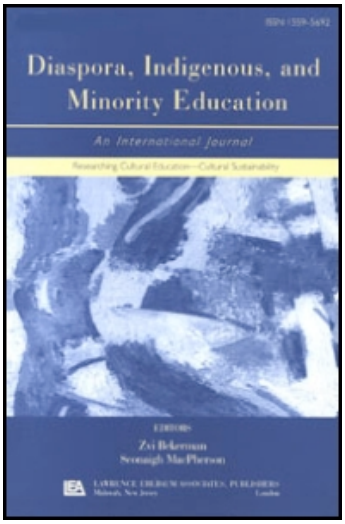

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Meeting the Challenge of Health Literacy in Rural Uganda: The Critical Role of Women and Local Modes of Communication

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Meeting the Challenge of Health Literacy in Rural Uganda: The Critical Role of Women and Local Modes of Communication

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This article seeks to better understand the relation between local and traditional modes of communication and health literacy within the context of a rural West Nile community in Northern Uganda. Drawing on social semiotics (multimodality) and Bakhtin's notion of the carnival, the focus is on a group of women participating in a grassroots literacy program and their use of local modes of communication to address the endemic problem of malaria in the West Nile region of Uganda. The argument is that women and local modes of communication can serve a critical role in disseminating primary health care information in particular and in community health care development in general. This article also makes a case for adopting a more holistic approach to health literacy promotion; one that brings together local and new modes of communication and knowledge with desperately needed health care services and trained personnel.

If I knew the mother of death
I would go there right away
And kill it
And never leave any of its family members

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Or relatives to remain.
I would destroy them completely
So that they never rob us again of our loved ones. (Translation from Alur, site visit, December 6, 2005)

This mourning rhyme was composed by people in the West Nile area of Uganda; when recited orally, the rhyme communicates grief during times of bereavement. In this article, we seek to better understand the relation between local and traditional modes of communication and health literacy within the context of a rural West Nile community. We focus in particular on a grassroots literacy program and its use of local modes of communication to combat the endemic problem of malaria in this region. We argue that women and local modes of communication can serve a critical role in disseminating primary health care information in particular and in community health care development in general.

The millennium development goals put forth by the United Nations in 2000 identify the eradication of malaria (along with HIV–AIDS and other diseases) by 2015 as central to the development of a nation (Muhe, 2002). In sub-Saharan Africa, it is malaria, rather than HIV–AIDS, that poses the greatest health threat (Yamey & Attaran, 2003). Although completely treatable, it claims over 3 million lives per year (Sachs, 2005). The Organization of African Unity established that "the re-emergence of malaria is due to many factors among them declining vigilance and a decrease in resources for malaria control" (Muhe, 2002, p. 6), and urged the international community to provide support for malaria control. Sachs (2005) argued that donor assistance to fight malaria is shockingly minimal given that it is truly a life-and-death concern. Indeed, for the International Monetary Fund and World Bank, malaria does not register on the "policy radar screen" (p. 200).

In 1998, the World Health Organization launched the Roll Back Malaria campaign with Africa as its target (Muhe, 2002). Although Uganda joined the campaign, malaria still remains a major killer in the country. Transmission is high in 90% of Uganda, with 5% of the country, mainly in the highland areas, subject to unstable transmission and epidemics (Centers for Disease Control, 2006). It is estimated that 93% of the total population is at risk from malaria. Malaria contributes to by far the major share of the disease burden in the country; current estimated annual numbers of deaths from malaria are from 70,000 to 100,000.

HEALTH LITERACY IN AFRICA: PROBLEMS AND PROSPECTS

In the past, most Ugandan health education programs targeting malaria have been based mainly in print media—pamphlets, leaflets, and newspapers—embedded

in the literacy practices of a reading culture (Majalia, 2004). Such information distributed in print form is often inaccessible to Ugandans in rural areas in particular, where oral culture remains the preferred means of communication. In recent decades, there has been a move toward television and Internet as an alternative to disseminating health information to the masses. Radio has also been a popular medium for health education because of its general affordability and the fact that it is embedded in spoken communication, which is more commensurate with cultural communication practices. Research, however, shows that broadcasting receivers per 1,000 inhabitants are still very low throughout Africa, where approximately one in five people owns a radio compared to other countries that have one radio per person (World Bank, 2003). In terms of Information and Communications Technology use, the United Nations Development Program (2001) reported that telecommunications and Internet costs are particularly high in developing countries compared to developed countries. For example, although monthly Internet access charges may amount to 1.2% of an average income in the United States, it is 614% in Madagascar. In Uganda, Internet costs are on average $50 per month (McConnell, 1998). Madzingira (2001) decried the high costs that make it difficult for telecommunications and Internet to reach a majority of rural communities.

Despite this low ratio, there is an upward trend in the introduction of various media including radio, televisions, telecommunications, and Internet as sources for disseminating health information (Madzingira, 2001). Technologically based means of communication, which currently dominant Western societies, are slowly increasing in urban areas of Uganda, replacing print-based methods of disseminating health information. New media for promoting health literacy, however, have yet to penetrate the whole Ugandan strata, particularly rural areas.

