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Refugees in Uganda between Politics and Everyday Practices

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The Quest for Therapy among Refugees in Uganda. Case Studies from Bidibidi Settlement and Kampala

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Abstract

Beyond the borders, inside refugees' settlements as well as in urban contexts, international and national policies shape refugees' bodies. Healthcare programs, medical prevention and screening activities are strictly connected to the "unfulfilling promise" of self-reliance (Hunter 2009). Refugees are constantly seen as in a state of adolescence, in need of constant monitoring. Their lives may not be at risk, but their basic rights remain unfulfilled after years of exile (UNHCR 2005). Both in the settlement and in the urban context, despite the lack of resources, numerous international and national bodies take on the task of managing and providing healthcare. Yet, refugees should not be regarded as passive subjects in these processes: they put in place an intricate web of practices of acceptance, request and refuse. In order to show the strategies and tactics refugees utilize to face health problems and other kinds of uncertainties, the article analyses two different settings: on the one side, it focuses on three medical campaigns carried on by RMF (Real Medicine Foundation) in Bidibidi refugee settlement on children malnutrition screening, children vaccination and HIV screening; on the other side, it examines the role of spiritual healing, provided both by Pentecostal churches and by other specialists in Kampala, as part of the therapeutic trajectories and of the quest for healing of refugees in Uganda.

Keywords: refugees; access to healthcare; medical pluralism; Bidibidi settlement; Kampala

Uganda, a pluralistic health landscape[1]

Important fluxes of forced migrants have various consequences on a poor country like Uganda, which accepted to host an extremely relevant number of them adopting a refugee self-reliance policy that allows a certain freedom of life and work. If the economic return of this policy seems to be positive, as some researchers have underlined (Betts 2016; Maystadt *et al.* 2019), changes and trends occurring in the health domain and in the strategies implemented by both refugees and host communities need to be studied. In this situation, diseases and infections usually raise while local health services are put under pressure. At the same time, external assistance and humanitarian aid increase the offer and the quality of services, at least in the short run. Moreover, the extreme mobility of populations and the different strategies adopted to cope with it reinforce the plural, cross-cultural health offer that is a prominent feature of African therapeutic systems (Rekdal 1999). Indeed, the availability of biomedical health services did not imply the abandonment of old systems of therapy and beliefs, which are widely used in Uganda as in many Sub-Saharan African countries. At the same time, therapeutic and religious conceptions tend to blend due to an open quest for therapy, which considers positively the possibility of access to a variety of different services.

The current healthcare landscape in Uganda integrates different therapeutic systems - modern biomedicine, African indigenous healing practices, elements of the Islamic medical tradition, healing practices that are part of Christian charismatic movements - which started spreading since the middle of the XIX century with the arrival of the Arabs and European missionaries and colonial administrators. The clash between these models, based on radically different conceptions of the human being, did not result in the destruction of local knowledge and belief systems. Deeply rooted in a spiritual vision of the universe, African medicine survived during colonial times undergoing profound transformations. In its diverse expressions, it is still widely practiced today as part of a complex pluralistic therapeutic offer that characterizes the African medical environment (Olsen, Sargent 2017).

Despite a common Western attitude to dismiss traditional healing as ineffective, it is important to recognize that medicine was present in Africa long before colonization. However, unlike other non-Western medical traditions (like the Chinese and Indian ones), African medical knowledge has never been transmitted through writings. The lack of written records weakened this tradition in the eyes of Europeans (Iliffe 2002: 5). The absence of literature contributed to represent African medicine as a non-scientific or even a fraudulent ensemble of practices, disregarding the effectiveness of ancient herbalist traditions and that of a holistic psycho-social approach to diseases. This negative vision is also connected with the attitude assumed by missionaries and colonial administrators toward African health practices (Beneduce 2010), generally considered as witchcraft and consequently forbidden by law, adopting a censorship similar to what was reserved to traditional rituals and dances.

It is only in the last decades that the representation of traditional African medicine begun to change, thanks to medical anthropological research that succeeded in enlightening its principles and remedies. The World Health Organization (WHO) declared that traditional healers are an important resource in health promotion (Rekdal 1999: 465). Nevertheless, a negative perception of African medicine is still present especially among NGOs and in international organizations' projects. Avoiding this reductionist approach enables to recognize the complexity and diversity of the African therapeutic offer. As medical anthropologist Christine Obbo stated, "a plurality of methods and medicines is used by both healers and their clients to achieve an effective cure. African, Western and Islamic methods of healing are not perceived as contradictory but rather as potential reinforcements of each other" (Obbo 1996: 186), and this is true even in the context of an increasing mobility of groups coming from neighboring countries.

Among the Bantu speaking groups of the Great Lakes region, health is conceived as part of the wellbeing of the person that inextricably connects his/her physical and spiritual dimension. This last element refers to the inner perception of human relations, including those with the deceased members of the family and, more generally, of the society. In social structures strongly built on descent groups, the identity of the individual is perceived as the product of a lineage indissolubly connected with its dead members. The wellbeing of the livings also depends on the spiritual world inhabited by the deceased; consequently, relations with them must be kept alive through offers and ritual practices. Breaking these ties can lead to misfortune, often manifesting itself in the form of a disease (Whyte 1997). Medicine is thus inseparable from spiritual and religious practices devoted to the ancestors or to other entities forming the spiritual pantheon. In recent years, the spiritualistic vocation of the therapeutic system appeared also in Charismatic and Pentecostal groups, where healing practices occupy a central position (Fancello 2008; Eves 2010; Schirripa 2012).

