The Health of Refugees: Are Traditional Medicines an Answer?
Gesundheit von Flüchtlingen:Ist traditionelle Medizin eine Lösung??

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Witchdoctors...are not the peculiar heritage of the African. They are rather the unsurprising accompaniment of poor social conditions, of fear, of ignorance and despair, and as such they are found, even today, in every civilisation earth. The witchdoctor is certainly an integral part of African cultures; he stands between man and spirits; he offers, and sometimes provides peace of mind to the distraught and anxious....He may be unhygienic, unskilled and avaricious - so is the back street abortionist....(GERMAN IN ORLEY 1970).

Abstract: Based on a wide range of data on refugees in East Africa, the essay discusses the roles of traditional medicine and healers within the context of displaced populations and the limits of humanitarian health intervention and of modern medicine. A combination of a number of cultural, geographical, financial and social barriers and the limited scope of humanitarian emergency health services leaves space for the practice of traditional medicine in displaced populations. In a refugee situation, it is not uncommon to see this role taken up by opportunist traditional healers, sometimes unqualified, who engage in this lucrative activity to benefit from the situation of chaos. The official rejection of traditional medicine in many parts of Africa has contributed to emergence of competing and conflicting relations between traditional medicine strongly supported by indigenous cultural practices and beliefs and modern medicine. Drawing from the experience in many parts of East Africa, the article challenges the tendency by many foreign observers to romanticise the role of traditional medicine and the powers and influence of the healers in the loght of the social changes that takes place after forced migration. The article points to the dearth of research on the use of traditional medicine by refugees and calls for more research into the potential role traditional medicine and healers can play in providing therapeutic medicinal and societal service.

Zusammenfassung: Dieser Beitrag erläutert, gestützt auf eine breite Datenbasis über Flüchtlinge in Ostafrika, die Rolle der traditionellen Medizin und der Heiler im Zusammenhang mit vertriebenen Bevölkerngsgruppen und die Grenzen humanitärer Gesundheitsinterventionen und der modernen Medizin. Eine Kombination zahlreicher kultureller, geographischer, finanzieller und gesellschaftlicher Schranken und die begrenzte Reichweite humanitärer gesundheitlicher Hilfsdienste lassen Raum für die Ausübung der traditionellen Medizin bei vertriebenen Populationen. In der Situation von Flüchtlingen wird nicht selten beobachtet, dass diese Aufgabe von opportunistischen - mitunter nicht qualifizierten - traditionellen Heilern übernommen wird, die sich in diesem lukrativen Gewerbe engagieren, um von der chaotischen Situation zu profitieren. Die offizielle Ablehnung der traditionellen Medizin in vielen Teilen Afrikas hat dazu beigetragen, dass viele konkurrierende und konfliktreiche Beziehungen zwischen der traditionellen Medizin, die durch heimische kulturelle Praktiken und Glauben stark gestützt wird, und der modernen Medizin entstanden. Angesichts der Erfahrungen in vielen Teilen Ostafrikas kritisiert der Beitrag die Tendenz gar mancher ausländischer Beobachter, die Rolle der traditionellen Medizin und die Macht und den Einfluss der Heiler im Licht der gesellschaftlichen Veränderungen, die nach erzwungener Migration stattfinden, romantisch zu verklären. Der Beitrag weist auf die mangelnde Erforschung der Anwendung traditioneller Medizin durch Flüchtlinge hin und fordert eine vertiefte Untersuchung der möglichen Funktion, welche die traditionelle Medizin und die Heiler bei der therapeutisch medizinischen und sozialen Betreuung übernehmen könnten.

Keywords: Africa, Culture, Modern Medicine, Traditional Medicine, Healers, Refugees, Afrika, Kultur, Moderne Medizin, Traditionelle Medizin, Heiler, Flüchtlinge.

Introduction

We live in a world which is marked by increasing levels of poverty, violence and political instability. One of the major symptoms of these ills are the millions of refugees and internally displaced. Since most refugees tend to avoid the camps and settlements established by humanitarian agencies, preferring to settle themselves among their hosts, many of these people do not have access to adequate ‚modern' (allopathic) medicine. Moreover, even the availability of adequate health services to refugees in camps is contingent on the flow of international aid, which is itself dependent on the vagaries of media attention and the political interests of the donors.

