

HEALTH CITIZENSHIP IN THE “FORGOTTEN DISTRICT”: NON-PROFIT
GOVERNANCE IN THE UGANDAN WELFARE STATE

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Abstract

The increasing presence of non-profit and non-governmental organizations as healthcare providers in Uganda has altered the role of the nation state in providing health services. This alteration of the nation state is especially salient in Bududa district, located in a region of Uganda that has been labeled as “the forgotten district,” where traditional modes of the government oftentimes do not reach. Through three months of ethnographic fieldwork conducted in Bududa, this thesis attempts to address the ways in which individuals understand their relationship to the government vis à vis the health welfare system, and the ways in which the presence of the non-profit alters this understanding. I argue that the non-profit clinic alters citizen relations to the state because of its ability to provide the health services that the state cannot. Within this argument, I first establish that political forms of the state do not directly reach the rural district of Bududa. Rather, healthcare becomes the primary way through which individuals interact with the Ugandan government. I then argue that individuals measure the inefficacy of this government service through the pharmaceuticals that they do or do not receive, as well as through the characterization of healthcare workers who distribute the pharmaceuticals as corrupt. Lastly, I demonstrate that these logics of pharmaceuticals as a measurement of quality care qualify the non-profit as a more desirable site to receive care. In this process, the non-profit creates a form of governance that functions as an alternative to the state. I end by thinking through the implications of these multiple forms of governance on the current and future role of the Ugandan state in development.

Table of Contents

Introduction: Untangling the Architecture of Global Health.....	1
Background and Context: The State of Health in Uganda.....	8
A Brief Exploration of Ugandan Political History	8
Situating Non-Profit Aid in Uganda.....	11
The Ugandan Health Welfare State	13
Bududa District, Eastern Region, Uganda.....	16
Methods.....	19
Chapter I: When Healthcare Becomes Governance.....	24
The Breakdown of Democracy in Bududa	26
Bududa and a Uganda-Kenya Citizenship.....	30
The Welfare Clinic as State	33
Chapter II: Pharmaceutical Actors.....	38
The Centrality of Pharmaceuticals as Treatment.....	40
The Healthcare Worker as an Actor	43
Healthcare Workers, Corruption, and the Government.....	45
Chapter III: The Non-Profit as an Alternative to the State	49
The Non-Profit as a Consistent Provider.....	51
Imagined Healing	55
Association with the Bazungu	57
Conclusion: Implications of the Para-State.....	62

Introduction: Untangling the Architecture of Global Health

“A revolution is under way that is fundamentally altering the way the haves of the world assist the have-nots.” Or at least, this is true according to Jon Cohen in his 2006 piece analyzing “The New World of Global Health.” In this article, Cohen delineates the history of global health aid, the evolution of its goals and methods, the existence and entrance of major global health players, the criticism the field has faced, and the steps that it is taking to rectify its shortcomings. He centers his analysis around the idea of an “architecture of global health”—or rather, a lack thereof—a concept first coined in an interview by Barry Bloom of the Harvard School of Public Health in 2006, then later reiterated in a 2010 article (Szlezák et al. 2010). In this modern day architecture of global health, organizations, governments, and other major players interact, cooperate, and interfere with each other, leading to a hindered service delivery system, one that focuses on specific diseases rather than general care while simultaneously being economically and financially inefficient (Cohen 2006).

Indeed, in this modern architecture of global health, non-profit organizations, local governments, and internationally working institutions entwine in heterogeneous ways on the ground, which result in both beneficial and deleterious effects. The architecture encompasses among other things a global pharmaceuticals market, a transnational research system, and an international humanitarian infrastructure. Cohen argues that the lack of coordination among the wide range of actors in the international arena hinders the efficacy of health delivery. For him, achieving maximum efficacy in the field would require a restructuring of the current global health system to better integrate the efforts of multilateral and bilateral institutions, international aid organizations, state governments, and non-governmental organizations (NGOs). Given,

however, that the system cannot necessarily be reformed in this way, the relationships among actors become an important site of examination for the sake of untangling and improving the architecture of global health.

The increase of global health efforts, in conjunction with an increase in foreign aid aimed at international development, have begun to rework the boundaries and duties of the nation state to its people. As a result of these processes, questions about the changing role of the nation state in providing services to its citizens begin to emerge. What happens to the authority of the state when global health enlists the power of non-state or inter-state actors? Through my research, I have become particularly interested in how the constantly evolving architecture of global health has affected the ways in which governance is provided and citizenship is understood by and negotiated for the individuals that the system aims to help. On the ground, actors within the architecture, such as non-profit and non-governmental organizations, begin to rework definitions of state, government, and citizenship. For the purpose of this thesis, although I recognize that they differ in particular ways and have fluid definitions, I examine humanitarian organizations, non-profit organizations, and non-governmental organizations as grouped together in their effects on the ground.

As these organizations aimed at rectifying global health inequalities have grown in number and spread in reach, they have populated and disrupted the global health field. It is these aid organizations that oftentimes provide essential medical services in rural or low-resource areas that are inadequately served by the options provided by the local public and private institutions. They interact with the government systems in place, forming relationships that are often ambiguous in definition but have the ability to reshape political environments. Especially given that many non-profit organizations operate on international funding, either through private

donations or international grants, this encroachment of non-profit health services into developing countries both supplements and interferes with the role of the government in providing care. This opens a space for new formulations of the idea of the state to emerge.

Social science researchers have written extensively on the relationship between the state and the non-profit organization. These theorizations center around the ways in which NGOs necessarily become entangled within political systems. Adams, Novotny, and Leslie (2008) examine the ways in which non-profits specifically in the realm of global health have increasingly become relevant tools for negotiating international diplomacy. William Fischer (1997) explores the ways in which the rise of NGOs in the developing world have reshaped the interaction between society and state, which challenge traditional notions of governmentality as located within the nation state. Stirrat and Henkel (1997), in discussion with Mauss's foundational exploration on gift giving and reciprocity, delineate the power dynamics associated with humanitarian practices. They describe free gift between the donor and the recipient as an imagined construct. The free gift in fact becomes layered with conditionalities and moralities, all of which interfere with the partnership that the NGO imagines itself to achieve with the recipient community and reinforces neocolonial power hierarchies. In their history of NGOs in Africa, Manji and O'Coill (2002) touch upon the relationship between the non-profit sector and state, particularly in the 1960's. They note, "While [NGOs] carried out 'projects' providing services in peripheral areas that the state was disinclined to reach, the bulk of social services were provided by the state under its social contract with the people"(2002:576). Thus, NGOs have been viewed in relation to state services from the very beginning of their establishment as institutions for development on the African continent.

This thesis takes a theorization about the non-profit relationship to the state presented by Victoria Bernal and Inderpal Grewal as a starting point for understanding NGO governance. In their introduction to a 2014 volume examining feminist struggles situated within NGOs, Bernal and Grewal argue that the modern day NGO has become defined in opposition to the state, a definition that encompasses the wide range of ways through which organizations have appropriated the label of the NGO form. Despite this perception of the non-profit as separate from the state, however, they contend that “the NGO form produces and converts what is outside the state into a legible form within a governmentality that parallels official state power”(2014:8). Thus, though imagined as discrete institutions, NGOs in fact derive their power precisely through their ability to work within frameworks of power traditionally associated with the state.

Though I do not aim to prove this exact point, Bernal and Grewal’s idea of the non-profit as an actor that oftentimes mirrors state apparatuses becomes central to the questions that I explore. With this context in mind, this thesis examines the themes of healthcare and governance in Bududa District, located in a region often labeled as “the forgotten district” of Uganda. More specifically, I ask: How do individuals in Bududa understand their relationship to the Ugandan state vis à vis the health welfare system? And how does the non-profit organization enter and disrupt this understanding?

These questions are particularly salient in the context of Uganda’s political history and of individuals perceptions of the Ugandan state in Bududa. Uganda’s protracted effort to establish a stable democracy post-independence established the country as a long standing target for international development efforts. In the wake of the human rights atrocities of Idi Amin’s dictatorship in the 1970’s, the absence of any strong state presence opened a gap in government service provision, which international non-profit organizations eagerly filled (Barr et al. 2005).

Thus, from their very entrance into the country, international non-profits in Uganda have been tasked with filling the perceived inadequacies of the state. Uganda's poor health measurements enhanced this image of a country in need of help, and Uganda became a popular destination for which international global health organizations could focus their efforts. Especially during the rise of the HIV/AIDS epidemic across the continent, Uganda's high prevalence rates—once over 30% in antenatal mothers in urban clinics—made it a target for international global health efforts. Following these interventions, the country became viewed as an international health success story, as HIV/AIDS rates dropped dramatically, supposedly due to both government action and international aid (Parkhurst 2004). Against this context of foreign health aid into the country, the Uganda Ministry of Health (MoH) has in the past three decades been developing its own internal health welfare system in an attempt to address growing health concerns, especially in poorer and more rural populations. This combination of government welfare programs that seem democratic, at least on paper, and of widespread coverage of non-profit health organizations make Uganda a particularly interesting location in which to explore the themes of healthcare related to the state, governance, citizenship, and the non-profit sector.

This thesis serves as an exploration of the people's perspective to the intersection between the Ugandan health welfare state and the non-profit clinic as they translate on the ground in Bududa. The presence of a non-profit clinic in the district has transformed the ways in which individuals in the district understand their healthcare, both in relation to the government welfare clinics and in relation to the non-profit. Through interviews with patients, community members, and staff members, I hope to address the questions I posed earlier, namely, what are the ways in which individuals in Bududa understand their relationship to the government as it

relates to healthcare, and how has the presence of the non-profit clinic altered this understanding?

Through three chapters, I argue that the non-profit clinic alters citizen relations with the state through its ability to fill the inadequacies of services provided by the state. In my first chapter, I establish the interactions between Bududa residents and Ugandan government and the interpretations of these interactions that cause the welfare system, and the health system in particular, to become the main way through which citizen-state interaction occurs. In such a rural region where only a select few government services are able to reach, welfare systems such as education and health begin to define recognition by and citizenship within the state. After establishing this idea of the health system as an agent of governance, my second chapter examines the ways in which individuals measure the efficacy of government services and formulate discourses to express their discontent. Through my ethnographic work, I demonstrate that the presence or absence of the correct pharmaceuticals—“correct” determined by the people—became a measuring stick of the competency of the clinic for individuals, particularly when viewed in relation to the healthcare workers distributing the pharmaceuticals. In my third chapter, I examine how this logic of pharmaceuticals as a measurement of quality constructs the non-profit clinic to individuals in Bududa as a preferable and more efficacious option for healthcare treatment than the government clinics. By choosing this alternative service provider to the state, I think about what this means for the types of citizenship for which individuals in Bududa search, as well as the forms of governance that become relevant in a world of a complex and convoluted architecture of global health.

Before I go on to the meat of my argument, I want to end this introduction with a note about the morals and ethics that accompany the material I address in this thesis. As a scholar, I

do not mean to critique the processes that I see unfolding in Bududa. I understand these processes occur through very tangible human decisions on both the part of the NGO, which has reached and dispensed medical care to a large segment of a population that would otherwise lack access to it, and on the part of the patients, who seek care in the ways that benefit them the most and thus make sense to them. One way to examine these decisions is to step back and theorize about the processes occurring in Bududa, and in doing so, to engage with the academic critique of the ethics, efficacy, and validity of non-profits in global health and international development at large. It is harder, however, to locate these critiques within the very real world in which individuals in Bududa seek healthcare from this NGO, which provides high quality care in the district often juxtaposed against government clinics that do not come close to addressing the needs of the people. Whether NGOs in general are positive toward development or negative is not for me to decide. Rather, I hope that through this thesis, I can discuss the facts as they have been shared with me and as I believe is appropriate to see them. I leave the critique of this system to the people of Bududa to decide.

