COVID-19, Religious Voices, and the Resurgence of Traditional Healing Practices in Uganda

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Abstract

Religious institutions and spirituality beliefs are in the spotlight not only for expounding the root of and intervention to pandemics, but also being a sanctuary for a population battling obscure pandemics. Religious voices on pandemics are treated with conviction, as affected societies seek their guidance. Religious voices to the first wave of COVID-19, both in Uganda and all over the world attest to this. However, the waning voices of religious leaders and institutions during the second wave in Uganda, on the one hand, and the reinvigoration of traditional healing remedies for treatment of COVID-19, on the other, are two contrasting features which water down previous scholars' postulation of the centrality of religious voices during pandemics of this nature. Using mixed methods approach, comprising of qualitative in-depth interviews with 19 respondents and an online quantitative survey questionnaire upon two social media groups with a total of 500 respondents, the study established a decreased visibility of religious voices with a change in the message by religious leaders during the second wave of the pandemic. Second, although there was no significant relation between dwindled religious voices and a sky-rocketing recourse to traditional remedies for COVID-19, in many respects, the decreased voice of religious leaders rescinded the optimism that the people held in religious ideology, with solace found in the effectiveness of traditional healing remedies. Third, the popular use of traditional herbal remedies for COVID-19 emanated from the deplorable capacity of Uganda's modern healthcare system to manage the pandemic, on the one hand, and socio-cultural traditions and beliefs of the people concerning the disease and medicine, on

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the other. The distinct contribution of this article to the scholarship of 'religion and pandemics' is that it purges religious beliefs and voices which have previously and overly been theorized to be central during pandemics, with the relegation of religion on one hand, and promotion of science on the other.

Keywords: COVID-19, Coronavirus, healing, second wave, traditional medicine, religion, Uganda

Introduction

This article reflects on the second wave of the Coronavirus disease in Uganda. The Coronavirus disease of 2019, abbreviated as COVID-19, emerged from the Chinese town of Wuhan in the year 2019, spreading wildly to the entire world, with massive infections and deaths (Liu, Kuo & Shih 2020:328). Due to the incessant mutation of this virus emerging into 'variants', scientists forewarned the evolution and manifestation of this pandemic into numerous waves (Liu *et al*. 2020:331; Ministry of Health 2021). For Uganda's case, the first wave of COVID-19 was experienced from March 2020 to the end of the year. In May 2021, the government of Uganda officially announced that the country had entered the second wave of the COVID-19 pandemic with an appalling 81 percent infection upswing between March and April of 2021. The second wave was therefore a resurgence of COVID-19, preceded by a period of less scary transmission witnessed in 2020 (GoU 2021). Whereas the country had a cumulative total of 361 deaths due to COVID-19 between March 2020 and May 2021, the more aggressive second wave was accounting for a positivity rate of 17 percent among those tested, as well as an average of 40 deaths per day. By the beginning of July 2021, the COVID-19 confirmed cases were 82,082 with 51 percent of these registered in the past three months of the second wave. The harmonized death count due to COVID-19 stood at 1,873 fatalities, representing a 2.3 percent fatality rate, with 19 percent increase registered in the past three months (Museveni 2021; Mwebesa 2021; Aceng 2021). The second wave was attributed to the opening up of workplaces, schools, worship places, a public non-adherence to standard operating procedures (SOPs) like social distancing, use of masks, and hand hygiene, as well as imported variants of the virus from India, Nigeria, South Africa, and the United Kingdom (GoU 2021; *Daily Monitor* 2021a; Aceng 2021).

Faced with the surge in COVID-19 infections and fatalities, on June 18, 2021, the President of Uganda imposed the second nationwide lockdown, with a host of measures intended to curtail the spread of the virus. Among these was the closure of places of worship, including churches, mosques, and other such congregating places, since they fuelled the rapid transmission of the virus (Museveni 2021; Aceng 2021). Unlike the first lockdown, which saw the president consult the Inter-Religious Council of Uganda (IRCU) and other such notable religious leaders in the country, it was not the case during the second lockdown (Blair *et al*. 2021:1).

The significance of religious voices during pandemics has been echoed by Dols (1979: 180) and Cunningham (2008:30) as critical in not only interpreting the occurrence of pandemics through pious traditions, but also guiding society and furnishing hope to a traumatized population due to the pandemic (Huremovic 2019:14; Isiko 2020:78). The reliance on religion to make sense of and help mitigate epidemics has clearly been evident since the pre-Christian era (Stange 2020:11-23) and more popular throughout the world in the past 200 years, when the first epidemic of the modern globalizing era, cholera, began to spread worldwide (Phillips 2020:436; Barmania & Reiss 2020:15-22; Huremovic 2019:7-35). However, the conspicuous waning and or quietude of religious voices and a reinvigoration of traditional healing remedies during the more drastic second wave of COVID-19 downplay the long-held centrality of religion in times of crisis.

During the first wave, there existed a mixed reaction from religious leaders over the government's decision to a nationwide lockdown, including the closure of places of worship. Religious leaders provided theological interpretations of the disease and attended to the practical needs of the populace, since a number were toiling due to the adverse effects of the lockdown to the economy (Isiko 2020:83-93). However, circumstances of the second wave in Uganda seemed to suggest otherwise with a diminished voice of religious leaders about the pandemic. The waning voices of religious leaders and the intensified recourse to traditional medicine for treatment of COVID-19 are two contrasting occurrences which defined the second wave in the country.

Conceptualizing Religious Leaders and Voices – Uganda's Context

Religious voices are hereby defined as responses, reactions, and attitudes of religious leaders, religious organizations, and their followers to the pandemic

in terms of their interpretation, solution, and reaction to government policy towards the pandemic. Although Uganda subscribes to the tripartite religious traditions of Christianity, Islam and African indigenous religious belief system, the study took interest in the visibility of Christian and Muslim religious leaders only. Their voices are public and the most visible. Official statistics indicate that Christianity constitutes 85% of Uganda's population and Islam 14%, totalling to 99% of Uganda's population. Less than 1% of Uganda's population affiliate to African indigenous religion(s) with their religious leaders marginal in the social dispensation of the country (UBOS 2016). The lone voices of African indigenous religious specialists had been suppressed by state sanctions during the first wave of COVID-19 in Uganda (Isiko 2020:82). Therefore, voices of Christian and Moslem leaders in Uganda are taken to be the public voice. In the context of this article, religious leaders are Christian clergy and lay leaders (bishops, priests, pastors, apostles, and influential leaders of Christian laity) as well as Muslim clerics (Sheikhs, Imams and any other Moslem clerics). In some cases, religious leadership is defined under umbrella associations and organizations, for example the Uganda Joint Christian Council (UJCC) which brings together mainstream Christian denominations, the National Fellowship of Born Again and Pentecostal Churches (NFBPC) – an umbrella association of all Pentecostal churches in Uganda, and the Inter-Religious Council of Uganda (IRCU), which amalgamates representative leaders from 'major' religious denominations in the country.

Basing on empirical evidence amassed on the second wave of COVID-19 in Uganda, this article raises and answers the following questions: What kind of religious voices were echoed in the second wave of COVID-19 and how did they differ from the first wave? Which circumstances shaped the change in religious voices about COVID-19 during its second wave? What kind of relation existed between the change in religious voices about COVID-19 and the increased popularity of traditional healing for COVID-19? Why did traditional healing remedies become popular for the treatment of COVID-19? This article is structured as follows: Introduction; conceptualizing religious leaders and voices; theoretical framework; literature review; methodology; religious voices on the second wave of COVID-19; the relation between religious voices and a recourse to traditional healing remedies, the popularity of traditional healing remedies; discussion; limitations; and the conclusion.