This essay is being written during the course of a fieldtrip to Kenya where a research programme to

compare the health and welfare of refugees living in camps with those who are settled amongst their hosts is beginning in this country and in Uganda. The discussion is drawn from data collected in the course of research conducted amongst Ugandan refugees living in the Sudan in 1983-4 (HARRELL-BOND 1986), 20 person days of observations and interviews in Kakuma Refugee Camp, Turkana District, Rift Valley Province, north-western Kenya, a report of an evaluation of health services conducted in Hagadera, one of three camps located in the north-east region of Kenya (BOELAERT 1996), and research concerning the global refugee phenomenon conducted over the past 15 years in many countries around the world. The discussion concerning the use of traditional medicine by refugees is, however, limited to examples of its practice from research in Africa.

There are some northern humanitarian organisations which see this situation as an ideal time to promote the practise of traditional medicine as an answer to the unmet health needs of such populations. In this paper, we use the term, traditional, with considerable misgivings when referring to medical practitioners who operate outside the boundaries of modern medicine. The use of the term, traditional, as an adjective to describe local healers in Africa or elsewhere is problematic, especially when used in an article in which the emphasis is on culture as a process and which is in disagreement with those who believe that what is ‚traditional' equates to some unchanged primordial past before the impact of outside influences from the West.

While acknowledging that both traditional and modern medicine have a part to play in health care for the forcibly displaced, this essay aims to caution those who tend to uncritically idealise traditional medicine and its practitioners. Laying aside the contested issue of the effectiveness of their treatments, refugees and others who are living in situations of instability in Africa are particularly vulnerable to the opportunism of some traditional healers whose interventions may actually contribute to increased conflict and further social disruption. A ‚human rights' approach to humanitarian interventions requires all those involved to equip themselves to be able to distinguish between those aspects of a culture which are functional and those that are dysfunctional, especially those which are at variance with international standards. This must be especially the case for those concerned with the rights and welfare of women.

With the intrusion of IMF and World Bank policies which insist on cost recovery health programmes, which most of the poor cannot afford, one may expect more of the world's population to be thrown back on alternative therapies as access to modern medicine becomes even more difficult. As such, it becomes even more important that the activities of traditional healers and the therapies which they administer are subjected to research in order that those who are able to provide useful therapies are distinguished from those whose interventions are iatrogenic. The term, iatrogenic, is usually employed to describe the negative effects of modern medicine, but the dictionary meaning, ‚caused by the process of medical examination or treatment', allows us to apply it to the interventions of traditional healers.

The Successes and Limits of Modern Medicine

Over the past fifty years modern medicine has developed powerful drugs to combat many infectious diseases, for example, anti-biotics, other anti-infectious drugs as well as vaccines for many childhood diseases. Even before that, life saving surgical interventions had been in practice, such as caesarean sections and other abdominal operations, but these became much more effective with the advent of anti-biotics.

Thanks to these developments, such killers as pneumonia, diarrhoea, malaria, meningitis, and tuberculosis all became easily curable with modern medicine. However, there are still many diseases for which modern medicine has no effective treatment, such as AIDS, most forms of cancer, mental disorders and many psychological and psychiatric problems. At the same time, some bacteria and parasites have been developing resistance to treatments, presenting serious challenges to the effectiveness of modern medicine.

Barriers to Accessing Modern Medicine

Modern medicine has undoubtedly achieved great successes, such as the eradication of smallpox throughout the world and the control of non-venereal trepanomatosis, but there are a number of barriers to accessing it. Cultural acceptance of various therapies differs widely from place to place. However, one form of medical intervention, the injection of drugs, has received almost universal acceptance. Because injections of anti-biotics and anti-malarials have been demonstrated to produce such rapid results, they

have become the preferred treatment in most parts of Africa *for any illness.* Many patients do not believe they have received proper medical attention unless they have received an injection. Similarly, the acceptance of surgical interventions varies widely from one area to another and for different types of ailment, but it is remarkable how willingly many people undergo major surgery for certain indications, while objecting to a life-saving caesarean section for a blocked labour.