Local healthcare professionals specialize in different but largely overlapping areas of intervention: herbalism, divination, mediumship, witchcraft, spiritual healing. Beside practitioners specialized in the treatment of symptoms, local medical systems include diviners who focus on diagnosis using different techniques of divination, and mediums initiated to spirit possession cults devoted to different kinds of spirits, who play a very important role in this complex health care system. These different therapeutic presidiums are meant to face and possibly treat diseases and misfortune within the framework of a complex cosmological vision of the universe and of the person. Even disasters – like war or epidemics affecting human beings and cattle – used to be treated through public rituals in order to restore the physical and spiritual wellbeing of the population.

In the colonial and postcolonial era, conflicts and diseases increased. In the last decades, AIDS and Ebola epidemics had a devastating impact on Uganda's society. Moreover, a new, modern conception of violence (Pennacini 2017) led to tragedies of unprecedented

scale, like the Rwanda genocide or the South Sudan conflicts, producing a massive flux of forced migrants. In front of such dramatic events, all therapeutic resources need to be activated, thus requiring an effort to integrate the biomedical treatment with psycho-social interventions realized through religious practices of different types. In this perspective, the government of Uganda formally recognized African traditional medicine in 1988, legalizing the Association of traditional healers called *Uganda N'eddagala Lyaio* (that literally means 'Uganda and its medicine'). This recognition marked a process of institutionalization of local medicine as part of a broader revival of traditional culture and heritage. Some international projects involved traditional healers as important vehicles of information and prevention in the fight of AIDS (Fissel, Haddix McKay 2006). Against this background, the article shows how an analysis of the quest for therapy among refugees who found safety in Uganda needs to include the role played by different therapeutic actors.

After introducing the topic of access to healthcare for refugees in the Ugandan context, in the next section Gilberto Borri will draw a picture of healthcare services in Bidibidi refugee settlement near Yumbe, in West Nile, Uganda. One of the largest and fastest growing settlements in the world, Bidibidi has been built at the peak of the South Sudan refugee emergency in 2016. Numerous international and local agencies work in the settlement providing health care services. In his contribution, Gilberto Borri shows three activities for screening and vaccinations that took place in the settlement at the beginning of 2019. In particular, Gilberto Borri had the chance to interact with the Real Medicine Foundation – Uganda, providing health services mainly in Zone Three, Four and Five of the settlement, with health centers of different levels ranging from dispensaries to clinics.

In the following two sections, Alessandro Gusman will analyse the role of Congolese Pentecostal churches in the context of urban refugees' therapeutic trajectories in Kampala. Refugees living in urban contexts are not entitled to the assistance provided in the settlements, and this creates a need for alternative protective networks and informal health practices. In his analysis, Alessandro Gusman focuses especially on charismatic healers who offer deliverance session, thus framing illness into a wider landscape of needs and relations.

Access to healthcare for refugees in Uganda

The relatively stable internal situation in Uganda, together with a progressive refugee policy and a traditionally open model of hospitality, made the country a hub that has attracted almost 1.2 million people.[2] From an anthropological and an historical point of view, this extreme mobility is not new. For economic and political reasons, for centuries groups have adopted livelihoods strategies traditionally characterized by mobility and an open idea of society (Shack, Skinner 1979).

Uganda policies on refugees started in 1955 with the Control of Alien Refugees Act

of 1960 (CARA). In 1987 Uganda ratified the 1969 Convention on Refugees of the Organization of African Unity (OAU), therefore mitigating some of the provisions stated in the CARA. In 1999, the United Nations High Commissioner for Refugees (UNHCR) and the government of Uganda started implementing a Self-Reliance Strategy (SRS) for refugees (Meyer 2006). The SRS sought to integrate services provided to refugees into existing public service structures and make refugee settlements self-reliant by allocating land to refugees and allowing them free access to government health and education services (Self-Reliance Strategy 1999-2003).[3]

The development of the Settlement Transformation Agenda (STA) started a more comprehensive approach addressing both refugees and host communities in line with the Comprehensive Refugee Response Framework (CRRF) and created an entry point for the Ministry of Health, enabling the development of the Health Sector Integrated Refugee Response Plan (HSIRRP). In May 2017, WHO resolved to develop the necessary capacities to provide health leadership and support to member states and partners in promoting the health of refugees and migrants in close collaboration with the International Organization for Migration (IOM) and UNHCR. It is against this background that the Ministry of Health has developed the HSIRRP to ensure equitable and well-coordinated access to health services for refugees and host communities.

Conflict and displacements, violence and changes in people's socioeconomic and environmental conditions increase the vulnerability to diseases. Food and shelter insecurity make refugees more prone to health problems. Access to health services by the refugee population is critical, as their large and unpredictable numbers may overwhelm public health systems. They may also be subject to disease outbreaks associated with congestion in the hosting areas (Kasozi *et al.* 2018). Uganda has tried to absorb refugees in the national health care system at every level. However, the challenges it faced in distributing these services often caused conflicts between the refugees and hosting communities.