Theoretical Framework

The study was based on the theory of religious coping. The theory of religious coping was first pronounced by Kenneth Ira Pargament, in his book, *The Psychology of Religion and Coping: Theory, Research, Practice* (Pargament, 1997). The theory postulates that when faced with a crisis, people tend to turn to religion to cope with adversity. The theory contends that religious people in crisis tend to cope by obtaining a personal closeness with God, a sense of meaning and purpose in life; engaging in religious coping activities, which are typically attempts to be less sinful and participation in religious groups; and searching for an explanation for the adverse event usually situated in religious-spiritual perspectives (Bentzen 2019; Sibley and Bulbulia 2012:2 - 4). Since then, several scholars have used it to explain the relationship between religion and pandemics, asserting that epidemic affected communities practice religion more (Cunningham 2008:30; Bentzen 2019). This theory has overly been used by studies on 'religion and COVID-19' to-understand the changes and impact that COVID-19 pandemic has had on people's religious life and practice. Empirical evidences available from variant scholars on religion and COVID-19 posit a positive relationship between religion and COVID-19 pandemic, with the global population becoming more religious and indeed depending on religion to cope with COVID-19 pandemic (Meza 2020; Boguszewski *et al.*, 2020:4; Thomas & Mariapaola 2020:1; Isiko 2022:22). This theory is significant to this study as it facilitates in interrogating the unusual negative association between religion and COVID-19, and the conspicuous silence of religion during the more disastrous second wave of COVID-19 as experienced in Uganda.

Literature Review

Religious voices and the use of traditional medicine shaped debates about interpretation and treatment of COVID-19 since its outbreak in 2019. The uniqueness of the COVID-19 pandemic to the medical research community, without any proven cure, surged recourse to traditional medicine remedies and spiritual beliefs especially in Africa and Asia (Mshana *et al*. 2021:6; Ganguly & Bakhshi 2020:3084). However, the application of traditional healing remedies and prayers against COVID-19 generated a notable discussion about their effectiveness after undergoing the vital biomedical processes to ascertain their efficacy (Mshana *et al*. 2021:9). Although the World Health Organisation (WHO) initially indicated that the use of traditional remedies against the pandemic was ineffective and detrimental, the global public interest in

traditional medicines for COVID-19 treatment compelled it to relent (Karabulut 2021; Richey *et al*. 2021). As the anti 'COVID-organics' protestations emerged from the nations of the Global North, the WHO signed a pact with the President of Madagascar to scientifically test Covid-organics – the country's 'cure' for COVID-19 (Richey *et al*. 2021). In some other African countries like Zimbabwe and Mali, a case for precision herbal medicine in the treatment of COVID-19 was made by scientists (Dandara *et al*. 2021:2; Sanogo 2020).

Scholars like Rodrigues & Metz (2021:2) argued for the centrality of traditional African healers in the COVID-19 pandemic, on account of their philosophy which is compatible with preventive measures for COVID-19. However, during the first wave, the case was different in Uganda, when both government and scientists were utterly against the possible use of traditional medicine for COVID-19. Uganda's Ministry of Health was apprehensive about the possible use of a herbal drug for COVID-19, which was manufactured by Madagascar (*Daily Monitor* 2020). Government further cautioned traditional healers against treating COVID-19 patients or anybody with similar symptoms. Traditional healers were required to refer all their clients with Coronavirus symptoms to modern health facilities for management (*Daily Monitor* 2020).

Instead, religious voices in terms of the assurance of miracles and healing for COVID-19 patients were more pronounced. In addition, primary healthcare preventive interventions for the pandemic were tightly hinged on the collaboration with religious leaders; yet a sizeable number of them were utterly against the closure of places of worship as a preventive measure to the spread of COVID-19 (Isiko 2020:81). A historical analysis of the outbreak of the great plague in 1347, the London plague in 1665, the Spanish flu in 1918, and the Ebola crisis in West Africa in 2014 depict the centrality of Christians in inspiring the world with their resilient faith and compassion in the midst of pandemics (Whiting 2020). During the Roman era, for example, oppressive emperors marvelled at the high visibility of humanitarian care of Christians towards the ailing and dying in times of plagues, as Christian churches opened their doors to serve as clinics (Whiting 2020).

Indeed, in African countries like Tanzania, COVID-19 increased the intensity of religiosity, with religious voices and activities being dominant during the pandemic (Isiko 2022:20; Ndaluka *et al*. 2021:131). This response in several African countries is not surprising, given the fact that African societies are fond of resorting to their cultural and religious beliefs whenever they experience pandemics with no obvious cure (Isiko 2021:238). However,

the second wave of COVID-19 in Uganda was characterized by two contrasting issues which challenged pre-existing literature. Despite the resurgence of the disease, religious voices were non-belligerent compared to the first wave. Second, there was an increased recourse to traditional healing for COVID-19, contrary to the reprimand during the first wave. The conspicuous waning of religious voices amidst the recourse to traditional healing needs to be analysed in the context of the historical negativity of foreign religious groups to African-healing remedies (Isiko 2018:148-183). This article analyses circumstances for these contradictions, seeking answers as to why the previously dominant religious voices in the first wave had no trace during the second wave, despite the increasingly visible recourse to traditional healing remedies.

Methodology

The study used a mixed methods research approach. This article is based on qualitative in-depth interviews and quantitative online survey. The study was done between June and July 2021. Qualitative in-depth phone interviews were conducted by the researcher himself with 19 key informants. It was not possible to have face-to-face interviews because the country was under a nationwide lockdown due to the resurgence of COVID-19. A smartphone with audio-recording function was used to record the interviews for each informant. In addition to audio-recording, the researcher jotted down the major issues as each interview progressed. This helped in making preliminary analyses of the information during the interview process. The key informants were purposively selected, based on their knowledge, interaction, and experience with Uganda's contemporary religious landscape. These included University lecturers of religion and theological studies; teachers of Religious Education with at least a basic degree in Religious Studies or Theology; public commentators on religion and religious expression and graduate students of religious studies. These categories of key informants were thought to hold not only vast knowledge about religious expression in Uganda, but also the capacity to contrast religious behaviour between the two waves of COVID-19 in Uganda. To triangulate expert opinions of key informants, the article relies on an extensive use of information in public media – both mainstream and social media – because these epitomize not only the thinking of common people, but also represent the public voice. Mainstream media includes national newspapers and television broadcasts. Social media includes Facebook, WhatsApp,

and YouTube. This article consequently carries references and quotations from public voices, visibly captured in public media on religious behaviour, and the utilization of traditional remedies during the second wave of the pandemic in Uganda.

An online survey sampled two social media groups: A WhatsApp group of 250 undergraduate students, offering religious studies as one of their course subject combinations, and a Facebook group of over 400 members belonging to an urban Pentecostal Church in Kampala City. The online survey questionnaire aimed at establishing three issues: How widely spread was the use of traditional remedies for COVID-19, whether religious voices on the second wave of COVID-19 were as significantly visible compared to the first wave, and whether they thought there was a relation between religious voices and recourse to traditional remedies for COVID-19. The choice of the WhatsApp group for the undergraduate students was based on two justifycations: First, government had suspended all activities of academic institutions, universities inclusive. The students went into a forced recess period. Students spread all over the country to their homes, which represented a reliable national picture – both urban and rural – in relation to the three aspects being surveyed. Second, the study required respondents who were abreast with religious sensitivity of the Ugandan society, devoid of religious biases. Based on the academic study of religion at the university, it was assumed that these participants possess religious sensitivity devoid of biases inherent at believer's level. The choice of the Facebook group for an urban church was thought to furnish an authentic picture on the opinion of the urban population on the three aspects, owing to the fact that urban areas are more exposed to public media, a channel for conveying voices of religious leaders.

A systematic analysis of information was done. For in-depth phone interviews, the audio recordings were transcribed into English, as the interviews were executed in this language. Carefully analysing the transcripts, three major themes were identified: These were 1) religious voices on the second wave of COVID-19; 2) the relation between religious voices and recourse to traditional remedies for COVID-19; and 3) the popularity of traditional healing remedies for COVID-19. The online survey questionnaire yielded percentages based on the opinions of the participants. The online survey safeguarded personal details of respondents like religious affiliation, gender, academic level, and ethnic status. This was because the study aimed at establishing how widespread the three aspects were in the community regardless of those considerations.