In Kakuma refugee camp in Kenya this was a particular problem for those working in the health services. Because many of the southern Sudanese women had been raised on a sub-nutritional diet, they developed pelvises too small to deliver the babies whose birth weight had been improved by the prenatal care provided in the camp. Their husbands, however, often refused to allow their wives to be delivered through a caesarean section. One Kenyan health worker hit upon the idea of employing ‚male motivators' to educate the men which was successful in at least reducing resistance. It is unfortunate to reflect on the fact that the diet fed to the refugees in Kakuma who are not targets of special feeding programmes like the pregnant women are, continues to fail to meet the nutritional requirements of this population. Hence another generation of girls is being raised with the same deficiencies of the adults.

Geographical barriers combine with poverty to prevent vast numbers of people, not only refugees, from accessing the services of persons competent to dispense modern medicine. In many parts of Africa the majority of people still live over ten kilometres from a health centre. Such a distance may be too far in the advent of an acute illness.

Moreover, the quality of training of medical staff and their motivations vary widely and the tendency is to staff the most remote health centres with the most junior, who then often receive inadequate supervision. In many instances, health systems have been created by outsiders without sufficient appreciation of the context in which medical personnel are expected to work. In some situations, people do not trust the health worker because s/he *is an outsider, or, because s/he is an insider whom they know to be untrustworthy.* In some African countries, for example, Burkina Faso, primary health care was interpreted as training a young person for each village through a crash course of a few weeks. This person might be able to learn to use modern drugs for a few life-threatening disorders, but s/he will never be able to know the limits of this knowledge. Once the inevitable serious mistakes occur, it will be impossible for such a health worker to regain the confidence of the community s/he is intended to serve.

Perhaps the most important barrier to accessing modern medicine is financial. The post-independence optimism that there could be free medical care for all has long evaporated. As noted above, in most countries everyone has to pay for health services, a situation which has been exacerbated by World Bank insistence on cost recovery. Practitioners of modern medicine almost always require cash payments for their services and, on the spot, while the availability of money in many rural areas is seasonal. There are even places where a monetary economy is non-existent any more, for example, in large parts of Zaire or Somalia.

The cost of treatments is related to the seriousness of the illness. In parts of rural Africa it has been found that often not less than 20 to 25 percent of a family's annual cash income is spent on direct medical expenses. People are often forced to divest themselves of land and other capital resources in order to receive treatment. For example, in Guinea it was observed that food stocks required to carry a family through the ‚hungry season' were being sold off early in order to pay the doctor to save the life of one of its members. There are social or class barriers as well which discourage the adequate utilisation of modern health services. Access to education in most African societies is very limited and those who achieve some qualification often feel superior to their less-educated compatriots. At the same time, because their reference group are the elite members of their professions, who live in urban centres and earn higher salaries, qualified health workers posted in remote areas are often frustrated in their social and economic ambitions. Few training institutions pay sufficient attention to training medical workers to be culturally sensitive towards other groups in their own country, or even to understand the special problems of the extremely poor. In the course of fieldwork in Kenya in March, a district medical officer working in Turkana remarked that when a woman was admitted, before examining her, he would require an assistant to cut off her beads. Since their beads completely cover a woman's neck from chin to shoulders, and because of the desperate lack of water in this desert environment, they are usually very dirty, one can understand the doctor's wish for his examination to be unimpeded by them. However, given the significance of the elaborate beads the Turkana women wear, one could assume that the tendency would be to avoid medical care if at all possible.

These factors combine to influence the relations of health workers with their patients who may be blamed for the health problems they present. For example, in the wake of such a preventable disease as measles or diarrhoea, very often nurses or doctors will berate the parent for not having taken the necessary precautions. The same happens if people delay consulting the health services and reach the clinic with an advanced or complicated presentation of a disease. As a consequence, the anticipation of such humiliation increases the tendency for people to further delay consulting medical practitioners.