Background and Context: The State of Health in Uganda

A Brief Exploration of Ugandan Political History

In attempting to understand the Ugandan state, I want to take a moment to situate the current system within the political history that allowed and motivated the system to take shape. In its existing structure, Uganda's government has been studied as one of the most corrupt governments in the world (Tangri and Mwenda 2006). Although democratic elections for the president are held every five years, the current president Yoweri Museveni has not yet lost an election since he came to power in 1986. There is still much debate about the most recent election, held in 2015, since most Ugandans and researchers believe that the opposition party won the popular vote (Karimi 2016). Though the current system is not ideal, it has been allowed to exist for so long because of Uganda's turbulent political past. Colonialist rule followed by a series of incompetent and corrupt rulers paved the way for the period of intense political instability perhaps most prominently marked by Idi Amin's dictatorship between 1971 and 1979, although political failures have been present throughout the entire existence of the independent Ugandan state. Compared with the atrocities committed during Amin's reign and the political stability before and after, Museveni's tenure has been embraced by many Ugandans, especially the older individuals who experienced the previous failures of the Ugandan state.

Uganda was first colonized by the British in 1894. Classified and ruled as a protectorate, the country was peacefully granted its independence by the British Crown in 1962. Following its liberation, a multi-party coalition government was put in place, which supposedly represented an alliance of the various political parties in the country. Over the first few years of independence, disagreements emerged between the two parties in the coalition government, and eventually Milton Obote, the leader of the Uganda People's Congress, staged a coup in 1966 and became

the sole leader of the country. In order to consolidate power, Obote created a single-party system and abolished the four kingdoms that had divided the country prior to and through colonial rule. Using military strength as an additional tool for power, he formed an alliance with the military general Idi Amin. Amin steadily gained more influence and staged a coup against Obote in 1971. In the next eight years, Idi Amin led a military dictatorship characterized by genocide and civil war. His government committed numerous human rights violations, and his administration was characterized by pervasive food insecurity throughout the country, along with a shortage of resources and government shortages. Eventually defeated by the grassroots resistance armies with the aid of the Tanzanian military, Amin fled and his government was dismantled in 1978.

Following the defeat of Amin, Uganda was ruled by a series of leaders, each of whom was strategically placed in power but ruled for only a limited amount of time. Obote briefly regained power in 1980 through a suspicious and potentially rigged election. In 1986, Museveni, a long-standing opponent of the Ugandan government, won the popular election as a member of the National Resistance Movement (NRM). By naming his party as a movement, Museveni campaigned with a discourse of inclusion for all Ugandans—anyone could join his movement and he welcomed differences.

In framing his party in this way, scholars have proposed that Museveni's administration has been able to suppress or altogether erase the influence of alternate political parties in the country (Bouckaert 1999, Jeppson 2004). In a study performed in 1999, the Human Rights Watch called the political situation in Uganda a violation of the universal human right to democratic political participation. The acceptability of Museveni's tenure has been tacitly underscored by development aid given to the government by the international community. Most of the attention of the international community has focused on donating funds to the government

to help develop the country. By doing so, rather than addressing these human rights violations by combatting the oppression of the government, international organizations reinforced the power of the Museveni's government (Bouckaert 1999, Oloka-Onyango and Barya 1997).

Much of the literature has cited Uganda as a successful example in the broader story of development in Africa. Especially in the years surrounding the turn of the twenty-first century, Uganda was often referred to as an international development and global health success story. Perhaps because of the continued funneling of money to the Ugandan government by international organizations, this success has been attributed primarily to the actions of the government (Jones 2009). As just one example, through the actions of international work, Uganda's HIV/AIDS rates fell significantly in the 1980's and 1990's despite its unstable political history, high rates of poverty, and poor public health infrastructure. Scholars attribute this to an awareness of the epidemic by a large portion of the population, which eased behavioral changes and thus made campaigns more effective. The improvements in Uganda far surpassed the results experienced in other African countries. Especially given that these improvements occurred largely prior to the introduction of antiretroviral therapy on the continent, the Ugandan government was praised for its successful cooperation and compliance to international efforts. Although scholars have since examined the external factors that could have contributed to reduced rates of disease in the country, the results established the country and its government as a success story (Allen and Heald 2004).

To combat this narrative of successful development via Ugandan government competency, scholars such as Ben Jones (2009) have performed ethnographic fieldwork examining the ways in which Ugandans experience governmental development work. Jones notes that the government may not be solely responsible, or indeed responsible at all, for

improving the lives of the Ugandan rural poor. Rather, Ugandan development policies do not meet rural needs so much as they extend non-democratic state bureaucratic control of the rural regions of the country. It is in this context of an ineffective government oftentimes bolstered by international institutions that the non-profit organization enters the country.

Situating Non-Profit Aid in Uganda

The non-profit in Uganda has long been associated with inadequate services provided by the state. Especially given the political instability throughout the years directly post-independence, multiple researchers have examined the ways in which the non-profit emerged in relation to the failing state. Oloka-Onyango and Barya (1997) propose that the political instability and resulting failures of economic development in the country constructed Uganda as the “sick man of Africa.” Framing the non-profit as a segment of civil society in opposition to the state, they examine the relationship between the state and NGOs in civil society over the course of the political history of Uganda post-independence. They argue that the creation of a one-party state during Obote’s administration severely restricted political, economic, and social organization throughout the country and repressed alternative ideologies of politics outside of the state political party. In this context, non-profit organizations as part of civil society were limited in their ability to provide services in opposition to the state.

Oloka-Onyango and Barya also argue, however, that the creation of Museveni’s NRM coincided with a weakened state. In this context, oppositional civil society actors became stronger and “the NGO explosion has been primarily in the area of social and economic welfarism—a sphere of operation in which the state feels little challenge and indeed often welcomes the filling-in of the breach that NGOs carry out through their multifarious

activities”(1997:121). While the government has allowed this “NGO explosion” to occur, it has simultaneously created new laws to monitor and thus entangle itself into the services provided by the NGO.

Barr et al. (2005) provide a similar narrative along a different timeline, in which they claim that the weakened state under Idi Amin in the 1970’s, rather than the beginning of Museveni’s administration, first propelled the proliferation of NGOs in the country, which continued into the 1980’s. After the defeat of Amin, as the state recovered from the genocide and attempted to rebuild its political structure, it was unable to provide the necessary services for its people, creating a gap for NGOs to fill. This same pattern emerged during the protracted conflicts that occurred in Northern Uganda at the turn of the century, which began with long standing disagreements between the northern and southern parts of the country, which were aggravated under Museveni’s regime and culminated in the reign of terror of Joseph Kony and the Lord’s Resistance Army during the 2000’s (Baines 2007). During this time, as the Ugandan state was unable to access the regions controlled by the LRA, humanitarian relief into the region increased precisely to fill the void in welfare services created by political instability and to combat the human rights atrocities committed by the LRA (Wendo 2003).

In addition to analyzing the entrance of non-profits into the country, Barr et al. (2005) provide one of the most comprehensive summaries of the current landscape of NGOs in Uganda. Through their research, they sampled a series of non-profits and determined the primary activities reported by the organizations. They additionally analyzed NGO monitoring structures in the Ugandan government. Of the organizations surveyed, 96.6% reported involvement in raising awareness through small-scale community outreach, a percentage that surpassed the percentage of organizations that identified as service provision organizations. 15.8% claimed to

deal with curative health services, which can be juxtaposed against the 20.6% that claimed to deal with HIV/AIDs awareness and prevention. Both these numbers suggest that non-profit resources in Uganda tend to be catered more toward education and awareness rather than toward the tangible provision of services. This generalization, however, may not apply to all non-profit organizations doing work in the country, especially since some scholars have noted the large gap between the perceived competence of international NGOs and of local Ugandan NGOs to fully provide the services necessary to serve impoverished populations (Omona and Mukuye 2013).

Barr et al. report that NGOs in the country are supposed to register with the national Registration Board of the Ministry of Internal Affairs. Upon registration, a certificate is first awarded for one year, while each subsequent certificate lasts for three years on the condition that the non-profit continues to fulfill the requirements set by the Ministry. 86% of Barr et al.'s sample reported registering with the board, although the authors note that some of these permits were overdue and thus considered void. Although the Ministry of Internal Affairs monitors the administration of these certificates, Barr et al. found that in Uganda, donors monitor non-profit services far more frequently than governmental agencies, suggesting that the government policies described by Oloka-Onyango and Barya may not be fully implemented on the ground. The relationship between the state and the non-profit, though tangible, remains ambiguously defined throughout the country.

The Ugandan Health Welfare State

As the Ugandan government has developed its state infrastructure throughout Museveni's tenure, it has simultaneously restructured state welfare services, including the public health provision system. Since the 1990's, Uganda has been steadily decentralizing and democratizing

its health system. In this process, two important changes have been implemented aimed at increasing access to care for all Ugandans. Firstly, the Ugandan government decentralized its healthcare system in the early 1990's. Secondly, the government eliminated public health center user fees in the early 2000's. Throughout the process of the implementation of these changes, social scientists have examined the efficacy of the new system, with general consensus that the system, though democratic in principle, fails to be democratic in practice.

In theory, decentralization of the national healthcare system empowers district governments to decide how and where to allocate resources. The national Ministry of Health (MoH) exists to monitor these decision-making processes. By allowing local governments to make decisions, the national government expected health services to become catered to the specific needs of each district. This is premised on the assumption that individuals have better contact with their local officials than with their national ones, and thus, decisions made by local officials are more specific to and accountable towards the needs of their local constituencies.

Scholars examining Uganda's health and government system and have noted that the decentralized system, which aims to increase equity and community participation in political decisions, both fails to promote political participation across socioeconomic classes and fails to address the needs of these various socioeconomic classes. Though the decentralized system supposedly encourages governments to be more accountable to the people—individuals are presumed to have more power in voting for their district officers as well as more opportunity to interact with these officers—a decentralized system in practice concentrates decision-making power onto a few elected officials, which in reality discourages communication with political constituents. Additionally, this supposedly democratic process does not transcend socioeconomic differences. The poor tend to be disproportionately hurt by the system, since low socioeconomic

status generally creates barriers to political participation for the poor (Kapirir et al. 2003). As the MoH has pulled out of the local context to make way for local governments to execute power, they have failed to build replacements to their services. Instead of being accountable for local community needs, the new programs taking shape through this decentralized system tend to follow general global health paradigms rather than the specific and relevant needs of each district (Jeppson et al. 2005). Throughout this decentralization process, the role of NGOs has increased across the country, as these organizations have become increasingly important in supplementing governmental systems with manpower and resources.

In a further attempt to make its health welfare state more accountable toward the poor, the Ugandan government removed user fees in 2001. With this development, individuals who utilize government services through government clinics do not have to pay to be seen or to receive treatment. According to analysis of this policy, the removal of user fees has successfully encouraged attendance while also increasing efficacy of care. It has not, however, addressed the social or cultural barriers to healthcare access, indicating that though the health services are more accessible financially, they may not be more accessible physically (Yates et al. 2006). By extension, the elimination of user fees has not helped to lift the financial burden of health services on the Uganda poor. Unable to physically access government clinics, the poor must continue to seek out private or traditional health carriers, both of which are excluded from the national law eliminating user fees (Xu et al. 2006).

