Wartime children's suffering and quests for therapy in northern Uganda

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Abbreviations

ADF	Allied Democratic Forces
AMREF	Africa Medical Research Foundation
AVSI	The International Service Volunteers' Association
CMR	Crude Mortality Rate
CSOPNU	Civil Society Organisation for Peace in Northern Uganda
DDHS	District Directorate of Health Services
DHO	District Health Officer
HIV/AIDS	Human Immuno-deficiency Syndrome/Acquired Immuno-deficiency Syndrome
ICRC	International Committee of the Red Cross
IOM	International Organisation for Migration
IDP(s)	Internally Displaced Person(s)
GRRH	Gulu Regional Referral Hospital
GUSCO	Gulu Support the Children's Organisation
HURIFO	Human Rights Focus
JCCMC	Joint Country Coordination and Monitoring Committee
LRA	Lord's Resistance Army
MOH	Ministry of Health
MSF	Médicins sans Frontières [Medicines without borders]
NGO(s)	Non-Governmental Organisation(s)
NRA	National Resistance Army
NRC	Norwegian Refugee Council
NURP	Northern Uganda Rehabilitation Programme
NUSAF	Northern Uganda Social Action Fund
RDC	Resident District Commissioner
SCiU(G)	Save the Children in Uganda
UN	United Nations
UNICEF	United Nations Children's Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
UPDA	Uganda Peoples' Defence Army
UPDF	Uganda People's Defence Force
WFP	World Food Programme
WHO	World Health Organisation
WVCFAC	World Vision Centre for Formerly Abducted Children

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Prologue

Ojok: An exemplary case of suffering and quests for well-being by wartime children in Gulu Municipality

I will call this child Ojok (not his real name) to ensure anonymity. In 2004 when I met him, Ojok was a fifteen-year-old boy (1989) who was born in Kitgum four years after the beginning of the then twenty-year-old insurgency in northern Uganda. When telling his life history, he related how, whenever he asked his mother who his father was, he provoked anger, tears and fear. His mother, like a substantial number of women in northern Uganda, had been raped by a group of men in the rebel army. When she went to report the case to the state army, instead of being helped she was detained for weeks and subsequently raped frequently by a group of state soldiers. She managed to escape to one of the camps in the neighbouring Gulu district, but was already three-months pregnant with Ojok – a child-of-rape. Statistics are unavailable but it is well-known that as a consequence of any armed conflict, there are a substantial number of children with a similar life history. Ojok serves as an 'archetypal case'. A substantial number of children such as Ojok were neglected till they died of malnourishment or abandoned in public hospitals and camps in Gulu. Ojok was lucky to survive till his age.

When Ojok was two years old, his mother got married to an ex-combatant with the Lords Resistance Army, who had escaped, and had settled in a camp in Gulu where she lived. In this marital union they had three children, aged 13, 9 and 7 years respectively in 2004. Although they were a relatively stable family, Ojok's stepfather succumbed to HIV/AIDS when his youngest child was five years old. Before his death he had introduced his family to his patrilineal kin, but made it clear that Ojok did not belong to the family. According to Ojok, they had been living together in good peace with his stepfather's kin even after his death. However, two years later, he also lost his mother to HIV/AIDS. Being the eldest in the family of four orphans, automatically Ojok assumed the responsibility of caring for his siblings, including providing for food, healthcare needs and where possible educational costs. He had to drop out of school in order to do *leja leja* (casual farm labour) and other income generating activities to meet all these expenses. One weekend in April 2004, he was summoned by his stepfather's kin for a meeting. In this meeting he was told that he did not belong to the family and was subsequently ordered to vacate their land together with his siblings. To confirm their determination, the entire kinship group uprooted all the crops Ojok had on his farm and demolished the children's house. Ojok together with his siblings left for Lacor night commuters' home where they lived at the time of interviews in July 2004. He still worked at the hospital premises and other neighbouring places, but had a lot of medical complaints.

When Ojok was asked about his experiences in a one month recall he mentioned malaria, cough and diarrhoea. For malaria he bought chloroquine from a grocery shop for 100 Uganda shillings (approximately 0.043 euros), but for cough he and his siblings

used mango and guava leaves. The nurse gave him some yellow tablets for diarrhoea. For his siblings, he bought chloroquine when they had malaria.

According to the night commuters' shelter nurse where Ojok lived together with his family, "he is always taking Panadol for his headache, which never recovers". Sometimes, the nurse gave him a higher Panadol dosage, say three instead of two tablets, but still he complained of headache. At night, Ojok presented another challenge to the people at the night commuters' shelter. If he was not tossing around on his mat he was always having violent nightmares. Therefore, the nurse gave him a dose of Valium each evening. However, in the recent past, the nurse complained, "even if Ojok took five Valium tablets, they did not work! The administration was considering giving him oxazepams and perhaps other very strong tranquilizers". Assessing Ojok holistically, it is clear that underlying his persistent complaints is a web of all sorts of social and psychological issues.

The main objective of this exemplary case is to show the complexity of the effects of armed conflict on children's lives, including their illness experiences and quests for therapy. The content in Ojok's story signifies a child facing uncertainty, having relatives dying of HIV/AIDS and the direct effects of the breakdown of social networks leading to complex healthcare issues in wartime. Ojok as I mentioned, is a synecdoche or archetypal case of a substantial number of children living in a situation of armed conflict. And for the armed conflict in northern Uganda which had lasted more than twenty years at the time of this study Ojok's experiences could only be a tip of the iceberg of the magnitude of problems in conflict and post conflict northern Uganda which are intertwined with health and healthcare issues.

Map 1 Map of Uganda showing districts of Gulu, Kitgum and Pader

(Source: IOM-Gulu office)

PART I

RESEARCH PROBLEM, THEORETICAL APPROACH AND RESEARCH METHODS

Part I has two chapters covering the research problem, theoretical approach and research methods. In Chapter 1, I provide an analysis of the prolonged civil war in northern Uganda, and the problem statement. What I extensively focus on are the complexities of the civil war in northern Uganda, and I attempt to make explicit issues related to the provision of healthcare services in wartime.

The phenomenon of armed conflict is linked to the suffering and healthcare issues confronted by wartime children. For clarity, 'suffering' is used to indicate an illness experience, and 'healthcare issues' are those which are pertinent to the prevention, diagnosis, and management (including self-diagnosis and self-medication) of forms of suffering – whether caused by infectious diseases or emotional distress – in the context of an adult centred, market oriented and pluralistic healthcare system. I attempt to give a proximal account of the civil war by privileging the voices of people who have known the direct and indirect effects of war in northern Uganda. A proximal account implies an experience-near viewpoint about the thematic issues discussed in this book. The macro-context provided leads to the statement of the problem, addressing issues in the provision of healthcare services to wartime children of primary school age.

I draw from different disciplines such as biomedicine, development economics, medical anthropology, phenomenology, psychiatry, and psychology, in order to explain children's suffering. Some of these disciplines approach their field of study primarily from *etic* perspectives since they are concepts and categories developed from *outside*; indeed, children frequently refer to their illness experiences in different ways, sometimes using biomedical terms including malaria. It is believed that *etic* perspectives have meaning for scientific observers while *emic* views have meaning for *insiders*. Since the information presented herein is based on an anthropological study, *etic* perspectives will be acknowledged, though *emic* or insider points of view will be privi-

leged, so that when children regard their experiences as forms of suffering – but they are not recognised as such in existing healthcare disciplines – in this book, I still discuss them as forms of suffering.

The content of Chapter 2 is organised into four sections: 1) the theoretical approach; 2) research methods; 3) ethical considerations; and 4) my personal involvement in the anthropological assessment of wartime children's experiences, signifying the underlying rationale in knowledge production. Concerning the theoretical approach, I refer to perspectives of child vulnerability in healthcare, child agency, political economy of healthcare, and health seeking behaviour in the context of medical pluralism. In the main, I critique some of the major assumptions in the health seeking behaviour model. This is because one of the findings from my assessment of suffering suggests that the underlying rationalities which this model proposes are less existent. Instead, it appears that wartime children are guided by a need to alleviate suffering much as there are various factors which influenced their choices in quests for therapy. However, whereas I propose that short term curative approaches are essential in guiding the reduction of suffering caused by infectious diseases, the model of pragmatism will be critiqued in relation to emotional distress; because while curative approaches may lead to unintended cure, in the main short term curative approaches of dealing with mental distress blur the core issues and reinforce the over-use of medicines or *pharmaceuticalisation* of suffering.

The second section of Chapter 2 supplies the research methods. Not only are the research techniques addressed, but also the criteria for case selection, the rationale for employing particular techniques, and the analysis of data. Ethical considerations and my involvement as an insider are presented in the third and fourth sections of Chapter 2.

1

Context and focus of the study

This chapter's objective is to describe the macro context in which children in northern Uganda lived in 2004 to 2005 when this study was conducted. The macro setting encompasses political and socio-economic context in which this study was conducted. The contextual issues addressed lead me to the statement of the problem, research questions, and study objectives. In 2004, northern Uganda had been a conflict-affected area for about twenty years. To give a clear impression of the prolonged armed conflict, and to shed light about the war, I give a report describing its history, the events surrounding this civil war's persistence, and other unfolding issues including strategies to end the war through peace talks. While I address these issues, I discuss empirical findings signifying the proximal realities of the war in northern Uganda. I privilege the voices of wartime people, including children, who bore the brunt of this armed conflict. Privileging their voices means that the viewpoints of people who experienced the war are given advantage over secondary data. My approach is to explore experience-near perspectives about the direct and indirect effects of the prolonged civil war through wartime people's narratives, for there is no better source of evidence about the implications of this civil war for those affected. Press reports, studies conducted in northern Uganda, and emergency aid reports function as secondary sources for this chapter's content.

This chapter is divided into two sections. The first section addresses the history of the civil war, how the state employed various strategies to bring it to an end without success, and state-led or humanitarian agencies' ways to ensure the well-being of people in northern Uganda. This leads to the second section in which I present this study's problem statement, focussing on issues related to the provision of healthcare services to vulnerable children.

The war in northern Uganda

A brief history of the armed conflict

Armed conflict in northern Uganda began in 1986. After President Yoweri Museveni's regime ousted the then ruling military junta in the early 1980s, the defeated army retreated to the northern Ugandan districts of Gulu,[1] Kitgum, and Pader, districts occupied by the Acholi ethnic group. In an attempt to regain control of the state, the defeated state army reorganised and launched a new war under the umbrella name of the Ugandan People's Democratic Army (UPDA) in northern Uganda. The UPDA was partially crushed by military force, and some of its fighters were absorbed into the national army by then-called National Resistance Army (NRA). Remnants of the UPDA later reorganized under a young woman, Alice Auma, also called Alice Lakwena. Under her leadership, what was left of the UPDA transformed into a rebellious ideological movement that blended Christianity and Acholi traditions into what was called the Holy Spirit Movement (HSM). The HSM was, however, defeated by the NRA in Busoga subregion, about 30 km east of the capital Kampala, and Alice Lakwena fled to Kenya where she lived in the Ifo refugee camp until her death in January 2007.[2]

However, her cousin,[3] Joseph Kony, put in place another rebellious movement which he named the Lord's Resistance Army (LRA). In its early stages, the LRA thrived on the cooperation of the Acholi ethnic group, whose members voluntarily joined the rebellion. It is also believed that most of the LRA's weapons were acquired from Sudan,[4] a neighbouring state to the north that also provided training. At the time of this study, the LRA had for over two decades assumed different names and committed various atrocities with impunity in northern Uganda.

The Lord's Resistance Army guerrilla war tactics

Following unsuccessful military attacks in 1991 by the state against the LRA, the LRA made civilians its soft targets by abducting children, maiming and mutilating civilians, destroying properties and homesteads, and committing all sorts of horrendous war

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[1] In 2007, Gulu district was divided into two districts, namely Gulu district covering Gulu municipality, Achwa and Omoro counties and Amuru district covering Amuru, Nwoya and Kilak counties.

[2] On 17 January 2007 Alice Lakwena died after a long illness in the Ifo refugee camp in north-eastern Kenya, after seventeen years in exile. The government minister of internal affairs, Dr Ruhakana Rugunda, during a British Broadcasting Corporation (BBC) Radio interview on 18 January 2007, for a morning broadcasting programme called Network of Africa, mentioned how the state wanted nothing to do with Lakwena. Yet two weeks later the state organised for Lakwena's burial, and on 3 February 2007 Lakwena was buried at her ancestral home at Latyen village in Bungatira sub-county, in Acwa County in Gulu district. The funeral was delayed until 17:30 that day since Mr Walter Ochora – the Resident District Commissioner (RDC) – had first to attend to President Museveni, who was on an official visit to Gulu that week. Lakwena's mother gave a speech thanking the ruling regime for caring for her family, and for forgiving and reconciling with them.

[3] Conflicting reports exist concerning the filial relationship between Lakwena and Kony. Although a substantial proportion indicate that they were cousins, others assert that Kony is a nephew to Lakwena. Mourners at Lakwena's funeral interviewed about this issue only indicated distant filial relations with Kony.

[4] The Ugandan government was bitter over a US$20,000 gift which the Sudan People's Liberation Movement/Army recently gave the LRA chief Joseph Kony as a good will gesture. Uganda fears Kony could use the money to rearm, plan, and launch more atrocities against Uganda (Matsiko 2006a).

crimes, flouting national and international law. During that period, the people in the three districts of Gulu, Kitgum, and Pader were still living in their communities. In 1995 the scale of the violence and the number of child abductions by the LRA increased. Human Rights Focus (HURIFO 2002) reported that 730 children were abducted in Pajule, over 250 in Puranga, 502 in Patongo, and over 600 from Atanga in Kitgum district.

Between 1993 and July 1996, 70 teachers were killed by the LRA in Kitgum district. In Gulu district in July 1996, 11 teachers and over 100 children were killed, 250 primary school children abducted, and 59 primary schools burnt down, leading to the closure of 136 out of 180 primary schools. On 25 July 1996, 23 girls were abducted from St Mary's College, and on 21 August 1996, 39 boys from Sir Samuel Baker School. On 10 October 1996, in an incident that has since galvanized public awareness of child abduction, 139 girls were abducted from St Mary's College Aboke, in Apac district (HURIFO 2002: 16; Allen 2006: 51; De Temmerman 2001).

Human Rights Watch (HRW) has documented LRA attacks, abductions, killing of civilians, the burning and looting of villages and homes, and ambushes of vehicles. In 2002, the LRA was reported to have killed and injured hundreds of civilians in villages, internally displaced persons' (IDP) camps, and Sudanese refugee camps. LRA attacks also targeted humanitarian relief convoys transiting through northern Uganda to internally displaced civilians inside southern Sudan (HRW 2005: 15-23). A United States State Department Report (2004: 1) suggests that up to 12,000 people have been killed by rebel violence, and over 20,000 children abducted over the course of the war. These figures do not include deaths from conflict-related malnutrition and disease.

The United Nations Children's Fund (UNICEF) reports that children account for approximately three out of every four abductions, most of whom are between the ages of five and seventeen (UNICEF 1998: 4; UNICEF 2005). They are generally abducted at night when the LRA raid villages, camps, schools, and churches. As a consequence, many children abandon their villages and families to seek refuge in neighbouring towns. Such displaced children suffer from malnutrition, death from easily preventable diseases, and have no access to basic education (Gardner 2004: 24). A United Nations systems report (2004: 24) also shows similar evidence when it argues that "in contravention of international conventions and national laws, primarily the Child Statute of 1996, children continue to be forced into rebel ranks with girls being used as sex slaves and 'wives'. Children commute nightly everyday from camps, a practice which has exposed them to various forms of violence."

It is important to note that the northern Ugandan insurgency intermittently spread to the north-eastern districts of Apac, Lira, Soroti, and Kumi. This phenomenon was not only viewed as an LRA expansion of its scope of attacks, but was reinterpreted as an attack by the Acholi (read LRA) against the Lango, Iteso, and other ethnic groups occupying these districts. As a consequence, intra-ethnic and inter-ethnic tensions occurred both in the Acholi sub-region and in the neighbouring districts. For example, after an alleged massacre in Lira district by the LRA in 2005, the state owned paper, The New Vision, reported an uprising of the Lango ethnic group against the civilian Acholi people who had fled to Lira due to insurgency. Among the Acholi, ex-combatants reintegrated as innocent victims of war-crime, experienced rejection, slander, and exclusion. In an interview by De Temmerman & Ochowum (2006: 50-51) with Kony's mother, she disclosed how the family was worried that people would seek revenge on them over Kony's atrocities, yet professed that they had nothing to do with it.

In sum, evidence points to the LRA committing numerous war crimes against civilian populations, not only in the Acholi sub-region, but also among neighbouring ethnic groups. The LRA's tactic of abducting children and recruiting them in guerrilla warfare made wartime children particularly vulnerable. Meanwhile, as I will show, the state failed in one of its major obligations to protect its citizens in northern Uganda, and instead played conflicting roles in the prolonged armed conflict.

Conflicting roles played by the state in its attempts to pacify northern Uganda

The state was under pressure to protect people during wartime, and bring the armed rebellion to an end by national and international civic groups. At the start of the conflict the state underestimated its adversary's capacity. This was implicit in the president's speeches, where he referred to the rebels in the north as 'groups of bandits',[5] 'thugs', and 'jiggers in the foot', among others.[6] Following the attacks in the USA on September 11 2001, the LRA was added to the USA's list of terrorist organisations (Allen 2006: 51). The word 'terrorist' was adopted in President Museveni's rhetoric; for example, in presidential press conferences and articles Museveni consistently referred to the LRA as terrorists and killers, and said that their activities constituted terrorism.[7]

In 1991,[8] the state launched a military offensive against the LRA, but retreated shortly afterwards, citing the difficulty of fighting a less organized group. In 1994 the state, under pressure from civic and religious leaders in northern Uganda, and in an attempt to protect people in the north from wartime dangers, drafted a plan to settle people in 'protected villages' – also called internally displaced persons' (IDP) camps – to enable the NRA to pursue the LRA without hindrance. This plan was implemented officially in 1996. Available information suggests, however, that although the decision to create camps was officially announced by President Museveni on 27 September 1996 to members of parliament and Foreign Affairs, in as early as August 1994 the NRA was already attacking villages and ordering people to move to trading centres (HURIFO 2002:26). There were varied forms of resistance to this since people were not certain of the state's intentions, and subsequently the state army employed militaristic ways to 'scare' Acholi people away from their villages and livelihoods. In this process, vast

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[5] In 1994 the LRA intensified their onslaught against the Acholi, maiming and murdering innocent civilians. Museveni, for the first time in ten years, openly spoke about the reason why the 'bandits' had not been wiped out. To remedy the situation, Museveni appointed his brother, then Major General Salim Saleh, to take charge of military operations against the LRA in northern Uganda. With the appointment of Saleh, Museveni bragged that he had finally found the cure for the LRA scourge and that Joseph Kony would be history. But the LRA continued to wreak havoc for several more years while President Museveni blamed Sudan and the international community (Gyezaho 2006: 20).

[6] See press conferences broadcasted on Uganda Television's (UTV) series Presidential Press Unit (PPU), April 1996 – September 1998. The UTV was later renamed Uganda Broadcasting Corporation (UBC).

[7] See articles to the press and press conferences by President Museveni, including one on 4 May 2006 entitled "The truth about the LRA" (The Sunday Vision, 7 May 2006: Museveni Special: 5).

[8] In a press conference on 4 May 2006, President Museveni gave conflicting information about the role of the state in the conflict, including the statement that as early as August 1986 the UPDF – then called the National Resistance Army (NRA) – had already launched its attack at Bibia on the LRA. Also compare with "The truth about LRA" (The Sunday Vision, 7 May 2006: Museveni Special: 5).

numbers of properties, lives, and social networks were damaged. In interviews with one medical doctor in northern Uganda, I asked how the camps were created and he elaborated as follows:

> I have known the suffering caused to Acholi people since this war started in 1986. As early as 1994, the NRA maltreated the people to unimaginable levels. There were sporadic bombings of the villages, killings and mutilations of people who showed any signs of resistance. People were literally smoked out of their huts. Hungry people herded in camps who traced their homes to look for food found their food stores, huts and gardens destroyed. The NRA was waiting for them there to attack and send them back to the camps. People went through numerous traumatising experiences so that it will be difficult to send them back to their places of origin, that is, their own villages.

Children's narratives in two workshops I conducted in 2005 showed how in 1994, at Awach camp, the NRA burnt their huts and shot at and beat those who resisted leaving their villages to move to camps. Fifty-two children in my study illustrated diagrammatically how huts were burnt by the NRA and how people fled with hastily gathered household items while the armed state soldiers ran after them or ordered them to move. In the 1995 Constitution, the Ugandan Government's army changed its name from the National Resistance Army (NRA) to the Uganda People's Defence Force (UPDF). The changes in nomenclature and responsibilities of the UPDF can be found in The Constitution (1995), article 208 and clauses 1-4. While this army was supposed to protect civilians from attacks by the LRA and promote their well-being, the contrary often happened. The Government of Uganda has admitted that it was recruiting former abductees and returning them to the battlefield as state combatants. Approximately 800 were recruited, hundreds of whom were believed to be below eighteen years of age (BBC News 2005), in spite of the fact that recruiting children in combat contravenes international and national laws against exposing children to the dangers of armed conflict.

More reports suggest rights violations by the Ugandan military against civilian populations, including arbitrary arrests and beatings of internally displaced persons[9] suspected of collaboration with the LRA (IGG 2005: 11). In an interview with the one camp leader, he disclosed how the UPDF gave the people in one sub-county a seven day ultimatum, and in Awach village three days to move to camps or 'protected villages', threatening to treat those who resisted as rebels. Rural communities were brutally uprooted from their homes and lands by the government, in an operation marked by the systematic bombing of villages, and the burning of homes, grain stores, and crops (HRW 2005: 24-36). Yet crimes committed against civilians were rarely prosecuted, and even when UPDF abuses were investigated the process was often kept internal, giving the army an appearance of impunity. The state army also consistently rejected allegations of such abuses and stated that it only shelled rural areas where it suspected the LRA to be present (HURIFO 2002; HRW 2005). However, a number of people who ventured back shortly after leaving their villages found them burnt down. In an assessment of how the twenty-four camps in Gulu were created in 2001, people in places like Pabbo, Opit, Anaka, Cwero, and Unyama narrated to me how they had their villages shelled and even bombarded by helicopters. "In a good number of cases, NRA soldiers

[9] Internally displaced persons (IDPs), as opposed to refugees, are people who flee from their original homesteads due to disasters, including armed conflict. Nevertheless, they stay within the borders of their countries. For instance, Acholi people fled their villages to settle in camps or so-called protected villages within Uganda. In contrast, people who flee to neighbouring countries become refugees. For example, a substantial proportion of people from southern Sudan crossed to Uganda when this region faced insurgency, and the people of southern Sudan became refugees in Uganda.

just stormed villages – often at dawn – without any previous warning, telling people to move immediately, even beating them" (Rodriguez 2006: 34). The tension which people experienced was unbearable:

> We were beaten by government troops, who accused us of being [LRA] rebel collaborators and told us to go to the trading centre. On the other hand, rebels would also come and threaten to kill us unless we moved deeper inside the bush. (Interview with a camp leader December 2005).

On one of the rare occasions when the now-retired General Salim Saleh gave an explanation of the 'protected villages', he indicated that the army had acted on its own in creating the camps because "it suspected bureaucracy and politicking over the issue" (The Monitor, 26 October 1997: 9). In Pabbo camp, former Deputy 4–Division Commander, Lieutenant Colonel, said in an address at the trading centre that "all rural areas should be left for the UPDF to finish the rebels in a matter of months" (Rodriguez 2006: 34). UPDF army officers frequently told people that staying in the camps would be a temporary arrangement that would last only a few months, and was intended to protect their safety. However, in 2005 the state's temporary solution of settling people in camps had already lasted twelve years, and had proved an indefinite strategy,[10,11] and in reality civilians were often attacked, injured, and sometimes abducted in these camps, even by the state army. Records show that in Opit camp between 1996 and 2001 there were eighteen attacks on IDPs (HURIFO 2002: 16; Rodriguez 2006: 34). Another problem, particularly in camps such as Pabbo, Alero, Cwero, and Awac, was that the state soldiers were based in the middle of the camps instead of at the periphery. This, in effect, exposed civilians to rebel attacks targeting the state army detaches.

Figures suggest that up to two million people in the eastern, northern, and north-eastern Ugandan districts of Kitgum, Gulu, Pader, Apac, Lira, Soroti, and Katakwi were displaced (UN 2004[12]; UN OCHA , 2001, 2004, 2005; UNICEF 1998: 4).

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[10] The state, at the beginning of March 2006, embarked on the resettlement and decongestion of displaced persons. In Acholi sub-region, the state opted for decongestion as an appropriate activity, whereby a camp of 30,000 people was split into several camps of 10,000 people each. As to whether these places where the displaced persons were relocated were safe is a debatable issue. The general view is that war-affected people were still exposed to rebel attacks since the state had not yet dealt effectively with the LRA – the core problem.

[11] Eighteen new sites had been identified to decongest internally displaced persons' camps in Pader district, the then acting RDC Christopher Omara said. Omara cited challenges in these new camps, including lack of social amenities and insecurity due to the presence of LRA remnants. Residents of the newly created Paula internally displaced people's camp in Pajule, Pader district, appealed to donor agencies to establish social amenities in the camps. The then sub-county LC3 chairman Alphonse Omona said the camp lacked water, schools, and a health centre ("IDPs ask" in The New Vision, 17 May 2006: Northern: 9).

[12] UN systems (2004: 34) report that 25,000 children were forced to enrol as soldiers, and girls as sex slaves. By observation at the World Vision Centre for Formerly Abducted Children, there were also former female ex-combatants – a phenomenon rarely discussed since girls are viewed within their feminine gender roles as wives and caregivers.

The World Food Programme (2003) estimated that 800,000[13] persons had been internally displaced to camps due to armed conflict in the districts of Gulu, Kitgum, and Pader in northern Uganda, the majority women and children. In May 2001 the UN Office for the Coordination of Humanitarian Affairs (UN OCHA) released a report suggesting that out of the 583,992 IDPs in northern Uganda, Gulu district – the location for this study – hosted the highest proportion with a total of 356,424 since 1994 (accounting for over 90% of this district's total population, estimated at 528,800 people in 2004-2005). HURIFO (2002) estimated that about forty-three protected villages or camps had been formed over the prolonged period of insurgency. Even in protected villages, as stated above, IDPs were exposed to multiple dangers of armed conflict including child abductions, infectious disease epidemics, and abject poverty, and there were high levels of malnutrition in the three districts. For example, prior to the civil war Gulu district – which lies at a distance of about 330 km from Uganda's capital city Kampala – was popularly known as the 'food basket' of Uganda, as various parts of the country, including Kampala, relied on Gulu's substantial food supply. However, through displacement and settlement in so-called protected villages, people were reduced to dependents on intermittent food rations from the World Food Programme. One child who extensively participated in this study frequently narrated the experience of his seven year-old sister Ajok in this way: "After spending many weeks without food, she became so thin, weak and the skin became folded like for a very old person." Malnutrition was a common problem, not only in displaced primary schools and resource poor person's suburbs within Gulu municipality, but also in camps where war-affected poor people resided.

Furthermore, a report by UNICEF (2005) suggested that over 50% of the women in Pabbo camp had been exposed to forms of gender-based violence, the most common form having been rape. The state army was identified as the main perpetrator. In April 2006 the state owned newspaper, The New Vision, reported the following:

> The High Court in Arua had directed the Government to pay 82 million shillings[14] [35,652 Euros] to two displaced women who were raped by UPDF soldiers in Awer displaced persons camp in Gulu district in 2004. One of the girls was infected with HIV and another got pregnant. The two girls told the court that two armed soldiers deployed to guard the camp waylaid them and raped them. The soldiers had threatened to shoot the victims had they not succumbed to their demands. The girl who conceived was paid thirty two millions, while the one infected with HIV would get fifty millions. However, one

[13] Different sources give different figures for displaced persons in the three northern Ugandan districts, ranging from 800,000 to two million people. As to whether accurate figures are quoted was a problematic issue since the state 'screened' all statistics and survey results generated to show the total number of displaced persons. Since the WFP was working closely with the state, it is likely that a relatively lower figure has been given. The state used 'controlled information' to justify its non-declaration of the northern region as a disaster area. It was presumed that when figures which portrayed the reality of the war and suffering were published, this would not only lead to public outcry, but would also put the state under pressure to restore normality in Gulu, Kitgum, and Pader. Other NGOs such as the concerned parents association were known to quote a figure of up to two million displaced persons. When some institutions cited high figures, this prompted criticism, stating that they inflated figures in order to justify their enormous budgets and expenditures. My rough estimate, made through additions of the number of people in different camps, is that the total number of displaced persons in the three districts could amount to 1.6 million people in 2004.

[14] At the time of this study, the exchange rate was that one euro was equivalent to 2,300 Uganda shillings.

official of Gulu based Human Rights Focus criticized the awards as paltry compared to the gravity of the case and its impact on the victims (Mafabi 2006: 21).

Uncertainty about the end of hostilities

The Government of Uganda had to prove to guests of the Commonwealth Heads of Government Meeting (CHOGM), held in November 2007 in Kampala, that there is peace in the country. The change in President Museveni's stance about how to deal with the LRA, reinforced by announcing unconditional amnesty to the top LRA commanders and accepting peace talks with the LRA in early to mid 2007, should be interpreted in the light of this meeting.

The Juba peace talks commenced in May 2006, mediated by Riek Machar, the vice president of South Sudan.[15] It is estimated that more than seven billion Shillings (304,347 Euros) was spent during the first year of this mission for allowances, travel costs (such as chartering the private Russian airline Antanov for delegates from Entebbe to Juba), and transporting the relatives – including 'rescued wives' of the LRA commanders – for a visit.[16,17] It is important to note that the initiative for peace talks and referring the LRA for prosecution by ICC were done also after a great deal of activism, from civil society groups such as Acholi Religious Leaders Peace Initiative (ARLPI), NGOs and concerned politicians for amnesty. The Amnesty Act was passed into Ugandan law in November 1999 and was enacted in January 2000. The Act provides for amnesty procedures for all rebels in Uganda, not only the LRA. Nonetheless, President Museveni remained unwilling to accept that the Act should apply to LRA commanders. President Museveni even indicated to the prosecutor his intention to amend the amnesty so as to exclude the leadership of the LRA, ensuring that those bearing the greatest responsibility for the crimes against humanity committed in northern Uganda are brought to justice (see Allen 2006: 82).

In early 2004 to 2005, former LRA fighters who had been granted amnesty reported to local radio stations in Gulu where they were interviewed about what had happened to them in captivity. They were frequently instructed to call on their friends still involved in active rebellion with the LRA to return home. By mid-2004, over five thousand adult former LRA fighters had surrendered and applied for amnesty (Allen 2006: 75). The LRA top commander, Joseph Kony responded to the radio announcements by prohibiting his followers from listening to any radio programmes. Against this backdrop, some legal analysts suggested that the entire Juba peace talks process was illegal, and the President of Uganda could not grant amnesty to the LRA leadership in light of the case

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[15] The New Vision reported the peace talks' delegation's return from Juba to Kampala on 24 July 2006, prior to reaching any comprehensive decisions to end hostilities.

[16] The weekly observer newspaper issue of 20-27 July 2006 had a major headline reading "Kony's wife was forced to go and visit him by the peace talks team". The story suggested that the now rehabilitated former child soldier did not want to re-unite with her 'former husband Joseph Kony'. Other press photos showed happy reunifications between 'former wives of LRA commanders with their husbands'.

[17] Matsiko, G., & Harera, J.(2007) "Juba talks closed, says LRA". In the Sunday Monitor, 21 January 2007: 1. The main reason proposed for reporting to Juba for peace talks after six months of negotiating was that Vincent Otti-the deputy leader of the LRA/M did not want Dr. Riek Machar as mediator, and that peace talks in Sudan were closed forever. The LRA leader suggested a change of venue to Nairobi or South Africa. Kenya in response made it explicit that the LRA was unwelcome, and since South Africa was the main arms supplier to Uganda, it was unlikely that it would agree to host the peace talks.

about LRA war crimes in northern Uganda brought to the International Criminal Court.[18]

In the past, the state had initiated peace talks on several occasions, including in 1993 when a government delegation headed by the then Minister of State for the pacification of the north, resident in Gulu – Mrs Betty Bigombe – met LRA leader Joseph Kony and his top commanders in Pagik, Gulu district. Some people I interviewed also cited meetings in the deserted hills of Kitgum. In February 1994, however, peace talks collapsed after General Museveni gave LRA leaders a seven day ultimatum to lay down their arms and surrender or be flushed out of the bush.[19]

In 1996 the government set up a parliamentary committee to probe the northern conflict. In early 2005, with aid from the American people through the Northern Uganda Peace Initiative (NUPI), platforms for peace talks both with the LRA and the Sudanese Head of State were organised. However, concrete results in terms of the complete cessation of hostilities remained to be seen. In May 2006 the Vice President of Sudan (also the President of Southern Sudan at the time of this study)[20] contacted President Museveni on behalf of the LRA chief Joseph Kony, requesting peace talks.

The various peace talks were frequently reinforced with different military offensives, code named in early 1991 as 'cordon and search operation'; other operations included Operation North, led by the then Divisional Commander Major General David Tinyefunza in 2002, Operation Iron Fist offensive,[21] and in 2006 Operation Mop-up,[22] among others, all with limited success. Thus, at the time of this study, the people in the northern Ugandan districts of Gulu, Kitgum, and Pader lived in fetid, crowded camps and relying on aid from humanitarian agencies. Some of the humanitarian agencies include World Food Programme, UNICEF, World Vision, the Norwegian Refugee Council (NRC), Médecins Sans Frontières (MSF) also called doctors without borders, and other numerous international and local non-governmental organizations. However, the

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[18] Lomo (2006) argued that since the people of Uganda are sovereign and have the right to decide on any matter that concerns them – including the complex conflict in the northern part of the country – if they wished for peace talks, or if they decided that those who had violated their human rights should be dealt with in accordance with their traditions, their decision should be respected. Therefore, the ICC imposition demanding that the four LRA top commanders be punished was in itself an act of impunity, an insult, and a violation of people's right to self determination.

[19] See related information in HURIFO (2002) and Tamale (1995).

[20] President Museveni announced on 16 May 2006 that Uganda and South Sudan had given LRA leader Joseph Kony until July 2006 to end hostilities. This agreement was reached with the President of South Sudan, Mr Salva Kiir, to give Kony a last chance during the 13 May 2006 meeting in Kampala. Museveni told the then British Overseas Development Minister, that "if Kony does not take the latest peace offer", Kiir and Museveni had agreed that the Sudanese People's Liberation Army (SPLA) and the Uganda People's Defence Force (UPDF) would jointly deal with him. Ibid

[21] Unlike other offensives which were within Ugandan national borders, Operation Iron Fist had unlimited access into southern Sudan and support from the United States Government, as Sudan had been identified as a terrorist state because it was a popular military base for the LRA.

[22] The 601 Brigade Commander, Major Joseph Balikudembe, one of the commanders of 'Operation Mop-up' in Pader, told journalists that thirty LRA rebels had been killed in Pader in April 2006. According to this report, three army commanders including David Lakwo, Bosco Ocaya Latela, and Jon Opio, were killed (Apunyo 2006). With sporadic fights in Pader, there was resistance for people in camps to be moved to other smaller camps in the decongestion process.

'protection' of the Acholi people given by the state as spelt out in The Constitution 1995 article (III) and clauses (i-v) about the national unity and stability at the time of this study is a debatable issue.

Enormous state expenditures in defence budgets

Since 1995 the state consistently allocated over fifty percent of the annual national budget to the Ministry of Defence, generally diverting finances from other ministries and from donations for other purposes. High defence budgets and expenditures were persistently justified by the state by arguing that "it urgently needs funds to facilitate its attempts to bring the war in northern Uganda to an end".[23] For example, 42 million dollars was spent in 1992 for defence, which grew to 200 million dollars in 2004.[24] A substantial proportion of this income was used to purchase war weapons; for example, in 1998 the state spent over 27 billion shillings in the purchase of junk fighter planes from Russia which were in poor mechanical condition, and which they were unable to repair. Reports show that a retired army general obtained a 2.4 million US dollars 'commission' from the helicopter traders for a 15 million Dollar deal meant for *sound* military helicopters (The Monitor, 7 May 2006: 6). Yet this debacle did not deter the state from purchasing more weapons, and its continued efforts to stock ammunitions – characterised by their high complexity and enormous quantities – has been evident since 2004 in the spectacular national day celebrations graced with deathful weapons, some of which were displayed for public viewing. In connection to the foregoing about high state expenditures in defence, in the budget presented to the parliament on 8 June 2005, the executive branch allocated a substantial amount of US$ 200 million to defence spending. The latter prompted donor protest against the high level of military funding (see Akwapt 2005).

President Museveni often used the national day celebration ceremonies to warn the state's enemies, including the LRA, about impending violent attack.[25] On such occasions, he would promise peace to the people in the war torn northern region, and the speeches also involved castigating and silencing opposition groups. As already mentioned, however, the state's use of arms to bring to an end the northern Uganda war had been going on intermittently for as long as the conflict itself – twenty years at the time of this study – and people lived in the camps in uncertainty and persistent fear of attack by both the state army and the LRA. Civic groups, on the contrary, including the Acholi Religious Leaders' Peace Initiative, instead constantly called for a peaceful means of conflict resolution through peace talks.

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[23] Mwenda (2006) "Are the NRM and LRA in an unholy alliance?" In The Sunday Monitor, 7 May 2006: Opinion: 6. The author argued that the war in northern Uganda had been used as an excuse for the ever-increasing defence budget, and the basis for acrimonious fights between Museveni's government and its international creditors.

[24] *Ibid*. Moreover, the real outcome of increased defence spending was the creation of many corrupt opportunities for graft, such as the purchase of junk military equipment, expired food rations, undersize uniforms, one foot/one size boots, plus filling the army with 'ghost soldiers' who by 18 October 2003 totalled more than half of the actual number of soldiers. Ghost soldiers are names in monthly payrolls but with false claimants.

[25] On 26 January 2007, at a national day celebration, the President broadened his scope to also warn the press about misinforming the public with sensational political stories.

It is highly unlikely that for a problem of armed conflict, 'the merchants of weapons of death'[26] will expeditiously act to end the war. Evidence suggests that the LRA had a constant supply of arms from Sudan, who justified its actions by asserting that Uganda supported its enemies in a similar way: the Sudanese opposition group – largely activists fighting for an independent southern Sudanese state. For example, Allen (2006: 49, 51) reports that "with Sudanese support, the LRA was able to launch some of its most ferocious attacks. One of the worst single incidents occurred in May 1995, when the LRA burned scores of homes and killed almost three hundred people in Atiak, a trading centre just south of a large army barracks". On this occasion, the government soldiers failed to respond until the rebels had already withdrawn. And by observation, the Sudanese fighters had, until 2005, stations and fighting bases in the north-western Ugandan districts of Arua and Yumbe.

Those who were trading weapons to Uganda, such as South Africa, Russia, and the United States of America, were largely silent concerning efforts to end the northern Uganda war. When the by then President Thambo Mbeki[27] of South Africa visited Uganda in January 2006, he did not criticise or condemn the killing and maiming of civilians in the north of the country, whether by the state army or by the LRA. He instead praised the Head of State and all the institutions in place for their good governance and rule of law. A few months after President Mbeki's visit, it was reported in The Daily Monitor that:

> (…) the UPDF procured 30 combat vehicles to end the lingering insurgency in northern and north-eastern Uganda. Part of the consignment from South Africa began arriving at a depot belonging to Maersk shipping firm in an industrial area in Kampala on 2 May 2006. The acting military and defence spokesman, Major Felix Kulayigye, declined to give details on the military vehicles. The 10-tyre trucks painted with Ugandan military colours excited workers and by passers in Kampala's busy 5th Street industrial area as they were hauled into Maersk depot. Military cooperation between South Africa and Uganda had been growing in the past few years. A military source said apart from the military transport vehicles, South Africa had been Uganda's key arms supplier. Private South African companies further supplied UPDF with non-lethal items like dry rations and clothing.[28]

Whereas there was a high representation of humanitarian aid agencies whose main objective is to ensure the well-being of people in conflict zones, there had been a limited focus addressing the core issue – namely a deliberate effort to end the armed conflict. In extensive interaction with various aid workers, both local and international, a clear message was communicated to me: that NGOs were non-political, non-partisan, and not directly mandated to address the core problem. "The war itself should be addressed by

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[26] There is a vast arsenal of Abdomat Kalashnikovs model 1947 (AK-47) from the Soviet Union, which is the most popular among African warriors; indeed it is the world's most popular rifle. It is a weapon all fighters love: a simple nine-pound amalgamation of forged steel and plywood, it does not break, jam, or overheat. It will shoot whether it is covered in mud or filled with sand. It is so easy, even a child can use it; and children – not only in northern Uganda – do. The AK-47 is Russia's biggest export. [See Tendo (2006) "Lord of war: Painful truths brought closer to home". In The Daily Monitor, 1 March 2006: 31].

[27] In a subtle bid to show more than just diplomatic relations, President Thambo Mbeki was among the first persons to confirm his attendance of the swearing in of President Yoweri Museveni. He was among only six African heads of state to attend this ceremony, scheduled for 12 May 2006. Barely a week preceding this ceremony press reports indicated the 'arrival of 10-tire vehicles from South Africa – to facilitate the UPDF's role in fighting the LRA in northern Uganda' (The Daily Monitor, 8 May 2006).

[28] See Matsiko (2006b). "UPDF acquires combat vehicles". In The Daily Monitor, 4 May 2006: 5.

Ugandans themselves", argued one international aid worker who had lived and worked in Gulu for about fifteen years during the time of interview. This assertion was contrary to the perspectives of locals, including children, who had lost trust in state intervention and were looking to the West or the international community to expeditiously act to end the northern Uganda conflict.

State invitation of the International Criminal Court

In July 2005, President Museveni invited the International Criminal Court (ICC)[29] to prosecute five senior LRA commanders: Commander-in-Chief Joseph Kony, his deputy Vincent Otti, LRA army commanders Dominic Ongwen and Okot Odhiambo, and a junior commander Raska Lukwiya (though at the time of writing this thesis, Lukwiya had been murdered by the UPDF and Vincent Otti was murdered by Joseph Kony in December 2007). In February 2006, the ICC announced that the prison for the LRA commanders in The Hague had been prepared.

> The ICC on 13 October 2005 unsealed the warrants of arrest for five senior leaders of the LRA saying there were reasonable grounds to believe that they committed crimes against humanity and war crimes in Uganda since July 2002[30]. Kony was indicted on 33 counts of murder, rape, enslavement, inhumane acts of inflicting serious bodily injury and suffering. He was also wanted to answer for the cruel treatment of civilians intentionally directing an attack against a civilian population, pillaging, inducing rape and forced enlistment of children. Otti has 32 counts to answer, while Okot Odhiambo has 10, Ongwen seven and Lukwiya four[31](Muyita & Bogere 2006).

In sum, multiple reasons could be proposed to explain why the civil war in northern Uganda had lasted twenty years at the time of this study. Multiple reasons include – but are not limited to – the state's reluctance to address the armed conflict while it was in its early stage; the state's preference for gunfire exchange at the warfront, which it attempted on numerous occasions with limited success; and the influence of traders of ammunitions to Uganda. Consequently, the prolonged civil war exposed the Acholi people to extreme events, vulnerabilities, and suffering. In this context of armed conflict, the state implemented many development programmes to which I now turn.

Development programmes implemented during civil war

There were various initiatives by the government of Uganda in collaboration with donor agencies like the World Bank and the European Union to promote development in northern Uganda in 2006. The initiatives included the Northern Uganda Social Action Fund (NUSAF hereon), the Northern Uganda Rehabilitation Programme (NURP hereafter) and the Joint Country Coordination and Monitoring Committee on northern Uganda (JCCMC for short). The JCCMC was a culmination of an inter-ministerial

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[29] The visit to the war-torn north by Jan Egeland in January 2006 also served to reiterate the UN and international community's position that Joseph Kony and the LRA army were criminals who have caused untold suffering to the people of northern Uganda, and that he and his LRA top commanders, including Vincent Otti, should be arrested and prosecuted.

[30] Even as early as 1986, fighters with the LRA were committing crimes. Noticeably, the ICC could only use evidence of crimes committed by LRA top commanders in July 2002, since ICC jurisdiction only came into effect on 1 July 2002.

[31] Muyita & Bogere (2006) "Besigye team reject Kony state witness", in The Daily Monitor, 5 May 2006: 1-2.

meeting that was held in Geneva on March 20 to discuss proposals by the government for a joint mechanism to coordinate the emergency humanitarian intervention in northern Uganda.

NUSAF was a World Bank and government of Uganda funded project intended for the communities in the northern Uganda sub-region to catch-up with the rest of the country in development terms. It aimed at assisting Local Governments tackle poverty and foster development through participatory community efforts under decentralisation framework. The overall objective of the project was to empower communities by enhancing their capacities to systematically identify, prioritise and plan their needs; and implement sustainable development initiatives that improve socio-economic services and opportunities. Through direct financing mechanisms, NUSAF made funds available to communities for sub-project activities, and helped in improving livelihoods. NUSAF had beneficiaries in 18 northern Uganda districts including Gulu, Kitgum and Pader. In Gulu district, an amount worth 216,528,824 shillings (94,143 euros) were released on 17th May 2006 by NUSAF for 39 projects. The projects were for ox-plough cultivation, bee keeping, piggery, displaced community poultry, restocking, orphans and widows and fish farming. The most expensive project was worth eight million shillings (3,478 euros) and the lowest cost 2 million shillings (870 euros). Evidence suggests that while displaced persons positively responded to NUSAF's invitation for applications for projects to be funded, only a few people managed to access funding due to World Bank requirements that revolved around the themes of peace building, traditional ways of conflict resolution and bee keeping. For example, in Kitgum, there were over 2,000 applications while only 900 were approved. Still, out of the 900, only 407 had received funding from NUSAF in 2007. It was not possible to establish the ultimate criteria NUSAF based upon to avail funds to its clients. This is because some of the beneficiaries were the elite who lived in Kampala and had no intentions of making investments in northern Uganda following the guidelines set by the World Bank.

One of the donors to NURP was the European Union who allocated 20 million euros to improve the living conditions of people in conflict affected areas in the north, in addition to rehabilitating social infrastructure, economic recovery, strengthening local governance, law and order (The New Vision, April 14, 2006: 7; The Daily Monitor, April 13, 2006: 5). Mostly, people interviewed cited how tedious it was to keep travelling to district offices for the funds until they gave up trying. One spokeswoman for Kitgum cultural leaders I interviewed complained about funds which were difficult to access thus: "People [affected by war] do not touch that money; it doesn't change the income of the people." Although members in district committees for implementation of NUSAF and NURP I interviewed often argued that people were already moving to their villages – as a prerequisite to access the development funds, by observation in places like Unyama, Pabbo, Pagak the people still lived in displaced persons camps. The then, LC 5 chairmen of Pader, Kitgum and Lira said they had only read about NUSAF and NURP exercise and funds in newspapers. In addition press reports indicated a lack of enough iron sheets to hand out to returning IDPs. In Pader alone for an estimated 77,000 households, the district received only 10,000 iron sheets (Muhumuza 2006: 13). Various interviews with district officials in Gulu district who preferred anonymity revealed how 'the war in the north has kept the Ugandan soldiers in the UPDF busy and they had benefited economically'. And indeed it was possible to observe that certain senior officers in the army became relatively wealthy from the situation of the armed conflict, also

during administration of funds availed by donors who attempted to rehabilitate the social and economic condition of northern Uganda.

One of the expected outputs of the JCCMC on northern Uganda was the implementation of decongestion programme for IDPs from the camp populations of 10,000-60,000 to camps of 1,000-3,000 people to make them more manageable and improve service delivery. The JCCMC's objective was also to facilitate humanitarian services, reconcile people and help them return and integrate into society. In one of the follow up visits to Gulu district in December 2006, I observed that camps like Pabbo, Pagak, Alero had been split into smaller camps. The newly created camps were spacious and supplied with many ecotoilets. The new camps however lacked healthcare facilities, schools and bore holes for clean water. A few people I talked to appreciated the innovation, but there were complaints about the lack of the amenities and waste of land. Some respondents who preferred to live in 'old Pabbo' camp despite its poor sanitation cited the presence of the health centre and a school, and narrated how people who moved to new camps had to deal with the challenge of travelling long distances to access the services at the health centre located at the old Pabbo camp. One land owner in Pagak I interviewed was not happy with the government's initiative to settle people in his property despite his resistance. Whereas one of the strategies for developing northern Uganda was decongestion, one of the top officials at the Gulu district NGO forum argued that people instead wanted to be resettled and not to be decongested. "Creating smaller camps would only perpetuate their encampment", he argued during interviews. Moreover, there was a general distrust of the decongestion exercise since as already mentioned in this chapter, whereas the original plan was to settle people in camps for 2-3 months, the temporary solution was over 10 years old in 2005. The latter phenomenon generally instilled in people to be decongested a belief that the process might be a permanent one. In the next section, I will highlight a few of the dangers of living in a context of armed conflict, focussing in particular on the domain of health.

Wartime people's vulnerability and exposure to health dangers

A survey by MSF-Holland (2004a) found that the main causes of reported morbidity were malaria/fever (47%), respiratory diseases (21%), and diarrhoeal diseases (21%), all closely associated with the living environment. Malaria was the main reported cause of death followed by diarrhoea. Further, a MSF-Holland survey on mental health in Pader town found that 79% of people had witnessed killing and 5% had been forced to physically harm someone; 62% of the women interviewed thought about committing suicide (MSF-Holland 2004b).

Findings in a July 2005 study by the World Health Organisation in Gulu, Kitgum and Pader districts demonstrated a Crude Mortality Rate (CMR) for all IDPs to be 1.54, and the under-five CMR was 3.18. Figures were worst in Pader district, which had a CMR of 1.86 and an under-five CMR of 4.24. In a Sydney Peace Prize lecture, *Saving our Children from the Scourge of War*, in November 2005*,* Olara-Otunnu, the former UN Under Secretary General and special representative for children in armed conflict (Olara-Otunnu 2006: 15), disclosed how in Uganda for over ten years a population of almost two million people had been herded like animals into 200 concentration camps. He commented upon the abominable living conditions, defined by staggering levels of squalor, disease, death, humiliation and despair, appalling sanitation and hygiene, and massive overcrowding and malnutrition. Since the process of settling people in camps

was haphazardly done, no advance plans were made for the tens of thousands of displaced persons in terms of putting in place healthcare facilities, sanitation, food, or proper shelter. The appalling living conditions in the camps and villages provide opportunistic factors for epidemics of infectious diseases, including sexually transmitted diseases, as well as a high prevalence of mental health problems (Olara-Otunnu 2006; HRW 2005: 63). Epidemics of infectious diseases affecting the population of northern Uganda in 2000-2005[32] included ebola, scabies, and cholera (District Directorate of Health Services-Gulu 2005, 2006). From August to December 2005 alone over one thousand cases of cholera were recorded by the district emergency health team (DDHS-Gulu Report 2006: 4). Although epidemiological data on age-related morbidity and mortality are lacking, wartime children were especially vulnerable to these epidemics and other major killer diseases such as malaria, diarrhoea, acute respiratory illnesses, and anaemia (UNICEF 1998: 11; UNICEF 2003; MSF-Holland 2004a).

Collapse of the healthcare system as a result of war

The asymmetrical allocation of funds to the Ministry of Defence contributed to the poor facilitation in the healthcare sector, especially neglect in the maintenance and equipping of hospitals and healthcare centres. For instance, the dilapidated Gulu Regional Referral Hospital (GRRH hereon) was last renovated in 1946 and therefore its structures were in appalling condition at the time of this study.

Further, there was poor remuneration of healthcare professionals; and the very ammunitions purchased by the government were used to destroy the few existing healthcare structures and systems in northern Uganda. The situation of insecurity caused an exodus of professional healthcare givers to safer regions of the world; the few who remained frequently resorted to private practice and thereby reinforced a market-oriented focus in the healthcare system. With the phenomena of poorly maintained formal healthcare systems, few professional health workers, non-existent health services in some areas, and a market-oriented healthcare system, a substantial proportion of persons including wartime children subsequently managed common illnesses themselves, which is the focus of investigation for this study.

Due to the armed conflict and commoditisation of healthcare people in northern Uganda managed their own health complaints. For example, people were displaced from their homes and livelihoods and settled in protected villages or camps, and there were hardly any formal healthcare structures in a substantial proportion of IDP camps. In the context of medical pluralism, wartime persons managed common illnesses themselves, whether through the use of pharmaceuticals or herbal remedies. In addition, wartime people employed various coping strategies to alleviate their suffering. The management of illnesses by sufferers themselves is also directly linked to Uganda's adoption of Structural Adjustment Policies (SAPs) since the mid 1980s. One major effect of SAPs was the liberalisation of trade; in the domain of health, SAPs facilitated multinational pharmaceutical companies' supply of pharmaceuticals as commodities. In Uganda all types of pharmaceuticals can be easily purchased without prior consultation with professional healthcare givers. And with the limited abilities and ineffectiveness of state structures like the National Drug Authority and the Uganda Revenue Authority, many

[32] See The New Vision, April 26, 2006 report about the cholera epidemic in Agoro camp in Kitgum district. Health officials attributed the epidemic to the poor sanitary conditions in the camp.

pharmaceuticals of varied qualities could be found in Ugandan markets. The amount of money which an individual had determined the quality and quantity of pharmaceuticals accessed (see Adome *et al*. 1996; Adome *et al*. 2000; Whyte & Birungi 2000). Meanwhile, as I will discuss in subsequent chapters, as a result of war and the collapse of healthcare systems, the humanitarian crisis in the north of the country attracted numerous Non Governmental Organisations (NGOs). Records of registered NGOs and community based organisations (CBOs) in Gulu district in 2006 show a total of 263 local, national, and international institutions in place, with the primary mandates of alleviating suffering in conflict zones (Gulu district NGO Forum 2006). NGO interventions by institutions including World Vision, UNICEF, the Norwegian Refugee Council (NRC), the International Committee of the Red Cross (ICRC), the World Health Organisation (WHO), the Africa Medical and Research Foundation (AMREF), Gulu Support the Children Organization (GUSCO), World Food Programme (WFP), Médecins sans Frontières (MSF), Save the Children in Uganda (SCiU), Noah's Ark, and Caritas – to mention but a few examples – had major project elements focusing on providing psychosocial support to people in conflict zones, which included sensitization seminars, counselling, and institutions were created to provide accommodation and rehabilitation services for people suffering from war trauma.

Focus of the study

Statement of the problem

The World Health Organisation (1997) stipulates that school health programmes should include the topics of HIV/AIDS and sexually transmitted infections, violence and injury, unintended pregnancy and poor reproductive health, helminth infection, poor nutrition and food safety, poor sanitation and water control, lack of immunisation, poor oral health, malaria, respiratory infections, psychological problems, alcohol, tobacco, and illicit drug abuse. According to the World Bank and the United Nations Children's Fund (UNICEF 1995; WB 1993: 33-35), an essential public health package for school health programmes should treat worm infection and micro nutrient deficiency, and provide health education. Underlying this focus is the general idea that children above five years will have developed significant immunity for communicable diseases (Jamison 1999: 13; MOH 1999a, 2000; WHO 2000a: 27).

In Uganda, school health programmes target children above five mainly for deworming and oral hygiene, and girls of child-bearing age for vaccination against tetanus (MOH 1999a, 1999b, 2000, 2001a). In wartime northern Uganda, health services were mainly provided through the national health policy drafted by the Ministry of Health (MOH), and there was a huge gap between these services and the health needs of wartime children, especially those living in child-headed households. Firstly, the MOH's main policy focus concerning children was on the healthcare needs of children below five years of age. Although malaria is acknowledged as an area of concern for older children, in implemented programmes the focus on children above five years is limited to the areas mentioned above. Whereas article 34(5) of the Ugandan Constitution (1995) defines children as individuals below sixteen years, children above five may, only under special circumstances, be allowed consultation in paediatric units, which largely have programmes for under-fives. Therefore, children above five years have to access adult healthcare provisions, where their vulnerability for infectious diseases and other forms of suffering is not recognised, let alone specifically addressed. Secondly, the general

trend in MOH policy is to target adults, especially mothers, in their traditional gender role of healthcare providers.

This conventional view of adults as caretakers tends to obscure children's own roles and contributions regarding their healthcare. The paradigm not only dominates popular perceptions in the case of childhood illness, but has also influenced most research about children (Christensen 1990). This dominant discourse about illness management – situating children in a marginal position and defining them as incompetent and passive, while adults are seen as competent, active, and in charge of healthcare (MOH 1999a, 2000, 2001a; UNICEF 1998, 2003; WHO 2000a, 2000b) – contributes to an adult-centred approach in healthcare. However, the researcher's fieldwork among children in a primary boarding school in Uganda (Akello 2003) confirmed that children of primary school age were involved in self-diagnosis, self-medication, therapy choice, and illness management, and may act as care-givers themselves. Similar findings were reported in Kenya (Maende & Prince 2000: 162; see also Geissler *et al*. 2000: 17-34). These findings show that for assessing children's needs, the perspectives of children themselves are necessary, for the worlds of children and adults do not fully overlap and children's voices are needed for a comprehensive account of their experiences and strategies. However, official healthcare policies and providers do not recognise children's agency in needs assessment or as healthcare seekers. Consequently, the MOH does not meet the health needs of the most vulnerable groups among its target population: children above five years old who are not under adult care, such as children in child-headed households in IDP camps and villages. Humanitarian agencies do not meet these needs either. I will address this issue in subsequent chapters.

This study sought to investigate how wartime children confront their suffering. While addressing this, I took into account that children are not a homogeneous group, but differ in their perspectives, experiences, needs, and strategies according to age and gender (Akello *et al*. 2006: 229; MOH 2005; Richters 1994; Scheper-Hughes 1994). One also has to take into account that, like in the rest of Uganda, the healthcare system in IDP camps and villages is pluralistic, consisting of a biomedical, folk, and lay sector (Kleinman 1980: 53-60). Furthermore, the medical domain is characterized by commoditization through the activities of profit-oriented healthcare providers and pharmaceutical companies (UDHS 2000; Whyte 1998; Whyte & Birungi 2000), where therapies, both biomedical and indigenous, are readily accessible in the market without prior consultation with health professionals (Adome *et al*. 1996; Akello *et al*. 2007: 74; Whyte & Birungi 2000). It is within this system that children's search for therapy takes place.