The Role of Traditional Medicines

Although modern medicine has taken a prominent place in African society, traditional forms of medicine have continued to be practised on a wide scale. Many of their practices are no doubt efficacious, for example, there are healers who specialise in bone setting, treating bites of scorpions and snakes. Many of the discoveries of ‚traditional medicines' have been the basis for the developments in modern medicine, usually with no regard to the ‚intellectual rights' of those who discovered them. The most classic example is the discovery of quinine by the Amazon Indians. For other examples, such as the Aboriginal Tea Tree remedy 'which treats everything from migraines to eczema, has not been popularised and is readily available to chemist in the west' ('The Spice of Life' in Sunday Monitor, 27 April 1997:19).

At the same time, however, some foreign observers of other societies suffer the tendency to romanticise the role of traditional medicine, and power and influence of the healers themselves. Among some humanitarian workers as well as anthropologists a kind of myth has been promulgated about the ‚harmony' between man and his environment as well as among ‚men' which supposedly reigned in African societies in which traditional medicine was an integral part. Those who hold such romantic views of ‚traditional' culture also believe that if there were only greater knowledge of, and respect for the traditions, it would be possible to return to such a harmonious past. How do those who hold such views of African traditions square them with other concerns, such as the rights of women in societies whose traditions include, for example, the practice female genital cutting?

As is common throughout the world, many patients use different combinations of modern and traditional medicine in their quest for healing. At the same time, in many parts of Africa, traditional medicine has been officially rejected and healers are unable to practice openly for fear of arrest. As a consequence of this difficult position vis-à-vis the law and modern medicine, that treatments involve as much contact with the supernatural as the use of different herbs or treatments, *and* the fact that their livelihoods depend on their knowledge, healers are understandably loathe to discuss their practices with others, especially with outsiders, or to subject them to analysis. As ROBERT CHAMBERS (1983) long ago pointed out, while the science of agriculture has long been highly developed in rural societies, medicine is not. It has always been possible, as he reminds us, for farmers to experiment with different agricultural techniques and thus employ scientific methods for improving outcomes, but attempts to learn about the causes of human illnesses and diseases involve life and death situations. Consequently, such experimentation could not be done. In every society, human life is invested with sacred connotations. In fact, all medical experimentation is faced with ethical dilemmas.

Most important, no culture is static, all are fluid; all societies are constantly adapting to influences, both external and internal. This is also the case with traditional medicine. It has already been noted that Africans, for example, believe that injections are the best treatment they can receive. This belief in injections is so strong that people reject other forms of medication. In Uganda we observed the Red Cross posters which read *‚Do not ask for injections. Tablets are just as good'*. Nevertheless, in order to impress their clientele with their up-to-date skills, many traditional healers now offer their patients an ‚African injection' which entails the use of a razor blade or knife to cut the skin to facilitate the absorption of their medicines in the body. More seriously, because many commercially manufactured drugs are easily available on the market in Africa without prescription, some traditional healers - without adequate knowledge of dosages or their consequences - have also incorporated anti-biotics and other powerful drugs into their therapeutic arsenal.

Traditional healers have long engaged in surgical interventions as well (see, for example, ROLES 1966). The circumcision of males and the cutting of female genitals are perhaps the most well-known. In some countries healers remove cataracts and perform other operations on the eye. The major complications which can arise from such surgery are serious haemorrhage and bacterial infections.

Because traditional healers are operating in direct competition with those who practice modern medicine, a serious problem of competition and *territoriality* has developed between them. Patients who admit having consulted a traditional healer before resorting to the recognised health facilities will be seriously reprimanded by the nurse or doctor treating them. Similarly, traditional healers may terrorise their clients by saying that there is serious incompatibility between their medicine and the treatment which they will receive from modern medical practitioners. Because the practices of traditional healers are not limited to dispensing medicines for specific complaints, but encompass other functions which rely on their supernatural powers, they are in a much stronger position to make the claim that their ‚medicines can not be mixed' with modern medicine.