To place these policies in the context of health in the country, Uganda has one of the highest rates of HIV/AIDS prevalence in the world at around 7.25%. The average life expectancy at birth in Uganda is 55 years with more than half of the population below the age of 18. The CIA World Factbook claims that the country has 0.12 physicians per 1000 individuals and the

government spends less than 10% of its annual GDP on health services. For a point of contrast, the United States has 2.45 physicians per 1000 individuals and spends nearly 20% of its GDP on health services (CIA 2017). Of note, Uganda's less than 10% health expenditure falls short Uganda's commitment to the 2001 Abuja Declaration, in which the government agreed to spend at least 15% of its domestic annual budget on health (World Health Organization 2011). Additionally, recent studies have noted that health has increasingly become less of a priority for the Ugandan government (World Health Organization 2016). As the state has decreased its emphasis on public expenditure on health while simultaneously ignoring the shortcomings of its decentralized health system, new structures must be put in place to address health issues around the country.

Bududa District, Eastern Region, Uganda

Located in the ranges surrounding Mount Elgon, Bududa district sits in the eastern region of Uganda adjacent to the Kenyan border. These mountainous regions at the foot of Mount Elgon have frequently been labeled as "the forgotten district" of Uganda. Previously part of Mbale district, the Bududa district lines were redrawn during a government reorganization of Uganda land in the mid-2000's, which some scholars have seen as an attempt by the Museveni administration to increase patronage to rural districts and thus increase the likelihood of his reelection (Green 2008). Classified as a rural district, the nearest urban center to Bududa is Mbale town, about thirty kilometers away by road.

The population of Bududa hovers slightly below 180,000 and consists almost entirely of members of the Bagisu tribe, which occupied the area prior to British colonialization of the country. According to district government statistics collected from a 2008 census survey, 97% of

Bududa's population live in rural areas, with the remaining 3% living in rural townships, which includes the main Bududa town as well as trading centers dispersed throughout the district. The district has a predominantly agricultural economy, and 33% of the population are classified as poor, a number that partially obscures the magnitude of the problem given that 86.4% of the population practice subsistence farming and own most of their assets in crops rather than in currency.

Healthcare in Bududa is accessed mostly through public government health centers, although there are a few private health centers as well. At the time of the 2008 government census, there were 12 healthcare centers operated publically and 3 privately-owned clinics, all of which were classified as health center IIs. Uganda has a hierarchical healthcare system, in which health centers are numbered based on their level of complexity and hospitals provide the most comprehensive array of care. At the most basic level, there are health center IIs (HCII), which offer medical services for basic diseases through registered nurses as well as antenatal care through midwives. Health center IIIs (HCIII) offer all the services of a HCII, in addition to a full laboratory and the presence of a clinical officer in addition to nurses. A health center IV (HCIV) is classified as containing an in-patient ward as well as a small operating theater, classifying it as essentially a small hospital. At the highest level of care, hospitals provide more comprehensive services and have a larger capacity (Kavuma 2009). Bududa hospital has one hospital, eight HCIIIs and seven HCIIIs. Three government HCIIIs in particular are widely used by individuals in Bududa: Bushika HCIII, Bushiyi HCIII, and Bufsanza HCIII.

Given the relative prevalence of health centers, fully two-thirds of Bududa's population has access to health centers within a five kilometer radius of their homes. This, however, does not necessarily reflect the frequency at which individuals seek health services, nor does it reveal

insights about the quality of care that individuals in Bududa receive. As one measurement, Bududa has one of the lowest rates of hospital births in the country, with 24% of all births in Bududa occurring in health centers compared with 39% of births throughout all of Uganda. The remaining births occur at home, both with and without the help of a qualified midwife or birthing attendant. Though not a thorough measurement of health care delivery quality in Bududa, this below average statistic suggests larger problems in Bududa's health situation; Bududa's below average statistics are even worse when placed in the context of Uganda's poor health conditions (Bududa District Local Government 2012). Given these poor health conditions in Bududa, as the non-profit enters into the district as an option for care, and it becomes entangled, in both good and bad ways, in governmental efforts to improve the health of the district.

Methods

This thesis is based off of twelve weeks of ethnographic fieldwork that I conducted in Bududa district from mid-May to early August of 2016. Fieldwork was performed primarily in and around the FIMRC Bushika Health Center III, located in the Bushika trading center slightly under seven kilometers from Bududa town. The clinic is operated by an American non-profit called the Foundation for the International Medical Relief (FIMRC), which runs health centers in eleven countries in Central and South America and in Asia. The Bududa clinic is the NGO's only clinic in Uganda, and on the African continent, and was first established in 2006 when FIMRC partnered with an American education non-profit already in the district. Though the partnership began with the goal of providing healthcare to the children attending the education non-profit's primary school, FIMRC expanded its services to the entire community when it realized the needs of the community in general. The organization primary receives its funds through the payments of volunteers who go to the clinic for global health experience and through global health grants.

As both the community and local government began asking for expanded services, FIMRC relocated two kilometers down the road to the Bushika trading center to open a larger clinic, which was opened in the beginning of March 2016, slightly more than two months before I began my fieldwork. This new location in Bushika allows for both an expanded clinic space and an expanded catchment area with a denser population. Because of its proximity to the trading center that hosts a weekly market day, the new clinic is able to attract and serve individuals who otherwise live dispersed in the mountains nearby. Still, it is close enough to allow continued partnership with the original community and FIMRC still operates community support and

education programs at the original clinic site, which is known as Arlington to locals, after the name the education non-profit.

The clinic itself offers a wide range of services. As a health center III, it has by definition a laboratory for testing of malaria, STDs, and UTIs; clinicians who offer primary care consultations; and a maternal and child health ward (MCH) that provides antenatal care and performs deliveries. It additionally has a room for wound care, which is also used to administer injections and will soon open as an in-patient ward for children. There is a pharmacy that contains over eighty medicines including antibiotics, malaria treatment, antenatal supplements, oral rehydration salts and zinc, deworming medications, and hypertension medication. The pharmacy also stocks various disease-specific medications for ailments such as asthma and epilepsy. Given the presence of the lab, which performs HIV tests, the clinic employs two full-time HIV counselors who provide voluntary test counseling (VTC) for individuals before and after testing.

Beyond treatment, the clinic runs a series of community health strengthening programs. These include a large group of volunteer peer educators known as PEPEs who discuss sanitation and basic health literacy with patients in the clinic while they wait to be seen. The clinic also operates a community health educator team (CHE) that is in charge of outreach to and education in the area around Bushika. The clinic organizes two social support programs: the post-test club (PTC) that provides support to HIV positive adults and the orphan and vulnerable children (OVC) program that provides support to HIV positive children.

The clinic, though operated by an American non-profit, employs only one American employee, a field manager in charge of connecting the Ugandan clinic to headquarters in Philadelphia. The clinician, who is from Bududa, serves as the second in command, although

there are separate supervisors for the lab and MCH. Other employees in the clinic include both registered and certified nurses as well as community volunteers and paid health assistants, who are tenured community volunteers that have been entered into the payroll. Overall, the clinic employs a staff of about thirty Ugandans, most from Bududa although there are some from neighboring Manafwa district, one from the capital of Kampala, and one from Kenya.

My fieldwork consisted primarily of participant observation and semi-structured qualitative interviews. As an Asian American woman and as effectively an employee of an American organization, I am sure that the answers I received in my interviews and the details I noted while I shadowed in the clinic were affected by the differences between me and my informants. Most people in the district perceived me as a *mzungu*, or white person, and viewed me as an employee of the clinic. Especially given the somewhat circuitous way in which I framed my interview questions to approach my research, I recognize the highly likely possibility that my informants changed their answers in order to better flatter or respect me and the clinic. I cannot parse out the precise ways in which this happened, but I acknowledge that my relationship as an outsider to Bududa, no matter how long I had been in the district and no matter how much I began to adopt the local customs, affected the ways in which I interacted with the patients who visited the clinic and the ways in which they interacted with me.

The vast majority of my participant observation took place in the clinic as I essentially took on the role of a clinic volunteer. Most of my field notes were taken as I helped transcribe consultations and appointments and as I talked with patients in the waiting area. I also performed some outreach to surrounding villages while shadowing the CHEs. With the CHEs, I also visited two other health center IIIs in the district (Bushiyi and Bufsanza) as well as the district hospital, which is the only hospital in the district and located in Bududa town.

I performed twenty semi-structured qualitative interviews, in which I followed a list of topics that I wanted to discuss but allowed the interviewee to direct the flow of the conversation. As I spoke with more people, my outline evolved to accommodate and explore the narratives that consistently came up in my conversations. To avoid directly asking about the government, which I assumed would evoke politically charged or veiled statements, my conversations were centered around asking individuals to explain their decisions to seek for care at the non-profit clinic rather than the government one. That is, I framed my conversation around people's current non-profit clinic experience with the hope that they would then provide information indirectly about their perceptions of their previous interactions with the health system, if they had indeed interacted with the health system at all.

My purposive sample consisted of a mix of healthcare workers, community individuals associated with the non-profit, and individuals seeking care at the clinic. I interviewed four clinic healthcare workers, three of whom also currently hold posts at government clinics in the neighboring district of Manafwa. Individuals are not allowed to be employed by two healthcare centers in the same district, although each of these three employees had an understanding with both their hospital administrators as well as their district health officer, which allowed them to work the two jobs as long as they completed five shifts at each job each week. Four interviews were conducted outside of the clinic with individuals in the community who had had experience with the non-profit clinic either through one of its support groups or as a community volunteer. The remaining twelve interviews were conducted at the clinic site with patients who volunteered for an interview while visiting the clinic for treatment. Out of the twenty interviews conducted, six were with males and fourteen were with females, with ages ranging from 18 to 63. The interviews were split between interviews conducted in English and interviews conducted in

Lugisu, the local language, through the help of a bilingual clinic employee. The interviews generally lasted between twenty and thirty minutes in length.

The interviews were recorded on an audio recording device then transcribed manually onto the computer. I have quoted the interviews verbatim throughout the course of this thesis without any corrections to my informants' English or to the translations given to me through the translators. The interviews were coded by hand, with salient and noteworthy points and quotes highlighted then reorganized under categories. The process was a combination of a bottom-up and top-down approach in the sense that the general categories of relevance had already been identified during the initial phase of the project prior to entering the field site and had been slightly refined through the course of the fieldwork. The final solidification of these categories, however, was not completed until the coding process had finished, and the final argument was formulated inductively through the results of the interviews and coding.

The study was submitted to and approved by the institutional review board of the University of Pennsylvania prior to entrance into the field. Given the absence of any review boards relevant to the district, the employees at the clinic served as the local ethics reviewers for this study.

Chapter I: When Healthcare Becomes Governance

Modern ethnographies of the state have increasingly begun to examine the changing role of the government of the nation state in the globalized world. In their introduction to *The Anthropology of the State*, Aradhana Sharma and Akhil Gupta (2006) write about the state as an entity constantly reconstructed through culture and context and thus substantiated differently in the everyday life of various populations. The anthropology of the state in the globalized world moves beyond examining the state as bound to the nation and instead examines a type of transnational governance that transcends national boundaries and allows institutions beyond the state to begin to exercise power. Within this form of governance, Sharma and Gupta note the importance of rethinking hegemonic ideas of the role of the state and instead focusing on attempting to understand the ways in which Western ideals of poverty, health, and development all co-constitute a “culture of governmentality,” which dictate the ways in which government should be enacted, but become embodied differently in various contexts around the world. Within this framework, institutions outside of traditional state apparatuses fulfill the functions of the government and offer alternative ways to think about governance. This understanding has been appropriated by governments in low-income countries, where welfare that promotes development has become prioritized tasks of the state as a method of exercising power, at least in theory.