Ethical considerations were taken care of. The key informants, were informed that the interviews would be recorded and they verbally accorded their consent. In a special study room, secluded untargeted individuals gave the ambience for making phone calls in privacy. The researcher collaborated with account administrators of the WhatsApp and the Facebook groups, who were familiar to the members. With the exception of ticking either 'Yes' or 'No' for each of the three questions which constituted the online questionnaire, the respondents remained anonymous. In circumstances where quotations attributed to key interviewees have been used, the quoted respondents are represented by titles and other such neutral personal data other than their actual names. However, individuals whose identities were disclosed in public media in regard to their personal experiences with the pandemic, appear in the article as such.

Religious Voices on Second Wave COVID-19

The online survey sought for opinion on the visibility of religious voices during the second wave of the pandemic. Out of the 250 members of the WhatsApp group, there was a response rate of 217 members (86.8%). From the 217 responses received, 193 members (88%), acknowledged that religious voices diminished in the second wave when compared to the first wave of the pandemic in Uganda, while 24 (11.1%) of the total respondents disagreed. Although it was difficult to get a definite number of people for the Facebook group, since individual members were known to have multiple accounts within this group, a total number of 283 responses was received on the visibility of religious voices during the second wave, compared to the first wave of the pandemic. Of the 283 responses, 233 responses (82.3%) were of the opinion that religious voices were not visible during the second wave compared to the first wave. Therefore, out of the grand total responses of 500 members from both WhatsApp and Facebook, 426 responses (85.2%) were of the opinion that religious voices were not visible during the second wave of COVID-19 pandemic.

The percentage representations above unwrap two revelations. First, religious voices on the second wave of the pandemic were not felt by the population, both in the towns and in the countryside. Second, the laity themselves did not feel the visibility of their own institutions during the second wave of the pandemic. With regard to the 19 key informants, 15 of them agreed that religious voices were not as much pronounced during the second wave as they were during the first wave. The four key informants who disagreed,

claimed that religious voices remained visible, only that there was a change in the message for the second wave. In brief, two key findings surfaced: Most religious voices during the second wave significantly waned in comparison to the first wave, and even with the negligible religious voices noticeable, the message was quite different from those of the first wave. In the foregoing paragraphs, the message and messaging of the second wave is discussed and an account for the waning of religious voices is made.

Conceptually, the message embodies religious views and explanations on the genesis and steps to conquer the pandemic. The first wave involved practical interventions of relief food and other basic items from religious leaders to the disconcerted population. On the other hand, the messaging includes the mechanisms, avenues, and frequency with which messages of religious leaders regarding the pandemic are relayed to the public. The study established that there was a significant alteration between the first and second waves of the pandemic in Uganda. Whereas during the first wave of the pandemic, religious leaders and institutions were comforting the people, challenging conspiracy theories that negated religion's connection to the pandemic, and providing basic needs for the most victimized, the situation was different during the second wave. One key informant provided a comparative argument about religious voices between the first and second wave of the pandemic, stating as follows:

> They were very strong in the first wave but now weakening in the second wave because their prayers are less effective. Miracles of healing COVID-19 are not happening. Original pomp of powerful and healing religious prayers is at stake. Religious leaders themselves are dying of COVID-19. Their powers have been challenged. Religious leaders failed to render practical and spiritual healing solutions to the pandemic (Religious cleric and Senior lecturer, Interview 28 June 2021).

In the first wave, religious leaders had a lot of explanations concerning the pandemic. They tried to make religious meaning out of the pandemic. They attributed the pandemic to the sinfulness of mankind and their accentuation was on prayer and repentance. They promised God's healing powers over those who contracted the virus, while some decreed that God's love for Uganda would never permit COVID-19 to outstretch to this country (Isiko 2020:86). Failure of fulfilment of these first wave COVID-19 prophetic utterances might have

weakened their faith in God as the healer. The prophecies pronounced in the first wave were not followed with substantiated evidence of healed people by the second wave of COVID-19. There were, however, arguments from some religious leaders that the non-repentance by people during the first wave, angered God, who decided to punish the disobedient people with the second wave. Since then, they emphasized the message of repentance, forgiveness, and faithfulness.

The first wave of the pandemic looked more distant than the second wave. Religious leaders' ideology and voices during the first wave were based on ravage by the disease in China, the USA, and other European countries. Religious leaders and their congregations in Uganda were imagining a mysterious experience. The pandemic was distant because, apart from Uganda register-ing quite lower cases and deaths compared to other countries, they were not affected at personal level. Uganda hardly experienced any death or critical case of any religious leader during the first wave, yet religious adherents felt affected by the lockdown, but not COVID-19. Their ideology about the pandemic in the first wave was therefore neither based on reality nor practicality. The religious leaders were not speaking about COVID-19, but government's responses to the pandemic, which were meaningless to an ordinary pastor and his congregants. Several religious voices publicly decried the closure of places of worship because Uganda had not experienced any serious threat of the disease, while others proposed that places of worship needed to be kept open on the understanding that they had the means to maintain SOPs for COVID-19. They fell short on this as they branded government's stance to close places of worship a political strategy to curtail religious leaders' massive influence during a presidential campaign season.

However, the second wave was affecting them individually, with an innumerable number of relatives and friends being lost to COVID-19. By June 27, 2021, a combined number of 22 well-known religious clerics from both traditional and Pentecostal churches and the Muslim community in Uganda had succumbed to COVID-19 (*Daily Monitor* 2021b). Given the massive deaths of their own, it left religious leaders at crossroads with regard to what message to relay to the distraught puzzled population. It was the gross impact of this second wave that forced religious leaders not to complain about or proclaim healing – a spiritual prescription justified to be ineffective. This low-key attitude of religious leaders during the second wave was psychological and part of human nature regardless of religious ideology, in that disease and sickness become more meaningful when are felt than imagined.

Although prayer remained noteworthy in the second wave, more stress was on science and following the SOPs. For example, although the Anglican Bishop, Fred Sheldon Mwesigwa of the Ankole diocese argued that the second wave was a spiritual warfare which the church had to fight by prayer, the church had to go scientific. Relatedly, the presiding Apostle of the Born-Again Faith (BAF), Apostle Dr Joseph Serwadda employed African perspectives to justify lockdown and quarantine measures instituted in the second wave, on account of previous application of similar strategies to contain pandemics in traditional Africa. He cited examples of both people and domestic animals that would be isolated when diagnosed with contagious diseases like small pox. These were in addition to religious leaders' willingness to solicit donations for more COVID-19 vaccines (*Daily Monitor* 2021b). Religious leaders accepted science entirely, contrary to their mixed attitude during the first wave. The second wave became more 'scientific', as religious leaders adapted more to scientific explanations than to religious ones. Religious leaders therefore emphasized the Ministry of Health SOPs for COVID-19. They further lobbied for consideration as 'essential workers', not for the sake of opening up places of worship, but to reach out and offer psycho-social support to those infected and affected by COVID-19. Religious leaders became part of government's drive to mobilize vaccination against COVID-19. The emphasis on science does not imply a disbelief in religion, but an attempt to appreciate that religion cannot do without science, for science affixes value to religious ideology.

Still, the change of stance and message of religious leaders during the second wave were attributed to the fact that several church leaders had been infected and several others dying of COVID-19. Based on the change in approach and message conveyed during the second wave, one interviewee was hesitant to acknowledge the invisibility of the religious voice and said the following:

> I disagree that religious voices have waned. Religious leaders are coming out, but differently in order to safeguard themselves from infection since they are among the gravely affected judging by COVID-19 deaths numbers. Maybe they have declined on the aspect of distributing food. This is because death and near-death experiences among religious leaders have been witnessed. They realized that it is no longer a fight for eating food but an issue for survival (Lecturer, Interview 23 June 2021).