The use of government health facilities by self-settled refugees, urban refugees and host communities exerts pressure on health resources that results in frequent stock-outs, increased workload and growing prices for both host communities and refugees. Although host communities living near refugee settlements have free access to health services in the settlements, communities that live farther away have limited access even though the government reserves 30% of any services and aid funds to the locals. Access disparities are intensified by the big difference in services provided to rich and poor districts in the country. Moreover, the fact that refugees sometimes move out of refugee settlements to live among host communities exacerbates the pressure on local social services. In the context of limited health resources for host communities, a parallel health system for refugees is unsustainable and promotes inequitable access to health. The strategic interventions under the HSIRRP are categorized into six pillars: Service Delivery, Human Resources for Health, Medicines (Health Commodities

and Technologies), Health Management Information System, Health Financing, and Leadership, Coordination, Management and Governance. However, inadequate staffing and skills negatively impact the quality of health service delivery. Disparities between government and NGO health facilities also contribute to the disruption of the local health system: for example, salary disparity between government and NGO health workers results into a low attraction and retention capacity of essential personnel in public facilities. The existence of a dual health system for refugees and locals thus represents a challenge to refugee-hosting districts (HSIRRP 2018). Nonetheless, Uganda may have a possible solution at hand. In recent years, following the example of other countries in the continent[4] and around the world, Uganda has started a process of co-opting "indigenous healers" in its health care system.

Regardless of the various labels under which they are known – 'traditional', 'complementary', 'alternative', 'integrative', or 'natural' – societies have used these medical systems throughout the millennia. However, their knowledge, products, and practices began to receive some international recognition only during the 1970s under the International Drug Monitoring program of the WHO. Mostly since the Alma Ata Declaration (WHO 1978),[5] the interest in local medical practices made them the focus of debates about possible uses of these medicines, especially regarding their interaction with Western biomedicine. The objective set by WHO is to co-opt other medical traditions in delivering basic health services in developing countries and to integrate them within the objectives of the Primary Health Care plans. The Alma Ata Declaration recognized for the first time "traditional African medicine" as a medical system with its original ideas and practices. This document expressed interest in co-opting traditional healers to improve the availability of healthcare services. Later, the same idea was implemented to broaden Primary Health Care plans and to develop health systems in countries of the Global South in line with the Millennium Development Goals. Moreover, it stated the right for individuals and groups to intervene in the planning of their healthcare system: a first step to open national and international projects to a wider participation of local populations in healthcare management.

Even though the decision to integrate traditional healers would require investments in terms of regulation and training of operators and their communities (WHO 1978), Sjaak van der Geest (2000: 56) argues that the amount of such investment would still be lower than that required to train a doctor or nurse, particularly considering that a traditional healer is trained almost entirely through informal channels.

Similar initiatives were promoted by African countries too, but most of them were focused on herbal medicine more than other practices. The risks of this approach are summarized as the 'chemical line', to use Bibeau's words (1982): the tendency to see traditional medicines only in their phytotherapeutic aspect and to consider them just as a raw material, a mine from which to extract active ingredients. This vision was probably influenced by the prevalence of biologists, chemists and botanists in the

debate, and it is not exempted from the strong interests of national and multinational pharmaceutical industries. Primary Health Care strategies were part of the development policies adopted in most of the countries of the Global South in the framework of the Millennium Development Goals and other global development paradigms. For this reason, several African states thought of the idea of co-opting different health care systems as an opportunity to free themselves from the capitalist and neocolonialist logic of humanitarian aid (Dozon 2000) and as a chance to reduce the dependence from donors and international agencies.

In the 2000s, WHO issued two documents, *Traditional Medicine Strategy* 2002-2005 and 2014-2023 (WHO 2002, 2013), which recognize the importance and spread of traditional and complementary medicines. WHO defines traditional medicine as the sum of knowledge, skills and practices based on beliefs and experiences, which differ from culture to culture, used for the prevention, diagnosis and treatment of physical and mental illness. Despite mentioning other forms of non-conventional medicines, the attention is focused almost entirely on phytotherapeutic products derived from the processing of herbs and medicinal plants. At the same time, WHO highlights the risks these medicines involve, such as: the poor quality of products or products containing harmful materials; healers unqualified to perform diagnosis or to prepare the remedies; risks of an inadequate dosage of the medical products.

Uganda followed the WHO suggestion in 2015 with *The Indigenous and Complementary Medicine Bill*: for the first time the government attempted to regulate the world of traditional medicine with the aim of standardizing these practices, and it established the Ugandan Traditional Healers and Cultural Association. The process of integration of traditional healers within the national healthcare system and the creation of professional associations still presents many obstacles, mainly in the field of recognition, of the protection of oral knowledge, and of the regulation of the healers and their remedies following Western standards of hygiene and dosage; yet, this process could be an example to follow in improving the medical coverage in the refugee context. The co-optation of refugee healers and practitioners in the services delivered by the government and international bodies can be an acceptable and low-cost solution to improve medical services in a situation characterized by a chronic lack of funding and personnel.