Sharma and Gupta’s analysis on the changing nature of the state in a globalized world is situated in a broader discourse examining the ways in which the state currently exists. Drawing from Philip Abram’s 1988 distinction between the state-system as the practices of the state and the state-idea as the ways in which the perception of the state becomes reified as a societal

construction, scholars have noted the difficulties around studying the state as a well-defined entity. Rather, the state can be studied through what Timothy Mitchell (2006) terms a “state effect,” the processes by which the state becomes imagined as an entity separate from civil society. Others scholars of the state such as Michel-Rolph Trouillot and his colleagues (2001) argue that any analysis of the state should be examined in relation to civil society, since the ways in which the state manifests itself on the ground exists within a social contract between state and society. The state, though nebulous and difficult to define, can become examined through the effects it has on civil society.

In addition to the state, government and governance also operate as key terms in this section. Throughout this chapter, I want to think of governance through the definition provided by Didier Fassin in his introduction to his book *Humanitarian Reason* (2012). He argues for an expanded definition “as the set of procedures established and actions conducted in order to manage, regulate, and support the existence of human beings: government includes but exceeds the intervention of the state, local administrations, international bodies, and political institutions more generally”(1-2). Through this definition, Fassin introduces both the notion that governance may apply broadly to aspects of individual existence and this notion may be enacted through institutions outside of standard governing institutions. His expanded definition becomes particularly pertinent in my examination of healthcare, in which I see governance as specifically applying to the ways in which institutions affect the physical existence of human beings at the most foundational level.

Given these definitions of state and governance, I establish in this chapter the ways in which Uganda’s health welfare system becomes one of the primary ways through which individuals in Bududa understand their relationship to the state. I show how in Bududa, the

welfare system—and the health welfare system in particular—becomes an institution through which state governance is enacted and citizenship is negotiated. In the rural district, the national democratic framework of the Ugandan nation state breaks down and political participation becomes defined through institutions outside of the Ugandan government. Within this process, other forms of citizenship, such as economic citizenship (in terms of inclusion in a global economy) or medical citizenship (in terms of the receipt of adequate and globally competitive healthcare), become more important than a strictly Ugandan citizenship. In this context, the health welfare system, and specifically the site of the clinic, emerge as an institution through which individuals in Bududa interact with the state because that is the only entity that is available.

The Breakdown of Democracy in Bududa

In his ethnography examining the translation of Ugandan national development policies on the ground in the Teso region of Eastern Uganda, Ben Jones (2009) finds that individuals in rural Uganda feel that the government has pulled out of their lives. Government policies in rural districts cater more toward abstract international development expectations than toward the tangible and urgent needs of the rural poor. As a result, rural Ugandans feel disconnected from the state and other forms of social connection, such as connection to and service provided by religious institutions, become more influential in initiating local social change, especially for the sake of economic development. From here, Jones notes a larger trend in which individuals in rural districts in Uganda have felt increasingly marginalized by and excluded from the state. James's thoughts on the disconnect between rural districts and central governments in African countries is not new; he cites Goran Hyden, who coined the controversial term “uncaptured

peasantry” in 1980 to describe populations in the Tanzanian countryside ineffectively reached by a weak post-colonial government. Indeed, scholars of foreign aid in Uganda have questioned the ways in which external donor assistance and funding has been used by the Ugandan government to promote its own political image rather than to eradicate poverty in practice (Oloka-Onyango and Barya 1997).

These same sentiments of disconnection between the Ugandan state and its rural citizens are echoed by many of the individuals in Bududa, just Southeast of the Teso region where Ben Jones performed his fieldwork. In Bududa, distrust of the government is situated in expectations around welfare provision and in feelings of isolation from the democratic processes that create the state. Because of this, distrust of the government fuels political disengagement, which in turn reinforces further distrust. Put another way, for individuals in Bududa, the failure of democratic voting processes to place preferred leaders into power reinforces a desire to exist in isolation from the formal government. This distrust and subsequent loss of faith in government leaders leads to a functional absence of the state for individuals in the district. Or rather, a functional absence of the state effect as defined by strictly political terms. The state becomes less visible in its politic effects and more visible in other effects.

Discourses of distrust of the government circulated constantly around the Bushika non-profit clinic throughout my time in the field. Negative stories were shared between staff members and among patients. Throughout the summer, the clinic faced ongoing struggles with the district health officer (DHO), who refused to recognize the legitimacy of the new clinic because she believed the clinic leadership owed her a bribe. Government officials who had previously lent benches to the clinic for patients waiting to be seen took away the benches overnight for a town meeting in July and then never returned them. In the summer of 2016, the

entire country was coming out of an election in which the opposition leader had supposedly won the popular vote, but the longstanding Museveni administration remained in power (Karimi 2016).

For Sarah, the in-charge of MCH, one of the midwives at the clinic, and a 28-year-old woman from the capital of Kampala who moved to the Eastern region for work, the election systems often favor political leaders unsupported by rural populations. Elections in Uganda are mediated and governed by the Electoral Commission (EC), which was established as part of an article in the 1995 New Constitution for Uganda. The EC was tasked with independently overseeing elections in Uganda, which are currently held every five years, and was created partly in response to the political instability that characterized Uganda's early government in the second half of the twentieth century post-independence. Despite its theoretical creation as part of the constitution, the EC did not successfully organize an election until the 2006 elections, more than a decade after its formation (Electoral Commission 2016). For Sarah, however, the EC excludes rural populations rather than includes them. She notes,

The people can support somebody else, then by virtue of anything like popularity elsewhere, maybe by the electoral commission, someone else goes through whom the public does not wish. So, the majority of the public, most of the people, the poor people in the villages, just keep looking, they look at whatever is going on as if life just continues.

In her assessment, Sarah describes the process by which decisions made by the EC and voters in other areas of Uganda become more important than the voices of the individuals in rural areas who vote for elected leaders. Through such a system, the rural poor observe the events from what Sarah describes to be an outsider point of view. Through her narrative, Sarah shows a distance between individuals in rural areas and the government.

In her analysis of the creation of the state in modern Haiti, Chelsey Kivland (2012) identifies a form of what she terms “disordered governance” in the post-dictatorial democracy. In Haiti, despite the institution of a new regime of a supposedly stable government, individuals perceived a sense of statelessness. She argues that “Ultimately, the notion of statelessness serves to express both the need for a normal or proper ‘state’ of public life and the inability to locate a sovereign authority that is responsible for providing this life”(250). In Uganda, a similarly post-dictatorial democracy, these same ideas of statelessness could be applied to the individuals in rural areas who cannot find a state that they perceive to be serving them in public life.

This sense of statelessness through a lack of perceived government authority becomes accentuated through stories of distrust that circulate through communities. Phiona, an eighteen-year-old secondary school student visiting the clinic, described her perceptions of the government.

Okay, you can just hear from some people I’m talking to in the village. Everyone knows those people [government workers] are not really working. Like, they can send them money to help a certain village, for helping poor families, widows, and people who cannot help themselves. For them, they just use on their own things, they don’t take that money to those people whom their government has directed them to take for them.

Phiona describes a normalized and generalized knowledge around government workers as corrupt and selfish, which is underscored by narratives shared by the other members of her village. These government workers, under the control of a larger “government,” which perhaps has better intentions than the local government, hoard money and results are not seen on the ground. Of note in Phiona’s narrative, these discourses are premised under the assumption that government work, especially at the local level, must be measured by the welfare benefits given by the state and by the use of funds for the needy who cannot help themselves. In this sense, the efficacy of the nation state government becomes strongly tied to the ability of the government to

distribute welfare benefits to its poor. On the other hand, scholars have also noted how governments use welfare to reify their power and organize their subjects (Jessop 1999). Thus, the Ugandan government, in its failure to help the poor, both becomes perceived as important precisely through its potential to provide welfare benefits to the poor, and yet fails in its perceived power.

These themes, in addition to and informed by Jones's work, highlight the importance of understanding how individuals find alternative means of interacting with the government, given this disconnect between rural Ugandans and the state. In the context of the abstract feelings of isolation from the government experienced by individuals in Bududa, it is even more important to untangle the specific and concrete ways in which people do interact with the government. Traditional ways of understanding citizenship begin to break down as individuals choose not to participate in democratic processes; nor do they have extensive interaction with the state because of their distrust of the government's ability to conform to their expectations of the ways in which the state should serve them.

Bududa and a Uganda-Kenya Citizenship

Throughout the course of my research, I began to see Bududa as particular in its location close to the Kenyan border, which placed Kenyan urban centers and Ugandan urban centers as equally accessible. I offer this section as a way of problematizing a notion of Ugandan national citizenship and as an example of a circumstance where alternative forms of citizenship become necessary for survival, especially in an increasingly globalized economy. In his theorizations of citizens in the context of social change, Maurice Roche (1987) describes three aspects of citizenship: a civil element that consists of individual rights to freedom, a political element that

consists of the right to participate in institutions of power, and a social element that consists of the rights granted by the economic welfare state, which compasses rights to security and rights to adequate living standards. I want to think about how social citizenship becomes a dominant form of citizenship for which individuals in Bududa strive, which is most easily seen in the ways in which they search for economic opportunity in Kenya. Of course, this discussion opens up a whole new area for exploration, which is beyond the scope of this paper. Still, it offers an example of the multiple other ways in which citizenship in Bududa is negotiated and necessitates the need to examine other forms of citizenship and governmentality in the district.

The geographical proximity of Bududa to Kenya allows for free movement of individuals across international borders. Since the independence of Uganda and Kenya in the mid-twentieth century, border towns have served as essential centers for the movement of resources, items for sale, and people across the border (Lorch 1994). Out of the twenty individuals interviewed for this study, four had been to Kenya in search of economic opportunities or had family members who had done so. By comparison, only one individual had moved to Kampala, the Ugandan capital, in search of economic opportunity. Researchers examining internal and international migration in sub-Saharan Africa have noted the drive of economic opportunity for border crossing as compared with internal migration. Especially in the case of South Africa, where high levels of economic development mean increased employment opportunities, researchers have noted that employment concerns drive cross-border migration while internal migration tends to be characterized by both employment concerns and social concerns (Wentzel, Viljoen, and Kok 2006). Migration in sub-Saharan Africa has thus increasingly become an economic survival strategy in light of stagnant socioeconomic conditions and political instability (Adepoju 2000). Movement from Uganda to Kenya is additionally facilitated by similarities in language and

culture (Adepoju 2006). Individuals who leave for Kenya generally return to Bududa, but their return to the country is precipitated by family and economic situations rather than for a desire for civil or political citizenship within the nation of Ugandan.

In Bududa, movement into Kenya is motivated by multiple factors. Mercy, a nineteen-year-old mother cited the strength of the Kenyan shilling against the Ugandan shilling. She described, “let’s say you work [in Bududa], you work but the payment is low, now people prefer Kenya. Whereby you get something little, you convert it to here, it’s a lot.” The promise of stronger currency and its somewhat free circulation across the border allowed for wealth that would be otherwise difficult to obtain in Bududa, but also in the entire country of Uganda. Other informants offered stories of jobs and better education in Kenya, which contrasted with the subsistence farming prevalent in Uganda and the low quality education offered in the rural districts.