The above view highlights the change in circumstances of religious leaders during the second wave, which had an impact on their visibility in society. The seriousness of the disease made them to retreat physically, away from the communities for fear of infection. It was important that they secured their lives first to be able to pastor the suffering followers. Religious leaders instead proved that they were as vulnerable as other categories of Ugandans, as they set out to safeguard themselves against the consequences of the lockdown, ensuing from the pandemic. It also highlights the notion that, possibly their starving followers preferred attendance to their practical need of food to encouraging them to follow scientific preventive measures against COVID-19 or even the gospel.

Nonetheless, the adoption of a scientific approach to the second wave of COVID-19 was not characterized by absolute abandonment of prayer. National prayers were conducted on July 25, 2021, the fourth since the outbreak of the pandemic in March 2020. Ecumenical prayers organized by the Inter-religious council of Uganda (IRCU) took place at State House, Entebbe. However, public responses to the fourth national prayer day during the second wave of the pandemic were in contrast to those during the first wave. The public was more receptive to prayers during the first wave, but became negative during the second wave. Probably, the ineffectiveness of prayer in the prevention and healing of COVID-19 in the first wave made Ugandans to re-examine the efficacy of prayer. Public scorn and contempt of the national prayers were witnessed, urging government to instead prioritize vaccination. The following two tweets portray the extent to which Ugandans felt that prayer and religious approaches were ineffective responses to the second wave of the pandemic and preferred refocusing their energies and resources to scientific approaches:

> Israel has fully vaccinated 55% of its population. It has agreements with Pfizer and Moderna to secure 18 million doses of the vaccines. Today, Ugandans have a public holiday to dedicate the country to the God of Israel. It is the fourth time since the pandemic cropped up in the country (tweeted June 25, 2021).

Another person tweeted:

> National prayers like the one organized today may be well-intentioned, but truth is some things don't need prayer but require common sense!

> Buy oxygen, PPEs, hospital beds, ambulances, and also enable medics to get to and from work to save lives (tweeted June 25, 2021).

Organizing national prayers for the second wave of COVID-19 seemed an unwelcome strategy for most Ugandans. They argued that unfortunately, while 'serious' countries were immersed in scientific research and socio-economic planning to deal with the health challenges posed by COVID-19, Uganda was gloriously squandering so much energy and financial resources rotating around its pulpit theatricals, including public holidays for COVID-19 prayers (Tacca 2021). Religious voices during the second wave changed from just prayer to urging government to secure medical supplies and moderate medical costs because religious leaders were personally affected. It was argued that more reliance on religion than science during the first wave of the pandemic was because COVID-19 was in its infancy, with neither a cure nor a vaccine. This was in line with common tradition in societies all over the globe that when humanity fails with demonstrable knowledge, they often turn to illusions of magic and religion (Tacca 2021). With a scientific breakthrough of COVID-19 vaccination, it restored the hope that religion and prayer could not do, making religious supplications for COVID-19 almost irrelevant. Religious voices for refocusing the fight against COVID-19 through science were echoed across the pluralistic religious divide in this country. The head of the Islamic Faith in Uganda, Sheikh Ramadhan Mubajje said to the president:

> Your Excellency, I have had an opportunity to visit my people in Mbale. My mother has been battling COVID-19 in the Mbale Regional Referral Hospital. The doctors in the hospital decry insufficient medical supplies to manage the Coronavirus patients, although they are committed. Yet in some hospitals, especially the private ones, they charge exorbitant medical bills for COVID-19 patients. Your Excellency, private hospitals charge between two to five million shillings per day. There are private hospitals that have turned COVID-19 treatment into a profitable business and they are indeed excited about this profitable opportunity (UBC Television 2021).

It was established that during the second wave of the pandemic, religious leaders used the national prayer day to advocate for equitable medical care for COVID-19 patients. They promoted a safe and conducive working environment for medical personnel giving medical care to COVDI-19 patients. They used the day to urge government to extend sufficient medical supplies for the

management of COVID-19 and raised a public outcry about the injustice and unfairness that COVID-19 patients were subjected to by private medical service providers. It can be argued that this alteration of the message by religious leaders happened because they themselves were victims, hence advocating science more than the religious rhetoric. Indeed, the realization of the futility of prayers alone to combat the pandemic led to the birth of the notion of a 'science-led church'. The debate on the effectiveness of religion and prayer against COVID-19 on the one hand, and science on the other, defined the centrality of national prayer celebrations during the second wave. President Museveni believed that prayers alone wouldn't curtail the surge in COVID-19 infections and deaths that were ravaging the country. He argued as follows:

> There is an issue here, refusing to do our mandate and only praying? This virus is avoidable. But if we don't do what we are supposed to do, then, we cannot only say, pray, pray and no effort. I reject the idea of making mistakes and then come and pray, I am not part of that. I believe in a science-led church because science is the study of the power of God (*Daily Monitor* 2021b).

The President's demeaning attitude towards prayer and religious people at a national prayer day at the State House may have been intended to send a signal to any possible religious voices against government's response to the pandemic. This finding resonates with the invisibility of religion in China's public arena, the initial epicentre of COVID-19. The invisibility was attributed to the bulging power and authority of the Chinese State, arising from its unlimited control strategies of the pandemic which cut off the religious actors' space to contribute to stopping the disease (Xiong & Li 2021:2). Religious leaders may have guarded against state reprisals as the case was with some pastors during the first wave. Indeed, such feelings of insecurity with the president's attitude were expressed by a religious leader as follows:

> The silence has been due to the president of Uganda taking himself as the religious head of the nation. In his address, he claimed that after 150 years of Christianity in Uganda, he has a bishop in his house, making reference to his own daughter, who is a Pentecostal pastor. The president views religious leaders as his children and no longer listens to them (Anglican Priest & Graduate Student, Interview 27 June 2021).

To some people, it was argued that the organization of national prayers to deliver the country from the COVID-19 pandemic was not on religious grounds but a political gimmick by the State managers to divert desperate citizens away from the ailing health infrastructure that was incapable of handling the pandemic. One public commentator wrote in one of Uganda's national daily newspapers:

> Museveni may not strike you as a natural religious cult leader. However, if there is space in the religious sphere, he can exploit it. Dispute it if you want, but the people praying at state house pretend to be in harmony because they fear and worship the president. God alone is incapable of drawing them to a shared understanding. These theatrical prayers at state house reinforce many people's beliefs that the pandemic is in the hands of God. So, Museveni can afford some breathing space (Tacca 2021).

Therefore, these findings reveal that as COVID-19 worsened in terms of numbers and infected cases and deaths, the belief in prayers, miraculous healing, and generally the power of the spiritual sphere to control the pandemic, waned. The trials and tribulations of COVID-19 that religious clerics and leaders experienced at a personal level did not only incapacitate their supposed anointing to deal with pandemics, but also weakened their spiritual stance in an ideology of which they are the custodians. The religious leaders paved the way for science because they could no longer hold on to religious rhetoric of the spiritual weaknesses of mankind as the cause of the disease. They could not proceed with the spiritual prescriptions of repentance and healing because the aggressive second wave of the pandemic had proved these ineffective. It also reveals that the call for national prayers during the second wave of the pandemic was nominalist in tendency, intended to provide illusory hope in a population which was already desperate for concrete solutions to the pandemic. This change in religious behaviour during the second wave yielded to alternatives for which the public would exploit to cope with the pandemic. One such alternative was recourse to traditional healing remedies.