Main question and research goal

Given the situation described above, this study's main question was: how do children of primary school age confront the common illnesses they identify in the contexts of war, the limited focus in healthcare planning, lack of state services, and various intervention agencies' approaches in ensuring well-being of people in conflict zones? In short, given wartime children's suffering, what are their healthcare needs, strategies, and coping mechanisms?

It was this study's goal that empirical findings provide a premise to guide the improvement of healthcare service provision, not only to wartime children but also to

children above five years in general, in a way that meets their 'right to health',[33] thereby taking children's own agency as well as their specific needs into account. In particular, the study focussed on the health and healthcare needs as seen from the perspective of the children themselves. Based on primary school age wartime children's own perspectives on health and healthcare, I will argue for the adjustment of existing school health programmes and emergency interventions in conflict zones. The focus on children of ages 8-16 years is guided by the assertion that from age eight onwards, children's thinking becomes logical and children can interpret changes in their bodily experiences and act upon them (Hartzema 1996: 353-375).

Research questions

- What are the common illnesses that wartime children between eight and sixteen[34] years old experience?
- How do these children know that they are ill and how do they determine the severity of their illness experiences?
- How do children situate themselves in the adult-centred healthcare system?
- Where do the children get medicines?
- What factors influence wartime children's access to, and use of, medicines?
- What other strategies do children employ to deal with the different illness experiences?
- Do boys and girls experience and treat illness differently? If so, why?
- How does the market-orientedness of the healthcare system influence children's illness experiences and quests for therapy?
- What are the structural arrangements and policy issues influencing children's access to therapies within a pluralistic healthcare context?
- What are wartime children's perspectives concerning appropriate healthcare?
- What are wartime children's priorities and needs in healthcare?

[33] Article 24 of the 1989 UN Convention on the Rights of the Child explicates the child's right to access health services of the highest possible quality.

[34] The Ugandan Constitution of 1995 was revised in 2005 to give 'children' an age limit of 16 years from the previously 18 years, [see article 34(5)] which states that children shall be persons under sixteen years. The age of sixteen is consistent with international legal documents such as the UN Convention and International Criminal Court legal documents in defining children. Therefore, to ensure relative international uniformity in reference to children, this study focussed on individuals aged 8-16 years. One has to realise however, that the notion of childhood is context specific and shifts according to whether an individual has gone through some 'rites de passage' or become parents themselves.

2

Methodology

This chapter has four sections covering the theoretical approach, fieldwork methods, ethical considerations, and my personal involvement in the study. My theoretical orientation is based upon four conceptual domains: child vulnerability in healthcare, child agency, political economy of healthcare, and health seeking behaviour in the context of a market oriented and pluralistic healthcare system. The section on fieldwork methods covers the techniques used in data collection, the choice of research setting, the rationale for validity, reliability, and generalisability of this research, case selection, the rationale for employing each technique, and details on how the data was analysed. The third section in this chapter describes ethical considerations, while in the fourth section I explain my relation to the topic and discuss possible consequences for data collection and analysis.

Theoretical approach

In investigating how children in child-headed households were actors in their quests for therapy during their illness experiences, four theoretical orientations have constituted this study's backbone. These are child vulnerability in healthcare (Jamison 1999; MOH 1999a, 1999b, 2001a, 2001b; UNICEF 1998, 2003; WHO 2000b), child agency (Alderson 1995; Christensen 1990; Christensen & James 2000; Hardman 1973; James & Prout 1995; James, Jenks & Prout 1998; Prout & Christensen 1996; Van der Geest & Geissler 2003), the political economy of health and healthcare (Akello 2003; Doyal & Pennell 1981: 46; Farmer 1999a: 80; Parker 2000: 419-433), and health seeking behaviour models in the context of a market oriented pluralistic healthcare system (Adome *et al*. 1996; Kleinman 1980; Tiping & Segull 1995). This study further draws from gender perspectives as a crosscutting issue throughout (Moore 1988; Oakley 1994; Ostergaard 1992; Richters 1994, 1998: 77).

This study's objective is to provide an experience-near analysis of wartime children's suffering. Nevertheless, in the course of my discussion I will introduce analytical categories drawn from various disciplines such as biomedicine, phenomenology, development economics, psychology, psychiatry, and medical anthropology. This is to ensure coherence and data manageability, to enable the identification of illnesses and medicines which the children named, and to assist in the logical presentation and analysis of empirical data. For example, whereas wartime children only discussed their experiences

with specific illnesses, such as malaria (and malaria *madongo*), *koyo, lyeto* (coldness, high body temperature), *cado* (diarrhoea) and cholera, scabies, *aona ki avuru* (cough and flu)*, aona opiu* (tuberculosis), for analytical purposes I have drawn from biomedicine to categorise such diseases under the umbrella of 'infectious diseases'. In subsequent chapters, I address this issue in greater depth, but I turn now to outlining theoretical orientations.

Theoretical orientations

In this section I shed light on the underlying discourses relevant for this study, and the extent to which they can be deconstructed and confirmed by this study. First, I present these discourses, and through adapting them to this study I critique, modify, or confirm their propositions. Further, with each theory I present study results as illustration. Thus it is not only the discourses underlying the four theories in this study that are presented in this section, but also (1) illustrations of how each theory is applicable to this study – thereby confirming it; (2) where empirical evidence conflicts with contemporary theoretical assertions, this study critiques some of the major assumptions in these theories; (3) drawing from several disciplines, this study has coined various terms suitable for children, in relation to the existing theory – two quick examples are replicational and transformative agency; and (4) this study adds knowledge to existing theories, which could then form the bases for the propagation of new discourses. Below I will illustrate these assertions with each of the four major theories, starting with child vulnerability in healthcare.

Child vulnerability in healthcare

I have adapted the perspectives of the child vulnerability in healthcare discourse for this study because I found insufficiencies in child agency perspectives (see below) for analysing the health situation of the children in this thesis. In a review of primary school age children's illness experiences (Akello 2003), one of my conclusions was that whereas the children in boarding schools were social actors in their self-diagnosis and medicine use, they were also vulnerable. Specifically, they were vulnerable because of wider factors which influenced their access to healthcare. For example, apart from the socioeconomic difficulties they experienced in their quests for therapy, they were also disadvantaged because of their young age, existing healthcare policies regarding children of primary school age, and the fact that the healthcare system is adult centred and market oriented.

I therefore developed a child vulnerability in healthcare perspective in order to attempt to limit an *overemphasis* on children's agency, but also place children's daily suffering within a situation of armed conflict into perspective. Over emphasis on patients' agency has been documented to have negative effects, including with issues pertinent to compliance in healthcare (Farmer 1997b: 355). For instance, such claims suggest that patients' non-compliance is the greatest problem in the control of tuberculosis. Moreover, it appears that an over emphasis on agency neglects environmental, structural, and operational factors that are beyond patients' control. These wider factors influence children's health and healthcare opportunities, and are addressed in the discussion of political economic theory below.

As mentioned above, existing healthcare policies regarding healthcare for children above five years contribute to their vulnerability. One example is that such policy documents imply that children of primary school age are a healthy group, while only child-

ren below five are vulnerable (Jamison 1999; MOH 2001a; WHO 1999b, 2000a, 2002b). Further, in emphasizing child vulnerability, adults are viewed as being in charge of, and having responsibility for, the child, therefore children are positioned as dependent and passive objects (MOH 2001a; UNICEF 2003; WHO 2002b). Placing children within this frame implies that adults are responsible providers and care givers, and that children do not yet contribute to society but receive care, protection, and training. Looking at the children whom this study focuses upon, there is substantial evidence that they are not yet mature, and are in fact in need of care and protection from the dangers of wartime. But furthermore, insufficiencies in healthcare policies addressing their needs make them even more vulnerable.

Contemporary healthcare planners and policy makers presume that it is mainly children below five who are vulnerable and in need of protection, thus different programmes including vaccination and immunization have been put in place for the prompt management of episodes of illnesses for these children (Jamison 1999; MOH 1999, 2001b, 2004; UNICEF 1998, 2003; WHO 2000a, 2000b). While children below five years receive a great deal of attention, evidence suggests that children above five years are a neglected group. In northern Uganda, which has faced the recent pandemic of HIV/AIDS and extended armed conflict, a substantial proportion of children were living on their own in child-headed households at the time of this study. They were not under the care of adult healthcare givers and they took charge of their healthcare needs themselves. They were also not a 'healthy group' who required only a limited healthcare programme of oral hygiene, de-worming, and vaccination of girls of reproductive age against tetanus (cf. MOH 1999a, 2001b, 2005), but were in fact actively engaged in quests for therapy for the various – and sometimes serious – illnesses they experienced.

Another dimension of vulnerability which could apply to children in healthcare comes from psychiatry, where vulnerability is said to exist to the extent that an individual defines a situation as stressful for him/herself and is unable to recruit effective coping mechanisms to remove or reduce the disturbance (Shuval 1980: 338). Wartime children were, however, able to survive despite their dire circumstances, and could deal with their daily challenges. Nonetheless, their survival strategies constituted insufficient and ineffective ways of coping and dealing with their problems, given their magnitude. To put it simply, wartime children were vulnerable because of the limited extent to which they engaged coping mechanisms in dealing with their daily challenges.

In general, the discourse on child vulnerability is adult centred. For instance, the 1989 UN Convention on the Rights of the Child views children as 'cultural minorities' whose rights to education are aimed at furthering their development, personality, talents, and mental and physical abilities to their fullest potential. Essentially children are viewed as not yet mature, and in the process of developing and acquiring culture, at risk and in need of protection. In mainstream anthropological literature, children were traditionally viewed as passive recipients of culture, being socialized by adults and not having a culture of their own. For example, such arguments place emphasis on cultural asymmetry, suggesting that vulnerable persons, including children, constitute the socially fragile, who lack agency and understanding of harmful settings and situations. Children should therefore be protected and their innocence preserved by adults until they are 'adults' themselves. Children are therefore viewed as appendages to adults and their behaviour is pitched to adult standards.

Vulnerability is also a common lexicon of development when poverty is addressed, and is mostly applied to the resource poor. This allows development planners to avoid

overusing the words 'poor' and 'poverty' (Chambers 1989: 4). With some precision, vulnerability is used to refer to 'vulnerable groups' such as pregnant women, children, the disabled, and disadvantaged racial categories (Chambers 1989: 1; Doyal & Pennell 1981: 1-47; Farmer 1999a: 47). The main focus is on defencelessness, insecurity, exposure to risk, and shocks and stress. Considerable evidence suggests that vulnerability is linked with deprivation, ill-health, and malnutrition. Different authors – including Chambers (1989: 1-8), Corbett (1989: 59-70) and Weiss (1989) – argue that vulnerability to sickness, and high economic costs to households due to ill health, make poor people poorer through delayed treatment, high costs of treatment, and loss of earnings. These scholars further point out that poor people are more exposed to sickness, pollution, infectious and vector-borne diseases, accidents at work, and malnourishment; further, that previous sickness tends to reduce resistance to disease and slows down recovery; and that the poor have less access to timely, effective treatment (Chambers 1989: 7; Corbett 1989: 59). Part of the solution, as suggested, is to inquire among poor people about what they want and need, and to strive to understand their conditions and how they cope. The answers will point to interventions, which will enable them to be better off on their own terms.

Addressing the gender issue, in wartime over 90% of casualties in contemporary wars are from the poorest sectors of society, and in general, women (girls) are more likely to be victims (Richters 1994: 40). Women/girls are also at a higher risk of HIV/AIDS because, among other factors, they often occupy the lowest economic echelons in most societies and in wartime are exposed to sexual violence.

Based on the assertions of the child vulnerability discourse, it is this study's contention that wartime children in child-headed households are indeed a vulnerable category. This is because they are likely to be defenceless, economically impoverished, socially deprived, and psychologically affected, among other variables which contribute to vulnerability. In children's lived experiences, vulnerability forms a vicious cycle involving deprivation of their adult kin, which subsequently causes their own deprivation. Further, due to an entire community's exposure to lack and abject poverty, there is an intergenerational cycle of lack, abject poverty, and misery. These factors have a direct influence on the health and healthcare possibilities of the children who participated in this study.

In sum, vulnerability is a multifaceted concept. It refers to risk, poverty, exclusion, immaturity, sickness and illness, exposure to infectious diseases and disasters, women and children, and passiveness in decision making. Consistent with this study's focus on children above five years, vulnerability will therefore be adopted to describe their lived experiences in armed conflict as victims, as the poorest among the poor, and as an excluded group who are lower in hierarchy relative to adults, as evident in adult centred systems including healthcare. In seeking children's own perspectives, however, I critique some parts of the 1989 UN Convention and conventional anthropologists' views about children as immature yet-to-be adults, without their own culture.

Child agency

Within this book children will be viewed as social actors exercising various forms of agency. Theorists of child agency currently approach children as social actors in their own right. It is also argued that childhood is a social and cultural construction, and children can be social actors with their own perceptions of the social world (Alderson 1995; Christensen 1990; Christensen & James 2000; Hardman 1973; James & Prout

1995; James, Jenks & Prout 1998; Prout & Christensen 1996; Van der Geest & Geissler 2003). Summerfield (1998: 8) argues that children are not just 'innocent' passive victims, but also active citizens whose values are connected to collective meanings and memories. Children are recognised in the UN Convention on the Rights of the Child (1989) as actors with values and perspectives. For instance, Article 12 of the Convention is explicit about the child's right to freely express his or her viewpoints in matters of concern to the child, and that, according to the child's age and maturity, those opinions must be taken into account in decisions made about the child[35].

Recognizing child agency is consistent with the international move towards studying children as social actors with the cognitive abilities to process their own experiences (James, Jenks & Prout 1998; Prout 2001; Prout & Christensen 1996). Scholars who view children as social actors therefore do ethnography with children to elicit their emic views, experiences, perceptions, and actions in the social and cultural world (Akello 2003; Alderson 1995; Christensen 1990; Hardman 1973: 89-99; Van der Geest 1996: 244).

Various forms of child agency – called replicational, transformative, relational, and transactional agency – have been coined for this study. They describe different ways in which children construct and shape their social relationships. Wartime children will also be viewed as active social actors exercising their power through 'weapons of the weak' strategies (Scott 1985: xvii).

Concerning replicational agency, children's dissemination and reframing of messages they receive from – among other sources – NGOs, will be analysed. For instance, the children in this study were frequently heard telling others about the importance of receiving counselling at Caritas and War Child. These messages, as will be explained, had been reframed and reinterpreted to suit their own level of communication so that, for example, what children talked about concerning the importance of counselling differed from what they practiced when confronting their suffering.

Relational agency will be used as a tool to analyse how children construct social networks, and in particular networks which are useful in dealing with daily challenges. For example, a substantial proportion of children indicated that child-to-child interactions were more useful to them than adult-to-child relations.

In transactional agency, children's quests for professional healthcare will be viewed as mediated by differential power relations. For instance, children's interactions in professional and non-professional healthcare contexts were in general shaped by their occupation of a lower social echelon than the healthcare givers.

Whereas transactional agency is used to analytically address children's disadvantaged position in social relations, transformative agency discourses assess children's perspectives in order to generate recommendations for emergency healthcare intervention, and school health re-programming for children above five years. In particular, such recommendations must be consistent with children's healthcare priorities and needs. Transformative agency should further be viewed in connection with non-responses to projects in wartime designed to promote children's emotional well-being. In short,

[35] Critically looking at the Convention, it is clear that for the age group represented in this book (8-16 years), there is an ultimate ambivalence concerning the right to expression and participation. Children are 'given' these rights with the right hand, but the left hand takes them away by asserting that children are 'immature' (cf. section on child vulnerability above). Therefore, this study will largely rely on scholars of child agency perspectives in studying children in their own right.

children's non-response to calls for counselling will be interpreted as similar to what James Scott, in his book W*eapons of the Weak: Everyday Forms of Resistance* (1985: xvi), calls 'foot dragging, feigned ignorance and weapons of the weak strategies'; as attempts to influence the re-design and implementation of appropriate and acceptable interventions, thereby *transforming* project designs. I use transforming here with caution since, as I elucidate in subsequent chapters, the functioning of humanitarian aid agencies is, in the main, guided by preset guidelines and rarely by the beneficiaries' perspectives, needs, and priorities.

Seeking to elicit children's points of view in the arena of health and healthcare is consistent with contemporary development discourse and planning which uses micro-to-macro level perspectives as opposed to macro-to-micro ones (Chambers 1989: 1-8; Katwikirize & Odong 2000; Lieten 2003: 10-18; Weiss 1988: 5-16, 2000; Weiss *et al*. 2000). Central to the process of drawing from micro-level perspectives in planning is the idea that many key project planners in the past century had only hazy ideas about beneficiaries' priorities, and were guilty of wasting resources on less successful ventures. The micro-to-macro level approach in project planning aims to avoid this pitfall through beneficiaries' participation, deriving development priorities through consultation, and using their viewpoints in project design (Chambers 1989: 6; Weiss 1988: 14). It has therefore been agreed that where donors' ideas override the needs of the beneficiaries, their present and future well-being may be jeopardized. Literature in the field of development economics further suggests that macro-economic planning has, in the past, allowed the introduction of projects which turned out to be expensive failures. Evidence shows that in some cases, projects even had a negative impact, such as an increase in women's workload, increase in wake-time, and a lack of sustainability (Chambers 1989; Oakley 1994; Weiss 1988). The need to elicit local level perspectives for project design became clear. According to Chambers (1989: 1), micro-level development involves modifying projects to fit local conditions through a decentralized analysis which encourages, permits, and acts on local concepts and priorities as defined by the poor people themselves.

Although the perspectives by Chambers (1994), Lieten (2003) and Weiss (2000) are donor community based and adult centred, their arguments are consistent with issues pertinent to this study: investigating wartime children's perspectives and emic views in order to generate recommendations for policy and planning for inclusive healthcare for children. It is proposed in this study that children can identify the 'common' illnesses that they experience, and I discuss how they deal with them themselves, according to their priorities. Premised on this participatory approach, recommendations will be made to child healthcare institutions, and a project will be designed which is empowering, and in which children have ownership (see Akello 2003; Chambers 1989: 8; Kalnins *et al*. 2002: 223; Lieten 2003).

It is one of this study's goals to introduce micro-level perspectives in planning for the healthcare needs of wartime children in child-headed households. It is likely that such a healthcare project will be more effective in directing income and budget allocation or expenditure towards priorities as identified by the children, and therefore it could be a successful and sustainable project. In a nutshell, by employing child agency within the theoretical framework, this study facilitates the identification of children's own perspectives and actions in health and healthcare, and the results can be utilized for the development of better healthcare for these children

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Political economy of health and healthcare

The theoretical orientation of political economy in healthcare has many overlaps with the child agency perspectives above. Essentially, scholars of the political economy of health and healthcare (Doyal & Pennell 1981: 1-47; Farmer 1999a: 80; Parker 2000: 419) argue that health, or lack of it, and the quality of healthcare accessed, is largely determined by social competition between groups of people in different economic classes and by the unequal distribution of resources. It is pointed out that problems in the field of healthcare in developing countries are often linked to social and economic inequality and poverty (Farmer 1999a; Parker 2000). These are interpreted as consequences of the penetration of a capitalist economy. Desjarlais *et al*. (1995: 19) point out that poverty takes a considerable toll on the well-being of its victims, as it creates the conditions for malnutrition, illness, social strife, political instability, and despair. Moreover, because poor people lack productive assets, they suffer from physical weakness, illnesses, and population pressures, and therefore poor people will always remain poor.

Poverty has also been documented as a contributing factor to people's high infection rates with HIV/AIDS, since people will engage in high risk behaviour such as prostitution as a source of livelihood (Farmer 1999a). Globally, poverty is the major risk factor for the transmission of AIDS and tuberculosis, as it is for most other forms of social suffering. An unjust distribution of disease and healthcare services characterises both the old and new world order, and the gap between the rich and poor is growing. Health gradients of premature mortality and excess morbidity separate rich from poor, both between and within societies (Farmer 1997a: 279; 2003). One of the unfortunate sequelae of identity politics has been the obscuring of structural violence, which metes out injuries of vastly different severity. It is possible to speak of extreme human suffering, and an inordinate share of this sort of pain is currently endured by those living in poverty (Farmer 1997a: 259).

The general trend revealed in the first phase of this study demonstrated that although Gulu district has two of the country's best healthcare centres, namely Gulu Independent hospital and Lacor Catholic hospital, no children above five years from child-headed households were observed, or had mentioned, seeking professional help there. This finding can be attributed to what Parker (2000) named structures of oppression, and Farmer (1999a, 2003) calls structural violence, whereby social inequality, injustice, and poverty (Farmer 1999a: 80) make wartime children in child-headed households a risk group in health and healthcare.

Since the adoption of structural adjustment policies and the malfunctioning of the national formal healthcare system in Uganda, a substantial proportion of healthcare givers have resorted to private practice. Further, it has been documented that there is a growing rate of private investment and trade in pharmaceuticals as commodities, and not as substances for healthcare (Bush & Hardon 1990; Hardon 1990, 1994; MOH 2001a; Van der Geest *et al*. 2002; Whyte 1998: 191; Whyte & Birungi 2000). The market-orientedness of the healthcare system, coupled with social inequality and poverty, are important contextual factors for this study's question of how wartime children in child-headed households are actors in the quest for therapy for the various illnesses from which they suffer.

Health seeking behaviour in a pluralistic healthcare system

Proponents of healthcare utilization models, including Kleinman (1980) and Good (1994), argue that variation in illness management is influenced by age, gender, and

differences in positions in the household, among other factors. The various pathway models available describe illness behaviour as a logical sequence of steps, starting with the definition and perception of symptoms to the use of different healthcare providers. Cultural and social factors are integrated into these models (Fiereman & Janzen 1992). Determinant models focus on a set of variables which explain health seeking behaviour and the choice of different forms of healthcare (Suchman 1965; Fabrega 1976; Fiereman & Janzen 1992; Igun 1979; Tiping & Segull 1995). These variables include: the recognition of and significance attached to the symptoms, the perceived seriousness of the illness, the persistence of the illness, the perceived cause, knowledge of illness remedies, and faith in the efficacy of medical care available; as well as economic factors such as the price of medicines, distance from healthcare services, costs in terms of time, and gaps in communication with healthcare providers. It is further acknowledged that therapeutic choice is the outcome of a hierarchical sequence of transactions, or of transactions that have taken place simultaneously (Fabrega 1976; Fiereman & Janzen 1992; Igun 1979; Tiping & Segull 1995; Unschuld 1986).

Tipping & Segull (1995: 31) provide a useful summary of the literature of healthcare seeking behaviour. They identify seven determinants, including socio-economic variables such as education levels, maternal occupation, marital status, and economic status; age and sex; healthcare costs; social status of women (Sergent 1989); type and severity of illness; patient and doctor relationships (Mechanic 1992); distance and physical access; and perceived quality of service provision. Importantly, all healthcare utilisation models so far developed are adult centred.

My own viewpoint follows Desjarlais *et al*. (1995: 255), who state that patients are pragmatists seeking results, and not purists seeking theory. The implicit reference to rationality in the health seeking model is far removed from the reality of lived experience, and the inherent desire or need to alleviate suffering in the case of an illness episode (see Good 1994: 56). While it is true that children's quests for therapy are influenced by the market economy, and other macro factors, I will show later the various complex dynamics in alleviating suffering. Ogden (1995: 1901) has also extensively critiqued the dominant healthcare seeking models by asserting that:

> (…) for instance, Tipping & Segull's conclusion that, therefore health seeking behaviour relates to the adequacy of household resources seems of an oversimplification given the evidence they themselves provide. It seems more likely that there is a wide range of variables affecting therapeutic decision-making. Being poor is probably an important factor, but inadequacy of resources is only one feature of poverty.

Turning to the issue of pluralism in healthcare, Kleinman (1980: 49-50) identifies that each society has a healthcare system consisting of three often overlapping sectors: the popular, professional, and folk sector. In their quest for therapy people may, depending on the illness, use all sectors in a sequence or simultaneously. In what follows, some general characteristics of a pluralistic healthcare system are described, as well as some specificities of the Acholi pluralistic medical system. The description is based on the literature as well on the findings of the first phase of this ethnographic study.

The popular sector of healthcare

In most countries, the popular sector is the largest healthcare sector, constituting a complex matrix over several levels: individual, family, social network, community beliefs, and activities. It is also in the lay, non-professional, non-specialist, popular culture arena where illness is first defined and healthcare activities initiated (Kleinman 1980). In

Uganda, including Gulu district, over 80% of illnesses are managed in this sector (Adome *et al*. 1996, 2000: 1-12; Birungi 1998: 1455-1460; Whyte 1998: 191-334), and over 90% of the therapies administered are pharmaceuticals.

Kleinman (1980: 53) regards the steps taken in dealing with disease and illness as being hierarchically ordered. These steps include perceiving and experiencing symptoms, labelling and evaluating the disease, the sanctioning of a particular kind of sick role (acute/infectious, chronic, impaired, medical, or psychiatric), deciding what to do and engaging in specific healthcare seeking behaviour, applying treatment, and evaluating the effect of self-treatment and therapy. In Gulu district, for common illnesses all the foregoing processes, including obtaining a remedy, occur within the popular sector, while the implicit hierarchy in steps taken is questionable. In reality, it is possible even to seek therapies before first determining disease aetiology, the options available, and all 'rationalities' involved. Noticeably, at the time of this study in Gulu, children in child-headed households independently sought therapies for common illnesses in the popular sector. For other illnesses, however, particularly chronic cases, patients including children are more likely to participate in all three over-lapping sectors in their search for a remedy and alleviation of their suffering.

The professional sector of healthcare

In Gulu district the biomedical sector is comprised of the organised healing profession. This sector consists of, for instance, the private profit making system such as Gulu Independent hospital, the missionary private non-profit healthcare system such as St. Mary's hospital in Lacor, and the state-funded hospital such as GRRH. The state also put in place sub-health units in each sub county, including Laliya, Laroo and Layibi health centres. However, the general trend during the study was for the state-aided health centres at all levels to be dilapidated, poorly staffed, and lacking most healthcare facilities, including pharmaceuticals. It was therefore common for individuals countrywide to seek healthcare in these centres only to be referred to the popular sector to purchase pharmaceuticals.

The situation in Gulu was also compounded by armed conflict. Apart from GRRH, which was partially functioning and highly dilapidated, other sub health units were virtually deserted in 2004, but re-opened in 2005. The regional referral hospital structures also functioned as areas of refuge and safety when the insurgency was at its peak. The units which were still partially functioning at this hospital were the maternity units for child deliveries and the paediatrics units where severe cases were admitted for treatment and close monitoring; severely malnourished children were admitted for feeding, and immunisation of under fives was carried out. The general wards where other patients were treated were virtually un-inhabitable buildings where admitted patients provided their own beds, food, and medicines. Occasionally, at the time of this study, GRRH received batches of pharmaceuticals and medical facilities such as syringes, cotton, and disinfectants, donation by charity organisations.

In general, it was the poor, including children from child-headed households, who constituted the highest proportion of patients visiting this district state-funded dilapidated government hospital. The middle class and the elite in Gulu largely resorted to the well facilitated Gulu independent hospital, St. Mary's hospital in Lacor, and other private providers for quality healthcare.

The folk sector

The folk sector is a small specialised sector in the healthcare system. Indigenous healers are the main healthcare providers in the folk sector, and in Gulu there were different categories of folk/indigenous healers. There were indigenous healers who have more knowledge about herbal remedies than the average individual, and as such were frequently consulted for specialist help. There were diviners, who in addition to administering herbal medicines also used the spirit media to diagnose, prescribe herbal remedies, and where necessary perform rituals in attempts to restore normality to their sick clients. Further, there are religious healers. I will come back to these three categories of indigenous healers at a later stage.

In general, during the study individuals consulted with indigenous healers for a variety of persistent and chronic ill health conditions, for all sorts of misfortune, and to mediate in reconciliation when inter-clan crimes had been committed. In one ceremony I observed in Pabbo displaced persons camp a wide range of rituals were conducted to ensure the well-being of an ex-combatant. It is to this sector that individuals who needed to alleviate suffering, and who had not been able to find effective care in the popular and biomedical sector, resorted. They may not find a cure, but it is believed that other aspects of healing for emotional suffering may be found in this sector.

Issues which were examined in this domain of inquiry other than this study's main objectives were, 1) whether children had other explanatory models for emotional distress and other forms of chronic illnesses and therapy quests; 2) how children situated themselves in the largely adult centred ceremonies; and 3) whether children did 'find healing' in this sector.

Apart from local indigenous healers, religious healing churches were on the increase in Gulu district. Next to the traditional religious churches of Protestants, Catholics, and a few Moslems, there were Pentecostals, Jehovah's Witnesses, and Charismatics. The Pentecostal churches and Charismatics from the Catholic Church were famous for their healing services, and for deliverance sessions for the spiritually oppressed and those seeking freedom from their suffering. My viewpoint is that the metaphors used in these churches, such as 'deliverance' and 'healing services', represent the role of religious healers in social, mental, or emotional healing. After extensive ethnographic study, I propose that religious healers can be considered folk healers because they use spirit media, supernatural powers, and invoke notions of divine powerful beings in their healing discourses. Perhaps their role borders the popular sector because regular attendants of healing services were taught that they are 'joint heirs' with Jesus Christ. Being a 'joint heir' is a characteristic intertwined with access to divine power, thereby enabling sick people to lay hands over themselves in case of any form of suffering and also to pray for other sick people to chase away *cen* (evil spirits), manifested as spirit possession in the popular sector. In subsequent chapters, I will show how religious healers' attempted to ensure mental and social healing among people who lived in the context of civil war.

Another group of healers were of Indian and Chinese origin, who came to Uganda as multinational traders in pharmaceuticals and other remedies. The Chinese and Indian traders also lived in Gulu municipality at the time of this study. In the first phase of this study I did not focus on them since no child explicitly mentioned seeking a remedy from them but they did mention that they used a variety of market drugs. In the second phase, I linked the services provided by the Chinese and Indian healers to the fact that children revealed using various market drugs including Action, Painex, Hedex, Malara-

lex, Vickskingo, and unspecified ointments, to mention a few examples. Indian and Chinese healers were major distributors of such pharmaceuticals and therapeutic herbal remedies.

In short, the complexity of the healthcare system has a role to play in influencing wartime children's quests for therapy. While the pharmaceuticals accessed in the popular sector for infectious diseases and easy-to-manage illness experiences were generally sufficient, for chronic illness experiences and complex emotional distress, sufferers also engaged in quests for therapy in the folk sector. In subsequent chapters, I will use empirical evidence as the basis for the suggestion that there are insufficiencies in the underlying assumptions focussing on rational choices in quests for well-being which are only influenced by factors such as disease aetiology, gender, social status in healthcare seeking behaviour model. There were also differences in individual wartime children's quests for therapy, which may be gender related.

Gender as a cross-cutting issue

Gender differences in children's illness experiences, and in how they were actors in their quests for therapy, will be addressed with the help of gender theories (Denzin 1997; Moore 1988; Ostergaard 1992; Richters 1994). Underlying these theories are explanations for differences in terms of power relations and symbolic constructions of femininity and masculinity. Women's (girls') experiences are different from those of men (boys), and therefore these differences should be the starting point for a more accurate representation of reality (Clough 1994: 74; Denzin 1997: 56; Richters 1994, 1998: 77-112). It is this study's contention that dominant gender differences in society are replicated in the power relations in child-headed households. This is because children live within these social relations, interact with them and even modify some of them according to the contexts in which they live.

Within households, there is gender inequity in terms of decision making and access to resources (Denzin 1997). The latter could affect treatment seeking by boys or girls, and the type and quality of healthcare received. Moreover, most gender theories were developed in household settings other than child-headed households (Moore 1988; Ostergaard 1992), and considered mainly adult behaviour. The question here is how gender discourses apply to wartime children, especially in regard to their illness experiences, quests for therapy, and differential access to healthcare.

Scholars who subscribe to gender theories spell out the unique experiences of women in wartime. It is demonstrated that women (girls) bear the greatest brunt of armed conflict due to their gender. They are often exposed to gender-based violence and rape (Richters 1994). Available reports show that although there is a significant reduction in HIV/AIDS prevalence rates in Uganda, in the war-torn areas of northern Uganda HIV/AIDS infection rates have increased (MOH 2001; UDHS 2003; UNICEF 2005). Recent statistics suggest that the prevalence of HIV in Uganda in general has declined significantly since 1995 from 18.5% to 6.2% in 2002, but in northern Uganda infections have increased. For example, HIV prevalence was lowest in Matany hospital in Moroto district at 0.7%, but was highest in Gulu district with an overall prevalence of 6.2% (MOH & STD/ACP 2003). This disparity has been attributed to the presence of the state military, which constituted the highest reserve of the HIV/AIDS virus, and also to the general breakdown of the social structure in the north, with a subsequent high pre-

valence of gender-based violence such as rape (MOH 2004; UDHS 2003; UNICEF 2005).[36]

Women (girls) in Uganda are at a higher risk of HIV infection than men due to biological, socio-cultural, and economic factors. Since unprotected sex is the main cause of HIV infection (MOH & STD/ACP 2003; MOH 2001b: 3; MOH 2004: 10), sexually related factors put women at higher risk of HIV infection. Studies show that there is increased pressure for young girls to engage in sex with older men as a survival strategy (MOH & STD/ACP 2003), and that poor women and girls are likely to engage in risky behaviour such as prostitution as a source of livelihood (Farmer 1999b; Schoepf 2003).

Refugee and internally displaced women are a high-risk group for HIV/AIDS due to the socio-economic and psychological breakdown of traditional family structures and support systems (MOH 2004: 14). What is not made explicit in the MOH reports is that with armed conflict there is an increase in sexual violence such as rape (See UNICEF 2005). Infection rates are more likely to increase among women and girls due to such crimes. With displacement also comes dire misery and abject poverty, and women as household providers have to forage for the food requirements. Evidence suggests that children who were commuting at night engaged in child prostitution (HURIFO 2002; UNICEF 2005). Results in this study also show girls' vulnerability to attacks, being waylaid, and experiencing various forms of gender-based violence, including rape and defilement. Although available literature above concerning women's asymmetrical exposure to HIV infection points to general problems such as lack of water, food, sanitation and poor housing, and with displacement as major issues, there had also been a breakdown of social networks, and the social structure including familial, legal, and kin relations in Gulu at the time of this study. Taking these factors into consideration, this study investigated the gender differences in children's experiences in wartime.

Research methods

Studies with children require the adoption of techniques particularly suitable for them. This study employed ethnographic methods suitable for investigating children's agency, perspectives, and daily experiences. Largely qualitative data collection techniques were employed in this study, the results of which were triangulated using a survey to assess children's perspectives on the common illnesses they experienced and their quests for therapy. What is more, a relatively different approach for the assessment of emotional distress, mainly based on children's emic views of stressors and extreme events in their daily life, were used. Concerning qualitative techniques, children were, in the main, asked indirect questions to elicit their emic views (Bernard 1988; Denzin 1997; Spradley 1979; Weiss 2000; Weiss *et al*. 2000). Details of the qualitative techniques used are given below.

Study population and case selection

The wartime children who participated in the study were:

[36] The terms prevalence and incidence, respectively, refer to the total number of cases of disease in a given population and the number of new cases over a specified period. Incidence implies the rate at which healthy people are being infected, while prevalence denotes the total cumulative disease burden on the population (MOH 2004: 7).

- Children aged 8-16 years[37] in child-headed households, who had lost their parents to armed conflict and HIV/AIDS, lived in resource poor suburbs of Gulu Municipality, spending nights in night commuters' shelters, and studying at displaced primary schools within Gulu municipality.
- Children identified through World Vision's HIV/AIDS programme for child-headed households, who were taking care of bed-ridden parent(s) living in villages and camps within a 5-7 km radius from Gulu municipality.
- Children (frequently boys) in child-headed households whose parents had rented cheap housing for them in Gulu Town to prevent their abduction. Children whose parents were unable to care for them because they were either maimed by landmines, disabled, or had drinking problems.
- Children and former child soldiers living in abject poverty. Abject poverty was included in addition to the four criteria above because there was a need to select a manageable (small number of study participants) or ethnographic sample and yet many children in Gulu municipality met the four criteria above. In addition, some children indicated having close kin who assisted them in various ways, including with material support, while others lived on their own with no support.

Twenty-four children, who met the above criteria, were requested to be study participants. Children were told about the length of the study, what was required of them, that they would be visited regularly to discuss their health complaints and quests for therapy, and that sometimes they would be called upon to be co-researchers. There was a deliberate attempt to include both boys and girls. All the children who participated in this study gave verbal consent and expressed willingness to participate in an extensive study involving frequent consultations, sometimes in their homes. These children showed their individual commitment through suggesting different activities, including workshops during weekends and end of semester activities. Although other children were invited for discussions, and participated in surveys and other qualitative techniques, twenty-four children participated actively throughout the entire phase of ethnographic fieldwork.

To ascertain whether the selected children were from child-headed households and met the four additional criteria in the study population selection, children were asked specific questions about their origin, whether they knew where their parents lived, whether their guardians took care of them, if they lived within the municipality or in camps, whether they spent nights in night commuters' shelters, how they came to live there, and for how long they had lived in a child-headed household. Children taking care of adult kin who were sickly due to HIV/AIDS were recruited into the study via World Vision food distribution points, which registered clients in its antiretroviral therapy (ART) programme. The World Vision district ART programme coordinator introduced six willing child participants to the researcher who also explained to them what the study was about and sought for their consent to participate in the ethnographic research.

Two more children from St Kizito Alero-Cuku disclosed during interviews that their parents were registered at Lacor Hospital for regular medicine collection. From children's description of their parent's health status and types of medicines they accessed

[37] No child had a birth certificate. The ages mentioned throughout this thesis are those which children told me. Cross verification was done with records at the displaced primary schools where children attended and the records at the World Vision projects for people with HIV/AIDS where registered parents also gave names of their children.

from Lacor hospital, and through interviews with the parents, I recruited them in the study. The parents of the two children were registered clients for ART at Lacor Hospital as part of the President's Emergency Plan for AIDS Relief (PEPFAR). The remaining eighteen children who extensively participated in this study were children who lived in child-headed households within Gulu town, orphans who spent nights in shelters and attended displaced primary schools.

Recruitment of children for extensive follow-up seemed a considerable and tedious exercise for the following reasons: 1) A substantial number of children, especially those who attended displaced primary schools and lived in night commuters' shelters, met all the four original criteria for participation in the study; 2) Owing to the profound need to include only a limited number of children for extensive follow-up, a substantial proportion was excluded, much as they met the study recruitment criteria. Hence, an additional criterion was added to the proposed four – indicated in the eight month paper submitted to the Amsterdam School for Social Science Research (see Akello 2005); 3) Only children who lived in abject poverty and barely accessed their daily basic needs, in addition to meeting the four criteria in sample selection stated in (Akello 2005) were recruited into the study. That is how twenty-four children were selected for intensive and extensive participation in the ethnographic research; 4) From the children selected, those excluded were siblings, and a number of children who 'knew' the common criteria NGOs employed when recruiting children for their projects. In order to investigate gender perspectives, both girls' and boys' illness experiences and quest for therapy were examined. As in any ethnographic study, willingness to participate was paramount. The children selected were of a minimum age of eight, a decision premised on child development psychology assertions that it is from age eight that children are able to interpret bodily changes, such as in the case of illnesses, and act upon them (APA 1990; Garmezy & Rutter 1985). As mentioned earlier, the upper age limit of sixteen years is consistent with both the national and international age brackets for children.

Data collection

Katwikirize & Odong (2000), Weiss (2000) and Weiss *et al*. (2000) suggest techniques for rapid appraisal which could be used to assess issues pertinent for communities, through their participation. Weiss (2000) recommends the use of rapid assessment procedures (RAP) to identify what the population perceives as their major problems or needs. Based on these priorities and available resources, NGOs and humanitarian agencies can select the issue(s) to address. Rapid assessment procedures essentially involve a participatory problem-solving process, where beneficiaries identify and rank problems, analyse priority problems and their root causes, rank potential solutions to address root causes, and subsequently develop a plan to address top ranking solutions (Katwikirize & Odong 2000; Weiss 2000; Weiss *et al*. 2000). For example, results from a RAP among displaced persons in Gulu district showed that *lweny* (insecurity) and congestion are the two problems of greatest concern for the camp population. The other priority problems were *kec* (hunger) – where the most vulnerable were disabled persons, widows or widowers, and orphans or child-headed families – and *two* (sickness), lack of land for cultivation, lack of drugs, and poverty (Weiss 2000). In addition to first hand data collection techniques used to elicit wartime boys' and girls' emic views, this study benefited from existing studies by various researchers in Gulu which have extensively assessed psychosocial distress in children. Key informants were also interviewed to explore their viewpoints about what children identified as healthcare issues and to assess

their perspectives in provision of healthcare services to children living in context of war. Nevertheless, children's perspectives were central to this study. Listed below are the specifically adapted techniques which I used for eliciting children's perspectives during data collection.

Qualitative techniques

Typical day: Children were requested to list their daily activities, the challenges they face in performing them, and the ways they deal with these challenges. As well as being an entry point and facilitating rapport, this technique was vital in gaining insight into the different activities that the children were engaged in, what their priorities were, extra-ordinary events linked directly to the civil war, and also in finding out how they themselves were actors in illness experiences, how they dealt with difficult circumstances, and how they situated themselves and their agency in different contexts.

Drawing: Children, regardless of age, were interested in diagrammatically illustrating their illness experiences and the medicines they used in both the first and second phase of this study. One hundred and fifty children illustrated common illness experiences and medicines used within a one month recall. Drawing was a useful technique, much as it presented difficulties such as the children's constant consulting with the author about how to illustrate 'persistent headaches' and 'stomach aches'. Nevertheless, this technique was used not only as an entry point but also as an avenue for illness experience categorizations, and for formulating questions for in-depth interviews and vignettes.

Time lines: This technique assessed children's life histories. Here, children were explicitly asked to name pleasant and unpleasant experiences in their lives, from early childhood in a 'time line' representation. Through this procedure I identified what the children considered as important life experiences. The time line was also used to facilitate a two week or one month recall of illnesses experienced and medicines used. Children were also requested to show other coping[38] strategies in the illustrations of time lines.

Venn diagrams: In the Venn diagrams exercise, a child represented him/herself as a central person surrounded by close kin, siblings, and any other social networks they perceived as important. This technique was used to investigate how children used their agency, and also to discover other strategies they employed in order to confront different problems in extreme living conditions, and within an adult centred healthcare system. The activity facilitated insight into children's social networks, community perspectives, and the various challenges that the community confronted together with the children. Other insights obtained were pertinent to the children's perceived enemies, how they negotiated difficult relationships, and also how child-to-child interactions were useful compared to child-to-adult interactions in dealing with daily life challenges.

Free listing and pile sorts: This approach was vital in eliciting and ranking the common illnesses and emotional problems that the children experienced. For example, children were individually and in groups asked to name 'common' illnesses they experienced within a one month recall, and to rank them by severity. Concerning emotional suffering, children identified the core problem, likely causes, and possible solutions. A similar exercise was administered to assess commonly used medicines and other coping strategies. After the lists were compiled, the children 'prioritised' them by sorting them

[38] Coping is used to imply all activities which children in wartime did to minimise their suffering.

into a hierarchy of importance. Free listing and pile sorts were vital in assessing the severity of infectious diseases, psychosocial suffering in wartime, and children's immediate needs and priorities.

Narratives of illness experiences and quests for therapy within a two week or one month recall: This technique was used to investigate the commonness of different illnesses, and how children dealt with them themselves. Narratives are systematic stories, sometimes written, through which children talk about their illness experiences. In such stories, the thematic areas explored in-depth included: how children knew they were ill, when they determined its severity, what steps they took in seeking therapies, where they got the medicines, and how they met the healthcare expenses and user charges. In the first phase of this study, the children wrote narrative compositions; in the second phase of ethnography, over 400 children wrote compositions or told me stories about recent illness experiences and procedures taken to ensure well-being.

Specific questions: In assessing some issues – including the particular emphases in healthcare policies and planning for children above five years, children's experiences in the context of armed conflict, and activities in daily life to ensure their well-being (such as income generating activities) – children were asked specific questions. For instance, I wanted to know how they perceived the de-worming project, oral hygiene, and tetanus immunizations for girls of reproductive age. Further, I investigated what health or ill health is, according to the children, and asked what they would like to see in emergency aid interventions geared towards ensuring their well-being.

Life histories: This technique was adapted to triangulate the 'time lines' method. Children's past experiences were extensively investigated through selecting specific timeframes; for instance, when the conflict was at its peak, what were individual children's experiences? Underlying the collection of life experiences or life histories, my objective was to establish typical and major experiences in a person's life and to show how large scale processes of socio-cultural change act out in local contexts (Schoepf 1992: 261). Since this study's main focus was to assess how, for all illnesses the children experienced, they were engaged in quests for therapy, the life histories allowed me to discover issues pertinent to different types of illness experiences, especially in the emotional category. I was able to understand how the children determined the severity of their illness experiences, where medication was sought – and if costs were involved, how they got these fees – and for chronic and emotional suffering, what were children's coping mechanisms in alleviating suffering.

Vignettes: Vignettes were a vital entry point for investigating children's illness experiences and emotional suffering. Using children's own narratives, diagrammatic illustrations, and other findings obtained through interacting with the children, vignettes were written and orally presented to different groups of between seven and twelve children, sometimes including both boys and girls for the discussion. Since Acholi was the most commonly used language, the vignettes were translated into Acholi. Questions were then asked in line with the 'experience of the person in the vignette', particularly whether the children had had similar experiences, and if so, how they dealt with them. Further, in order to elicit emic views concerning sensitive life experiences, such as gender-based violence, the researcher used 'typical stories' in the third person in order to facilitate discussions on these topics. In the process, the author requested the children to give examples about issues of gender-based violence and rape. They were specifically asked whether they personally had witnessed, heard about, or were perpetrators, and whether they or their friends were victims. Where the children had heard about such

events, they were requested to discuss such scenes, giving examples. Such discussions shed light into differential gender experiences, and the problems which boys and girls of primary school age confronted. Subsequently, I was able to gain insight concerning gendered life experiences in armed conflict.

Other issues were also raised by the vignettes, such as the 'life stories' of a child who had different illnesses such as malaria and diarrhoea, and the medicines used for these illnesses. Children were then asked questions, for instance, how would they advise the child in the vignette? They were asked if they had had similar experiences to the child in the vignette, what medicines they used for different illness episodes, and if they did not use any medicines, what factors constrained them from accessing these medications. What recommendations do they have for healthcare providers, and what advice would they give to the person in the vignettes?

Further, vignettes were used when the author investigated the experiences and daily lives of a group of children aged eight to sixteen years, and how they dealt with their daily life problems in the context of displacement, abject poverty, and misery.

Structured and unstructured in-depth interviews: Structured in-depth interviews involved an extensive discussion about particular thematic issues. For instance, after an examination of medical records, children were requested for an in-depth interview in which their illness experiences were discussed in detail. Frequently, there were also study themes specific to individual children. For example, former child soldiers needed numerous and in-depth interactions in order to investigate their life world, their challenges, and how they dealt with them.

I used unstructured interviews when following the children during their day to day activities, for example during tea breaks, meals, and weekend meetings. Other ideal places for unstructured interviews were at the children's homes and on our numerous journeys to visit NGO premises to find out about their activities geared towards alleviating children's suffering. Authors, including Hammel (1990) and Price & Hawkins (2002: 1334) underscore the importance of gossip in finding out about social dynamics, which this method is particularly good at eliciting.

In general, the most informal emic views and data were obtained through unstructured interviews. For instance, the topics which the individual children and NGO staff talked about at length provided insights into their social contexts, their values, relationships of power, and the vested interests that operate 'under the surface'. It was during unstructured interviews that some children even acknowledged that they did not use medicines for such illnesses as cough and flu – much as they had frequently mentioned various medicines for them – unless the symptoms were persistent and severe. Frequent disturbances by *cen* (evil spirits), and the use of *atika* (Labiate species) plants and medicines for sleep, were overt components of unstructured and in-depth interviews. This ethnographic research therefore embraced and analysed in-depth or unstructured interviews as an essential component of ethnographic data collection.

Examining medical records: Persons visiting any government aided healthcare centre in Gulu were required to present an exercise book to the health professionals for record purposes, and writing a diagnosis. This was a vital source of information regarding the children's health problems. Regular examination of these medical records was done at GRRH, Layibi, Laliya, and Laroo outpatients' health units. During frequent visits to the children's homes, discussions of recent illnesses were validated by examining their medical records. In general, it was largely infectious diseases which were recorded in these books, usually malaria.

As indicated above, in-depth interviews would frequently be conducted following an examination of such medical diagnoses, in order to analyse wartime children's experiences. Further, through participant observation in various state-aided and private healthcare units, insights were obtained concerning contemporary medical practice, child-doctor interactions, and the medications the children used most frequently for these illnesses.

Participant observation and 'following the children around': This study adopted the phrase 'following the children around' in order to show the extensiveness and intensiveness of the interactions with the children in child-headed households. In essence, for the twenty-four children who were willing to participate in the study, there were numerous meetings and interviews aimed at gathering their life experiences in armed conflict, finding out what they did when they were sick, what medicines they used, where and how they got these medicines, and if they were buying them, where and how they got the money. The researcher engaged with the children in their daily life activities to assess how they were actors in managing illnesses and their quest for therapies. Through regular visits to a psychotherapist and psychiatrist, I also participated in the available interventions addressing the effects of experiencing traumatic events.

Focus group discussions: Bernard (2002: 228) and Morgan (1997) recommend having six to twelve members per focus group discussion, plus a moderator. Between seven and eight people is a popular size. Bernard further asserts that if a group is too small, it can be dominated by one or two loudmouths. In a substantial number of discussions, groups of between seven and twelve children were involved in analysing various themes in this study's problematic. Central to these discussions were children's participation, both as co-researchers and facilitators of focus group discussions.

The children had to be willing to take on these special roles, which included interviewing other children recruited in the study. Willingness to participate was one criteria, but I was also interested in their skills in asking questions, being articulate and group-oriented, and whether they had some basic knowledge of the study's problematic. If the child fulfilled these criteria, they were invited to join to facilitate peer group studies (see Price & Hawkins 2002: 1334). Price & Hawkins (2002) also demonstrate the importance of using peer researchers as key informants, who are strategically placed by virtue of their membership and understanding of the communities in which the research is undertaken.

Workshops: Regular group discussion sessions – also called workshops – were organised for twenty to fifty children, especially during the weekends and at the end of the semester. Five of these workshops assessed severe experiences in wartime, and medicine use. Three sessions addressed the commonness of infectious diseases, and how individual children dealt with such episodes. In one workshop children represented diagrammatically what they regarded as extreme, horrific, and unbearable events in wartime.

Participant observation in Non Governmental Organisations' (NGO) functioning, and making written requests to NGOs: I investigated NGO dynamics through participant observation in workshops, sensitisation seminars, and counselling activities organized by NGOs for 'beneficiaries'. One other key technique to assess NGO functioning was making written requests for major NGOs to intervene to ensure the well-being of a select number of children in child-headed households. Other data given are from secondary sources including NGO publications and reports.

Collecting and presenting children's pharmaceuticals to paediatricians and pharmacists: Children were observed in the activities related to their quests for therapy, including at various pharmaceutical distribution centres such as drug shops, groceries, and pharmacies. Children also named and represented diagrammatically their pharmaceuticals, and brought the pharmaceuticals they commonly used for presentation to workshops on medicine use. Each of these samples were collected and presented to specialists in the disciplines of pharmacy and biomedicine to identify their active ingredients. A list of the various pharmaceuticals and active ingredients are given in Appendix 3.

Collection and presenting of children's herbal medicines to Makerere University's Botany herbarium for identification: Each of the different plant species presented by children in workshops on medicine use, during home visits, and when discussing particular illness episodes were collected and presented to specialists for identification, and the scientific names of plants were obtained. Some indigenous species were, however, not identified, and therefore when reference is made to their medicinal properties, the *Acholi* name is used. Some scientific names of identified species are presented in the Appendix Eight to facilitate the reader's grasp of the plant types.

Participation in NGO and healthcare institution activities: Another approach by which emotional issues were assessed was through collaboration with the psychiatric unit at Gulu Regional Referral Hospital (GRRH), and with NGOs, including the World Vision Centre for Formerly Abducted Children (WVCFAC), Caritas, Gulu Support the Children Organization (GUSCO), Noah's Ark, and Save the Children in Uganda (SCiU). These were key organizations which had projects addressing trauma and psychosocial issues in wartime children and former child soldiers.

Quantitative techniques

A survey on common illnesses and medicine use: One hundred and sixty-five children of whom eighty eight were boys and seventy seven were girls responded to questions about the illness experiences or health complaints which affected them within a two weeks to a one month recall, and about the medicines they used. The sample of 165 children was purposively selected basing on criteria for sample selection above and children's willingness to participate. In addition, the context of insecurity due to war meant that the study population was highly mobile, there were no records for reference and some children (especially former child soldiers) were not willing to share their experiences with researchers. Nevertheless, representativeness of this sample calculated at 95% confidence interval (i.e. CI at 95% = 1.39-1.54) suggests a normal distribution by gender (see Table 4.1.below for more details). Questionnaires were self administered, but in the main a substantial proportion of children in night commuters' shelters and displaced primary schools needed help in answering the questions, for instance in writing the name of illnesses and medicines used.

While different techniques were used where appropriate, the core of this ethnography lies in in-depth interaction with wartime children. This facilitated the author in gaining insights through experience-near discussions, sampling by time (see below), and documenting realities in their lives, and not merely offering information which they imagined the author would be interested in. Gender disaggregated data was collected by involving both boys and girls throughout the entire study, in all the activities above.

Clearly there are techniques which are more suitable for assessing variables in common illness experiences, such as experiences with infectious diseases and quests for

therapy, than for studying emotional distress. However, a considerable number of the above techniques were crosscutting both areas. What is more, a lot has been done in assessing post traumatic stress disorders in children in Gulu, and this study drew from such top-down assessments of psychosocial distress in war affected children.

Validity, reliability, and generalization

The study population constituted children aged eight to sixteen years living in child-headed households, and those taking care of close kin sickly due to HIV/AIDS. Child-headed households are a growing phenomenon in Uganda, and in Africa in general. Data yielded from this study is therefore potentially generalisable for a substantial proportion of the child population in Sub-Saharan Africa. Reliability, essentially, is the idea that the method used to assess a concept measures it accurately and gives the same answer each time it is used (Fielding & Gilbert 2002: 11). Reliability therefore concerns consistency. Validity's concern, on the other hand, is the extent to which a method used to measure a concept does it *accurately*.

The findings generated by this study of wartime children's illness experiences as lived experience, using ethnographic methods, are not only valid but also reliable. Different methods of data collection were used, including surveys triangulated with narratives, participant observation, focus group discussions, and vignettes, while gathering the perspectives of key informants and available records facilitated validity. Sampling by time was another technique employed in order to increase the validity and reliability of data collected. Here, respondents were observed in different situations – both in terms of setting and timing – in order to holistically assess their daily life activities. The meanings of these activities, and why they engaged in them, were subsequently established through in-depth interviews. Becker (1998: 119-121) gives advice on how to increase the validity of findings by looking for 'excluded' or 'atypical' cases in data collection. Such excluded cases in this study included children living in normal households, children living with chronic illnesses, and former child soldiers. Their particular perspectives regarding the different meanings of healthcare issues were assessed, including common illnesses and medicine use, trauma, and the medicalisation of psychosocial ill health conditions. Moreover, excluded cases or atypical cases frequently provided insights which the general respondent population did not provide.

Studying with children generated questions of reliability regarding their perspectives, since their *emic* views were frequently different from dominant or existing viewpoints. In such cases, children's perspectives were documented as belonging to a cultural group distinct from that of adults. Throughout the text, and in the discussion of results, children's perspectives are presented and some of their ideas compared to dominant discourses, particularly those of adults and documented literature.

Key informants

Two psychiatrists, five nurses, two paediatricians, seven NGO coordinators, fifteen counsellors, twenty-eight primary school teachers, five primary school head teachers of wartime primary schools, four camp leaders, and thirteen drug shop and clinic owners were regularly interviewed to assess their perspectives on children's healthcare needs and priorities. Parents and legal guardians were also interviewed to assess their perspectives about children's healthcare priorities.

Data analysis

Qualitative data collected was analysed by first transcribing the interviews, and then categorising them; categories consistent with this study's problematic were selected either for quotes or for frequent use within this thesis. In attempting to maximize the voices of the children, direct translations and the proximal meanings of phrases are given, where possible, and every attempt was made to present the children's perspectives as they themselves would like them represented. In particular, some children's narratives and written illness experiences were adapted and presented verbatim.

- Case analysis

Children's illness narratives and quest for therapy were categorized into 'typical cases' and 'atypical cases'. 'Typical case' narratives were used as 'synecdoche' (see Becker 1998: 67-68) or as representative illness narratives for wartime children in child-headed households. In this thesis, the prologue and selected compositions and excerpts from children's discussions provide such synecdoche cases. In contrast, 'atypical cases or narratives' represent experiences which could be less representative for the study population. These atypical narratives were used in analyses for the triangulation of results. Adapting typical and atypical narratives facilitated a holistic representation of wartime children's experiences and quests for therapy.

- Survey data analysis

Statistical Package and Service Solutions (SPSS) is a well known computer software programme for the analysis of social science data. SPSS version 9.0 was used for this study. In the survey with one hundred and sixty five children, the questions in the semi-structured questionnaire which I issued were open ended, requiring multiple responses. Therefore, in data analysis I took a multiple response analysis approach. The 165 self-administered questionnaires were coded and fed into an SPSS spread sheet, prior to the computation of results. Some of the statistical summaries and P-values are presented as quantitative data and analytical categories of quantitative data in subsequent chapters.

Ethical considerations

The study was approved by the Uganda National Council for Science and Technology. The Resident District Commissioner of Gulu district, the Chief Administrative Officer, the District Director of Health Services (or District Health Officer as the position holder was renamed in late 2007), school head teachers, and NGOs that provided services to war affected children in Gulu district, provided additional permission to conduct this research.

Wartime children were approached as social actors for this study. Permission was sought from each of them to participate in the ethnographic research. Children who accepted to participate in the study were given the option to commit themselves to regular interviews and home visits. The twenty-four children who were extensively involved in the study were told of the purpose of the study, the length of the study, and what was required of them, and they gave verbal consent to participate in the study. Children who were not willing to participate in the study either due to their demands for money before they share their experiences or individual attributes such as shyness were excluded. Some child soldiers were particularly reluctant to share any of their experi-

ences either with researchers or counsellors. When all efforts to discuss with them failed, I focussed on ex-combatants who were willing to participate in the study.