To promote health literacy[1] in rural communities, various researchers are calling for the revitalization of African traditional and local modes of communication. Morrison (2003) argued, "if rural people are to be reached and persuaded to change behaviour, expanded uses of more traditional media are needed" (p. 2). In Uganda, where 80% of the population lives in the rural areas—the majority being women (United States Central Intelligence Agency, 2006)—adequate health information is unlikely to reach the most needy if technological media such as radios are the only source of dissemination. Furthermore, women, who are the primary caregivers, do not typically have access to radio broadcasted information because most have no control over family finances and therefore no means of purchasing radios or batteries. To further compound the problem,

[1]According to Nutbeam (2000), health literacy represents "the cognitive and social skills that determine the motivation and ability of individuals to gain access to, understand, and use information in ways that promote and maintain good health. Health literacy means more than being able to read pamphlets and successfully make appointments. By improving people's access to health information and their capacity to use it effectively, health literacy is critical to empowerment" (p. 264).

the overburden of domestic responsibilities permits women no time to listen to radios. To reach this critical group means alternative modes of information dissemination are required.

Conversation remains vital in Uganda, and many rural communities prefer the interpersonal speech that technology fails to provide (Morrison, 2003). Boateng (1983), who examined the various ways language was used to communicate African cultural values, identified four categories of oral tradition—fables, myths, legends, and proverbs—that were inseparable from other segments of life. Fables were used to pass on moral values; this storytelling genre was often characterized by periodic bouts of singing that kept listeners engaged, interested, and involved. Myths and legends were used to communicate cultural and political information by relating precedents to present, everyday beliefs, actions, and codes of behavior. Proverbs were powerful tools for initiating conversations about the natural world to measure and promote cognitive development among young people. The young people who deciphered the deeper meaning of the proverbs were considered wise and were taught how to pass on this information (Reagan, 2005). Boateng (1983) wrote that proverbs helped both child and adult to see the world from the same vantage point. African modes of communication ensured continuity of traditions but, more important, they facilitated intergenerational communication. As Boateng concluded, "traditional education was not there to be only acquired but also to be lived" (p. 332). These modes of communication have been eroded by formal schooling where unschooled parents feel unable to contribute to their children's learning. This erosion has led to the breakdown of intergenerational communication, which was central to African traditional education.

African modes of communication have contributed to communities' sense of agency and empowerment to act, something that has been completely lost in technological media where information is targeted to individuals and provided by experts unknown to members of the community (Majalia, 2004). This factor may be one of the primary reasons why health literacy has not fully penetrated the rural communities and why oral modes of communication are currently being considered as alternative sources of health information for rural communities. Silver (2001) highlighted the advantages of African modes of communication. First, there are high levels of engagement with the audience because messages are developed from what communities already know, giving ownership to the local people as they apply the story to their own lives. Second, there is the repeatability factor inherent to oral modes of communication, which makes it possible for communities to remember the conveyed message. Of equal importance is that oral tradition bridges the generational gap, hence fostering intergenerational communication. Finally, unlike expensive technologies, human resources are locally valued, inexpensive, and readily available. Silver, too, called for the revitalization of African modes of communication if health literacy is to be achieved

in African communities. Similarly, Mushengyezi (2003) made a strong case for rethinking indigenous media as forms of public communication. He suggested that the rituals of "talking" drums and orality in Uganda can be highly effective in disseminating health information in particular. He argued that because indigenous forms of communication are embedded in the cultural ideology of the people, as Uganda adopts new modes of communication, communication planners should take into account how these cultural forms of information can enhance learning.

THEORETICAL LENSES

Until recently, there has been a privileging of written modes of representation in theories of communication. However, scholars are increasingly recognizing that in any communicative mode, language, whether written or spoken, is only partial to the meaning-making process (Kress & Jewitt, 2003). Indeed, any communicative event involves *simultaneous modes* whereby meaning is communicated in different ways through images, gestures, and speech. Kress (2000) asserted that we need to take a completely fresh look at theories of communication to set a new agenda that includes the full range of semiotic modes in use in a particular society. Integral to this new agenda is how cultures select from and choose to develop particular multimodal possibilities for communication (Kress & van Leeuwen, 1996).

The human body has a wide range of communicative possibilities; each of the senses is attuned in a specific way to the natural environment, providing us with highly differential information (Kress, 2000). Communicative possibilities draw attention to the idea that "meanings are made, distributed, received, interpreted and remade in interpretation through many representational and communicative modes—not just through language" (Kress & Jewitt, 2003, p. 1). A multimodal–social semiotic approach to learning begins from a theoretical position that treats all modes of meaning making as equally significant.

We find Betts's (2004) perspective on communicative practices particularly helpful in the cultural context of Uganda, where oral tradition historically has played a key role in communication (e.g., Mushengyezi, 2003). Betts combined "communicative practice" with the anthropological notion of "cultural performance" in what she referred to as communicative performance, which she described as "conscious acts of performance, moments of theatre in a complex, multidimensional and shifting tapestry of discourses" (p. 82).