Bidibidi: three examples of health care services in the settlement

Bidibidi settlement was founded in 2016 in the heat of the South Sudan refugee emergency, following the rekindle of the hostilities on the other side of the border that caused the displacement of approximately 1.2 million people.[6] "In the beginning we were overwhelmed. People were coming by the thousands [...]. If I remember correctly, back then, it was about twenty thousand people per day".[7] The arrival of so many refugees turned Bidibidi into the biggest refugee settlement in the world, with a population

of more than 270,000 inhabitants. Its population increased and decreased as the war in South Sudan did. At the time of fieldwork, in 2019, the population was estimated to be around 233,000 people (RMF 2018). Leaving the settlement is easy and almost unrestricted, which creates a flux of people moving in and out. Many families have members who go back to South Sudan for a limited period of time before returning to the settlement. Bidibidi has a surface of 250 square kilometers and is divided in five zones of different size. Gilberto Borri's research took place mainly in Zone 3 and 4, mostly populated by Bari speakers.

The intertwining of transnational health providers and the public health care system is not unusual for African countries and more so for situations of 'prolonged emergencies' such as refugee settlements. Pressured by the large influx of refugees, the national health care system quickly showed its fragilities: Structural Adjustments Programs in the 1990s caused the decentralization of health services, increasing the disparity between rich and poor districts. Filling the gaps in public health service provision, numerous non-governmental and private humanitarian agencies work in and out the settlement. This resonates with what happened all over the continent: in the 'development' era of the 1960s and the 1970s, numerous African countries tried to extend public health provision supporting the development of their health care systems. The Alma Ata conference and its vision of Primary Health Care fostered the idea that it was necessary to develop local health care systems. However, this idea was short-lived and soon it came to be considered impracticable and expensive. Attempts at creating public healthcare systems were undermined by global economic politics, political instability and inadequate budgets. The debate around public healthcare policies also shifted from discourses about basic needs to discourses of containment of diseases, security and development (Prince, Marsland 2014). A new vision of selective intervention was implemented, targeting single communities and emergency situations and promoting individual responsibility for health (Prince 2014). NGOs became then the preferred means of implementation of healthcare projects and were pivotal in the attraction of funds in situations or areas where public healthcare service provision was inadequate. Their approach privileged emergency management, prevention and the development of community resources and knowledge.

Healthcare systems in the refugee settlements reflect these guidelines. Health services in the settlements are provided in the framework of the humanitarian response coordinated by the Office of the Prime Minister (OPM) and the UNHCR, in collaboration with UN agencies and partners under the HSIRRP. The latter is expected to improve the health status of host communities and refugees through building a resilient healthcare system that can withstand shocks and guarantee sustainable and equitable access to essential health services. Locals and refugees have access to the health facilities in the settlement and to prevention and vaccination campaigns. Limited stocks and personnel can hinder host communities' access, but every agency working in the settlement

is obliged to direct 30% of funds, activities or materials to the local communities. Nonetheless, the perception of Ugandans living inside and around the settlement is that they are neglected by international assistance.

In February 2019, Borri has followed RMF (Real Medicine Foundation – Uganda) health workers in some of the activities of screening and prevention implemented in the settlement. The first one was a screening for malnourishment in children under five years of age in the village of Yoyo (Zone 3).[8] Yoyo is a big village: people live in small houses made of mud bricks and recycled materials from the first semi-permanent houses provided by UNHCR in the beginning. These houses rise in a quite barren landscape of rocks, dust and few bushes dotted with isolated trees. The health workers' group moved between the households with the few tools they needed: a plank for measuring children height, a meter and a bracelet for measuring the circumference of their arms. Village Health Teams (VHT) are responsible for health promotion, health education, identification and referral of sick/malnourished individuals and follow-up in the community, including linking the sick/malnourished community members to ambulatory services (Hovil 2018). They had the role to mobilize mothers and children, to bring them to the health workers and to translate.

During the visit, mothers came to the NGO post bringing their little children one by one at the beginning, then increasing by the minutes. Mothers and children were identified by the documents released by UNHCR at the time of their arrival to the settlements and then screened. If malnourished, they were referred to the groups of aid organized by Action Against Hunger or the International Refugee Council Uganda where they could receive food and counseling. Many mothers were engaged in groups and had an active part in pressuring the NGOs for more help, food or other necessities for their babies. Others, instead, confessed being interested in the food for its market value: "I don't want my children to go hungry, but I have five [...] my husband is in Sudan and my mother. You can see her, she's very old. Sometime we need other kind of food, sometime a new pan or... but never let my children to go hungry".[9] Cases of malnourishment are immediately sent to the health center, while the mothers have the responsibility to attend the meetings the organizations set up in order to train them about nutritional issues.