It is also important to note that the legal framework in which this study was conducted regards individuals below sixteen years as cultural minorities and that the adult caretaker would be approached on behalf of children or for the adult to provide permission to participate in the study. Where possible, the adult caretakers or adults children regularly interacted with, were approached to seek their permission for children's participation in the study. What I need to emphasise however, is that children who lived in child-headed households were independent actors and this study generally approached children as social actors. Institutional managers such as school teachers and NGO coordinators of night commuters' shelters mentioned above were consulted about children's participation in this study and they provided additional legal consent.

Children who shared with me their severe experiences in wartime were referred to the regional psychiatrist and psychologists for review and counselling. Although I organised this myself, I am ambivalent about the existing approaches to help children relieve their distress at the time of the study. On one hand children identified and prioritised differently how their distresses could be minimised. On the other hand it was an *ethical requirement* in assessment of psychosocial distress that any child who named having suicidal thoughts or having recently been exposed to extreme events should be immediately referred to professional counsellors. Moreover, I did not believe that medical anthropology, like other social science disciplines, had a firm enough foundation or knowledge base to refute the preset procedures of science especially in assessment of mental distress. Perhaps results from medical anthropological data could complement assessment and management approaches of wartime mental distress.

All the one hundred and sixty five children who participated in the general survey and the additional 24 children who were followed about during ethnographic research process were requested to participate in a study about their common illness experiences. All the children gave verbal consent.

Examining life histories and narratives in the context of armed conflict was quite a delicate issue. Children were assured of anonymity and confidentiality, and interviews were only tape recorded if respondents granted permission to the author. Nevertheless, throughout my analyses I have used the children's real second names, first to place them in the northern Uganda locality, and secondly, these second names are not specific to the children, but rather they are names commonly used by Acholi people. Occasionally, however, I refer to individuals also by their first name, since a specific request was made and they consented to my using their two names.

A summary of some general information and life experiences of the twenty-four children who extensively participated in the study are provided as an Appendix One in this thesis. I have chosen to use pseudo first names and their correct second names when giving such biographical information, to ensure anonymity. Use of only first or second names for this particular group would not suffice since there are children who participated in this study with similar second names.

My personal involvement in the study

My personal involvement in this study should not be left unmentioned. Consciously or unconsciously, it has influenced the way I approached the field of study, the way I interacted with informants, and the analysis of my data [see Akello (2007) for further ana-

lyses of the intersubjectivity issue]. Throughout the discussion I acknowledge the importance of intersubjectivity and detachment in my research. In this section I will provide some biographical information to suggest how I view myself as an insider with proximal interpersonal subjectivitivies with wartime children.

I have historical and symbolic attachments to Gulu district in northern Uganda where this study was conducted. I speak Acholi, and also conducted research in the same district in 1999 in Pabbo camp, 27 km west of Gulu Municipality. More importantly, however, part of my childhood experiences as an orphan[39] living in abject poverty, and at the time of this study, my experience of taking care of a close kin member sickly with HIV/AIDS, take centre stage in my intersubjectivity and shared subjectivities with wartime children. With my childhood experiences, I can fully relate to living in a poor, fetid environment, I know how these are core predisposing factors to preventable and curable infectious diseases, and I have experienced hunger due to lack of food and lack of basic necessities. I am aware of the emotional suffering which comes from losing my father at an early age. These are often expressed in somatic symptoms such as persistent headaches and the feeling of something invisible moving around my body causing a lot of pain and suffering. In essence, by recognising my shared experiences with wartime children, and employing intersubjectivity as an analytical tool, I show how wartime children and I drew from shared subjectivities to compose the stories told in this thesis. Ultimately, I make it explicit that the research process has also been relevant for my own therapy.

Another essential objective of this section is to demonstrate the importance of the researcher being his/her own research instrument in introspective research, to facilitate the collection of concrete and valid data. In short, whereas studying a culture close to the researcher's means that one understands most of the issues, I am conscious that the closeness might mean that one neglects some aspects of the culture. This study's strength lies in the researcher's ability to understand the issues at stake.

[39] In Uganda, an individual is an orphan after loss of one or both parents. This is slightly different from the Western context where being an orphan entails losing both parents.

PART II

MICRO-LEVEL SETTING IN WHICH WARTIME CHILDREN LIVED

After my description of the macro context of war in northern Uganda in Chapter 1 and the study's methodology in Chapter 2, I now move on to a description of the micro-level setting in which the children who participated in my study lived, both in institutional and informal settings. The aim of this section, which consists of only one chapter, is to serve as a bridge to Part III where the children's illness experiences and quests for therapy will be analyzed.

An understanding of the institutional context of the children's lives has been derived through an examination of the ways in which major multi-layered issues in the context of civil war become institutionalized through structures put in place to ensure the wellbeing of war affected people. For example, the problem of insecurity in camps and villages was addressed by the creation of night commuters' shelters, to nightly host people-mainly children severely affected by the war. I also sought insights into wartime children's social lives, particularly regarding what they considered to be their daily challenges, their predisposition to the dangers of armed conflict, and their coping mechanisms. Part II will also demonstrate how the activities and operations of emergency aid institutions, aimed at alleviating children's suffering, had the double impact of both minimizing their suffering and creating even more complex forms of suffering.

3

Social lives of primary school age children in Gulu Municipality

This chapter presents an experience-near discussion of the social lives of primary school age children in child headed households, living in Gulu Municipality at the time of the study. It is an experience-near account because it describes the proximal realities of children's daily life. Such a discussion is special because the analysis of these contextual issues has its basis in an intersubjective understanding of children's life worlds, and therefore the content of this chapter should provide the reader with insights into children's daily lives during armed conflict in northern Uganda.

The main purpose of this chapter is to show the micro-context in which the study population was embedded, and also to reveal how the wider context of armed conflict manifested itself differently at the micro-level. This is then linked to the illness experiences with which the children themselves were confronted. In order to facilitate the reader's grasp of children's lived experiences, information about the children's social lives is given, arranged into particular themes. Such themes include the phenomenon of night commuters' shelters, displaced primary schools, churches, children's housing, and their social networks. The themes were selected to facilitate a coherent presentation of the facts about children's social lives in institutional and informal settings, however I must mention that there are no strict boundaries between what constitutes institutional/formal and informal settings.

Although this chapter is mainly based on the experiences of the twenty-four children who were recruited for extensive study – and whose life experiences is provided in Appendix 1 – this discussion also draws from information obtained from other children in Gulu district. Further, empirical evidence from key informants is provided to give an

impression of contemporary discourses in the task of alleviating the suffering of vulnerable people affected by armed conflict, especially children.

This chapter is organized in such a way that what constitutes children's life worlds as mediated by institutional settings will be presented first. Following that I will shed light on children's social lives at home, their typical days, and times spent in general informal settings. The rationale for this basic order is that at the time of this study, children spent much of their time in institutions, compared to other settings, and further that contemporary interventions frequently exhibited a unique pattern in which even socio-economic issues became institutionalized, an issue to which I now turn.

Night commuters' shelters

In a phenomenon widely known as night commuting, every evening an estimated 40,000 children walk for miles from their villages to neighbouring towns in search of shelter and safety from LRA attacks (FP 2006; Allen 2006: 54).[1] A survey by Falk *et al*. (2004) in April 2004 of eleven night commuter sites in Gulu town found almost 20,000 children. The numbers varied according to how recent the attack had been. Figures from Lacor hospital show a rise from 3,000 in December 2003 to 6,000 in March 2004.

Noah's Ark night commuters' shelter was one of the first and main shelters which existed during the period of fieldwork in 2004. Its coordinator, stated that the organisation's main objective was to promote moral development and encourage peace building. Although most of its activities took place in the central districts of Uganda such as Kampala, in Gulu it was known for its provision of shelter to wartime children aged between four and seventeen years. According to the coordinator of one other night commuters' shelter:

> (…) in 2002 when the insurgency was at its peak, there was a desperate need for a shelter structure for the children who commuted to the safer Gulu Town. Such children spent nights in bus parks, shop verandas, church premises and other public places where they felt safe and could be warm. These children were, however, often taken advantage of and attacked, even by other residents in Gulu Town. For instance, bicycle men took advantage of the girls through promises to provide more comfortable accommodation. Petty thieves also sometimes took some of the children's belongings such as blankets. After carrying out a needs assessment, I designed a project for a night commuters' shelter which was readily approved by donors. (Night commuter centre coordinator, during interviews in July 2004)

During the first phase of this research (July to December 2004) three hundred children regularly spent nights at Noah's Ark shelter also called *baghdad*. However, when rebel activities such as the abduction, maiming, and killing of civilians intensified, the shelter hosted up to four thousand children. "Some children will even be sleeping outside the tents when rebels begin attacks", disclosed the centre manager during an interview in August 2004. Prior to the establishment of the shelter, the centre staff registered orphans who commuted to Gulu Municipality for safety in the evenings, especially

[1] This statement is open to criticism since it portrays a very simple statistic, with the figure of 40,000 children lying at the upper limit of attendances of night commuters' shelters. This figure was especially applicable in 2002 and mid 2004, when insurgencies were at their peak, however when there was relative stability, the number of attendees at night commuters' shelters drastically declined. Such high figures have been known to be used by organisations seeking donations for the 'vulnerable children', who actually rarely accessed such funds. Nevertheless, it gives an impression of how, when the security situation deteriorates, there are a significant number of night commuters.

those children without adult caretakers. Although some children had parents in camps, such as in Palenga, Awer, Laliya, and Unyama, the parents would often send their children alone to the municipality every evening to ensure their safety from the abductions that were frequent in the camps. Nevertheless, records suggest that over 95% of the children who spent nights at the Noah's Ark shelter were orphans.

According to Noah's Ark's coordinator, the shelter was established to put an end to the problems associated with people fleeing insecure camps and attacks within Gulu Municipality, and to ensure that children were safe. In addition to providing a safe place for children to spend the night, counsellors were employed to tell children stories, pastors were regularly invited to counsel children, and children were encouraged to engage in music and drama activities to promote their mental wellbeing. It was such creative activities that attracted emergency aid funding, especially from NGOs focusing on promoting the psychosocial wellbeing of vulnerable children, which included War Child, Save the Children in Uganda, Gulu Support the Children Organization (GUSCO), UNICEF, World Vision, Médecins sans Frontières (MSF), and the Norwegian Refugee Council (NRC). As their contribution, Gulu's municipal Anglican Church (also called Christ Church) agreed that the children could use one of its structures, which was previously a conference hall, under Noah's Ark management. UNICEF donated tents, and other NGOs constructed bathrooms and pit latrines. The Madhvani group of companies donated portable toilets which were, however, never used due to difficulties in maintaining hygiene and disposing of waste.

With increasing numbers of children spending their nights at night commuters' shelters, more shelters were put in place. For example, Lacor Hospital, with funding from MSF, created a night commuters' shelter and employed psychosocial counsellors to facilitate children in processing the memories of traumatic events. Ojok – the boy whose case was used in the Prologue – lived with his siblings at Lacor night commuter's shelter during the first ethnographic phase of this study, in July-December 2004. Gulu Regional Referral Hospital also provided a night commuters' shelter by erecting two tents close to a dilapidated unit where patients bed-ridden with tuberculosis were admitted, and the Holy Rosary Catholic Church put in place structures where vulnerable children could go at dusk to spend the night. At the district water processing centre, more tents were erected to ensure the safety of children and adults who fled their villages due to insurgency. The overcrowding and temporary nature of many of the night commuters' shelters facilitated an epidemic of scabies during the first phase of research. Scabies is a highly contagious skin infection directly linked to over-crowding, poor hygiene, and the sharing of basic necessities such as blankets, washing utensils, and sleeping mats. Night commuters' shelters offered such opportunistic conditions.

For instance, at Noah's Ark, which hosted up to 3,600 or 4,000 children in July-December 2004, there were but a few structures where large worn out polythene mats were spread out in the evenings and which beneficiaries shared along with the few available blankets. Bathrooms, washing utensils, and all facilities were shared by everyone who spent nights there.

In 2005, and more precisely in the months of July-December, much as there was relative peace and stability in northern Uganda, there were even more night commuters' shelters put in place. Children referred to all these night commuters' shelters as *baghdad.* Save the Children in Uganda, through its partner Rural Focus in Uganda (RUFO), had established another night commuters' shelter neighbouring Noah's Ark to the west,

Box 3.1 Structure of Noah's Ark

At Noah's Ark night commuters' shelter, located at Kaunda grounds, there were nine tents where children came in the evenings for safety, and two brick and steel structures where younger children below nine years were accommodated. All these structures were enclosed by a barbed wire fence. Very close to the gate was a container-like structure which functioned as an office for the centre manager by day and a clinic at night. Although one of the permanent structures was intended to be used as a library and a venue where school children could do their class work, it was used instead as a dormitory for younger boys below nine years. It was here that they spent their nights on polythene bags, and where one unhygienic blanket provided by the shelter was shared by at least four children. Girls spent the nights in three tents in the upper section of the enclosure, and the younger girls below nine years sheltered in the larger permanent building donated by Christ Church to Noah's Ark. The tents were provided jointly by UNICEF and MSF, and the portable toilets and one permanent structure for bathing, located between the boys' and girls' tents, were donated by the Madhivan Group of companies.

One would quickly sense the stench in these dormitories, tents, and pit latrines. Over use, filth, and poor hygiene in every facility at the shelter is a mild way of describing the situation, and although four cleaners were employed to ensure the general cleanliness of the shelter, I observed no significant difference in cleanliness before and after 'cleaning activities' had been performed, due to the haphazardness of the work. Although the centre coordinator mentioned that the tents were treated with insecticides, the children complained of the numerous mosquitoes, lice, and bedbugs at the shelter, which I also observed during interviews in these tents in the evenings. In fact, some of the children during focus group discussions mentioned lice as a 'common disease', and one twelve year old girl complained that "These lice can bite. They are a disease in themselves. There is no one who sleeps here at the shelter who goes home without lice!" While scratching her head she described the pain of the bites, and how there were presently many lice in her clothes, hair, and blankets.

Importantly, the shelter was meant purely for accommodation purposes. No meals were provided in 2004. Sometimes, however, the shelter would give out different items to the children, especially when the numbers showing up were dwindling such as in 2005. Occasionally, very dirty children were given soap and counselled to go and bathe. The centre manager mentioned that the problem of dirt was common among all children, but particularly in younger boys.

Although the centre employed two nurses, they only administered first aid drugs and analgesics, and sometimes tranquillisers using the centre manager's office as a clinic in the evenings. By observation, the nurse largely provided pain killers such as Panadol, and on rare occasions a few antibiotics like Pen V, Valium, Flagyl, and Amoxicillin would be administered to sick children, though in insufficient doses. "If the child is given the first dose, s/he is expected to inform those at home to buy other drugs in order to complete the dose", explained one nurse.

Other shelters were quite similar to Noah's Ark in their physical structure and functioning. For example, Lacor hospital night commuters' shelter, GRRH shelter, Tee'okono, and Bukipa were characterised by overcrowding, insufficient facilities, and poor or non-existent sanitation.

and two more night commuters' shelters called Tee O'kono and Bukipa were put in place with funding from the Japanese government neighbouring Noah's Ark to the east. One counsellor at Noah's Ark disclosed how they were barred in August 2005 by Christ Church and the district security committee from using the biggest structure because their coordinator had declined to share some of the donor funding which Noah's Ark had received since it started functioning. Moreover, Save the Children and RUFO justified the existence of yet another new night commuters' shelter by claiming it was a real necessity for vulnerable children. There were, however, strict regulations governing this RUFO shelter, so that I was not granted permission to observe inside the dormitories.

In general, the reduced numbers of children reporting to the numerous night commuters' shelters in 2005 turned the humanitarian agencies into stiff competitors, which resulted in the introduction of 'pull factors'. In the period 2005-2006, some night commuters' shelters broadened their scope to providing food stuffs, exercise books, pens, and blankets, designed to attract children to the shelters even if they felt safe staying at home. Announcements or informal communiqués were made in advance about the likelihood of distributing such items on specific nights, in order for clients to pass on the information to other children in an attempt to promote increased attendance.

When I inquired one evening about the absence of children spending the night at the RUFO shelter, the centre manager discussed with me their policy of requiring registration at a specific time before clients could stay the night: clients of the SCiU and RUFO shelters could only report after 9:00 in the evening, which was very different from the normal 6:00 to 8:00 p.m. timing. What was disturbing about this was the fact that it was insecurity which prompted children to spend nights at the shelters, yet by having to wait until 9:00 p.m. to access certain shelters, the children were more likely to be exposed to danger. This is illustrative of the fact that although night commuters' shelters were instrumental in providing a safe place for wartime children and adults during the period when insurgency was at its peak, the entire activity also promoted the exposure of clients to increased dangers, in particular of girls to forms of gender-based violence, especially rape. For instance, at about 8:00 p.m. one evening in September 2004, I had just finished interviewing some children at Noah's Ark shelter and was walking back with my research assistant when we met a girl of about twelve years old who was crying and moving towards the shelter. She was being followed closely by five boys of about her age. Upon inquiry, she disclosed that the boys had attacked her on her way to the shelter. We accompanied her to the shelter and reported the issue to the centre manager and nurse, however this proved fruitless since they clearly showed no interest in the case. The centre manager asserted that such cases were very common and it was difficult for them to do anything about it; rather it was the girls' responsibility to report early to the shelter for their own safety. In another case, a fourteen year old girl who participated extensively in the study shared with me the experience of her friend who was attacked by secondary school boys on her way to Lacor night commuters' shelter. She was raped, but when she reached her destination she just went to sleep. Later, she told only close friends about her ordeal, but did not take any further steps – not even informing the shelter counsellors and managers – for fear of being shamed and ridiculed.

Night commuters' shelters also had a direct link with increased girl-child prostitution due to the fact that armed men, secondary school students, policemen, bicycle men, and other small scale businessmen were often strategically stationed at Kaunda grounds – an epicentre for night commuters in the evenings. Numerous press reports in The New Vision and The Daily Monitor, about the local north exposed how girls as young as ten years often exchanged sex for a small charge of 200-500 shillings (0.09-0.22 euros). In one locally publicized scene in F.M. Radio stations in Gulu Municipality in September 2004, a policeman had raped a thirteen year old girl in one of the public pit latrines. He was, however, simply transferred to another district to avoid creating a negative image of the police as an institution.

In all of these shelters, activity schedules were devised to improve the wellbeing of war affected children, and usually involved various types of 'counselling', from traditional talk therapies with counsellors of various natures to singing, creative dances,

prayers, and talks by Pentecostal preachers about moral support and peace building. The counsellors came from a variety of backgrounds as there was no uniform set of qualifications or training for such personnel; most commonly they were individuals who, regardless of their educational backgrounds, had undergone one to two weeks' training in counselling. I argue, however, that effectively these various counselling activities stand as an example of how humanitarian interventions in wartime reduce complex social, economic, and political problems to intrapsychic issues.

In sum, though night commuters' shelters in Gulu have been described by visitors and aid workers to this conflict zone as 'one of the most unique interventions in the face of the problems of armed conflict', they offered only limited short term solutions to complex socio-economic and political problems. They provided night time accommodation for vulnerable children, but also facilitated epidemic outbreaks of infectious diseases such as scabies. Night commuting was indirectly linked to an increase in incidences of rape, child prostitution, and the commercialization of humanitarian assistance whereby humanitarian agencies became competitors, sometimes going beyond their mandates in order to attract the limited targeted beneficiaries. Such practices led to agencies operating in secrecy, monitoring projects closely, and writing reports which did not reflect reality.

Displaced primary schools

If children living in child headed households in 2004 and 2005 who participated in this study were not at night commuters' shelters or their homes, they were likely to be found at displaced primary schools, of which there were six in Gulu Municipality during this period. Displaced primary schools came about when schools had to be relocated because their original structures were destroyed or plundered during the armed conflict, and/or because their original locations were too insecure or dangerous for civilian habitation. These schools in the main provided a formal education for children within Gulu Municipality who had fled insecure villages, and were hosted by mainstream or recognized municipal schools which were less severely affected. It is also important that many wartime children of primary school age did not go to school either due to inability to provide for their scholastic needs, teenage pregnancies, and responsibilities of taking care of siblings. I however include this theme in describing children's social lives because all children who participated in this study attended displaced primary schools.

Displaced primary schools often consisted of several schools pooled together in one temporary location on a municipal school's compound, which by observation consisted of makeshift structures crowded with children who were either not in school uniform, or were wearing different types of uniform. For example, Gulu Prisons P.7 School to the west of Gulu Municipality hosted St. Peters Bwobomanam and St. Kizito Alero-cuku, merged into one school. Gulu Town P.7 School hosted Labong'gali from Amuru County, Kitino-tima from Acwa County, Angaya from Paicho Sub-County, and Bucoro and Gweng'dia primary schools from Awach Sub-County. Layibi P.7 School hosted Layibi Adera and Abole primary schools from Omoro County. Pece P.7 School hosted Coo-pii, Tee-got, and Atede primary schools displaced from Omoro. St. Kizito Agwee hosted Lapainati, Adak, and St. Mary's Lapiny Oloyo from Omoro County.

The construction of displaced primary schools was essential in order to cater for the substantial number of children of primary school age who had fled their communities to go to the safer Gulu Municipality. The schools within the municipality were, however,

reluctant to take in more pupils, especially those from rural areas because they were viewed as unable to compete favourably with their 'mainstream' students, thus separate displaced schools were created. In addition, the municipal schools were often having more students than the recommended school population. The prejudice against rural pupils was partly based in fact since such wartime children would miss whole school semesters or even years at times when the insurgency was at its peak. In addition, such children, like in any other rural schools in Uganda, were far behind in school syllabus coverage. As a general trend, fewer primary school teachers liked to teach in rural primary schools because of their remoteness, their lack of facilities, over crowding, and lack of scholastic materials, and the teachers that remained were often incompetent and had also personally suffered as a result of armed conflict. The district inspector of schools for Gulu was interviewed concerning the creation of displaced schools which produced the unintended yet immediate effect of discriminating against rural, war affected children. In his defence, he said:

> Those schools would disappear if they were simply absorbed into municipal schools. Teachers who had fled their insecure locations to Gulu Municipality were still getting their salaries yet they did not teach. Therefore to ensure that they earned their income, the district council negotiated with NGOs to put in place structures for displaced schools. It is unfortunate that they were simply makeshift structures as in emergency aid. Presently, however, we want all of them [displaced primary schools] to go back to their original locations. They are posing a lot of sanitation problems for municipal schools. (Field notes, January 2006)

Naturally, the need to separate rural pupils from the municipality pupils was received differently by teachers, national and international NGOs, district administrators, children in child headed households, and parents living in abject poverty in Gulu Municipality. Different stakeholders reacted differently to this unique phenomenon, for underlying their reactions were the various vested interests of the key players. To start with, World Vision, which had been long established in Gulu, registered with the district to construct displaced primary schools. Although the Save the Children (SCiU) coordinator for the Gulu office claimed on several occasions that *his* NGO had constructed numerous displaced schools for vulnerable wartime children within Gulu Municipality, all the displaced primary schools I visited bore World Vision logos, and the head teachers all disclosed that it was World Vision who had constructed them. One major visible characteristic of such schools was that they were poorly constructed makeshift shelters. Although there was agreement among teachers, administrators, and pupils that they were stationed there only temporarily, these structures were still very basic. The classrooms were small, and the buildings were without cemented floors, desks or chairs, windows, or door shutters. In the event that the region had windy rains, the children would have to gather in the relatively sheltered classes in the mainstream schools. Most frequently however, children would leave school if they predicted a heavy downpour to avoid getting wet.

The displaced schools were also characterised by a lack of basic scholastic materials. At the beginning of the third school semester in September 2005 at St. Peters Bwobomanam and St. Kizito Alero-cuku, all textbooks, important school records, food stuffs, and other scholastic documents kept in the headmaster's office had been destroyed by termites. The headmaster claimed, however, that this was not *his* problem since he had frequently requested that World Vision cement the classrooms and his office, but the NGO had declined. The teachers also variously indicated the need to complain to the district education committee, WV, UNICEF, and SCiU, but added that they considered

it a waste of time to do so as they would be told that it was not within these organisations' mandates to provide textbooks to the displaced primary schools.

Whereas it was a pre-requisite for children who attended mainstream municipal primary schools to wear school uniform and have school bags and shoes, these items were optional in displaced primary schools, in part because they were not practical regulations for the characteristically resource poor community. By observation, a substantial number of children attending displaced primary schools wore partially torn clothes, were often dirty and bare footed, and carried a plate and polythene bag so that they could have their meal and sit in classrooms. Since different primary schools were merged into one displaced school, in one classroom one could observe three or more different school uniforms, worn by those few who could afford them. Meanwhile, in mainstream primary schools, only one type of school uniform was acceptable, plates were distributed at school, classrooms were clean and had desks, and in general there were fewer children per classroom.

Since displaced primary schools offered virtually free education services, a substantial number of parents in the lowest economic echelons in Gulu Municipality shunted their children from municipal schools to displaced primary schools. Thus, in general, displaced schools had more than twice the total number of children than they were planned for. Those children who attended displaced primary schools were largely those who had missed years in education due to war, children living in poverty, ex-combatants, children living in child headed households, and children whose parents resided in distant camps. Although such children did not pay school fees, they had to pay examination and school meal preparation fees, however this too was optional since most of the children could not afford it. But of course, only those children who paid this substantial fee were allowed to have prepared meals at school, and this regulation was

Box 3.2 Structure of a displaced primary school

Although the children who were extensively followed attended different displaced primary schools, sixteen out of twenty-four (66.7%) attended the Gulu Prisons P.7 School. This displaced school had two primary schools merged into one: St. Peters Bwobomanam and St. Kizito Alero-Cuku, whose original locations were in Alero in Nwoya County, 20km west of Gulu Municipality.

Part of Gulu Prisons P.7 School compound had two makeshift basic structures constructed by World Vision in the year 2000. The two buildings were only partially complete structures divided into seven classes, with one additional room between Primary Six and Primary Five reserved for the teachers' staff room and the headmaster's office. Apart from Primary Seven, all the classes had no furniture, were not cemented, and had no windows or door shutters. Some children improvised using polythene bags for seats on the haphazardly cemented floors, though more than half of the children per class simply sat on the dusty floors. By observation, the classrooms accommodated far more children than was their intended capacity, and there was often barely any space left for the teacher to place her chair in the fully packed classrooms. As will be discussed, this form of classroom arrangement had implications for the spread of airborne and contagious diseases such as flu and cough, and scabies and other skin fungal infections. The school had two pit latrine blocks approximately 100m away which were relatively clean in 2004; but by 2005, due to their over-use and misuse, they had become filled up. Dirt, stench, and houseflies were their general added characteristic. All the other displaced primary schools where other children who participated in this study shared similar characteristics.

implemented through roll-calls each meal time, identifying children who had made payments.

Another observable scenario was that even though the mainstream municipal schools and displaced primary schools shared the same compound, rarely did children from the different schools interact with each other. For instance, at break time children from Gulu Prisons P.7 School, in their white and maroon uniforms, went to the east side of the compound, while children who attended the hosted displaced schools made distinct groups with their fellows to the west and north of the school. When teachers were asked about this, they cited variously the poverty of the war affected children, their dirtiness, their inability to communicate in English, and in 2004 they cited the fact that these children were more likely to have scabies. Scabies is widely believed in Gulu to affect only dirty people, and mainly those who spend nights at commuters' shelters (it was indeed true that scabies, or any epidemic of an infectious nature, largely affected children who spent nights at shelters and attended displaced primary schools). The teachers' remarks, which reflected a substantial proportion of people's views in Gulu Municipality, in effect bordered on the subtle pathologizing of children who attended displaced primary schools, and such remarks can be understood within a wider framework of poverty, social inequality, discrimination, and prolonged civil war.

The teachers' assertions that children in displaced primary schools were often dirty and poor were further exemplified by the following event. One day in July 2005 a fourteen year old girl heading a household of five children was summoned by a schoolteacher for punishment because she and her siblings were often dirty, wore torn clothes to school, showed no commitment to their personal hygiene, and lacked scholastic materials. However, this girl shared with me her difficult experiences of heading a household, and how she was constantly unable to provide for all her siblings. From this example I argue that it is impossible to comprehend the children's life worlds unless the wider effects of war, living in abject poverty and misery, and their general socio-economic condition are taken into account.

By observation in 2004, a substantial proportion of children in displaced primary schools did have scabies. Avoiding close contact with those affected was quite difficult in the over-crowded classrooms, and most of the children spent nights in congested night commuters' shelters, thus the epidemic spread like wild fire. What is more, the numerous children who attended displaced primary schools and slept in night commuters' shelters also occupied the lowest economic echelon, and could therefore hardly afford washing detergent and individual basics such as blankets, washing utensils, and other household items. At the shelters, some of these basic necessities were provided in insufficient quantities for *communal* use, and it is likely that communal use of such things facilitated contagion and transmission of infections.

In January 2006, most displaced primary schools were closed by Gulu district's education committee, and children and staff were ordered to go back to their schools' original locations, regardless of insecurity. Most schools were declared a health hazard since some were already collapsing, all their pit latrines were filled and unhygienic, and no NGO wanted to help to construct other structures. Only the displaced primary schools at Layibi P.7 School and Laliya P.7 School were not closed, partly because they still had proper sanitation, and partly because the displaced schools' original locations in Anaka were still recognisably insecure. For the closed displaced primary schools, no attempt was made by mainstream municipal schools to use the remaining structures, and

no one knew precisely what to do with them. One teacher at Gulu Prisons P.7 School mentioned that "their children did not like to use those substandard structures. They feared fleas and jiggers which inhabit non-cemented displaced primary school floors". Noticeably, one immediate consequence of the closure of the displaced primary schools was that a substantial number of primary school aged children subsequently dropped out of school. For example, Ajok, who was fifteen years old when the schools were closed, instead took up work with the International Committee of the Red Cross (ICRC) sweeping the compound and washing cars in order to earn money to pay for her siblings to attend Bardege Primary School. Other children, such as Apiyo and her brother, relocated to the displaced primary school at Layibi.

Factors linked to poor academic performance records in displaced primary schools

Children in displaced primary schools on average achieved far lower academic standards than those in mainstream schools, and this can be attributed to several different socio-economic, as well as bureaucratic, contextual factors. For example, there was no child who passed in division one from all displaced primary schools within Gulu Municipality during the mid-year examinations for primary seven pupils. One immediate decision which was made by the local government and educational department in Gulu upon the creation of displaced primary schools was that they would have different schedules from municipal schools. For example, since children in displaced primary schools could not favourably compete in academics and did not pay school fees, they were given different types of examinations. Whereas the mainstream schools had typed examinations, displaced school children wrote their examinations on blackboards, and every examination except for the end of year examinations were handwritten by teachers. During interviews with one of the officials at the municipal schools' office, concerning the distinct programmes and structures for displaced primary schools, she argued:

> Displaced primary schools are beyond our jurisdiction. When we plan for school activities, even examinations, but we only target our forty-six registered municipal schools. It is the district inspectorate of the schools department to plan for such [displaced] schools.

Further, teachers who were better at their work, and who had authentic diplomas, preferred to teach in mainstream municipal schools, therefore it was the norm that in displaced schools there was a severe shortage of teachers. On average one teacher took responsibility for more than one hundred pupils, a figure far higher than the national recommended figure of forty children per class. During my fieldwork in displaced schools it was also common to observe children sitting outside in the school compound rather than attending classes, and they were often unwell due to *koyo* (fever), *abaa wic* (headache), vomiting, or acute respiratory tract infections (ARIs). This study partly links the high prevalence for infectious diseases to the overcrowding and congestion in displaced primary schools. Episodes of infectious diseases have been reported to have a significant effect on school performance (MOH 2004), and hardly a day would pass without seeing a sick child who upon inquiry would assert that they had malaria, or simply *koyo* and *kum ki lit* (their body is sick). The teacher on duty would either tell the child to go home or go to *ot yat adit* (Gulu Regional Referral Hospital) where healthcare services could be accessed free of charge. In later chapters where I discuss the illness experiences which the children named, I will shed more light on the dynamics involved in seeking treatments at state aided health centres. At this stage, however, it suffices to mention that children commonly preferred to buy pharmaceuticals directly from private

healthcare sources instead of going to line up at *ot yat adit* the whole day only to be told to go elsewhere to buy medicines.

By observation, children at displaced primary schools commonly came to class without exercise books, pens, or pencils; rather, they would borrow from friends if possible. Appendix 1 outlining the twenty-four children's biodata and experiences in wartime shows how the children indicated classmates as being in their social networks, and how friends lent them basic school supplies. In the month of October 2005, more than forty of the 105 children in Primary Five, where Oketch was a member, did not attend mathematics classes since the teacher had made it a prerequisite that only those with mathematical sets could attend his class. Oketch approached me with this problem in the first week after the teacher passed this regulation, and I gave him money for it. However, in the third week I observed that Oketch was sitting with the children who were not allowed in the mathematics class. Upon inquiry, he gave conflicting answers: at first he said it had been stolen, but after in-depth enquiry he disclosed how on the day he was given the money, he had used some of it to buy food, and the remaining money had not been sufficient to buy the mathematical set. I did not press Oketch further on this issue.

Meanwhile, the teachers also had to adjust to this difficult situation. One teacher stated that his role was merely to teach and complete the syllabus, therefore the issue of children not being able to afford exercise books and pens was beyond his jurisdiction; perhaps this was the responsibility of the NGOs. In general, however, NGOs indicated their need to function within their mandates, which meant that only registered clients – in practice merely a select few – could be assisted. World Vision, for example, had only twelve registered children in the two displaced primary schools at Gulu Prison P.7 School.

During weekdays within the school semesters the children attended different classes, and had meals *if* they were provided at school. It is *if*, because meals were not always provided because various factors influenced whether it was possible to prepare them at all. In the months of July to September 2005, both St. Kizito Alero-Cuku and St. Peters Bwobomanam displaced primary schools did not receive any food supplies from the World Food Programme (WFP). When the WFP distributed food rations in mid-September, six of the displaced schools visited still could not prepare meals since few children had paid the school meals charges. That meant that there was neither firewood for cooking nor money to pay workers in the school kitchen. It was not until November that all the displaced primary schools could provide meals for their children. By observation, fewer children, especially in the lower classes, attended school when there were no meals prepared. During morning and lunch breaks a substantial number of children would simply lie in the shade under the trees around the school or talk to each other in classrooms. Furthermore, since fewer teachers worked after the lunch break, the children would not wait for the official closing time of 4:00 p.m. to go home. Therefore, in the months when no meals were prepared at school, in practice, schools would close at 1:00 p.m.

Children frequently left school early because they needed to secure their food needs, which they could do by performing various jobs including fetching water for construction sites and neighbours, or carrying farm produce to the market for money. As thirteen year old Ojok mentioned, "when the food reserves are about to get finished, I do not go to school at all so that I can do *leja leja* (farm labour for money)". It is therefore likely that when there were intermittent supplies of foodstuffs provided by the WFP, fewer children would attend school in order that they could earn enough to eat,

and for a fee of 1,500 shillings (0.65 euro) it was possible to purchase enough grain and green vegetables for a day's meal in the open markets.

It is important to know that while the WFP had regular schedules for monthly food distribution, things were rarely ideal, and sometimes it would be two months or more before a particular community received food rations. This reinforced the need for wartime children aged between seven and sixteen years to engage in farm labour and other income generating activities during the times when they should have been attending school. Such absenteeism was quite unheard of for children attending mainstream municipal schools. However, even within the displaced schools some children did not particularly engage in farm labour during school hours; for example, in Olobo, Ojok's friend only went to seek *leja leja* on weekends, and not during class times, since he lived with both his parents.

A further factor influencing academic performance was that since wartime children often resided farther away than children in mainstream schools, the school teaching programme started an hour and a half later, at 9:30 a.m., rather than the usual 8:00 a.m. for municipal schools. By 9:30 a.m. children like Ajok, who walked over 5 km to school, would have arrived for the day's first lesson. The day's schedule was interrupted twice, between 10:00 and 11:00 a.m. and between 1:00 and 2:30 p.m., to allow for some of the children to access meals, and since the children needed time to journey back home, the displaced schools closed at 4:00 p.m.

It was therefore a combination of factors which contributed to poor performance in displaced primary schools, ranging from the fact that many children had missed semesters and sometimes years in their education; some had only a limited grasp of the English language; they followed a different schedule from mainstream schools; the student to teacher ratio was high; and their rural background possibly had a significant impact. Further, these children were faced with poverty, often came from child headed households, and lacked basic scholastic materials.

Key informants' perspectives on poor academic performance in displaced primary schools

From an interview with the Gulu District Inspector of Schools (DIS), I learned that the DIS attributed poor performance in displaced primary schools to the fact that, among other factors, "both teachers and pupils are traumatized". Workshops had therefore been organized by his office to sensitize teachers about the underlying causes of children's lack of motivation and psychosocial wellbeing. Needless to say, regardless of the intensiveness of these sensitisation courses, the DIS recognized that there was no substantial improvement in performance in such schools.

The assertions by the DIS concerning poor performance in displaced primary schools are in line with the existing discourses of numerous aid agencies, which attribute even complex socio-economic problems in wartime to trauma and Post Traumatic Stress Disorders (PTSD hereon). Thereby simple solutions, including counselling and sensitisation seminars, were implemented with limited success. At the time of this study, psychologists' and psychiatrists' working perspectives in northern Uganda shared similar limitations. For example, thirteen year old Oketch, who was mentioned above, was referred to a psychiatrist for assessment. Concerning Oketch's poor performance in class, the regional psychiatrist noted:

> Oketch scored an average of thirty aggregates last term. This is a poor performance given that the best score is four aggregates. It is because Oketch moved to Gulu after witnessing the brutal killing of both

> parents by the LRA in 2001 and whilst in Gulu, he had another tragedy in that the brother who was their caretaker was killed in early 2005 in a road traffic accident. Subsequently he has constant nightmares of his mother coming back to collect him. This poor performance in class is because Oketch is sad and depressed. Another contributing factor to his poor performance is that the class teacher constantly refers to him as an orphan. This reference makes Oketch upset and unable to concentrate in class.

In sum, the phenomena of displaced primary schools were useful in giving wartime children living in abject poverty, who were often orphans or living in child headed households, a chance to access formal education. However, after many schools serving the resource poor communities in conflict areas had become too unsafe, or had been plundered, attendance at displaced primary schools became overwhelming. Children attending such displaced schools faced institutionalized discrimination, stemming from the clear distinction made between the resource poor and those who were relatively better off, and further discriminating conditions such as overcrowding which facilitated a high prevalence of infectious diseases, and sources of emotional suffering.

Churches

Gulu is a predominantly Catholic region, therefore on Sundays many of the children indicated going to one of the prominent Catholic cathedrals within the municipality, in particular the Holy Rosary. They talked about the importance of these churches for praying for the sick, telling them 'good news', advising them on how to behave, and in general as a place where they listened to God's messenger. Seven of the twenty-four children (29.2%) who participated extensively in this ethnographic study, including the fifteen year old Omony and Okello, were saved[2] and they therefore attended Pentecostal churches, including the Bridge Builder's Church (BBC) which had branches in Gulu Town Primary School, Layibi, and Kirombe suburbs, the Pentecostal Assemblies of God (PAG) in Kirombe, the Lifeline Ministries neighbouring Gulu district offices, and the Deliverance Church in Cereleno suburb. Noticeably, five children who were taking care of kin sick with HIV/AIDS attended Pentecostal churches. A fourteen year old girl with epilepsy also said that she had been saved because the preacher had told them that God would heal all impossible diseases. Another common phenomenon was that ex-combatants who were rehabilitated at the WV centre for formerly abducted children also attended Pentecostal churches. Their main problem was in needing to deal with *cen* (spirits) which commonly disturbed them.

I participated in a substantial number of Pentecostal church services, especially the healing and counselling sessions. I will return to the importance of Pentecostal churches in conducting healing services, especially for those with persistent headaches, a-specific body aches, stomach aches, and *cen,* in Chapter 11. It suffices to mention here that these religious communities instilled some hope, and promoted emotional – and for lack of a better word – what I will call unintended healing/cure in this population, which had to confront extreme forms of suffering related to wartime.

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[2] *Saved* is a noun in reference to persons who profess strict adherence to Christian values. Such persons often attended Pentecostal churches in Gulu. In an act of being saved, an individual is told to confess their sins and surrender their lives to Jesus Christ. Saved people are therefore admonished to tell others what Christ has done to them – as in testimony. Often the testimony is that Christ has set them free, loosed them from the bondages of Satan and sin, and also healed them of their suffering.

Child abductions and the rehabilitation of former child soldiers

Evidence suggests that children of school age (five to seventeen years) were at the greatest risk for abduction. In the event that such children escaped or were 'rescued' from captivity, the now former child soldiers were rehabilitated in two main centres in Gulu. Below I will elaborate on how the rehabilitation process became institutionalized in Gulu.

Evidence suggests that children of primary school age represented the greatest proportion of victims, and were at most risk in the northern Uganda conflict. UNICEF publications show that children account for three out of every four abductions, mostly of school age (UNICEF 1998: 24), and they are generally abducted at night when the LRA raid villages, camps, schools, and churches. It has also been reported that both the LRA rebel group and the UPDF targeted children because of their vulnerability to control and manipulation, and prepubescent girls were especially targeted as less likely to have AIDS or other sexually transmitted diseases (BBC News 2005; Human Rights Watch 2003: 17).

Human Rights Watch (HRW forthwith) reports show increased and widespread atrocities as the LRA stepped up the abduction of children for use as combatants, sexual slaves, porters, cooks, and domestic workers (HRW 2003). One HRW report revealed how children abducted by the LRA described being forced to carry out raids, burn houses, beat and kill civilians, abduct other children, and fight against the UPDF, while girls were used as domestic servants and forced into sexual slavery as 'wives' of LRA commanders (HRW 2004; UNICEF 1998: 3).

The issue of child abduction is therefore essential for this thesis, not only because the study respondents fell within the age group at greatest risk, but also because the UPDF, which was supposed to ensure their protection, also violated children's rights. According to a HRW report, since 1996 the UPDF were responsible for breaching fundamental human rights, for while Protocol 11 of the Geneva Convention allows for civilians to be moved if their security is threatened, or other imperative military reasons demand it (Article 17), the forcible displacement of civilians in northern Uganda did not actually improve the security of those moved. Children of primary school age who had been moved, or who had migrated to Gulu and its neighbouring districts to the north, were at a considerably higher risk for abductions, yet in camps and villages neighbouring Gulu Municipality, security was not guaranteed; instead, they were left unguarded and exposed to LRA attacks, abduction, rape, and murder. The government of Uganda even admitted to recruiting former abductees and wartime children and exposing them to dangers on the battlefield. Statistics suggest that approximately 800 children below eighteen years of age had been recruited (BBC News 2005). In March 2003, HRW documented the ongoing recruitment of children into Local Defence Units. They were intended to provide security to local villages, but were reportedly being used to fight alongside the UPDF against the LRA. The same children were separately deployed alongside the UPDF in operations in the Democratic Republic of Congo (DRC) and Sudan. Recent reports from the Coalition to Stop Use of Child Soldiers indicate ongoing child recruitment into the UPDF, including children who had escaped from the LRA (HRW 2003: 13).

A complex phenomenon has emerged, especially since 1997, whereby a substantial number of children abducted by the LRA have either been rescued or have escaped from captivity. These formerly abducted children or ex-combatants were often handed over to two prominent rehabilitation institutions for counselling and subsequent reintegration

with their kin. Akello *et al*. (2006) highlight the dilemmas and controversies in dealing with this pertinent issue; suffice it to mention here that the process of counselling and subsequent reintegration of ex-combatants yielded limited success in northern Uganda. Interview results do suggest that as a result of the numerous sensitization seminars for teachers, administrators, and children, ex-combatants were viewed as traumatised; traumatised because they had witnessed extreme events or had been forced to carry out atrocities, and central discussions about ex-combatants by international and national NGOs focused on the ideas that ex-combatants exhibited characteristics such as hyper arousal, lack of interest in activities and poor concentration, restlessness and aggression. The local idiom for these symptoms states that ex-combatants had *cen* (evil spirits). Children in schools therefore constantly made fun of former child soldiers, called them names, and avoided interacting with them. I will demonstrate later how it was this very response by communities towards ex-combatants which partly contributed to the various characteristics they exhibited. For example, Apiyo narrated how classmates distinctly excluded her from their interactions, but when they had been sensitized they initiated conversations which they later used against her, thereby reinforcing her aggressiveness, isolation, and hyper vigilance. Such practices were central to the limited success of the reintegration process in northern Uganda.

Wartime children in informal settings

Since I am making a transition from institutional settings to informal settings, I will give a brief introduction to what I mean by non-formal/informal settings. Night commuters' shelters, displaced schools, and churches are viewed in this study as institutional settings in wartime children's life worlds. In this following section, I attempt to describe the non-formal settings in which this study population moved. For instance, I shed light onto what their residences and homes were like, their daily challenges, how they confronted them, and their social networks. Firstly, I will present information about where they carried out their activities when outside institutional settings, and shortly following I discuss children's typical days, the routine activities they performed, common problems at home, how their social networks were shaped by age and class, and other dynamics.

Housing in Gulu Municipality

Children and adults who migrated from their villages to Gulu Municipality due to insecurity, and who needed to access formal education, mostly resided in the suburbs with cheapest housing such as Pece, Cereleno, Kanyagoga, Kirombe, Bardege, Aywee, and Agwee, Kasubi, Layibi and Koro camps. In these suburbs was a distinct pattern of residence characterized by numerous closely spaced huts, largely mud and grass shelters.

By observation, several huts would be built around one larger hut (or mud and iron sheet house, or a brick and iron sheet house), where the landlord lived. This new residential pattern is directly linked to the period of displacement and the severe shortage of accommodation for those who had fled their rural and village residences to the relatively safer zone within Gulu Municipality. In an attempt to provide accommodation to those in urgent need of housing, property owners within Gulu Municipality and other safer areas constructed as many huts as possible within their compounds. However, such huts had no sanitation facilities such as pit latrines or washing shelters, which led to the common complaint from children about the lack of sanitation facilities, and about land-

lords who were hostile to those who over-used the pit latrines. Five of the children's homes visited were located close to the filled up, over-used, and unhygienic pit latrines, catering for most of or even the entire neighbourhood. Such areas had characteristic smells and houseflies which are known transmitters of diarrhoea-causing pathogens.

In addition to poor sanitation, the suburbs, including Pece, Kirombe, and Kanyagoga, had few sources of clean water, were highly populated, and had high crime rates. Subsequently, children in child headed households were not only exposed to the health hazards associated with living in such fetid conditions, but were also a target group for criminal attacks. For example, children's ready exposure to infectious diseases and frequent complaints about malaria, diarrhoea, cholera, and persistent headaches and stomach aches can be partly linked to such living conditions. Another common complaint from girls who lived in these suburbs was about the night attacks by men who wanted only to rape them without taking their property.

Another important dimension of this haphazard housing situation was that owing to insecurities in areas outside the municipality, in the event that individuals died – unlike prior to the civil war where the deceased persons would be transported to appropriate burial grounds (each village having specific ancestral burial grounds) – such burial ceremonies were performed within the over-crowded areas themselves. Due to the limited space, it was common that people were buried very close to the huts where people resided.

Depending on how numerous the graves became, some landlords had difficulties in renting such premises, which therefore meant that they would go to persons in the lowest economic echelons, often children in child headed households and children taking care of sickly and disabled persons.

Although these premises were avoided by many for fear of *cen*, and children too indicated fear of the polluting spirits, they devised various mechanisms for dealing with *cen* and generally integrating such suffering into their daily life. I will come to this issue in Chapter Eleven where emotional forms of suffering are addressed through the use of medicines for sleep, placing branches of *atika* plants at the doorposts, and smearing *atika* leaves and seeds on the forehead and mats before going to sleep.

Making monthly payments for housing was not only a new responsibility for wartime children, but was also an activity which they performed with great financial difficulty. Given their lack of reliable or constant sources of income, and the responsibility to fend for themselves, such children often faced severe eviction threats. They were 'severe' since intermittently the property owners would close their huts with their utensils and belongings inside for days or weeks until payments were made. On some occasions, property owners would simply throw out the child tenants' belongings while hurling insults at them, and when the landlords received offers from other tenants, it was common for the children to be instructed to vacate the premises with immediate effect. On three occasions in 2005 I interacted with children who were residing at one of the Catholic cathedral's compounds due to such acts. During the first phase of the study in 2004, approximately twenty children who lived at one night commuters' shelters disclosed having experienced severe evictions by property owners, and further, a change in the policies of night commuters' shelters in 2005 compounded children's exposure to emotional suffering since they were only permitted to stay at the shelters during the nights and not during the day. A visible complex scenario stemming from this was that in the event that children were evicted mercilessly by property owners, they had to stay

at one of the Catholic cathedral's compounds, bus parks, or displaced primary schools during day, and spend nights at a night commuters' shelters.

Though landlords and property owners were central in providing accommodation for people who fled their homes due to war, there were many families – such as those of Ojok, and Apiyo – who could not afford such expenses. Since they were Catholic, they were offered some land at Laroo Forest to reside on for a specific period of time. In October 2005, the administrators gave them notice to vacate the land because they had not put in place any sanitation facilities, and were therefore accused of misusing the church's forest. In addition, the surrounding villages were still insecure. Although Ojok managed to get a hut to rent in Pece, with some financial support, it was still difficult to know what would become of him and his sickly father, who was taking ARVs at the time. Ojok and his family chose to stay in their precarious situation because, in part, they were still uncomfortable with the idea of going back to their village where there had been sporadic attacks on people who had attempted to return, and also because – since World Vision had registered them for the Laroo division antiretroviral (ART) programme – they would find it difficult to access counselling services and intermittent food supplies if they moved to distant areas. This connects to another issue which relates to the frequent mobility of persons in wartime, and the lack of economic capacity to afford basic needs and meet daily expenses, for such mobility meant that individuals and families would miss WFP food supplies if their names were not on that zones' list, they would miss out on formal education, and they experienced homelessness and difficulty in integrating into other communities.

In summary, this section concerning housing for children in Gulu Town has outlined where these children lived, the health hazards that were directly linked to their living conditions, and how the children confronted these and other problems. Explicitly, I argue that the described living conditions had a direct link with the prevalence of children's illnesses, including exposure to infectious diseases and deep rooted forms of emotional suffering.

Living conditions in wartime children's homes

In assessing the thematic areas for this study – children's common illness experiences and ways of dealing with them – the children were asked about common problems they faced at home. Results indicate that children commonly lacked basic needs, faced diseases, insecurity, hunger, poor shelters, and were in constant need of money for rent and school uniforms. These are the issues on which I will shed more light in the subsequent chapters.

To give a short but comprehensive description of children's homes, which in general reflected a specific pattern in their nature, location, and constitution, I will use my impressions gained from visits to the homes of several different children. Wartime children who attended displaced primary schools were likely to live in the overcrowded and resource poor suburbs of Kirombe, Kasubi, Pece, Cereleno, and Bardege, all of which had high crime rates. All of the children lived in grass thatched huts, apart from Apiyo Malaika who lived in a completely iron house.[3] In 2004-2005 within Gulu Municipality, such huts were rented out at 3,000-10,000 shillings (1.30-4.35 euros) per month. A hut

[3] The structure of this house resulted in quite high indoor temperatures. Apiyo, however, often said that regardless of the heat, at night she still covered herself completely with a blanket for fear of *cen*. Such houses were originally intended for armed men and police forces who had subsequently been transferred to different stations.

is a mud and wattle structure, often round and covering an area of less than two square metres. Where tenants paid a lesser fee, it was often due to the location, in particular if it was neighbouring a graveyard as people fear polluting spirits. In most cases, it was the most disadvantaged – including child headed households – who occupied such premises. Oketch was only paying 3,500 shillings since the hut was poorly maintained and was very close to a filled up and filthy pit latrine. Ojok also paid 3,500 shillings because the property owner had sympathy for his and his siblings' suffering and had significantly reduced the rent charges. The hut, however, had severe leakages and was poorly maintained.

The children prepared meals, washed utensils, processed foodstuffs, stored all their household utensils, and slept in these small huts. Apart from Oketch's house where I found an extra item of a green mosquito net donated by MSF, all the huts visited had two or three saucepans, one or two Jericans for fetching water, worn out blankets, and one or two papyrus mats. Depending on whether the WFP had recently distributed food items, there might be signs of cooking beans or cowpeas at the fireplace. This fireplace also served another purpose – which I will come to later – for burning branches of *atika* plants on partially broken pots to ward off *cen,* mosquitoes, and sleeplessness.

One common danger of these huts, especially during dry seasons, was that they very easily caught fire and within a few minutes would totally burn down. Only on rare occasions would the owners manage to save their utensils or household belongings. In a workshop where children diagrammatically represented incidents they feared in their lives, forty out of fifty children represented burning huts. One child drew their younger sister who was burnt in their hut in 2004. Ojok, in an in-depth interview about severe events in wartime, demonstrated extensively how he had 'almost become insane' when his sister-in-law burnt their hut with all their belongings and the money he had earned for a month.

Omony discussed how in early 2005 their hut was accidentally burnt by neighbour's children playing with fire. All their food stuffs, exercise books, and utensils were burnt within five minutes. Other severe incidents of course included abductions (all fifty children represented this in another workshop as children being held in captivity, tied together, and being directed to move by an armed child or adult), and the killing of civilians by either the UPDF or LRA. In diagrams or interviews children rarely differentiated between the two warring factions; nevertheless, there were illustrations where children clearly indicated how the NRA burnt down huts and at the same time ordered villagers to move to camps.

Regarding the lack of basic needs at home and the sharing of worn out blankets, and sometimes having no blanket at all, I am reminded of one day during fieldwork when siblings of Ajok came to collect me to visit her, since she was sick with malaria. At Bardege where they lived we found Ajok lying on a mat which was partially damp since it had rained in the night and the house was leaking, and covered by two torn blankets which could not keep her warm. I find it difficult to know exactly whether Ajok's fever was due to malaria, or because she was sleeping in a damp and cold place. Or was it that Ajok, who recovered after taking a sub-therapeutic dose for malaria, had emotional suffering. If the immediate problems which wartime children named reflected a lack of basic needs, hunger, and living in abject poverty and misery, when it came to discussing their illnesses, they largely talked about infectious diseases. Infections, poverty, poor sanitation, and congestion in the context of armed conflict have direct links. Such are the grey areas which I intend to analyze in subsequent chapters.

How children dealt with challenges at home

I have already begun to address in the sections above how wartime children of primary school age dealt with their daily life challenges. Since for this study my main focus is on illness experiences and therapy quests, I will briefly give examples of what children considered their priorities and coping strategies, given the context in which they lived. When I made inquiries into common problems which the children experienced, the children largely answered that they lacked basic needs, experienced hunger, lived in poor shelters with poor sanitation, confronted infectious diseases, and faced numerous other problems including abductions and attacks by the state army. The children actively engaged with these problems, though their engagement can be categorized into constructive/positive and destructive/negative survival strategies.

Children confronted with living in abject poverty

One particular characteristic of the children who participated in the study is that they lived in abject poverty in the fetid over-crowded camps and cheaper suburbs of Gulu Municipality. They did, however, get by through performing various income generating activities and survival strategies. To facilitate a coherent presentation of the empirical data concerning children's survival strategies, I categorise them into constructive/positive and destructive/negative practices. By positive practices I mean activities with minimal harmful unintended consequences, and which are socially acceptable livelihoods in wartime, such as *leja leja*, fetching water for sale, smearing and thatching other people's huts for money and taking care of neighbours' children. Meanwhile, negative practices are those which are harmful or had major negative unintended consequences, and as such these activities are not socially acceptable. These include theft (although the children also often warned others of the dangers of theft), begging, lying, and child prostitution.

Constructive survival strategies

Children performed various income generating activities such as fetching water for sale, doing *leja leja,* carrying farm produce to the market, and for Oketch and his family, taking care of the property owner's child in order to get foodstuffs. In this study's prologue, which presents an exemplary case, Ojok performed various activities in order to enable him to access basic needs. The activities ranged from doing *leja leja,* slashing the hospital courtyard and *boda boda* (carrying people on a bicycle[4]) for money. Ajok elaborated on how she dealt with daily challenges by performing income generating activities as follows:

> When I think that I have worked the whole day doing *leja leja* and I can only buy food for one day, *pi loya* (I am totally discouraged or frustrated with living). This is because all of us now have only torn clothes. I even fear washing my two sisters' clothes because they will get torn beyond repair if I did that. Sometimes I just sit and think about it until I have a lot of headache. And in any case, *can dek dwong ba* (the problem of lack of food is enormous); there is no way I can use the little money we get

[4] There are various ways an individual could get a bicycle to do this business. Mostly, as in Ojok's case, it was rented from relatively richer people. The money earned during the day would then be shared, or simply a small proportion of the earnings would be given to people like Ojok at the end of each day.

> from *leja leja*[5] to buy clothes. That is why it makes me angry each time dirty children at school are barred from entering class; all of us [Ajok and her four siblings] are always part of them.

Through my personal contact with this family, I observed that they did indeed wear torn clothes and often complained of hunger and a lack of food. They would attend class without the basic scholastic materials, had a dirty appearance, and frequently became sick with easily preventable and curable illnesses. One child from this household even contracted tuberculosis.

In another narrative, Ojok said that he had gone to Lacor, about 5km from Kirombe, to do *leja leja*. A day's labour was rewarded with 1,500 shillings (0.62 euros). For the same day's labour in villages neighbouring Gulu Municipality an adult would receive a minimum of 5,000 shillings (2.17 euros) – more than twice the amount paid to children. There was, therefore, a preference for using children as labourers, though it was a frequent complaint of the children's that land owners declined or under paid them because of shoddy work, and claimed that they would have to get an adult labourer the next day to re-do the same work. Perhaps this was due to their feeling that children were unlikely to pursue legal procedures in demand for their wages, and the situation was made more complex by weak or non-existent legal structures in Gulu during the time of the study.

Fetching water for sale

A substantial proportion of children mentioned fetching and selling water as a survival strategy, especially in the suburbs within Gulu Municipality – including Kirombe, Pece, Kanyagoga, and Cereleno – which had insufficient water supply at the time of this study. Regardless of the distance to the water sources, a twenty litre Jerican of water will cost 50 or 100 shillings (0.021 or 0.043 euros). Some children still preferred to fetch water from much distant water sources since the closest ones frequently had more people and longer waiting times, however it was, of course, difficult to fetch more than ten Jericans of water for sale in one day from such a distance. A few children also indicated rare opportunities for fetching water for hut builders or other construction sites where they earned more income.

Smearing and thatching people's huts

Wartime children, especially girls, would smear huts for other people at a fee. This was, however, a risky activity since some children were subsequently exposed to gender based violence, including rape. I will come back to this point, and provide examples from children's narratives which describe extreme experiences. Boys mainly collected grass from distant villages to sell to property owners, but sometimes they also thatched huts at an additional fee.