Bakhtin's (1984) notion of *carnival* extends our understanding of performance as a pedagogical tool. Bakhtin (1984) described the carnivalesque as something that is created when the themes of the carnival blend, mutate, and invert social order. With its masks, monsters, games, dramas, and processions,

carnival juxtaposes, mixes, and confronts the spiritual and material, young and old, male and female, daily identity and festive mask, serious convention and parody, in a "temporary suspension of all hierarchic distinctions and barriers ... and of the prohibitions of usual life" (Bakhtin, 1984, p. 15). The aspiration of carnival is to uncover and undermine the hegemony of any ideology that seeks to have the final word about the world, and also to renew and illuminate hidden meanings and potentials, while simultaneously projecting an alternate conceptualization of reality.

Bakhtin's (1984) association of carnival with the collectivity also allows us to examine modes of communication within a *wholistic* structure whereby people, when gathered together, do not merely constitute a crowd; rather they are seen as a whole, organized in a way that defies socioeconomic and political organization (Clark & Holquist, 1986). According to Bakhtin (1984), "[A]ll were considered equal during carnival. Here, in the town square, a special form of free and familiar contact reigned among people who were usually divided by the barriers of caste, property, profession, and age" (p. 10). At carnival time, the unique sense of time and space causes the individual to feel he or she is a part of the collectivity from which arises a heightened awareness of one's sensual, material, bodily unity, and community (Clark & Holquist, 1986).

Dialogism is a fundamental aspect of the carnival—a plurality of "fully valid consciousnesses" (Bakhtin, 1984, p. 9). Multiple voices—each bringing forth a different point of view, a different way of seeing the world—come together in the free and frank communication that carnival permits; although "each retains its own unity and open totality, they are mutually enriched" (Bakhtin, 1984, p. 56). "Carnival is the place for working out a new mode of interrelationship between individuals ... . People who in life are separated by impenetrable hierarchical barriers enter into free and familiar contact on the carnival square" (Bakhtin, 1984, p. 123).

CONTEXT

Backdrop to the Research Project

Plagued by civil war over the past 20 years, the northern part of Uganda has become extremely isolated and unsettled, placing rural residents at a distinct economic and social disadvantage in relation to other parts of the country. Just to the west of this northern war-affected region is the West Nile, which is the site location for this study. The people in this region are primarily Alur speakers, and oral and performance traditions such as story, song, and dance are integral to communication in this community. People share knowledge indirectly by singing, dancing, and dramatizing their understanding of a wide range of information and events in their lives.

An innovative community literacy program (UPLIFT-Uganda[2]) responded to the urgent need to provide health literacy in rural parts of the country by using local and traditional modes of communication as a platform for providing critical information about malaria, which remains this rural population's greatest health threat. This pedagogical approach emerges from the work of Augusta Boal (1979), who used theatre as a mechanism for self-liberation of oppressed populations in Brazil and Peru, and Freire (1973) who used interactive theatre in Brazil as a tool for facilitating dialogue in education. UPLIFT-Uganda, which is based on the Freirian philosophy of emancipation through interactive participation (Freire, 1973), has been operating in West Nile since 2000. The literacy program, although open to all community members, is designed for women because they are primarily responsible for family health care, household and compound maintenance, and food production. In addition, in the area of Uganda, the vast majority of women (90%) are unable to independently access print-based information.

Data Sources and Participants

As part of a larger study on literacy, gender, and development in three Ugandan communities, the study we report on here focused on 15 women who were enrolled in the UPLIFT literacy program from March to December 2004. Data sources included observations based on program and home visits, informal interviews, and document collection. Dramatic performances were videotaped. Key informants such as the UPLIFT program director and developer, the attendants (nurses and medical assistants) at three local parish health centers, and the local council chairman were also interviewed. All interviews, which were conducted in Alur and translated into English with the assistance of two locally trained research assistants, were audiotaped.

The women in the literacy program were from three parishes (five from each parish), all within a 30 km radius. They ranged in age from 22 to 53 years; all were married with children[3] and had no prior formal school experience. All of the women in the literacy program were invited to participate in the research study. Selection of the 15 women was based primarily on the likelihood that they would complete the literacy program, which to a large extent was dependent on whether they had the support of their husbands and families.

The rhythm of daily life. The women's daily activities revolved primarily around domestic duties such as food preparation for the family. Cassava was their main food crop, with other crops such as millet, beans, maize, and sorghum

[2]Uganda Programme of Literacy for Transformation.

[3]On average, each of the women had six children.

grown in smaller quantities. They described a typical day as follows: Wake before sunrise, sweep the compound, clean the house, chop wood for the fire, prepare breakfast, prepare children to go to school, go to the garden to dig or weed (and sometimes harvest food), collect water (usually from the River Nile), prepare breakfast for self, cook lunch for the family as the children return from school, collect more water for the family's use, collect firewood, prepare tea for the children when they return from school in the late afternoon, pound cassava for the evening meal (they emphasize this is a very strenuous task), cook supper for the family, then sponge-bathe the younger children. In between afternoon and evening activities, some of the women tried to do homework with their children in lower primary (Primary 1 and Primary 2). On the days when the women had their literacy class, the day started much earlier; sometimes they had to miss going to the garden to make time for attending classes twice a week from 3:00 to 5:00 p.m.