In the reverse direction, movement into Bududa is equally unregulated. Individuals return to Bududa for various reasons, which include marriage, a desire to be with their families, or the loss of economic profitability in Kenya. For example, another of the clinic midwives Jane had been born in Kenya to parents originally from Bududa. Her family had moved to Kenya in search of employment opportunities, and her mother found work as a housemaid and supported the family as a single mother after she separated from her husband. Later, her mother contracted HIV and was forced to return to Uganda, fearful of stories of forced euthanasia of HIV positive individuals in Kenya. Once driven back to Bududa at the age of seventeen, Jane spoke vaguely about the process through which she reclaimed her Uganda citizenship when she and her family returned to her mother’s family in Bududa. When asked about the citizenship process, she replied, “Okay, the process I don’t know very well. Because when we came this side, I live

permanently this side and I have ID for Uganda.” She was unable to speak of how she got this ID for Uganda, nor did she share information on her experiences—they were, from her point of view, insignificant and uneventful.

Given this freedom of movement across borders in search of economic opportunity—specifically economic opportunity rooted in the stability and strength of the globalized Kenyan economy—what happens to perceptions of citizenship and feelings of loyalty to the Ugandan state? Relationships with the Ugandan state seem to be pushed aside in favor of broader forms of inclusion. The freedom of movement in search of economic opportunities between Uganda and Kenya demonstrates a deprioritization of formal connections with the state. Given this lack of interest in explicit forms of governance from the Ugandan state, compounded with a general lack of trust and interest in the government as articulated in the previous section, how can relationships between citizens of Bududa and the state can and should be examined in other ways.

The Welfare Clinic as State

In the context of these fluid forms of Ugandan citizenship in Bududa, and as mentioned before, social welfare services become a key way through which individuals interact with the government. Social welfare in Bududa is predominantly delivered through the institutions of health and education. Especially when juxtaposed against a neglected physical infrastructure and a corrupt law enforcement system, social welfare in Bududa become a consistent and indeed essential way through which individuals access the services given by their government. In this context, though not the only institution through which governance can be enacted, the clinic becomes an important way for understanding how individuals interact with the state. This is not

to say that the clinic is the only site through which to understand citizenship in Bududa, but it provides insights into understanding rural citizenship vis à vis institutions outside of the classical understandings of governance, which fail to properly reach the population of the district.

Michel Foucault (1984) writes about the concept of biopower to describe how power in modern society is based off of governance that regulates the life of individuals. For Foucault, the government and its associated laws become normalizing institutions that regulate populations by creating strict definitions of normality in life. This comes in contrast to the regulation of populations through death found in most exercises of power prior to modern times. He extends this analysis to examine health in the eighteenth century, where he traces new state experiments that treat the body as an object to be controlled. Thus, government politics in the eighteenth aimed to improve the health of populations as a means of enacting power, and the clinic became a site through which governments could reinforce their power over populations by defining health standards and regulating treatments. Such a reformulation of government politics opens the door for the analysis of health as a way through which power can be enacted. Through this framing, the clinic in Bududa and its ability to regulate health can be seen as a way through which the state may exercise authority. That is, the clinic becomes a site through which government power is enacted and through which this power must be analyzed. This is especially important given the political system in Bududa in which government control in a politically democratic sense is perceived as absent by the people.

Individuals in Bududa, though they feel distanced from the government, nevertheless recognize the ties between the clinic and the state. This knowledge is especially well explained in the viewpoints of healthcare workers. James, the in-charge of the clinic and a clinical officer at a HCIV in a neighboring district, notes the driving forces behind the Ugandan government's

creation of the free health care system in 2003. For him, the government changed its policy “because now everything, they are like pushing it to politics. They want to make it free so that people can think that the government is helping.” In this statement, James gives the government credit for recognizing its failure to properly attend to its citizens. Simultaneously, he notes that government uses its supposedly democratic health care system to construct an image of efficacy. Health care from the top down becomes a way through which the government connects with its citizens on paper. This mentality is consistent with much of the government rationality behind creating a decentralized system. Decentralization ideally brings government services closer to the people, constructing an image of a competent and accessible government. Scholars have noted, however, that as decentralization has become normalized, its motivations have changed and it has increasingly also become a means through which the government consolidates power (Awortwi and Helmsing 2014). In the end, the creation of a theoretically accessible government serves to reinforce the power of the state.

The intrinsic ties among the government, citizenship, and health are further illustrated by the expectations of the clinic midwife Sarah, who in describing the Ugandan healthcare system notes that “the citizen is a business of the government.” When asked to elaborate on this statement, Sarah uses the example of death in the clinic, explaining that a death in a health facility would be a reason for the government to “come in with its long arm [and] reach you wherever you are.” In this blunt statement relating regulation of the state to the biology of the individual, protection of citizen life becomes a responsibility of the health clinic. When the clinic fails, the government comes in and intervenes. The clinic thus becomes an intermediary institution. The government oversight and regulation of the clinic for the sake of protecting its citizens further underscores the presence of the government specifically as it relates to health.

Indeed, every health clinic is responsible for reporting statistics for each month to the Ministry of Health. Surveillance of health thus becomes a main task of the state and the clinic allows for its execution.

The perspectives of James and Sarah support the idea of the post-eighteenth century clinic as a site of governance, especially as it pertains to Bududa. The government exercises its control in Bududa precisely through its ability to regulate the health of populations. In people's lived experiences, the government perhaps does not concretely execute power over populations. Nevertheless, the image that the government strives to create underscores the importance of the clinic as a site through which the government can create an image of exercising control for both itself and for its citizens. These connections between the government, its free clinics, and its potential to care for its citizens underscore the importance of examining governance specifically as it relates to health in Bududa.

Though the interrelatedness of the government and healthcare clinics are less explicitly stated in opinions of the general public, there is nevertheless an appreciation of the government specifically because of the healthcare it provides. That is, individuals in Bududa recognize the potential of the government run healthcare clinics. When asked about the benefits of the free government clinics, almost every individual answered that the free clinics were a good thing. Mercy, the nineteen-year-old mother from Kenya visiting the clinic notes that the free clinics are "good mostly in the village 'cause more people here are so poor actually mostly in the village, they cannot be able to afford themselves actually in private hospitals." The government, with its ability to provide welfare benefits to the poor if only on paper, is more appreciated when speaking in the context of healthcare than when speaking of the state in general. Still, though individuals praised the government's ability to provide healthcare for the poor, many individuals

would add that they personally would never use the clinics though they themselves identified as poor. In this way, the government successfully creates an image of providing for its citizens. This image, however, does not necessarily become internalized by individuals in Bududa and the benefits of the clinic remain inaccessible and thus unrealized.

Thus, the clinic becomes a significant way through which individuals understand their interactions with the state. It is through the clinic that individuals most potently feel the state effect. Though they feel disconnected from their government officials or disappointed by their ability to participate in the governmental system, people in Bududa recognize the state within their healthcare systems. As a result of this, citizenship, as navigated through the healthcare system, is essential for understanding how individuals feel included or excluded by the state, and how they exist under a Ugandan government and within national identity that is not necessarily viewed as the most important element of citizenship with which they chose to identify.

Chapter II: Pharmaceutical Actors

Given that individuals in Bududa understand their relationship with the government primarily through the healthcare system, this next section attempts to understand the ways in which they measure the efficacy of the healthcare system, and thus the Ugandan state at large, as well as the ways in which they frame their discontent. Through my fieldwork, I found that this relationship to the government is mediated through pharmaceutical medicines and the ways in which they are provided by healthcare workers. In Bududa, as in many cases, the pharmaceutical becomes an object onto which perceptions of medical care can be projected and thus becomes constructed as a symbol of acceptable treatment. As medicines become viewed as the only adequate form of treatment, the ability of healthcare workers to provide them is perceived as a measurement of the ability of the clinic. In this way, the healthcare worker becomes competent only in his or her role to provide medication. By extension, since pharmaceuticals are the way through which people measure the quality of care they receive, healthcare workers become the liminal actors that connect individuals with government services. That is, they become constructed as political figures and officials precisely in their ability—or failure—to successfully provide the drugs needed.

This chapter is titled “Pharmaceutical Actors” because I want to discuss both pharmaceuticals as actors in themselves and the actors who use pharmaceuticals to understand their relationships with each other. In the introduction to their book *Social Lives of Medicines* Susan Reynolds Whyte, Sjaak Van der Geest, and Anita Hardon identify five properties of medicines, the first of which is as follows:

Medicines are substances. Their materiality, their thinginess, is a property of great analytical importance for anthropology. As things they can be exchanged between

social actors, they objectify meanings, they move from one meaningful setting to another. They are commodities with economic significance, and resources with political value. Above all they are potent symbols and tokens of hope for people in distress”(2002:5).

Drawing off of this, I examine the pharmaceutical as a site through which to understand the broader context in health is understood in Bududa. Specifically, the pharmaceutical becomes an object through which power relations between the government and individuals in Bududa are understood and negotiated. The pharmaceutical becomes a representation of forms of power, as well as a place onto which individuals project their interpretations of the government. Similarly, Aliaa Remtilla (2011), writing about the ways in which Muslims living in rural areas imbue images of their religious leader with an external sense of significance, discusses the ways in which the “focus is on the content of what the images *say* and not on what they *do*”(190). In a similar way, the pharmaceutical becomes significant particularly in how individuals perceive it rather than in its tangible biological effect.

In this chapter, I examine the narratives circulating around pharmaceuticals and governmental clinics in an attempt to understand how individuals understand the ways in which the Ugandan state serves them. I begin by establishing the centrality of medicines to receiving care. Pharmaceuticals in Bududa were both a means by which individuals expected care and a means by which they negotiated for care. I then examine the ways in which pharmaceuticals become located within the relationship between the healthcare worker and the patient, and how it becomes an essential aspect of how patients interpret the competency of the healthcare worker. Since the healthcare worker serves as the liminal actor that physically connects the government service of pharmaceuticals to patients, they become essential players in mediating the relationship between individuals and the Ugandan state. I end by discussing the ways in which the experiences of patients around pharmaceuticals frame the healthcare worker as part of a

larger narrative of a corrupt government. With this narrative of the healthcare workers as a representative of an incompetent government through its inability to pharmaceuticals to its patients, individuals present their dissatisfaction with the welfare clinic, and by extension the Ugandan government.

The Centrality of Pharmaceuticals as Treatment

Shadowing the consultations between patients and the clinical officer or nurses, I often noticed that patients frequently negotiated with the physician for either different prescriptions or an increased number of prescriptions. For example, while sitting in a consultation and helping transcribe medical notes with Stella, a nurse with a diploma and thus the equivalent of a nurse practitioner, I experienced the following interaction from my fieldnotes:

Woman with very high BP [blood pressure] comes in for the first time, complaining about LAP [lower abdominal pain] and dysuria [painful urination] for two weeks... then she and Stella talk for a while (in Lugisu) and Stella tells me to add backache to her complaints... then asks the patient (in English) “Are you done?” She shakes her head and we add headache and joint pains to the list. Stella tells me that she told the patient that we can’t collect all the drugs to deal with all her complaints... so she gets a prescription of MGN [magnesium, helps with gastrointestinal disorders] and Aprinox [for high blood pressure] and a request to return for review [of blood pressure] in a month.

Throughout my interviews, individuals consistently used pharmaceuticals as a measure of the quality of care that they received from the clinic. If they received what they believed to be the correct pharmaceuticals, they were satisfied. If they did not receive any prescription, they did not believe that they had received care at all. As Whyte et al. note about medical care in rural Uganda, injections “were the prototype of biomedical therapy to the extent that people who went to a health unit and did not receive an injection were heard to remark that they did not get treatment”(2002: 109). For Whyte et al., injections in rural Uganda are equated with care and

thus become the only measure of receiving sufficient treatment. This definition of a prototype of biomedical therapy is expanded to pharmaceuticals in general in Bududa.