Small-scale trade

A substantial proportion of children engaged in small scale trade. One child discussed extensively how with a day's meagre earnings she and her four siblings would purchase sugarcanes which they would carry over a distance of about 5km in order to sell them. For this they would make a 'profit' of 300-500 shillings (0.13-0.2 euros), much to my

[5] This activity was particularly demanding since it involved moving to distant places to find where the peasant farmers needed extra labour

surprise. Thirteen year old Oketch would take care of her landlady's child as she conducted her small scale business, in exchange for a day's meal.

In seven focus group discussions and interviews, the children revealed some of the difficulties involved in engaging in small scale trade; for example, they would invest their meagre day's earnings into a business prospect, but would lose their money when people did not buy their commodities. One fifteen year old boy discussed his difficulties in conducting small scale trade as follows:

> (…) When I came back to Kirombe, I revived my business of selling boiled eggs, paraffin, and salt. My uncle kept borrowing money from me without repaying it, until the business collapsed.

Fifteen year old Omony would carry farm produce for peasants to the market, and sometimes his wage labour involved carrying firewood for small scale traders from neighbouring villages to the market. A day's labour would earn him 1,500 Shillings, regardless of the demands required of the work, and yet – to give the reader an impression of the meagreness of such earnings – such an amount was only sufficient to purchase one meal in the cheapest restaurant in Gulu Town at the time of study in 2005.

A randomized controlled study by Bolton *et al*. (2006) which was conducted in Gulu district suggested that there was a link between participation in Interpersonal Group Therapy (IPT-G) and economic wellbeing. However, from my research I did not find the claimed links. There was no single child who mentioned the need for group therapies in order to ensure their economic wellbeing. It is probable that indeed Interpersonal Group Therapies "helped children to figure out ways of earning money or start income generating activities; reducing their thoughts of suicide (…)" (Bolton *et al*. 2006: 29), but nevertheless the validity of such findings are, to my mind, quite doubtful, principally because there are difficulties in linking the aims of counselling and talk therapies for adolescents with ways of addressing their socio-economic needs.

Destructive coping strategies

The following findings were not explicitly discussed by wartime children, however through observation at the night commuters' shelters I noted how many men, including policemen, UPDF soldiers, bicycle men, and small scale businessmen, often converged on these places to pick up girls willing to have sex for money. In one locally publicized incident, a policeman was transferred to another district as a result of the community's outcry over the fact that he had raped a girl at a public pit latrine at Kaunda grounds – an epicentre for night commuters' shelters. Other people, however, argued that such a phenomenon was not new since a substantial number of girls engaged in sex for money. Perhaps, they suggested, the concerned girl had raised the alarm because she was not paid. During a focus group discussion a vignette was presented portraying a scenario at Kaunda grounds, in which night commuting boys and security personnel exploited girls; the children excitedly discussed what they often 'saw those people (mainly security personnel) doing with girls who sell their bodies without shame'. One twelve year old boy disclosed how:

> (…) with people coming from the villages, especially girls, they see many nice things in the town. They also want to have them, and therefore they sell their body in order to get the money.

The vignette below features a child living in abject poverty, confronting hunger due to lack of food and basic needs. The children were called upon in informal group discussions and focus group discussions to consider how they would advise such a child.

> Bongomin always comes late to school. This is because he comes from very far and he just walks that long distance. Bongomin stays only with his younger brothers and sisters. He has no parents. He does not eat anything before coming to school. When it is time for break, Bongomin just plays with friends. He has nothing to eat as well. And when food is not cooked at school, he just stays hungry. Now when Bongomin goes home, he has to fetch water, light a fire, and prepares food for himself and his sisters. He has to sleep early because they do not have paraffin for their lamp. Bongomin and all his sisters share one mat and blanket (…).

In twelve out of fifteen focus group discussions, children of all ages advised the child in the vignette not to steal. Below is the response of one twelve year old child:

> Stealing is a bad thing, since people in the camps can be very cruel and tell him to leave the camp. In Pece, there was a *latin kwan moo* (a school going child) about fourteen years old, who was always stealing people's food and anything from neighbours. He was only rescued from death by police when one time people laid a trap for him with food. When he went to pick it, those who were watching started screaming and called others to beat him up. It was because people were tired of him picking their clothes, food, and sometimes he could steal all the food someone had just collected from World Food Programme. (Field notes, December 2005)

Subsequently, in all fifteen focus group discussions, the children discussed their experiences of living in abject poverty, which was characterised by lack and an inability to secure even food and other basic needs. In the main, however, children mentioned begging from other children, especially those of the property owners, for the things they needed. In one focus group discussion, five twelve to fourteen year old boys disclosed how they would deceive their landlord's children by saying that they had been sent by the landlord to collect certain items. More commonly, if the children noticed that a new person was interacting with other children, immediately it was interpreted as an NGO representative recruiting vulnerable children for an upcoming project; they would then try to enrol themselves on the project as well. I had to deal with this issue personally, since even the teachers and head teachers of displaced primary schools tried to draw my attention to children they regarded as particularly vulnerable and who needed to be registered, not only to participate in my research but also to benefit from an upcoming NGO I might create. I will return to this issue in subsequent chapters.

In sum, I have shed light on wartime children's stressful living conditions. The categorisation of children's survival strategies into constructive and destructive strategies is not meant to suggest differences in children's morals, but has been done for coherence's sake, largely because it was common for an individual child to engage in both constructive and destructive survival strategies. Further, it is very important to note that it was the contexts in which children lived which forced them to engage in such negative coping strategies, and yet – as the children themselves disclosed – it exposed them to such things as HIV/AIDS, hostile treatment by neighbours, evictions, and incarcerations in Gulu municipal juvenile prisons.

Typical days

In extensive interaction with wartime children, they were asked to give an overview of their typical days and weekly routine activities. Further, through participant observation, it was possible to holistically assess their daily lives. Since the study population attended displaced primary schools, from Monday to Friday during school semesters they were obliged to be at school by 9:30 a.m. and stay to 4:00 in the afternoon. However, as described above, during weekends and sometimes during school time as well wartime children sought casual employment. A substantial proportion of children – whose parents lived in distant camps but who rented huts for them in Gulu Town in order for

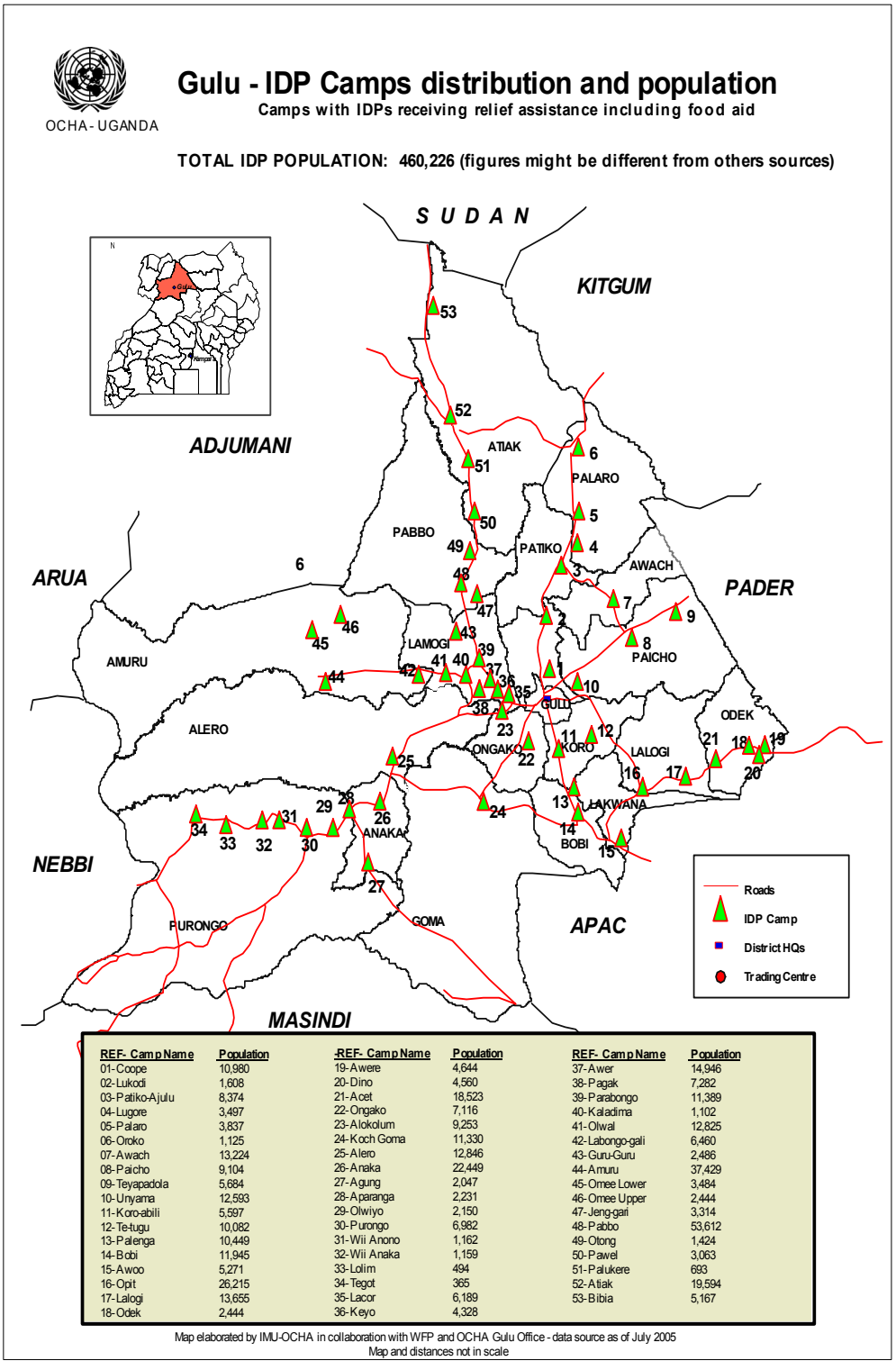
them to access formal education – would go back to the camps on Friday evenings. For instance, fifteen year old Apiyo often left school by 2:00 p.m. on Fridays in order to walk back to Palenga camp where her father resided. During the weekend, she helped him by selling papyrus mats and alcohol, and also participated in any small scale trade managed by her father; on Sunday evening she returned to Layibi suburb. Omony, Anek, Acan, and Ajok were some of the wartime children who went to Alero, Anaka, Opit, and Unyama camps for their livelihoods during weekends, and then more regularly when school closed at the end of a semester.

Fifteen year old Ojok indicated that it was only when he could not find any income generating activities on Sunday that he went to church. He was an *ajwaka* (indigenous healer), and children often referred to him since he knew a wide range of herbal remedies for most illnesses. For example, during one workshop on herbal remedies commonly used by wartime children, Ojok gave a distinct presentation where he elaborated on herbal remedies for common diarrhoea, bloody diarrhoea, and cholera. He also gave an overview of different types of *atika* plants and how to use them appropriately, to the children's amazement. In general, it was children who had to confront extreme events – such as ex-combatants, girls who were victims of sexual violence, and boys whose deceased kin demanded in their dreams for *guru lyel* (last funeral rites) – who commonly shared their experiences with using *atika* plants and seeking healing in deliverance sessions in Pentecostal churches.

Conclusion

In presenting the social lives of wartime children I have addressed issues pertinent to who they were, where they lived, and how they came to live there. I have also shed light on their daily lives, the challenges they faced, how they confronted them, and how key actors in conflict zones influenced these processes. My conclusions are therefore multifaceted, viewing wartime children as actors, as vulnerable, as beneficiaries, and as young people in wartime. Evidence suggests that wartime children were actors in their own social world; they defined their priorities and dealt with problems, whether they were socio-economic, health related, or psychological/ emotional in nature. However, the same children were also vulnerable. They were among those in the lowest economic echelons, were resource poor, and were taken advantage of by key institutions – including NGOs offering emergency aid interventions – which claimed to know better than they what their problems were, and then offered only haphazard solutions. Wartime children were also maltreated by the very communities and adults who were supposed to provide security, exemplified by child abductions, underpayment for their labour, and social exploitation through child prostitution.

Map 2 Gulu District with its 'protected' villages
(Source: OCHA-Uganda)



REF- Camp Name	Population	REF- Camp Name	Population	REF- Camp Name	Population
01-Coope	10,980	19-Awere	4,644	37-Awer	14,946
02-Lukodi	1,608	20-Dino	4,560	38-Pagak	7,282
03-Patiko-Ajulu	8,374	21-Acet	18,523	39-Parabongo	11,389
04-Lugore	3,497	22-Ongako	7,116	40-Kaladima	1,102
05-Palaro	3,837	23-Alokolum	9,253	41-Olwal	12,825
06-Oroko	1,125	24-Koch Goma	11,330	42-Labongo-gali	6,460
07-Awach	13,224	25-Alero	12,846	43-Guru-Guru	2,486
08-Paicho	9,104	26-Anaka	22,449	44-Amuru	37,429
09-Teyapadola	5,684	27-Agung	2,047	45-Omee Lower	3,484
10-Unyama	12,593	28-Aparanga	2,231	46-Omee Upper	2,444
11-Koro-abili	5,597	29-Olwiyo	2,150	47-Jeng-gari	3,314
12-Te-tugu	10,082	30-Purongo	6,982	48-Pabbo	53,612
13-Palenga	10,449	31-Wii Anono	1,162	49-Otong	1,424
14-Bobi	11,945	32-Wii Anaka	1,159	50-Pawel	3,063
15-Awoo	5,271	33-Lolim	494	51-Palukere	693
16-Opit	26,215	34-Tegot	365	52-Atiak	19,594
17-Lalogi	13,655	35-Lacor	6,189	53-Bibia	5,167
18-Odek	2,444	36-Keyo	4,328		

Map elaborated by IMU-OCHA in collaboration with WFP and OCHA Gulu Office - data source as of July 2005
Map and distances not in scale

IMU - OCHA Uganda - If you need a copy of this map, please refer to this code: IDPGULU200507
Organizations are most welcome to provide new information on the camps locations and population numbers - please send your comment to ocha-uganda@un.org

Illustration 1 LRA activities in abducting children

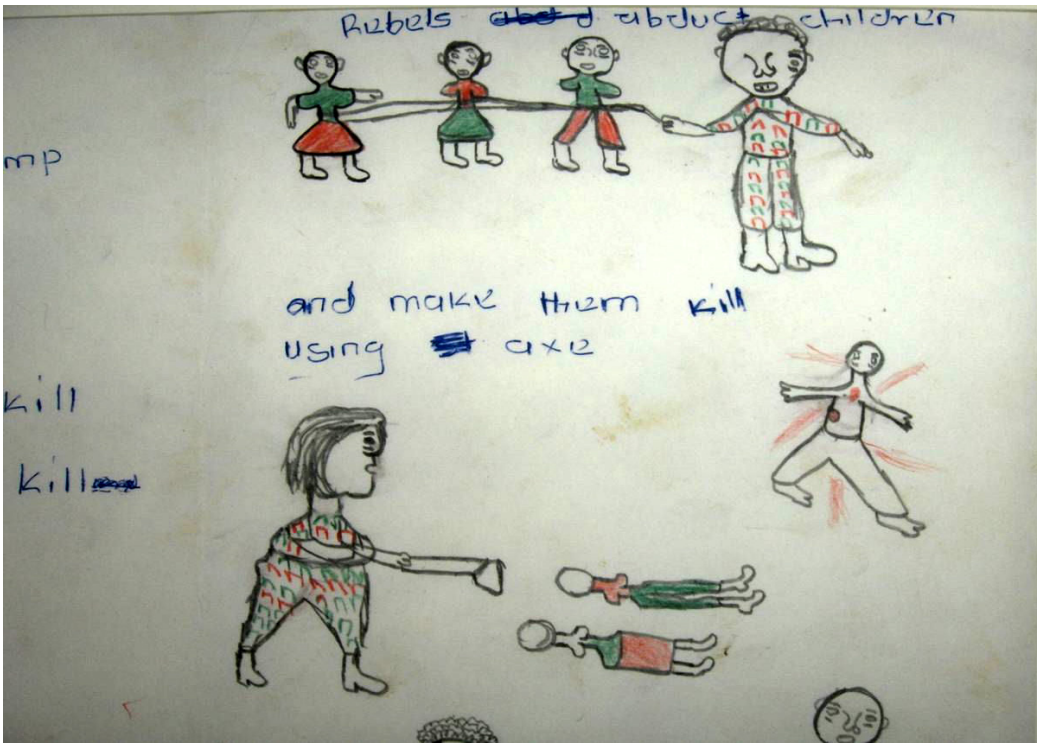


Illustration 2 UPDF activities in 'protecting' children in displaced persons camps

Photo 1 A ‘protected’ village in 2006

PART III

CHILDREN'S SUFFERING AND QUESTS FOR THERAPY

In Part III, I focus on children's suffering and quests for therapy. I analyse children's common illness experiences and their attempts to restore health and normality, whether through the use of pharmaceuticals, herbal remedies, or other strategies. The most common illness experiences which children identified turned out to be infectious diseases, wounds, injuries, snakebites, epilepsy and complaints symptomatic of emotional distress. In examining children's illness experiences and quests for therapy *emic* perspectives will be privileged, much as I draw from *etic* perspectives to explain the illness categories.

First I present children's experiences and treatment of self-diagnosed malaria, diarrhoea, infections of the respiratory system, scabies, and eye infections. In presenting children's viewpoints about infectious diseases, I follow the children's differential ranking of their experiences with them by their perceived severity, commonness, ease of management, and whether their daily lives were disorganised by such experiences. In addition, I explore the fact that the children frequently self-diagnosed various health conditions – including somatic and psychosomatic complaints – as infectious diseases, in particular malaria. I then progress from a discussion of experiences with infectious diseases to the analysis of children's experiences with wounds and landmine injuries, epilepsy, and complaints symptomatic of emotional suffering. Epilepsy is a neurological chronic condition. In effect, the pattern in themes presented in each chapter suggests a progression from discussion of experiences with infectious diseases to analysing experiences with emotional distress. At this stage, in quests for therapy, I will be presenting both children's use of pharmaceuticals, but mainly other survival strategies in situations of armed conflict. I will return to this issue in chapters eleven and twelve.

Although I have assigned specific names to different types of suffering, including the use of various categories of infectious diseases and emotional distress, the reader should bear in mind throughout that these different categories can and do affect individuals simultaneously, and affect children with varying severity; some illnesses were experienced as more severe and therefore children prioritised them. Further, the categories I

use were principally adapted for purposes of data manageability. The reader might sense that some categories adapted for a particular chapter, such as Chapter Five on malaria, covers more than what is suggested by the title. By way of explanation, I argue that my guiding principle has been a need to identify similarities in children's interpretation of symptoms, and of what medicines they were likely to access for particular health complaints. In short, the isolation and analysis of children's suffering into distinct chapters is ultimately not meant to suggest boundaries in experiences (for example between infectious diseases and emotional distress), but only to bring order to children's experiences for the purpose of this thesis.

As mentioned earlier, *emic* perspectives are privileged in my discussions. Nevertheless, when needed I refer to *etic* viewpoints such as biomedical concepts and key informants' perspectives, in an attempt to triangulate the data. For example, where children referred to their experiences of *koyo* (coldness)*, lyeto* (high body temperature), *abaa wic* (headache), malaria, and *malaria madongo* (severe malaria), I refer to and analyse these five complaints in the discussion section simply as malaria. This is because such complaints were indeed frequently self-diagnosed and/or clinically-diagnosed as malaria, and children self-medicated, or were treated with antimalarials in health centres and by private healthcare providers.

As an introduction to the following chapters where I examine the various illness categories in detail, I first present in Chapter 4 a general overview based on quantitative data about the illnesses or health complaints which children mentioned experiencing within a one month recall. This quantitative data was obtained through a survey in Gulu Municipality with 165 children aged nine to sixteen years, of whom 88 were boys and 77 girls. I will then extract from this quantitative overview data about infectious diseases and mental distress or emotional suffering, which will be analysed in the subsequent chapters addressing particular illness experiences, coded according to the medicines children were likely to access for those symptoms, their ultimate self-diagnosis for the illness, and biomedical categorisations of symptoms. Generally speaking, each of the seven chapters on specific illness categories first present both quantitative and qualitative data, capturing children's perspectives about prevalence and their quests for therapy within a one month recall. Secondly, key informants' perspectives about pertinent issues for each illness experience are presented. Results are then analysed in the discussion and subsequently conclusions are drawn.

4

Survey data from assessment of common illness experiences and quests for therapy

The results obtained from a survey of children of primary school age are obtained in this chapter. In the subsequent chapters, the quantitative data provided below will be analysed according to the separate illness categorisations.

General characteristics of respondents

Quantitative data were collected in a survey using semi-structured questionnaires from 165 children, aged between nine and sixteen years. At the time of the study they were attending displaced primary schools within Gulu Municipality and spent nights in night commuters' shelters. Table 4.1 presents the major characteristics of the sampled children.

Table 4.1 Study sample characteristics (N=165)

Variable	*Sample size*		*Age*		*Education*	
Gender	Number (%)	CI at 95%	Age	CI at 95%	Number of years	CI at 95%
Boys	88 (53.3)	1.39-1.54	13.4	13.11-13.73	6.27	6.05-6.49
Girls	77 (46.7)		13.4	13.02-13.93	6.28	6.04-6.53

Prevalence of children's illness experiences

One of the questions posed to children was: What illness experiences or health problems affected you in the recent past, for example in the past month? The multiple responses obtained are presented in Table 4.2.

Table 4.2 Illness experiences or health complaints within a one-month recall (N=165)

Illness	*Boys*	*Girls*	*Total*	*P-values*
Aona ki avuru (cough and flu)	76	68	144	0.71
Gwinyo (scabies)	83	33	116	< 0.005
Tyena lit / wang vu (wounds and injuries)	38	57	95	< 0.005
Amwoda ici (stomach ache)	22	61	83	< 0.005
Cado (diarrhoea)	40	35	75	1.00
Cado pii pii (diarhoea with watery stools)	32	30	62	0.73
Lyeto (fever)	35	24	59	0.25
Malaria	20	21	41	0.50
Lit wang (red eye)	15	23	38	0.05
Trachoma (for those who went to health centres)	17	12	29	0.53
Koyo (coldness)	13	12	25	0.88
Abaa wic (headache)	11	14	25	0.31
Twol okayan (snakebites)	17	2	19	0.001
Cado marac / remo (diarrhoea with blood)	9	4	13	0.23
Malaria madongo (severe malaria)	5	3	8	0.59
Two cimu (epilepsy)	1	1	2	0.35
Total	**434**	**400**	**834**	

Table 4.2 shows that there were sixteen types of different illness experiences or health complaints mentioned by the children who participated in this study, while the total number of responses was 834 (D=834). There were a high number of responses because the survey question was open-ended and therefore yielded multiple responses. In essence, what can be gathered from this data is that there was a high disease burden for these wartime children. For gender-disaggregated data, the total count for illnesses (d) mentioned by boys was slightly higher than those for girls; boys mentioned 434 counts of illness experiences (d=434) compared to girls' 400 counts (d=400).

Pearson's chi-square test was performed in order to establish whether there is a relationship between the observed data and expected data. For example, one of the sub-questions is whether boys and girls experience illnesses differently, and if so, why. Data obtained from the survey (observed data) could suggest that there is (1) no significant

relationship, (2) a significant relationship, or (3) a strong significant relationship, between boys' and girls' illness experiences. In analyses with Pearson's chi-square tests, the larger the difference and consequently the larger the value for chi-square, the less likely it is that the two variables are unrelated or independent, in which case I deduce that there is no statistically significant relationship between the two variables under examination. However, there is always a possibility that even if the observed data are very different from expected data, that could have occurred by chance. It is this chance that is reported as the significance value – that is the P-value (see Fielding & Gilbert 2002: 265). In short, it was deduced that two variables have a statistically significant relationship if the P-value is smaller than or not exceeding the reference limit of 0.05. For example, we can deduce that there is a statistically significant difference for P-values less than or equal to the reference point of 5 percent or 0.05 (i.e. P-value < or = 0.05). Looking at the P-values column in Table 4.2, the P-value for boys and girls' experience with wounds and injuries within a one month recall is P<0.005, so there is a strong statistically significant difference between girls and boys' reporting of experiences with wounds and injuries. This strong statistically significant difference is also observed for boys' and girls' experiences with scabies (P<0.005), stomach aches (P<0.005) and snake bites (P=0.001). There is also a statistically significant difference in boys' and girls' experiences with red eye disease (P=0.05). The value (P=0.05) for red eye disease falls on the upper limit of significance of five per cent. The deduction here is that the statistical difference between boys' and girls' experience with red eye disease is not a strong one. Data suggests, however, that there is no statistically significant difference in boys' and girls' experiences with the remaining illnesses.

As shown in Table 4.3, various symptoms were categorised together to ensure data manageability. The criteria chosen for re-grouping or categorising the various complaints were either similarities in symptoms, low prevalence of conditions, or the type of medication sick persons were likely to access and use for the health complaints. For example, *abaa wic, lyeto* and *koyo* – in addition to malaria and *malaria madongo* – were usually diagnosed by the various involved parties as malaria, and were subsequently treated as such (see the results of the qualitative study in Chapter 5). In addition, when children inquired into what medicines to buy for these three illnesses – as well as for malaria and *malaria madongo* – in drugs shops, clinics, and grocery shops where medicines were sold, they were advised to purchase antimalarials. What is more, in health centres where participant observation was conducted, these five complaints, when made by the children, were diagnosed as malaria. I therefore coded the five symptoms together as malaria. Another example is the three different categories of diarrhoea which children discussed – *cado* (diarrhoea)*, cado pii pii* (watery stools)*,* and *cado remo* (bloody diarrhoea) – which were coded as diarrhoea and addressed in greater detail in Chapter 6 mainly due to similarities in symptomatic presentation though with variations in severity.

Trachoma and *lit wang* were health complaints that affected the eyes and they were together coded as eye infections, and in 'others' I combine the illnesses which few children (less than 20) mentioned to have experienced in a one month recall. That is how I categorise epilepsy and snake bites together.

In Table 4.4, it is evident that malaria had the highest count: 158 of the 165 children either received malaria diagnoses – through self- or clinical-diagnosis – or used antimalarials in treatment of symptoms, within a one month recall. In short, children were

Table 4.3 Coding of illness experiences (or health complaints) within a one-month recall (N=165)

Illness	*Boys*	*Girls*	*Total*	*P-values*
Lyeto (fever)	35	24	59	0.25
Malaria	20	21	41	0.50
Koyo (coldness)	13	12	25	0.88
Abaa wic (headache)	11	14	25	0.31
Malaria madongo	5	3	8	0.59
Malaria	**84**	**74**	**158**	**0.84**
Cado pii pii (watery stools)	32	22	54	0.73
Cado (diarrhoea)	40	35	75	1.00
Cado remo (diarrhoea with blood)	9	4	13	0.2
Diarrhoea	**81**	**61**	**150**	**0.59**
***Aona ki avuru* (cough and flu)**	**76**	**68**	**144**	**0.71**
***Gwinyo/* scabies**	**83**	**33**	**116**	**<0.005**
Wounds	**38**	**57**	**95**	**<0.005**
Trachoma	17	12	29	0.53
Lit wang (red eye)	15	23	38	0.05
Eye infections	**32**	**35**	**67**	**0.24**
***Amwoda ici* (stomach ache)**	**22**	**61**	**83**	**<0.005**
Two cimu (epilepsy)	1	1	2	0.35
Twol okayan (snake bites)	17	2	19	0.001
Others	**18**	**3**	**21**	**0.001**
Total	**434**	**400**	**834**	

Table 4.4 Illnesses as ultimately coded (N=165)

Illnesses	*Boys*	*Girls*	*Total*	*Percentage of responses*	*P-values*
Malaria	84	74	158	19	0.84
Diarrhoea	81	69	150	18	0.59
Cough and flu	76	68	144	17.1	0.71
Scabies	83	33	116	14	<0.005
Wounds and injuries	38	57	95	11.4	<0.005
Stomach ache	22	61	83	10	<0.005
Eye infections	32	35	67	8	0.24
Others	18	3	21	2.5	0.001
Total	**483**	**400**	**834**	**100**	

most likely to mention that they had an experience self-diagnosed or clinically-diagnosed as malaria within a one month recall. In comparison to the entire summation of illness experiences, the prevalence of health complaints related to or diagnosed as malaria had the highest percentage response of 19.0% (158 out of 834). Further, both boys' and girls' responses suggest equally high prevalence, with 84 boys (19.4%) and 74 girls (18.5%). There was no statistically significant difference between boys' and girls' self-reported and clinically-diagnosed experiences of malaria (P=0.84).

How children knew they were ill

In order to understand the children's health complaints for the above illness experiences within a one month recall, they were asked how they felt during these episodes. The summary of results is presented in Table 4.5. The symptom most highly ranked by the children was headache. Data also suggests a statistically significant difference in boys' and girls' experiences with headache (P=0.05). Nevertheless, the statistical relationship is not a strong one as the P-value obtained lies at the upper limit of statistical significance of 5 percent (i.e. P =0.05). Because there were more girls (bearing in mind that girls were fewer, n=77) who shared their experiences with headache, I can deduce that results possibly suggest that girls were more likely than boys to share their experiences with headache. The second most commonly mentioned symptom was *koyo* (coldness), with a strong statistically significant difference at P<0.005. Since about twice as many girls than boys reported having had *koyo* within a one month recall, it is probable that girls were more likely to complain of *koyo* than boys. Data suggest no statistically significant difference for other symptoms. An issue of great importance in Table 4.5 are the symptoms of persistent headaches and pain in the body. These I discuss in Chapter 11, addressing complaints symptomatic of emotional distress.

Table 4.5 Symptoms of illnesses within a one-month recall (N=165)

Symptoms	*Boys*	*Girls*	*Total*	*P-values*
Abaa wic (headache)	63	65	128	0.05
Koyo (coldness)	34	51	85	<0.005
Kuma leb leb (weakness)	48	35	83	0.24
Lyeto (high body temperature)	41	40	81	0.49
Abaa wic lela (persistent / severe headache)	36	35	71	0.56
Pe mito cam (appetite loss)	28	28	56	0.54
Ngok (vomiting)	27	26	53	0.67
Kuma rem (pain in the body)	17	11	28	0.39
Skin rashes	12	12	24	0.72

Medicines used in the management of common health complaints

Children were asked to name all medicines they had used in the recent past, for instance in the past month. The question about medicine use was open ended, again allowing for multiple responses. The results are presented in Table 4.6. The 165 children named using a total of 1,571 medicines (D=1,571) over the past month. Boys (n= 88) named 833 (d=833) medicines in total, and girls (n=77) a total count of 738 (d=738) medicines. Such a finding suggests that there was a high level of medicine use by the study population. This finding is in line with high rates of medicine use by populations with a high disease burden. I will come back to this issue, and also make a connection between high medicine use and the presence of a wide range of pharmaceuticals in the market with the same active ingredients, but which were frequently used by children concurrently.

Table 4.6 Medicines commonly used by children (N=165)

Medicines (*Yat mwono* as opposed to *yat acholi*, i.e. medicines which are not herbal remedies)	*Boys*	*Girls*	*Total*	*P-values*
Red and yellow capsule	53	60	113	0.03
Black and red capsule	24	12	36	0.07
Amox (as called in drug shops)	10	4	14	0.23
Amoxicillin or Tetracycline	**87**	**76**	**163**	**0.92**
Yat matar ma tye 500 ma wac (white medicine with 500 and tasteless), or Panadol (500mg)	85	71	156	0.22
Chloroquine (white medicine which is bitter for malaria)	78	71	149	0.44
Opele (ointments for scabies)	64	64	128	0.11
Pen V (Penicillin V or phenoxymethylpenicillin)	62	64	126	0.06
Flagyl (yellow tablets for diarrhoea)	55	53	108	0.39
Multivitamins (or vitamins)	55	49	104	0.88
Eyedrops	55	43	98	0.39
Piriton (*yat nino matar*)	53	42	95	0.46
Action	43	46	89	0.18
Vemox (*yat kwidi* – deworming medicines)	41	39	80	0.60
Valium (*yat nino makwar*)	50	29	79	0.01
Lagarctil (the medicine for vomiting – this medicine was identified in drug shops and in two medical records I observed)	36	40	76	0.16
Fansidar	32	23	55	0.38
Septrin	21	22	43	0.49
Quinine (*yat labira ma lyeto ki malaria madongo* – injections for *lyeto* (fever) and severe malaria)	16	6	22	0.05
Total	**833**	**738**	**1571**	

I recognise the difficulties encountered when discussing pharmaceutical properties based on their colours, principally because pharmaceutical companies often use different colours when packaging the same active ingredients into a capsule or tablet. During the period of research, the red and yellow capsules were most commonly Amoxicillin. Tetracycline did, however, sometimes come in red and yellow capsules. And although both Amoxicillin and Tetracycline are antibiotics, Tetracycline is well known for its broad spectrum effects (acting on more bacteria types, for example *Escherichia coli*, *Salmonella*, and *Vibrio cholerae*), while Amoxicillin has moderate spectrum properties.

The general statistics above suggest that there are medicines that girls were more likely to use than were boys. These mainly included analgesics and antibiotics such as the red and yellow capsules (n=60 : 8.1% : P=0.03), Action (n=46 : 6.2% : P=0.18), Largactil (n=40 : 5.4% : P=0.16), and Pen V (n=64 : 8.8% : P=0.06). There is a statistically significant difference between boys' and girls' use of the red and yellow capsules (P=0.03). The red and yellow capsules were also frequently recommended in drug shops for clients with stomach aches, and findings indeed suggest a higher prevalence of stomach aches in girls (n=61 : 15.3%) compared to boys (n=22 : 5.5%), at a P-value of <0.005. This issue will be addressed in detail in Chapter Eleven. Other areas where I discerned statistically significant differences in medicine use by boys and girls are in the use of Valium, with boys having higher reported usage (n=50) than girls (n=29), with a P-value of 0.01; and in self-reported use of quinine within a one-month recall (P=0.05). I, however, will deduce that the difference in boys' and girls' use of quinine is not a strong one, for the value of (P=0.05) falls at the upper limit of significance of five per cent. I will return to this in analyses. From the wide range of medicines which children mentioned using within a one month recall, it was possible to categorise them according to likely active ingredients, and by the illness which the children were likely to have purchased them for. The different kinds of medicines used are shown in Table 4.7.

In general, the data in Table 4.7 shows that children were seven times more likely to mention having used Panadol than the least used medicine quinine. This could be due to the easy accessibility and oral administration of Panadol as opposed to the special intramusculine and intravenous administration of quinine in hospitals and in some clinics. In addition, children indicated that they used Panadol for various health complaints as opposed to using quinine for malaria. For example, Panadol was used for self-diagnosed malaria, aches and pains and children applied crushed tablets of Panadol on wounds to minimise pain. A further observation is that although Piriton is known in biomedicine for its properties to counter the allergic effects of histamine released during an attack of flu or allergies, with its sleep causing effect considered to be only a side effect, children frequently put emphasis on this side effect of Piriton. I will therefore discuss Piriton as a *yat nino* (sleep medicine) as opposed to its intended purpose of minimising allergic effects.

From Table 4.8, which must be viewed as second level categorisation of medicines by their active ingredients, it is clear that antibiotics were the most commonly used pharmaceuticals at 28.0%. This phenomenon could signify a presence of various types of antibiotics which children could access and a high prevalence of illnesses which necessitated administration of antibiotics. However, the high rate of antibiotic use might also suggest the unnecessary and over-use of such medicines. Psychopharmaceuticals, at 16.0%, were the second most frequently used medicines. This is not a particularly un-

Table 4.7 Coding of medicines used by children within a one-month recall (N=165)

Medicines	*Boys*	*Girls*	*Total*	*P-values*
Amoxicillin	53	60	113	0.03
Tetracycline	24	12	36	0.07
Amox (as called in drug shops)	10	4	14	0.23
Flagyl (metronidazole)	55	53	108	0.39
Pen V (penicillin V)	62	64	126	0.06
Septrin (cotrimaxazole)	21	22	43	0.49
Antibiotics	**225**	**215**	**440**	
Panadol (paracetamol)	85	71	156	0.22
Action (paracetamol/acetylsalicylic acid/caffeine)	43	46	89	0.18
Antipyretics	**128**	**117**	**245**	
Mabendazole (vemox)	**41**	**39**	**80**	**0.60**
Lagarctil (chlorpromazine)	36	40	76	0.16
Valium (diazepam)	50	29	79	0.01
Piriton (chlorpheniramine)	53	42	95	0.46
Psychopharmaceuticals	**139**	**111**	**250**	
Chloroquine	78	71	149	0.44
Fansidar (sulfadoxin/pyrimethamine)	32	23	55	0.38
Quinine	16	6	22	0.05
Antimalarials	**126**	**100**	**226**	
Opele (ointments for scabies)	**64**	**64**	**128**	**0.11**
Multivitamins (or vitamins)	**55**	**49**	**104**	**0.88**
Eyedrops (gentamycin)	**55**	**43**	**98**	**0.39**

Table 4.8 Medicines used by children as ultimately coded (N=165)

Medicines	*Boys*	*Girls*	*Total*	*Percentage of responses*
Antibiotics	225	215	440	28.0
Psychopharmaceuticals	139	111	250	16.0
Antipyretics	128	117	245	15.6
Antimalarials	126	100	226	14.4
Opele (ointments for scabies)	64	64	128	8.1
Multivitamins (or vitamins)	55	49	104	6.6
Eyedrops (gentamycin)	55	43	98	6.2
Mabendazole (vemox)	41	39	80	5.1
Total	**833**	**738**	**1571**	**100**

common finding for a population which had to confront war related emotional suffering, and which had found treatment largely through the use of pharmaceuticals. What is more, in institutions put in place to ensure children's well-being, such as night commuters' shelters, there was regular distribution of such pharmaceuticals as Valium and Piriton. Further, I will show how children managed complaints like sleeplessness through the use of pharmaceuticals commonly called *yat nino* (medicines for sleep). This practice had implications for the issue of comprehensive management of emotional distress. Meanwhile, antipyretics (15.6%) were the third most used medicines by children. This could be due to children's use of Panadol, for instance, as part of a combination of therapies for episodes of self-diagnosed malaria. Antipyretics were also used to minimise aches and pains, which could be seen to demonstrate children's medicalisation of complaints symptomatic of emotional distress. I will pursue this insight further in Chapter 11, allowing for an interpretation which sees the possibility that such symptomatic management of emotional suffering or distress reflects some of the curative approaches children employed to minimise their suffering, given the context in which they lived.

Antimalarials (14.4%), like psychopharmaceuticals, were also commonly used by children. I have explained above how a wide range of health complaints were diagnosed as malaria, and for which antimalarials were subsequently administered; this suggests one reason accounting for the high use of antimalarials by children within a one month recall. A second reason could be the easy access of antimalarials, and the fact that children minimised their health complaints mainly through the use of pharmaceuticals which could be easily accessed over the counter, without prior consultation with professional healthcare providers. It also appears that children had great trust in pharmaceuticals, particularly as they provide an immediate solution for minimising their suffering.

The points below represent additional factors which likely influenced the results obtained concerning medicine use by war affected displaced children.

- The timing of the questionnaire coincided with scabies and eye infection epidemics in the study region. Having been confronted by these epidemics, particularly scabies, children indicated having used various medicines in attempts to minimise their suffering – sometimes even using antimalarials on their skin rashes caused by scabies.

- At night commuters' shelters such as Noah's Ark and Lacor Hospital night commuters' shelter analgesics, psychopharmaceuticals and sometimes chloroquine were administered on a daily basis to children who presented health complaints such as headaches and pains in the body to nurses.

- The Gulu District Directorate of Health Services (DDHS) implemented school health programmes in October 2004 whereby children who attended displaced primary schools were given free de-worming medicines (Vemox) and multivitamins. During the same school visits by DDHS staff, girls of reproductive age (from twelve years of age) were vaccinated against tetanus.

Children described the medicines coded above by colour, taste, or specific names. Where specific names of medicines were mentioned, they were likely to be pharmaceuticals prescribed from health centres, market drugs (which always have the names clearly written on them), or medicines most frequently accessed and used by the children. For example, Panadol had the number 500 – indicating the dose in milligrams per tablet – clearly written on the packaging, and this number was therefore frequently evoked

when speaking of the medicine. Its being *wac* (tasteless) was also used as a description for it. A substantial proportion of children also knew the name of Panadol.

I compiled a list of medicines as described by colour or taste, and indicated how the children used them. I then discussed the list with drug shop owners and three pharmacists in order to verify the likely active ingredients in these medicines. At first, categorising medicines by colour and taste – as the children had discussed them – presented a problem for me since different pharmaceutical companies used different colours for the same medicines. Therefore I had to choose the names which the colours and medicines were likely to represent. In order to gain insights into the sources of the medicines named above, children were asked where they obtained the medicines which they had recently used (see Table 4.9).

Table 4.9 Sources of medicines used by children (N=165)

Source of medicines	*Boys*	*Girls*	*Total*	*P-values*
Drug shops	56	36	92	0.03
Clinics	31	47	87	0.001
Hospital	37	28	65	0.46
Forest	23	15	38	0.31
Bush and near home	18	16	34	0.96

Results suggest that children mainly accessed medicines from drug shops. In Gulu Municipality drug shops were of varying quality at the time of this study. There were drug shops which were managed by pharmacists and there were those which were owned by people with no qualification at all in pharmacy. They dispensed medicines according to what the clients demanded and could afford. In the discussion of medical pluralism in Chapter 2, I provided the example of how it was common for clients at state aided health centres to be referred elsewhere for medicines, and for clients to receive prescriptions and be referred to drug shops and clinics to buy the medicines. This could also explain why more children mentioned having accessed their medicines from drug shops.

It is observable from the table above that there is a statistically significant difference between girls' and boys' accessing of medicines in drug shops (P=0.03) and from clinics (P=0.001). The figures suggest that boys were about twice as likely to access medicines from drug shops than girls, while a slightly higher number of girls than boys – 47 compared with 31 respectively – mentioned having accessed medicines from clinics. However, for the children there were actually no clear boundaries concerning what a clinic or drug shop was, and the differences adults gave during interviews were also blurred. One child who attempted to make a distinction between a clinic and drug shop only suggested one difference, namely that injections were administered at the clinic and not at the drug shops. In another example, at Olailong trading centre there were two medicine outlets managed by retired nurses. One was called Merrywood Clinic, the other Olailong drug shop, and the two centres offered essentially similar services to clients. Up to the time of writing this book the distinction between clinic and drug shop is still unclear to me, given the actual practices observed at the time of the study, and

from regular visits to Gulu after fieldwork was completed. It was common to visit a clinic and find an individual who had no qualification at all in a biomedical discipline or pharmacy dispensing medicines and also advising clients on what medicines they could buy for their health complaints. Further, retired nurses and clinical officers often owned either clinics or drug shops. If a basic distinction between the two states that at clinics clients may be given prescriptions and medicines by a professional health worker, while in drug shops clients only access medicines after presenting prescriptions, then this distinction is blurred for Gulu. I will therefore discuss children's perspectives concerning sources of medicines, bearing in mind the blurred boundaries between theoretical categories and preferences in nomenclature for the various sources of medicines.

In general the word *ot yat* – literally meaning 'house of medicine', but with reference to a hospital or health centre – was commonly evoked as a source of medicine during informal conversations. At this stage the children also referred to clinics or drug shops as *ot yat*, and ultimately the distinction could only be made when the child was asked more questions concerning whether s/he had bought the medicines or accessed them free of charge. As mentioned earlier, all clients of the state aided health centres of Gulu Regional Referral Hospital, Layibi, Laroo, and Laliya accessed medicines free of charge, therefore when a child indicated having bought the medicines it was likely that the child had visited a drug shop or clinic.

Returning to the results in Table 4.9, they suggest that there is no statistically significant difference between boys' and girls' accessing of medicines from hospitals (P=0.46), the forest (P=0.31), or the bush near their home (P=0.96). It is probable that both boys and girls accessed medicines from these three sources equally. In the context of medical pluralism, children often used herbal remedies to manage common illnesses which affected them. Some of the remedies captured in the survey are presented below.

Herbal medicines used by children

From the various sources of medicines which children named in Table 4.9, it is evident that some of the medicines were herbal remedies. In Table 4.10, I provide a summary of the different herbal medicines which the children mentioned having used within a one month recall. A list of herbal medicines, including those which children brought to the

Table 4.10 Herbal medicines used by children within a one-month recall (N=165)

Herbal medicines	*Boys*	*Girls*	*Total*	*P-values*
Mango roots	79	69	148	0.97
Pawpaw leaves	82	59	141	0.003
Mango bark	75	51	126	0.004
Garlic	34	39	73	0.12
Banana sap	29	19	48	0.24
Neem leaves	24	11	35	0.042
Guava leaves/bark	20	4	24	0.001
Total	**343**	**252**	**595**	

workshop on commonly used herbal medicines, were presented to the department of Botany at Makerere University for identification.

In general, children mentioned using about three times the number of pharmaceuticals (1,571) than herbal remedies (595) in the management of common illnesses within a one month recall. This could be due to the fact that pharmaceuticals were easily accessible and children regarded them as efficacious. It is also possible that children had greater trust in pharmaceuticals compared to herbal medicines.

Through gender disaggregation of the data I discovered strong statistically significant differences between boys' and girls' uses of pawpaw leaves (P=0.003), mango bark (P=0.004) and guava leaves or bark (P=0.001). A slight statistical relationship was obtained in girls' and boys' use of neem leaves (P=0.042). Further, boys in general were more likely to mention using herbal remedies (d=343) compared with girls (d=252), therefore this finding may suggest that boys used more herbal remedies than girls.

The figures for mango bark and mango roots remain separate because children were very particular about the distinct importance of the two parts of the same plant. Even pictorially it was common for children to draw both the mango tree stem/bark and the mango roots. For example, twelve year old Okello, after drawing the mango tree, indicated that the roots are for whooping cough and the bark for stomach ache. Nine year old Abwo also drew two mango trees, and shaded one of the trees at the roots, making an indication for 'abdomen pain' (stomach ache) and the other at the bark, writing 'for cough'. Meanwhile twelve year old Apio, after drawing the mango tree, wrote 'mango tree root for diarrhoea'. A similar drawing was done by twelve year old Acen and eleven year old Aol, who showed in one illustration a girl digging out the mango tree roots and wrote 'for diarrhoea', while in another illustration she showed a girl getting part of the mango bark, with a caption 'for cough'. During one group discussion at Noah's Ark night commuters' shelter, children suggested that each part of the mango tree had different medicinal purposes and indicated using *kor muyeme me aona* (mango bark for cough) and *tee muyeme me cado* (mango roots for diarrhoea).

There were, in general, overlaps in the use of different medicines for common illnesses which affected children. In each of the subsequent chapters an attempt is made to link the various medicines with individual illness experiences. This exercise is guided by qualitative data since in some instances it was quite difficult to tell from the quantitative survey what the child used the medicine for within their one month recall; in particular when the child also indicated having had multiple illness episodes. Further, in the course of presenting and discussing various diseases, more medicines will be introduced. These are medicines or remedies which children discussed only when qualitative data collection methods were used.

In summary, Chapter 4 has acted as a general introduction in which mainly survey data about children's illness experiences and quests for therapy were presented. In subsequent chapters the findings are extracted from the overview of results and analysed separately.

5

Malaria

Children stated having had malaria, malaria *madongo* (severe malaria)*, koyo ki lyeto* (coldness and high body temperature), and *abaa wic* (headache) within a one month recall. These illness experiences were ultimately coded as malaria, principally because the children self-diagnosed these illness experiences as such, but also because when children inquired about what medicines to buy for their symptoms in drug shops, clinics, and grocery shops, they were advised to purchase antimalarials. Further, in health centres where participant observation exercises were conducted, these complaints were diagnosed as malaria. Malaria is therefore presented as the first illness category for in-depth analysis because children readily shared their experiences with health complaints which were ultimately diagnosed as malaria. The general statistics drawn from the overview above also suggest a higher prevalence of self-diagnosed malaria compared to other illnesses which the children identified, and furthermore, qualitative findings suggest that children ranked malaria as a severe and frequently experienced illness.

After presenting both quantitative and qualitative data signifying children's and key informants' viewpoints about malaria, I will discuss this data in relation to (1) how children rank the severity of malaria, (2) the prevalence of malaria and medicine use, (3) the idea that a high count of antimalarial use within a one month recall suggests that children were pragmatists in their quests for therapy, and (4) the idea that a high count of pharmaceuticals could suggest a *pharmaceuticalisation* or over-use of pharmaceuticals for common febrile illnesses and complex forms of suffering in situations of armed conflict. Based on empirical evidence, a suggestion is made regarding the need to address wider socio-economic and political inequalities in the effective prevention and control of malaria in holoendemic regions (i.e. areas of high transmission), including northern Uganda.

Quantitative data: Prevalence of and medicine use for episodes of malaria from children's perspectives

Table 5.1 shows the prevalence data on malaria among the 165 sampled boys and girls during the month prior to the interview. Although data was gender-disaggregated, there was no statistically significant difference between boys' and girls' self-reported experiences with malaria within a one month recall (P=0.84).

Table 5.1 Prevalence of malaria within a one-month recall (N=165)

Illness	*Boys*	*Girls*	*Total*	*P-values*
Lyeto (fever)	35	24	59	0.25
Malaria	20	21	41	0.50
Koyo (coldness)	13	12	25	0.88
Abaa wic (headache)	11	14	25	0.31
Malaria madongo	5	3	8	0.59
Total for malaria	**84**	**74**	**158**	**0.84**

Medicines used in the management of malaria within a one month recall

As shown in Table 5.2 below, various medicines – antimalarials and antipyretics – were used by children for their cases of malaria. These medicines were either advised by workers at drugstores or by healthcare providers. Children were also observed making specific requests for antimalarials and various antipyretics.

Table 5.2 Medicines used in the management of malaria within a one-month recall (N=165)

Medicines	*Boys*	*Girls*	*Total*	*P-Values*
Chloroquine	78	71	149	0.44
Fansidar (sulfadoxin / pyrimethamine)	32	23	55	0.39
Quinine	16	6	22	0.05
Antimalarials	126	100	226	
Panadol (paracetamol)	85	71	156	0.22
Action (paracetamol / acetyl salicylic acid / caffeine)	43	46	89	0.18
Antipyretics	128	117	245	

In general, and as shown in the chi-square tests determining whether there is a difference between boys' and girls' use of medicines; and as in P-values in Table 5.2 above, apart from a statistically significant difference between boys' and girls' use of quinine (P=0.05), there were no other observed statistically significant relationships in using antimalarials and antipyretics for malaria. These pharmaceuticals could be ob-

tained from clinics, pharmacies, drug shops, and grocery shops, and at these various medicine distribution points prescription-only medicines, including medicines for malaria, were also readily accessed without prior consultation with professional healthcare providers. What is more, through personal experience with such a highly prevalent infection, many people, including children, knew what pharmaceuticals to buy for self-diagnosed malaria. Antipyretics were regarded as necessary by many, especially for the headaches and fever associated with malaria. However, during workshops in 2004 for community based health workers, the prescribing of antimalarials together with antipyretics was frequently discouraged, much as this practice was still observed in the local management of malaria episodes in Gulu district in 2007.

Qualitative data:
Prevalence, symptoms, severity and management of malaria

A similar pattern of results concerning the high prevalence of malaria and antimalarial/antipyretic medicine use was obtained through qualitative data collection techniques. Additional data obtained concerned the experiential severity of malaria and children's use of sub-clinical doses in their management of it. Further, I was faced with dilemmas concerning whether complaints which were ultimately regarded as self-diagnosed episodes of malaria could in fact be obscuring more complex forms of suffering.

Exemplary narratives of experiences with malaria within a one month recall

Below I give two exemplary narratives signifying children's experiences with malaria. In this particular exercise over four hundred children, in the first and second phase of the study, wrote about or narrated their experiences with malaria within a one month recall. I present here the exemplary narratives of Ojok and Acan to represent symptoms leading to self-diagnosis, experiential severity, and the differential quality and quantity of medicines children accessed for malaria. This is how Ojok, a fourteen year old boy, wrote about his experience with malaria:

> I used to go and do *leja leja* quite far from home during school holidays. One day I was coming back to Kirombe from Lacor, where I had gone to dig. It rained on me. By the time I reached home, I had *abaa wic* (headache) and *koyo* (was feeling very cold). I lit a fire and sat as close to it as possible but I was still cold. I bathed with warm water but the *koyo* (coldness) did not stop. I went to sleep. By the morning time I was still feeling cold even though I had covered myself with two blankets and was sitting under the sun. I used the money I had earned to go and buy medicines from a clinic in Kirombe. After swallowing the chloroquine and Action tablets I vomited them. Even the next day I vomited the medicines. I could not drink or eat anything, not even cold water. I was drinking only warm water. I bought two more chloroquine and Panadol. The landlady instructed me to use warm water to drink them. After two days I started feeling better though I was still very weak and dizzy. I had a slight headache and by the end of the week I had recovered completely. I have not fallen sick again for one month now.

Acan, a ten year old girl, also shared her experience as follows:

> It started by feeling *koyo* (coldness/shivering or fever) and later with *ngok* (vomiting), and I had *abaa wic* (headache). I did not come to school that Tuesday. My older sister [thirteen years old] told me to bathe and go and buy medicines for malaria. She gave me one hundred shillings [0.04 euro] for chloroquine and fifty shillings [0.02 euro] for Panadol. I brought two tablets of Chloroquine and two Panadol. I took them but the next day my body started itching. My sister bathed and took me to Gulu Hospital. By that time I could not talk and was told to get ten injections at the hospital. After three days I started feeling better and decided to go to the well to fetch water, but when I came back, I was feeling cold, had a stomach ache and started vomiting again. I also had diarrhoea. I was taken back to

> the hospital by my grandmother. That time I was given Fansidar and Panadol and yat acholi (herbal medicines or Acholi medicines) from home – it was *kor muyeme* (mango tree stems) and *lace* (not identified species) for malaria. Then I started feeling better. I was also given orange and passion fruit juice to drink.

From the narratives above, children self-medicated their malaria episodes with sub-clinical doses. This is not inline with the recommended dose that children of school going age take four tablets of chloroquine on the first day of diagnosis, and subsequently two tablets on the second and third day of treatment (i.e. a regimen of 4:2:2). In a more scientific approach, a patient's weight is determined before an appropriate prescription – how many tablets s/he should take and at what frequency – can be recommended. The prescription should also be preceded by a laboratory examination of the patient's blood samples for malaria parasites. In northern Uganda *Plasmodium falciparum* parasites are the major malaria transmitting agents. However, during the fieldwork period these scientific procedures were not carried out due to poor healthcare facilities and inadequate staffing.

Another dimension of the children's self-medicating for malaria is a sense of pragmatism in their quests for therapy in the popular sector. Recovery and wellbeing are defined on the patients' own terms, and are not based on theoretical knowledge that specific dosages should be completed after determining the disease aetiology. For instance, like ten year old Acan above, other children often bought far less medicine than what would be scientifically recommended for a complete dose, perhaps because this was all they could afford. They also indicated feeling better after such haphazard management of episodes of self-diagnosed or clinically-diagnosed malaria. I will return to this point, particularly in connection with the complexity of the various dimensions of healing and recovery.

Itching – as mentioned by Acan – is one of the most common side effects of chloroquine, and some children indicated experiencing this. Although one nurse at GRRH suggested that such children should take Piriton or other anti-allergic tablets in addition to the antimalarials, no child did so. Neither were such additional tablets given to people who exhibited allergic reactions to the free antimalarials in state aided hospitals. An alternative would be to take other types of antimalarials such as Fansidar, quinine, and Coartem, but these are often more expensive than chloroquine, and therefore few children could afford them.

Prevalence, symptoms, and management of malaria

The 24 children interviewed during ethnography each had an average of three episodes of either clinically or self-diagnosed malaria during a six month follow-up period in 2005. Further, at the displaced schools hardly a day passed without seeing a child who had *koyo* and wanted to stay under the sun all the time. Such a child would complain also of feeling weak and of having a headache. Other children mentioned *lyeto* (high body temperature) as a symptom for malaria. Thus in this book, whenever a child complained of the three symptoms – *koyo* (coldness), *abaa wic* (headache) and *lyeto* (fever/ high temperature) – it was deduced that the child had self-diagnosed malaria. Other commonly mentioned symptoms included *me kume leb leb* (weakness), vomiting, desire to stay under the sun all the time, inability to stand straight, and lack of appetite.

When the following vignette featuring an episode of a febrile illness was read to different groups of between seven and twelve children, they identified the condition as *malaria*, *lyeto, koyo*, or *malaria madongo*.

> One of the children we found in Unyama camp was called Komakech. He was eleven years old. One Saturday when we went to visit him we found that Komakech was sick. He was sleeping under the sun, yet it was about 2:00 o'clock in the afternoon. He said he was feeling very cold. Meanwhile everyone around him was sweating and other children were playing in the shade. The sun was very hot. Komakech also vomited everything he was given. We bought for him a bottle of soda, but he said he did not want to eat or drink anything. His forehead was very hot and he told us that he had headache. When he was told to get up, he could not manage. He said he had no energy.

Subsequently, each child who participated in the discussions narrated his or her similar experiences. The management by individual children of malarial episodes was, however, slightly different, with individual experiences mediated by their place of residence, whether they had an adult caretaker, how much money they had at that time, and the severity of symptoms. For example, thirteen year old Aol indicated that she had bought only two tablets of chloroquine and two tablets of Panadol when she had malaria; she recovered after two days. In the prologue presented at the beginning of this book, Ojok and his three siblings indicated having had malaria within the past month; for each of their malaria illness episodes, Ojok had bought chloroquine from a grocery shop at one hundred shillings (0.043 euro). One weekend I organised a workshop for the twenty-four children selected for extensive study. One of these children, Omony, did not turn up; he was sick. He had woken up *me kume leb leb* (feeling very weak), and had *abaa wic* (headache). He narrated later how he had borrowed money from his landlady and bought Action tablets for headache and chloroquine for malaria. Although he was still feeling weak on Monday, he indicated that he was already feeling much better.

I found diagnoses of malaria in approximately seventy out of one hundred medical records of children aged eight to sixteen years which I examined at the out patient units at GRRH, Laliya, Layibi, and Laroo health centres in September and October 2005. During a one day participant observation exercise at GRRH's outpatient unit in November 2005, all fifty-six school age children (five to sixteen years) who were examined were clinically diagnosed with malaria.[1] Some received all the medicines prescribed, but this was an exception rather than the norm. Seventeen of the fifty six children on this particular day were advised to purchase medicines elsewhere since the unit had exhausted its day's pharmaceutical reserve.