Relation between Religious Voices and Recourse to Traditional Healing Remedies

From the online survey of 500 respondents, emerging from both the WhatsApp and Facebook groups, the study sought to establish whether there was a relation between the change in religious voices during the second wave and the increased use of traditional healing remedies for COVID-19. A combined number of 367 respondents (73.4%) of the total respondents objected the existence of a relation between waning religious voices and recourse to traditional healing remedies for COVID-19. Relatedly, 12 of the 19 key informants disputed the supposed relation between religious voices and recourse to traditional healing remedies for COVID-19. These statistics therefore reveal that a substantial percentage of the population did not presume that the change in religious voices coerced masses to pursue traditional healing remedies. However, a smaller number of the people were in concordance.

Emerging from the key informants' interviews, it was certified that during the first wave of the pandemic, religious voices were significant in laying out grounds for hope among the dismayed citizenries. This made the people so comfortable that it was pointless to solicit for alternatives. During the first wave, prayers dominated and were central at each single event when COVID-19 patients were discharged from hospitals. No single public prayer ceremony existed at the release of healed victims during the second wave. Yet, there were countless testimonies by individuals who were healed of COVID-19 after the application of traditional remedies. Such personal testimonies pointed to the effectiveness of traditional healing remedies, which lessened the hype that religious leaders had enjoyed in the past. Their silence was therefore anchored on their inability to furnish any sort of solution (Religious Education Teacher, Interview 16 June 2021). Another interviewee stated that gone were the days when Christian clergy and Muslim clerics proclaimed healing with their 'mighty touches and holy water'. Their silenced powers meant a shift in the healing paragon from pastors to herbalists (Senior lecturer, Interview 08 July 2021). Therefore, recourse to traditional healing for COVID-19 was largely justified by the impotence of religious institutions, coaxing people to unearth a substitute.

Arguments against any relation between religious voices and recourse to traditional healing remedies are based on the fact that traditional medicine in African societies boasts of a long-acknowledged history that dates back to the pre-colonial era as well as Christian and Islamic entries into Africa. Instead, the popular use of traditional medicine for COVID-19 during the second wave has its rationale in the socio-economic and political environments in which COVID-19 emerged, and generally the dysfunctionality of health service

provision in Uganda. In the next section, a discussion is presented on circumstances that account for the popular recourse to traditional remedies for COVID-19 in the second wave.

Popularity of Traditional Healing Practices for COVID-19

Traditional healing practices have existed since time immemorial and have been an integral part of human cultures (WHO 1978; Isiko 2018:3). Traditional healing practices, also termed 'traditional medicine' are defined as 'the sum total of knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement of treatment of physical and mental illness' (WHO 2001; 1978). Traditional medicine entails diverse health practices, approaches, knowledge, and beliefs incorporating plant, animal, mineral-based medicines, spiritual therapies, manual techniques, and exercises applied singly or in combination in order to maintain the wellbeing, as well as to treat, diagnose, or prevent illness (WHO 2001; Kebede *et al*. 2006:127).

Whereas the definition of traditional medicine is comprehensive, the concern of the WHO has always been limited to herbalism (Isiko 2019:72). Similarly, in contemporary Uganda, with the COVID-19 context, much concern has been on herbal remedies, physical exercise, and taking advantage of natural climatic conditions. Spiritual healing therapies by diviners were visible, although suppressed during the first wave. For example, there were efforts by the Acholi cultural society in Northern Uganda and Tondism faith in Buganda of central Uganda to revert to divination, amidst the COVID-19 outbreak (Isiko 2020:88-90). In the second wave, traditional healing practices for COVID-19, involving spiritual beliefs were rare and unpopular. However, a preference for herbalism and other such exploitation of the natural environment in which people lived gained more popularity during the second wave than in the first.

The online survey sought to establish scope and popularity of herbalism in the treatment of COVID-19 in Uganda. Out of the 500 responses, 479 (95.8%) respondents agreed that herbalism was popular among the population for treatment of the disease. Special interest was drawn on the stand of members of the Facebook group which constituted two categories of people traditionally thought to be apprehensive to the utilization of traditional healing remedies: 1) Pentecostal Christians, and 2) Urban dwellers. However, study findings established otherwise. Out of the 283 respondents from the Facebook group, 269 (95%) agreed that herbal remedies were sought-after for the

treatment of COVID-19. This meant that from their vantage viewpoint as urban dwellers and Christians, they were witnessing a high number of people using herbal remedies for the treatment of COVID-19.

Herbal remedies for COVID-19 in Uganda can be grouped into three categories. The first category is processed herbal medicines by fairly literate herbalists who have mastered the benefits of processing leaves, stems, and roots of locally available plants. They have transformed the herbs into various forms including powder, liquid, and sometimes tablets. These are well packaged and branded with the specific diseases they cure. This category is produced by 'second generation' herbalists who mastered herbalism through apprenticeship from kindred. The paramount distinction between the second-generation herbalists and their mentors is that the former acquired some moderate level of education which enabled them to appreciate the added value of processed herbal remedies, commensurate with medicinal traditions of their generation. The second category consists of scientifically proven herbal drugs whose chemical composition, dosage, indications, and side effects are notable and documented. This category is made by highly trained scientists who have specialized in natural therapeutics, ethnobotany, biochemistry, and pharmacology among others. In this category is COVIDEX and COVILYCE, which became prominent during the second wave of the pandemic. These were made by Professors at Mbarara University of Science and Technology and the Gulu University respectively. The third category include commonly known herbs, previously used for treatment of common colds, flu, high fever, and all those symptoms that are associated with COVID-19. These are locally available from plants around homesteads and in the bushlands. Locally available herbs were used in a concoction form for drinking, inhaling, steaming oneself, body smearing, and smoking among others. These herbal remedies were accompanied by sunbathing and physical exercises at regular intervals. With no specific treatment for COVID-19, the local populace, professional scientists, and researchers perceived herbal remedies as likely alternatives to deal with the pandemic. In the proceeding paragraphs, a presentation is made on the circumstances which made traditional herbal remedies for COVID-19 popular in the second wave.

An interviewee, commenting on the popularity of herbal remedies for COVID-19 asserted: 'The first wave equipped us with cooking tactics, but the second wave shaped us into wonderful herbalists (Assistant lecturer, Interview 23 June 2021). The first wave of the pandemic was less serious than the second one. The first wave lockdown domesticated people. Being indoors was the only

coping strategy in the absence of categorical information about managing the disease. Ugandans were more threatened about the lockdown restrictions and its effects on survival than the disease. Food, but not medication was the most vital item during the first wave. They therefore kept at home with the major task to prepare their own meals, since food kiosks were closed. They did not need medication, since the disease had been restricted to a measly group of people who had had contact with foreign travellers. The second wave, though deadlier, found a fairly elucidated citizenry. The application of herbs to boost immunity was a reckoned preventive measure. The wave was so tenacious that people could not turn a deaf ear to what was unfolding, as various people were ailing. People's wellbeing was a priority. This brought trepidation and agitation among the population, as herbal remedies would be prescribed by anybody to anyone as a preventive measure for COVID-19. Therefore, people had to master all the herbs that were commended to be miracle cures for COVID-19, just in case they developed any symptoms similar to those of the confirmed cases.

The challenge of inaccessibility to modern health and pharmaceutical remedies during the second wave of the pandemic facilitated the penetration of herbal remedies for the treatment of COVID-19. Access to health embodies three aspects, namely availability, proximity, and affordability. Medications for the COVID-19 treatment in the first wave were inexpensive and available all over the country. The most common pharmaceutical medications prescribed for COVID-19 patients included a combination of Azithromycin, Hydroxychloroquine, Zinc, paracetamol, and Vitamin C tablets (Ministry of Health 2020). These medications were accessible over the counter at a modest cost of less than 20 US dollars per dose. These were basic drugs that any government health facility would avail to any suspected COVID-19 case at zero cost. This was in addition to encouraging Ugandans to take a lot of fresh water and fruits (rich in vitamin C) which are within the reach of any household. The number of COVID-19 cases was quite dwarfish during the first wave, such that sickbeds were afforded by each victim in medical facilities designated for the management of COVID-19. Uganda was battling the Wuhan variant of COVID-19 which was deemed less aggressive than the newly imported variants in the second wave. COVID-19 patients with the Wuhan variant experienced mild symptoms which never required highly specialized management. Due to a handful of patients and affordable charges, the treatment of COVID-19 cases during the first wave was restricted to government health establishments (Kamurungi 2020).

