, Timothy G. 'It's not just Trump. Much of America has turned its back on Europe.' https://www.theguardian.com/commentisfree/2018/sep/28/trump-america-europe-united-states. Accessed on May 10, 2023.

Baguma, P. 'The traditional treatment of AIDS in Uganda: benefits and problems. Key issues and debates: traditional healers.' *Soc Afr SIDA* 13 (1996): 4-6. PMID: 12179373.

Bettiza, G. 'States, Religions, and Power: Highlighting the Role of Sacred Capital in World Politics.' Berkley Center, 2020. https://s3.amazonaws.com/berkley-center/200330BettizaStatesReligionsPowerHighlightingRoleSacredCapitalWorldPoliticsWorkingPaper. Accessed on May 15, 2023.

Blair, Robert A., et al. 'Foreign Aid and Soft Power: Great Power Competition in Africa in the Early Twenty-First Century.' *British Journal of Political Science* 52, no. 3 (2022): 1355–1376. https://doi.org/10.1017/S0007123421000193.

Bourdieu, Pierre. 'The Forms of Capital.' *Handbook of Theory and Research for the Sociology of Capital*. J. G. Richardson. New York, Greenwood Press: 1986. 241-258. https://home.iitk.ac.in/~amman/soc748/bourdieu_forms_of_capital.pdf

Boyd, Lydia. *Preaching Prevention: Born-Again Christianity and the Moral Politics of AIDS in Uganda (Perspectives on Global Health).* Columbus: Ohio University Press, 2015.

Bruner, Jason. 'What is a European Hospital but a Pagan Shrine? Missionaries, Progress, and the Problem of Materiality in Colonial Uganda.' *Material Religion* 14, no. 3 (2018): 314-338. https://doi-org.proxy.library.uu.nl/10.1080/17432200.2018.1485429.

Center for Economic and Policy Research, 'The devil is in the detail: Christian missions' heterogeneous effects on development in sub-Saharan Africa.' https://cepr.org/voxeu/columns/devil-detail-christian-missions-heterogeneous-effects-development-sub-saharan-africa. Accessed on May 15, 2022.

Cook, Albert R. 'On Sleeping Sickness as Met with in Uganda, Especially with Regard to Its Treatment.' *Transactions of the Royal Society of Tropical Medicine and Hygiene* 1 (1907): 25. https://doi.org/10.1016/S0035-9203(07)90008-5.

Dawes, Daniel E. *The Political Determinants of Health*. Baltimore: Johns Hopkins University Press, 2020.

Dijkstra, Bram. *Uganda's Future: Navigating a Precarious Transition – The Role of the International Community.* New York: Open Society Foundations, 2022. https://www.opensocietyfoundations.org/uploads/b7e2f972-c1a9-4455-bd8d-bce660a450ae/uganda's-future-navigating-a-precarious-transition-20220704.pdf.

Doyle, Shane. 'Missionary Medicine and Primary Health Care in Uganda: Implications for Universal Health Care in Africa.' In: Medcalf A, Bhattacharya S, Momen H, et al., editors. *Health For All: The Journey of Universal Health Coverage*. Orient Blackswan, 2015. https://www.ncbi.nlm.nih.gov/books/NBK316272/. Accessed on May 15, 2022.

Doyle, Shane. 'Pandemics and Soft Power: HIV/AIDS and Uganda on the Global Stage.' *Journal of Global Health* 15, (2020) no. 3: 483. doi:10.1017/S1740022820000248.

Doyle, Shane. 'The Blessings of Medicine? Patient Characteristics and Health Outcomes in a Ugandan Mission Hospital, 1908-1970.' *Social History of Medicine* 33, no.3 (2019). https://doi.org/10.1093/shm/hky125.

Dunn, Peter. 'Robert Felkin MD (1853-1926) and Caesarean Delivery in Central Africa (1879).' *Archives of Disease in Childhood - Fetal and Neonatal Edition* 80, nr. 3 (1999): 250-251. http://dx.doi.org/10.1136/fn.80.3.F250.