At five private clinics and eight drug shops children were observed making specific requests for recommended pharmaceuticals for malaria, fever, cough, headache, and diarrhoea, or sometimes asking the drug shop owner or shop keeper for advice about which medicines to buy. The most recommended pharmaceuticals were chloroquine, Panadol, Action, and Hedex, and depending on whether a client had more money, one drug shop owner frequently advised buying stronger medicines like Fansidar, or opting for quinine injections which he could administer. One fourteen year old girl from Laliya, however, had a bad experience in August 2004 when she developed an abscess due to a locally administered quinine injection from a drug shop. In general, however, many children I observed purchased sub-clinical doses of chloroquine and Panadol due to the small amount of money they had.

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[1] By observation at the outpatient unit at Gulu Regional Referral Hospital, the issuing of numbers to clients in order to be seen by 'daktars' would end at 10:00 o'clock. If you were lucky enough to be among the first people to be examined, you were likely to receive some pharmaceuticals before they were 'distributed out'.

One fourteen year old boy wrote about his experience with malaria and his subsequent purchase of chloroquine and Panadol in this way:

> I had malaria last week because of many mosquitoes at the shelter [Noah's Ark]. I knew it was malaria because I had headache, dizziness, coldness, and I wanted to be under the sun all the time. I went to the drug store near home and I bought chloroquine and Panadol for one hundred Shillings each.

Another boy, Okello, narrated his experience as follows:

> When I had malaria, I bought Panadol and Fansidar from a shop near home. I first went to the hospital alone but I found that the medicines were finished. I went to another hospital but they were asking for a lot of money. I did not have a lot of money.

In addition to the use of pharmaceuticals, in their illness narratives and during interviews children indicated using herbal remedies including *lace* (not identified species), *laburi* (*Vernonia amydalina*), and *labika* (*Comellina banglesis*), among other herbal remedies.

Severity of malaria

One child, at the time of writing his composition, had a cough and other acute respiratory symptoms indicative of influenza, yet he still wrote about malaria. Such selective writing about illness experiences provides insight into how particular illnesses were prioritised, and their severity conceptualised. For example, if the child suffering from cough and flu, who is asked to narrate an illness experience in the last month, writes about malaria, then it becomes evident that malaria is accorded a certain priority and severity in the child's mind.

Children listed and ranked diseases like malaria, diarrhoea, cough and flu, and scabies as severe and commonly occurring illnesses. In ranking illnesses by severity, some children – 20 out of the 24 – regarded malaria as the most severe disease they commonly experienced. Of the 120 children at Noah's Ark night commuters' shelter who listed and ranked common illnesses by severity, all named malaria as the most severe and common illness. One fourteen year old girl described malaria to me as a deathful disease, and a fifteen year old girl concluded her composition by writing, "I have written about three diseases [eye infection, scabies, and malaria], but the most painful was malaria". In diagrammatic representations of illness episodes, the severity of malaria was most often portrayed as a child fully covered and sleeping under the sun, with chloroquine, Panadol, or Fansidar tablets drawn adjacent to the individual. Some children, however, drew a person being carried to *ot yat adit* (GRRH), or a child being admitted to hospital and administered quinine injections.

An exception to this general pattern was observed among child caretakers to people with HIV/AIDS, who were registered with the President's Emergency Fund for AIDS Relief (PEPFAR) at Lacor hospital and the World Vision Antiretroviral Therapy (ART) programme. Such children – eight of whom participated extensively in this study – frequently named and ranked HIV/AIDS as the most severe illness.

When children were specifically asked to compare their experiences of malaria with other episodes involving sadness, witnessing or hearing about extreme events, loss of a close relative, or their hut being burnt down in the camps, many displaced children still placed emphasis on the severity and acuteness of malaria. For example Kidega, a thirteen year old boy, stated:

> I could move around even when my father had been killed by the rebels. But with malaria I feel very weak, and it is painful all over my body. I will have no appetite in such times and even if I use two blankets I will be feeling a lot of *koyo*.

Further, in one focus group discussion, ten to fifteen year old children in Gulu were asked whether malaria was more severe than any of the other illnesses which humanitarian agencies mainly focus on as commonly experienced by boys and girls during armed conflict; the children responded as follows:

> *Two tam* (illness of the mind or trauma) does not make you weak like malaria. You can walk around, even if you have *two tam*, but with malaria you feel generally weak and have pain all over the body so you cannot even move about. Malaria makes you dizzy and you cannot walk, unlike *two tam* where you can still walk freely.

The displaced children did not deny or dismiss their experiences of emotional suffering. However, in prioritising and making explicit their healthcare needs, they named malaria as a high priority illness. I will come back to this issue in subsequent chapters, and as part of my analysis of the major areas of focus for contemporary interventions in wartime.

Malaria madongo (severe malaria)

Beyond the experience of common malaria, children also named *malaria madongo* (severe malaria). Apiyo's mother became *dano me wiye obaale* (mentally ill) due to *malaria madongo*, perhaps a result of the fact that no one was able to buy medicines for her; since that episode her mother has not regained her sanity. Prompted by an inquiry into the most severe experience children had confronted in the recent past, a thirteen year old girl and her three siblings provided another example of *malaria madongo* which took more than two weeks to treat. The four siblings mentioned that it was only after neighbours had taken their then very sick sister to the GRRH for admission, where she was given strong medicines and injections, that she recovered. In their discussion the siblings disclosed how all their attempts prior to admission to administer chloroquine, Panadol, Hedex, Action, and also Fansidar, had proved fruitless. This finding could be linked to an increase in emerging cases of drug resistant malaria-causing parasites.

Healthcare providers' perspectives on the diagnosis and prevalence of malaria among children, and on healthcare priorities

In five interviews with clinical officers working at GRRH and Laroo Health Centre, I posed a question regarding the frequency of diagnoses of malaria. Here is an account from one clinical officer:

> With this war, people are staying in camps or in over crowded places like Pece, Kirombe and Kanyagoga. Such an environment provides opportunistic conditions and therefore people are easily predisposed to malaria infections. So the first diagnosis I always indicate when people complain of symptoms including headache, fever, and lack of appetite is that of malaria.

In another interview I presented the case of one of the extensively followed children who frequently complained of persistent headaches. Each of his attempts to find a cure in health centres like Layibi and GRRH ended with a diagnosis of malaria. This was the case despite his making it clear at Layibi that he did not think his persistent headaches were due to malaria. The interviewed clinical officer defended the consistent diagnoses of malaria as follows:

> You see how ill-equipped our health centre is. We basically rely on the symptoms the patients tell us, and maybe the knowledge about diseases we obtained from school. One of the symptoms of malaria is headache. Therefore, since we are not able to do a blood smear, we often give a diagnosis of malaria for such patients.

When the coordinator for the Child Health Unit at the Gulu District Directorate of Health Services was interviewed about the high prevalence of malaria in children of primary school age, she elaborated:

> With the war, not only are children above five years exposed to malaria infection, but also the general population. The target risk group are always children below five and pregnant mothers. But that is a narrow approach. All people are vulnerable since there are no preventive measures against infection. The people living in camps are also highly exposed since they live in poor living conditions, which are overcrowded, and mosquitoes can easily transmit malaria-causing parasites to many people in resource-poor, overcrowded living conditions.

The District Director of Health Services (DDHS) replied to a question concerning asymmetrical efforts to save under fives and pregnant mothers from malaria as follows:

> In annual budgets for district healthcare planning, we align expenditure with areas of emphasis by the Ministry of Health (MOH). Presently, efforts are towards reducing morbidity and mortality due to malaria of the vulnerable groups, who are the under fives and pregnant mothers. That is why, even in camps, when there are mosquito nets to be distributed, only households with pregnant mothers and children below five years of age will receive such donations. Of course, malaria affects everybody in the community, but policy objectives help us to streamline our interventions. The other groups benefit from awareness messages on how to prevent infections.

Discussion: Prevalence and management of malaria

Malaria is highly endemic in most parts of Uganda, with 63% of the 26.9 million Ugandans exposed to high malaria transmission levels and 25% to moderate levels, while only 12% live in areas with low or unstable rates of transmission (MOH 2005). Malaria contributes to a big share of the disease burden in the country, accounting for 39% of outpatient visits and 35% of inpatient admissions (MOH 2005: 1). A report by the Health Management Information System (HMIS) for the government, and another report by NGO facilities, show an increase in clinically diagnosed malaria cases, from five million cases in 1997 to 16.5 million in 2003 (MOH 2005; Ouma 2006: 21), and a recent report by Roll Back Malaria (RBM) and The Joint Medical Store (JMS) (2006: 21) estimates the number of malaria deaths at between 70,000 and 110,000 every year in Uganda.

Northern Uganda is considered to be a holoendemic region for malaria – i.e. an area with high transmission – and therefore malaria contributes substantially to morbidity and mortality rates for the region. Empirical evidence suggests higher prevalence of malaria in the war affected districts of Gulu, Kitgum and Pader than national statistics indicate (DDHS-Gulu 2005; MOH 2005), for as I show in this chapter, a relatively low percentage of cases are actually presented for outpatient treatment because cases are largely self-diagnosed and self-managed. This phenomenon is facilitated by the easy access of prescription only pharmaceuticals in the popular healthcare sector without prior consultation with health professionals, linked to the dilapidation of the formal health sector and the privatisation and commoditisation of healthcare. Further, it appears that people – including children – depend on previous experiential knowledge in order to self-diagnose and self-medicate when they feel malaria associated symptoms.

There is, however, a further dimension to the assessment of the prevalence of malaria, which is that it could in fact be much lower than the current national figures and the number of self-diagnosed malaria episodes suggest. It is possible that among the cases of malaria upon which figures are based, a number are false positive diagnoses since blood smears are rarely done, and/or because national disease surveillance records rely on figures produced from district hospitals and health units which are not well equipped to register and follow up malaria cases or perform assessments about the prevalence of malaria. Further, the widespread use of antimalarials might point to the neglect of other febrile illnesses and emotional suffering, which are incorrectly diagnosed and treated as malaria. It is also likely that with symptom based purchases of pharmaceuticals, there is a process of medicalisation and pharmaceuticalisation of other complex socio-economic and political issues in wartime; an issue which need redressing. I will analyse this issue in detail in subsequent chapters.

Prevalence of malaria

Empirical evidence, based on self- and clinically-diagnosed cases, suggests a high prevalence rate of malaria among displaced children of primary school age. Statistics indicate that 19% of children in the survey mentioned experiences with malaria within a one month recall. MSF-Holland (2004a) however reports a higher percentage of 47% for a reported morbidity due to malaria/fever. The high figure reported by MSF-Holland (2004) could be because the survey covered the entire population including children aged below five who are more vulnerable to malaria. Data obtained through qualitative techniques further show a high prevalence of malaria.

One reason for a high prevalence of malaria could be due to high rates of infection and re-infection with malaria causing parasites. High infection rates among displaced children are linked to the fact that no child practiced preventive measures against mosquito bites, such as using treated (or not treated) mosquito nets. Data also suggests numerous opportunistic conditions predisposing people in conflict stricken northern Uganda to infection. The DDHS and coordinator of the Child Health Unit in Gulu named, for example, overcrowding, living in poor conditions in camps, and limited practices of preventive measures. At Noah's Ark, the surrounding environment offered a breeding ground for mosquitoes since it was a wetland area with stagnant water. If one child in this environment became infected with malaria parasites, the chances of malaria pathogens being transmitted to other children would be higher due to the presence of female Anopheles mosquitoes which are vectors for transmission of malaria parasites, and this is confounded by the lack of preventive measures. Further, poor management of previous malaria episodes could contribute to the constant presence and source of malaria causing parasites, hence facilitating both infection and high re-infection rates for children who had already experienced and managed their malaria episodes.

Closely connected to the above point is the idea that the various symptoms associated with a diagnosis of malaria could also indicate that children were suffering from different febrile illnesses. This finding is similar to that produced from research by Reyburn *et al*. (2004: 1212-1214), who suggest that over-diagnosis of malaria and the consequent neglect of febrile illnesses could lead to avoidable morbidity and mortality.

In addition, over-diagnosis burdens health services and individuals with costs they can ill afford. Over-self-diagnosis of malaria presents a significant financial burden for children who self-medicate through purchases of various types of pharmaceuticals, without prior consultation with professional healthcare workers. And with the increase

of drug resistance, it means that there is a need to try considerably more expensive drugs.

It can also be argued that high prevalence of malaria is directly linked with poor management of malaria episodes. Proponents of this logic assert that poor use of pharmaceuticals, under dosages, the existence of drug-resistant strains of malaria-causing parasites, and the presence of non-effective pharmaceuticals in the market, are responsible for a high prevalence of malaria (see Kamya *et al*. 2007: 8; Premji *et al*. 1993: 48; Staedke *et al*. 2004: 1951). It is likely that wartime children experienced drug-resistant episodes of malaria. For example, the above narrative of *malaria madongo*, in which the thirteen year old girl and her three siblings discussed using different antimalarials, including chloroquine and Fansidar, with limited success, could indicate an episode of drug-resistant malaria. It was only after the administering of quinine injections at GRRH that the sick child recovered. Another issue at stake here is that the medicines which people buy from shopkeepers, drug peddlers, and in unlicensed drug shops are of various qualities. Reports suggest that most pharmaceuticals from such sources have expired and are often administered in incorrect doses, since it is the amount of money which a client can raise which is the major determinant of quality and quantity of what is accessed (MOH 1999b, 2002). Other press reports reveal that counterfeit medicines were sold by different pharmaceutical companies in Uganda. The research supported by the World Health Organisation (WHO hereon) found that counterfeit medicines sold to unsuspecting clients had known trade marks but the drugs were not genuine and tested for absence of any active ingredients (see Kajoba 2008: 4). Further, the poor use of pharmaceuticals could be linked to the fact that antimalarials may be frequently used to manage health complaints mis-diagnosed as malaria, but which could actually signify other forms of suffering.

In connection to the foregoing complexities, it has been proposed by the Ministry of Health that communities should be sensitised about the correct use of antimalarials. At policy level, proponents of this advocate passing a directive recommending that communities resort to combined treatments – i.e. prescribing and using both chloroquine and Fansidar for non-complicated episodes of malaria*,* and using second line antimalarials for more complicated cases. For instance, press reports suggest that due to the increased resistance of malaria parasites to chloroquine and Sulfadoxine/Pyrimethamine, a new and highly effective drug – Artemether/Lumefantrine (Coartem) – had been introduced as the first line treatment for uncomplicated malaria, and Artesunate/Amodiaquine combination (ACT) as the alternative (Roll Back Malaria & Joint Medical Stores 2006: 21; Ouma 2006: 21). In northern Uganda, a WHO intervention in Gulu in 2005 'donated' a one-time package of Coartem, an effective antimalarial for non-complicated *Plasmodium falciparum*, to combat such a high prevalence of malaria. I highlight donations here since it was likely that WHO were utilising global funds meant for malaria control in Uganda in order to buy the Coartem. However, as findings suggest, it is unlikely that displaced children will actually practice combined treatments, especially if it requires purchasing both chloroquine and Fansidar for each episode of malaria, let alone purchasing Coartem. Such children rarely had sufficient funds to purchase even a complete dose of the cheapest antimalarials such as chloroquine (at a relatively low price of 200 shillings (0.087 euro)), not to mention Fansidar (which cost 600 shillings (0.26 euro)). An average market price for Coartem in 2005 was estimated at between 18,000 and 24,000 shillings (7.83 to 10.43 euros), and no child in war-torn Uganda could afford that, even if they truly wanted to alleviate their suffering, for given the average basic

wage of 1,500 shillings (0.65 euro) for a hard day's labour, most children would need to work for a month to afford a dose of Coartem.

Most importantly, owing to the challenges in accessing Coartem, its high cost, and the fact that Gulu district is an area of high malaria transmission, it might be appropriate to implement more aggressive approaches to malaria control. Such approaches must go beyond curative measures to include malaria control measures such as the provision of insecticide treated nets (ITNs) and the use of indoor residual spraying. These combined approaches are likely to decrease the malaria burden and reduce drug pressure due to repeated use of modern Artemisinin Combination Therapies (ACTs) (see Kamya *et al*. 2007: 8). More concretely, however, there is a need for a more concerted approach that addresses wider socio-economic and political factors which create opportunistic conditions for the transmission of malaria. Such interventions could focus on living conditions such as overcrowding and living in camps, as these factors offer opportunistic conditions for the parasites and the vectors which transmit them. Improving people's abilities to practice preventive measures as opposed to curative approaches could constitute the most effective intervention.

I, however, recognise the financial difficulties such aggressive approaches in control of malaria might face. On the one hand the target community including wartime children are resource poor and the context of armed conflict and displacement from their livelihoods influenced their approaches to minimising their suffering; on the other hand, Gulu district is a holendemic region for malaria. Findings show how children mainly resorted to short term curative approaches through use of pharmaceuticals in case of malaria. Given the context in which children lived in, I propose that despite their frequent exposure to malaria parasites, it was fitting for them to engage in the curative ways as opposed to effective preventive approaches in managing malaria.

Another dimension to the foregoing analysis is that child patients frequently presented complex emotional forms of suffering such as living in misery, worrying, bitterness, and unsuccessful mourning, in somatic idioms. Supportive data and detailed analysis of the preceding insight will be analysed in Chapter 11. Since malaria, other types of infections, and various forms of emotional suffering present with similar symptoms, distinguishing when an ill child might be presenting with an illness caused by mental distress, which therefore requires a non-pharmaceutical intervention, was problematic. Subsequently, the limited focus on prescribing pharmaceuticals for all self-reported illnesses led to the pharmaceuticalisation – i.e. a phenomenon where pharmaceuticals are prescribed and perceived as a cure for every illness or health complaint – of emotional suffering. In particular, it appears that children purchased and used pharmaceuticals for somatic and/or psychosomatic complaints.[2] One example of such a somatic symptom is persistent headaches, but these were frequently diagnosed as malaria. Thereby the practice of frequent diagnosis of malaria not only suggests its possible high prevalence, but also suggests the medicalisation and pharmaceuticalisation of complex forms of emotional suffering.

Management of malaria in the context of medical pluralism

Children used a wide range of pharmaceuticals and herbal remedies in the management of malaria. In particular, children mentioned using chloroquine, Panadol, Hedex,

[2] Somatic symptoms are emotional aches which children presented as body aches, while psychosomatic symptoms are physical and/or emotional problems which cause genuine physical suffering.

Action, Fansidar, and quinine. In some instances *lace, laburi,* and *neem* tree leaves were also used in the treatment of malaria. Pharmaceuticals were readily accessible over the counter without prior consultation with professional healthcare workers. Such findings have implications for emergency aid intervention and priority setting in healthcare.

Although children readily accessed pharmaceuticals, including prescription only medicines, over the counter from clinics, drug shops, health centres, and market vendors, it appears that pharmaceuticals may not actually be magic bullets for alleviating children's suffering. Symptom based management of malaria episodes might lead to the abuse of medicines, for instance by buying various medicines to treat one symptom; one child purchased Panadol and Hedex for pain relief, both of which are analgesics and therefore made of the same active ingredients. Subsequently, it appears that children often used more pharmaceuticals than necessary.

The market orientedness of healthcare, where even pharmaceuticals are a commodity, reinforces self-medication and over use of pharmaceuticals. A wide range of advertisements for pharmaceuticals – stating which ones provide effective relief, fast cure, and other appealing qualities – which appear in print and in audio and visual media, are a common phenomenon in Gulu. These advertisements were vital in disseminating knowledge about pharmaceuticals and informing people on how to manage common symptoms themselves. It was therefore only the amount of money which an individual had that determined the quality and quantity of pharmaceuticals accessed. The proliferation of pharmaceutical companies, and the subsequent unregulated import of such pharmaceutical commodities to Uganda facilitated easy access to various types of medication, including those which are prescription only, over the counter and for a fee. Moreover, with the adoption of structural adjustment policies since the 1980s and subsequent privatisation of healthcare and liberalisation of the markets, Uganda has witnessed an increase in imports of pharmaceuticals of varying qualities, which explains the presence of, for instance, Hedex, Panadol, Action, and Painex, to mention only a few examples for headache relief.

In the management of self-diagnosed malaria, it appears that children were pragmatists in alleviating their suffering. In their quests for therapy, children not only engaged in practices to find a cure, but they also went beyond acceptable rationalities and norms in their own life world in these attempts. For instance, children frequently discouraged the mixing of pharmaceuticals and herbal remedies for illnesses. In their own narratives they disclosured such practices, for example having mixed or used chloroquine with *kor muyeme, lace*, and *laburi* for an episode of self-diagnosed malaria. Further, children indicated trying out other pharmaceuticals, to see if they offered a solution to their symptoms, if the previous one was not effective. In general however, children had trust in the healing properties of pharmaceuticals.

Conclusion

Malaria was a common illness experienced by displaced children of primary school age. Children self-diagnosed malaria and subsequently managed it with both pharmaceuticals and herbal remedies. The fact that displaced children readily discussed their experiences with clinically- and self-diagnosed malaria points to its acuteness, severity, and high prevalence. The latter demonstrates that malaria is a priority and an immediate healthcare need. In analyses of empirical data I have propositioned that children ranked malaria as a severe illness which commonly affected them, and also that the high prevalence of

malaria could account for the substantial use of antimalarials. The high count of antimalarials used within a one month recall suggests not only that children were pragmatists in their quests for therapy (or opted for short term curative approaches in the management of malaria), but also that the high prevalence of self-diagnosed (and even clinically-diagnosed) malaria might reflect a neglect or mis-diagnosis of other febrile illnesses. This highlights the need for blood smears in order to confirm whether the prevalence of malaria is in fact as high as the number of self- and clinically-diagnosed cases indeed suggest. Further, a high count of pharmaceutical and herbal medicine use could suggest the *pharmaceuticalisation* and *herbalisation* of complex forms of suffering in situations of armed conflict.

Based on empirical evidence which signifies a high prevalence of malaria, and the contemporary emphases on curative approaches including the introduction of artemisinin combination therapies as a first line drug, I propose that there is instead a need to address wider socio-economic and political inequalities in the management of malaria. I suggest that effective strategies in prevention and control in areas of high transmission, including northern Uganda, need to go beyond curative approaches to encompass preventive approaches. However, given the dire context in which wartime children lived, I propose that it is appropriate for them to engage in short term curative approaches in management of malaria. I propose the latter while recognising that the effective approach in malaria control lies in preventive measures which wartime children could not practice because of poverty, lack, poor living conditions and displacement from their livelihood.

6

Diarrhoea

This chapter's objective is to analyse children's experiences and medicine use for episodes of diarrhoea. Children frequently discussed their experiences with *cado* (diarrhoeal diseases), *cado remo* (bloody diarrhoea), *cado pii pii* (diarrhoea with watery stools), dysentery, and cholera, which they treated with pharmaceuticals and herbal remedies. Cholera epidemics in northern Uganda during the two phases of research are presented and analysed in this chapter as a severe form of diarrhoea.

In this chapter empirical data is organised following these themes: prevalence, medicine use, disease aetiologies, and epidemics of diarrhoeal diseases. Analyses of data will focus upon questions concerning the prevalence of diarrhoeal diseases, including cholera epidemics, and its differential prevalence within Gulu district (in affecting mainly resource poor communities); contemporary areas of emphasis in the control of epidemics of diarrhoeal diseases; and the conflict between children's perspectives about their own diarrhoea episodes compared to others'. I will also explore how control of the cholera epidemic in Gulu district at the time of this study presented various challenges.

Quantitative data: Prevalence and medicine use for episodes of diarrhoea

Table 6.1 shows the prevalence of diarrhoea among the 165 children. A positive response of 150/834 (approximately 18%) makes the burden of diarrhoeal diseases for the study population second only to malaria. Results suggest no statistically significant difference (P=0.59) between boys' and girls' experiences with diarrhoea within a one month recall.

Children often managed their episodes of diarrhoea with antibiotics (Table 6.2). Other medicines which children mentioned having used for cases of diarrhoea were analgesics, multivitamins, and Lagarctil. Noticeably, no children mentioned using Oral Rehydration Salts (ORS) in the treatment of diarrhoea.

Table 6.1 Prevalence of diarrhoea(s) within a one-month recall (N=165)

Illness	*Boys*	*Girls*	*Total*	*P-values*
Cado pii pii (diarrhoea with watery stools)	32	22	54	0.73
Cado (diarrhoea)	40	35	75	1.00
Cado remo (diarrhoea with blood)	09	4	13	0.23
Total for diarrhoea	**81**	**61**	**150**	**0.59**

Table 6.2 Medicines used in the treatment of diarrhoea within a one-month recall (N=165)

Medicines	*Boys*	*Girls*	*Total*	*P-values*
Amoxicillin or Tetracycline	87	76	163	0.92
Flagyl (metronidazole)	55	53	108	0.39
Pen V (penicillin V)	62	64	126	0.06
Septrin (cotrimaxazole)	21	22	43	0.49
Antibiotics	**212**	**215**	**427**	
Action	43	46	89	0.18
Vemox (*yat kwidi* – deworming medicines)	41	39	80	0.60
Multivitamins (or vitamins)	55	49	104	0.88
Lagarctil	36	40	76	0.16

Table 6.3 Herbal medicines used in treatment of diarrhoea within a one-month recall (N=165)

Herbal medicines (extracts)	*Boys*	*Girls*	*Total*	*P-values*
Mango roots	79	69	148	0.97
Pawpaw leaves	82	59	141	0.003
Mango bark	75	51	126	0.004
Neem leaves	24	11	35	0.042
Guava stems and leaves	20	4	24	0.001
Total	**343**	**252**	**595**	

I include a summary of data for herbal medicines used for diarrhoea (Table 6.3), since it appears that in the main children managed diarrhoeal diseases with herbal remedies. Although some children spoke of the importance of the two parts of the mango tree (mango roots and bark) interchangeably in their narratives, a higher proportion of children illustrated mango tree roots being used for diarrhoea and/or stomach ache, while the number of children who mentioned mango roots at all was slightly higher than those who mentioned mango bark. This high reported usage of mango tree roots may

correlate with a high prevalence of diarrhoea and stomach ache among the children. In Illustration 4, the child drew a girl harvesting mango roots, but wrote about mango stem(bark) for diarrhoea. These are some of grey areas in narrating findings as children relay them, and yet the practice could be slightly different. The latter is also linked to errors in recall data and that is why I regard triangulation of qualitative and quantitative data with high importance.

Strong statistically significant differences in the use of herbal remedies for diarrhoea were observed in boys' and girls' use of pawpaw leaves (P=0.003), mango tree bark (P=0.004) and guava stems or leaves (P=0.001). There is a weak statistical relationship observed in boys' and girls' use of neem leaves (P=0.042). Except for the use of garlic (boys 34, girls 39: P=0.12), data suggests that more boys than girls used pawpaw leaves, mango tree bark, and other herbal remedies for diarrhoea within a one month recall. This correlates with the findings in Table 6.1, which shows that more boys reported experiencing diarrhoea within the same month. Could this suggest that boys were more likely to have diarrhoea than girls? Could it be that boys shared their experiences with using herbal medicines more easily than girls? Could it be that boys more frequently used herbal medicines for their common illnesses, including diarrhoea?

Qualitative data:
Prevalence, symptoms, severity and prevention of diarrhoeal diseases

Through qualitative data techniques it was possible to elicit more specific data, particularly that pertinent to severity, to the differential explanations for the aetiology of one's diarrhoea as opposed to others', and about other medicines not captured by quantitative data. In general, the children's narratives signify a high prevalence of diarrhoeal episodes, consistent with the quantitative data presented above.

Exemplary narratives of experiences with diarrhoea within a one month recall

About 200 children either wrote about or narrated stories related to their experiences with diarrhoea and how they managed them. Some of the archetypal stories are presented verbatim below. They are exemplary because they contain children's perspectives concerning disease aetiologies, differences in interpretations of symptoms and severity, and examples of pragmatism in their quests for therapy. Oketch, aged 13-years narrated his story of having diarrhoea as follows:

> I went back home from school at lunchtime when I was hungry. I got some mangoes, which I ate before washing my hands even. That afternoon I started frequenting the pit latrines and my stomach was aching. I felt very weak by the time I went back home after classes. I would go to the latrine four times in an hour. Our landlady gave me *tee ocok* (extracts from roots of Sodom apples) but diarrhoea persisted. The next day I went to school but still kept on going to the latrine frequently. If I found the door locked I would defecate near the latrine. At school, teachers advised me to stop eating dirty things. I was taken to hospital and given medicine but it still could not work. The landlady told me to eat *cam ma nwang* (sticky foods or difficult to digest food) such as *kwon kal* (millet bread), cassava, and bread. It was difficult to find such food. I was later admitted to Lacor for one day and then told to go home. Our landlady got for me *tee lira ki tee lango* (roots of neem tree[3]and Rhamnaceae plants) to drink and it stopped the diarrhoea after three days.

[3] *Lira* was identified as Meliaceae (Neem Tree) and its name *Melia azdarach L*. and *Lango* tree was identified at the Botany department at the Faculty of Science as a plant belonging to class Rhamnaceae, and its name is *Ziziphus abyssinica*.

Oketch gave conflicting ideas about aetiology for his own diarrhoea episode, attributing it to eating very ripe mangoes or a mixture of foodstuffs, contrary to when he discussed how his sister got diarrhoea through drinking dirty water fetched from an unprotected well. Oketch, in his own words:

> When it was a very dry season, there are so many people at the well. People fetch water which is very muddy, yet other children play in it. Cows drink from the same source. Such water always causes my younger sisters to have diarrhoea. When it is difficult to get water, sometimes we do not wash *jami cam* (cooking and eating utensils).

When asked if he thought the conditions around his home – such as the hut being very close to the pit latrine which many people in the neighbourhood used – could contribute to his having diarrhoea, Oketch responded:

> That latrine is often full of houseflies. These houseflies easily come to our hut and if food is not covered, you find them playing on the food. When you go to that latrine, you remove your clothes and leave them outside. Otherwise, you can have a smell of faeces the whole day. After visiting such a latrine and you have no water to wash hands, you can easily put dirt on your food, even on the mangoes that you eat.

Ojok aged 14-years narrated his experience with diarrhoeas as follows:

> I was very hungry one afternoon so I bought some roasted pork, raw cabbages, tomatoes, and cassava chips. After eating, I started feeling stomach aches. In the morning, I had a running stomach. I had *cado*. I had to sit near the pit latrine all the time and I had a feeling of needing to go to the latrine all the time. I went and bought two Panadol and two Flagyl and took them. But I felt like this for three days. I only got better after using *tee lira ki tee langо* (extracts from roots of a Neem tree and Rhamnaceae plants). I was advised by neighbours to eat *cam ma nwang* (sticky or difficult to digest foods) like cassava and white bread.

The attributions of diarrhoea to food allergies, or eating too much food, was also found in girls' narratives. For example, Ajok narrated how she had diarrhoea over one weekend, mainly because she had gone a long time without eating and so when she finally ate, she ate more than usual and a mixture of different foodstuffs, which made it difficult for her to sleep for two nights. She kept going to the pit latrines. She recovered when she drank extracts from mango tree stems and *tee ocok* (roots of Sodom apple plants). Anek gave an extensive account of her recent experience with diarrhoea:

> One day we went to harvest maize and ground nuts with my sisters. We roasted some of the maize and ground nuts for ourselves. At night, my stomach started hurting and in the morning, I started having *cado*. I decided to go to school all the same. While there, I kept going to the latrine all the time. One time, since the latrines are so far, I could not make it to there on time. *Cado* flowed through to my legs. I was so embarrassed. I sat there trying to clean myself, but many houseflies started coming over me. I went home. I washed my clothes but I was feeling very weak by that time. I went and collected *tee ocok* and *ki lace*, pounded them and mixed with water. I drank it. I also asked our landlady for Flagyl. She gave me two tablets. I took them as well before I went to sleep. By evening time when I woke up, I was feeling much better.

Critically looking at the illness narratives above, the children related their episodes of diarrhoea to specific practices. In all the narratives, associated factors could signify that the children did know the causes and disease aetiology of diarrhoea. Whether the children had ways of establishing the incubation period for the ingested pathogens, or whether they were able to link the source of pathogens to the illness episode, are, however, another matter. I envisage that the coherence in the children's narratives – in terms of breaching the gap between aetiology and illness – reflects an attempt to create a logical order to their suffering. In having episodes of diarrhoea, children were prompted to reflect on the questions of how they got the infection and why they were

suffering from it. The incubation time for diarrhoea causing pathogens, however, could mean the children might have ingested them much earlier than their narratives suggest; though on the other hand, their episodes could indeed be linked to their perceived cause.

Another aspect of this could be that in narrating an illness experience to another person, the requirement of being orderly and logical prompted children to link their theoretical knowledge to their experiences. In the process, however, the narratives created seemed quite coherent as opposed to the realities where, for instance, an individual might not be aware of the source of infection, or even perhaps how s/he recovered from the illness episode.

No child directly associated his or her illness episode to dirt or eating contaminated foods. This is contradictory to the opinions they expressed in general discussions, or while discussing the likely causes of someone else's diarrhoea, where they readily associate dirt, or the eating of food on which houseflies have been playing, with the perceived causes of diarrhoea. Perhaps Oketch, in his narrative, came close to attributing his diarrhoeal illness to not washing his hands, but in interviews he still explained it by the fact that he ate both mangoes which were too ripe, and ate a mixture of foodstuffs. Ojok focussed on the fact that he had eaten too much fat as the cause of bloody diarrhoea. In focus group discussions, individual experiences with diarrhoea were related to eating food that the stomach did not like (as in food intolerance or allergies), newly harvested foods, or eating too much. Some children talked about having the illness after *camo mupera* (eating guavas) which are very difficult to digest, cowpeas, beans which are not well prepared, and food which your stomach did not like such as eggplants, green vegetables, and *camo dek angic ki cam anumu* (cold food and foodstuffs which are not well cooked). Some children even mentioned *camo jimi m' okwok* (eating stale food) as the cause of their diarrhoea.

Prevalence, symptoms, severity and medicine use for diarrhoea

After presenting the vignette below featuring a child with an episode of diarrhoea to twenty-one different groups of between eight and fourteen children, a substantial proportion of the children told stories about their experiences similar to that of the child in the vignette.

> At one of the primary schools we went to, we found a girl called Apio Violet. We had started talking to her about our study when she asked to first run to the latrine. She delayed there a lot. When she came back to talk to us, she said she had stomach ache and had been passing watery stools. Before she finished telling us this, she ran back to the latrine again. While there, she saw that her stools had blood as well. Her stomach continued to pain her. This time she did not come back for the interview. We went to the latrine and found she was sitting near it. She said she wanted to go to the latrine all the time. Her mouth was very dry by this time, and she did not have energy either.

Children frequently mentioned diarrhoea, during individual interviews and group discussions, as one of the common illnesses which they suffered them. In naming and ranking common illnesses, children ranked the severity of diarrhoea second to malaria, though of the twenty-four children recruited for extensive follow up, four children taking care of parents sickly with HIV/AIDS ranked diarrhoea as the most severe disease. One of the four children was a thirteen year old girl who gave this rationale for ranking diarrhoea as more severe than malaria:

> Diarrhoea is the most severe, since when you have it, you cannot come to school. My mother always suffers from it. In such times, what I do, even during the night, is to clean her, to wash her clothes, and sometimes we do not have soap.

Results from a naming and ranking exercise for common illnesses which children experienced, conducted at two displaced primary schools with children aged nine to eleven years, show that all two hundred children regarded diarrhoea's severity as second to malaria. In one exercise, where I requested twelve to fourteen year olds to name and rank their common illnesses, twenty of the one hundred and twenty children did not name diarrhoea as a common disease in their home, but ranked it second to malaria in severity. One twelve year old girl concluded "in comparing malaria and diarrhoea, diarrhoea is not as serious".

In an exercise to diagrammatically represent illnesses experienced within a two week to one month recall, conducted with seventy-five children at Noah's Ark night commuters' shelter, all children illustrated episodes of diarrhoea. The medicines written against these illustrated episodes ranged from mango tree roots, guava leaves, Flagyl, Amoxicillin, and Septrin. Two children indicated that they only ate *cam ma nwang* (sticky and difficult to digest food) for their diarrhoea and they recovered after three days. Ojok, in the prologue, named both malaria and diarrhoea as illnesses which he and his siblings had suffered from within a one month recall; they had largely used herbal remedies as treatment. In one workshop discussing how children managed episodes of diarrhoea, forty-six of the fifty children (92%) admitted that they had had diarrhoea within the past month. Individual management of episodes showed slight variation: in the main children indicated using herbal remedies including mango and Neem tree roots, though they had also used Flagyl, and five children had used Flagyl and Amoxicillin.

During observation exercises in September and November 2005 at GRRH, Laliya, Laroo, and Layibi health centres, no child aged between five and sixteen years presented with diarrhoea, and during home visits and frequent discussions with the twenty-four children who were interviewed indicated that they used herbal remedies rather than visiting the hospital, and purchased or asked their neighbours for Flagyl. By observation, and through examination of younger children's (below fives) health records, I determined that antibiotics and analgesics were most frequently prescribed for stomach ache complaints and diarrhoeal diseases. In one of the five drug shops where observation was conducted, one time seven girls came wanting medicines for stomach aches; the attendant first inquired if they just had pain in the stomach, or whether they had diarrhoea as well, and also asked if the pain had been persistent. He subsequently gave each of the girls Flagyl and Panadol, in quantities which depended on the amount of money they had. At the state aided health centres complaints of stomach aches were regarded either as a symptom of malaria or as an infection in the digestive and urinary system. For example, in September 2005 one fourteen year old girl who extensively participated in this study was prescribed Imodium and Amoxicillin after a diagnosis of a UTI (urinary tract infection) by a clinical officer at GRRH, when she presented with stomach ache. I will return to this example in a later chapter on emotional distress, for I suggest that stomach ache might also be a signifier of more complex emotional suffering.

Only children taking care of adults sickly with HIV/AIDS put greater emphasis on the severity of diarrhoea in comparison to malaria; and they gave a unique rationale for this. They particularly put emphasis on the difficulties in taking care of their sick kin when they had (chronic) diarrhoea. For instance, this meant that they needed to wash them frequently and aerate their beddings, and this was a lot of work. Commonly, children taking care of sick kin indicated giving them Flagyl tablets which they could

collect on their behalf at one of the hospitals, upon presentation of the patient's 'medical card'. Such children's ranking of diarrhoea as most severe was not due to their direct illness experiences, but because of the challenges confronted in caring for the sick.

For this chapter, I deduce that generally speaking children's perspectives concerning diarrhoeal diseases suggest that they rank it second to malaria in severity. Nevertheless, I recognise that such deductions raise certain questions, which include: (1) If only one child indicated that diarrhoea was the most severe illness s/he had had in the recent past, could that then conflict with the deduction? (2) Is the severity of cholera (see below) comparable to the severity of self-diagnosed malaria? And (3) What about cases where children did not want to rank their illnesses by comparable severity, but only asserted that all illnesses were severe? Ultimately, I question the need to rank illnesses by comparable severity, since individuals might have various perspectives on their own experiences. It nonetheless seems logical to discuss illnesses as independent experiences, and indeed the children demonstrated some ability to rank them by severity. For example, when children were specifically asked to compare their experiences with diarrhoea to the major category of emotional distress introduced by humanitarian agencies – *two tam*, literally meaning 'illnesses of the mind' – this is what they had to say:

> With other illnesses, such as *two tam*, you can go to school, sit in class, and listen to the teacher. At break time you can join your friends to play. However, if you have diarrhoea you cannot even sit in class, you keep on running to the pit latrines. You cannot play because you will want to go to the latrine all the time. After one day with diarrhoea, you become very weak, you cannot stand straight and will need help to walk (focus group discussion with children aged 12-15 years old).

Prevention of diarrhoea

One fifteen year old girl's response to a question concerning the prevention of diarrhoea was as follows:

> Do not eat what your stomach does not like and also drink extracts from mango tree stems. The red and yellow or red and black capsules [Amoxicillin and Tetracycline] and extracts from Sodom apple roots can also stop diarrhoea. That is how to prevent diarrhoea.

Another relatively similar account was given by fourteen year old Ojok:

> You could avoid getting diarrhoea by not eating foodstuffs which they sell by the roadside. Last time I ate *samosas* sold by the roadside it was stale, but since I was very hungry I just ate it. That very afternoon I got diarrhoea. We can prevent diarrhoea through using medicines, both *yat acholi* (herbal remedies) and those from the hospitals. I use *tee ocok* (roots of Sodom apples) and *kor muyeme* (stems of mango trees) to prevent diarrhoea. Also capsules which are yellow and red in colour [commonly Amoxicillin or Tetracycline], Flagyl, and Indocid [very small yellow tablets]. They work quickly to prevent diarrhoea, but mostly the *yat acholi*. Those medicines prevent and treat diarrhoea fast. You do not have to buy them even. The medicines which I always use you get from *ilum* (surrounding bushes). Others can be got from the hospital, like Gulu Hospital. For me I like going to the clinic. There are very many near home.

Meanwhile, thirteen year old Anek narrated how to prevent diarrhoea as follows:

> I always get medicines from neighbours. One of our neighbours has many mango trees. We just go and cut part of the stems. At the same time I ask them if they have Flagyl.

When different groups of children were asked how they evaded the likelihood of getting diarrhoea due to exposure to disease causing pathogens, one girl responded:

> Our landlady does not allow us to use the latrine as frequently as we would like to. In case you have diarrhoea, she would instead abuse you for being dirty, not knowing how to cook, and that you will cause the whole neighbourhood to fall sick. Therefore, when one of us has diarrhoea, we instead tell

> her that she has stomach ache; that in fact she simply has a feeling of going to the latrine but there is nothing there. On such occasions she can even help us with medicines like Panadol, Septrin, Flagyl, and advise us on what *yat acholi* (herbal remedies) to use.

Children's perspectives, in short, reflected a curative approach to diarrhoea, rather than taking actual preventive measures. There was also an apparent avoidance of ideas linking episodes of diarrhoea to dirt or contagion through the oral-faecal route of transmission of pathogens, and other causes of infection. Nonetheless, these apparent contradictions in children's narratives diminished in discussions about the cholera epidemic, to which I now turn.

Intermittent epidemics of cholera: Children's perspectives concerning a severe form of diarrhoea

In the second phase of ethnographic research conducted between July and December 2005 there were intermittent epidemics of cholera in Gulu district. At Pabbo camp, it took about five months to control a single epidemic. A substantial proportion of children referred to the diarrhoea accompanying cholera as the most serious illness they had ever seen. In one focus group discussion, one fifteen year old boy gave a graphic description of his impression of cholera:

> Last Saturday [in September 2005], I went to Pabbo to visit my aunt. As I approached her home, I saw about five tents fenced with black polythene bags. There were messages warning people not to even touch the tents. It was because persons who had cholera were being treated from there. As I moved further on, I could see the entire path had no one else moving there. I later met a group of five men carrying another man. The men were all covering themselves with green polythene bags. They also covered part of their noses. One of the men signalled with his hand that I move away from where they were going to pass. I hid quite close to the path. They bypassed me, but what I saw was very scary. A man covered in faeces, and more *cado* just flowing through him. My aunt told me that many people have died in the camp because of that disease. The camp leader always told people that it was cholera. Cholera is the most serious illness I have seen with my own eyes.

In various interviews at one displaced primary school, four children shared their experience with cholera. Twelve year old Opiyo attributed his survival to the fact that his grandmother took him quickly to Lacor hospital; otherwise, as he often put it, "I would have died on the same day". Apart from Opiyo and the four other children who had personally had cholera, all the others, including the twenty-four children involved in extensive study, had only seen people suffering from cholera, and sometimes even dying. For example, Oketch had seen two neighbours dying shortly after complaining of diarrhoea. In the main, children expressed fear of ever contracting cholera. Anek shared her experience of seeing a neighbour's child, six year old Orach, die within a few hours due to diarrhoea which health workers in Pece told them was cholera. She elaborated:

> That day, Orach, after going to the pit latrine next to our hut twice, collapsed due to weakness just outside the pit latrine. I ran and called his mother. She came running toward Orach and quickly wanted to take him to Gulu Hospital, but Orach was already badly off. She went to collect *yat acholi* in the bush nearby, but found upon her return that Orach had already died. When the nurse from the neighbouring clinic was told about the death of Orach, she told everyone to leave that place, since it had cholera. I and my sisters quickly returned to Alero camp. Our father later rented for us another hut in Kirombe.

In a discussion of a vignette portraying a child who had diarrhoea, some children instead identified it as cholera. One twelve year old girl even started discussing the similarities between the way the illness had affected the child in the vignette and the

symptoms which had led to the death of her neighbour in Pece. She elaborated further on how "Cholera attacks those who are dirty, who do not wash their household utensils and were often eating cold food". Out of nine children in one such discussion, seven still identified the illness episode simply as diarrhoea, and not as cholera; their rationale was that the child could still walk to the pit latrines, whereas with cholera people quickly become weak as their bodily condition rapidly deteriorates, and further, if such a person was at school all the other children would have been affected. Thirteen year old Aol discussed the seriousness and the highly contagious nature of cholera:

> Cholera is a very serious disease. This is because the place where the sick people are put is often covered with black polythene bags and no one is allowed to go there. At the hospital, we were told that just touching that person can make you sick as well. In Kanyagoga, when a child died of cholera, even her parents were not allowed to bury her. The *daktars* who came from *ot yat adit* first covered themselves and also covered the dead body in polythene bags before carrying it away.

Another twelve year old boy from Pece graphically described an incident in which a neighbour died from cholera within a few hours of developing symptoms:

> Since people had been ordered through radio announcements and camp leaders kept telling people not to touch others suffering from cholera, the affected family went to collect health workers at Gulu Hospital to help them take the sick person to hospital. The *daktars* took a very long time to come and see the sick child. They found his mother already struggling with him, and trying to give him something to drink. Shortly after their arrival, the child died. The *daktars* ordered everyone not even to touch the dead child since they could also get the same disease. They even brought black polythene bags, and first covered themselves with green clothes before carrying away the dead child.

Key informants' perspectives on, and intervention approaches towards, the control of diarrhoeal diseases and cholera epidemics

The information in the excerpts below constitutes much of what was broadcast in print and audio media about the dangers of cholera during the period of research in 2005 when Gulu district experienced a severe epidemic of cholera. Similar information exists in biomedicine, and is evident in what medical workers often gave as a response to my inquiries concerning the aetiology, severity, prevention, and treatment of cholera.

> Cholera is an acute form of diarrhoea caused by bacteria *Vibrio cholerae*. Its major mode of transmission is through the oral-faecal route. This infection in the intestines will cause heavy loss of body fluids and electrolytes, minerals and rapid loss of body weight. Management of cholera episodes is mainly through restoring fluid balance much as sometimes an antibiotic may be used. Since cholera is a highly contagious infection, it is advised that people at risk take extra precautionary measures to avoid being infected. Measures like avoiding contact with infected persons are quite effective, but the best way to control cholera epidemics is through ensuring good sanitation.

A doctor at GRRH, interviewed about children's notion of the link between diarrhoeal diseases and allergies to different foodstuffs, refuted the children's perspectives on the following basis:

> Diarrhoea due to allergies in some people is basically due to fats and lactose intolerance. Such food intolerance mostly affects children below five years of age and elderly persons. There is, however, no scientific explanation for episodes of diarrhoea due to eating such foods likes green vegetables, fish, and cowpeas. Well, it is possible that those children were really allergic to those foodstuffs, but we cannot attribute those diarrhoeas to fats and lactose intolerance. The major causes of diarrhoea, especially in children above five years, are associated to the oral-faecal route of transmission of pathogens.

Concerning children's opinions on the practices which caused their diarrhoea, one doctor indicated that:

> The incubation period of diarrhoea causing pathogens is dependent on the quantity and virulence of the organisms. But on average, the incubation period could be one day to two weeks.

Between July and November 2005, Pabbo camp and the suburbs largely inhabited by resource poor persons within Gulu Municipality experienced an epidemic of cholera. In the various attempts to control the epidemic, the issue became politicised, was misrepresented, and awareness messages were spread which implicitly blamed victims for their ordeal. Key healthcare officials at the District Directorate of Health Services (DDHS) frequently castigated the Water and Sanitation Department during their joint and regular meetings, demanding that they investigate new strategies for controlling the cholera epidemic. In addition, they instructed the Water and Sanitation Department not to politicise the cholera issue by sending alarm messages to the 'masses', and even discouraged disseminating the information that water sources were infected with *Vibrio cholerae.* The DDHS office's approach for checking the epidemic was narrowed down to sensitising the population at risk, and to therapeutic or curative management of severe cases at emergency cholera centres, as depicted in the child's description of Pabbo camp above, where tents had been fenced in with black polythene bags for the treatment of severe cases.

In sensitising the population at risk, workshops, radio announcements, placards, and t-shirts were designed with messages about *Vibrio cholerae*, and how cholera cases should be handled. The dominant messages were about improving hygiene, identifying cholera victims, and stressing the importance of immediately reporting cases to cholera emergency centres. In practice, it is difficult to comprehend how people at risk were expected to avoid infected persons while at the same time ensuring their prompt transportation to designated sites where cholera cases were managed.

In early October 2005, at the peak of the controversial public debate about the failure to control the cholera epidemic after almost four months, and the increasing number of deaths, President Yoweri Museveni was invited to Pabbo camp. In his speech the president attributed the persistence of the cholera epidemic to the existence of the Lords' Resistance Army in the region. Presenting a different view, during a meeting in November 2005 organised by the WHO's Gulu office, for key healthcare officials from Gulu district and NGOs focussing on the healthcare issues of people in conflict zones, one medical doctor from Lacor Hospital presented his findings on the sanitation status in Pabbo camp. In this report he disclosed how all the water sources, especially the shallow water wells, were infected with *Vibrio cholerae* bacteria, and shed light onto the poor sanitation practices and conditions in the camp, particularly the fact that most of the pit latrines were shallow and virtually filled up. In sum, a substantial proportion of the population in Pabbo camp had no sanitation or access to clean water. He proposed that these were the central issues which needed to be addressed if the cholera epidemic was to be controlled. In response, one key healthcare official severely criticised his argument and instead pointed to the relevance of promoting awareness messages in the control of cholera.

In Gulu district between July and September 2005, cholera led to the loss of life of numerous children and adults. The people most severely affected were those from displaced person's camps like Pabbo camp, and the over populated suburbs within Gulu Municipality such as Pece, Kirombe, Kanyagoga, and Kasubi. These suburbs and camps had one unifying factor, which was that of providing housing to resource poor persons. The sanitation situations were appalling and in the main there were few or no basic healthcare amenities in these areas. Yet in the Gulu DDHS's strategic healthcare plan

for 2006-2007, the first chapter, providing a brief overview of Gulu district's health status, gave only a succinct report stating that "there were two major cholera outbreaks which lasted most of the year. About 10 IDP camps were affected and over 1000 cases treated" (Gulu DDHS 2006: 4).

Discussion: Prevalence and management of diarrhoea

Cholera is caused by the bacterium *Vibrio cholerae* and is endemic throughout many resource poor regions of the world. Epidemics often occur during or after war, civil unrest, and natural disasters when water or food supplies become contaminated, and is compounded by crowded living conditions with limited sanitation, poor hygiene, and poverty (Hartley *et al*. 2005: 7; Hill *et al*. 2006: 362). Mild to moderate cases of cholera are often indistinguishable from other causes of acute diarrhoeal disease (WHO 2007). Transmission occurs through ingestion of faecally contaminated water and food, and large amounts of bacteria (10^8–10^{11}) are needed to establish infection in people with normal gastric acidity. Cholera is characterised by the sudden onset of profuse watery stools, with occasional vomiting (Sack *et al*. 2004: 223). The incubation period is usually two to five days, but may be only a few hours. In severe cases of disease, which occurs in 5-10% of those infected, dehydration, metabolic acidosis, and circulatory collapse may rapidly develop (Hill *et al*. 2006: 362).

Treatment of cholera is by rehydration with oral or intravenous fluids. In severe cases, antibiotic treatment can be given to reduce the volume of diarrhoea and duration of excretion (Sach *et al*. 2004: 223). There is increasing drug resistance of the *Vibrio cholerae* bacteria to Doxycycline, the antibiotic of choice, so alternatives such as Co-Trimaxazole (Trimethoprim-Sulfamethoxazole), Erythromycin, Chloramphenicol, Ciprofloxacin and Azithromycin can be used where organisms are sensitive (Mhalu *et al*. 1979: 345; Threlfall *et al*. 1993: 1173; WHO 1993).

In the analysis I interpret data under two thematic areas. The first theme addresses the question of why empirical evidence suggests a high prevalence of diarrhoeal diseases, including cholera. In particular, I examine the predisposing factors, including socio-economic ones, which could account for this phenomenon. I further link the emphasis on curative approaches, the persistence of cholera epidemics and the high prevalence of diarrhoea in situations of armed conflict; to the fact that disempowered people living in dire contexts were told to themselves prevent being infected. In the second theme, I assess the efficacy of various curative approaches. While addressing this issue, I link my analysis to the concept of pragmatism. Though I recognise that curative approaches are short term approaches and are not effective in dealing with infectious diseases in the long term, I propose that using pharmaceuticals and herbal remedies in the management of diarrhoeal diseases is an appropriate strategy for the wartime children, given the context in which they lived.

High prevalence and prevention of infection

Both quantitative data and children's narratives signify a high prevalence of diarrhoeal diseases, and the explanation for this should take into account the presence of (socio-cultural) predisposing factors to contagion by diarrhoeal disease causing pathogens. The foregoing assertion is consistent with MSF-Holland's (2004b) data suggesting a prevalence of 21% for diarrhoeal diseases-closely associated with the living environment in which war-affected people in northern Uganda lived. Nevertheless, children were reluc-

tant to attribute individual illness episodes to probable environment-related causative factors. It is possible that the children's causative theories – which included eating a mixture of foods, and eating food which your stomach 'does not like' – were responsible for children's diarrhoea. However, from the doctor's assertion above, it is largely through the oral-faecal route that diarrhoea causing pathogens are transmitted; thus children's places of residence should provide indicators of such sources of contamination. This is also consistent with the likely causes of the cholera epidemic identified in the doctor's research conducted at Pabbo camp, presented in brief above.

Concerning the predisposing factors to cholera infection, all of the children who were interviewed lived in congested suburbs characterised by poor sanitation, unhygienic living conditions, and a lack of clean water. There was a direct link between the children living in such an environment and their exposure to sources of diarrhoeal disease causing organisms. It is therefore plausible to argue that there was a high prevalence rate of diarrhoea among children because their living conditions were conducive for diarrhoeal disease causing pathogens, which therefore put the children at high risk of exposure to infection.

In information dissemination, key healthcare givers and institutions sensitised people at risk with messages which bordered on blaming them for their inability to practice hygienic living. Such messages advised people in resource poor communities to practice better hygiene, but only had limited success. In my interpretation, such messages contributed to children redefining their episodes of diarrhoea, for in essence, it is more acceptable to have allergy related diarrhoea than diarrhoea which is directly linked to poor sanitation or living in unhygienic conditions. This could explain why in the main, children appeared to attribute their diarrhoea only to non-stigmatised causes. I argue further that children (consciously or unconsciously) realised their inability to practice the preventive measures outlined in the awareness messages. Subsequently they reshaped their explanations as a survival strategy, and also as part of an attempt to communicate their inability to practice good hygiene, such as drinking clean and safe water or washing their hands with soap and clean water after every visit to the toilet. In short, it appears that the children were constrained by wider socio-economic and political factors from practicing or implementing the knowledge gained from sensitization messages.

During frequent interactions with the children, diarrhoea prevention was often discussed concurrently with its treatment. There was a confusion of sorts whereby, for instance, a child would mention ways in which to avoid diarrhoea, yet still put emphasis on how to cure it once it had been contracted. In general, it appeared that there was no distinction between curative and preventive measures for diarrhoea, and I got the impression that preventing episodes of diarrhoea, or infection by diarrhoea causing pathogens, lay in stopping episodes of diarrhoea. Perhaps the children were making it explicit – especially in light of the numerous awareness messages – that given their circumstances it was possible to treat episodes of diarrhoea but not to prevent contagion. I still cannot precisely explain why there was such confusion when discussing this simple question. It might be that while the public health messages clearly spelt out ways to avoid infection, the children's lives and circumstances posed great challenges in adhering to such messages. It could also be because the children did not comprehend the idea that they could prevent diarrhoea by implementing preventive measures, and therefore they merely resorted to curative approaches.

Another significant factor is the narrow approach taken in the control of infectious disease epidemics, namely through promoting awareness and sensitisation seminars.

Although healthcare providers linked the exposure of vulnerable people to their lack of information – and it was true that such people lacked information about pathogens such as *Vibrio cholerae* and the treatment of cases – I am doubtful as to whether information dissemination was an effective intervention to control the cholera epidemic. I propose that a lack of information about an epidemic contributes only minimally to the spread and prevalence of infection compared to the effect of living in squalid conditions characterised by poor sanitation, lack of access to clean water, overcrowding, and living in camps due to prolonged civil war. Further, although existing literature suggests that there is a link between low gastric acid levels, low socio-economic status, and cholera (Sack *et al*. 1972: 857; Zuckerman *et al*. 2007: 521-530), and that gastric acidity is a major determinant of the size of inoculum required to generate disease, and further that gastric acid acts as a natural barrier to *Vibrio cholerae* (Sack *et al*. 1972: 858; Van loon *et al*. 1990: 1361), I propose that people living in resource poor settings are more likely to be exposed to *Vibrio cholerae* because of poor sanitation and other opportunistic conditions than because of their gastric acidity levels. However, differences in gastric levels could help to explain why even in Pabbo camp, there were some people who did not fall sick regardless of their being exposed to cholera-causing pathogens. In Gulu district, these opportunistic conditions were commonplace, especially in camps and suburbs within the municipality where the poor lived. Such conditions easily made residents vulnerable to *Vibrio cholerae*, therefore affirming the WHO reports which suggest that most cholera cases occur in Africa: 95% in 2005, and 94% in 2004 (WHO 2005, 2004: 262-268).

Perhaps President Museveni needed to expand on his philosophy that the high prevalence of cholera in Pabbo camp was linked to the fact there were LRA fighters in the area. In this statement he implicitly acknowledged that the epidemic was linked to broader factors such as political insecurity, which culminated in people settling in squalid, congested, and unhygienic camps, and living in abject poverty and misery. That the president instead narrowed his focus to telling people to stop drinking unboiled water and ensure they lived in a clean environment, and to providing emergency funds to the DDHS to effectively manage the cholera cases through curative procedures, again reflects the dominant approach taken in the management of infectious epidemics, namely through sensitisation (information dissemination) and curative approaches, as opposed to practicing effective preventive measures.