The women and their families lived in circular-shaped mud houses with thatched roofs; the homes were typically one room, which served as both living and sleeping quarters for all family members. None of the families had access to electricity or running water. The nearest public health clinic was 30 km away. It is also worth emphasizing that without exception, the women had primary responsibility for the health and well-being of their family members.

Data Analysis

We adopt a critical ethnographic stance in our analysis of the data (Brodkey, 1987; Carspecken, 1995), taking the view that the ethnographic context is one of cooperative storymaking that ideally results in a polyphonic text that transcends notions of observer–observed (Tyler, 1986). All transcripts of conversations, interviews, and observations were analyzed and coded using a constant-comparative method (Glaser & Strauss, 1967; Lincoln & Guba, 1985). Triangulation of codes and themes was applied across the various data sources and a constant application of member checks (with members of the research team, literacy facilitators, and the women themselves) was used throughout the data collection and analysis cycle. The data are presented thematically, beginning with local health care challenges and progressing to an innovative solution to meeting these challenges. For the purposes of this article, we concentrate our discussion on a traditional performance example.

HEALTH CARE IN THE WEST NILE

Means of Disseminating Health Information

People in the West Nile relied primary on oral communication for disseminating new health information (e.g., about vaccinations, epidemics, etc.). Parish

mobilizers[4] and church leaders in particular were heavily depended on to transmit key health information to other community members:

> These people access health information through parish mobilizers, also LCs [local council members] through whom we can send our information … we have got Churches and mosques whereby announcements concerning health are made in those areas when people gather for prayers. (Attendant at local health center in Parish 1, December 2004)

The rural communities in this area also relied to some extent on radio communication for new health information. In recent years, however, economic difficulties significantly diminished radio communication because many people could not afford replacement batteries for the one radio in the village, and electricity is not yet available in this area of Uganda. Although spoken communication through community leaders has been effective in certain areas, disseminating health information in more remote areas was routinely problematic because of transportation difficulties:

> If there is enough money [we] use the radio, but since there is very little money, we use these people [parish mobilizers] to spread the message. … Some people are very far from the health centre. Some people are something like five miles or even more so information can not reach them in time, if you fail to get these people to send. … We need at least something to make transportation easy. Here since it is a health centre, there is no motorcycle. We need a motorcycle to ease our transport, because bicycles at times break down. … There are only two bicycles in good running condition. (Attendant at local health center in Parish 1, December 2004)

Print material such as health posters and information letters were sometimes distributed in remote areas, but with limited success because of low literacy levels. One of the solutions was to organize health education workshops in more central locations, but the problem of low literacy also made it difficult to inform people about where and when the workshops were to be held:

> We have posters. Sometimes we send posters, like at the landing sites, the market, the churches, and these can be given out at funeral rites. Sometimes we give them health education here when they come for health services. This is when they get their health messages. (Medical assistant at health center in Parish 3, December 2004)

> The LCs are very important people we use to send health messages. … Usually we use the Parish mobilizers. We use them, we write to them letters, and call for them to come here … [but] sometimes people are away from home, the landing

[4]Parish mobilizers work together with the Local Council II in district governance.

> sites. Some remain in the garden for long. The whole day long, they might not get the message. That is the biggest problem . . . some people do not know how to read and write so when you put things down, they may not know. The literacy level here is still low. (Medical assistant at health center in Parish 3, December 2004)

Barriers to Providing Health Care and Treatment

In addition to the ongoing challenge of communicating health information to the rural population, health attendants were also confronted with considerable difficulties in providing health care and treatment. One of the most persistent problems was the issue of medical staff in this area of the country. Lack of appropriate accommodation for essential personnel such as midwives and traditional birth attendants, unqualified health care workers, lack of medical supplies including medications, and low or non-existent salaries continually exacerbated the problem of providing health care to the West Nile residents:

> This health centre was supposed to have a good number of staff, but recently one staff member died, and there has been no replacement. Another one was transferred and no replacement. These are the problems I am facing. Also there is a lack of accommodation. The midwife was supposed to stay within the quarters, but it is not good for her to stay here because there is no place for her . . . one cannot work from morning to sunset and then evening again until the next morning. . . . This is the most challenging problem. (Attendant at local health center in Parish 2, December 2004)

> We are still lacking a lot of things. Number one, the health staff here, most of them are unqualified with the exception of one. Only one is a clinical officer. So manpower is the problem. Then drugs. This is a community centre although the government does assist us, drugs are not regular. Then our three salaries. We pay the staff from the money generated from here and sometimes the patients are very few and the money is not there . . . [and] accommodation—we are so bad here—you can see we have only for two staff and you see we are seven supposed to be staying here. So you see the problem. And even transport. Like me, if I am wanted in Nebbi [town], I have to ride, there is no means. (Attendant at local health center in Parish 2, December 2004)

> Drugs, as I told you, is a problem. We get a grant from the government, but for the last one month, we have not got. . . . The [maternity] ward is not enough, and this one is not a maternity ward; we have only designed something like maternity, but ideally a maternity ward should not be like that. . . . I have six medical staff with two support staff. . . .For the last two months, we have not been getting salary. (Attendant at local health center in Parish 2, December 2004)

Some of the complex challenges of health care identified by members of this Ugandan community are being addressed by UPLIFT-Uganda, a locally

developed and operated community literacy program. We focus on the health challenges associated with malaria, which constitute the first unit in the program.