Egmont Institute. 'EU-Uganda Relations: Friction, Change or Business as usual?' https://www.egmontinstitute.be/eu-uganda-relations-friction-change-or-business-as-usual/. Accessed on April 10, 2023.

European Commission. 'EU Global Health Strategy: Better Health for All in a Changing World.' https://health.ec.europa.eu/publications/eu-global-health-strategy-better-health-all-changing-world_en. Accessed on May 15, 2023.

European Parliament. 'Uganda's anti-homosexuality bill.' https://www.europarl.europa.eu/doceo/document/P-9-2023-001272_EN.html. Accessed on May 15, 2023.

Farmer, Paul et al. *Reimagining Global Health: an Introduction*. Berkeley: University of California Press, 2013.

Fukuyama, Francis. *The End of History and the Last Man*. New York City: Free Press, 1992.

Good, Charles. *The Steamer Parish: The Rise and Fall of Missionary Medicine on an African Frontier.* Chicago: University of Chicago Press, 2004.

Gresford Jones, Herbert. *Uganda in Transformation 1876-1926.* London: The Camelot Press Limited, 1926.

Guldi, Jo. & David Armitage. The History Manifesto. Cambridge: Cambridge University Press, 2014.

Hackenesch, C. 'It's Domestic Politics, Stupid! EU Democracy Promotion Strategies Meet African Dominant Party Regimes.' *World Development* 75 (2015): 85-96. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2971437. Accessed on June 10, 2022.

Hanefeld, Johanna & Gill Walt. 'Knowledge and Networks: Key Sources of Power in Global Health: Comment on "Knowledge, Moral Claims and the Exercise of Power in Global Health".' *International Journal of Health Management and Policy* 4, no. 2 (2015): 119-121. doi: 10.15171/ijhpm.2015.25.

Headrick, Daniel R. 'Sleeping Sickness Epidemics and Colonial Responses in East and Central Africa, 1900-1940.' *PLOS Neglected Tropical Diseases* 8, no.4 (2014). doi: 10.1371/journal.pntd.0002772.

Isiko, Alexander Paul. *Gender Roles in Traditional Healing Practices in Busoga*. Leiden: Leiden University, 2018. https://scholarlypublications.universiteitleiden.nl/access/item%3A2904502/view. Accessed on May 15, 2022.

Joint United Nations Program on HIV/AIDS. 'UNAIDS urges the Government of Uganda to not enact harmful law that threatens public health.' https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2023/march/20230322_Anti-Homosexuality_Bill_Uganda. Accessed on June 10, 2023.

Kagimu, M. et al. 'Religiosity for HIV prevention in Uganda: a case study among Christian Youth in Wakiso District.' *African Health Sciences* 12, no. 1 (2012): 17-25. PMID: 23066415.

Karkour, Haro L. 'Liberal Modernity and the Classical Realist Critique of the (Present) International Order.' *International Affairs* 92, nr 2 (2022): 569-586. https://doi-org.proxy.library.uu.nl/10.1093/ia/iiac006.

Kelley, Lee & Adam Kamradt-Scott. 'The Multiple Meanings of Global Health Governance: A Call for Conceptual Clarity.' *Globalization and Health* 10, nr. 1 (2014): 28. https://doi.org/10.1186/1744-8603-10-28.

Kickbusch, Ilona et al. *Global health diplomacy: concepts, issues, actors, instruments, fora and cases.* New York: Springer, 2013.

King, Noel Quinton et al. *Islam and the Confluence of Religions in Uganda 1840-1966*. Tallahassee: American Academy of Religion, 1973.

Kleinman, Arthur. 'Four Social Theories for Global Health.' *The Lancet* 375, nr. 9725 (2010): 1518–1519. https://doi.org/10.1016/S0140-6736(10)60646-0.