Despite its importance for prevention, vaccination is subordinated to the quantity of doses available, mostly provided by UNHCR and other donors. Weather conditions, such as extreme heat, are likely to affect the transportation of vaccines, as it happened in March 2019 when the high temperature caused the melting of the ice used to refrigerate the thermal box where vaccines were stored. The objective of the activity the researcher followed was to vaccinate children between three and twelve years of age for measles, rubella, TB and HPV for females. VHTs had the task to sensitize on the importance of vaccination moving from household to household to mobilize refugees and take them to the doctors, but the final choice to be injected was free. Mothers'

attendance to this activity was inferior to the previous one: many children came alone or were accompanied by older brothers and sisters carrying a small paper book with handwritten notes of previous vaccinations. While participation was not mandatory, many children came but many were sent back either because they had already taken that vaccine or because they were too young to be vaccinated, which was particularly the case for young women for HPV.

The last activity was HIV testing. It was the only one the researcher saw happening in Zone 5. It started in the late afternoon with the team moving around with the VHTs to advertise the screening and mobilize people. Most of the refugees did not seem to appreciate the initiative. Nonetheless, when the screening started at sunset, a large number of people came. Most of them were men, but women participated too. Doctors positioned themselves under the lampposts and started the screening. Leaving the shadows where until that moment they were praying or just sitting in silence, one by one people were called under the light cone of the lamppost and were told their condition and handed a few condoms. Shouts, jumps, prayers, hugs passing around the piece of paper to which their life was hanging, or silence, rage, sorrow and the papers disappearing quickly in pockets were the most common reactions.

These three activities exemplify the approach to health care in situations of emergency in the presence of inadequate public health care services. All of them were aimed at controlling and preventing; they were conducted by non-governmental institutions; they targeted quite delimited communities; and they relied on the members of the community. Although not completely bottom-up, refugees' will to take part in the control and vaccination campaign as well as follow-up activities was necessary for their implementation. The responsibility for their health care laid on the refugees and on their willingness to participate and comply. VHTs, prominent members of the community who decided to be involved and to be trained, were essential to the success of the activities.

With the Self-Reliance Strategy and the HSIRRP, the refugees and the national health care system are expected to become more independent from international aid and to contribute to the development of the country in general. So far, however, the road for the settlement to become an incubator for progress is still long and the health structures of Bidibidi are still too dependent from selective intervention from international bodies.

Kampala: urban refugees and the problem of access to healthcare

Over the last decades, an increasing number of refugees decided to live in urban settings instead of camps or settlements. Many of them usually moved to town in search of security and access to social services such as hospitals and schools (Omata 2012).

In Uganda, refugees living in urban areas are not entitled to assistance from the local government or from the UNHCR; yet, Ugandan legislation concerning refugees is considered a positive exception in the continent, as the already mentioned Refugee Act

recognizes them the right to live where they prefer, to move freely within the country, and to work. Before this law was passed, the old Control of the Alien Refugee Act, since 1964, obliged refugees to live in camps. Despite the improvements, the new law was criticized because according to some observers it is still insufficient to guarantee protection and assistance for refugees who live in the urban centers (Bernstein, Okello 2007). In should be noted, however, that in the majority of other African countries, policies are oriented to keep the refugee population in the camps, with limited or no access to assistance for those who decide to live in urban areas; in some cases, living outside the camps is even illegal (Fábos, Kibreab 2007).

Despite the growth of the phenomenon of "urban refugees", their presence in African towns has begun to attract the interest of both international organizations and scholars only in recent years (Dryden-Peterson 2006). In this situation, once they arrive in town, refugees look for relatives or friends who already live in the city to receive initial assistance and to find a place to sleep. When they do not know anyone in town, as it is frequently the case, they rely on the 'protective networks' usually organized by religious organizations (Sommers 2001), which help them to settle in town and give them instructions on how to move and live in Kampala, including the process of obtaining refugee status. Therefore, the relative weakness of the welfare services provided by the government and international organizations leaves room for alternative forms of assistance from religious groups and from non-governmental organizations. These organizations are an important part of the assistance provided to people who come to town, especially during the early phases after their arrival in Uganda.

Moreover, as the period of temporary protection in Uganda is becoming longer and longer, many people are experiencing a "protracted refugee situation", an expression that indicates refugees who have been waiting for resettlement for five years or more. Refugees then find themselves stuck in Uganda, with little or no possibility of going back to their home country, and an unclear perspective about the future and the resettlement to a third country (Gusman 2018). In this situation marked by lack of protection and assistance and delays in the resettlement process, legal uncertainty and physical insecurity are two of the main characteristics that define the life of refugees in town. Because of this situation, in the new context refugees often build 'kinship-like' relationships with people they have just met; religious groups and non-governmental organizations play a central role in these dynamics, as they provide people with networks to reconstruct social relationships and find assistance, comfort and (mainly informal) job opportunities.

In this situation, what kind of healing strategies do refugees pursue in the urban context of Kampala? How do they interact with available health care providers? From the research Alessandro Gusman carried out among Congolese refugees in Kampala between 2013 and 2015, it is evident that the harsh economic and social conditions most of the refugees experience in such a context prompt them to develop pluralistic

and multilevel modalities and trajectories of health care, relying both on the formal health care sector (public hospitals as well as private clinics) and on informal health practices (traditional medicine and religious healing). This is a continual health seeking that also reflects the need to find relief from the pain they experienced both in Democratic Republic of Congo (DRC), before fleeing, and once arrived in Uganda.