However, the resurgence of COVID-19 during the second quarter of 2021, overwhelmed the available public health facilities, with a surge in infections, critical illnesses, and death. Many health facilities, with the exception of the national and regional referral hospitals and private hospitals in the urban areas, did not have the capacity to attend to COVID-19 patients. The worse new variants were resistant to basic tablets used in the first wave. The majority of the casualties required critical care in high dependency units (HDUs) and intensive care units (ICUs). The number of patients who required ICU, exceeded the availability of ICU beds in the country. The cost of HDUs and ICUs was unaffordable by the low-class Ugandan. Personal protective equipment (PPEs) for medical personnel were not only in short supply, but also acquired at an extortionate cost, due to the increased demand. Private hospitals were charging about five million Ugandan shillings, equivalent to 1,500 US dollars per day, for COVID-19 patients in ICU. Corpses were confiscated by private hospitals on the failure to settle the exorbitant medical bills (Abet 2021a; Muhumuza 2021a).

The cost of treating COVID-19 went beyond the ability of not only the working class, but also relatively affluent Ugandans. This was accentuated by a respondent:

> The people cannot afford those colossal amounts of money charged for managing COVID-19 patients in hospitals. Uganda's per-capita income is so disheartening that even a university lecturer cannot comfortably meet the five million shillings per day to treat a Covid patient. Also, the medical insurance scheme cannot meet such exorbitant expenses. Herbal remedies fall in the means of most Ugandans. These remedies have been motivated by limited resources and selfish increase in the hospital bills. It is exorbitant. It is like we have apartheid of some sort; segregation of some sort; it is only the rich to get treated. So, what does the poor man who can't afford five million shillings do? One resorts to herbs which have worked since time immemorial (Lecturer, Interview 23 June 2021).

Uganda's per capita income stood at 817 US dollars for the year 2020 (World Bank 2021). This means that the majority of Ugandans were tottering between life and death, between poverty and destitution. All the above were in addition to the high cost of testing for COVID-19 which was restricted to accredited testing facilities, not widely spread in the countryside. A PCR test for COVID-

19 ranged between 180,000 and 250,000 Uganda shillings, equivalent to 51 and 71 US dollars respectively (*Daily Monitor* 2021b). Hospitals with oxygen plants and supply were isolated and distant from the rural folk. Medical oxygen was scanty and afforded by only the well-off. Accounts of deaths due to denial of oxygen to poverty-stricken patients trended in public media (Muhumuza 2021b). Apart from the outrageous and prohibitive cost of healthcare for COVID-19 in the second wave, these services were not accessible to the majority of Ugandans, who survive on less than one dollar a day. The second nationwide lockdown restricted travel between districts, making it strenuous for most people to access treatment in districts where the services existed. Yet, also hospitals were perceived by many people as hotspots for COVID-19.

All these empirical challenges at the height of the second wave are contrasted with the open and free availability of herbs that Ugandans had revelled since time immemorial for both preventive and treatment of symptoms synonymous with those of COVID-19. At a non-professional level, herbal remedies are shared gratis within the communities. People resorted to taking herbal concoctions, not only to elude the contraction of COVID-19, but also to evade the abhorrent and repugnant medical bills. Even among the educated and urbanized Ugandans, information on the types of herbal remedies was gravely sought-after and circulated over social media, with clear procedures on how to prepare the concoctions. The availability of these herbs all-over-the-place kept everyone on the good side of the law as far as the travel ban was concerned. Noticeable was a Facebook post prescribing taking lemon juice and ginger, shared over 40,000 times (*Daily Monitor* 2020). Processed herbal remedies were cost-effective to any native Ugandan. The much sought-after local herbal drug, COVIDEX, was approved by Uganda's National Drug Authority, but was valued at a tolerable retail price of 12,000 Uganda shillings, equivalent to three US dollars per dose (Abet 2021b).

In addition to the inaccessibility was the perceived ineffectiveness of modern treatment for COVID-19 in comparison with herbal treatment. Many Ugandans lost confidence in government hospitals, citing incompetence, mismanagement, understaffing, poor remuneration, occasional paucity of basic supplies, as well as corruption, exposing a social fault line where only the wealthy could afford health services (Kyeyune 2021; Muhumuza 2021b). These were in addition to the media crowded with messages of death of people previously under hospital care in the ICUs of government and private medical facilities. The argument that medical oxygen weakened rather than strengthened COVID-19 victims was commonplace among the local

population. This was a result of improper messaging by medical facilities whose messages of emphasis were on the number of fatalities rather than those who had healed from the disease. On the other hand, success stories of those healed from the disease were severally told in both mainstream and social media, but with the glorification of herbal remedies as the breakthrough trick. In the Daily Monitor publication series titled, *Beating Covid*, seven of the 10 individuals analysed by this study confessed to the use of herbal concoctions and attributed their recovery from COVID-19 to herbal use. This made people to believe that herbal treatment is a much better alternative. In line with these public perceptions, one respondent stated:

> Some people doubt the efficacy of hospital medical prescriptions. This is catalysed by social media. In this phase, everybody has become a doctor. Even the ministry is failing to come up with clear guidance. Many herbs are on market through social media, coaxing people to move to the bushes the following day. The use of social media has escalated the use of herbal medicine. Those who come up to speak about beating COVID-19, glorify herbal remedies. All these are done over social media (Assistant lecturer, Interview 27 June 2021).

The unregulated social media space which makes everyone a 'journalist' of some sort, facilitated the proliferation of 'social media herbalists' for COVID-19. There is an illusory belief among the citizenry that all public media reports are authentic. In contemporary contexts, the social media influences choice and preferences, including health seeking behaviour. The nationwide lockdown made people, especially the urbanized unoccupied, spending precious time on social media. Telecom companies in Uganda devised friendlier data bundles and easing internet access during the lockdown. Africell, for example, came up with 'stay home' data bundles, which offered double the amount of data one purchased during the lockdown. Social media henceforth became one of the unregulated major sources of Covid-19 updates. This became a viable tool for rapid information dissemination during the pandemic (Alotiby 2021: 3146).

Earlier studies in other countries indicate the significance of social media and internet in influencing the pursuit of herbal remedies for COVID-19 (Alyami *et al*. 2020:1328). The *Wall Street Journal* reported about a war between global health policy makers and social media companies that were spreading phony cures for COVID-19 (Vyas 2020). This kind of information about herbal remedies was all over the world, right from Venezuela's president

who suggested on his Twitter account that 'tapping into ancestral wisdom of recipe for ginger-lemon tea' was a cure for COVID-19 to Indians who promoted a concoction of cow dung, garlic, and prayer (Vyas 2020). The popularity of COVIDEX, Uganda's herbal drug for COVID-19, was due to the hype it received from social media, gaining the attention of the public, the Ugandan drug regulators, and the Head of State (Nakkazi 2020). Actions by YouTube to ban and expunge video content on COVIDEX from its sites, simply increased its demand among Ugandans as it was interpreted as sheer envy from modern pharmaceuticals and arrogance of Western epistemology on medicine. For Uganda's case, individuals circulated personal videos on Facebook and WhatsApp, steaming themselves with concoctions, directions on using herbs, as well as personal testimonies of healing from COVID-19 as a result. However, social media carried several videos containing falsehood and conspiracy theories about COVID-19 and the approved vaccines for the disease. By so doing, the social media dissuaded Ugandans from modern healthcare services, consequently promoting herbal remedies for COVID-19. This was the case with India, Nigeria, and the Democratic Republic of Congo where social media indirectly hyped-up false news and misinformation with regard to COVID-19, overflowing social media much more than factual information about the pandemic (Sharma *et al*. 2020).