Cost is also a problem for those who consult traditional healers. Although the practitioner may not demand cash immediately and may be more flexible than their counterparts who dispense modern medicine in the manner and timing of payments, the user will eventually have to pay in one way or another and often the price demanded is also considerable. Unlike his modern counterpart, the traditional healer has supernatural sanctions to ensure payment!

The Consequences of Forced Migration on Social Structure

When people are forcibly uprooted from their homes they rarely flee as complete communities. Families are separated, elderly often left behind, individuals may have been killed and others are away, engaged in fighting. People do not easily leave their homes. The pattern of flight very often finds families or groups of individuals hiding for long periods of time as near as possible to their homesteads with the hope that they will be able to return. In these situations, often for prolonged periods of time, they often lack access to adequate food and water and the normal health services available to them before the conflict which caused their flight ensued. In such a situation the only services which are likely to be available are those persons who claim expertise in the use of traditional medicines.

When people settle in another place they are often forced to live among strangers or with groups with whom they are in conflict. It is not unusual for civilians loyal to different fighting factions to find themselves sharing the same living area. Many people have been bereaved and are mourning lost relatives; others are uncertain whether or not members of their families have survived. Having survived for long periods of time in remote areas where access to even food and water was severely restricted or where they may have been exposed to diseases for which they have no immunity; they may be malnourished, exhausted and ill and often severely traumatised by their experiences of violence, flight, and loss. Not only have they lost material possessions, but, most importantly, they have also lost their networks of social support. They face a future of profound uncertainty.

Often people who have been forcibly uprooted are forced to live in camps or settlements organised by humanitarian agencies and made completely dependent on charity. Their freedom of movement is curtailed and their normal day-to-day routines are profoundly disrupted. For example, the way of organising life in refugee camps, which requires people to remain on an assigned plot whether or not they have other kinsmen living in another part of the camp, actively hinders if not prevent the reconstruction of social networks. Another dimension of camp life are the relationships of competition and conflict which are exacerbated by the presence of humanitarian agencies which are themselves competing for power and influence among themselves (VOUTIRA & HARRELL-BOND 1995). Camps also expose the inhabitants to the added danger of communicable diseases which rapidly turn into epidemics (VAN DAMME 1995). Humanitarian agencies organise emergency health services which offer a limited number of services for what have been deemed as the priority needs, leaving many real and perceived needs unmet. Most notably, treatments for mental and psychosomatic disorders are not covered by these health services. In fact, most of the resources of these emergency health programmes are focused on health services and activities aimed to reduce child mortality.

As a result, there is an enormous space for traditional healers to operate, but the problem in such a disrupted society is that many of the people who formerly delivered such services are simply not there. This space is rapidly filled by opportunistic individuals who may or may not have any previous experience as healers. It has indeed been observed that in such situations, ‚new' traditional healers appear almost overnight. For example, during research conducted among Ugandan refugees, in one settlement of 3,000 people it was found that there were 93 individuals who claimed that they could cure various illnesses (HARRELL-BOND 1986:320).

The Social Roles of Traditional Healers in Refugee Situations

It has already been emphasised that populations which have been violently uprooted cannot be regarded as normal ‚communities'. The social chaos which is typical of refugee camps provides an ideal situation for manipulation and exploitation of people by political factions as well as by charlatans whose motives are monetary or power-seeking, whose method of encouraging compliance is articulated in terms of a return to ‚traditional values'. As GEERTZ (1973) has noted, in situations of crisis, conservatism may emerge as one way to cope with suffering, injustice and chaos. Humans ‚can adapt...somehow to anything his imagination can cope with but he cannot deal with chaos....Therefore our most important assets are always the symbols of our general orientation in nature, on earth, and in society, and in what we are doing' (as quoted by Landau nd). The way in which chiefs are regaining power by redefining ‚traditional values' in the chaos of war-torn southern Sudan is illustrated in the manner in which disputes have been resolved according to ‚customary law' which, in the absence of statutory law, is being redefined.