Kleinman, Arthur et al. *Social Suffering.* Berkeley: University of California Press, 1997.

Kodesh, Neil. 'Renovating Tradition: The Discourse of Succession in Colonial Buganda.' *International Journal of African Historical Studies* 34, no.3 (2001). https://doi-org.proxy.library.uu.nl/10.2307/3097552.

Langlois-Klassen, Deanne et al. 'Use of Traditional Medicine by AIDS Patients in Kabarole District, Western Uganda.' *American Journal of Tropical Medicine and Hygiene* 77 (2007) no. 4: 757-763. http://dx.doi.org/10.4269/ajtmh.2007.77.757.

Lloyd, Robert et al. *Religion and Healthcare in East Africa: Lessons from Uganda, Mozambique and Ethiopia*. Bristol: Policy Press, 2019.

Mackenbach, Johan P. 'Political Determinants of Health.' *European Journal of Public Health* 24 no.1 (2014): 2. https://doi-org.proxy.library.uu.nl/10.1093/eurpub/ckt183.

McKinnon, Andrew et al. 'Bourdieu, Capital, and Conflict in a Religious Field: The Case of the 'Homosexuality' Conflict in the Anglican Communion.' *Journal of Contemporary Religion* (2011). doi:10.1080/13537903.2011.616033.

Mlambo, Victor H. & Daniel N. Mlambo. 'Disunity in times of crisis: COVID-19, geopolitics and vaccine nationalism.' *Humanities and Social Sciences* 29, no. 1 (2022). doi: 10.7862/rz.2022.hss.04.

Musisi, Seggane. 'Afrocentrism and Healthcare: The Legacy of Colonial Medicine in Uganda.' https://www.afyanahaki.org/download/afrocentrism-and-healthcare-the-legacy-of-colonial-medicine-in-uganda/. Accessed on May 15, 2023.

Namuddu, Betty et al. 'Prevalence and Factors Associated with Traditional Herbal Medicine use among patients on highly active antiretroviral therapy in Uganda.' *BMC Public Health* 11 (2011). https://doi.org/10.1186/1471-2458-11-855.

Nye, Joseph. 'Soft Power.' *Foreign Policy* no.80 (1990): 153-171. https://doi.org/10.2307/1148580.

Orach, Sam Orochi et al*. Is Religion Relevant in Health Care in Africa in the 21st Century? – The Uganda Experience*. https://s3.amazonaws.com/berkley-center/09ARHAPReligionRelevantAfrica.pdf.

Otolok-Tanga, Erasmus et al., 'Examining the actions of faith-based organizations and their influence on HIV/AIDS-related stigma: A case study of Uganda.' *African Health Sciences* 7, no. 1 (2007): 55-60. doi: 10.5555/afhs.2007.7.1.55.

Parkhurst, Justin O. & Louisiana Lush, 'The Political Environment of HIV: lessons from a comparison of Uganda and South Africa.' *Social Science & Medicine* 59 (2004): 1913-1924. doi: 10.1016/j.socscimed.2004.02.026.

Pret, Tobias, et al. 'Painting the Full Picture: The Conversion of Economic, Cultural, Social and Symbolic Capital.' *International Small Business Journal: Researching Entrepreneurship* 34, no.8 (2016): 1004-1027. https://doi-org.proxy.library.uu.nl/10.1177/0266242615595450.

Pringle, Yolana. 'Crossing the Divide: Medical Missionaries and Government Services in Uganda, 1897-1940.' in *Beyond the State: The Colonial Medical Service in British Africa*. Manchester: Manchester University Press, 2016. https://doi-org.proxy.library.uu.nl/10.7228/manchester/9780719089671.001.0001.

Putzel, James. 'The Politics of Action on AIDS: A Case Study of Uganda.' *Public Administration and Development* 24 (2004): 19-30. doi: 10.1002/pad.306.