A LOCAL RESPONSE TO HEALTH CARE CHALLENGES: MALARIA AS A CASE EXAMPLE

UPLIFT-Uganda Literacy Program: Malaria Unit

UPLIFT-Uganda focuses on the notion of transformation to help marginalized populations overcome social and educational injustices. The program, which was developed by the East African educator Hizzaya Hissani, is taught initially in the language of Alur, then progresses to English, which is the official national language of Uganda. Six thematic units based on a range of local challenges were developed in close consultation with the community: malaria, compost, personal development, maize production, cassava production, and tree planting. The malaria unit emerged as one of the community's most pressing challenges. Indeed, during the course of the community literacy needs assessment, the program developer witnessed the death of six people in one village within 1 month. The content of this first unit focuses on causes, symptoms, prevention, and treatment.

Information from the medical officer complemented by notes from medical books and posters from the Uganda Ministry of Health formed the greater part of the unit. Consultants in the preparation of the unit included target mentors and learners and community literacy workers. The medical officer also helped in the refinement of the notes and information before their incorporation into the malaria unit.

The unit content and pedagogical approach were designed to combat three major challenges. First, the majority of the people in this community, and in particular women, who have primary responsibility for family health care, are unable to read and write.

Second, most community members were unable to identify the symptoms and causes of malaria. Prior to the implementation of the literacy program, most people believed malaria was any other disease such as meningitis and typhoid accompanied by fever and headache:

> We thought malaria is a fever caused by cold weather, rain or a witchdoctor [traditional spiritualist]. So, we would either sit close to a fire to drive away the fever. . . . Some of us thought malaria was being caused by an encounter with an evil spirit. Thus, we used to ask a witchdoctor to chase away the evil spirit. To do this, the witchdoctor put pounded leaves in our ears and noses. Sometimes we thought someone was vomiting, feeling cold, and had a headache because the witchdoctor had poisoned him. Again the witchdoctor would be asked to remove the poison.

> He removed the poison by mixing food with a concoction of the pounded leaves. … Many people used to die because the parasites would not be killed by the concoction. At that time also, many people used to see a witchdoctor as the cause of sickness. This created a lot of disunity and hatred in the community. Very often it led to fighting and deaths. (Chairman, Local Council, August 2004)

Although some community members knew mosquitoes were the cause of malaria, very few had any knowledge of symptoms, treatment, and prevention:

> Compounds were full of grass, broken pots, and ponds of stagnant water. We did not know that these things were the ones that were increasing the number of mosquitoes in our village. Because of many mosquitoes; we were always suffering from malaria. (Chairman, Local Council, August 2004)

Third, improper treatment and inaccessible clinics created additional challenges to combating the disease:

> Some people used to take panadol or aspirin which does not cure malaria. We would be well for one or two days, then we would fall sick again. … Clinics were very far from our village. The nearest clinic was about 30 km away. One had to have enough money for medicine, for food, for lodging, and for transport. Many people chose to die because they could not meet these expenses. … Because of ignorance, costs, negligence, superstition, carelessness and improper treatment, deaths from malaria were very common. Even today some people still die from malaria because of these things. Even the rate of abortion was very high at that time [before the literacy program started] because many pregnant mothers could not receive proper treatment. (Chairman, Local Council, August 2004)

The Role of Women and Local Modes of Communication

UPLIFT's pedagogical approach to teaching the malaria unit centers on using local and traditional forms of communication as a bridge to new literacy practices and new knowledge. Oral and performance traditions have a long history in this community, and the women in the literacy program made use of this familiar mode of communication to explore and express what they were learning in the literacy program. Dramatic performances (plays, songs, skits, analogies, poems) were developed both with the assistance of a literacy mentor and by the women independently.

The women began constructing dramas orally at the outset of the literacy program before they were able to read or write in Alur. They performed these dramas for a variety of audiences and purposes. Many were performed exclusively in class to promote a deeper understanding of the subject matter. Other dramas were performed for the community as a whole to teach moral lessons such as the consequences of indiscriminate sexual behavior or to change

particular beliefs and attitudes about the causes of diseases such as HIV–AIDS or malaria. The women also took responsibility for encouraging others to join the literacy program and used dramatic performances to demonstrate why literacy is important. Community performances typically took place during important functions such as graduation, marriage ceremonies, and political meetings. Following their performance, the dramas were written in Alur, the local language, and used as follow-up reading material.