See ALUR (1997). Monyluok Alur, who served as a ‚magistrate' in the areas under the administration of the Sudan Peoples Liberation Alliance (SPLA), has recorded cases which he judged over a ten year period. One of the most extreme examples he has recorded which illustrates the dangers of encouraging an unchecked ‚return to traditions' involved a charismatic traditional leader who asserted that to achieve peace, his community must make a human sacrifice to appease God. Although arrested and tried for murdering his own young son before the community, the SPLA was afraid to punish him for his crime because of the support he had from his followers.

While there is a growing appreciation in medical circles of the value of traditional folk medicine, little attention has been paid to the social roles of those who claim to have such ‚traditional' healing powers. The problem is that in addition to prescribing herbs which may or may not have therapeutic value, healers also involve themselves in divining who or what is responsible for the illness (which, at times, may well have psychological value, but at others, may be seriously dysfunctional). Healers may play an apparently useful role is legal disputes, administering oaths on ‚medicines' which are believed to kill those who lie, but some are also prepared, *for a price,* to practise ‚black magic' against a client's enemy.

Among the Ugandan refugees in southern Sudan, self-proclaimed healers actively sought out patients. Finding someone ill, the usual diagnosis was that the patient had been ‚poisoned'. For example, a trained nurse/midwife who was ill was found to be receiving treatment for ‚poisoning'. She was asked how could she, a person trained in modern medicine, subject herself to a treatment which involved small incisions with an unsterilised blade in the neck? She explained that during the period they had been hiding in the bush from military attacks the only medicine that was available was from such people. In the camp she had fallen ill and had been treated for malaria, but did not recover. Three healers came to visit from a nearby camp to warn her mother that her daughter had been poisoned.

As in many African societies, illness among the Ugandans was explained as having resulted from someone else's actions, from inter-personal malevolence, and the guilty person(s) have to be found and punished Thus curing someone who has ostensibly been poisoned involves not only treating the illness through a method which in itself endangers life, but divining to determine who was guilty of the poisoning. Both activities are chargeable professional services. Once the guilty is identified, s/he, and it is most *frequently* a she, punishment must be administered. Among the Ugandans, there were cases where entire communities joined in stoning the individual identified by the healer as guilty. People who escaped death had to flee for their lives and not everyone escaped (HARRELL-BOND 1986: Chapter 7).

The cure for poisoning involved stripping and bathing the ill person (in the open, whatever the temperature) with a mixture of cold water and oil mixed with a powder made from a root which produces a foam when rubbed into the skin of the patient; the foam is the evidence that the poison is coming out! In Uganda, it was said that such healers used motor oil; in the refugee camps they used the vegetable fat that was supplied in the ration provided by the World Food Programme (WFP). Apparently, liquid vegetable oil was not a suitable vehicle for their ‚cure', but a spate of poisoning events could be predicted when the WFP food allocation included solid edible fat!

Nevertheless, an American non-governmental agency (NGO) responsible for administering some refugee camps appointed a ‚chief' herbalist to supplement the health services of the clinic. Staff of the clinic in one of these camps complained that although the ‚chief herbalist' was being paid a salary by the

NGO (paid for by UNHCR), he was also charging his patients while their services were free. They complained that among other things, co-operation with their preventative health programme was hampered because of this man had other solutions and was actively advising the residents not to comply, in fact, they were strongly advised to avoid the clinic. Their problems in delivering health services in competition with the camp's chief herbalist were exacerbated by the shortage of medical supplies in their clinic and the fact that the most senior member of their staff was a Sudanese who had less training than the Ugandan refugee staff (ibid.:322).

This ‚chief herbalist' was given a test in curative herbs by a medical anthropologist who happened to be working in the area; it was found that he lacked even a basic knowledge of standard medicinal plants (HARRELL-BOND 1986:321). Nevertheless, this humanitarian agency proudly reported to UNHCR on their appointment of the herbalist, saying that ‚the results appear satisfactory'. Moreover, they also reported that they were considering setting up a ‚laboratory' in a nearby village for the study of traditional herbs, in apparent ignorance of the enormous expense of such an undertaking and the scientific expertise such pharmaceutical studies require.