Rédaction Africanews, 'Effects of Ugandan Anti-LGBT Law: Emptying HIV clinics.' https://www.africanews.com/2023/06/12/effects-of-ugandan-anti-lgbt-law-emptying-hiv-clinics/. Accessed on June 24, 2023.

Reuters. 'Archbishop of Canterbury urges Ugandan Anglicans to reject anti-gay law.' https://www.reuters.com/world/africa/archbishop-canterbury-urges-ugandan-anglicans-reject-anti-gay-law-2023-06-09/. Accessed June 10, 2023.

Ruckert, Arne & Ronald Labonté, 'Public–private partnerships (ppp's) in global health: the good, the bad and the ugly.' *Third World Quarterly* 35:9 (2014). https://doi-org.proxy.library.uu.nl/10.1080/01436597.2014.970870.

Sandeman, John. 'New anti-lgbt law welcomed by Church of Uganda.' https://theothercheek.com.au/new-anti-lgbt-law-welcomed-by-church-of-uganda/. Accessed June 10, 2023.

Sherwood, Harriet. 'Anglicans reject Justin Welby as head of global church amid anger at same-sex blessings.' https://www.theguardian.com/world/2023/feb/20/anglicans-reject-justin-welby-as-head-of-global-church-amid-anger-at-same-sex-blessings. Accessed on June 10, 2023.

Stanley, Henry Morton. 'Letters of Mr. H. M. Stanley on His Journey to Victoria Nyanza, and Circumnavigation of the Lake.' *Proceedings of the Royal Geographical Society of London* 20, no. 2 (1875): 149. https://doi.org/10.2307/1799875.

Stonehouse, Aidan. *Peripheral Identities in an African State: A History of Ethnicity in the Kingdom of Buganda since 1884*. Leeds: University of Leeds, 2012.

The Centre for Africa-Europe Relations. 'The EU Global Health Strategy: How to Make it Work.' https://ecdpm.org/work/eu-global-health-strategy-how-make-it-work. Accessed on May 10, 2023.

The Diplomatic Service of the European Union. 'Religion and Democracy in Uganda: A historical perspective.' https://www.eeas.europa.eu/sites/default/files/documents/Keynote%20address%20by%20Dr%20Jimmy%20Spire%20Ssentongo--Religion%20and%20democracy%20in%20Uganda.pdf.

The Lancet. 'Political Science and Health'. https://www.thelancet.com/series/political-science-and-health. Accessed on April 10, 2023.

United Nations Human Rights. 'Uganda: UN experts condemn egregious anti-LGBT legislation.' https://www.ohchr.org/en/press-releases/2023/03/uganda-un-experts-condemn-egregious-anti-lgbt-legislation. Accessed on May 20, 2023.

Vongsathorn, Kathleen. 'First and Foremost the Evangelist? Mission and Government Priorities for the Treatment of Leprosy in Uganda, 1927-1948.' *Journal of East African Studies* 6, no.3 (2012): 544. doi: 10.1080/17531055.2012.696906.

Weber, Max. Politik Als Beruf (1919); English translation: 'Politics as a Vocation.' in *Max Weber: Essays in Sociology*, edited and translated by HH Gerth and C. Wright Mills (New York: Oxford University Press), 1946, 77-128: Selected Topics.

Willis, John Jamieson. *The Church in Uganda: A Charge to Missionaries of the Uganda Mission 1913*. London: Longmans, 1914.

Winiger, F. & Simon Peng-Keller, 'Religion and the World Health Organization: an Evolving Relationship.' *BMJ Global Health* 6 (2021). http://dx.doi.org/10.1136/bmjgh-2020-004073.

World Bank. 'Prevalence of HIV, total (% of population ages 15-49) – Uganda.' https://data.worldbank.org/indicator/SH.DYN.AIDS.ZS?locations=UGwe. Accessed April 10, 2023.