COMMUNICATIVE PERFORMANCE: AN EXAMPLE

It was late afternoon when a large group of people gathered in a circle under the shade of the big mango tree in the center of the village. Men, women, and children of all ages came to watch the women from the literacy class perform. Some of the women sat on mats nursing babies and toddlers; other people stood on tiptoe peering over the heads of those who had secured positions up front; even some of the children from the neighboring village watched with shy excitement from the confines of the outer circle. Other observers marked the special occasion by donning suit jackets, fancy dresses, and closed-toe shoes. The purpose of the performance, which was intended for a broad audience, was to bring to the community critical health information that would help people identify the causes and symptoms of malaria and provide information about an alternative, highly effective, and locally available treatment.

> The first segment of the performance features three female performers: a mother, her child, and a mosquito. In the opening scene, we witnessed as a mother sat in her hut, encircling her child in a protective embrace. She desperately tried to ward off the mosquito frenetically swarming around the outside of the hut. The scene was dominated by the constant buzzing of the mosquito as it repeatedly poked its head into the hut. Completely undaunted by the mother's frantic swatting, the mosquito adeptly darted under the mother's arm, and plunged its stinger into the child.
>
> Very soon, the symptoms of malaria presented and the child began violently shivering and trembling despite being under several warm blankets. Her mother along with two local spiritualists, who she consulted about her child's mysterious symptoms, began performing a ritual to cure the child. We observed as the three performers chanted and shook animal skins and instruments in a circular motion around the child. The intensity of the child's trembling increased, which provided evidence for the audience that she had not been cured by the traditional spiritualists.
>
> The child's symptoms had not lessened by the third segment of the drama. The mother's expression was one of extreme worry and concern. She embraced her child, not seeming to know what to do. A new performer entered the scene; she

introduced herself as someone from the UPLIFT Literacy Programme. The woman carefully explained to the mother that her child was suffering from malaria as a result of a mosquito bite. She instructed the mother to immediately take neem leaves and boil them in water; the boiled liquid was to be given to the child twice a day, once in the morning and one in the evening, for three days. (Transcription of videotaped performance recorded May, 2004)

DISCUSSION

During the performance, the people in this community joined together as a collective, engaged in a dialogue that reflects a hybrid mixture of the multi-faceted, "cross-pollinated discourse" of the class, social group, and speech communities to which these people belong (Bakhtin, 1981). In the moment of the performance, the women are free to transpose and invert the social order of this community; they take on the roles of traditional spiritualists, doctors, and mosquitoes and occasionally draw in and direct men as secondary performers. Together, young and old, male and female, rich and poor move across communication and ideological systems, blending traditional modes with new knowledge and new identities to bring forth a critical message about the cause, symptoms, treatment, and prevention of malaria. The atmosphere created by the performance is "carnavalesque" (Bakhtin, 1981); it is at once joyful and somber, humorous and tragic, playful and serious—a tumbling together of diverse groups of people, ideologies, and modes of communication. Both Bakhtin (1981) and Boal (1979) believed that in performance the separation of people into those who act and those who watch is artificial and counterproductive to social interaction. As Bakhtin (1984) wrote, "Carnival does not know footlights, in the sense that it does not acknowledge any distinction between actors and spectators" (p. 7); nor does carnival distinguish between modes of communication, as also exemplified by Boal's notion of "image theatre," which places emphasis on aesthetic communication that transcends spoken language and educational difference. In the women's performances, all people and all modes of communication are considered equal; all participants potentially see the world from the same vantage point.

The performance is also a site of exchange and a key to understanding "how the deeply different can be deeply known without becoming any less different" (Geertz, 1983, p. 48). In this area of Uganda, women play a central role in performance traditions. Dramatic performance as a means of health promotion thus begins with what is deeply known; that which is non-threatening to the larger community and intimately familiar to the women. Alongside the familiar is the deeply different—in this case, new knowledge about the cause and treatment of malaria. Although the new prescribed medicine (i.e., neem leaf tea) is not biomedical, which is one of the most common treatments for

malaria, the storyline in the performance mirrors the prognosis–prescription format well-known from health center visits. The final segment of their message is a recommendation that if there is no improvement following the course of the neem treatment, then a visit to the hospital is warranted. The performers advocate a treatment regime that is an intermingling—a blurring—of traditional, environmental, and biomedical methods of understanding and treating malaria. As Barba (1986) argued, "it is the act of exchanging that gives value to that which is exchanged, and not the opposite" (p. 268). The "act" in this case is the performance as a communication strategy located within the realm of the learners' experiences and designed to create mutual understanding and visualization of the central ideas in the messages to naturally invite participation (Majalia, 2004).

The rich oral and performance traditions of this West Nile community serve not only as a powerful means of transmitting critical health information, but also for supporting new practices in the community. One of the primary strengths of these traditions is their ability to draw in the audience (Boateng, 1983). Oral performances, as well as songs and storytelling, are lively and highly entertaining; they bring health messages to life by making abstract ideas more concrete (Silver, 2001). These stories command attention in a way that a health lecture never can. The "truth" communicated through the oral performance is for the audience to discover and internalize on their own terms. Moreover, health messages communicated through oral and performance traditions avoid confronting or criticizing members of the audience about their personal beliefs (e.g., traditional spiritualists). Instead, the performers present themselves as role models who are using a new approach to treating malaria.