Because of this belief in the centrality of pharmaceuticals as correct representations of care, individuals in Bududa use their interactions with healthcare workers to ensure that they receive the medications that adequately cover their symptoms. In order to become satisfied with their care in government clinics, they attempt to present their symptoms in ways that allow them to better get the medicines that they believe will properly address what they perceive as their specific medical issue. This medical issue is imagined prior to contact with the clinic, and thus individuals enter clinic interactions with specific expectations of how their symptoms should be addressed. Even in patient interactions with healthcare workers in the non-profit clinic, individuals emphasize their illness in order to gaining medical recognition from the clinic, behavior that suggests remnants of the ways in which individuals in Bududa interact with government clinics to ensure some semblance of proper care.

In her ethnography examining the aftereffects of the Chernobyl nuclear disaster on Ukrainians suffering from radiation poisoning, Adriana Petryna (2013) identifies the emergence of a class of citizenship based on illness and biology. In what she calls biological citizenship, only individuals who fit into specific criteria of demonstrating radiation poisoning are eligible for compensation from the Ukrainian state. These criteria excluded the wide majority of the individuals who were affected by the nuclear disaster. As a result, Petryna finds stories of individuals who leveraged their medical symptoms in order to gain inclusion into the highly specified group of individuals able to gain recognition and benefits from the state. For Petryna, recognition from and inclusion into the Ukrainian state post-Chernobyl compensation system

becomes defined by restricted biological indicators. On the other hand, biology can also become a way through which citizenship is negotiated and individuals refuse to be silenced.

These same patterns emerge in Bududa, especially in consultation where patients meet with healthcare workers to describe their symptoms and receive treatment. Individuals who come to the health clinic in Bududa discuss their symptoms in such a way to maximize their chances of receiving pharmaceuticals and ensuring care and recognition. This point was not lost on the healthcare workers, as the in-charge of the clinic, James, was quick to note his distrust of patients' descriptions of their medical issues. He describes his process of examining patients:

You see, there are like, mostly, there's something we saw triage. Before you enter here to see patients, it is better for you to first move around. We check physically, we check this, it is like inspecting, you inspect how they are. By the face, you are teaching but you are monitoring them, yes? So, there are some who come here to exaggerate their symptoms, so that you can give them what? Medication. They think that when they come back like, maybe, they are like, squeezing their face you will see that this person is sick so you give a lot of drugs. So that is why when you check outside there, you can know who is exaggerating when they enter here. And when a patient comes in here and expresses himself or herself, the way you think it pretends, you can make that patient sit outside there, then you move outside as if you are going to do something else. When you are monitoring that patient, specifically him or her, then you see changes.

On both sides of the interaction, both healthcare workers and patients recognize that symptoms become a way through which individuals negotiate for increased care from the medical system in the form of increased medication. Individuals who do not receive enough medicines from healthcare workers view this lack of pharmaceuticals as an inefficiency of the healthcare system. As the government clinics do not properly serve them, patients use their interactions with healthcare workers specifically as a site through which they attempt to get the treatment and recognition that they deem satisfactory. Whether their demands are answered by the healthcare workers remains inconsistent.

The Healthcare Worker as an Actor

Jumping off this last vignette in which James becomes the ultimate decision maker about whether or not to provide pharmaceuticals to patients, healthcare workers enter the relationship as essential players through which individuals in Bududa assess the efficacy of the government clinics. Healthcare workers who deny or give the incorrect pharmaceuticals to patients become imagined as the reasons for why individuals find care at government clinics inadequate. For example, when asked if she was satisfied with the care from government clinics, Serena, a twenty-one-year-old mother described through a translator,

If she goes to Bufsanza [government HCIII], they don't give her all the medications. They can give her some and tell her to go and buy the rest. And again the drugs that she gets at Bufsanza that she feels nauseated when taking them, she really doesn't feel so good than the care that she gets from the private health care.

Serena even identifies times in which the healthcare workers were “not friendly” and turned patients away instead of giving the drugs. Her understandings of pharmaceuticals given by the public clinic go a step further in the sense that she identifies physical manifestations of what she perceives to be the low-quality of drugs given at government clinics, which do not compare with the care that she receives in the private providers.

Serena's narrative becomes situated in a theoretical framework presented by Whyte et al. Referring to work done by Mark Nichter and Carolyn Nordstrom in Sri Lanka, they note, “Whether a medicine works is not so much the result of its therapeutic substance but depends on the person who prescribes it”(2002:117). Nichter and Nordstrom call this “the power of hand,” in which the efficacy of the medicine comes with the perceived authority of the prescriber. Whyte et al. take this analysis a step further by delineating five facets of prescription, most notably that

the medicine represents the concern of the physician; that the prescription reaffirms the physician authority over patients; and that the prescription serves as an object of significance for both the physician and the patient. Thus, they argue that “the medicine is the materialization of a comforting word... the belief in the knowledge and kindness of the doctor adds to the reassuring effect of medicine”(2002:121). In this context, Serena’s perception that the medicines given to her by the government healthcare workers are inefficient and even harmful suggests a distrust with the authority of the healthcare workers and the government clinic in general.

These same themes become echoed in other narratives that patients presented about their experiences with government clinics precisely through their interactions with healthcare workers. Kari, a twenty-year-old student came to visit the clinic for general weakness and discomfort. She explained that she does not like going to the government clinics because of a previous experience with healthcare workers. “Okay, the people who were working there, they are tough. Sometimes, they just deny you medicine and yet it is maybe there. They don’t even tell you what is paining you, so, they just there like that.” For Kari, the government clinics give neither diagnoses nor treatment, but it is the healthcare workers who are actively causing the government clinic to fail in its ability to deliver care.

Similarly, Aidah, a forty-nine-year-old grandmother living up the road from Bushika market also worked as a peer educator volunteer for FIMRC, in which she came to the clinic a few times a week to give patients in the waiting room education on basic health topics. She was trained by the non-profit. She described the process by which she lost faith in the government health centers in a conversation through a translator.

They were confusing. So the last time that she went to the hospital, she was very sick. So when she went, they told her you have given problem. And uh, they wrote medication and said we do not have them here, but the other clinic, go and you find a drug shop and you’ll find some medicine for 30,000. So when she did

not have money, so she didn't go. She came back, she told of the pain, and said maybe now, this time when I go I will get medicine. When she went, they examined her again, they told her you are not sick at all. You don't have any problem. So she lost trust with them.

In all these stories, individual encounters with the healthcare worker, specifically tied to the absence or shortage of pharmaceuticals, become equated with dissatisfaction with care given and distrust of the healthcare workers, the primary providers of direct care in Bududa. In this context, the credibility of the government healthcare workers to provide appropriate care to patients becomes questioned. As healthcare workers lose their credibility precisely through their inability to provide effective prescriptions, their actions can be seen as undermining the authority of the Ugandan health welfare system in general. Healthcare workers, as the direct actors who distribute—or fail to distribute—pharmaceuticals thus become perceived as agents of the state onto whom dissatisfaction with government clinics is projected.

Healthcare Workers, Corruption, and the Government

In this context, a general mistrust of the healthcare worker forms in the district, one which is not dissimilar from the mistrust of general government workers described in the first chapter. Researchers have studied the ways in which Uganda's inefficient pharmaceutical distribution system leads to narratives of corruption around government healthcare workers. Within this inefficient distribution system, large chunks of funds in the budget become lost in spending and government-provided pharmaceuticals oftentimes do not make it to rural areas. As a result, healthcare workers become accused of hoarding pharmaceuticals and then selling them for their own profit (Nakabo-Ssewanyanya 2009). In Bududa, patients often received prescriptions rather than physical medicines at the government clinics. These prescriptions could then be used to purchase pharmaceuticals from private sellers in the market. Thus, despite the national

eliminated user fees in 2001, individuals in Bududa still must spend money to purchase medications that are not provided to them by the government clinic.

Sarah, an eighteen-year-old student delineated this precise narrative in describing that she always paid for government clinics whenever she turned to them for care. When asked what she paid for in the government, she responded:

In government? Okay, in government there are some, okay they don't have enough medicine so you know they can sometimes test you and when they find a disease they direct you to the clinic to buy from there, of which they are very expensive. They are not having. You can only get like panadose, and maybe also coartem. Then the rest they can direct you to go buy in their clinics 'cause those nurses they are working in the government hospitals. When the government sends for them medicine, they have their own clinics in the trading centers. They also carry the medicine in their clinics. Now, if you don't find in the hospital, they direct you their clinics to buy from there.

In her narrative and understanding of government health workers, Sarah echoes the well-documented understandings mentioned above about the corruption of healthcare workers as responsible for the shortage of government provided free pharmaceuticals in the district. This discourse of healthcare workers as corrupt and using government resources for their own benefits echoes the sentiments about distrust of government workers in general that I explored in previous chapter, which causes individuals in Bududa to lose trust in the Ugandan political state.

This sentiment was echoed by Edward, a 44-year-old man who walked eight hours with his ill father to reach our clinic while the government clinic was much closer, when he described his preference of the non-profit clinic to the government one. "People at the government, they want money. People from the government, they just give paracetamol, then they leave you there. Then they just write you go and buy it. It's not good." The healthcare workers, who perhaps cannot distribute these drugs precisely because of systemic issues in the distribution of drugs around the country, become blamed for the inability of the government clinics to properly serve

individuals. Regardless of whether the healthcare workers wanted money in reality, they become constructed as careless individuals due to their inability, or perhaps imagined unwillingness, to provide free pharmaceuticals to patients.

This inability of the healthcare workers to provide affordable medications for patients has implications on the care they receive. This narrative of corruption, widely circulated, also becomes used to explain individuals' dissatisfaction with the care that they receive at government clinics. For example, Agnes, a sixty-three-year-old subsistence farmer spoke about the economic limitations of the extent of her health-seeking behavior described her perception of healthcare workers in a conversation with me through a translator after she initially remarked that she believed the government health workers were careless. Of note, the translator Musa, who serves as the primary HIV counselor in the clinic, interjected to clarify during the translation.

J: So, can she give an example of when the government workers were careless? Can she tell a story of why she feels like the government workers don't care that much?

A: Sometimes, the government tells her, the medicines are supposed to be free. But sometimes, they want money but you don't have money. So sometimes, they can make you sit there for a long time, they don't attend to you.

J: So what do they do with the money, do they keep it?

Musa (translator, clarifying): Yes, corruption.

J: Interesting, okay, but they know it's supposed to be free? So why do the officials keep trying to get money?

Musa: Because, sometimes they want to get money for them.

For Agnes and Musa both, the perception of the inability of the government clinic to properly give free medications is tied to the individual greed of the healthcare worker. This has physical effects on the care that Agnes receives--she becomes inadequately served by the government clinics precisely because of the greed of the healthcare workers. In this way, the healthcare workers, through the narratives that circulate around their greed, become imagined as responsible for the incompetencies of the public clinics.

Thus, in Bududa, pharmaceuticals become the main ways in which individuals perceive quality care and demand for recognition of their illnesses. Within this centrality of the pharmaceutical, healthcare worker as the main administrator of pharmaceuticals becomes implicated as the agent and cause of poor quality care in Bududa. Dissatisfaction with the healthcare system in the form of dissatisfaction with drug supplies becomes mapped onto the worker as an agent of the state. By extension, individuals begin to imagine healthcare workers as similarly corrupt to the rest of the government. Whatever the mechanisms that cause these narratives to be formed, and no matter whether these narratives are true or false, they reveal how dissatisfaction and distrust of government healthcare workers in particular get translated into and conflated with distrust of the government system in general.