In sum, results suggest high prevalence of diarrhoeal diseases, not only among children of primary school age but also the entire war affected population. In particular, resource poor persons living in displaced persons' camps were disproportionately affected. This discussion has made it explicit that, in the main, high prevalence of diarrhoeal diseases coincided with poor socio-economic and living conditions. In Gulu Municipality, records of cholera admissions in August and September 2005 suggest that the majority of those affected lived in suburbs like Pece, Kanyagoga and Kirombe – areas mainly inhabited by resource poor persons. These suburbs were characterised by congestion, poor sanitation, poor living conditions, and a lack of basic amenities. If the empirical evidence provided in this chapter could be used as a premise for emergency healthcare intervention, then it is likely that a major focus on wider socio-economic factors is necessary for the control of diarrhoea and cholera epidemics. The fact that a substantial proportion of emergency interventions focused mainly on curative approaches, and on the pathogens including *Vibrio cholerae*, is quite disturbing. However,

it could also be that the healthcare interventions function within a meagre budget and that is why, it is not possible to implement costly preventive approaches.

Treatment of diarrhoeal diseases and related complaints

In the context of medical pluralism, children used both herbal and pharmaceutical remedies in the treatment of episodes of diarrhoea. When the episode of diarrhoea was considered less serious or life threatening, children frequently indicated opting to eat *cam ma nwang* (difficult to digest food) including cassava, white bread, millet, and maize meal. Whether difficult to digest foodstuffs are in fact a remedy for diarrhoea is, however, contestable. Although it is apparent that difficult to digest foods might stop diarrhoea or the 'running stomach', and a substantial proportion of children indicated how readily they recovered after such practices, there are inconsistencies to such an explanation; for example, Ojok above had diarrhoea after eating foodstuffs which he had bought, including cassava – a difficult to digest food. If it is true that it is possible to treat diarrhoea episodes with difficult to digest foodstuffs, then children in Gulu should not have episodes of diarrhoea at all since their daily meals always include at least one component of difficult to digest starchy food. Where episodes of diarrhoea reportedly started after eating difficult to digest foods, it is doubtful how these foods could then provide the remedy.

The pharmaceuticals used in the management of diarrhoea were, in the main, antibiotics and analgesics. However, these were rarely if ever taken in complete doses, in part because it was rare that a child would have the money to buy a complete dose, and further, if a child asked for the pharmaceuticals from neighbours, it would be unlikely that s/he would be given a complete dose. Here lies another contradiction in children's opinions on diarrhoeal disease aetiology and their treatment of it; namely the use of antibiotics for diarrhoea which children attributed to food intolerance or allergies, but which were probably due to infection, involving a pathogen or bacteria in causation. Children's use of antibiotics perhaps demonstrates a pragmatism in their short term approaches for restoring normality in case of illness. Regardless of the causes of disease, during an illness sufferers strive to find an effective remedy, and where there is experiential knowledge concerning an effective remedy, various attempts are therefore made to access it. Nevertheless, available publications suggest the dangers of over use, under use, and the misuse of antibiotics and other pharmaceuticals, particularly in generating drug resistant pathogens, reducing the efficacy of drugs, and poisoning (Hardon 1990; Van der Geest 1996: 243). These dangers are likely to be present for children in Gulu.

Here I present my dilemma, which I could call the pharmaceuticalisation of diarrhoea. Although it is clear that diarrhoea causing pathogens are predominantly transmitted through the oral-faecal route, and therefore addressing these associated factors would constitute a concrete intervention, major healthcare institutions including the World Health Organisation had narrowed their focus to curative approaches in 2005. Recent research about diarrhoeal diseases also reveal a focus on finding better therapies (medicines or pharmaceuticals), rather than prevention. For example Bhuta *et al*. (2000: 1516-1522) demonstrated how a two week course of daily zinc tablets significantly reduced the severity, duration, and mortality of diarrhoea in young children. In line with this finding, the World Health Organisation and UNICEF recommended that children under five years with diarrhoea receive 20mg zinc for 10-14 days, in addition to the newly formulated lower asmolarity oral rehydration salts (WHO/UNICEF 2004). In the

same vein, Ellis *et al*. (2007: 701) designed an intervention study to promote household and community level management of childhood diarrhoea through a short course of zinc. Although these studies and pharmaceuticals have contributed substantially to saving lives, this book propositions that the high prevalence of diarrhoeal diseases, including childhood diarrhoea, could be effectively minimised through concerted efforts to address social-political factors linked to oral-faecal transmission of pathogens.

Pragmatism in quests for therapy for diarrhoeal diseases

There is a conflict between children's frequent assertions about the danger of mixing pharmaceuticals and herbal remedies in case of illness with what they actually practiced when they were ill. In case of illness, children indicated using both pharmaceuticals and herbal remedies concurrently. Underlying this conflict between theory and practice is the inherent need to alleviate suffering and find a cure for episodes of illness, and it is this conflict which is a central issue at stake when pragmatism is evoked in the analysis of quests for therapy or attempts to minimise suffering. That children did not adhere to the rationalities they themselves proposed is not consistent with conventional anthropological literature suggesting disease aetiologies as determinants of healthcare seeking (Foster 1998; Pool 2003). In addition, although scholars' evidence points to non-western 'exotic' disease aetiologies which culminate in personalistic quests for therapy (Foster 1998; Pool 2003), this study's findings firstly suggest naturalistic disease aetiologies for a non-western population. Secondly, there is inconsistency in the way children attributed individual illness experiences to allergies or to eating a mixture of different foods or fatty foods, yet in their quests for therapy they instead focussed on finding a pharmaceutical or herbal cure or way to minimise their suffering. In short, there was no link between the definition of the apparent disease causing agent and the rationality behind the steps taken to alleviate suffering.

The children's curative approach in management of such illness experiences, including the therapeutic management of cholera cases, are just short term and are not very effective in dealing with infectious epidemics. Nonetheless, I propose that it was fitting to that context for children to engage in curative approaches for infectious diseases such as diarrhoea, because to a great extent the dire circumstances in which they lived made it impossible for them to practice effective preventive measures. However, as long as questions are not asked by healthcare intervention agencies about the key sources of infection, who are most likely to be infected, and how to prevent a recurrence of episodes, cure-guided solutions packaged up in medicines including antibiotics, zinc, and analgesics, seem to serve as perfect solutions. This is despite the fact that if preventive approaches were implemented it would drastically reduce the likelihood of a population confronting diarrhoeal diseases in the first place.

As findings suggest, no children indicated using oral rehydration salts (ORS) in case of diarrhoea. This finding is likely to have implications concerning the concerted efforts to promote ORS in the management of common episodes of diarrhoea. It is probable that many children needed the ORS, as they probably lost valuable body fluids during episodes of diarrhoea. It is also likely that if the episodes of diarrhoea which the children experienced were of an infective type, they might need to use antibiotics rather than ORS. If, as reported by Weiss (1988), a majority of programmes promoting the use of ORS highlight its ability to increase strength, prevent dehydration, and save children's lives – while acknowledging that ORS does not stop diarrhoea – then promoting use of ORS is likely to be problematic if sufferers' primary aim is to stop the diarrhoea.

Similar findings from Mali were reported by Ellis *et al*. (2007: 701), indicating that although nearly all parents knew that ORS would replace valuable lost fluids, its inability to stop diarrhoea caused them to seek antibiotics, anti-malarials, or traditional medicines from local markets in order to cure the illness.

Conclusion

Statistical evidence and qualitative data show a high prevalence of diarrhoeal diseases among the study population. Children's narratives suggest a severity, acuteness, primacy, and rapid deterioration of bodily condition due to illness episodes of diarrhoea, and children managed diarrhoeal diseases with both pharmaceuticals and herbal remedies, similar to malaria. Its primacy as a healthcare priority is portrayed in children's narratives which depict how it causes disorganisation of daily life, and how they require immediate attention when they fall ill. In the discussion, however, I highlight how the focus of emergency interventions aimed at reducing the high prevalence of diarrhoeal diseases through sensitisation seminars and case management was a contentious issue in 2005. For instance, upon closer examination of the distribution of cases, it is evident that figures were skewed towards people living in overpopulated camps, the congested suburbs of Gulu Municipality, and in general to areas where resource poor persons lived. This therefore leads me to deduce that wider socio-economic factors, including poor living conditions, a lack of sanitary facilities, congestion, and living in camps due to insurgency, play a substantial role in determining who becomes infected, how many get infected, and at what rate. Answers to such critical issues are likely to lead to concrete ways of minimising epidemics of an infectious nature. In contrast, interventions focussing on the treatment and education of people at risk serve to redefine the problem of an infectious epidemic as an issue of a lack of information. This could be the likely reason why efforts to control cholera epidemics in Gulu district have yielded limited success, and raises broader questions concerning the relevance, efficacy and acceptability of contemporary healthcare interventions during wartime.

Nonetheless, at the micro level it is probable that short term curative approaches for the management of infections offer the most practical solutions. In fact, the ready availability of pharmaceuticals over the counter made it easier for individuals to access a pill to cure their diarhoea episode than to prevent its occurrence. This curative approach in dealing with illnesses such as cholera and diarrhoea were less effective, however, it is proposed that preventive means could constitute better ways of managing such easily preventable diseases. The real solution to diarrhoeal diseases, like other infectious diseases, therefore lies not in pharmaceuticals or herbal medicines but in dealing with wider social-economic factors, regardless of how costly the procedures could be.

7

Respiratory tract infections

In this chapter, children's viewpoints concerning the prevalence and management of respiratory tract infections are presented and analysed. Children referred to infections in the respiratory system as *aona ki avuru* (cough and flu) and *aona opiu* (tuberculosis). As this discussion views tuberculosis as a chronic infection of the respiratory system, I adapt the overarching label of Acute Respiratory Infections (ARIs) from biomedicine – to cover cough and flu; but tuberculosis will be examined as a chronic condition which affects the respiratory system. I will not discuss other forms of tuberculosis in this book since the only child who discussed his experience with tuberculosis had an infection in the respiratory system. For purposes of this discussion, flu should be viewed as an episode of influenza.

The rationale for presenting a chapter on ARIs and tuberculosis following discussion of malaria and diarrhoea lies in the fact of ARIs' dual characteristics of presenting with less severe symptoms but with high prevalence. This excludes tuberculosis (TB), which will be discussed as a severe respiratory system infection but with relatively low prevalence among children of primary school age in northern Uganda. Nonetheless a substantial proportion of the children were at a high risk of becoming infected with *Mycobacterium tuberculosis.*

Findings in this chapter are presented under the thematic areas of children's perspectives concerning the prevalence of and medicine use for ARIs and tuberculosis, and how children regarded the severity, symptoms, and disease aetiologies of ARIs. Key informants' perspectives, mainly about tuberculosis prevention and control, will be presented following the children's perspectives. In the analysis I will discuss the dilemmas encountered in the management of tuberculosis in resource poor settings, complicated by the situation of armed conflict and HIV/AIDS. While addressing this issue, I will juxtapose existing interventions in the control and management of tuberculosis for peo-

ple in Gulu with broader socio-economic factors which contribute to a high prevalence of ARIs and tuberculosis.

Quantitative data: Prevalence and treatment of acute respiratory infections

The prevalence of respiratory infections among the 165 children is shown in Table 7.1. Acute respiratory infections constituted a high proportion of health complaints within a one month recall, and there was no statistically significant difference (P=0.71) between boys' and girls' experiences.

Table 7.1 Prevalence of acute respiratory infections within a one-month recall (N=165)

Illness	*Boys*	*Girls*	*Total*	*P-value*
Aona ki avuru (cough and flu)	76	68	144	0.71

Children mainly used antibiotics and analgesics in the treatment of ARIs (Table 7.2). As with the prevalence of ARIs, there is no statistically significant difference between boys' and girls' management of coughs and flu, with two exceptions observed in the use of Valium (P=0.01) suggesting a stronger likelihood of boys using it than girls and in using the red and yellow capsules (P=0.03) in a one month recall. A slightly higher number of girls (n=60) narrated that they used the red and yellow capsules than boys (n=53). I will come back to this issue in a chapter focussing on complaints symptomatic of emotional distress.

Table 7.2 Medicines used in the treatment of acute respiratory infections within a one-month recall (N=165)

Medicines	*Boys*	*Girls*	*Total*	*P-values*
Red and yellow capsule	53	60	113	0.03
Black and red capsules	24	12	36	0.07
Amox (as called in drug shops)	10	4	14	0.23
Amoxicillin or Tetracycline	**87**	**76**	**163**	**0.92**
Yat matar ma tye 500 ma wac (white medicine with 500 and tasteless), or Panadol	85	71	156	0.22
Multivitamins (or vitamins)	55	49	104	0.88
Piriton (*yat nino matar*)	53	42	95	0.46
Action	43	46	89	0.18
Valium (*yat nino makwar*)	50	29	79	0.01
Septrin	21	22	43	0.49

In the analysis of survey data, I did, however, encounter a dilemma in discussing pharmaceuticals used when multiple conditions were experienced concurrently, or when children experienced multiple illnesses within a one month recall. If children mentioned several illnesses which had affected them within a one month recall, and mentioned

using Valium, Piriton, Action, Panadol, and antibiotics, it was not clear which specific pharmaceuticals were used for which particular illness. This issue only became clearer through the triangulation of quantitative data with qualitative inquiries into medicine use. Here is one example: the symptoms of ARIs are sometimes severe and can cause sleep disturbances, therefore Valium or Piriton tablets could both be used in for this purpose, while Piriton was also used to counter the allergic effects of histamine released during an attack of flu. Nevertheless, children also used Valium and Piriton for disturbances by *cen* (evil spirits), deep thoughts, and fear. Children also referred to Valium and Piriton as *yat nino* (medicines for sleep), and these were used for this purpose generally. Therefore, if children mentioned that they had used Valium and Piriton for cough and flu, I discuss them in this section as pharmaceuticals used in the treatment of respiratory infections.

Since available publications, for instance (Hay *et al*. 2004: 1062) suggest that some respiratory system infections are viral in nature, and need not be treated because they are self limiting, in this chapter I discuss the management as opposed to treatment of ARIs such as flu, since recovery could occur even without the use of medications. In addition, where individuals used medications for symptom relief, I question whether they are treating the illness or simply managing it through minimising the severity of symptoms.

Whereas I indicate here the two herbal medicines (Table 7.3), I do it with some caution since children discussed their uses interchangeably. It was however more likely that children used mango tree bark for cough (P=0.004) suggesting a strong statistical relationship in boys' and girls' use of mango bark for cough.

Table 7.3 Herbal medicines used for cough within a one-month recall

Herbal medicine (extracts)	*Boys*	*Girls*	*Total*	*P-Value*
Mango roots	79	69	148	0.97
Mango bark	75	51	126	0.004

Qualitative data:
Prevalence, symptoms and management of respiratory tract infections

Prevalence, symptoms and severity of ARIs from children's perspectives

Episodes and experiences with *aona ki avuru* (cough and flu) were a common occurrence. Children frequently named *aona ki avuru* as common illnesses which they experienced, and by observation in displaced primary schools and night commuters' shelters, symptoms of ARIs were a common occurrence. In children's narratives, however, they agreed that such illnesses were not severe, and frequently the two illnesses 'got cured by themselves'. Ojok, in the prologue of this thesis, did not make it explicit that he had had cough and flu within a one month recall, yet in night commuters' shelters these infections were common, and he and his three siblings exhibited symptoms of ARIs during all interview sessions between July and September 2004. One fourteen year old boy narrated his story of *aona ki avuru* in this way:

> *Aona ki avuru* commonly attack me, but they are not serious. Often, for cough I only need to chew *cwiny lapena* or *cwiny kalatuc* (leaves of pigeon pea or eucalyptus plants) and I will be cured. Sometimes I may take Action tablets, smear *Vickskingo* or use Piriton for flu, but often it goes away by itself.

Although older primary school children ensured some cleanliness during times of illness through the use of handkerchiefs, and some children were observed blowing their noses or coughing outside their classrooms, some unpleasant practices were observed among younger children. Careless coughing, even without covering their mouths in densely packed classrooms, was a common scene, and these practices are linked in this chapter to the high prevalence of ARIs, particularly in classes with children of between five and nine years old.

Through examination of medical record books at GRRH, Layibi, Laliya and Laroo outpatients units, where malaria was the most frequent diagnosis, in only a few instances were ARIs also registered. In October 2005, only four medical records of children aged eight to sixteen years showed that Valium and Amoxicillin had been prescribed by a clinical officer for cough and flu, and during interviews about how children managed their cough and flu, only twenty-two of the seventy-eight children in one class indicated having been told at Layibi and Laroo health centres to purchase Septrin, Panadol, and Amoxicillin capsules. Perhaps the relative absence of ARIs in medical records was because children hardly ever sought specialised care for them.

A substantial proportion of children named cough and flu as common illnesses, when listing and ranking common illnesses which attacked them. However, in one focus group discussion with twelve to fifteen year old boys at Noah's Ark night commuters' shelter, they concluded that cough and flu were diseases which were only serious in younger children. One fourteen year old boy told how it was only when the cough was very frequent, and there was pain in his chest, that he bought the red and yellow capsules for cough.

In an exercise to diagrammatically illustrate the common illnesses children experienced in displaced primary schools, cough and flu featured as common illnesses in their drawing. In one class of seventy children at St. Peters Bwobomanam, all children illustrated *aona ki avuru* as individuals with air droplets or particles around the head region. In interview sessions which followed, many children asserted that at the moment of our discussion they had cough or flu or both. However, the episodes were not considered severe since they could still perform their routine activities. Children further told stories of how other children frequently developed a cough after sweeping the dusty classes and school compounds.

In Chapter 5, I provided an example of how one boy wrote about his experience with malaria within a one month recall, even though at the time of writing his narrative he was experiencing flu and cough. When I inquired about his selective writing, he argued that it was because "flu and cough were not *serious* illnesses. This is because cough and flu do not make people weak like malaria does". Further, he would probably not need medicines in order to recover. Generally speaking, cough and flu were illnesses of lesser importance to children of primary school age, because even children who discussed their recent episodes with cough and flu had first discussed their experiences with other illnesses which were regarded as severe in comparison.

In short, ARIs were highly prevalent among respondents. They were, however, not regarded as severe. The general agreement was that they were illnesses which went away by themselves and which did not make people weak. Children even continued

with their normal 'typical days' while experiencing episodes of acute respiratory infections. Children used both pharmaceuticals and herbals remedies in treating ARIs, and data suggests the use of mainly market drugs, including pharmaceuticals such as Septrin, Action, Piriton, Valium, Panadol, and Amoxicillin. The various herbal remedies used included *cwiny lapena* (leaves of pigeon peas)*, kalatuc* (eucalyptus leaves), and *muyeme ki mupeera* (mango tree and guava leaves). These three herbal remedies were outlined in illness narratives and during presentations in two workshops on common herbal medicines which children used for their illnesses, yet they were not captured in the quantitative survey data. Other remedies mentioned were green *Pepsi, Vickskingo, Balms*, and other unspecified ointments from India.

Using my experience to explore the management of ARIs

During one focus group discussion with girls aged ten to thirteen years, I was at the time personally experiencing cough and flu, and so I used my own illness to inquire about the severity and treatment of it. One girl aged thirteen years gave this account in response to my inquiry:

> Well, you can pray about it. Prayers can heal all illnesses [here I request to be taught how to pray]. But I do not know how to pray. The prayers I was talking about were those often done by the priest at Holy Rosary Catholic Cathedral every Sunday. He prays for the sick, and sometimes sprinkles water on them. But this is how I deal with *aona ki avuru*. I do not use any medicines for those two illnesses. It is because they can be cured by themselves. Even now I have cough and flu. I have not taken any medicine. But I can play, I have been coming to school. At home, I can do all the work which they send me to do. I just leave it to go by itself. But when the cough takes a long time, say one week without curing, then I can drink *kor muyeme* (extracts from mango bark) or chew *cwiny lapena* and *kalatuc* (leaves of pigeon peas and eucalyptus plants).

Another twelve year old girl added to the discussion:

> If the cough has taken long, or you are coughing frequently, then you can chew the *cwiny lapena, cwiny kalatuc*, or even drink *kado atwona* (extracts from soda ash mixed with salt). The cough will go away within one day. The flu often disappears by itself. Cough and flu rarely make people very sick. You can have them but you will have energy to dig, to cook, to go to school and do whatever you like. It is only when children in class laugh at you and make bad comments when you cough that is when you feel bad.

On the same day, I posed the same question about my ill health with flu and cough in a focus discussion for boys aged eleven to fifteen years. One twelve year old boy first disclosed how he had the same problem, and then mentioned how his neighbour (who sold medicines) had given him two Piriton the previous day, after he had fetched for him a jerican of water. Another boy, fourteen year old Ojok, elaborated:

> There are many medicines you can use for cough and flu. You can drink *kado atwona* (extracts from soda ash) mixed with salt. You can use Amoxicillin capsules if you have money to buy them. Also, other medicines in the shop are *Vickskingo*, Action, and sometimes Valium. But still you can use cwiny lapena, mupera, and *kalatuc* (leaves of pigeon peas, guava, and eucalyptus). These are always sufficient in curing those diseases.

Since Ojok was popularly known as *ajwaka* (indigenous healer) by other children, I promised to try out all the therapies he recommended, and so I picked and tasted leaves of pigeon peas and eucalyptus from the school compound. I gradually got better since the cough and flu appeared to be self limiting, though Ojok was happy that I took his advice. Other girls also kept inquiring whether they could bring *cwiny lapena* for me. I mention at this stage that there was a deep internal feeling which I registered as a result of the children's care, which I will call the 'unintended effect' in quests for therapy. For

instance, in using the herbal remedies which the children suggested and also brought for me, I perceived my recovery as being more a result of the care they exhibited than from a belief about the efficacy of herbal remedies. Further, in the constant inquiries from the children about whether I needed more of the *cwiny lapena* as opposed to the bitter *cwiny kalatuc,* I felt and recognised the importance of care in situations of suffering, whether with infectious diseases or emotional suffering. I will return to the importance of what I call the 'unintended effect' in quests for therapy for complex forms of psychological suffering.

In a workshop on herbal remedies, 20 out of 32 children brought *cwiny lapena* and *cwiny kalatuc* as remedies for cough. For flu, only six children brought Robb and *Vickskingo*. The thirty-two children mentioned that while flu may attack them frequently, it goes away by itself. Sometimes, however, if the children asked what medicine to buy for cough and flu they were given Piriton, Valium, and red and yellow or red and black capsules (Amoxicillin or Tetracycline capsules) from drug shops, clinics, or hawkers who sold medicines in the congested suburbs such as Pece, Cereleno, Kanyagoga, and Kirombe. Only five children bought *Vickskingo* and *Pepsi* (hard green crystalline sweets) during a one month observation exercise in one drug shop at Olailong trading centre in Kirombe suburb. Each of them indicated that the medicines were for cough and flu upon inquiry.

ARIs disease aetiologies

Children frequently mentioned exposure to dust as the cause of cough and flu. This they knew since they saw that children who were instructed to sweep the non-cemented dusty classrooms started to cough and developed flu shortly afterwards. One child put it this way:

> At home there is no dust since regularly we buy cow dung to smear the floor huts with. Sometimes we use mud to smear floor huts to reduce the amount of dust in huts. The compound is very small, so there isn't much dust. I have flu now since yesterday I was late at school and was punished by being told sweep primary six class. By the end of the activity I was coughing and sneezing.

When children were asked how they prevented cough and flu, numerous answers were given, including sprinkling water in the classrooms before sweeping, and avoiding playing in dust or playing in a compound with a lot of dust. In one focus group discussion with girls aged twelve to fifteen years, they recommended regularly smearing the classroom floor with cow dung, and indeed any other buildings which were not cemented. This helped to minimise the amount of dust and subsequently the likelihood of getting cough and flu.

In another discussion with eight to twelve year old boys, one boy argued as others agreed in unison:

> This *aona ki avuru* is common especially in children of P.1 – P.3. Children there do not care about cleanliness. Some of them can just leave the mucus to flow through their noses up to their shirts. Even when they are coughing, they just spit anywhere. Some children cough in front of others. Some even swallow what they have coughed. That is why there is a lot of flu and cough in such classes.

Children's perspectives about the causes of cough and flu pointed to an awareness of the air-borne nature of these infections, which are essentially naturalistic disease etiologies. Although children could not directly attribute these illnesses to particular viruses and bacterial pathogens, it suffices to say that within their level of education and experience it was hardly expected that they would be able to name and link the various microbes to their illness episodes. Perhaps notions of microbes and microscopic disease-

causing pathogens also reflect a high level of specialty in knowledge, largely influenced by age and level of education in the medical sciences.

Beyond the common experiences with cough and flu, the children interviewed also knew a type of serious illness which they called *aona opiu*, i.e. tuberculosis. Children indicated a need to avoid people with tuberculosis, and also mentioned how it could be acquired through inhaling cat fur, and from sharing household utensils and even huts or compounds with those suffering from *aona opiu.*

Children's perspectives concerning the severity of tuberculosis

Tuberculosis (TB) is a respiratory system infection which children considered severe. Tuberculosis was, however, less prevalent among children of primary school age. During the entire ethnographic research, only one child who extensively participated in the study had tuberculosis. Nevertheless, eight of the twenty-four children (33%) were at a higher risk of contracting tuberculosis since they were caretakers of adult kin sickly with HIV/AIDS, infected with an opportunistic tuberculosis infection.

In two workshop discussions on the common medicines used at home, one child brought with him Rifampin tablets which he used for his cough. In his presentation of the medicines, he argued that he had been ordered to stop using *cwiny lapena* and *cwiny kalatuc* at GRRH when he had been diagnosed with *aona opiu* (tuberculosis), and the only medicine for it was Rifampin (Rifampicin). Thirteen year old Okello also argued that he "had used those *yat acholi* (herbal medicines) for a long time, sometimes even using the green capsules (commonly Imodium) and red and yellow capsules (Amoxicillin or Tetracycline) for my cough, but I did not get better". Following Okello's statement, various children focused their discussion on the severity of *aona opiu* and how it spreads, advising Okello about what he should do, and what other remedies he could use in order to recover. This particular workshop turned out to address the severity of tuberculosis, its perceived disease aetiology, and how Okello could stop spreading tuberculosis to others.

In this discussion, children's perspectives about tuberculosis were detached, focussing on disease aetiology. It is likely that this is due to the fact of their experience-distant perspectives. The tone of the discussion portrays the tuberculosis victim as the 'other' and the children seemed not to comprehend Okello's realities. This distant stance in children's viewpoints was, however, not observed in discussions on any other infectious disease which children identified as common. This also tells us about the information available from much anthropological literature which exhibits an experience-distant assessment of the 'other's' illness experiences, with the main focus on personalistic disease aetiologies

One twelve year old boy elaborated on the severity of tuberculosis while giving this account:

> *Aona opiu* (tuberculosis) is a very serious disease. In Pece, there is one man whose wife died of *slim* (AIDS), but for him he was healthy for sometime. He even remarried. But with time, he started coughing, and his coughing was very persistent. He tried to purchase for himself various medicines but did not recover. However, when he went to Lacor Hospital, he was told that he had *aona opiu.* Although he was given so many types of medicines, he still coughed persistently, sometimes coughing just blood only. That is how I know that *aona opiu* is a very serious disease.

One thirteen year old girl shared an experience of a neighbour's daughter who had tuberculosis in order to show its severity:

> Her mother says that Acen is about thriety-two years old. The reason why Acen was brought back to Gulu from Kampala was that she was sickly with *aona opiu.* When she was taken to *ot yat adit* (GRRH), she was admitted for a short time and told to go home. She was, however, still coughing. She is very thin and needs help to stand from her bed. She had *aona opiu.* Although she takes medicines like those Okello has, she does not recover. Neighbours, however, keep gossiping about dangers of getting *aona opiu.* Some people say that someone could get *aona opiu* by just crossing the compound and coming close to the hut where that woman sleeps.

In various focus group discussions with children aged nine to sixteen years, sometimes disaggregated by gender, the predominant theme among all children was that *aona opiu* was a serious disease. Furthermore, tuberculosis, the children argued, was caused by the swallowing or inhalation of cat fur. In one session, five boys aged twelve to fourteen years specifically asked Okello whether he had a cat at home, and if so, advised him to get rid of it. Okello, however, insisted that he did not have a cat in his home or his neighbourhood. In the same discussion, children narrowed down their 'advice' for Okello to what to do in order not to spread *aona opiu*:

> He should not sit close to others. At home he should sleep in a hut alone. He should use his own cup, plate, and blanket. Above all, since Okello's medicine seemed to work for him, he should never miss a day without taking any of them.

By the time Okello's response below was completed, there was a peculiar silence in the classroom. Here is how he shared his experience:

> Perhaps I got this *aona opiu* when I was taking care of my mother last year [2004]. She died of *aona opiu.* Some neighbours say she died of *slim* [HIV/AIDS], since even the soldier whom she had a child with also died last year. It was the child she gave birth to who first died, then later my mother. However, I had to take care of her at hospital. During that time, Ajok was always taking care of my younger sisters and brothers at home. She would also cook and bring food to hospital daily. But I cannot do all what you are telling me to stop *aona opiu* from getting other people at home. We have only one hut for all of us. We have just two blankets for sharing by five of us. We have two cups and three plates. We have been sharing all this. There is no one at home who has got this disease!

The complete silence which followed Okello's narrative was only interrupted by one outspoken eleven year old boy who began by arguing that perhaps Okello had already infected him with *aona opiu.* However, he added that he may not have, since people often told him that he is very strong (resistant to diseases), and much as the people around him at home sometimes fell sick, he remained healthy. Other children present for the discussion hypothesised that it was because they had not shared cups, plates, or pens with Okello that they were still healthy. Most importantly, they did not have *aona opiu* because they did not have cats at home, and neither did anybody in their neighbourhood.

I closely monitored Okello's medical records which he regularly took with him to Lacor Hospital when he went to collect his medicines. Over a six month period when Okello took Rifampin tablets he exhibited complete adherence. In my follow up visit to Gulu in May 2006, I visited Okello and his health condition had deteriorated substantially. Together with his sister they narrated how, after the six months of taking his medicines, he was told that his chest had not responded to the medicines. The x-ray result showed a black thing in his chest. I organised to take Okello to Lacor for check-ups, and the clinical officer confirmed yet another case of multi-drug resistant tuberculosis (MDR-TB). The hospital was, however, still awaiting the arrival of another line of drugs to combat it. I felt helpless, like the children and the clinical officer and other people who had gathered to watch us. Nevertheless, Okello was again registered for Rifampin medicine, this time with strict advice for him to adhere to the schedule and

timing in taking them. In another follow up visit to Gulu in January-February 2007, I traced Okello again. To begin with, I discovered that the brother of their landlady, Alobo, had instructed them to find somewhere else to live as they were becoming a danger to his children, since he had also developed tuberculosis which had been diagnosed at Lacor hospital as MDR-TB. Ajok and Okello were therefore now living at the extreme end of the village with virtually no neighbours. According to Okello, the brother of Alobo – having learnt that the tuberculosis they had was not curable and that there were no medicines in the entire country – instructed them to leave the neighbourhood. He had demolished their huts. That is how they moved to the extreme end of the village to rent a piece of land from the present land owner. Okello and Alobo may therefore have been important sources of infection for MDR-TB. Due to high loss of adult lives in Gulu and northern Uganda, a unique scenario has developed whereby it is children who are the principal caretakers of HIV/AIDS victims, and since HIV/AIDS clients frequently have tuberculosis, it is likely that such children are also exposed to it. Nevertheless, there is hardly any data about the dangers of such children's exposure to tuberculosis.

While living in isolation, each of the family members had a card and had to regularly report to Lacor Hospital for *isoniazid prophylaxis.* Okello had recovered remarkably compared to my judgement of his condition in May 2006, since he could move unaided and had gained some weight. During another visit in September 2007, each member of the family had a certificate of completion of *isoniazid*, and "Each of them had no traces of active tuberculosis and had perhaps recovered", said one medical doctor during interviews.

Tuberculosis as an opportunistic infection for HIV/AIDS clients

Another finding which pointed to the severity of *aona opiu* as a health problem came from three children taking care of their parents, sick due to HIV/AIDS. Their parents had a persistent type of cough which they frequently discussed; it was *aona opiu*, or tuberculosis. Such children often made it clear that even though they did not have cats in their homes, their sickly kin were still affected by *aona opiu.* One eleven year old boy, Abonga, discussed his experience of taking care of his sick mother:

> *Aona opiu* is a very serious disease. My mother has it. Sometimes she can cough for more than one hour until she vomits blood. She had since become very weak and thin. Although she was one time admitted for one month at Lacor Hospital due to that cough and given various medicines, she does not recover. When she was sent home, she kept on coughing. She was also given more medicines which she would take from home. Still she does not recover. She often sends me to call the pastor of BBC (Bridge Builder's Church) at Laroo to pray for her. When he comes, he makes us kneel down and raise our hands. He first tells us to repent of our sins, before he can chase away the Satan which makes my mother very sick.

Abonga also frequently discussed the difficulty surrounding her mother's failure to go for more medicines at Lacor Hospital. In yet another discussion, he explained his experience this way:

> My mother was admitted two months ago at Lacor Hospital but was told to go back home before she recovered. She was told to go back for more medicines when she completes what she was given. Since she came from the hospital, she has been very weak. She can no longer go and dig or do *leja leja*. She cannot even buy for us exercise books, pens, and school uniforms. Today she was supposed to go for more medicines but she needs 700 shillings for the hospital and money for transport [about 1,000-2,000 shillings by public transport], which she does not have.

Another child aged twelve years discussed in depth her mother's persistent cough which made her elder brothers go to night commuters' shelters to sleep:

> My mother has *aona opiu.* Although she has been taking medicines, she does not recover. Sometimes she coughs throughout the night. You do not know what to do. I get scared when I see her vomiting blood due to that cough. The landlady threatened to chase us from her hut due to that cough. She said my mother makes a lot of noise for her at night when she wants to sleep. At World Vision, they always tell us not to share plates, cups, food, or a hut with people with *aona opiu.* But we have only one hut and a few cups and plates. We share all these with my mother. I cannot go to sleep at the night commuters' shelter because it is at night when my mother needs someone to light the lamp for her, to clean her, and to give her medicines.

Key informants' perspectives about the severity and management of tuberculosis

One doctor was interviewed concerning the extreme fear children have of TB contagion, and about the advice he would give them:

> Tuberculosis can be effectively treated within six to eight months with medicines such as Rifampicin and Isoniazid. However, when a patient has been given that medicine consistently for at least two weeks, then it is not infectious anymore. The only thing which that patient needs to do in order to avoid more complicated problems like developing multi-drug resistant tuberculosis [MDR-TB] is for them to take their medicines as prescribed. The major problem we have in Gulu here is that after the patients are discharged from hospital, they *believe* they have recovered, therefore most of them stop taking their medicines. This has contributed to the high incidence rate of MDR-TB in this region. MDR-TB is virtually impossible to manage and at Lacor, there is a policy that facilitates management of those patients without the resistant strains of TB. It is preferred that those with MDR-TB are managed in their communities. MDR-TB is the most dangerous form of TB. Perhaps the children who are taking care of sickly patients are not predisposed to infection, since most of them are in ART programmes, and therefore have taken Rifampin for more than three weeks.

Upon further inquiry concerning how the 'community' is facilitated to manage those with resistant strains of tuberculosis, the doctor gave the example of the Directly Observed Therapy (DOT) project which had been put in place, but which was no longer operating because of lack of funds.

Another doctor in private practice in Gulu, interviewed about the role of *isoniazid prophylaxis* in 'curing' Okello's MDR-TB, responded as follows:

> Isoniazid, like Rifampicin, is a first line drug for treatment of tuberculosis. If that boy did not recover after taking Rifampicin, then it would be better to give him a second line treatment for tuberculosis. My experience, even with those very rich people taking ARVs is that, if they do not respond to Rifampicin, they have just been left without any medications. Perhaps, it is because the second line medicines are very expensive. I have not even seen anyone in Uganda taking them.

Further, a clinical officer at Lacor Hospital elaborated on the issues at stake in the DOT project during an interview. The clinical officer, in his own words:

> The directly observed therapy was initiated by this hospital five years ago in an attempt to reduce non-adherence rates of our patients. There was also a high increase of multi-drug resistant strains of TB in the clients who did not come back to collect their medicines as were instructed. Often such clients would come back for a refill after realising their TB had become more serious. The DOT project was only active five years ago. Presently however, the hospital is not able to follow up our clients. There are various problems including limited staff, finances, and also the insecurity caused by LRA in our focal communities. There are camps which the DOT project staff have not tried to visit due to insecurity. The most important problem is lack of facilitation [funds].

In an interview, the coordinator of an HIV/AIDS unit at GRRH elaborated on the phenomenon of increasing episodes of MDR-TB:

> MDR-TB is a big problem in Gulu Hospital not only in adults, but also in children. Partly it is because of clients' non-adherence and another problem is that when we diagnose MDR-TB, we have a policy of sending such people home. This is to limit their likelihood to infect other TB clients in the ward with drug resistant strains of tuberculosis. The sad thing is that, about two months ago, I sent home one such case, but after a few weeks a caretaker reported with TB infection similar to the strain in *his* patient. It was MDR-TB. To make matters worse, these persons are living in the communities, which are camps, with poor housing, congestion, and poor sanitation. It is likely that with time the hospital would be confronted with more people with strains of multi-drug resistant TB as first time attendants.

At Lacor Hospital and other state aided health centres, a typical TB unit during the time of the study had a bed capacity of forty patients or less. Although it is a requirement that after such patients are admitted they are closely monitored for the next six months, the clinical officer in charge of Lacor TB unit explained:

> We have a policy to admit serious cases of TB for one month. Thereafter, they have to be discharged but they are required to report regularly to the clinic for follow up and refills. In which case progress is monitored and they are given more medicines. Often, however, clients do not adhere to these demands by the hospital. This is because, when we discharge them, most of them think they have recovered.

If Abonga's mother above is representative of clients who do not adhere to the treatment requirements for tuberculosis, then it is clear that the hospitals' policies need to take into account such difficulties.

A substantial proportion of NGOs had programmes addressing the needs of persons affected by HIV/AIDS and tuberculosis, and their general approach was to promote awareness through sensitisation seminars and the dissemination of awareness messages concerning the dangers. For example, one of the counsellors in World Vision's ART programme *counselled* the people taking care of ARV clients, who were exhibiting symptoms of tuberculosis, as follows:

> So many of our clients do not only have HIV/AIDS, but also *aona opiu.* My task today is to tell you how to take good care of them, as well as of yourselves. First of all, although the HIV/AIDS virus cannot be easily got through interacting with our clients, TB can easily be spread from one person to another. Its being an airborne disease makes it easy for one person to get it from another sick person. Therefore, you should avoid close contact with them. At home, if possible use another hut so as to avoid constant exposure to infection through sharing one hut and other basic utensils.

Indeed, consistent to the counsellor's advice, available publications suggest that unlike many of the opportunistic infections afflicting those with HIV/AIDS, and unlike HIV infection itself, *Tubercle bacillus* may be transmitted without sustained intimate contact. Viable bacilli are aerosolised by coughing TB patients, and they may remain in the air for hours. Perfectly immunocompetent persons may subsequently inhale these organisms and become infected (Farmer 1997b: 348).

Discussion: Prevalence and management of ARIs

In the interpretation of empirical data about the prevalence and management of acute respiratory infections and tuberculosis, I organise my analysis under three subsections: firstly, I look at the high prevalence of and curative approach to ARIs, then I examine the silence following proximal discussions about tuberculosis (i.e. accounts from tuberculosis patients), and finally, the last subsection links the prevalence of tuberculosis among children to wider socio-economic factors. In analysing the efficacy of curative approaches, I suggest that use of pharmaceuticals in the management of ARIs and tuberculosis serve only as short term approaches, and in some instances I contest such

short term approaches, especially where tuberculosis is concerned. Tuberculosis poses various complexities, not only due to the fact that it is a chronic and infectious condition, but also because dire socio-economic conditions, coupled with it being an opportunistic infection in HIV/AIDS clients, play a role in determining the prevalence and the effectiveness of its management among people in the situation of armed conflict.

High prevalence and curative approaches to acute respiratory infections

Empirical evidence suggests that cough and flu were highly prevalent among the study population, but while the frequency of experiences with ARIs was emphasised, its severity was not. ARIs were not seen as life threatening and posed less severe symptoms – with the exception of TB – and were seen to be self-limiting, with individuals recovering without taking any medications. When children did pursue treatment, it was with certain pharmaceuticals, market therapies like *Robb* and *Vickskingo*, and home-made treatments such as soda ash mixed with salt and herbal remedies. This attitude to ARIs could explain why children did not pay much attention to them. It is further likely that for highly prevalent infections, children learned to integrate them into their daily life experiences.

However, children's perspectives suggest that they consider *aona opiu* to be severe. TB presents a severe type of cough because it makes people weak, is persistent, and sufferers cough blood. Further, the fact that people were admitted to hospital, and also had to take pharmaceuticals for a long period of time, were indicators that *aona opiu* was severe. Apart from Okello who was taking Rifampin (Rifampicin) during the time of study to treat an episode of TB, no other child shared their illness experiences with TB. There were, however, six children in 2005 taking care of parents sickly due to HIV/AIDS and tuberculosis. The link between HIV/AIDS and tuberculosis was made in the late 1980s (Rouillon 1991) and this link is becoming increasingly evident as many TB deaths are due to HIV (Raviglione, Snider & Kochi 1995). That child caretakers of HIV/AIDS clients knew about TB is not surprising. They frequently referred to it as a cough which does not cure, a cough which is persistent, and one that can disturb people during the night, with the occasional coughing up of blood. Such symptoms are at the core of the suffering caused by tuberculosis, and child caretakers of sufferers of HIV/AIDS are at a high risk of contracting it themselves.

In short, cough and flu were common illnesses in wartime children, and children made distinctions between the 'normal cough' and a 'serious cough'. Normal cough and flu were those which they got from dusty areas, or from children who came to school with a cough and passed it on. It did not make them weak, though children laughed at those who coughed in class, and it could be cured by itself. For *aona opiu,* on the other hand, there was a peculiar silence following narratives of individual's experiences with tuberculosis.

Silence following one child's discussion of his experience with tuberculosis

The above sub-title attempts to make explicit the dilemma children were confronted with in discussions about tuberculosis by a child who himself experienced tuberculosis. Interventions with the desired aim of reducing AIDS related mortality through antiretrovirals (ARV) distribution programmes might also draw some lessons from this phenomenon. Unlike discussion sessions about other infectious diseases which commonly affected wartime children, for which children appreciated the short term curative solution of pharmaceuticals, tuberculosis seemed to not exactly fit the pattern. Experi-

ences with tuberculosis resisted simple short term solutions, much as there were efficacious medications such as Rifampin, Isoniazid, and Ethambutol. Even indigenous means of avoiding contracting tuberculosis appeared to border on impractical and detached suggestions, such as the avoidance of cats and cat fur. Hence there was often silence, especially after listening to a proximal or experience-near narrative about tuberculosis.

Discussions which followed the 'silences' seemed to shift to an individual's need to avoid 'falling into the trap' of being exposed; but how could resource poor wartime children, and indeed all people at risk, living in over-crowded conditions with limited resources, prevent infection? Further, I question whether the major operational technique employed by emergency aid institutions and healthcare professionals – of sensitising wartime people at risk, including caretakers of ART clients – is sufficient.

That the infected, the predisposed, and 'at risk' children were forced into silence while discussing the dangers of tuberculosis is revealing in a number of ways. Firstly, while an experience-distant stance seems to offer simple solutions, such as avoiding cat fur and not sharing utensils and huts, an experience-near narrative challenges individuals to re-shape their model. One such model is for the infected to 'take their medicines without fail'; in short, adherence. However, in the promotion of adherence, individuals are confronted with wider socio-economic and political difficulties including abject poverty, crowded living conditions in camps, and insecurity, as well as the deteriorating bodily condition of ART clients, which cannot be ignored. It is clear that being confronted with experience-near accounts makes it harder to suggest preventive ways of dealing with opportunistic infections, including tuberculosis, among ART clients and children. What is more, the major opportunistic infection, tuberculosis, is gradually broadening in scope to affect child caretakers. While it is true that a substantial proportion of people at risk were not aware of the medical-technical details regarding infection, in the main the factors reinforcing the spread and increased infection rates of tuberculosis (including MDR-TB) are of a socio-economic nature. This is consistent with Farmer's (1997: 355) observation that calls for "lifestyle and behaviour" changes are often made to precisely those persons whose agency is most constrained. The critique I pose of contemporary intervention agencies, whose major approach is to sensitise people about the dangers of *Mycobacterium tuberculosis*, is that if the contextual factors of wartime were to be scrutinised by such key players, they may also be forced into silence, and into rethinking their interventions. Failure to do so leads to the suggestion of simple, impractical, and detached solutions.

Unilateral, detached suggestions for the prevention of TB were easily articulated by children who had no direct experience of TB. It was more difficult, however, for children taking care of sickly parents, or for the siblings of Okello, for instance, to effectively decide upon or even implement preventive measures for TB infection. This is partly linked to their obligations and social roles as healthcare givers. For Adokorach, it was her own mother who was sick, not a stranger, which made it impossible for her to implement preventive measures which would, in effect, signify neglect and alienation of her mother at a time when she needed her most. For instance, her mother needed to be cleaned when she coughed up blood, she needed someone to give her medicines, even at night, and she also constantly needed water to drink; how could Adokorach leave her mother alone to go spend nights elsewhere, such as at a night commuters' shelter? Furthermore, they had few utensils, and had difficulty in getting enough food for the family, thus whatever her mother did not finish would become Adokorach's meal.

In short, it appears that proximal narratives of ways of dealing with ART clients with tuberculosis break all knowledge barriers and rationalities of the inherent needs of people to alleviate suffering. While it is true that children who took care of sickly kin, especially those who had developed TB, knew of the dangers and were the constant targets of awareness messages, their daily life experiences offered few opportunities for implementing the advice in these messages. Okello was well aware of the need to heed the children's advice in the focus group discussion, and the instructions he received at GRRH each time he went for a 'refill' when he was 'taught' how to avoid infecting others. Yet Okello told how he and his siblings had to share only two cups, three plates, and two blankets, and could hardly manage to rent even a single hut for themselves.

Wider socio-economic conditions linked to increased prevalence of tuberculosis

Although the clinical officer in charge of one TB unit attributed non-adherence to patients' perceptions that they had recovered, it is possible that other factors were at play. Findings suggest that many adults admitted to TB wards also had HIV/AIDS. Tuberculosis was therefore just one of the several opportunistic infections and problems they had to deal with. Through visits to various clients of the Presidents' Emergency Programme for AIDS Relief (PEPFAR) and World Vision's ART programme, I found that such persons often lived in camps and municipal suburbs, mostly at a significant distance from Lacor Hospital or other ARV distribution points. Nevertheless, ART clients were required to travel to these ARV distribution points at least twice a month, yet a substantial proportion often had no means to report to the hospital. Explanations commonly given were a lack of transport facilitation, the inability to raise the 700 shillings each client is required to pay for each refill, and frequently such clients would be bed ridden in their homes. Similarly, a report by the World Health Organisation estimated that one third of AIDS deaths are due to TB (WHO 1999a). Where HIV has established itself, the prognosis is even worse: in Sub-Saharan Africa, from 1990 to 1999, TB incidence escalated by almost 250%, and poverty remains an overwhelming risk factor for tuberculosis related mortality (Shin *et al*. 2004: 1536). Effective community based tuberculosis control therefore requires comprehensive initiatives that incorporate efforts to address the root causes of disease, notably poverty and the resultant ills (Kironde & Nasolo 2002: 276). Similar findings are presented by Farmer (1997b: 347), suggesting a patterned occurrence of MDR-TB in the United States afflicting those in homeless shelters and in the inner city, indicative of some of the large scale social forces – including poverty, economic inequality, political violence, and racism – at work in the new epidemic, which begun even before the advent of HIV.

If what experts in tuberculosis suggest about MDR-TB is true – for instance that patients are resistant to three or more first line agents including Isoniazid and Rifampin (Farmer 1997b: 348; Shin *et al*. 2004: 1529) – then Okello's tuberculosis was not MDR-TB; in a second follow-up visit, Okello had improved greatly, and in a follow-up visit in September 2007, Okello showed remarkable signs of recovery. He had also received a certificate of recovery and completion of Isoniazid regimen. As Okello's tuberculosis responded to Isoniazid, and he showed improvement, does that not imply that he did not have MDR-TB?

Although TB is easily preventable and can be treated – and even immunised against in children under five years of age with the BCG (Bacille Calmette Guerin) vaccine –

there is an emerging trend for TB to be diagnosed in children above five years in northern Uganda. One example is of Okello, above, and his infection was closely linked to his being the caretaker of a kin member sick with HIV/AIDS. If TB spreads through such simple practices as sharing basic household utensils and beddings, and through sharing limited space in congested camps characterised by poor sanitation, then it is concrete to argue that TB will likely affect a substantial proportion of people in Gulu. The children of my study were caretakers of sick kin who could not implement preventive precautionary measures due to the poverty, misery, lack, and difficult socio-economic conditions in which they were embedded.

Conclusion

Empirical evidence suggests a high prevalence of ARIs in children. ARIs were generally regarded as less severe than malaria or diarrhoea, for example, and if children used medications in the management of episodes of ARIs, these included market drugs which provided symptom relief, pharmaceuticals with antibiotic properties including Amoxicillin, Septrin, and Tetracycline, and other unspecified capsules. Children also used painkillers such as Panadol, Action, Hedex, and Painex to minimise the pain caused by ARIs, though more commonly children used herbal remedies.

Beyond the high prevalence and non-severity of common ARIs lies tuberculosis. Children at risk of contracting tuberculosis were those taking care of kin sickly due to HIV/AIDS. All children recognised *aona opiu* as a very serious disease. It was considered severe because they had never seen anyone recover from it, and people needed to take medicines for a long time, yet while they took the medicines, they still appeared sickly. Such people also needed to make frequent hospital visits, or even be admitted to hospital. Attempts to ensure that people at risk practiced preventive measures to avoid contracting tuberculosis were couched in idioms highlighting the dangers of the highly contagious *Tubercle bacilli* and emphasising adherence with medicines. Nevertheless, such approaches met with more difficult challenges of a socio-economic nature. The socio-economic difficulties include, but are not limited to, difficulties in meeting basic needs, poor living conditions, and lack of a basic income which restricts travel possibilities for examination and medication refills. Even attempts to put in place a directly observed therapy project through Lacor Hospital met with difficulties in facilitation due to lack of funding, limited staff, and other problems within the hospital.

8

Scabies

This chapter's main focus is on *gwinyo* (scabies), in particular children's experiences with scabies and how they managed such illness episodes. In Gulu, scabies, like ebola, was one of those less known infectious epidemics, closely linked to the phenomenon of institutionalisation in the management of problems related to armed conflict. Institutionalisation here refers to the creation of institutions for rehabilitation, counselling, and shelters, which were viewed as solutions to the insecurity caused by the displacement of people fleeing frequent LRA attacks to go to the safer areas of Gulu Municipality.

In Part II, I mentioned that children attending displaced primary schools were more likely to have *gwinyo* or scabies than children who attended mainstream municipal schools. Such children were also those who spent nights at night commuters' shelters – including Noah's Ark, Lacor Hospital night commuter's shelter, Holy Rosary, and the district water processing centre – places commonly referred to as *bagdhad* by children. Scabies was common in these shelters, and was managed in various ways, though it frequently led many children to the point of despair. Some children referred to scabies as *anyoo* (measles), but such suggestions were quickly refuted by others in the same age group. In one group discussion at Noah's Ark, six children argued how measles only affected children who were not immunised when they were still young, but scabies affected everybody at *bagdhad. "*Everybody who spent nights at *bagdhad* quickly got scabies, regardless of whether they were immunised in childhood against measles. Therefore, scabies is not *anyoo* (measles)", argued one fourteen year old girl.

The basic structure of this chapter follows the themes of prevalence, medicine use, and symptoms of scabies. An analysis of findings is made in the discussion section, and subsequently conclusions are drawn.

Quantitative data: Prevalence and management of scabies

The prevalence of scabies among the sampled children is shown in Table 8.1. A relatively high proportion of children – 116 out of 165 (14%) – mentioned having had an experience with scabies within a one month recall. However, the data shows a disproportionate prevalence rate of scabies in boys – 83 (19.1%) – compared to girls – 33 (8.3%) – consequently suggesting a strong statistically significant difference between boys and girls (P<0.005). This is, however, a unique outcome since by observation there were no major variations by gender in the prevalence of scabies. In addition, as evident in the presentation of quantitative data related to medicine use below, a similar number of boys and girls indicated that they used *Opele* (Benzyl Benzoate ointment) within a one month recall, which is the particular medicine used to treat scabies.

Table 8.1 Prevalence of scabies within a one-month recall (N=165)

Illness	*Boys*	*Girls*	*Total*	*P-value*
Scabies	83	33	116	<0.005

It is important to note that at the time when this survey was conducted, children who spent nights at night commuters' shelters and those who attended displaced primary schools were still recovering from the scabies epidemic, and the questionnaires were administered shortly after Medicines sans Frontiers (MSF) had implemented a curative scabies intervention to affected persons in night commuters' shelters.

Results about medicine use for scabies (Table 8.2) show no statistically significant difference between boys' and girls' use of medicines, except for use of red and yellow capsules (P=0.03), used by girls slightly more than boys. As mentioned earlier, it was difficult to judge which particular health complaint a child was treating when she had multiple infections – which could include scabies – and used Amoxicillin within a one month recall. Results concerning the use of pharmaceuticals therefore overlap. Where children mentioned the use of Pen V, Amoxicillin, and Septrin for scabies, they indicated crushing the pharmaceuticals and applying the powder onto the affected skin. One of the most commonly used medicines for scabies, however, was *Opele*, a market drug in the form of an ointment often described by children as the best medicine for

Table 8.2 Medicines used in the treatment of scabies within a one-month recall N=(165)

Medicines	*Boys*	*Girls*	*Total*	*P-values*
Red and yellow capsules	53	60	113	0.03
Black and red capsules	24	12	36	0.07
Amox (as called in drug shops)	10	4	14	0.23
Amoxicillin or Tetracycline	**87**	**76**	**163**	**0.92**
Opele (ointment for scabies)	64	64	128	0.11
Pen V (penicillin V)	62	64	126	0.06
Septrin	21	22	43	0.49

Table 8.3 Herbal medicines used in the treatment of scabies within a one-month recall (N=165)

Herbal medicines (extracts)	*Boys*	*Girls*	*Total*	*P-values*
Pawpaw leaves	82	59	141	0.003
Garlic	34	39	63	0.12
Banana sap	29	19	48	0.24
Neem leaves	24	11	35	0.042

scabies, and which they commonly stated was first introduced to Gulu by MSF. The *Opele* I purchased in 2004 had Benzyl Benzoate as its active ingredient.

In the context of medical pluralism, herbal remedies were used, sometimes concurrently with pharmaceuticals, in attempts to minimise suffering. Remedies which children named for scabies included washing with pawpaw leaves, as mentioned by 141 children (23.7%), garlic, as used by 63 children (10.6%), banana sap by 48 children (8.1%), and neem tree leaves by 35 children (5.9%). Apart from a strong statistically significant difference observed in the use of pawpaw leaves (P=0.003) – showing higher use by boys (n=82) than girls (n=59), and a slight statistically significant difference in use of neem leaves (P=0.042) – there was no significant difference in boys' and girls' use of herbal remedies for scabies. Boys' higher reported use of neem leaves (P=0.042) for scabies is not a strong association, and this could signify that other factors influenced the outcome of results. Such factors could include the presence of other remedies for scabies on the market and easy access of other herbal remedies for scabies or remedies at state aided centres within Gulu Municipality. The latter analysis is consistent with the fact that fewer boys reported to have used neem leaves compared to pawpaw leaves.

Qualitative data: Prevalence, symptoms and management of scabies

Exemplary narratives about an experience with scabies within a one month recall

About two hundred children wrote compositions discussing their experiences with scabies during the first phase of the study. One fourteen year old boy, Owino, described his experience as such:

> I suffered from a disease called scabies. It was transmitted to me from my neighbour, i.e. the boy whom I sleep together with at the shelter. Then I was told to bathe four times per day, and I even heard this from the radio. If you have this kind of disease you should bathe four times per day, so I started bathing four times with soap. Then when I did this for four days, the scabies did not cure. I told this to my guardian, and then he told me to go to the hospital. Then I went to hospital the following day in the morning after washing my body. When I arrived at the hospital, I go to the doctor, then he writes the name of my disease, then I go to another doctor to inject me. Then after, I left the hospital for home. So I stayed home for one week and the scabies disease got cured.

Fourteen year old Akello narrated her experience as follows:

> One day there was a disease called scabies which attacked my body. My sister said to me, go to the hospital. When you are going, you buy a book of 100 Shillings where they will write your name, and give it to the doctor. The doctor told me you go and wash your body and you come back in the office.

> So I go to one house and wash my body. The doctor treated me with white medicine [Benzyl Benzoate]. So I go home and I am now okay.

Generally speaking, as exemplified in the two narratives above and indeed in fifty percent of the children's narratives about their experiences with scabies, there were notions of blame and accusation, the most dominant of which were about a lack of personal/bodily hygiene as a major predetermining factor, and about former child soldiers as the main perceived source of the epidemic. I discuss this in more detail below.

Scabies was one of those epidemics in Gulu which received emergency intervention – mainly in the form of awareness messages. In Owino's narrative above, and other children's narratives also, there were references to hearing messages over the radio, in workshops, during counselling sessions, and in seminars in displaced primary schools, educating people at risk about scabies. In the awareness messages there was advice about bathing with medicated soap and avoiding sharing basic facilities with infected persons. In July 2004, one frequent awareness message broadcast over Radio Mega and Choice FM, sponsored by various key healthcare institutions in Gulu, advised people on how to avoid infection, how to manage scabies through bathing four times a day with medicated soap, and if symptoms persisted, that they should consult their nearest doctor. In the main, scabies was connected to the dangers of dirt, and subsequently people at risk were advised to ensure that they lived hygienically and avoided contact with infected people. This is why, despite the fact that mainstream municipal schools hosted displaced primary schools within their compounds, it was rare that children from municipal schools interacted with displaced children, especially during the period of the scabies epidemic.

Prevalence, symptoms and severity of scabies from children's perspectives

By observation, between July and September 2004 all children of primary school age who spent nights at Noah's Ark night commuters' shelter had scabies. This prompted the Noah's Ark, counsellors, to conduct what they called counselling sessions for their infected clients. In these counselling sessions, which I regularly attended, health awareness messages focused on notions of cleanliness, hygiene, the use of medicated soaps, and how to avoid catching scabies. Occasionally Protex medicated soap would be distributed to what counsellors called "the dirtiest children, perhaps because they did not want to bathe at home". Such children would then be forced to bathe before going to sleep.