The ineffectiveness of modern healthcare responses to COVID-19 was not just a matter of perception, but reality. This was evidenced by challenges associated with the Ministry of Health's COVID-19 vaccination program. People turned to herbal remedies partly because of limitations and misconceptions associated with the vaccination strategy in Uganda.

First, the country experienced issues of inaccessibility to the vaccine, since all WHO approved vaccines were manufactured outside Africa. They were mostly too expensive for individual country outsourcing, causing African countries as part of the African Union to lobby for supply through the COVID-19 Global Vaccine Access Facility (COVAX facility) (Atwine 2021). There was a hoarding of vaccines by the wealthy countries and middlemen who bought off most vaccines from the manufacturers, to sell at unimaginable prices to developing countries (Binagwaho *et al*. 2021: e1169; Merelli 2021). Vaccine nationalism exemplified by countries' decisions to hoard vaccines and inoculate groups that were not at high risk, substantially reduced the availability of COVID-19 vaccines in most African countries (Binagwaho *et al*. 2021: e1169).

Second, the first batch of vaccines only contained 864,000 doses to serve a country of more than 40 million people. The government strategy on vaccination was to target a select group of people thought to be at high risk of contracting the virus. These were the medical and security personnel, teachers, adults aged 50 years and above, as well as all those people with comorbidity (WHO 2020). This meant that the majority of Ugandans would not be vaccinated immediately.

Third, there was a slow uptake for the vaccine due to long distances to authorized vaccinating health facilities, mistrust, and misinformation about the drug (Echoru *et al*. 2021:2). There was propaganda that the vaccine changes one's DNA, causes infertility and blood clotting, and that it reduced one's longevity. A study by Echoru *et al*. (2021:4) highlights rumours as a major roadblock to effectiveness of previous vaccination pro-grams in Uganda. However, the AstraZeneca vaccine, which was being used in Uganda, was also not 100 percent effective against the virus. Studies done by Chagla (2021) as well as Hung and Poland (2021:854), rated the Astra-Zeneca vaccine at 70 percent efficacy against COVID-19, more than 14 days after the second dose. To ordinary Ugandans, this raised a debate as to whether the vaccine was better than the herbs that had stood the test of time. Several Ugandans were therefore hesitant to take vaccines whose efficacy was lower than those used in other countries at the time. The emerging of five COVID-19 variants in Uganda, against which the AstraZeneca vaccine was not effective, revealed that nobody was completely safe with the vaccine alone. The worst came when India, the principal manufacturer and supplier of the Astra-Zeneca vaccine to most African countries, including Uganda, stopped exportation in order to deal with a disastrous second wave of the pandemic at home, which had claimed the lives of thousands. India could no longer produce enough for both its domestic demand and export. All these factors brought desperation among Ugandans with the only resort available being traditional medicine.

Consequently, the increased use of traditional medicine for COVID-19 in Uganda had its genesis in the inadequacies in modern medical institutions and services which created a vacuum for traditional herbalism to take shape. However, arguments from public commentators that traditional therapies like steaming with exotic weeds or drinking cockroach soup to cure COVID-19 dismayed ordinary citizens. They struggled to come to terms with the complexities of the failing health service institutions and service delivery in the country. These are incapable of comprehending the impact of global health politics in the discovery, manufacture, financing, and distribution of COVID-

19 vaccines upon developing economies like Uganda. Nonetheless, these pseudo-beliefs in the efficacy of traditional medicine for COVID-19 gave the failing government some breathing space (Tacca 2021).

It is still worthwhile to note that traditional medicine is intertwined with the cultural, religious, socio-economic, geographical, and political environment of societies in which they evolve (Isiko 2019:72). Therefore, with or without the failure of the modern health system to support the management of COVID-19, traditional remedies would still take the day until an effective and trusted vaccine or cure that counteracts their traditional beliefs is discovered. It has been part of African Christians and Moslems, in times of crisis like those of pandemics with no cure, to revert to African traditional religious beliefs for solutions. Ugandan Christian and Islamic clerics, for example, encouraged the reliance on traditional medicine at the height of the second wave. Herbal remedies for COVID-19 did not entail consultations with spirit mediums, which would otherwise have compromised religious people's beliefs in Christianity or Islam (Lecturer, Interview 16 July 2021).

Politically, President Museveni shielded and promoted the manufacture and use of COVIDEX and COVILYCE herbal drugs produced by local Ugandan scientists. The president's intervention reigned above the bureaucratic Western pharmaceutical ideological inclinations of the national drug regulator, which had barred the production and use of the above herbal drugs (Owiny 2021). The touting of traditional herbal drugs by the African political class as it was in Madagascar, Tanzania, and Uganda was not necessarily a celebration of a 'medicinal jackpot' which would alleviate Africans from the deadly COVID-19, it was rather a demonstration of a liberation struggle of a new type, an intellectual liberation struggle to get out of unhealthy dependency on Western medicine and vaccines (Nakisanze 2021).

The political attitude in Uganda towards African herbal remedies for COVID-19 was not in disarray with those across the continent. Madagascar's Covid-Organics, for instance, were given a nod in several African countries not as a tested cure for COVID-19, but as part of a deeper engagement with the question of Africa's place in the world. COVID-Organics promoted the Pan-Africanism ideology which depicted African countries as sufficient and independent, capable of producing its own medicines, rather than importing them as aid from the Global North, thereby undercutting economic and racial discrimination that was already visible in the global COVID-19 vaccination strategies (Richey *et al*. 2021).

Culturally, the recourse to herbalism in the face of COVID-19 in Uganda was rooted in 'tradition'. Africans have for innumerable years been using traditional medicine remedies for uncountable diseases. It was therefore not surprisingly for Ugandans to trust traditional medicine to treat COVID-19. The herbs used, are plants within their midst. One respondent described the unsurprising recourse to herbs for COVID-19 in the following words:

> People are experts in treating flu. So, they think they are masters in managing the prevalent symptoms of COVID-19. People already had their traditional remedies of expelling the mucus from the lungs. They knew all these even before the widespread of hospitals. They still employ traditional herbs for healing purposes. For example, steaming is not a new invention. African mothers would make use of several herbs and mango tree leaves to treat common cold, flu, and high fevers among children – characteristic symptoms of COVOD-19. The consumption of greens and vegetables, rich in vitamin C is a common practice in several African traditional communities. In addition, prayer and sacrifice and the taking of herbal concoctions are integral to the lifestyle of Africans (Assistant lecturer, Interview 10 July 2021).

Herbalism is one of the indigenous knowledge traditions which have been inherited generation after generation. The opinion of the above respondent insinuates to the proposition that even when Ugandans were uninformed of this new disease called COVID-19, they would still use these herbal remedies to treat the symptoms as before. COVID-19 presented symptoms that are not alien to Ugandans, except for the level of severity with which these manifested. Uganda has herbs which regulate the constant flow of mucus and normalizing body temperature. Therefore, Ugandans were utilizing their inherent herbal knowledge to survive the pandemic.

Discussion

The study sought to investigate the change in religious voices during the second wave of COVID-19, seeking to establish the genesis of conspicuous invisibility of religious voices during the second wave. The study also sought to establish whether or not a relation existed between the waning religious voices and recourse to traditional healing remedies for COVID-19 and the rationale behind the popularity of the remedies. Contrary to studies conducted during the first wave (Isiko 2020; Blair *et al*. 2021), religious voices were

marginal in the second wave. This finding contradicts the religious copying theory and earlier studies which postulate the centrality of religious beliefs and voices during pandemics whose aetiology and cure are bizarre (Huremovic 2019:14; Isiko 2021:240). Whereas previous studies have advanced religious explanatory models for pandemics of this nature (Isiko 2020), this study has established the relegation of religion and the promotion of science, with religious leaders championing the vaccination exercise and observance of SOPs in contradiction of their moving religious messages of miracles, healing, and spiritual hope, manifested in the first wave of COVID-19, and earlier disasters (Cunningham 2008:29-31). Empirical evidence from the first wave of the pandemic indicated that during COVID-19, most victimized people used their religion more intensively and thereby becoming more religious than others (Bentzen 2020:4). However, findings of the second wave in Uganda reveal that as COVID-19 infections and deaths escalated, the belief in prayers, miraculous healing, and generally the power of the 'spiritual' to control the pandemic waned. The public was apprehensive about the relevance of national prayers in dealing with the pandemic.