The use of dramatic performance as a means for the learners in the UPLIFT program to demonstrate and share their understanding of the causes, symptoms, prevention, and treatment of malaria recognizes that oral and performance traditions are central to traditional ways of knowing in many African communities. As Morrison (2003) stated, in African tradition, performance traditions enable communities to take ownership of new knowledge as they publicly articulate their thoughts. In everyday communication practices such as a group discussion, the number of participants would be limited and would not likely include many women. The use of dramatic performance organized by women, who are typically the primary health care providers in their families, not only empowers women in the community, but ensures that health information gets to the most vulnerable population. The approach gives the community in general and women in particular ownership and control so they are not dependent on health care professionals for identifying, treating, and preventing malaria.

Using local and traditional modes of communication also brings about cross-fertilization with technology- and print-based communicative tools. As mentioned at the outset of the article, this community previously had to rely on radio programs and health posters for receiving new health information.

Communicative performances not only complement what is heard on radio or represented on posters, but they also embed the information in the ideologies of the community (Madzingira, 2001). The tools of complementarity and embeddedness are powerful because the performances bring to life the deadly nature of malaria and the need for immediate action. As Mushengyezi (2003) pointed out, dramatic performances lead to community cohesiveness because the audience owns the problem and together seek means to overcome the problem. This collaboration leads to a cross-fertilization of ideas by paving the way for medical assistants to provide further information on how to prevent malaria.

Local and traditional modes of communication such as this performance provide highly effective ways of passing on knowledge and information in rural areas. The language is accessible to the community and the actions utilize all senses—body movement, gestures, sound, in combination with language. As Boateng (1983) posited, traditional performances that employ all senses keep the listeners alert and consider the communicative needs of all people. At the peak of the performance, the audience and performers are led to view the world through the same lens, in this case, to understand why children suffering from malaria cannot be cured through traditional spiritualists alone. The purpose of health literacy, which is one of the objectives of UPLIFT's malaria unit, is to bring about behavioral change and challenge fatalistic views about diseases such as malaria and HIV–AIDS (Nutbeam, 2000); this West Nile community has new hope that malaria is preventable and treatable.

Pedagogically, the performance creates an interactive atmosphere, which is a central characteristic of many African communities. Morrison (2003) pointed out that interaction is central to bringing about behavioral change in communities. Because dramatic performance can also include invitations for audience members to stop the action and insert their own reflections and understandings of a particular subject (e.g., as in Boal's, 1979, *Theatre of the Oppressed*), it gives voice to the community and enables them to "talk back" to the educators about their health challenges. This participation process also has the potential to reveal information gaps, providing community medical personnel with insights into how to tailor information to address community needs.

Primary health information coupled with local and traditional modes of communication and education provides a highly effectual, culturally relevant strategy for addressing current challenges in rural health care in Uganda, including dissemination of health information, access to knowledgeable health care workers, and availability of medical supplies such as medication. As Silver (2001) argued, a good deal of health care activity is a form of communication involving the interaction of health providers and health receivers, providing information as well as medicines and clinics. Moreover, the community itself is one of the most overlooked resources for local health care development. Dramatic performances are proving to be one the most effective forms of information

dissemination in many African communities because they favor intergenerational interactions and a shared sense of responsibility for the welfare of the community. As Morrison (2003) observed, to promote health literacy in African communities, information should target the entire community because it takes a whole community for transformation to occur. Understanding the context of the community, including local and traditional modes of communication, is critical in health literacy promotion.

The purpose of this article is not to valorize traditional modes of communication in solving local health care challenges, but to make a case for situating them within broader systems of communication characterized by multiplicity and heterogeneity. We argue that it is the interchange between traditional, local, and new practices that contributes to the successful treatment of malaria in this area (e.g., see Uganda Ministry of Health, 2002). This performance example from the UPLIFT program demonstrates that it is not about juxtaposing one system of communication against another, but rather a recognition of existing communication practices as a foundation for presenting alternative methods and ideas. Each system of communication (e.g., linguistic, pictorial, musical, gestural) has its own potentials and limitations; knowledge changes in generative ways when humans are given opportunities to utilize and move between these different meaning-making systems. Siegel (1995) demonstrated that different communication systems are not in opposition but are tools that, when used together, can advance the meaningful constructions of knowledge.

To achieve health literacy, however, requires more than providing the right information to a target population. As emphasized by the West Nile community leaders, the health centers and medical care facilities in this area are poorly equipped and resourced. If the promotion of health literacy continues to encourage the use of hospitals, which at present cannot provide adequate health care services, it may cause communities to become skeptical about such campaigns. A more holistic approach to health literacy promotion that brings together local and new modes of communication and knowledge with appropriate medical care is required if malaria in Africa in general and Uganda in particular is to be eradicated. Health care services and trained personal are desperately needed alongside the traditional and local ways of preventing and treating malaria.

REFERENCES

Bakhtin, M. (1981). Discourse in the novel (C. Emerson & M. Holquist, Trans.). In M. Holquist (Ed.), *The dialogic imagination: Four essays by M. M. Bakhtin* (pp. 259–422). Austin: University of Texas Press.