Among the refugee population in Kampala there are a number of traditional healers and – more relevant in the context of the present article – people who are believed to possess the charisma of religious healing and of deliverance from evil spirits. In their trajectories of health-seeking, Congolese refugees in Kampala meld all these different practices, pushed by economic constraints and following their own faith and other people's advices. Indeed, while refugees in the settlements are provided with integrated and comprehensive health care packages, the situation is more complicated for those living in town.

UNHCR supports refugees assistance through the national healthcare system, addressing them to public health facilities and, in more severe situations, to the national hospitals in Kampala (Mulago and Butabika). However, a recent study (Kasozi *et al.* 2018) has highlighted that several barriers exist for refugees to access these public health services, including linguistic problems (some of the Congolese refugees speak a poor English, especially soon after their arrival in Kampala), discrimination from health workers, difficulties in accessing drugs for free. The National Health Service is only nominally free: some of the investigations and drugs have a cost, which is often very difficult to meet for refugees. Due to the shortage of drugs in public health facilities, in some cases only starter doses were given to refugees, who were then advised to buy more from drug shops. For this reason, many Congolese refugees resort to either private (and usually ill-equipped) clinics, or to other healing systems. What the cited study does not report is the presence of a considerable network of traditional healers and religious healers among the Congolese refugee community in Kampala.

The study Alessandro Gusman carried out focused mainly on the role of Congolese Pentecostal churches in the context of refuge. During his research, he got in contact with several Congolese Pentecostals who received clients at their home for private healing and/or deliverance sessions. Besides, most - if not all - Congolese Pentecostal churches in town gave deliverance a central place in their activities, and some of them had specific weekly deliverance services. Moreover, they usually offered counselling services, thus becoming an important element in the healing trajectories of many among the Congolese refugees in town.

The widespread recourse to religious healing as part of health seeking should not be surprising; this fact cannot be explained only through an economic register (the cost of drugs, which are not affordable to many refugees), but rather as part of a worldview in which the interaction among religious forces and healing trajectories is part and parcel of local medical systems. Far from disappearing, religious healing (not only in Africa)

has become even more relevant in recent years, and the expansion of Pentecostalism throughout the world has been accompanied by the success of deliverance. The field of healing in the African continent is a complex one, in which religious therapies play a significant part. This is not only due to the lack of adequate and available public health care services; the success of this kind of healing strategies should be explained also with reference to the growing condition of uncertainty and vulnerability many people (not only among refugees) experience in Africa (Gusman 2019). Deliverance and religious healing, with their reference to a persistent presence of evil forces, locate individual stories and misfortunes within a broader picture of satanic persecutions (Fancello 2011).

It should be noted that, in the Ugandan case, the growth of deliverance services and of the recourse to religious healing occurred especially during the last two decades, a period when the public health care system was improving, due to the relative economic stability of the country; the quest for spiritual resources in this field has been increasing, despite the growing availability of medical and hospital care. This means that spiritual healing is part of complex "therapeutic trajectories", which combine religious and medical resources.

The integration of the two dimensions (spiritual and bodily) is crucial to understand the concept of "disease" as it is widely understood in the African continent; here, the causes (and the solutions) of illness and other problems affecting the individual and the community have to be found in the spiritual domain and in the interference of evil forces. From this point of view, spiritual healing should not be conceived as something alternative to clinical medicine, but rather as part of a form of medical pluralism in which the spiritual dimension is central. Spiritual practices cooperate with and integrate medical activities in the trajectories sick people and their families put in place. Alternative modes of explanation may be activated to confront illness; in these etiologies, disease is often seen as the result of transgression, or of an attack from a spiritual entity. Disease is thought in terms of "misfortune" (Whyte 1997), an event that has to be understood with reference to different levels of explanation. As an example, a common headache can be treated with a painkiller; yet, temporary removing the pain does not mean that the cause of that pain has been removed. A traditional healer or a Pentecostal pastor can be consulted in order to identify the deep cause, usually a spirit oppressing the individual; to "heal" thus means to eradicate this oppression, not just to remove the symptom, as it is clear from the case of the psychiatric patient who tells Ludovic Lado "because I know that if I take tablets, drugs, they only calm my madness; in fact I can take drugs but I will not be healed" (Lado *et al.* 2018: 342).

Against this background, in the next section we will analyze the place spiritual healing practiced in Congolese Pentecostal churches and by Pentecostal healers have in the quest for therapy among the refugee community. It will become clear from these examples that public health services are just one option for Congolese refugees, in a

scenario marked by several therapeutic possibilities. In this as in many other African context, biomedicine has to coexist with other practices of care, which place health and therapy outside the hospital and beyond the biological body (Prince 2014).

Pentecostal healers and the quest for therapy of Congolese refugees

François is a Congolese refugee in his forties, who reached Kampala with his wife and three sons in 2012, fleeing from the violence they experienced in Goma (North-Kivu). At their arrival in Kampala they did not know anyone, so they were directed by another Congolese man to a Congolese church, where they were hosted for few weeks; there, a Congolese woman helped them, giving them some money to pay the rent of a small one-room house for the first three months. When we first met in 2014, François was selling second-hand shoes in the street at nighttime, within the so-called *magendo* informal commerce, a very common activity among unemployed people (including refugees), or a side business for those who have a formal employment in Kampala.