The change in the message by religious leaders during the second wave of COVID-19 portrays not only the disillusionment, but also shortcomings of religious elites, especially when confronted with unfortunate burdens synonymous with those their 'sheep' encounter. The waning of religious voices during the second wave at a time people needed them, waters down prior postulations that religions have an immense bearing on society's socio-political direction, influencing policy preferences inclusively (Isiko 2020). The shift of messages from religious explanations to scientific explanations for COVID-19 during the second wave, was not disbelief in religious tenets, but sustained evidence of the complementarity of religion and science. This argument conforms to postulations advanced by both Whitaker (2020) and Whiting (2020), that being religious does not necessarily make one anti-science. They illustrate their argument with the example of Martin Luther who did not pit faith against reason during the bubonic plague of the 16th century. As a religious cleric, Luther urged Christians to pray, but he also felt the duty to remain in Wittenberg to nurse the sick and the dying. He, however, advocated for the SOPs by then, reasoning that while he believed in God's ultimate power to cause healing, human responsibility was important. Human responsibility included following responsible practices of sanitation, medication, self-quarantine and social distancing to curb the spread of the contagious disease (Whiting 2020).

However, the invisibility of religious voices and religious leaders' preference for scientific explanations should not be surprising during the second wave of the COVID-19 pandemic, given sustained evidence of decline of religious explanations with the ascent of explanations on biomedical science (Phillips 2020:434; Barmania & Reiss 2020:15-22). Science in its infancy is ineffective in affording alternatives to faith-based explanations. This was the case in the early 19th century Christian Europe, when it was pounced on by cholera. Faith communities, both religious elites and lay people, took little heed of any explanations but their own to account of cholera, since medical healers of all persuasions never supplied cogent alternatives. However, the persistent non-success of religion to account convincingly for pandemics renders biomedicine more pertinent. For example, once biomedical sciences concluded on exactly the aetiology, transmission, and germ revolution of cholera, science gained pre-eminence over religion. In Uganda's case, the public embracing of science by religious leaders was due to discoveries and innovations of COVID-19 vaccines and their effectiveness as the pre-eminent game changer.

Historical studies like Isiko (2018) have analysed the negative perception, castigation, and censorship of traditional medicine by European Christians in Uganda, adjudging them not only as satanic but also life-threatening. The overwhelming impact of Christian and Moslem religious clerics during the first wave of the pandemic in Uganda, could have accorded a sprinkling of alternatives to deal with the pandemic (Isiko 2020). It was initially thought that religious leaders' conspicuous silence in the second wave could have left the population with haphazard responses and alternatives, finding their way to traditional healing remedies. The findings, however, reveal no significant relation between diminished religious voices and people's recourse to traditional herbal remedies for COVID-19. The historical hatred that the Christians hold upon traditional healing remedies, have been proved to be non-existent in this study, with religious clerics instead justifying the utilization of herbal remedies, based on biblical perspectives. Contrary to initial assumptions, the refractory recourse to traditional herbal remedies for COVID-19 emanates more from the flaws and inadequacies within modern healthcare (in Uganda) and the entrenched traditions of cultural societies than religious leaders' silence about the pandemic. This finding grants an augmentation to the precursory studies which posted that traditional healing practices evolve from the cultural, socio-economic, and political organization of societies, and this can progress devoid of any foreign influences (Isiko 2019). Despite the enormous breakthrough and general acceptance of bio-

medical practice, it has fallen flat in comprehensively substituting traditional healing – instead, they exist side-by-side (Tabuti, Dhillion & Lye 2003:120). This is because traditional healing practices are not only proximal and low-end, but also deeply embedded in the wider belief and cultural systems, an integral part of the lives of most Ugandans and Africans at large.

Various studies have largely linked the use of traditional medicine in the developing societies to the inaccessibility to modern healthcare. The unavailability of or long distances to medical facilities, high medical costs, and inadequate medical staffing, supplies, and equipment are a thorn in the flesh (Kebede *et al*. 2006:127-128). The increased recourse to traditional remedies for COVID-19 in Uganda is not shocking, since previous studies indicate that about 60 percent of the population utilizes them. These study findings fulfil expectations in a previous article, postulating that it would be a matter of time for Ugandans to embrace traditional healing in the wake of COVID-19 (Isiko 2020:79). These factors seem to be recurrent in all situations of medical necessity regardless of the gravity of the disease.

Limitations

Just like other studies carried out at the peak of the pandemic (Phillips 2020; Barmania & Reiss 2020; Isiko 2020; Richley *et al*. 2021), the lockdown measures made it strenuous to reach religious leaders and traditional healing practitioners who would have been the most primary respondents to the study. There were conceptual limitations too. Religious leaders and voices were limited to Uganda's two significant religious traditions of Christianity and Islam. Although, traditional healing practices are a significant component of African indigenous religious ideologies, the voices of their professional practitioners – traditional medicine specialists were not part of the study. The study also, experienced inaccessibility to primary source material due to the library lockdowns, a heavy reliance on uncorroborated social media and other internet sources for information about COVID-19 pandemic, and real consequent dangers of generalization, of mistaking a part for the whole, and the predominance of official religious positions over viewpoints of lay members of faith communities (Phillips 2020:435).

Conclusion

The study sought to investigate the waning voices of religious leaders on one hand and resurgence of traditional healing practices for treatment of COVID-19 during the second wave, on the other hand. This was premised on religious explanatory postulations of pandemics and earlier studies which posit an increased recourse to religion for people experiencing adversities, and in this particular case pandemics like COVID-19. The study however, established a decreased visibility of religion and religious voices during the second wave of COVID-19, with a sky-rocketing recourse to herbalism for COVID-19. In many respects, the decreased voice of religious leaders rescinded the optimism that the people held in religious ideology for the disease, with solace found in the effectiveness of science and traditional herbal remedies. The popular use of traditional herbal remedies for COVID-19 emanated from the deplorable capacity of Uganda's modern healthcare system to manage the pandemic, on the one hand, and socio-cultural traditions and beliefs of the people concerning the disease and medicine, on the other.

Uganda being a significantly religious country, religious leaders are taken to be the salt and light of the nation. Their silence, especially at the height of a cureless pandemic like COVID-19 is an abdication of their mandate, obliging citizens to act in darkness by exploiting any feasible escape route.

Religious leaders are important gatekeepers to their communities, playing a vital role in policy implementation regardless of whether or not a policy makes no overt reference to religion. Individual religious leaders may disseminate health information, allow health professionals to relay information to the congregants, or reach out to the marginalized during a pandemic. They are to transmit messages in a wholesome way, always paramount when the trust in science is lost, but so imperative during a pandemic. However, the religious leaders' dwindled voices during the more disastrous second wave of COVID-19 devalued the centrality of religious beliefs, previously theorized to be the bedrock upon which pandemic victims cope with adversity. This is a clear demonstration that whereas majority Ugandans claim either Christian or Muslim religious affiliation and identity, the silence, inaction or impotence of Christianity and Islam in times of adversity make the people to revert to African indigenous religious ideologies and practices for which traditional healing practices are an observable component.

From the evidence, the study therefore confirms the continued importance of traditional remedies in healthcare provision in Uganda and recommends an integration with modern healthcare provision. Significant

resources ought to be provided for continuous research and studies to establish the efficacy of these herbal remedies.

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