The popularity of diagnosing poison as the cause of illness has been explained by Willis as another example of the ability of traditional healers to adapt their treatments to conform to new ideas: ‚It is obvious that, alone in the whole body of sorcery beliefs, „poison" corresponds to an idea in current and accepted western belief since it has a putatively empirical basis. This fact...gives it heightened validity under the pressure of western influences...especially those in closest contact with the centres of modernisation.' See HARRELL-BOND (1978) for a discussion of the functions of such beliefs among the elite in Sierra Leone.

Whether or not as a result of the improving health of refugees in the camps in southern Sudan, or in response to the problematic social conditions which persisted among these populations, as time passed, ‚traditional healers' began to become more innovative in their efforts to secure clients. For example, one ‚divined' that a particular member of one extended family had entered into a contract with another such practitioner to ‚get rich'. This involved writing down a list of names of family members and assigning each a number. Over an unspecified time, this herbalist would arrange for each member to die. Just before death, the victim would see his ‚number' appearing somewhere on his or her body, usually on the back. (In the absence of mirrors, this would obviously require someone else to point out that yes, a number had appeared!) Once all the relatives on the list had died, the person who had paid the herbalist heavily for his services would simply wake up rich.

The diviner managed to support these allegations with a convincing story describing one of the members of the endangered family and than rattled off a long list of the potential victims, citing names so common that he could be sure that some at least would be among the extended family group. People became hysterical, but the herbalist reassured them, if they paid enough, he could arrange the ritual which would protect them. Needless to say, almost overnight the frightened family managed to collect the required payment, money, cloth, meat, sugar, and soap, and received the protective ritual. The problem did not stop there; the story circulated and within days, all over the district, Ugandan refugees began seeing numbers appearing on their bodies. As the hysteria spread, the prices for protection also rose (ibid.:322-3).

Conclusions

There is no doubt that traditional healers play significant roles in refugee situations. They have been found helpful in facilitating family tracing (BOOTHBY 1993). They have also played an important role in ‚cleansing' demobilised soldiers, allowing them to resume their place within civilian society (DOLAN & SCHAFER 1997). They also play a crucial part in helping people come to terms with bereavement, especially where deaths have occurred in the process of war and flight and it has been impossible to bury the dead or to perform the appropriate funeral rituals.

In most African societies, where proper funeral rituals have not been performed, it is believed that the living will be punished by supernatural forces - by the spirits of the deceased. Illness is often explained in these terms and in some cases it may be impossible for a health worker to convince a patient to comply with a prescribed treatment until s/he believes that these spirits have been appeased. In such cases, the role of the traditional healer will be a crucial adjunct to modern medicine.

Healers, however, have also been credited for providing the spiritual and political justifications for

war and individual violent acts (for example, see RANGER 1991). ‚Healers' were also employed in the war in Mozambique to oversee cannibalistic rituals which initiated boy soldiers into accepting their new role as killers (BOOTHBY et al. 1992:5). The problem is that we are not dealing with a homogeneous ‚traditional' medical profession which has standards for the training of its members who then hold recognised credentials and who are subjected to the discipline of their profession when they depart from its standards.

In most African societies there is a broad range of practitioners whose activities range from dispensing herbs, divining, rain-making, casting out evil spirits, administering oaths, identifying those guilty and determining punishments for breaches of social norms (which are normally defined and articulated by men), selling protection against being shot in warfare, and identifying and killing the enemies of their clients. It is not unusual for one traditional healer to claim the powers to perform all of these activities. Since their practice is highly lucrative, in situations of extreme chaos and material deprivation, the temptation for individuals to exploit the hardships of their fellows may be irresistible.

Few humanitarian workers have either the skills or the time which would be required to discriminate between those traditional healers who are charlatans and those whose interventions will have genuinely therapeutic medicinal or societal effects. There is obviously a great need for research concerning this phenomenon as it is played out among uprooted populations. As ‚culture' is a process and traditions are constantly being reinterpreted and redefined by those with the power to influence others, humanitarian organisations cannot simply rely on anthropological texts - even where they do exist.

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