Bakhtin, M. (1984). *Rabelais and his world (H. Iswolsky, Trans.)*. Bloomington: Indiana University Press.

Barba, E. (1986). *Beyond the floating islands*. New York: Performing Arts Journal Publications.

Betts, J. (2004). Creating the gender text: Literacy and discourse in rural El Salvador. In A. Robinson-Pant (Ed.), *Women, literacy, and development: Alternative perspective* (pp. 68–84). London: Routledge.

Boal, A. (1979). *Theater of the oppressed* (C. A. McBride, M.-O. L. McBride, & E. Fryer, Trans.). London: Pluto.

Boateng, F. (1983). African traditional education: A method of disseminating cultural values. *Journal of Black Studies*, *13*, 321–336.

Brodkey, L. (1987). Writing critical ethnographic narratives. *Anthropology and Education Quarterly*, *18*, 67–76.

Carspecken, F. (1995). *Critical ethnography in educational research: A theoretical and practical guide*. London: Routledge.

Centers for Disease Control. (2006). Malaria control in Uganda: Towards the Abuja targets. Retrieved October 19, 2006, from http://www.cdc.gov/malaria/control_prevention/uganda.htm

Clark, K., & Holquist, M. (1986). *Mikhail Bakhtin*. Cambridge, MA: Harvard University Press.

Freire, P. (1973). *Pedagogy of the oppressed*. London: Penguin.

Geertz, C. (1983). *Local knowledge: Further essays in interpretive anthropology*. New York: Basic Books.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine.

Kress, G. (2000). Multimodality. In B. Cope & M. Kalantzis (Eds.), *Multiliteracies: Literacy learning and the design of social futures* (pp. 182–202). London: Routledge.

Kress, G., & Jewitt, C. (2003). Introduction. In C. Jewitt & G. Kress (Eds.), *Multimodal literacy* (pp. 1–18). New York: Lang.

Kress, G., & van Leeuwen, T. (1996). *Reading images: The grammar of visual design*. London: Routledge.

Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.

Madzingira, N. (2001, October). *Culture, communication and development in Africa*. Paper prepared for the African itinerant college for culture and development, African Institute for Economic Development and Planning, Harare, Zimbabwe.

Majalia, M. L. (2004, April). *Conscientizing and empowering young people in Kenya to own the fight against HIV/AIDS using problem-posing, entertaining, creative Ngoma: Introducing PECNOSC communication strategy idea*. Paper presented at Entertainment–Education and The Global African Experience Conference at Ohio University, Athens, OH.

McConnell, S. K. (1998). NGOs and Internet use in Uganda. Who benefits? In C. Ess & F. Sudweeks (Eds.), *Proceedings of cultural attitudes towards communication and technology* (pp. 147–167). Australia: University of Sydney.

Morrison, J. (2003, September). AIDS education in Africa: The uses of traditional performance. Paper presented at Journalism Conference, Stellenbosch University, Stellenbosch, South Africa.

Muhe, L. (2002). *Community involvement in rolling back malaria* (Doc. No. WHO/CDS/RBM/2002.42). Geneva: World Health Organization.

Mushengyezi, A. (2003). Rethinking indigenous media: Rituals, "talking" drums and orality as forms of public communication in Uganda. *Journal of African Cultural Studies*, *16*, 107–128.

Nutbeam, D. (2000). Health literacy as a public health goal: A challenge for contemporary health education and communication strategies into the 21st century. *Health Promotion International*, *15*, 259–267.

Reagan, T. (Ed.). (2005). *Non-Western educational traditions: Indigenous approaches to educational thought and practice* (3rd ed.). Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

Sachs, J. (2005). *The end of poverty*. New York: Penguin.

Siegel, M. (1995). More than words: The generative power of transmediation for learning. *Canadian Journal of Education*, *20*, 455–475.

Silver, D. (2001). Songs and storytelling: Bringing health messages to life in Uganda. *Education for Health*, *14*, 51–60.

Tyler, S. (1986). Post-modern Ethnography: From document of the occult to occult document. In J. Clifford & G. Marcus (Eds.), *Writing culture: The poetics and politics of ethnography* (pp. 122–140). Berkley: University of California Press.

Uganda Ministry of Health. (2002). Malaria control and prevention in Uganda [Electronic version]. Retrieved May 9, 2007, from http://www.health.go.ug/malaria,htm

United Nations Development Program. (2001). *Human development report*. Oxford, England: Oxford University Press.

United States Central Intelligence Agency. (2006). The world factbook: Uganda. Retrieved May 20, 2006, from https://www.cia.gov/library/publications/the-world-factbook/geos/ug.html

World Bank. (2003). *Enhancing the contribution of adult education and non-formal education to achieving education for all and millenium development goals (HDNED EFA/Adult outreach paper)*. Washington, DC: Author.

Yamey, G., & Attaran, A. (2003). Deaths from malaria in Africa [Electronic version]. *Student British Medical Journal*, *11*, 438–439.

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