Chapter III: The Non-Profit as an Alternative to the State

Given the distrust of the state and the perceived inability of the government clinics to meet the needs of residents in Bududa, the non-profit enters as a placeholder and an institution more attractive than the government clinics. In this section, I trace the logics that cause the non-profit to become an institution for governance through its ability to provide higher quality healthcare within the district. That is, I look at the patterns that emerge that cause individuals to believe that the non-profit clinic is the most worthwhile institution through which they can attain some measure of health, and by extension, some sense of social inclusion within a larger system. The location of the non-profit and the services that it offers become a new institution of governance, and thus a sort of alternative state, through which individuals wish to negotiate for care and gain recognition.

This entanglement of the non-profit with the state and the subsequent reordering of state relationships as a result of this is not new in Uganda. As noted in the introduction, the rise of NGOs in the country in the 1970's and 1980's coincided with the collapse of the Uganda government and the instability and political reorganizing that followed. At that moment, the NGO took hold because of its ability to fill the gaps left by the fallen government (Barr et al. 2005). Similarly, the systems that currently restrict the ability of the Ugandan welfare state to properly serve its citizens have simultaneously carved out a space for the non-profit to take a hold in the sector. In this sense, the entire history of the relationship between Ugandans, the state, and the non-profit sector has been rooted in the idea of the non-profit assuming the roles of the state in serving its people.

The non-profit has more generally been recognized as an alternative to state and an institution through which power is consolidated, especially in Africa. In the evolution of the non-profit within the larger movement of humanitarianism, the NGO became reformulated as a necessary variety of humanitarian aid to promote “good governance” in Africa in the 1990’s. Indeed, as international organizations encouraged African nations to allow for alternative providers of welfare within the state, the number of non-profits in Africa grew dramatically throughout the last few decades of the twentieth century (Manji and O’Coill 2002). Through this process, scholars have noted that NGO’s have become “the preferred channel for service provision in deliberate substitution for the state”(Edwards and Hulme 1995: 6). NGO’s have thus become a substitute for state welfare programs at the same time in which need and demand for these welfare programs have increased.

Indeed, in theorizing about the state in the globalized world, Trouillot et al. (2001) discuss the ways in which there has been a “*déplacement* of state functions,” or a move away from the state system. They draw upon James Scott’s 1998 formulation of legibility: “a state’s attempt to make society legible, to arrange the population in ways that simplified the classic state functions of taxation, conscription, and prevention of rebellion”(2). In this displacement of state functions, other actors emerge that have the ability to create their own legibility effects outside of the state. With this ability to create legibility effects that parallels those of the state, these organizations begin to perform state functions better than the states themselves.

The process of creating the non-profit as a more desirable institution through which to seek care begins with pharmaceuticals. Just as individuals measure their relationship with the government through medications—by measuring the capacity of the government clinics to provide care and by negotiating for recognition from the governing bodies through these

medications—individuals use pharmaceuticals to form relationships with the new state of international governance, the non-profit clinic. The process by which individuals understand their relationship to governing institutions remains tied to healthcare and to the allocation of medications through the district. The non-profit clinic, because it is able to fill the void left by the absence of pharmaceuticals in the governmental system, comes into fill a void, and in this process becomes reimagined as a new, improved, and desired state of governance.

In this section, I look at this process of reimagination through three distinct aspects of the clinic's healthcare provision. First, I examine how the non-profit becomes reimagined as desirable through its ability to predictably provide pharmaceuticals. I then turn to the ways in which the competence of the clinic becomes perceived as going beyond predictability and consistency. The pharmaceuticals themselves, which are given by the clinic, become imagined as greater than the pharmaceuticals given by the state. Finally, the care provided by the clinic in general becomes associated with whiteness and the West. All three of these perceptions of the clinic contribute to its image as a more desirable institution through which individuals in Bududa seek healthcare and negotiate for some semblance of social inclusion.

The Non-Profit as a Consistent Provider

Just as the government clinics are deemed insufficient because of their inability to provide the correct drugs for individuals, the non-profit clinic is viewed as adequate precisely because of the consistent and accurate care they provide in the form of pharmaceuticals. As previously shown, pharmaceuticals in Bududa become the unit of measurement by which individuals view proper care by the system. Because government clinics fall short in their ability to meet the pharmaceutical expectations of patients, non-profits become understood as decent

providers of care because of their ability to meet individuals' expectations of what health clinics should provide them. Beyond having a consistent supply of drugs, the non-profit clinic charges a flat rate for drugs. Whereas individuals going to the marketplace could spend tens of thousands of shillings purchasing the prescription subscription drugs written by the government health providers, patients visiting the non-profit clinic spend a 2,000 shilling (1USD = 3,330 UGX at the time of my fieldwork) flat rate for being seen by the healthcare provider and receiving drugs. This becomes compounded with the resources of the non-profit clinic, which allow for testing of individuals prior to diagnostics and thus more trustworthy treatments given. As pharmaceuticals become the yardstick by which individuals measure care, the non-profit clinic goes above and beyond the failures of the government welfare clinics.

Sarah, an eighteen-year-old student studying in her senior four year at a school in Mbale, came to the clinic during a visit home. She reported suffering from stomach, muscle, and head pains in addition to bloody urine for three days, which she attributed to poor sanitary conditions in the bathrooms at her school. Since she was in Bududa visiting family, she decided to seek out care in the district before returning to town. Prior to the opening of FIMRC in Bushika, she would go to Bududa Hospital for healthcare. Though she reported that Bududa Hospital was significantly closer to her home, she explained her reasons for visiting the non-profit clinic instead:

Here, I know that when I come here and I pay my 2000 [shillings], they test me, they find a disease which is disturbing me, they will give me enough medicine which is going to treat that disease and I become well. But there [at the government clinic], they find a disease, they direct you to buy. Okay, sometimes, you cannot even be having the money to buy from their clinics because they are very also expensive. So you cannot buy from them and you continue suffering from a disease.

Notably, Sarah's logic centers around the predictability of the non-profit clinic. Her reasons for visiting FIMRC are strongly tied to the fact that she knows what to expect when she visits the clinic. The amount of money she pays, the ways in which they determine the disease that she has, and the provision of drugs by the clinic are all constructed as certainties, juxtaposed against the "sometimes" that she experiences in the government clinic. Her narrative ties together certainties with cure and uncertainties with continued suffering. The availability of pharmaceuticals plays a central role in the distinction between the certainty of the non-profit and the uncertainty of the public.

In one of the few ethnographies examining health in Uganda, Susan Reynolds Whyte (1997) writes about the uncertainty and misfortune in Tororo district, just south of Bududa. In her work, she explores how individuals understand their misfortunes, which encompass illnesses, and the factors that cause them. She argues that individuals in Tororo are aware of the uncertainty associated with misfortune, and by extension illness, and thus their systems for help-seeking are tied with a desire for pragmatic certainty to combat their world, which they see to be filled with uncertainty. Though Whyte's analysis follows the Nyole people rather than the Lugisu, Sarah's understanding of her preference for the non-profit clinic seems to echo this pattern of certainty-seeking as a defining feature of sufficient help.

These narratives of the certainty of the non-profit clinic become circulated throughout surrounding communities and create an image of FIMRC as an institution of predictability, all of which reinforce the non-profit clinic as a more desirable location for care. I interviewed Aidah in her home, about a ten minute walk up the road from the heart of Bushika trading center. A twenty-nine-year-old mother of four who had visited the clinic with her children on multiple occasions, she explained through a translator her understanding of the reputation of FIMRC,

which again is highly tied to the consistency of the drugs provided by the clinic. This consistency becomes equated with the moral weight of goodness; Aidah projects her own morals and valuations onto the services provided by the clinic. As a result, the community accepts the efficacy of the clinic.

So, the good from the FIMRC is that since the clinic started, she has never met any problem from FIMRC because every time she goes there she always gets drugs. And the picture from the community, what she believes is that, uh, there is no one person that is talking bad about the clinic, everyone is just appreciating the services and there is nobody who can pause and say maybe we shouldn't be accessing, everybody is just supporting it to accessing.

Similar sentiments were echoed by Mercy, a nineteen-year-old who had grown up and given birth to a two-year-old daughter in Nairobi, Kenya and had just recently returned to Bududa in March (she was interviewed in August). When asked why she chose to come to FIMRC for care rather than the government clinics, she explained,

Yeah I've never come here actually it is my first time for come for treatment but for what I know most of the people who come here I know them, but they've never complained of being, I've not been treated, they told me to come tomorrow, they have not given me this kind of medicine... they always get full treatment of the medicine they are prescribed for.

The words of her community, which emphasized the certainty associated with the non-profit clinic, influenced Mercy's care-seeking behavior and the ways in which she understood the care options in the district. As a predictable institution that rectifies the shortcomings of the government clinic, the non-profit becomes reified in both community discourses and in the imaginations of individuals in the district as not only a desirable location for care, but also as something good, as perceived by people in Bududa.

Imagined Healing

Beyond this ability of the non-profit to consistently fill the pharmaceutical gaps left by the governmental system, the medicines provided by the non-profit become reimagined, beyond their consistency, as products more effective than the standard pharmaceuticals. These drugs provided by the non-profit clinic become reimagined and reified as objects with more value than the (same) pharmaceuticals provided by the government clinic or local marketplace sellers. In their narratives about receiving treatment from clinics, the patients perceive drugs from the non-profit clinic as being superior, thus providing superior care that physically manifests itself in the body. Compared with the drugs offered by the government clinics, the drugs from the non-profits react better in the body and lead to a healing beyond simply a cure. Through these perceptions of the non-profit clinic drugs, the non-profit clinic becomes constructed as a more desirable locale for treatment and recognition within a larger state of governance.

Violet came to the clinic for family planning services. She was twenty-six and had three children, but she was looking for birth control from the clinic so that she could wait a few years before having another child, which she wanted to be the last. Specifically, she wanted to receive Injjectaplan, the Ugandan Ministry of Health-provided depo-provera option, which comes in the form of a shot given every three months. Through a translator, she explained her reasons for coming to the non-profit clinic rather than the government clinics closer to her home.

So she heard from a friend that here at FIMRC they first test you before they inject you, that some other health centers that you just go for family planning and they just inject you, give you a shot for injection, they don't test. So when she heard that she was very happy and she said I should go other side... She believes that when you are tested first with the health workers, and then they inject you, you first of all, you will have normal periods and secondly, saying you will not an injection when you are already pregnant because people get injections when they are already pregnant.

Violet later explained that she did not associate any danger with getting the injection if already pregnant, she just simply wanted to avoid the scenario. She did not provide any reason to why this was the case. Her story jumps off of the previous discussion with pharmaceuticals. In this specific case, however, the Injectaplan provided by the government clinics is the exact same drug used by FIMRC--the MoH provides the option for free for all clinics as part of its family planning initiative, which is notably significantly funded by international development multilateral agencies. The difference comes from the quality of the testing prior to the delivery of the injection. The injection provided by the non-profit, though exactly the same chemically, differs in the procedures prior to administration, and has the power to thus both lead to “normal periods” and to avoid the undesirable outcome of receiving the injection while already pregnant. The non-profit in this way becomes reimagined as an institution that has the power to create normality safer than the dangers associated with the government clinics, despite the actual medication being consistent between the two providers.

In the family unit in Bududa, the reasons for which parents entrust care of their children to the non-profit clinic reinforce ideas of the drugs of the non-profit acting beyond healing. Two mothers talked about the clinic as the place that healed their children, and subsequently the place to which they want to bring their other children. One mother with her child at the clinic declared, when talking about why she decided to bring her child to the non-profit option, said, “That in Arlington, she believes they can give her treatment and education that will lead to healing of the baby. Other than, taking to Bufsanza because she feels in Bufsanza they will not give her the proper medication.” For this mother, the proper medication so elusive from Bufsanza, when paired with proper education, leads to healing of her child beyond simple medication provision

or care. She emphasizes healing in this sense, trusting her child to the non-profit because of the benefits it provides beyond basic healthcare solutions.