In Congo, François had grown up in a Catholic family; when he was 26, he started praying with a Charismatic group, but he reports he still did not find the kind of relationship with God he was looking for. Moreover, he wanted to preach, as he felt that – while not educated in theology – he was inspired by God and had important thoughts to share with other believers. "In the Pentecostal view – François says – we are not priests because of our studies, but because of the anointing we receive from God".[10] In his words, God was calling him to open a ministry, and so he did. However, after few months, a group of rebels attacked the village where they were living, just outside Goma, and they fled to Uganda.

In the church where they were hosted, François started preaching during some services, in exchange for the hospitality they received. During their first months in Kampala, he preached in several Congolese churches, but after some time he "felt the call to help people who are in need, who are suffering here in Kampala".[11] François reported that already back in Congo he sometimes had requests to pray for people who were sick, but he did not think of himself as a "healer", or as someone who had the charisma of deliverance until he felt this call in Kampala. In 2013, he received the visit of a Congolese woman who had experienced a number of tragic events and losses; she felt she was under the attack of evil spirits and said a voice told her to go to François' house and ask him to pray to deliver her from these spirits. He reports that after three intense and very long prayer sessions (the third lasted more than five hours), the woman finally passed out on the floor and slept for a whole day. When she woke up, she felt restored and the misfortune apparently left her. Since that day, François realized he had a gift to deliver and heal people, and after one year of this activity at home, he was well-known in town for this gift. Many Congolese people referred to him when they had problems they attributed to spiritual *blocages*; yet, it is worth noting that among his "patients"

he had Ugandans too, and that a number of the people who visited him asking for help were not Pentecostals, but Catholics.[12]

During his visits at François' house, Alessandro Gusman had the possibility to take part in some prayer session. In one of these occasions, a woman came saying she felt something that was squeezing her throat. According to the story the woman told François, the problem had begun three months earlier and was getting worse and worse: she now had problems even in breathing. One month before she had gone to the hospital; after the clinical examinations, the doctor told her that he could not detect anything wrong. Yet, she was still feeling that hand around her throat. She said she then realized this was not a medical problem, but something related to witchcraft; so, she decided to go to François to ask him to pray for deliverance from the demon who was oppressing her, causing pain to her throat. At the first deliverance session, François prayed quietly for around forty minutes with the woman, until he said the Holy Spirit had told him to recommend to the woman three days of fasting and prayer, from 6am to 6pm. After these three days, she should have come back to François to continue the deliverance process.

After three days, we met again at Francois' house; the woman complained that the pain to the throat had increased and she now felt really bad, she had not been able to sleep for the last two nights. This second deliverance session was extremely long, it went on for the whole afternoon, from 2pm to 6pm; during the first half, the woman cried and moaned for most of the time, lamenting that the pain was becoming intolerable, the "hand" around her throat was squeezing stronger and stronger. François suggested it was the demon who was desperately trying to resist against the prayers, saying it was a positive sign, as the struggle becomes harder when it goes towards its end. It was at the climax of the prayer that François stopped and remained silent for around ten long minutes. Then he said, "the Holy Spirit told me to put my left hand on your throat and command the demon to go away. He will make you free from the oppression of this spirit".[13] After another half an hour of prayer, the woman reported she started feeling as the hand was releasing her throat, and at the end of the session she said the pain was now over, and François declared the deliverance was complete.

François is one of the several Congolese Pentecostals in Kampala who are recognized by the community to have the gift of healing and deliverance. Yet, the phenomenon of deliverance is not limited to this form of private session that people carry out at home or in specific rooms at the church. The most common expression of deliverance is the collective and public session during Sunday services or in separate dedicated services, usually on Saturdays. Most of the Congolese Pentecostal congregations in Kampala have at least a weekly deliverance session; this is conceived as a purifying practice, both for the body and for the spirit, for the individual and for the community, an instrument to remove health problems as well as other kinds of "misfortunes" that

refugees experience in their daily life in Kampala, from unemployment to the opacity of the long process of resettlement to a third country.

Due to the condition of extreme economic and existential uncertainty and vulnerability most of the refugees experience in Kampala, it is not surprising that deliverance acquired such a central position within the Congolese Pentecostal community in town. It is the whole history of Pentecostalism in Africa to be marked by this self-attributed role in the struggle against demonic spirits and to solve the individual and social troubles their action is bringing to the continent. It is not by chance that all these churches emphasize the centrality of spiritual healing, and that this is often at the very source of the birth of the congregation. Take for example the case of the Aladura Churches. Back in the 1960s, Peel (1968) identified the origin of this movement in the establishment of prayer groups to counter the spread of the Spanish flu in 1918, which caused many deaths in Nigeria.