During twelve focus group discussions and over forty individual interviews in August 2004, all children at Noah's Ark named scabies as the most severe skin disease they had ever experienced. One fourteen year old girl described her experience of scabies, and her disgust with the epidemic, as follows:

> When you are attacked by scabies, the skin keeps on itching as you scratch it. Pimple-like swellings appear on the skin, which are quickly filled with pus. These are quite unpleasant to look at. Worst still, children from other primary schools laugh and call you dirty, someone who does not bathe and a rebel from the bush.

One boy whose entire body was affected by scabies could hardly sleep due to the persistent itching of his skin. He bought two Pen Vs to apply on his skin, but he could not afford enough for his entire body. In another example, drawing again from the case in the prologue of Ojok and his siblings, I observed that they were all infected with scabies. Ojok's hand had both severe fresh pimples and those which showed signs of healing, but his youngest sibling was even more affected. Ojok indicated that since his

younger sibling's scabies was more severe, he had bought Amoxicillin capsules and applied it on the affected areas. Fortunately for them, in late August to early September 2004 MSF implemented an emergency intervention effectively treating all affected persons with *Opele* ointment.

In an exercise in 2004 at five displaced primary schools, listing and ranking common illnesses experienced at home or at Noah's Ark, some children ranked scabies as the most severe. In one focus group discussion with twelve to fifteen year old girls, an argument ensued about which was the most severe, scabies or malaria. After a lengthy argument, the children agreed that malaria was more severe than scabies since they had not seen anyone yet die of scabies; what is more, malaria affected almost everybody, but scabies attacked only children who slept at *bagdhad* or those children who escaped from the bush. In diagrammatic representations of common illnesses done by children in one displaced primary school, all of the 120 children portrayed an individual with scabies. The pictures featured a person scratching his/herself, and showing dark spots and patches on his/her skin. In one exercise at a displaced primary school, as five boys discussed the drawing exercise they wondered if the child had been sleeping in Noah's Ark shelter, or had recently escaped from the bush, indicating that he was a former LRA fighter.

In various interviews with former child soldiers we discussed the commonly held belief – expressed by the children above – that they were the likely source of scabies infection; something they strongly denied. One fourteen year old former child soldier instead attributed such assertions to the common practice of blaming them for every bad thing which happened in Gulu. While it could be true that because of the living conditions in the *ilum* (bush or rebel captivity) such persons were exposed to various infective agents and could therefore be sources of infectious epidemics, it is also true that former child soldiers faced severe hostilities and exclusion in the very communities in which they were reintegrated.

In July 2005, when I conducted similar information gathering exercises, fewer children mentioned scabies as a common illness, perhaps because the epidemic was by then under control, and affected the children less severely. However, there were still exceptions. Children who were affected used both pharmaceuticals and herbal remedies to treat scabies. The pharmaceuticals used were largely antibiotics; the same used for other purposes such as treating cough and diarrhoea. In one focus group discussion an eleven year old girl shared how she had tried – with limited success – using "a mixture of goat's milk, delident toothpaste, and garlic as a remedy for scabies. However after so many times of trying, there was no improvement. I stopped trying". In this discussion, some children laughed at her description, but by the end, after each individual's narrative, no child laughed anymore. Other children also shared their use of delident toothpaste as a treatment for scabies, but it was very expensive so they had to give up. A substantial number of children disclosed that they had tried washing in the River Nyao, since one healer had once told them about its curative powers, but the river could not cure scabies. One boy even indicated having used chloroquine tablets – knowing full well that that they are used in the treatment of malaria – by crushing them and applying the powder to his scabies infected skin. In his conclusion he mentioned how, "with scabies, the way it pains, the way the skin keeps on itching, you can do anything to get better".

In a one month observation exercise in two drug shops in Cereleno suburb in September 2004, sixty-seven children aged between six and sixteen bought *Opele* for sca-

bies. Each package of this ointment cost 1,500 shillings (0.65 euro), and this relatively high amount of money for a one time expenditure was unique since, unlike malaria tablets which children frequently bought two or three of at a time, the packaging of *Opele* did not allow children the flexibility of buying smaller quantities. One child indicated using his entire day's earnings from *leja leja* to purchase *Opele* to treat his scabies. However, as compensation, it was also possible for an entire family to share one package of ointment. In unstructured interviews with one drug shop owner in Pece, where three children had reported for an application of *Opele* on their scabies, he disclosed that he had made a special arrangement in order to help parents who could not afford to buy the entire tube. Each child paid 200 shillings (0.085 euro) each time he applied the *Opele* to the severely affected areas.

In August and September 2004, approximately 150 children were observed in five drugs shops in Cereleno and Pece purchasing Amoxicillin capsules for the treatment of scabies. Although Amoxicillin was also used for cough, sprinkling on wounds, and for diarrhoea, a substantial proportion of children observed at the drug shops indicated that the capsules were also good for sprinkling on scabies-infected skin. One nurse running a drug shop also advised five children who asked for Amoxicillin for their scabies to ensure that they first cleaned the infected areas with Protext before applying the Amoxicillin capsules. In her drug shop she sold various medicated soaps, including Protext, however no child bought what they described as "that expensive soap".

Key informants' perspectives on and interventions to control scabies

In order to tackle the scabies epidemic, the general approach taken was the dissemination of numerous awareness messages about the spread, control, and management of scabies, funded by the African Medical Research and Educational Foundation (AMREF), MSF, and other healthcare institutions, including the District Directorate of Health Services (DDHS). Gradually the messages evolved from washing four times a day, to emphasising the importance of washing several times a day with medicated soap. In short, focus was on individual hygiene as the main preventive measure to the control of scabies. The DDHS was overwhelmed by various placards, awareness messages, and announcements about scabies from various NGOs attempting to ensure the wellbeing of vulnerable people in conflict zones. Their message, in short, was that scabies was a highly infective skin disease which people should deal with as follows: they should bathe regularly with medicated soap; they should avoid coming into contact with people who are infected; and if affected, they should seek medical attention at a state aided health centre.

The most phenomenal response to the scabies epidemic came in the intervention by MSF. Announcements were made over local radio stations, including Radio Mega, calling for all affected persons to gather in one of the various night commuters' shelters at specified times. At Noah's Ark, MSF staff arrived one evening in early September 2004 with a white liquid. Nobody was able to tell me its name, not even Noah's Ark's head nurse. Affected persons were instructed to bathe with the Protext soap provided, and then come for administration of medicines all over their body. Some children described the activity as 'dipping', where the whole body was smeared with the white liquid. Subsequently, most of the children's and adults' scabies dried up and was cured within two to three days. That marked the phenomenal control of the scabies epidemic. A few children missed their chance for 'dipping', but the shelter nurses were left with some of the medicine which they could administer themselves.

MSF responded at a time when most wartime children were virtually exhausted from trying various remedies, including toothpaste, to no avail. Children who went to health centres for medications for their scabies were often told about the importance of individual hygiene, and it was these individuals' experiences with the recommended hygiene rituals that led to the messages being redefined several times over; from bathing many times, to bathing many times with soap, to then needing to bathe often with medicated soap. Needless to say, the fact that a substantial proportion of wartime children had difficulties in accessing basic food requirements, let alone medicated soap, and lived in a situation of great insecurity, was not taken into consideration in these awareness messages. For example, at Noah's Ark during the months of July through September 2004, there were sensitisation efforts and seminars for the people sheltering there who needed a safer place to spend their nights. In each of the sessions, children and adults were told about the importance of hygiene, using medicated soap, and avoiding close contact with scabies infected persons at the shelter. In Chapter Thirteen I will show how some counsellors frequently singled out children who appeared very dirty for more intensive counselling about the importance of personal hygiene. Only on rare occasions, however, were the very dirty children given Protext medicated soap and instructed to bathe.

Discussion: Prevalence and management of scabies

Scabies is an ectoparasite infestation, caused by the mite *Sarcoptes scabiei*, variety *hominis*, and transmitted by person to person contact. The typical and atypical clinical presentation of pruritus (skin itching) is the hallmark of scabies, which occurs in young, pregnant, immuno-compromised, and elderly persons (Hengge *et al*. 2006: 769). Hengge *at al*. further argue that despite commonly held beliefs, scabies is only infrequently acquired from contaminated fomites (e.g. clothing, towels, and bedding). Although Hengge *et al*. (2006) suggest that scabies is endemic in impoverished communities, in Gulu District scabies was a new disease, closely linked with displacement and the phenomenon of people spending nights in night commuters' shelters characterised by overcrowding facilitating person to person contact and poor hygienic conditions. For example, it is alleged that after scabies was first identified in Noah's Ark night commuters' shelter, it was only a few weeks later that it presented in epidemic proportions.

Topical Benzyl Benzoate therapy (of a 10-25% concentration) has been widely used for adults and in a diluted form for children, babies, and breastfeeding mothers. The most common adverse event is an initial burning sensation caused by local irritation, which is common with the more concentrated lotion (25%). When severe, the Benzyl Benzoate must be washed off; however, with analgesia and antihistamines before treatment the stinging often diminishes after 10-15 minutes, allowing the lotion to remain applied (Hengge *et al*. 2006: 774).

In analyses of data pertinent to children's and key informants' perspectives about scabies, I will only address the issues of prevalence and the management of scabies. Other findings related to scabies are directly aligned with the institutionalisation of complex socio-economic and political factors, which have been elaborated upon in preceding chapters. The advantages and disadvantages of employing short term curative approaches in the management of this infectious epidemic are also addressed in the preceding chapters focussing on malaria, diarrhoea and respiratory tract infections. Where I again evoke the limitations of focusing on the disease itself in its management,

it is for the purposes of emphasis, but also to show that infectious diseases have unifying factors in their occurrence and management.

Prevalence of scabies

As mentioned earlier, Gulu District experienced an epidemic of scabies in 2004. By observation, the people affected were, in the main, children who attended displaced primary schools, spent nights at night commuters' shelters, and people residing in displaced persons' camps. The major unifying factor was that they were resource poor persons, residing in overcrowded areas and they were severely affected by armed conflict.

In the previous chapter on the social lives of wartime children, I mentioned how at break times children from Gulu Prisons P.7 School avoided interacting with children from displaced primary schools. One of the reasons for this in 2004 was that they were considered dirty and often had scabies, and this is in part because at *baghdad* and displaced primary schools there was limited space and few facilities to cater for the numerous children and even adults who nightly commuted to these shelters for safety. In a large part congestion, poor living conditions, and a lack of basic sanitation measures – especially in contexts where all basic facilities were shared – provided opportunistic factors facilitating the easy spread of such infectious epidemics. That the scabies epidemic reached alarming proportions within only a few months of the first case being identified – that of a former child soldier who spent nights at one of the shelters – is therefore no surprise.

Although the statistical evidence suggests a higher prevalence of scabies in boys than girls, by observation there was no statistically significant difference in infection rates according to gender. It is possible that the quantitative results indicate that scabies affected more boys than girls, since more boys spent nights in night commuters' shelters in 2004. However, the fact that only a small proportion of girls reported having had scabies is important since it reveals something about attitudes towards the disease. The displaced school and all the night commuters' shelters where I carried out my research had experienced an epidemic of scabies, meaning that virtually all the children had been affected. However, through sensitisation of displaced persons through varied media, including radios and health seminars, the children interviewed had come to shun this disease and associate it with dirt, poor hygiene, and lack of soap. Such attributes are rarely associated with the female gender in patriarchal societies, and it is therefore likely that while a higher number of girls were probably affected, quite a few were unwilling to discuss it. It is also likely that girls were reluctant to share their experiences with scabies since general notions of *baghdad*, dirt, carelessness, and poor individual hygiene were used to explain the epidemic. The specific notions in awareness messages about scabies, promoted by key emergency healthcare interventions, contributed to such negative connotations.

Management of scabies

Noah's Ark's approach of counselling the wartime people at greatest risk of scabies infection is telling. As mentioned earlier, the Gulu-DDHS was mainly involved in the dissemination of awareness messages about the prevention and management of scabies, while MSF adopted an emergency therapeutic approach of applying Benzyl Benzoate to infected children. It is doubtful that the awareness messages from the DDHS were in any way effective in controlling the scabies epidemic, much as the health personnel often boasted about how they had intervened, and curative interventions such as that of

MSF, though immediate and quite effective, also reveal a narrow approach which focuses on the pathogen and medicalises socio-economic problems. Certainly it is commendable to employ any technique available or within contextual factors such as limited funds in order to minimise suffering, but there are questions which remain to be answered. Are there not better ways to completely put an end to such intermittent infectious epidemics? Although Hengge *et al*. (2006: 777), Lawrence *et al*. (2005: 34-42), Reid *et al*. (1990: 595) and Taplin *et al*. (1990: 67-73) suggest that there is evidence that health education combined with improved diagnosis skills and improved drug supply will result in a significant reduction of scabies, in Gulu only MSF's intervention – of applying scabies medicines on infected people – led to control of the scabies epidemic. All information disseminated about how to avoid contracting scabies and how to individually manage it were fruitless. This discussion does, however, critique the idea of simple mass treatment in the case of scabies since this will produce little long term effect as people at risk are not empowered to manage the epidemics themselves. And as mentioned earlier, the most effective interventions for infectious epidemics lie not in curative approaches but in preventive measures.

When children were confronted with scabies, their approaches were to systematically (or non-systematically) search for a cure. By non-systematic I imply desperate *bricolage*-like efforts undertaken to minimise suffering, such as the use of crushed Amoxicillin, Pen V, and other antibiotics applied onto the infected skin. Other narratives suggest the use of goat's milk and different types of toothpastes. Needless to say, rarely were such frantic attempts useful as effective treatment for scabies. Nevertheless, there is some inherent satisfaction which individuals achieved through having at least tried their best to intervene, to challenge, and to minimise their suffering. It is this satisfaction which, for lack of a better way to put it, I refer to as the 'unintended effect' in the quest for therapy, because the idea that individuals have tried everything possible within their means – even with limited or no success – means that they do not feel the need to blame themselves about having done nothing. I will pursue this insight in subsequent chapters, particularly in the discussion concerning dilemmas in short term curative approaches in the management of emotional suffering.

Furthermore, information gathered from the children about how they managed their scabies infections implies that they did attempt to adhere to the awareness messages broadcast throughout the region. And although it was expected that people at risk would be able to manage their scabies based on information provided, one of the examples above shows how despite the fact that one child strictly adhered to the information disseminated, he had only minimal success. This leads me to suggest that perhaps even curative approaches are better than information dissemination in the control of infectious disease epidemics. What is more, such messages advocated using medicated soap, which at a cost of 1,500 shillings (0.62 euro) was far higher than normal soap at a price of 200 shillings (0.13 euro), and beyond the financial means of most wartime children. It then becomes clear how such simplified messages could send conflicting messages to people who are suffering and are in need of a solution, yet are constrained by poverty, low purchasing power, and an inability to meet their basic needs for such things as shelter, clean water, and food. That there were no efforts to address such complex socio-economic factors in the control of scabies is not surprising given the typical ways in which healthcare interventions attempted to alleviate the suffering of people in conflict zones through promoting awareness messages, emphases on curative approaches,

counselling people who were infected and those at risk, and sensitisation seminars. I will come back to the foregoing analysis in subsequent chapters.

Conclusion

Scabies was a severe epidemic due to its acuteness, severity, and highly contagious nature. The scabies epidemic was also distinctly connected to resource poor living and overcrowded sleeping conditions. Although children indicated various ways of dealing with scabies, they were generally of limited success. Even approaches recommended by key healthcare intervention agencies, which relied on the persistent dissemination of health awareness and preventive messages, were not effective in minimising the epidemic. MSF's focused curative approach – where they instructed affected people to bathe with the medicated soap provided, and then smeared each client with Benzyl Benzoate ointment – did drastically minimise the epidemic, and such a one time intervention is certainly welcome. Nevertheless, it leaves questions pertinent to the social determinants in disease production unanswered. In the main, I attribute the phenomenon of scabies – and other infectious diseases discussed in previous chapters – to wider socio-economic factors in wartime.

9

Eye infections

Eye infections, also called red eye disease and trachoma by children, were intermittent epidemics in Gulu. In September and December 2004, and August 2005, the red eye epidemic in particular struck children in displaced primary schools and one night commuters' shelter. The objective of this chapter is to present empirical findings about eye infections and its management by children, which included using eye drops (for example Gentamycin, which could be easily accessed over the counter without prior consultation with a professional healthcare giver), and herbal medicines. I first present quantitative data, which will then be followed by qualitative data regarding children's and key informants' perspectives about the prevalence, treatment, and severity of eye infections.

Quantitative data: Prevalence and management of eye infections

Eye infections were one of the least shared illness experiences within a one-month recall, despite the fact that at the time of the survey, the children could have readily remembered whether they had been affected by red eye disease or trachoma in the past month. Was this low level of reporting because there was a much greater focus among the children on more severe illnesses?

The prevalence of eye infections is shown in Table 9.1. Of the 67 cases (8.0%) of children who mentioned having had eye infections within a one month recall, thirty-two (7.4%) were boys and a slightly higher number, thirty-five (8.8%), were girls. There was no statistically significant difference (P=0.24) between boys' and girls' experiences with eye infections within a month's recall. Nevertheless, prior to coding the category for eye infections, data suggests a weak statistically significant difference (P=0.05) between boys' and girls' experience with red eye disease, with more girls talking about their recent experience with this infection. This could be because more girls were af-

fected with the disease, but it could also be that girls as opposed to boys more readily shared their experiences with it, for by observation, when the two displaced primary schools in Gulu municipality were affected by the epidemic of red eye disease, boys and girls were equally affected.

Table 9.1 Prevalence of eye infections within a one-month recall (N=165)

Illness	*Boys*	*Girls*	*Total*	*P-values*
Trachoma	17	12	29	0.53
Lit wang (red eye)	15	23	38	0.05
Eye infections	**32**	**35**	**67**	**0.24**

About the same number of boys and girls shared their experience with using eye drops within a one-month recall (Table 9.2), thus there was no statistically significant difference (P=0.38) between boys' and girls' use of medicines for eye infections. In 2004 to 2005, the most commonly accessed eye drops at drug shops and state aided health centres was Gentamycin. A small bottle of the medicine was sold for 1500 shillings (0.65 euro).

Table 9.2 Medicines used in the management of eye infections within a one-month recall (N=165)

Medicines	*Boys*	*Girls*	*Total*	*P-value*
Eyedrops (Gentamycin)	55	43	98	0.39

Qualitative data: Prevalence, symptoms and management of eye infections from children's perspectives

In this section, I will first give exemplary children's narratives of experiences with eye infections within a one month recall, and then provide general excerpts of data obtained through other qualitative data collection techniques.

An exemplary narrative about an experience with eye infections

Unlike malaria, diarrhoea, or acute respiratory infections, fewer children (about one hundred) wrote or told me about their experience with eye infections. During the epidemic of red eye disease observed at the two displaced primary schools hosted by Gulu Prisons Primary School in August 2004, some children instead chose to narrate their experiences with malaria, even if they had red eye disease at the time of the interview. Perhaps this is due to the fact that eye infections were less severe compared to other illnesses which the children had to confront.

In one displaced primary school, in an exercise administered to children aged thirteen to sixteen years, two boys narrated their experiences with eye infections. Fourteen year old Okot wrote:

> I am very glad to write this composition in my life. These are the diseases which I suffered from. I suffered from trachoma. This eye disease which can be caused by virus [bacteria] transferred by houseflies. I started suffering in the morning and till noon, but it takes a long hour before I start seeing again. My eyes swell and there was a discharge of water. That is the sign by the time I went to the hospital. The doctor told me that I go back so that I can prevent the disease through good hygiene. I treated it with eye drops.

Meanwhile, another fourteen year old boy, Opio, shared his experience below:

> Some time ago I had an eye problem. Sometimes I cannot see well, but I did not go to hospital. I did not use any medicine to prevent it. That eye problem is still there. I am suffering from it since every time there are yellow things coming out of my eye.

I gave this boy money to buy medications for his eye infection, and he reported the next day that he had obtained eye drops at the drug shop in Olailong trading centre. He was instructed by the drug shop owner to apply them as many times as possible, and showed a remarkable improvement after three days.

Prevalence, treatment and severity of eye infections

Through various qualitative data collection approaches, children identified eye infections as a common disease, in particular red eye disease, which they treated with eye drops. Eye infections presented like a severe bruise to the eyes and a substantial proportion of children I observed frequently had tears flowing constantly and uncontrollably. In August 2005, at the two visited displaced primary schools, the first aid box had a stock of Gentamycin eye drops, and all children who were affected were instructed to report regularly to the headmaster's office so that a staff member could apply the eye drops to their infected eyes. Children showed a commitment to the treatment sessions, and by observation a substantial proportion of children even reported more frequently than once an hour. One child, when I asked about her persistence in reporting for treatment, stated that she had a greater likelihood of a faster recovery from the red eye disease if more eye drops were applied to it.

In naming and ranking common illnesses, there was a general ambivalence about the importance of eye infections, and there were diverse views among the children at Noah's Ark night commuters' shelter. Although eye infections were mentioned as one of the illnesses which frequently attacked children, and red eye infection reached epidemic proportions in August 2005 – more than 50% of 760 children were affected at one displaced primary school – children placed hardly any emphasis on this infection. On the whole, children still attended school, and some carried Gentamycin eye drops with them which they frequently applied to their eyes.

In one workshop in December 2005, aimed at discussing the medicines children commonly used at home, twenty-three out of fifty (46%) of the participants brought a wide range of herbal remedies for eye infections. For example, thirteen year old Okello brought *acaka caka* with large leaves, which was identified at the Botany department as Eurphorbiaceae (*Euphorbia heterophylla L*), and *acaka caka* with small leaves, identified as Euphorbiaceae (*Euphorbia hirta L*). The two types of *acaka caka* produced a milky sap when pricked, which was used medicinally. All children who brought *acaka caka* to this workshop indicated that they applied it to their infected eyes, and they also indicated that they recovered after using it. Two girls also brought *Labika*, commonly known as Black Jack (*Compositeae-Bidens pilosa*). Fourteen year old Acan indicated using the rough edges of the *Labika* fruit to scratch both her siblings' and her own eyes to relieve itchiness and pain.

Eye infections disease aetiologies

Children rarely paid much attention to issues of disease aetiologies. In focus group discussions and in interviews inquiring about the causes of eye infections, the immediate responses were *pe angeyo* – 'I do not really know'. Eye infections are introduced as a subject in science from Primary Three, when children are about eight years of age, and children were taught about the Four Fs – *food, fingers, faeces, and (house) flies*. It is therefore not surprising that Okot, in his composition above, explicitly stated that his trachoma had been transmitted by houseflies.

Key informants' perspectives about the severity of eye infections

Apart from the two head teachers at the displaced primary schools where eye infections reached epidemic proportions, who indicated that they "were easy to manage by using communal eye drops", eye infection epidemics did not receive as much attention as the scabies and cholera epidemics. There were negligible messages heard over the radio or in other sensitisation seminars about the dangers of red eye disease or how to avoid infection. Red eye disease itself is self limiting, relatively speaking is not severe, and is not life threatening, which may account for why there was no particular attention paid to this epidemic by healthcare intervention institutions in Gulu. It could also be due to the fact that this was simply yet another infectious epidemic that this wartime community had to bear.

The examined records from Laliya and Laroo health centres indicated that diagnoses of trachoma were made in some children, and they were written prescriptions of Gentamycin. However, one medical doctor based in Kampala saw it slightly differently; in management of the red eye epidemic – which he described as an acute haemorrhagic viral conjunctivitis – he suggested that maintaining general hygiene through "frequent washing of the infected eyes with clean water and soap, and application of Tetracycline eye ointment, would constitute the best way of managing the epidemic". The doctor's viewpoint is directly linked to the Global Elimination of Blinding Trachoma by 2020 (GET 2020), and the World Health Organisation set strategy in dealing with trachoma when they recommend Surgery, antibiotics for active disease, facial cleanliness and environmental change to reduce transmission (SAFE). This is especially important if trachoma is viewed as a chronic conjunctivitis, with different manifestations depending on the number, severity and longevity of bouts of infection experienced (West 2003: 18). I will come back to this shortly.

Discussion: Prevalence and management of eye infections

Trachoma remains the most common cause of infectious blindness worldwide (Mabey *et al*. 2003: 224; Resnikoff *et al*. 2004: 844) and it is caused by *Chlamydia trachomatis*. Occurrence and transmission is favoured in communities in poor countries where there is overcrowding, and access to clean water, sanitation, and healthcare is inadequate (Mabey *et al*. 2003: 223; Kumaresan 2005: 20). Ensuring hygiene is therefore crucial in preventing transmission of the disease. Bailey *et al*. (1999: 137) suggest that the initial infection with ocular (eyes) *Chlamydia trachomasis* results in a self-limiting conjuctivitis that typically heals without permanent sequalae. In medically underserved, poor rural regions where blinding trachoma most often occurs, eye infection with *Chlamydia trachomatis* is spread by close personal contact, or by flies that carry infective ocular discharge from the eye of one child to those of another (Mabey *et al*. 2002: 224;

Kumaresan 2005: 21; Gambhir *et al*. 2007: 424). Signs of active disease are seen mainly in young children, but also occur in older children and some adults. Conjuctiva follicles at the upper limbal margin of the cornea leave a characteristic shallow depression, known as Herbert's Pit, after they resolve. After years of reinfection, resulting in chronic inflammation, fibrosis leading to scarring appears in the conjuctiva. As the scarring progresses, generally over many years, there is a distortion of the lid margin, causing the lashes to turn inwards and rub against the cornea. Constant trauma to the cornea, as well as being painful, leads eventually to corneal opacity and blindness. Although the signs of follicular and inflammatory trachoma, and the process of conjuctival scarring, are caused by *Chlamydia trachomatis*, secondary infection of the traumatised cornea with other bacteria or fungi may also contribute to its opacification (Mabey *et al*. 2002: 224).

In 1998, WHO established the Alliance for the Global Elimination of Blinding Trachoma (Gambhir *et al*. 2007: 420). The World Health Assembly of 1998 recommended SAFE strategy encompassing Surgery, use of Antibiotics, Facial washing and Environment change for the control of trachoma. The four procedures are relevant at various stages of infection including surgery for the turned lashes, and use of the Antibiotic Azithromycin for active disease, which is as effective as six weeks of topical Tetracyclines, represents an important advance in trachoma control. Facial cleanliness and Environmental change have been documented to reduce eye infection with *Chlamydia trachomatis*. By means of the SAFE strategy, WHO and partners aim to eliminate trachoma as a public health problem by the year 2020 (Kumaresan 2005: 19; Mabey 2003: 223). In current public health programmes for treating active trachoma, antibiotic ointment is applied to the eyes of all children in communities where trachoma is endemic (Schachter & Dawson 1979). Mass treatment requires more antibiotics, but may be a more effective (Holm *et al*. 2001: 194-200; Mabey *et al*. 2002) and cost effective (Frick *et al*. 2001: 201-207) approach for communities with moderate or high frequency of active disease. If transmission of *Chlamydia trachomatis* is to be stopped or significantly reduced, the age groups at most risk – of infection and of infecting others – must be adequately treated with antibiotics (Mabey *et al*. 2003: 228). However, although Gambhir *et al*. (2007: 421) report that "a major component of SAFE strategy as mass administration of macrolide antibiotic azithromycin as a comprehensive strategy", I propose that a major component in the control of trachoma must focus on the wider social-political factors. Consistent with this thesis' proposition is what Mabey *et al*. (2002) discuss as "trachoma disappeared from Europe and North America not as a result of antibiotics or surgical treatments, but as a result of improved living conditions" (Mabey *et al*. 2002: 224; 2003: 228).

I recognise that it is only for emphasis of cross-cutting explanations for the high prevalence of infectious diseases that I discuss issues arising from empirical data about eye infections. Perhaps the only new point about the eye infection epidemic is that it is not a life threatening one, and presents with mild symptoms. What is more, there were efficacious remedies for it, including eye drops and herbal remedies, which made it easy for affected people to manage their self-diagnosed trachoma or eye infections.

Prevalence of eye infections

As empirical evidence suggests, it appears that wartime children had various experiences with eye infection epidemics, and the most commonly affected were those in displaced primary schools and night commuters' shelters. Although Kumaresan (2005:

1067) suggests that trachoma disproportionately affects women and children below five years of age, in Gulu Municipality trachoma affected mainly children of primary school age who attended displaced primary schools and spent nights at night commuters' shelters. If trachoma is spread by hands, clothing, or flies that have come in contact with discharge from the eyes or nose of an infected person, then these overcrowded conditions provided the perfect opportunistic conditions.

It is my viewpoint that eye infections, like any other type of contagious infection, are directly linked to poor and fetid living conditions, lack of basic shelter or clean water, and congestion. Such factors were a common occurrence for children in Gulu, especially those living in child headed households. Further, in a situation of armed conflict, even more opportunistic conditions existed for the rapid spread of such epidemics. Within the contexts in which wartime children lived, it is likely that WHO's recommended SAFE strategy, with it emphasis on surgery and antibiotic administration for trachoma control, may encounter obstacles and therefore yield limited success due to the high likelihood of reinfections, because trachoma is a disease associated with poverty, low income, poor hygiene, overcrowding, and lack of access to clean water, all of which are implicated in its prevalence (Kumaresan 2005: 1073; Mabey *et al*. 1999: 1261).

In primary schools in Uganda, from an early age, children are taught the role of hygiene, dirt, and vectors such as houseflies in the transmission of diseases – the Four Fs. It is therefore not exactly correct to presume that epidemics of an infectious nature attack displaced persons because they do not have information concerning causative agents and means of transmission. I suggest that it could be due to the presence of wider opportunistic conditions, including dire socio-economic contexts in wartime, which contribute significantly to the transmission of such disease causing pathogens.

Treatment of eye infections

For eye infections children indicated using eye drops, and the most observed type which was administered was Gentamycin. My intuition is that if there were no such effective remedies on the market, then perhaps there would be so many people experiencing such unmanageable suffering that key NGOs and healthcare institutions' attention would be drawn to it.

Children also indicated having used herbal remedies and subsequently recovering from eye infections. However, the use of the rough edges of *labika* for itching eyes could instead aggravate the children's condition by causing trauma to the infected areas, and perhaps bruising the delicate eye membranes in the process of alleviating suffering.

Conclusion

In general children showed that eye infections were not an acute or severe illness, yet they recognised its high frequency in occurrence and its ability to attack large numbers of people at once – either the whole school or all people staying in night commuters' shelters. Perhaps such suffering was considered less important because it could be readily alleviated by easy to access remedies, including Gentamycin eye drops. Eye infection epidemics rarely attracted the attention of key healthcare institutions, including the Gulu-DDHS, the print and audio media, or NGOs. This could be because its symptomatic presentation is not severe, or it could be because there were a wide range of eye drops, especially Gentamycin, on the market which meant that people could readily deal

with eye infections. Furthermore, it could be that because epidemics of eye infections were such a common but non-life threatening occurrence, the limited resources available to deal with health problems in poor communities were therefore directed to the more major, life threatening types such as cholera, HIV/AIDS, and tuberculosis.

10

Wounds, injuries and epilepsy

Both survey and qualitative data suggest that children had experiences with wounds, injuries, snakebites, and epilepsy, and this chapter aims to analyse how they dealt with these afflictions. In the main, data concerning the prevalence of physical wounds, injuries, and snakebites was obtained during the first phase of the study from recently rescued former child soldiers, who were undergoing rehabilitation and counselling at the World Vision Centre for Formerly Abducted Children (WVCFAC). In addition, four displaced boys mentioned having been bitten by snakes within a one month recall, and these incidents occurred on their way from Laliya camp to Noah's Ark night commuters' shelter.

The rationale for presenting wounds, injuries, snakebites, and epilepsy together in one chapter is because of their general effect of physical scarification and low prevalence in comparison to other illnesses which children identified within a one month recall. Data presentation and analysis in this chapter will follow a basic structure, first outlining children's perspectives about the prevalence and management of wounds, injuries, epilepsy, and snakebites, followed by key informants' perspectives, and then finally analysis of the empirical findings.

Quantitative findings: Prevalence and management

Table 10.1 provides an overview of the prevalence of wounds, injuries, epilepsy and snakebites within a one-month recall. Generally speaking, about twice the number of girls than boys mentioned having experienced wounds or injuries within a one month recall ($P<0.005$). This could be due to hazards in their daily activities, which involved doing *leja leja* and performing daily household chores, and could happen during their nightly commute to shelters within Gulu Municipality. Nonetheless, through general ob-

Table 10.1 Prevalence of wounds, injuries, epilepsy and snakebites within a one-month recall (N=165)

Illnesses	*Boys*	*Girls*	*Total*	*P-values*
Wounds or injuries	38	57	95	<0.005
Twol okayan (snakebites)	17	2	19	0.001
Two cimu (epilepsy)	1	1	2	0.35

servation, but also specifically at the WVCFAC, I saw more males with injuries and wounds. It is possible that the results point to a greater readiness among girls to discuss such experiences.

Data in Table 10.1 also suggests that boys were about eight times more likely than girls to experience snakebites, with a statistically significant difference of P=0.001. The probable explanation for this phenomenon could be that there were more male former child soldiers, and they indicated the dangers – including snakebites – to which they were exposed during attacks on their enemies. That boys had a greater chance of becoming child soldiers therefore explains why there is a statistically significant difference between boys' and girls' experiences with snakebites within a one month recall.

Only two children who participated in the survey – one boy and one girl – indicated experiences with epilepsy. I recognise that a complex illness such as epilepsy does not exactly fit in this chapter alongside injuries and snakebites; it is a physical disorder of brain functioning, and carries with it a substantial social burden that expresses itself in personal isolation and the stigma of a 'spoiled identity'. Nevertheless, I present it here for two key reasons: (1) its symptomatic presentation also led to various forms of bodily and emotional injuries, and (2) in the entire study, there were only two children who presented with epilepsy. One was a twelve year old boy, whose medical records from GRRH stated that he had a very severe form of epilepsy. At Noah's Ark where I met him he enjoyed special treatment since his grandmother was allowed to spend the nights with him in the elders' tent due to his condition. His medical records suggested that he reported on a monthly basis to GRRH for a refill of Phenobarbital, which he was advised to take on a daily basis. The second case of epilepsy – which was not medically diagnosed but was reported from the child's own perspective – was fourteen year old Namungu.

As mentioned in foregoing chapters, it was very difficult to judge which illness a child was treating when they had multiple infections and used red and yellow capsules or red and black capsules (Amoxicillin or Tetracycline) within a one-month recall. Nonetheless, some children did indicate using the two capsules for wounds and injuries (Table 10.2). In general, where children mentioned that they had used Pen V, Amoxicillin, Tetracycline, and Septrin, they indicated opening or crushing the capsules and applying the powder onto the wound or injured area. Evidence suggests that there were no statistically significant differences in girls' and boys' use of pharmaceuticals for wounds and injuries, except for red and yellow capsules (P=0.03), which were used by a relatively higher number of girls (n=60, bearing in mind that girls who participated in the survey were fewer) than boys(n=53).

Table 10.2 Medicines used in the management of wounds, injuries, epilepsy and snakebites within a one-month recall (N=165)

Medicines	*Boys*	*Girls*	*Total*	*P-values*
Red and yellow capsule	53	60	113	0.03
Black and red capsules	24	12	36	0.07
Amox (as called in drug shops)	10	4	14	0.23
Amoxicillin or Tetracycline	**87**	**76**	**163**	**0.92**
Penicillin V	62	64	126	0.56
Septrin	21	22	43	0.49

Qualitative findings: Prevalence, severity and quests for therapy

Former child soldiers' experiences of gunfire, landmine injuries and snakebites

In 2004, I spent five weeks at the World Vision Centre for Formerly Abducted Children (WVCFAC), and during this time I requested that former child soldiers who were respondents to diagrammatically illustrate their illness experiences within a one month recall. In one such exercise in November 2004, all seventy former child soldiers aged between ten and sixteen years illustrated fellow children injured through gunfire exchange. One exemplary illustration depicted a severely injured child with a gun on his back fallen on the battlefield and immersed in blood, with war helicopters – coloured in with the government of Uganda's green and grey army uniform colors – hovering over the injured child. Other graphic illustrations by former child soldiers depicted children hiding in forests while being shot at by the Uganda People's Defense Force (UPDF). In informal interviews conducted after such illustrations, the former child soldiers discussed how they had sometimes successfully attacked the UPDF while in captivity with the LRA, but nevertheless the UPDF attacks frequently caused severe loss of life among child soldiers, and many had suffered major injuries. By observation, at WVCFAC injured former child soldiers applied crushed Amoxicillin or Tetracycline capsules every day after washing their injuries, which they had been shown how to do by the centre nurse.

At WVCFAC, during morning devotions, two pastors who regularly counselled former child soldiers prayed to God to heal not only their physical wounds – especially remembering those in a serious condition admitted to Lacor Hospital – but also their emotional wounds. There were two former child soldiers at WVCFAC who were amputees; one was about thirteen years of age, and his left leg had been amputated as the result of a severe landmine injury. At the time of interview, he had recently been discharged from Lacor Hospital and had subsequently been admitted to WVCFAC for rehabilitation prior to reintegration in the community. Two counsellors at WVCFAC had the special responsibility of monitoring the severely injured and taking food on regular basis to Lacor Hospital where there were about twenty severely injured former child soldiers who needed intensive treatment. Some were scheduled for surgery to remove bullets; I met two fifteen year olds scheduled for surgery whose x-rays showed one with bullets lodged in the chest, and the other in the upper right arm.

During the first phase of the study there were three children of around twelve to fifteen years of age at Noah's Ark who had already undergone rehabilitation at WVCFAC

and Gulu Support the Children Organisation(GUSCO), and had subsequently been re-integrated in Gulu Municipality. Two of the three former child soldiers had scars in their faces, showing that they had recovered from severe wounds; the fourteen year old girl described her scars as the result of "a close range gunshot". This girl participated regularly in Sunday healing services in a Pentecostal church in Pece suburb where I sometimes attended. In prayer for her, the pastor frequently evoked the healing power of the blood of Jesus, to heal not only her physical wounds but also her emotional and spiritual wounds.

Former child soldiers also disclosed how snakes were one of the 'dangers' they were exposed to while in captivity. One twelve year old boy illustrated a snake as being among the common illnesses which affected him within a one month recall, and disclosed during interviews that he had been bitten while in hiding. Attempts to gain insight into how former child soldiers managed snakebites yielded no answers, except that they had been advised by their commanders to tightly tie off the affected area until they could present it to one of their *daktars* (medical persons) who would operate on the area to extract the poison and apply herbal remedies. One former child soldier told me that he had used a black stone from southern Sudan to suck the poison from the snakebite and had been healed that way.

Displaced children's experiences with wounds, injuries and epilepsy

- Wounds

In a diagrammatic illustration exercise of common illnesses which affected displaced children within the past month, one eleven year old boy illustrated a wound on his leg as an indentation with drops of blood emerging from it. He later told me that he injured his leg while doing *leja leja*, and to treat it he had applied the 'red and yellow' capsules (probably Amoxicillin or Tetracycline) onto the wound. Most frequently, children talked about receiving injuries as they performed household chores, or injured their feet by knocking stones while they walked to and from the night commuters' shelters. In their compositions, no girls wrote about having experienced wounds within a one-month recall, however, one fourteen year old boy wrote about his experience as follows:

> When I was digging, I cut my leg. I went to the hospital, the doctor gave me the Penicillin tablet to grind and put on the wound area.

It is important to note that children frequently referred to clinics, drug shops, and pharmacies as 'hospital' and the word *daktar* (doctor) was a title given to any person who dispensed medicines. Therefore this narrative can be understood much better after comparing it with the professional healthcare givers' perspectives below, as it is likely that this child received medical attention from a non-professional source, such as a drug shop owner, with no training in biomedicine.

One eleven year old boy spoke during interviews about his recent wound in this way:

> For me I did not write about the wound which I have because it can cure by itself. Only for the first week I can have the pain. But when I grind the Pen V tablet and put it on, it dries quickly. Even sometimes I put on it the red and yellow capsule.

Children who diagrammatically represented the red and yellow or red and black capsules, and Pen V (or white medicines with Pen V written on it), mainly indicated having used the medicines for cough, diarrhoea, or stomach ache, but some children indicated that they applied the same medicines to wounds and injuries.

Below I present an exemplary account of my interaction with ten year old Aciro, who discussed frequently and extensively how she was once attacked by her drunken aunt at knifepoint because she had declined to fetch water for her late one evening. On the injured area, Aciro had applied what she called 'the red and yellow capsules' given to her by a neighbour, who was a nurse at World Vision. I relayed this incident to the senior female teacher and a counsellor at St. Kizito Alero-Cuku displaced primary school, and the counsellor immediately decided that we should visit and counsel Aciro's aunt "about proper child up-bringing". So the counsellor, Aciro, my research assistant, and myself went to Aciro's home, which was about seven kilometres from St. Kizito Alero-Cuku. At Aciro's home, we waited for her aunt to come from a neighbouring hut where she was buying alcohol, although it was still quite early in the morning. Gradually neighbours started to gather until we were surrounded by onlookers, one of whom offered to call Aciro's aunt for a meeting after the counsellor made our objective clear. When Aciro's aunt came, we exchanged greetings and introductions, and explained the reason for our visit. The counsellor then spoke to the aunt as follows:

> As I told you, I am a counsellor and a senior woman teacher at St. Kizito Alero-Cuku. It is the displaced school where Aciro attends. I felt very bad to see Aciro's injured hand. She told me that you were drunk when you injured her with a knife. But madam, drinking alcohol is not good for you. You see where it had led you. You could have even killed Aciro. Also, I know that with this war, so many parents do not know how to take care of their children. They do not even know when a child needs to be sent to fetch water or not. Especially when it is getting dark, it is not good for you to send Aciro for water. And when she is not willing to do the task, it is better to try to negotiate with her instead of punishing the child in such severe ways, even using a knife.

In response, Aciro's aunt said that she had done nothing to Aciro. In fact, she went on, ever since Aciro and her sisters started living on their own, she did not interfere any more in their lives. I observed during this exchange that Aciro became uncomfortable and eager to share her experiences; however Aciro's attempts to talk were silenced by an elderly woman in attendance, who interrupted everybody in the meeting to narrate a story telling how Aciro and her sisters had helped her when she was admitted at Lacor Hospital. This elderly woman turned out to be Aciro's grandmother, who was also already drunk at eleven in the morning.

After this meeting, I regularly inquired about Aciro's wellbeing and how she interacted with her aunt. In the large part, the immediate outcome was that Aciro's aunt became more hostile to her, alleging that Aciro, instead of attending school, was reporting her to counsellors. She also threatened many times that if she were ever to see Aciro bring home a counsellor, she would attack them both. Although I wanted to visit Aciro more, I was afraid of doing so, partly because of her aunt's threats, and partly because Aciro and her sister Namungu suggested thereafter that our discussions should take place outside their home environment. For these reasons, during the six months of study, unlike with other twenty-two children whom I visited more frequently and whenever I desired, I only visited Aciro and Namungu's home three times, which came to a climax with our visit with the school counsellor. It appears that despite our best intentions, we created more complex problems both for myself as a researcher and for the actual victim of the violence. In the analyses I will address three issues which arose from this encounter: firstly, I discuss how some children's wounds were the result of attacks from adults with alcohol problems; secondly, I examine the limitations and even dangers of equating the problems people are confronted with on a daily basis in a situation of prolonged armed conflict to a lack of knowledge (as the counsellor did); and thirdly, that as a result of this misunderstanding of the root causes of people's problems,

the solution of counselling is proposed to ensure that affected persons are given the correct information about their problem.

Another child who discussed the dangers of wounds was fifteen year old Okello from Aywee, whose 'foster uncle' had given him and his siblings a free hut on the condition that they took care of his leprous mother. In fact it was only when I visited Okello that I found out that 'the wounds' he always talked about and dreaded were the leprous presentations of his foster grandmother. During interviews, Okello disclosed that they started living with their foster grandmother when his foster uncle found them at the Holy Rosary compound; they were residing there after forceful eviction from Pece due to failure to pay their monthly hut rent. He promised them free accommodation if they would take care of a woman with 'wounds' (their uncle had instructed the three children to refer to the suffering of their now foster grandmother not as leprosy but wounds). Thus, Okello and his siblings lived with and took care of their leprous foster grandmother, but spoke to others about a caretaker whose wounds would not cure. She did love to live with them, and made sure that they were comfortable, but nevertheless, ever since their foster uncle had left for Kampala, Okello neither heard from him nor received the monthly parcels he promised. "If only the war would stop, I would immediately go back to my home in Pader", Okello said at the end of our interview in his home. Okello indicated that together with his siblings they attended the neighbouring Pentecostal church to pray because of their fear of getting leprosy. Okello specifically indicated that he liked the pastor in that church because he frequently prayed for them and admonished them not to fear since Jesus would protect them, and was able to heal those with leprosy.

- Landmine injuries

Two children discussed the effect of landmines on their parents. Thirteen year old Laker often told me how the wound on her aunt's left leg, which was the result of stepping on a landmine, had taken so long to heal that the *daktars* at Lacor Hospital decided to amputate it. Her aunt lived with one leg for a long time until the International Association for Volunteers (AVSI) registered to have a prosthetic leg made for her at GRRH.

The second child related how his father had died after stepping on a landmine as he was returning to Pabbo camp after a *kacoke* (meeting) in Pagak camp. His father was admitted to Lacor Hospital but the doctors could not save him. Although this child mentioned the use of *atika* plants to minimise disturbances by the *cen* of his late father, the disturbance persisted and he failed to obtain healing. "Perhaps this *can en cango kene* (this suffering heals itself)", he would frequently assert. This was a sentiment also commonly heard from other children after they had narrated their severe experiences and attempts to find a cure. I will return to this issue in Chapter 11.

- Snakebites

One thirteen year old boy wrote about the experience of being bitten by a snake as follows:

> It was a Wednesday morning when I was going to the camp at Awer from the shelter when I was bitten by a snake on the way. The pain was so much I could not walk. I sat down and cried until a certain man with a bicycle came to help me. He carried me to the hospital where I was told to drink raw eggs till I vomited. After some time, I was okay.

In diagrammatic illustrations done at St. Kizito Alero-Cuku and St. Peters Bwobomanam displaced primary schools, two boys aged ten and twelve years drew and

coloured black and brown snakes. The class teacher, who came to inspect the exercise that had been given to the children in his class, attempted to correct the boys by asserting that "instead of drawing worms which children of that age suffered from properly, they had drawn snakes. Perhaps it is because they did not know the difference". Yet the two boys were interviewed about their illustrations and they both indicated the danger of snakes; the twelve year old had actually been bitten by a snake in the week previous to the exercise as he commuted from Laliya to spend the night at Lacor Hospital night commuters' shelter. Fortunately, the centre manager had immediately taken him for medical care at Lacor Hospital, where the boy described how the "*daktar* cut the place where the snake had bit to remove something the *daktar* said was from the snake". The second boy told me that he had wanted to represent in his drawing the experience of being bitten by a snake, even though it had happened about four months earlier (and not within a month's recall, as specified in the exercise). He chose to represent snakebite because he had felt so afraid, to the extent that he thought he would have died if he had not been taken to hospital by his neighbours. At the hospital, "the *daktar* first cleaned my leg before he cut the place which the snake had bit in order to remove the snake's teeth".

- Epilepsy

One twelve year old boy who participated in the illustration exercise drew wounds on his forehead, his arm, and his chest, and generally his body exhibited various levels of scarification and injuries. "The wounds on my forehead came about when I fell in fire while I assisted my grandmother with cooking", he said during interview. This boy, as indicated earlier, had in 2004 a special arrangement to spend the night at Noah's Ark in the elders' tent due to his epilepsy. His medical records suggested that he reported to GRRH on a monthly basis for refills of Phenobarbital, which the regional psychiatrist described as anti-convulsion medicine, or medicine to minimise the frequency of his seizures. As additional treatment, the grandmother of this boy frequently shaved his hair and applied various herbal medicines into incisions on his forehead. On one occasion in September 2004, he reported to Noah's Ark with most of his visible body parts showing signs of incisions and application of herbal medicines. He disclosed that they had visited an indigenous healer in Laliya who had applied the medicines on him. Both the boy and his grandmother indicated that they had no idea what the herbal remedies were since the indigenous healer did not disclose it to them.

Another child who indicated having epilepsy was fourteen year old Namungu. She participated in the extensive ethnography and her epilepsy was self-diagnosed, though perhaps it was not severe since during the six months of study she reported only one seizure. The incident happened when she had gone to do *leja leja* in Koro camp together with Aciro, her ten year old sister. Aciro narrated the incident this way:

> Suddenly Namungu started screaming that she was seeing people who wanted to burn her and yet she could not run. She screamed for mercy when she fell, but there was no one who came to help her. People in the neighbouring garden said that the moment they stepped on Namungu's saliva, they would also get the sickness. So, I knelt near Namungu, removed the rosary [crucifix] from my neck and placed it on her forehead. I also looked for *atika* plants and placed its branches around her and some on her chest. That is how she recovered. We went home and thereafter my grandmother organised to take Namungu to *mini for God* [indigenous healer called the mother for God] who lives in Kasubi.

All my offers to take Namungu for a medical examination at the psychiatric unit at GRRH were fruitless, and Namungu's grandmother had ordered against her ever having

biomedical tests performed to establish whether her condition was due to epilepsy. What was unique with Namungu was that during particular phases of the moon she would not attend school or do other intensive activities, since her grandmother told her that this was the only way to avoid the embarrassment of falling in front of other people or getting injuries.

Namungu disclosed that she been 'saved', because during one Pentecostal crusade at Kaunda grounds the pastor had told the crowd that "Jesus could heal all diseases, including epilepsy". Despite the fact that during the prayer session for Namungu the pastor had warned them against visiting traditional healers or using herbal remedies, Namungu and her sister Aciro did mention not only using *atika* plants, but also making regular visits to a healer in Kasubi suburb. During such visits – especially during particular times of the month "when the moon was mature" – the indigenous healer would perform rituals involving animal sacrifice. Nevertheless, despite these efforts her epilepsy persisted and Namungu lived in constant fear of having a seizure, especially in crowded places such as at school.

Details about Namungu's quests for therapy for her epilepsy suggest desperation, uncertainty, and a certain haphazardness in her approach. For instance, Namungu and her grandmother attempted to control the frequency of her seizures through limiting her activities when there was a full moon, therefore it was with disbelief that Namungu and her sister narrated how her only seizure had occurred when even their grandmother had assured them that there was no danger of performing farm labour at Koro camp since the moon was still in its early stages. There was haphazardness and uncertainty in her quests for therapy as well, but perhaps she achieved what I discuss in this as *unintended effects*. In short, she received care and attention, and those around her made varied attempts to find a cure for her condition, but with limited success; so gradually, though she may become more resigned to her situation, she will nevertheless have gained some feeling of comfort or confidence that she has done everything within her capabilities.

Of course it could be argued that the seizure(s) that Namungu suffered from were in fact non-epileptic psychogenic seizures, and since they had perhaps a psychological origin, in a certain way she and her caretakers were comfortable only with particular types of healthcare givers, and not with the biomedical sector. It is important to note that at the psychiatric unit at GRRH, during six months' observation in 2005, the majority of regular visitors were people suffering from epilepsy – from the four districts of Gulu, Kitgum, Pader, and the proposed district of Amuru, and some people from Southern Sudan – who reported to this centre for free refills of epilepsy medications. Namungu's alcoholic grandmother's insistence that she should not report to this unit for examination is therefore peculiar to her and not representative of the perspectives of people in Gulu in general.

Key informants' perspectives

- Healthcare givers' perspectives

From interviews with key informants a picture emerges in which the application of crushed or opened tablets or capsules directly onto wounds is not recommended. As one healthcare giver put it:

> To use Pen V on the wound is not recommended. However, when the wound is very septic, patients are advised to first wash it and then apply capsules or Flagyl tablets after grinding them.

The nurse at the WVCFAC indicated that the application of Pen V was not recommended for wounds, much as a substantial proportion of children had used it as such. The probable reason why children mostly used Pen V as opposed to other medicines for wounds could be attributed to the role played by private sellers of pharmaceuticals, who had no formal training in the area of prescribing and administering medications for varied illnesses, but also, in Gulu Pen V was cheaper than other medicines such as Flagyl.

At Lacor Hospital one doctor narrated his experience of performing surgery on recently rescued former child soldiers as follows:

> We have had to carry out emergency and other surgeries sometimes throughout the night depending on how many critical cases are admitted at the hospital. One night we received about ten adolescents who had been severely injured during the gunfire exchange between the UPDF and the rebels, three of whom had been shot in the face, and we had to work overnight trying to reconstruct the shattered bones and extracting bullets lodged in various parts. Some had been left there for many years. Mostly people who are injured in the neck region and back rarely make it, but we simply try our best.

One psychiatrist at GRRH's psychiatric unit frequently attributed the relatively low levels of people reporting with 'mental illnesses' for biomedical care to their belief in witchcraft, and their perception that the psychiatric unit was only for psychotic patients. In response to my narration of Namungu's experience, and her difficulties in deciding whether to seek specialised help, still the emphasis was that it was likely that the caretakers' perception was that the psychiatric unit was for psychotic patients.

The adherence of twelve year old Opira to his epilepsy medication, and his regular visits to the hospital for refills of Phenobarbital, was commended. The regional psychiatrist, however, indicated his own difficulties in explaining to clients and parents of children with epilepsy that the taking of medications was long term and indefinite, as they were not curative but simply controlled the condition.

- Religious healer's perspectives

At Kaunda grounds there were frequent preaching and healing services conducted by, among others, Pentecostal churches, Life Line Ministries, Bridge Builders' Church, Pentecostal Assemblies of God, and the Deliverance Church. One of the dominant messages for the sick and people experiencing various forms of suffering was that "Jesus would heal all illnesses; all diseases, whether chronic, spiritual, or HIV/AIDS, would be healed by Christ".

In 2004, at WVCFAC, former child soldiers undergoing rehabilitation and counselling had to attend daily morning devotions. During morning devotions various pastors and 'saved' counsellors taught them about Christian notions of forgiveness, fear, love, and healing. In prayers for injured former child soldiers there was recognition of the fact that physical wounds heal easily compared to emotional wounds. Visiting religious healers to the trauma centre frequently taught and prayed for former child soldiers that:

> Jesus would heal both their physical and emotional wounds. Jesus would heal them of all those emotional wounds which children were exposed to through child abductions, being forced to commit various horrendous acts, and being exposed to physical injuries by gunfire. Man (biomedicine) can heal physical wounds through medicines, but emotional wounds can only be healed by Jesus.

I will pursue this insight further in Chapter 11 where I discuss children's perspectives regarding emotional wounds and their deeply felt sadness. What I need to mention here is that it appears that there are direct links between physical and emotional wounds in the context of armed conflict, but although pharmaceuticals were mainly efficacious in

healing physical wounds, there might be a need for more complex procedures in quests for therapy for emotional wounds.

During church services at the Gulu Municipal Protestant Church, also called Christ Church, sermons focused on Jesus' ability to heal injured hearts and spirits. In one church service which I attended, the retired Bishop Baker Ochola led the service and drew from his own experiences to show that the death of his wife due to severe landmine injuries, and the death of others who had died in similar war related events, injured the hearts of the survivors. Nevertheless, the people in attendance were advised to forgive the soldiers who planted landmines and caused the deaths of relatives, and seek healing in Jesus:

> The reason Jesus died on the cross is that he could be able to feel the physical and emotional pain in man's life. Jesus can heal both the physical and emotional wounds

Christ Church in Gulu was unique in comparison to other protestant churches I have attended nationwide in that they conducted healing services every Sunday. One reverend suggested that over seventy percent of the people she prayed for (mostly women) had bodily aches and pains, and though some of them had tried using all types of medicines, they came to God to heal not only their physical wounds but also their emotional aches and pains.

Discussion: Quests for therapy in the context of uncertainty

In the discussion I will (1) examine the prevalence of injuries and wounds due to indiscriminate use of ammunitions, (2) examine the phenomenon of quests for therapy for chronic illnesses in situations of uncertainty, and (3) analyse concepts such as the individuation of social-processional suffering, and the unintended effects of quests for therapy for caretakers and sufferers of chronic illnesses.

Prevalence of bodily injuries and quests for therapy

Statistics are difficult to find on the exact magnitude of the exposure of children to wounds and injuries during armed conflict. However, as exemplified by the children's own experiences, a substantial proportion of former child soldiers exhibited injuries of varying severity, obtained during gunfire exchange. At Lacor Hospital, five former child soldiers admitted to the intensive care unit were considered very critically injured, and their lives could only be saved if they had complex surgeries in well equipped hospitals in developed countries. It was unfortunate that none of the five children critically injured got an oppportunity to be treated in well-equiped hospitals, so their lives were not saved. The lack of facilities to perform relatively complex surgeries is not a new phenomenon, however, and nor is it limited to northern Uganda.

There were some children whose injuries were inflicted through mistreatment and abuse by adults. Furthermore, as seen in Aciro's case above, and in many other examples from former child soldiers' narratives about their abduction and initiation into guerrilla fights, there is substantial evidence that children were not only wounded or injured physically, but also suffered emotionally. The next chapter, will address the issue of emotional suffering or emotional distress in detail. What I need to mention here is that although physical wounds might be treated at the hospital, I experienced a general sense of powerlessness regarding the prevention of such violence. And much as I propose in previous chapters that preventive measures are more effective than curative approaches for common illnesses children experienced, I am still grappling with how children them-

selves could engage in preventive approaches for suffering due to domestic violence or war-related violence. There is a sense of powerlessness in how children could be social actors in prevention of violence. However, these children are citizens of Uganda, and it is provided by law that the state is obliged to protect them. Various mechanisms need to be implemented by the state to ensure their safety. However, the state had many limitations in implementing the activities geared to protecting children. Whereas our visit to Aciro's home with the counsellor instead resulted in more violence against Aciro and her siblings I believe our initiative was not fruitless. There was an attempt to promote awareness about the dangers of violence against children. The scene was also a learning experience concerning the complexities involved in dealing with such issues as domestic violence. This is not only due to the perceived intrusion on our part on 'private' matters, but also to the fact that our approach might not have been the appropriate way to deal with this issue.