Another mother echoed this sentiment and elaborated further on her perception of the non-profit clinic. Out of her multiple children, she talked about how her previous experiences affected her perception of the clinic and her decision to bring more of her children for care with the non-profit clinic over the government clinics. Through a translator,

There are three children. When they were sick, it has taken long period now, they took them to Arlington when this clinic was still part of Arlington so she took the two there. Since then, they have never fallen sick again up to know. That's why she always brings them, the remaining, this way. She's saying there is one she brought here, had cough, but now he's very okay.

She attributes the fact that her children have not fallen sick again to the healing power of the non-profit clinic. For her specifically, the non-profit then becomes the most desirable place that provides the most long-lasting care, care that transcends her normal expectations for the quality that she had expected. Especially in the context of Bududa, in which most of its residents are subsistence farmers, fewer trips to the clinic equates to less money spent on medications on care and less time diverted from farming. In this context, the power of the non-profit clinic to provide transcendent, long-lasting care, becomes even more salient and imagined as even more powerful.

Association with the Bazungu

With this belief in the power of the non-profit clinic to provide care, other forms of recognition and inclusion become important in the role of the non-profit clinic. There becomes trust and appreciation in the non-profit's ability to provide a different form of recognition for individuals in Bududa. The power of the non-profit begins to transcend the actual physical

capabilities it provides, becoming associated with a greater world and form of governance that extends beyond the state. Most saliently, the non-profit clinic in Bududa becomes associated with the *mzungu* (plural *bazungu*): white person. The desirability of the non-profit clinic becomes connected to the presence of these international whites. In the process of this association, the clinic also becomes reimagined as something more desirable, something transcendent and even better than the services it provides. This reimagination suggests to me an indication of a desire for recognition and inclusion into a larger international architecture of medicine and development.

Edward, a forty-four-year-old man accompanying his elderly father to the clinic echoed the general sentiment that the non-profit clinic provided drugs, which made it a more preferable site for healthcare seeking than the untrustworthy and inadequate government centers. His reasons, however, attributed the predictability of the non-profit clinic to the presence of whites. He explained through a translator that he came:

Because here we [the healthcare workers] are cooperative and we give medicine and we treat it well. And they saw you *bazungu*, when you are here, they just come because *bazungu* treats us very well... You are not like us Africans. You treat very well and you handle them very well. And you give drugs. You see... So, that's why he decide to come here, but in Bushiyi, if you go in Bushiyi, they just give you only paracetamol so the remaining tablets you go and buy it. But here for us we don't want to send them away.

Similarly, a conversation I had with Kari, a twenty-year-old in her senior four year at the Bulu Girls High School in the district, echoed these same themes.

K: Yeah, why I like the service? At first, they told me that there are whites, so I had that interests, that whites are social, so I had that interest.

J: Whites? Like white people?

K: They're social to people.

J: Even though most of the nurses are from Bududa, you still think they are nice?

K: At least those ones who are working within you, they are social and friendly. But, some hospitals, they are tough, they don't want to listen to someone's problems, just like that.

For Kari, the power of the *bazungu* rubs off on the healthcare workers. They become social and friendly, in contrast with the healthcare workers at the African centers, who both Edward and Kari agree are unfriendly and threatening. For these patients, the proximity of the clinic to individuals who are white creates a clinic that is more welcoming and more desirable than the Ugandan clinics. This proximity to the *bazungu* leads to better and more predictable care; it leads to a more desirable location of health provision than the Ugandan welfare state. This association becomes especially prominent when placed in the context of pharmaceuticals seen as the most acceptable form of care. As Whyte et al. (2002) found while examining the ways in which mother seek medications for their children in Manila, “it became clear that modern medicines’ efficacy is related to their metonymic associations—made in the United States—tested by doctors—made in clean laboratories”(28). As in the Philippines, these individuals in Bududa begin to create discourses of metonymy that recreate the most efficacious medicines, and the most efficacious care, as conflated with proximity to the *bazungu*.

This patient perspective on the non-profit clinic in relation to the government clinics seems to be based simply in perception of individuals based primarily on their appearance, with other facts serving to reinforce this perspective. To perhaps put this patient perception into context, both Emma, the lab technician at FIMRC, and Sarah, the head midwife of the Maternal Health ward explained their preference for the non-profit clinic. Both Emma and Sarah work at government healthcare centers in the neighboring district of Manafwa, and both hold leadership positions in their respective government centers. They both expressed sentiments, however, about the high quality of care provided by the non-profit clinic over the government clinic precisely because of its role as part of a greater Western international system. For Emma:

Ideally, love has been a forgotten thing. We are just trying to catch up with the Western countries whereby somebody should get to know like, what they are really suffering from 'cause of Western education. Before in the olden days, they are not really that. You just come and present your problem and somebody thinks of any drug, like there's a lot of, uh, trial and error in your treatment method, there is someone tries to combine a number of drugs, antimalarial, antibacterial, like that, and maybe you get better along the way, which is one thing we are fighting currently. Like, you should treat what you know. If you don't know, this person should be referred to the next level.

Emma juxtaposes the difference between Western medicine, which involves treating a known disease found through testing, and old Uganda medicine, which involved trial and error. In his statement, he echoes the voices of the patients in the recognition of the juxtaposition of certainty versus uncertainty, but for him, the certainty comes from the fact that the treatment is distinctly Western. He sees his country as working to catch up with the Western standards, but the efficacy of the clinic comes from its ability to be standardized and predictable within a scientific framework.

Sarah echoed a similar sentiment. For her, the Western standards are essential for ensuring discipline and proper care.

Actually I think working, actually not thinking but the real thing is, working at FIMRC is much more better than working at government because at government, somebody just does what he or she wants, but at FIMRC being an NGO, you have to really look at the standards that have been set by your employer or else you can easily be fired from your job. But with government, yeah government they also come in and look at the way we work but in most cases we are so many so everyone will be saying, 'ah, so and so will be doing this, so and so will be doing this.' But now like, at FIMRC, I am now the in-charge of MCH and therefore I must make sure that every other corner of MCH is in proper condition.

These perspectives from Emma and Sarah help to put the perceptions of the patients in context. From both an abstract level of the kindness of individuals working in the non-profit clinic to the more concrete level of the standards of treatment and care set by the non-profit, FIMRC becomes, in relation to the government clinic, more powerful and more desirable

because of its proximity to Westerners and to the *bazungu*. Through this process of the reimagining of desirability of the non-profit clinic, individuals turn to the clinic not simply because of its ability to provide better care, but because of its ability to provide better care, which is situated in an understanding of its connection to a broader Western international development system. Through this process, then, the non-profit not only fills the gaps left void by the government clinics, it provides a peek into an alternative form of governance. This more desirable alternative, reinforced through the healthcare options in the clinic, thus reinvents understandings of governance beyond the state in Bududa.

Conclusion: Implications of the Para-State

Through these three chapters, I have attempted to deconstruct the specific ways through which the non-profit health clinic reworks citizens' relations with the Ugandan state in Bududa. Since healthcare provided through the welfare system becomes the primary means of interaction between the citizen and the nation state, the Ugandan government fails its citizens through its inability to adequately provide the necessary services to maintain the health of its population. As the non-profit enters the scene and more competently offers the services that the state cannot, it interrupts the social contract between the citizen and the government and introduces new contracts to be made. Patients seeking care from the non-profit health clinic negotiate for inclusion through an institution of governance beyond the nation state because it offers more desirable care. As they search for the care that will best support their existence, patients in Bududa create and mediate this shift in understandings of the Ugandan state. Their actions both result from and contribute to the changing notions of healthcare governance as provided by the Ugandan state in relation to the non-profit.

One aspect of the Ugandan government has been conspicuously absent from my analysis, and I will use this conclusion to briefly situate my argument within the fact that the Ugandan government is a stable and supposedly democratic state. One narrative of development suggests that perhaps the goal of international aid should be to create societies that catch up to the standards of the "developed" world. Even the vocabulary used around "developing" nations imply that they are on their way to becoming developed. Within this development, a specific kind of government becomes legible, which is oftentimes based in the Western project of spreading democracy and neoliberalism. Uganda, like many other post-colonial African nation

states, tried and has continued to try to make their own experiment in democracy. Within this experiment, the country has created democratic election process, written and amended constitutions, and formulated a health welfare state. These elements of democracy, however, have not necessarily translated on the ground, where I have shown the ways in which the health welfare state has not achieved the intended benefits to its people.

The narrative expected for countries like Uganda places an imperative on helping the country to become more democratic through the course of development. The democratic experiment in Uganda competes with the influx of international aid aimed at improving the social and economic elements of people's lives. One perspective to examining these effects could conclude that the democratic elements of the Ugandan state are challenged through development efforts aimed to improve the health of the population. That is, one element of development is compromised for the sake of achieving another element.

An alternative perspective could conclude that the democratic elements of the Ugandan state are neither challenged nor enhanced through international efforts to achieve development. Rather, the Ugandan democratic state becomes transformed. In 2015, P. Wenzel Geissler published a collection of essays examining the presence of "para-states" in Africa, especially in the context of medicine science. He defines this "para-state" as "the chunk of the original nation-state that is parceled out and run differently, shaped by market operations. This para-state 'takes on some of the roles' of the nation-state without being part of or coextensive with it"(9). Despite this, the para-state is still connected to the nation. He argues that the nation state remains highly present in African nations, but its presence is obscured by and often enacted through the presence of these para-states. For Geissler, even when perceived as absent, the state is constantly present.

In Uganda, then, I see the presence of a form of non-profit governance as creating a sort of para-state within the nation. The non-profit clinic, though it offers a different possibility of governance for individuals because of its ability to provide healthcare, still operates within Uganda's borders. It may be imagined as separate from the state, but in fact mirrors state apparatuses and exists within state systems. This para-state begins to exist because the non-profit fills in the gaps where the Ugandan state is absent or inadequate. Collectively, they might possibly form some sort of whole. That is, the Ugandan state and the non-profit collectively begin to provide the services necessarily for the holistic life of the population. Neither can provide all the necessary services for Ugandan citizens on its own.

The creation of this para-state makes clear one of the ways in which the architecture of global health becomes mapped onto Uganda. Though the architecture of global health is by no means well-coordinated or at its maximum efficiency, I hope I have shown the ways in which two particular actors—the Ugandan state and the international non-profit organization—have interacted on the ground. In this context, I want to end by thinking about the implications of this intersection on healthcare in the country. What are the implications of this para-state for sustainability? What motivates the government clinics to improve their services if the non-profit clinics in the area can often the services needed by the people? What happens to if the non-profit pulls out? And does the non-profit have any responsibility to pull out at all, if it can provide the essential services that are lacking in the state institutions? By this logic, does the non-profit have responsibility to stay, regardless on the effects on the government structure?

These are perhaps rhetorical questions that cannot be answered by generalizations or ethical theories. The fact of development is that despite all these complexities inherent in the ways in which development is enacted, especially through non-profit institutions, individuals

who are sick will seek care from the clinics that will best serve them and their families. In viewing healthcare given by the non-profit as changing the ways in which individuals interact with and understand their relationship with the state, expanded notions of citizenship and governance become essential to understanding forms of governance created through the new world of transnationalism created by globalization, international aid, and the architecture of global health.

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