Deliverance and other practices of spiritual healing are thus part and parcel of the therapeutic scene in the African continent; this medical pluralism consists of three main elements: pre-colonial medical systems, usually referred to as "traditional medicines"; the biomedical system, brought by the colonizers; and finally, systems based on spiritual healing. The three elements interact in complex forms, creating different medical systems and a plurality of opportunities for sick people, who design their own trajectories. In this scenario, where different healthcare options exist, biomedicine is just one option among several others, in a therapeutic offer that gives the patients an array of interpretations of causation and alternative treatments (Olsen, Sargent 2017: 2). In this situation, people rely on these different modalities that may be utilized simultaneously; they are not mutually exclusive, and not usually seen as contradictory. As we have already seen, choices may be influenced by one's own beliefs and worldview, by the advice of friends and kins, but also by economic constraints and other problems in accessing biomedical care. This is even truer in the case of refugees, who have experienced extreme forms of violence, had to flee from their own countries, often live in bad economic and hygienic conditions, and are thus highly exposed to both mental illness and health problems related to lack of adequate nutrition. The risks for both individuals and groups, both within refugee settlements and in urban contexts, are considerable. The health needs of refugees are a major concern to the humanitarian community, as it is very difficult to guarantee even basic health standards.

These last considerations position the quest for therapy of refugees within the broader context of the need to reframe the problem of 'global health'. As several scholars have highlighted in recent years, treatment access is extremely unequal not only when we compare different areas of the world, but also within the same country. Far from disappearing or even receding, inequalities have been proliferating under the neoliberal regime (Kapczynski 2019). As Joao Biehl has demonstrated, ethnography is particularly well-positioned to analyze the contradictions this system creates, as "close attention

to particular realities and to the various technologies and metric in which they are cast highlights the productive and fraught coexistence between the design of global health systems and the alternative models people craft for engaging the real" (Biehl 2016: 135). The cases described in these sections show how for Congolese refugees in Kampala, as well as for many other people in the African continent, the quest for therapy is part of a form of "spiritual agency", one that can be used to counterbalance the certainties of biomedicine, and to put uncertainty and multiple possibilities at the core of health seeking.

Conclusions

Uganda is often referred to as a pioneer of refugee hospitality, and its policies are considered as an example to follow; yet, the way ahead to a comprehensive and totally functional integration of the refugees is still long. The National Development Plan and its appendix, the HSIRRP (Ministry of Health Republic of Uganda 2018), are not yet totally applied because of the lack of funds and personnel, and due to the huge dimension of the refugee influx from the neighboring countries, South Sudan in the first place. In a context still characterized by a large disparity between urban and rural areas, and among different districts and social strata of the population, not only do refugees represent a core case to analyze the policies implemented by the Ugandan state and by international organizations, but also to look at the particular healing trajectories that people build in situations characterized by violence, war and insecurity. The two cases presented by Gilberto Borri and Alessandro Gusman, although different both for the locations and for the countries of origin of the refugees, show the quest for healing, security and welfare among refugee groups, and the search for meaning in a world characterized by violence, precariousness and danger. In the settlements as well as in urban areas, health and access to healthcare services play a central role in defining refugees' identities, and how they are perceived by the hosting communities. The refugees move freely between agencies and care services, in a context where the services provided are often fragmentary and lacking. They exercise their agency in the choice of the therapeutic itineraries. They often engage simultaneously religion, tradition and the government-provided health care when facing suffering and illness. Refugees are thus not passive recipients but have the possibility to shape the health landscapes in which they move.

These cases show how health is a key value for understanding refugees' lives in the hosting countries, and for gathering insights on how to make policy making and service delivery more effective. In a broader vision, health development can be a key factor in planning the economic, structural and cultural development of the country, as UNHCR and WHO have often underlined for the future of all the refugee hosting countries around the world and of Africa in particular.

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NOTES:

1 - The article was conceived and structured by the three authors together; yet, the first section was written by Cecilia Pennacini; the second and third sections by Gilberto Borri; the fourth and fifth sections, and the conclusions by Alessandro Gusman.

2 - *Figures at a Glance,* "UNHCR", July 2019: https://www.unhcr.org/figures-at-a-glance.html.

3 - However, research in the early 2000s showed that the implementation of the policy was problematic mostly for the absence of free movement. Therefore, when the international community reduced the amount of aid, the refugees were left in conditions of terrible poverty (Hovil, Werker 2001).

4 - For example, the Ghana Associations of Medical Herbalists (GAMH) was founded in 2005 but the process has its roots in the early 1930s of the XIX century; and in 1980 the Zimbabwe National Traditional Healers Association was created (Chavunduka 1986).

5 - The Alma Ata Declaration by the WHO (1978) refers to the need of integrating traditional healers into the national medical systems of developing countries, in order to expand the opportunity of access to health care for the local population.

6 - *Statistical summary as of 31 December 2017*, "UNHCR Uganda", December 2017: https://ugandarefugees.org/wpcontent/uploads/December-2017-Statistics-Package.pdf.

7 - Interview with J. K. social worker at IRC Uganda, Yumbe, January 2019.

8 - The screening went on for more than two weeks. Yoyo had a children population of around 1,500 in that age group (RMF 2019).

9 - Interview with K., Yoyo, February 2019.

10 - Interview with François, Kampala, November 2014.

11 - *Ibid.*

12 - Indeed, Alessandro Gusman got to know François through one of his key informants - Alex - who was a Catholic; yet, when his girlfriend experienced some problems during the pregnancy, Alex went to François and asked him to pray for her and for the baby.

13 - Interview with François, Kampala, December 2014.

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