In various interviews with the then, coordinator of SCiU in northern Uganda, he mentioned how his NGO was mandated to protect war-affected children against violence. One of the ways SCiU did the protection was to wait for children to report any acts of violence against them. It was assumed that SCiU would then follow up such a matter through taking legal procedures against the perpetrators of violence. However, for the entire time of this ethnographic study, no child did report to SCiU for assistance. It could be that the children were not aware about this opportunity. It could also be that children themselves felt powerless to the extent that could not envisage the outcome of prosecuting the victimisers – also given the weakened legal system in Gulu. The foregoing issue is even more precarious if the violator is a family member or caretaker. What would happen to Aciro, for instance if her aunt had been arrested by the child protection unit and prosecuted but later released? Couldn't this act alone expose Aciro and her siblings even to severe forms of violence?

Earlier, I mentioned how problematic it could be to link common problems children experienced to lack of information. I shared an experience in counselling adults who had problems with alcohol and how this resulted into even more complex problems also for the child. Such social problems and their consequences need multifaceted approaches in dealing with them. However, whether it possible that the approaches in dealing with violence can be decided and agreed upon by the affected people themselves is a debatable issue since it appears that individuals affected have different viewpoints about how to deal with the domestic violence.

Other children indicated getting hurt while doing *leja leja.* That children were engaging in *leja leja* in attempts to secure their basic needs, is linked to the prolonged civil war and the phenomenon of child headed households. I perceive this phenomenon not only as child labour, but also as exemplary of how the twenty year old conflict not only led to the breakdown of social structures, but also of traditional ways of life. The emergence of child headed households is only one example of how Acholi social structure has been destroyed.

The two children who discussed their illnesses due to epilepsy highlight the fact that some people experienced a persistence of symptoms, in the form of a chronic illness, regardless of the various quests for therapy and procedures they engaged in. Nevertheless, I did not perceive a sense of futility in sufferers but rather attempts to define uncertainty and suffering and deal with chronicity. In this discussion, I call the outcome of this the unintended effects in the quest for therapy. Even though Namungu, the second of the two epilepsy sufferers, underwent similar treatment to twelve year old Opira at

the indigenous healers' residence in Kasubi, there were no assurances of her finding a cure; nonetheless, the two epilepsy sufferers and their caretakers made it explicit that they were willing to continue and repeat the therapeutic procedures. This persistence in their quests for wellbeing is linked to complex cognitive processes which border on irrationality. They are irrational because technically the 'rational man' assesses all available options and chooses the best, limited only by a few constraints including the economic situation (Good 1994: 52); yet underlying this are various attempts to find a remedy, some of which sometimes transcend local perspectives and beliefs. The notion of transcending perspectives is adapted to suggest a scenario whereby however much individuals are aware of the conflicting perspectives in their quests for therapy, they are nevertheless willing to go beyond them. For example, Namungu indicated having being 'saved' due to the promises from the pastor about finding total healing, and she indicated frequently that she was taught by the *morokole* (saved people) that it was abominable for her to seek therapies from indigenous healers. However, in conflict with this notion was the fact that Namungu still willingly visited an indigenous healer, especially during the 'critical stages during the moon'. I suggest that it is a sense of desperation in the quest for therapies for chronic illness that makes it possible for sufferers to transcend their own or others' imposed rationalities. Perhaps the context of living in dire misery influenced sufferers in opting for short term curative approaches and the severity of such forms of psychological suffering also plays a significant role.

Although the indigenous healers – including the one at Laliya – claimed to know herbal remedies for epilepsy, their clients did not recover. What is more, whereas Namungu was told about using *atika* plants by her indigenous healer, the healer at Laliya was reluctant to disclose what constituted her herbal remedies, though it is likely that it also consisted of *atika* plants due to its common characteristic of chasing away *cen.* As mentioned earlier, the inability to find a cure from indigenous healers did not stop clients from repeatedly reporting for more remedies, some of which included animal sacrifice. Could it be that in an individual's confrontation with suffering, children transcend their own perspectives? Could it be that even when there is no remedy or hope of finding a complete cure, the mere act of doing – or seeming to do – something about the issue at stake produces unintended effects? In their various quests for therapy, the sufferer recognises care from his or her kin, and care for the sick or those who have to confront severe emotional and collective pain is viewed as one of the dimensions of the unintended effects of quests for therapy.

Closely connected to this is the idea that chronic forms of suffering such as epilepsy are unique in their being a form of 'social-processional' suffering, because their symptomatic presentation affects families, communities, and societies as much as it does individuals sufferers. Ideally, therefore, the process of finding therapy should not take a narrow focus only on the severely affected individual, but also on the entire household or all individuals closely involved. Broadly speaking, the close kin of people with a chronic illness also experience the suffering in fundamental ways. For example, although the two children in this study with epilepsy were the main individual sufferers, their symptomatic presentation involved screaming, injuries, seizures, and living in uncertainty, and this did not only cause individual suffering but also household, communal, and societal suffering. In effect, these two examples demonstrate the societal experience of the symptoms of chronic illness, and where there were communal or collective visits to the *ajwaki* (indigenous healers), I see a societal or collective quest for therapy and collective healing for close kin and a child who is severely affected by *two cimu*

(epilsepsy), or who is frequently attacked by violent *cen* and *tipu* (spirits of deceased close kin).

Another example of social-processional suffering and emotional wounds comes from the subtle exploitation of fifteen year old Okello and his siblings' distress, through making them take care of a foster grandmother with leprosy. Though the four children benefited from a secure residence and reciprocal care, in reality it is difficult to measure the magnitude of suffering such children are forced into when living in constant fear of becoming victims of leprosy. Their dire context left them with limited options for negotiating their roles as fostered children. Perhaps that is why, in trying to make sense of their situation, they referred to their foster grandmother's condition not as leprosy but as incurable wounds, for incurable wounds could signify both the leprosy (physical/bodily suffering) and the emotional wounds of distress as a consequence of living in fear of contracting leprosy.

Another finding pertinent to children's experience with epilepsy is linked to their isolation, and the stigma attached to the illness. This is evident in people's beliefs about the easy transmission of epilepsy through contact with the sufferer's body fluids such as saliva. Sufferers were therefore avoided rather than helped during seizures, and this further predisposed them to injuries and discrimination. Although for many people epilepsy can be a self limiting or easily controlled health problem, for twelve year old Opira above epilepsy appears to be a lifelong disorder requiring ongoing treatment and enormous resources to manage, cope with, and hopefully prevent, many disabling physical, social, cognitive, and emotional burdens. Therefore, in his quests for therapy, caretakers and close kin also need to be targeted in a bid to promote awareness about epilepsy and minimise stigma.

Quests for therapy for chronic illnesses in the context of uncertainty

Empirical data concerning the various quests for therapy for epilepsy suggest that its chronicity was evident, and that there were numerous difficulties which such suffering presented, not only to individual sufferers but also to their close kin. The indigenous healers' methods, and indeed the biomedical management of epilepsy, reflect uncertainties about the hope of restoring normality. Nevertheless, indigenous healers occupied a position which made them alternative reference points in healthcare seeking; regardless of whether they promised healing or not, sufferers approached them to do whatever was in their means to restore normality. In the section below I suggest that the various therapeutic procedures that sufferers of epilepsy are subjected to are not fruitless, which is why I propose the concept of unintended effects in the quest for therapy. Though they may still experience seizures after treatment from an indigenous healer, and even at the psychiatric unit it was made explicit to them that the medication does not cure but only controls the seizures, they feel cared for, and feel that at least something is being done about their suffering.

In the context of quests for therapy for chronic illness, and uncertainty in the outcome, indigenous healers were shown to prefer secrecy regarding their medicines and the meaning of their procedures. It could be that the procedures carried out did not have precise effects on the illness itself, but the intended effect was to instil a sense of hope and well-being in people who have to confront a lifetime of suffering. This also relates to the use of *atika* plants (commonly used in warding off *cen*) as a means to restore normality to persons who have experienced seizures, yet such an action is in conflict with the explanatory model for epilepsy which aligns it to phases of the moon and not

attacks by *cen*. Could *atika* plants therefore be a therapy for illnesses which are beyond daily rationalities, and therefore explains why Acholi people resort to them? Could it be that use of *atika* plants are in reality a way of making it explicit that individuals are attempting everything within their means in the context of uncertainty to restore normality? And could it be that in the process of using *atika*, people hope to assure the sufferer that they are not apathetic to their suffering, and much as they are unable to effectively address the issue at stake, they nevertheless engage in attempts to restore normality? The preceding question could also apply to biomedical approaches to epilepsy since, for instance, clients who received Phenobarbital were also informed that they should not view the medicine as an ultimate therapy, but only as a medication to minimise the number of seizures.

Conclusion

Wounds, as discussed in this chapter, represented physical wounds and frequently, stakeholders linked physical to emotional injuries. Physical wounds were caused by exposure to landmines, being taken captive and forced to engage in armed struggle, doing *leja leja,* searching for a safer place to spend nights, and physical wounds were from fire accidents where huts burnt down. Alcoholism in one case also led to the bodily injury of a child. Some of these physical injuries were an entirely bodily phenomenon, and in their quests for therapy pharmaceuticals like Amoxicillin, Pen V, and other antibiotics would suffice. However, there were some experiences, for example chronic illness like epilepsy (which also led to bodily injuries), and extreme events in wartime such as the abduction of close kin, close kin deaths due to landmines, and a general apathy concerning children's wellbeing, that lead to psychological forms of suffering which will be addressed in detail in the next chapter. In their quests for therapy for such forms of suffering, children mentioned visiting indigenous healers, using *atika* plants, and attending religious deliverance services to chase away *cen,* all without any real effective results, but which led to beneficial unintended effects. It is possible that even though no specific improvement to their wellbeing was realised, the children felt they had to engage in these short term approaches because of the context in which they were embedded. Such a context is characterised by uncertainty and severity. And in not finding the remedy for their suffering, individuals might be prompted to transcend their own rationalities in their quests for wellbeing. Attention also needs to be paid to the role of stigma, a major component of epilepsy's social burden as well as a key barrier to accessing care and developing effective self-management behaviours.

11

Complaints symptomatic of emotional distress

In this chapter I present data on children's emotional distress and how they dealt with it. Emotional distress or emotional suffering encompassed the following complaints: stomach aches, persistent headaches, pain in the body, *cwinya cwer* (bleeding heart/ sadness), *can dwong ataa* (deep emotional pain), and *cen* (evil spirits). I use the terms emotional and psychological suffering interchangeably to refer to the psychological effects of experiencing extreme wartime events. There are illness experiences in the form of emotional distress not captured in survey data, which children described during in-depth interviews and focus group discussions, through the use of vignettes, and in workshops where we discussed severe experiences in wartime.

It is important to mention here that in the first phase of the study the children did not readily share with me their emotional distress. Children only shared their feelings when I asked specific questions about it, and more generally, after I had established rapport with them, and this varied between children. The use of vignettes as well as workshops within peer groups also helped children to disclose their feelings related to emotional distress.

Some quantitative data presented difficulties in interpretation. For instance, persistent headaches could be due to emotional distress, or they could indicate a symptom of malaria; stomach aches are also symptomatic of diarrhoeal diseases and urinary tract infections. A painful body could be due to tiredness, stressful living conditions, or disturbances by *cen*, rather than a symptom of physical illness. My role as an ethnographer was to identify the underlying causes of such complaints through eliciting children's perspectives. Inquiries were made about what these complaints meant to the children, and they were invited to suggest appropriate ways for their effective redress.

The questions I address in this chapter are: (1) How do children themselves link particular illness experiences to certain forms of emotional distress? (2) If children themselves do not link their symptoms to such underlying distress, does an *etic* in-depth analysis suggest an interpretation of these symptoms as expressions of emotional suffering? (3) Which symptoms caused by underlying emotional distress – according to *emic* and/or *etic* analysis – were expressed in local idioms of distress?

The chapter first presents quantitative and qualitative data about the different complaints children mentioned and their quests for therapy. In addition, key informants' perspectives are provided, followed by a short discussion and conclusion.

Quantitative data: Common forms of complaints possibly symptomatic of emotional problems and quests for therapy

An overview of the prevalence of complaints possibly symptomatic of emotional distress is given in Table 11.1. From this general overview it is evident that girls were three times more likely to mention an experience with stomach ache within a one month recall than boys, suggesting a statistically significant difference ($P<0.005$). Stomach ache covered a wide range of complaints including urinary tract infections, indigestion, diarrhoea, and painful periods for girls. This partly explains the gender difference regarding the prevalence of stomach ache. However, for both boys and girls some stomach aches were symptomatic of more complex forms of emotional suffering, and in this chapter they are addressed as such. There was no statistically significant difference in boys' and girls' mentioning of complaints such as persistent headaches ($P=0.58$) and pain in the body ($P=0.39$).

Table *11.1* Prevalence of complaints possibly symptomatic of emotional distress (N=165)

Symptoms of illnesses	*Boys*	*Girls*	*Total*	*P-values*
Amwoda ici (stomach ache)	22	61	83	<0.005
Abaa wic lela (persistent/severe headache)	36	35	71	0.58
Kuma rem (pain in the body)	17	11	28	0.39

In general, Piriton and Valium were popularly called *yat nino* (medicines for sleep) by children (Table 11.2). The two pharmaceuticals indeed have sleep-causing properties much as for Piriton, the sleep-causing effect is viewed as only a side effect since its main purpose is to counter allergic reactions. Children also indicated using *yat nino* to alleviate pain in the body such as *abaa wic lela* and common colds. With the exception of Valium – for which boys' reported use exceeded that of girls ($P=0.01$) – there was no other statistically significant difference between boys' and girls' use of pharmaceuticals for these complaints within a one month recall. Children also mentioned that they used herbal medicines for stomach ache (see Table 4.10). There were linkages in such narratives with stomach aches associated with diarrhoea. Since this chapter will focus on stomach aches associated with emotional distress, I will link the discussions with other herbal medicines which children named for stomach aches during workshops on severe

experiences such as *atika*. However, to acknowledge that sick individuals implement any activities which they believe will restore normality, it is likely that children also used mango tree bark (P= 0.97) and roots (P=0.004) for stomach aches discussed in this chapter.

Table 11.2 Medicines used in the management of complaints possibly symptomatic of emotional distress (N=165)

Medicines	*Boys*	*Girls*	*Total*	*P-values*
Panadol	85	71	156	0.22
Piriton (*yat nino matar*)	53	42	95	0.46
Vemox (*yat kwidi* – de-worming medicines)	41	39	80	0.60
Action	43	46	89	0.18
Valium (*yat nino makwar*)	50	29	79	0.01

Qualitative data: Emotional distress and quests for therapy

In five workshops aimed at discussing severe experiences and medicine use in the context of civil war, many children brought *atika* plants. In the workshops they elaborated on how *atika* was variously used for *cen* (evil spirits), sleeplessness, persistent headache, and when 'a child who often sees visions of cruel people or *mony* (soldiers) who want to attack him or her during sleep'. I will address each of these complaints shortly. In narratives and through other qualitative techniques, children also mentioned other therapeutic strategies in addition to using medicines – both herbal and pharmaceutical – such as attending healing services at Pentecostal churches, carrying out income generating activities, and conducting *guru lyel* (last funeral rites).

Some children, including fifteen year old Okello whose story I present in the case study below, told me about their experiences with persistent headaches and something painful moving around the body without mentioning their own thoughts on the issues underpinning their suffering. In Gulu, individual emotional suffering and community distress (also called social pain in this study) occurred where an extreme event causes emotional distress to an entire community – for example death of a close kin were frequently expressed in somatic idioms, or what I call 'legitimised idioms of distress'. I use this phrase because expressions of emotional suffering by showing one's feelings were frowned upon in Gulu at the time of this study. People were rewarded with praise when they presented a stoical detached façade when confronting various forms of emotional distress and social pain. I will return to the issue of silencing distress in Chapter 12.

Sleeplessness

During a two day observation in three drug shops in November 2005, eight boys and two girls of primary school age purchased *yat nino* (medicines for sleep). Two nurses and one drug shop owner (without training in biomedicine) inquired whether they wanted Piriton or Valium; five of the boys bought four tablets of Valium each for 200 shillings (0.087 euro). During interviews and focus group discussions children told how they used Valium and Piriton for a certain type of painful headache which often affects

only one side of the head. They also used it for pain in the forehead, which comes from having flu. In a group discussion, however, three boys mentioned that "If Piriton and Valium are *yat nino*, then their only use is when someone needs to sleep". Further, one fourteen year old boy stated in one group discussion, as eight others agreed in unison, "This is because at *baghdad* there were many mosquitoes, lice, and bedbugs; we sleep on the cold cement floor, tents are torn, and when it rains sleeping in a cold, damp place is difficult. We therefore need *yat nino* to make us sleep".

A slightly different explanation was offered by children at Noah's Ark. Many of them indicated the need for *yat nino* since at the shelter many children cried, shouted, and others, usually former child soldiers, seemed to fight with invisible people in their sleep. Other children, when asked about their dreams, told how they were dreaming of being abducted, and how in their sleep they fought the *mony* or *lotino lum* (soldiers or other LRA abducted children) who wanted to take them to the bush. Three ex-combatants related having given up on the idea of taking *yat nino*, since they did not work anymore. For example:

> For the first few days of swallowing two and sometimes three or four tablets of *yat nino*, I could sleep. [But] after a few days of taking that *yat nino*, I would remain awake all night. The medicines did not work. I still have *cen* disturbances and my headaches, whether I swallow four or more Valium and Piriton at the same time.

Cen *and* tipo *(evil spirits)*

Children used the terms *cen* and *tipo* interchangeably. C*en* refers to evil spirits, which present as dead people in nightmares: as imaginary persons attacking people during the day, or as dead people seeking revenge and compensation because they suffered a wrongful death or burial. *Tipo* refers to images of deceased close kin.

In relation to nightmares, two children interchangeably referred to disturbances by *cen* and *tipo. Tipo*, the spirit of a deceased kin, could turn into an evil spirit depending on the frequency with which it appeared, and the disturbance it caused to its victim. Fifteen year old Akello explained this distinction, upon inquiry into the persistent nightmares caused by her deceased father's spirit:

> At home my mother often corrected me if I talked about seeing *cen* of my late father in my dream. She always told me that the spirit of someone I knew and close relatives who did not want to harm me is *tipo* and not *cen.* But since I had reached a level of not sleeping and screaming in my sleep, even during the day, due to my late father's disturbance and his demand for *guru lyel* (last funeral rites), even my mother started referring to it as *cen.* I suffered very much during that time due to that *tipo,* until my mother and *lodito* (clan elders) organised the ceremony of *ryemo cen/tipo* (to chase away or get rid of evil spirits) at Karuma, involving the strongest *ajwaka* (indigenous healer).

As I shall explain later, *cen* can be viewed as the epitome and culturally appropriate symptomatology of distress in Gulu. There are overlaps between how *cen* was presented by children and the documented literature pertinent to the symptoms of Post Traumatic Stress Disorder (PTSD) – such as nightmares, hypervigilance, fear, and persistent headaches – but for purposes of clarity *cen* will be adopted to refer to the specific idiom of distress through which displaced children experienced and explained some of their emotional suffering.

Children identified *cen* as a core cause of sleeplessness during a workshop to discuss severe wartime experiences. Although children perceived the severe and more persistent forms of *cen* to be also present during the day, commonly *cen* disturbances were described as occurring during sleep.

In one narrative, fourteen year old Ojok talked about his nightmares and sleep disturbances which started the moment he witnessed the brutal killing of his father in Pader by the LRA. Ojok mentioned his frequent use of *atika* plants, but also said that ultimately he would have to fulfil the demand by his father's *cen* to conduct *guru lyel.*

Ex-combatants also needed *atika* plants to prevent them from reliving and re-experiencing the horrendous acts they committed themselves while in captivity, to stop being disturbed by the spirits of people whom they killed. "Such spirits are very violent. They come in your sleep, even during the day, with a gun, sharp knives, and sometimes they struggle to remove a gun from you in order to kill you in a dream. So you need these plants", argued one female ex-combatant in interviews. When the attacks were very violent, children sought specialized help from an *ajwaka* – an indigenous healer specialized in mediating with spirits – who would make incisions on their forehead and apply extracts from *atika* plants. In Akello *et al*. (2006) we discussed extensively the experiences of former child soldiers with the cen of people they had killed.

Quests for therapy for tipo *and* cen

After a 'deliverance session' aimed at alleviating experiences with *tipo*, at a healing crusade organized by Life Line Ministries Church, fourteen year old Ajok elaborated on her experience during the session as follows:

> I always have dreams about my late mother's *tipo* coming for me. She appears while I am asleep to tell me to go and join her. When I told the pastor that story, he prayed for me and chased that Satan. He also told me that every time I see the *cen* of my mother I should tell her I do not know her. This is because she decided to die and leave us to suffer. I should also call fire from heaven to burn her.

In five workshops on severe experiences and medicine use in wartime, held with a total of 77 children between the ages of eight and sixteen, children presented *atika* plants as an important medicine. The only exceptions were five children who attended Pentecostal church services and told they were 'saved/born again'. The children who brought the *atika* plants mentioned having used them from the day they accidentally stepped on or viewed a dead body and were subsequently haunted by the scene. They shared how therapeutic such a procedure had been, since using *atika* plants around their sleeping place would ensure that the *cen* they picked up during such horrific scenes would not disturb them.

In the subsection on stomach aches below I shed more light on girls' use of *atika* plants against the visions of huge men who want to rape them in their sleep. However, boys also used *atika* plants when they could not sleep due to war related events, after Valium had failed them. Two boys discussed how their dead parents often demand that they perform the *guru lyel* ceremony, but they did not yet have the money; so they used *atika* plants to ward off such demanding spirits. Overall, indigenous practices seem to offer solutions that help people to cope with the symptoms, but are not able to remove the causes. For example, although some children insisted that they got better through constant use of *atika* plants, most children maintained that the effects were not lasting, requiring the need for continual use of *atika*. It is therefore clear that indigenous practices are insufficient to address the underlying causes of emotional suffering. This leads to desperation, as can be seen from a focus group discussion with twelve to fifteen year old children who recommended that if *cen* did not respond to all these practices, the affected child should join the armed struggle since *cen* fear anyone with a gun. In effect, it is plausible to argue that the preceding statement suggests children's consideration of addressing core causes of emotional distress. As explained elsewhere (Akello *et*

al. 2006), exclusion and discrimination of ex-combatants by the communities in which they were reintegrated contributed to children's distress. Subsequently, such distress could be minimised through former child-soldiers becoming part of armed struggle where they are accepted and not constantly criticised.

Persistent headaches

I asked children why so many of them frequently presented with headaches at shops where medicines were sold. In two focus group discussions girls aged twelve to fifteen years made a distinction concerning 'normal headache for malaria' and 'headache which pains only one side of the head and often leads to bleeding through the nose'. The latter is similar to the one described by the two children with epilepsy. Although this headache was managed with analgesics including Panadol, Action, Hedex, and Painex – sometimes by taking more than the recommended dose, such as three or four tablets of Hedex instead of two – and *atika* plants were also sometimes used, these headaches were persistent, severe, and there was no specific cure for them.

In compositions written by children concerning their illness experiences, it was quite difficult to distinguish whether they wanted to discuss their experience with persistent headaches, or simply describe headache as a malaria symptom. However, fourteen year old Opio wrote about a particular headache as follows:

> I had a headache problem for some time. My head pained so much. I did not go to hospital but my good friend bought for me Action tablets to take. It cured. But the pain came back again. Each time, when I have money I buy Action tablets for that headache. For many months now, I have that headache.

Another explicit pattern of persistent headaches came from five children taking care of their kin sickly due to HIV/AIDS. Fourteen year old Oceng often complained about "severe headache which is not due to malaria". "Perhaps it is the *cen/Satan* that makes my mother sick which is disturbing me as well". As he frequently told, "Each time a pastor from Bridge Builders Church comes to visit us at home, he prays for my mother and for me. He often prays to chase away the Satan which disturbs our family".

Fifteen year old Okello, who was living under very stressful family conditions, narrated how he had "very painful headache" in addition to something very painful moving around his body. For this painful headache he had frequently bought Panadol at the beginning, but he did not use it anymore since it had stopped being effective. Instead, he now bought strong medicines for headache such as Action, Hedex, and Painex, and sometimes bought these medicines in conjunction with Valium. As time went on, he even started taking three or more tablets of pain killers since the headache had become very strong. Here is how Okello discussed his experience with persistent headache:

> This headache I have been having for the last three months is not the one for malaria. It starts with something moving around my body. Such a thing is painful and when it reaches my head, I feel intense headache. I often swallow Hedex or Action, sometimes three of them at a go, but the headache only subsides. A week ago when I went to Layibi Health Centre, I told the *daktar* that instead of giving me medicine for malaria, let them *gi pime ikum ki wek gi nongo two en ni* (perform all possible laboratory tests to find out the illness causing the headache). Instead, he wrote for me to buy chloroquine, Panadol, and Fansidar for malaria.

Four former child soldiers of primary school age also shared their experiences with painful headaches as 'headache which affects only one side of the head', or 'headache which only reduces when you take Action and Hedex, but it still comes back'. One

former child soldier who extensively participated in the ethnographic study linked her headache to constant disturbances by *cen*:

> It is mainly the *cen* of the people I killed without cause which disturb me. In the bush, it was possible to kill even young children without fear. However, the *cen* of such children can really disturb. Sometimes, especially the *cen* of children can just come and sit on your head for a long time, thereby causing headache.

Based on children's own narratives and close examination of their lived experiences, it could be deduced that underpinning children's complaints with persistent headaches were severe emotional experiences. These included guilt and remorse due to killing innocent people including young children (this was especially so for former child soldiers), fear, anger, bitterness due to living in a stressful family situation, and the stress which is associated with taking care of a parent or guardian with HIV/AIDS.

Pain in the body

The first example of bodily pain I encountered involved a fifteen year old boy residing at Lacor night commuters' shelter in August 2004. His experience is presented as an exemplary case in the prologue. Earlier, I gave the example of a child living under strained family relations who had multiple somatic complaints, including 'something invisible but painful moving around my body'. During numerous in-depth interviews with this child he disclosed how he was mistreated and was often forced to spend nights at a church, how his uncle had sold the family's card which had given them access to food from the World Food Programme (WFP), and how his mother and uncle were showing signs of HIV/AIDS. On being denied fulfilment of his basic needs, he asserted:

> I do not feel well generally. I always have severe pains in my body. It starts with something invisible moving around my body. It starts from the head and spreads to my back and when it comes to my chest I feel a lot of pain in my heart.

Fifteen year old Okello attributed his pain and severe headache to torment by Satan, who also tormented his mother in the same way. Thus they regularly engaged in prayer and fasting at the Pentecostal Assemblies of God, and often invited the pastor to cast out such demons. The pain, however, persisted. In one such session which I attended, the pastor advised them to take charge of their situation as 'joint heirs' with Christ to chase away the Satan themselves, as Jesus gives all believers power over the spirit of darkness. In another healing session, the same pastor invoked notions of forgiveness and reconciliation. He told Okello and his mother to forgive the uncle who had brought HIV/AIDS into the family, and to stop 'holding this member of the family in their hearts'. The pastor suggested that Okello and his mother 'leave their burdens of bitterness and un-forgiveness at the cross of Jesus and walk away with light burdens of peace, love, joy, forgiveness, and happiness'. Okello indicated feeling better for only a few days. In another interview session, Okello asked me to give him money for Action tablets. He literally ran to the nearest drug shop and bought four tablets, three of which he swallowed immediately since his pain and headache were severe.

Generalised body pain complaints were even more common in children taking care of sickly kin with HIV/AIDS. For example, twelve year old Adokorach and ten year old Abonga variously complained of pain in the body, "probably because we are always oppressed by Satan", said Abonga. Abonga often related how his mother frequently invited the pastor of Bridge Builders Church to pray for her and her family. The pastor always prayed, and chased away Satan which tormented this family. Two children aged twelve and thirteen years, shortly after they had been forcefully evicted from their hut in

Pece due to failure to pay rent, also talked about having bodily pain. One of them attributed her body pain to the likelihood that she and her siblings had malaria, since they had spent nights in an overcrowded night commuters' shelter where there were many mosquitoes. I will come back to this complex overlap of symptoms between emotional distress and experiences with infectious diseases. Since infectious diseases were also highly prevalent during wartime, a single encounter between me and a child (or professional healthcare worker) was not sufficient to determine whether a presented illness episode was due to malaria or emotional suffering. The narratives presented in this chapter are exemplary cases, where extensive interaction with the children involved made a hypothesis of emotional distress plausible.

Stomach aches

Children, and especially girls, talked about stomach aches which were not due to diarrhoea. During regular observations at drug shops, grocery shops, and clinics, where about one hundred children were observed making specific requests for pharmaceuticals, each demand for medicines for stomach ache was followed by an inquiry into whether it was due to diarrhoea, to painful monthly periods for girls, or whether it was just pain in the lower abdomen. In the clinics I observed about forty occasions where the two nurses prescribed a combination of analgesics (Panadol, Painex, or Action) and antibiotics (Amoxicillin, Tetracycline, or Ampicillin) for all stomach aches presented.

At two drug shops in Cereleno, two girls were given tablets of Action and Hedex for their stomach aches. During an interview with him, the drug shop owner mentioned that Acholi people rarely bought medicine for diarrhoea, since there are so many *yat acholi* (herbal medicines) which are very good for it. In the same interview, the drug shop owner shared his experience that most people who purchased medicines from his drug shop only had pain in the stomach and not stomach ache with diarrhoea. Since Painex and Hedex are advertised as medicines for any strong pain, he advised people who suffered from stomach ache to use either Painex or Hedex.

Another source of data was the children's exercise books which they presented in the state aided centres for a written diagnosis. In one such record, a fourteen year old girl, Akellocan, who presented with stomach ache at GRRH was given the diagnosis of a urinary tract infection. Subsequently, Amoxicillin and Indocid had been prescribed, which she bought in a drug shop and took. Nevertheless, she experienced the same stomach ache two weeks later. This is her explanation about the persistence of her stomach ache:

> This stomach ache has been disturbing me for a long time. Since *mony* attacked our home in Anaka and also took with them my elder brother Odokorach, I have been having this stomach ache. There is no medicine which I have not tried. My mother used to buy Panadol, Hedex, Action, Indocid, and Amoxicillin (…) and in one clinic I was told if I buy *cipro* (Ciprofloxacin) I would be getting better. But after using *cipro* I was not okay. The pain is still there as I told you.

In a workshop, two girls aged thirteen and fourteen years, who often talked about having stomach aches, presented *atika* plants as the medicine which they were advised to use for such persistent pain. During this workshop, they both told about their nightmares about violent men who wanted to rape them in their sleep. It is therefore plausible to assume that the girls used the idiom of stomach ache to represent episodes of rape. For example, the thirteen year old girl gave this account:

> For a year now I have been having bad sleep. The moment I close myself in the hut at night, even before I sleep, I see a very huge man who wants to attack me. Sometimes he comes with a knife. The

> moment I fall asleep, that same man comes to rape me. In such moments I scream and wake up. My two younger brothers also wake me up when I keep shouting in my sleep. When I told our landlady about it, she advised me to put branches of *atika* plant at the doorpost and window, to smear its seeds over my head and around the mat. When I am going to sleep, I should burn some *atika* plants in a partially broken pot.

During home visits and inquiries about income generating activities, this girl disclosed how she had previously cleaned and smeared neighbours' huts with cow dung to make them neater. However, one time she was attacked by the man who had asked her to clean his hut, so she subsequently avoided carrying out such activities.

The fourteen year old female ex-combatant recruited for extensive study also frequently complained of persistent stomach aches. Although she did not exactly attribute them to her experiences in captivity with the LRA, she mentioned how all the medicines she had used did not work. She had simply resorted to going for prayers when there were healing services in Gulu Town or at Life Line Ministries Pentecostal church. She did, however, disclose how her neighbour had exactly the same complaints:

> My neighbour has been having stomach aches ever since she was attacked and raped by five boys on her way to Lacor night commuters' shelter. The night she was attacked, she had a lot of work at home and only started walking alone to the shelter after 8 pm. That is how she was attacked. When she reached the shelter, she did not tell anyone. She simply went to sleep. But since that day, she has taken all kinds of medicines but has not recovered. She often visited *ot yat adit* (GRRH) and much as she has been given many medicines, she still has stomach aches.

During one workshop girls identified a correlation between an increase in the severity of their stomach aches to fear of the LRA when they were rumoured to be in the neighbourhood. Girls who had experienced gender based forms of violence often presented with stomach aches and headaches, thus it appeared that girls used metaphors to describe such experiences. In Chapter 12, I will explain contextual factors which contributed to children's expression of their distress in somatic idioms. I for example mention that victims of sexual violence were reluctant to disclose their experiences due to fear of ridicule, community's reward of people who confronted stressful situations in silence and apathy exhibited towards those experiencing distresses of varying severity.

Exploring quests for therapy for stomach ache using my own illness

To find out more about the management of stomach ache complaints – especially when children presented the complaint at clinics, drug shops, grocery shops, and to hawkers – I visited each of these pharmaceutical sources with a complaint of stomach ache in a three day period in November 2004. The medicines I was advised to buy for my stomach ache were as varied as were the clinics and shops I visited.

In one clinic, the clinical officer prescribed procain penicillin fortified also PPF injections for five days, with Amoxicillin capsules. I inquired if I could start my treatment by only buying Amoxicillin capsules for 500 shillings; she gave me twelve capsules and advised that I take two capsules every six hours. In a grocery shop in Cereleno, I was given a dose of Fansidar at 600 shillings and Panadol at 200 shillings. The shop owner advised that magnesium tablets were also good for stomach ache, if I wanted to be sure that I was effectively dealing with it. One nurse in another clinic first asked whether it was stomach ache with diarrhoea; I indicated that I only had stomach ache. She immediately prescribed *cipro*: "*Cipro* for five days will do". "You have to pay 6,000 shillings", she added. Since I thought the price she asked was too high compared to other clinics, and I did not have the stomach ache in the first place, I only asked for two *cipros*, which I was given at a price of 1,000 shillings. In a drug shop in Gulu municipal

market, the nurse gave me 'ENo', an oral re-hydration-like mixture with an orange flavour. "Pour the contents in this sachet in about one litre of water and drink. It will help with your indigestion", she advised. I paid 1,500 shillings for the sachet. Meanwhile, in two other clinics – one at Kakanyero and the other on the main street – I was advised to buy a dose of antibiotics for five days. I was given green and grey capsules (in this case Ampicillin) to last five days, for which I was asked to pay 2,500 shillings. In another clinic I was given a dose of Ampicillin capsules for five days and asked to pay 4,000 shillings.

As discussed earlier, the children also indicated using a variety of medicines for stomach aches, ranging from chloroquine, Fansidar, Panadol, Hedex, Vemox, Amoxicillin, Ciprofloxacin, and Imodium. Where herbal remedies were also used due to the persistence of the complaint, these were mostly mango tree stem extracts, mango tree roots, banana sap, and *atika* plants. All children interviewed revealed that the medications they used were effective, but also that the stomach aches frequently recurred.

My investigation into the pharmaceuticals prescribed for stomach ache confirms the effects of trade liberalisation since Uganda's adoption of structural adjustment policies. Over the counter and by-prescription-only pharmaceuticals can be accessed from any drug outlet in Gulu town. For stomach aches, the complexity of the complaint itself predisposes the ill person to the risk of accessing any type of medication, even those which they might not need. Moreover, there was a wide range of medicines offered for the same stomach ache complaint, and the quality and quantity of the pharmaceuticals I received were determined by the amount of money I could raise. In Gulu, with about three clinics per street, pharmaceutical business is very profitable. Especially dangerous is the flexible administration of the pharmaceuticals, including antibiotics. If I had indeed needed a complete course of antibiotics, but was only given amounts according to what I could afford, it is likely that other children and adults would have had similar experiences in their quests for therapy.

Cwinya cwer *(bleeding hearts/sadness) and* can dwong ataa *(deep emotional pain)*

In interviews and workshops to discuss children's severe experiences, the phrases *cwinya cwer* (bleeding hearts) and *can dwong ataa* (deep emotional pain) were mentioned by forty children. Bleeding hearts in this chapter is interpreted as sadness. For instance, fourteen year old Akellocan disclosed one of her severe experiences during the armed conflict in the following narrative:

> (…) Ever since the *mony* (soldiers) attacked our home in Anaka and took away my elder brother Odokorach, life has been very bad for us. Each time we hear that the government soldiers have brought back some LRA soldiers we keep on going there to see if we could find Odokorach, but we have never seen him. Even when we ask from *latin lum moo* (certain former child soldiers) whether they ever saw a certain boy called Odokorach from Anaka, none of them indicate so. Well, even when *cwiny ii cwer* (feeling emotional pain) there is nothing you can do about it.

Another twelve year old boy concluded how, following the LRA abduction of his brother and the killing of his father, "with such *cwiny cwer*, even when they give you everything, you cannot enjoy this life".

Ojok discussed extensively how his sister in law had burnt down their hut and all of their belongings, including his entire week's earnings and school uniform. He mentioned having been thrown into desperation and frustration, to the extent of removing his clothes and "acting like a mad man". In his narrative, the phrases *cwiny cwer* and

can dwong ataa were evoked several times. In the same vein, Ojok told how he witnessed the killing his father by the LRA when he was about twelve years old:

> We had decided to stay in Pader, regardless of what happens to people during the attacks by *mony*. My father often told us that he was not afraid of anything anymore. One day we were going to dig outside the camp when we met *latin lum moo* (certain child soldiers). They ordered us to drop the hoes and kneel on the road. My father started arguing with them, that he needed to go and dig and not to start playing. That is how one of the soldiers shot him in his head. *Caawa en ni awinyo cwinya cwer-cwer moo; awinyo can dwong ataa ma latin lum en oneko my father* (at that moment I felt a lot of emotional pain; I felt deep emotional pain when the child soldier shot and killed my father).

In the same narrative, Ojok also shared his experience with lack of sleep and persistent nightmares because of the *tipo* of his late father, who demanded that he perform a *guru lyel* ceremony.

> I rarely sleep throughout the night. I am constantly disturbed by my late father's *tipo* who demands that I give him money for alcohol and organise the ceremony of *guru lyel*. I told my mother about it, but she advised me to smear *atika* plant all over me and put its branches at the doorpost and also where I am going to sleep. Meanwhile she is still selling alcohol so that she will save enough money for the ceremony.

Guru lyel, literally meaning 'repairing graves', was a ceremony frequently recommended by displaced children as an effective activity to deal with spirits of close kin who brought nightmares and sleeplessness. During *guru lyel* close kin gather to perform the last funeral rites, which involve offering an animal sacrifice and feasting by close kin. The items frequently demanded by the deceased kin in nightmares are collected and placed at his/her grave.

Similar features also appeared in fifteen year old Apiyo's narrative about her mother's insanity, which she attributed to *malaria madongo* (very severe malaria – see the narrative in Chapter 5). In particular, she felt *cwer cwiny* and *can dwong ataa* when children in the camps kept laughing at them. She frequently said, "children often say that my mother has no shame since she even walks naked where people are. In such moments *awinyo cwinya cwer cwer moo, ki can dwong ataa* (I feel sad and deep emotional pain)".

In another session where children diagrammatically represented their experiences in wartime, about forty children illustrated burning huts and chained children being directed to southern Sudan by the LRA. Another group of children also illustrated similar scenes of burning huts, but with the UPDF ordering people to move to camps. Two children depicted the burning of their younger siblings who were still asleep in the huts, whom they were unable to rescue. Twelve year old Ajok was quite emotional during her narrative, and she evoked frequently and interchangeably the phrases *cwinya cwer* and *can dwong ataa* in reference to the accident of a hut fire in Pabbo camp. Her narrative was as follows:

> It was a Saturday (…) I still remember clearly. During that *yweyo* (end of school term holidays) I went to live with my aunt at Pabbo camp. This story always makes me feel *cwer cwiny* and *can dwong ataa.* My aunt always left me in the camp with Otoo [Ajok's two year old cousin] so that I could take care of him and make sure that nothing bad happened to him. (…) I always did as she said, and on that day I had fed him and put him to sleep. I was at the neighbour's place when people begun shouting 'fire, fire!' Everyone was running away from the camp. The fire was already burning huts in the zone where my aunt's hut was. I tried to run towards it and see if I could get Otoo out [here she wept bitterly as everyone watched speechless]. In reality, I do not know what to do with the *cwiny cwer* and the can I have experienced since that day.

She blamed herself for putting her cousin to sleep in that hut, and for her inability to run fast enough to rescue him.

In one Sunday service in October 2005 I sat next to a girl of about fifteen years who told me that her name was Angella. She was one of the people who went to the pulpit to be prayed for that Sunday. Although she mentioned that boys had stoned her the previous night as she went to the shelter, she had no physical wounds. I think we may assume that Angella, and many other girls who spent nights at night commuters' shelters, was seeking healing for her sadness (*cwer cwiny*) resulting from exposure to gender based violence.

Quests for therapy for cwer cwiny *and* can dwong ataa

All children who participated in the five workshops I organised about severe experiences during wartime engaged in various coping mechanisms and quests for therapy. For example, some children mentioned the use of medicines for sleep, use of *atika* plants to ward off *cen* and *tipu,* the need to perform *guru lyel* ceremonies (even though at the time of the study they were constrained from carrying them out due to lack of funds and insecurity in their places of origin), and attending healing services at Pentecostal churches or healing crusades in Gulu.

I posed a question to various children, asking about what specific methods and interventions were effective in dealing with such suffering of *cwer cwiny* and *can dwong ataa*. This is what Akellocan argued during an in-depth interview:

> Sickness involving disturbances by *tipo*/*cen* cannot be dealt with in the hospitals. I have never heard or seen anyone go to *ot yat adit* [GRRH] with such problems. People instead use *atika* plants, and some go for prayers with *morokole* (saved people). For me, all these things did not work until we went to see an *ajwaka* at Karuma.

In eight focus group discussions with children aged twelve to fifteen years, one fourteen year old girl concluded, after a long discussion about the use of *atika* plants and other pharmaceuticals for *can dwong ataa* and *cwer cwiny*:

> But for me, I have been using *atika* plants for many years now. First I was using it because when my elder brother was abducted by *mony* I could not sleep. I would scream most of the night, even sometimes during the day time. Later, when that stopped, and I was living in Gulu town, I again started having nightmares of huge men who wanted to rape me. Although I use *atika* plants, I still have those dreams. Maybe *can en cango kene* (this suffering heals itself).

At the mention of *can en cango kene,* the other nine children present reacted by narrating their own experiences with *can* or *can dwong ataa*, and all agreed that misery and deep intensive suffering should perhaps heal itself.

Key informants' perspectives about children's experiences with emotional distress

I asked the nurse working at Noah's Ark about the commonness of headache as a health complaint in children, after I had observed that in one week she had brought seven plastic containers of Panadol (with about 500 pills in each container) which she distributed to children in the first two hours after opening the shelter clinic. She acknowledged that there was a 'high demand' for Panadol due to children's frequent complaints of head and body aches. The nurse, in her own words:

> Yes, there are many children here in the shelter with that disease. Headache is very common and one time we had a meeting with all the centre staff to try to find out about the headache. We had many complaints of headache in children whom we tested for malaria and there were no parasites. The same children often came back to the clinic with the same complaint the next day. Sometimes, as you saw,

> we run out of pain killers in the first thirty minutes of opening the clinic in the evening because the children always complain of headache.

The nurse was reluctant to name likely causes of the headache if not malaria. She instead linked the pains and complaints of headache to fatigue, since some of these children commuted to camps as far as 10 km away.

In one discussion with two nurses, three matrons, and Noah's Ark's centre manager, various ideas were raised about stomach ache as a common health complaint, especially among the girls. One matron argued, "Even me, I always have that disease. I feel pain in my stomach for a long time, but there is no diarrhoea. For me I use Action and Flagyl to treat it". The nurse confirmed that quite a number of girls came to her for medicine for stomach ache. She said, "I always give them de-worming tablets, Panadol, and sometimes Flagyl. I have come to realise that even when I give them de-worming tablets they always come back, so I give them Flagyl". She attributed the commonness of stomach ache to the dirty water that children drink: "You see, our water here comes from a very dirty source. And it is long since the water section repaired their pipes".

One paediatrician shared his experience with a particular girl who presented with stomach aches as follows:

> There was a problematic thirteen year old girl this year [2005] who week after week sought medical attention for stomach aches. Clinical officers at the outpatients unit referred her to me since she was not responding to any drugs, and all laboratory tests were negative. All tests were negative, perhaps because she had already been given all types of antibiotics and pain killers for stomach aches. After reviewing her records, and asking her a few questions, I knew she had hysteria. So I calmed her down, and admitted her in the general ward. I told her how I was going to administer to her the best medicine for her condition. I just placed a false IV over her hand. I did not even prick it. The girl slept the whole night and when she awoke I discharged her. But after a few days she came back. I referred her to a consultant (psychiatrist). He diagnosed the 'hysteria' as *cen* and consequently as PTSD.

The regional psychiatrist referred to the phenomenon of *cen* during an in-depth interview as Post Traumatic Stress Disorder coupled with anxiety, and elaborated that:

> (…) if such children reported to the psychiatric unit for review, depending on my assessment I would prescribe antidepressants. The problem is these people think the psychiatric unit is only for mad people [psychotic cases]; that is why they cannot seek for help for such disorders. These days I feature every Saturday [10 to 11 o'clock] on Radio Mega F.M. to sensitise people about such disorders. However, they have not yet responded to my pleas for them to seek professional help.

Meanwhile, at all healing services at Pentecostal churches which I attended, there were often deliverance sessions for people who were disturbed by Satan (*cen* or *tipo*). One pastor at Life Line Ministries church was popularly known for his expertise in chasing away every Satan, especially those which disturbed ex-combatants and those who had recently lost close kin. The pastor explained to me his ministry of healing during an interview, which was conducted in English:

> When Jesus died on the cross, he said *it is done.* It means Jesus carried all our sickness and burden with him to the cross. His resurrection implies victory over the power of sin and death. As God's children we share in that victory. Through Jesus we have power over sin and death. We know that it is Satan behind all sin, death, and suffering. It is up to individual Christians to use that power given unto us to deal with any kind of principalities. That is why, when I conduct healing services to people with different problems, I call on the name of Jesus to grant me victory over the power of Satan.

In one healing service I attended the pastor spent a lot of time in delivering one fifteen year old former child soldier from the *cen* which was particularly violent and frequently wanted to kill her. The pastor, as he put it during interview, "used power and authority from above [heaven], as a joint heir with Jesus Christ, to command all the evil

spirits which disturbed every child of God to leave them". In another related scenario, a pastor of Cereleno Deliverance Church, who also worked at World Vision Gulu head office, disclosed that he had about one hundred former child soldiers in his congregation who resided within Gulu Municipality or camps close to the municipality. Some of them actively participated in his church services. The former child soldiers especially needed counselling and deliverance prayers due to their constant disturbance by evil spirits. The pastor also told how former child soldiers under him would contact him anytime during the week to request that he conduct deliverance sessions for them. At Cereleno, there were mid week services where every Christian who felt oppressed by Satan would participate in deliverance prayers.

Discussion: Chronicity of emotional distress

Persistence of emotional distress and children's priorities

The empirical data suggests a high prevalence of complaints symptomatic of emotional suffering. For the most part, children presented forms of emotional suffering in somatic idioms, and these somatic complaints were minimised with pharmaceuticals – which generally had analgesic, antibiotic, and psychopharmaceutical properties – and herbal remedies such as *atika* plants. Children also attended deliverance and healing services in attempts to minimise their suffering and deal with persistent nightmares, body aches, and disturbances by *cen* and *tipo*. Nonetheless, despite all these therapeutic quests, their symptoms generally persisted. Neither traditional or biomedical medications, nor prayers or the laying on of hands apparently sufficed to answer this type of suffering.

One could think of different reasons why such symptoms resisted the various forms of therapy. A symptom based management approach to emotional pain neglects the complex causality underlying such suffering. For instance, a wide range of pharmaceuticals was advertised as effective remedies for headaches at the time of the study. If the headache and other body aches of a child are due to factors such as living in poverty or mourning brutally murdered kin, a focus on the headache of course does not provide any real solutions. Given children's helplessness in the face of the underlying problems, children's opting for short term curative solutions seems only rational. Their strategies, however, are not only ineffective, but also lead to the over use and abuse of medicines.

In Gulu little was done to address children's structural poverty, and thus far no efforts had been undertaken by the state to compensate children, their families and indeed their communities, for how they had been wronged. Humanitarian agencies did help to alleviate suffering within the mandate allowed to them by the state. In northern Uganda, some of the humanitarian agencies had as main objective the alleviation of the suffering of vulnerable children, generally focussed on ensuring their psychosocial well-being, and problems of an emotional nature were labelled as trauma. The NGOs' primary approach to counter such problems at the time of study was that of counselling and creative activities: plays, traditional dances, promoting compositions, and singing peaceful songs. Elsewhere in this book I have shown how these projects were not particularly useful for the children who participated in this study. Similar ideas can be found in Giller (1998: 113-128), for example, who wrote that whereas her team was in Uganda to initiate a trauma project, the local women wanted advice, medication, and practical and financial assistance. They wanted to make practical arrangements for their children, and their only priority was material assistance. No one asked for psychological assistance in the form of counselling and psychotherapy (Giller 1998: 113-128).

Currently most researchers recommend taking a holistic approach (as suggested by Bracken 1998: 38; Summerfield 1998: 7-9; Richters 1998: 122; Giller 1998: 128; Weiss 2000; Bala 2005: 169-182) in interventions for people in wartime, including rebuilding informal networks for mutual support, listening to local priorities, and strengthening the family and community structures on which children depend for their security and development. This analysis has added substantially to the lively debate on such issues by investigating – from children's perspectives – their priorities in healthcare for both infectious diseases and emotional suffering. The basic idea is that children as social actors have abilities to identify what they need, and that their priorities and perspectives reflect general healthcare needs and suggest appropriate ways of addressing their problems.

There are emotional wounds especially linked to children's extreme experiences, such as child abductions, the murder of close kin, and loss of property and lives during hut fire accidents. Although emergency aid interventions place emphasis on the need for counselling and sensitisation seminars in attempts to ensure the wellbeing of people in wartime, no child mentioned the relevance of such procedures in ensuring their well-being. What is more, children like Akellocan, Opio, and Ojok, whose narratives show that they experienced emotional suffering, instead used *atika* plants, with limited success. The child who discussed how he and his mother had already tried various ways of addressing their problems after their family members were abducted suggested they could have even realised some unintended effects in their quest for therapy, but they were in need of real healing; and that real healing was difficult to achieve given their context, especially as they could not do much about the death, nor bring back their abducted family member. I propose that such attempts to alleviate emotional suffering need to be viewed as *processes* in the quest for therapy, and not an end in themselves.

This brings me to a critique of the curative short term solutions which children opted for to minimise their emotional distress. Although curative approaches in quests for therapy are commendable in the management of infections, for complex forms of suffering, curative approaches only provide simple solutions and serve to prolong suffering, even making symptoms more severe. For example, regarding the use of analgesics for persistent headaches, the children not only overly relied on pharmaceuticals – i.e. pharmaceuticalised the problem – they also exposed themselves to poisoning, abuse, and over use of medicines. Children also develop false hopes in the pharmaceuticals' abilities to restore them to normality, so that when their hopes are not met, they experience anxiety and frustration, sometimes culminating in despair. In short, to opt for short term approaches, including the use of pharmaceuticals and *atika* plants for complex emotional suffering, is not appropriate for the children who participated in this study. These short term approaches lead to the individuation of social problems. Although the core problem lies in the social context in which the child lives, the child administers therapies to his/her individually experienced bodily pain.

Two conclusions may be drawn from this. Firstly, in the context of civil war in northern Uganda, and in the light of children's dominant expression of emotional distress in physical symptoms, healthcare providers should take extreme caution when diagnosing. The client might need antibiotics, antimalarials, or medicine for indigestion, but attention must be paid to the possible likelihood of an underlying presentation of emotional suffering. But if it is accurately diagnosed that a child presenting with headaches, stomach aches, and the sensation of something painful moving around the body is suffering from emotional distress, how can this best be addressed?

The second conclusion from my data is that the only sound way to effectively manage children's complaints symptomatic of emotional suffering, is to address the underlying structural inequity that they suffer from, to acknowledge how they have been wronged and find ways to compensate them and help them to mourn. But given the breakdown of the legal and social systems in Gulu at the time of this study I am at loss how this can be done in the present situation. Is it through counselling? Is it in leaving the *can* to *cango kene* (suffering to heal itself)? Children must feel assured that other people recognise and acknowledge their suffering, but they must also be allowed to gradually come to terms with the severe events themselves, and thereby experience emotional healing. It is painful to conclude that addressing the core causal factors of complaints symptomatic of emotional distress is beyond children's abilities in the study context, and moreover, that they recognised this.

A holistic approach

Beyond children's curative ways of dealing with emotional suffering is the presence of professional healthcare givers and religious healers, and their approaches to promoting emotional wellbeing. Their perspectives on how best to deal with emotional suffering encompassed general biomedical perspectives, psychiatric, psychological, and religious healers' viewpoints.

It is important to note here that the GRRH, unlike other referral hospitals countrywide, was uniquely privileged to have a psychiatric unit, constructed in 2005. This privilege is directly linked to NGO discourse which proposed the phenomenon of 'a hidden epidemic' of trauma in the region. In one consultative meeting at the WHO Gulu office there was a proposition to construct a five-storey house, fully equipped with enough beds to handle the hidden epidemic of trauma in the near future. However, as empirical data suggests, there was limited community response to calls from the psychiatric unit for individuals to come forward for review. During my regular visits to the psychiatric unit, no traumatised clients were observed seeking professional help there, regardless of the radio talk shows, sensitisation seminars, and announcements calling for people who had witnessed or experienced traumatic events to seek specialised help from this unit. Was this because Acholi people think psychiatric units are only for 'mad' people? Was it because Acholi people – including children – know indigenous ways of dealing with such suffering? Or was it because the unit itself has a history of only providing short term solutions and temporary relief from symptoms? In what better ways can the new psychiatric unit address this 'hidden epidemic' of trauma?

Even in the psychiatric approach there is a danger of medicalizing highly complex problems – which have their root causes in the socio-economic and political realm. Whereas antidepressants are widely known for providing symptom relief, their efficacy in addressing children's core issues is questionable. I do not intend to imply that the regional hospital's psychiatric unit is not in any way beneficial for this community which has experienced prolonged civil war; in fact, at the time of this study, many clients – mainly sufferers of epilepsy and psychiatric disorders such as psychosis, from Gulu, Kitgum, Pader, Amuru and Southern Sudan – received free medical attention from this unit. In 2007, it was sometimes difficult to find an empty bed due to the presence of many people admitted for close monitoring. Nonetheless it is striking that whereas a 'hidden epidemic' of trauma was acknowledged no children with related symptoms were approaching the psychiatric unit for help.

As the results suggest, children frequently named religious healers as instrumental in conducting healing services for people with various forms of emotional problems. The approach was to deal with the evil spirits and teach people to take charge of their own condition by chasing away Satan themselves. During healing services there was a major focus on Satan, and ordering him to stop disturbing God's children. If such approaches are useful, and are consistent with indigenous ways of dealing with distress, they are commendable. Nevertheless, such approaches can pose problems. If the child identifies that it is the *cen* of a close kin member that needs appeasement, then perhaps ordering every *cen* to leave the 'children of God' is in fundamental conflict with the child's ready identification with the *cen* as recently departed kin. I propose that if children are suffering through the experience of *cen* due to the recent loss of close kin, they need to be made aware of the link between their recent loss and the expression of their symptoms. In the process, it must be acknowledged that there are certain realities, and forms of emotional suffering, which such children must come to terms with. Children may then be made aware that with time – no specific period of time since this depends on how the individual client was affected – they may experience less and less of such symptoms.

Noticeably, however, I have attempted to bring clarity to what could constitute a holistic approach to minimising emotional suffering in Gulu Municipality, including counselling, religious approaches, material support, and even simply recognising the complexity of suffering. I use here the term *minimising* as opposed to finding a *therapy* for emotional suffering, based on my own belief that it is likely that emotional suffering cannot be dealt with in a one time intervention. Further, viewing the overcoming of emotional difficulties as a process might help in limiting the prescription of short term solutions to complex forms of suffering.

Conclusion

Assessment of emotional distress presented with initial non-readiness for children to disclose their experiences. It was only after the researcher established rapport with them, that they disclosed their distresses. Even then, children complained of somatic aches and pains. There are indications that children linked particular complaints to emotional distress. Where children presented with somatic complaints, an *etic* in-depth analysis suggested an interpretation of the symptoms – as expressions of emotional suffering. Subsequently, there are symptoms including persistent headaches, *cen,* and something painful moving around the body which have been described as complaints symptomatic of emotional distress.

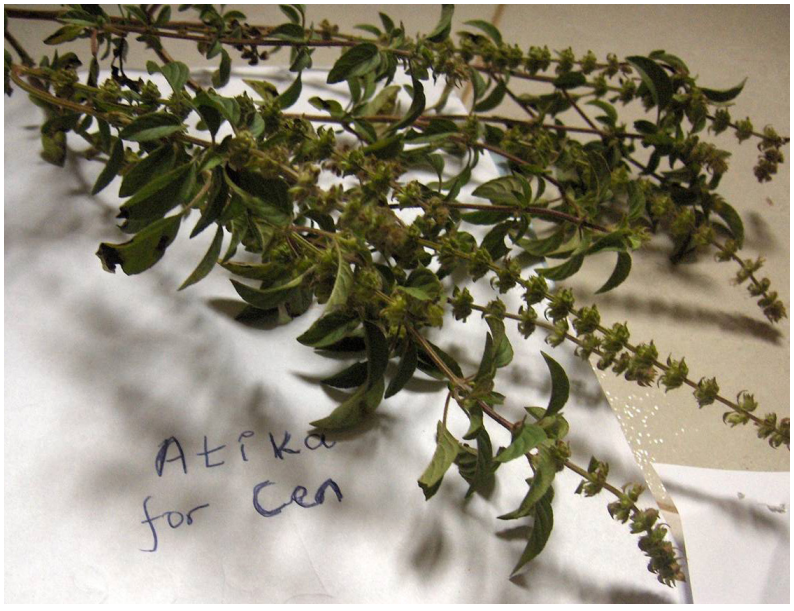
In sum, the empirical evidence above is multifaceted. Symptoms such as persistent headaches, stomach aches, *cen,* and something painful moving around the body were indicators of underlying social problems including, but not limited to, living in strained family relationships, acts of violence committed by former child soldiers while in captivity, and gender based violence. Children described emotions such as anger and bitterness, and feelings of guilt and misery as well as disturbing memories that resulted from these social problems.

Complex emotional suffering needs a holistic approach. Children were already engaged in minimising their suffering through the use of analgesics, antibiotics, *atika*, and seeking healing from religious healers. Overall, however, these practices offered only short term solutions. By employing curative, symptom-based approaches to deal with complex problems of emotional suffering, no attempts were made to address underlying

causes. Although curative approaches might be commendable in addressing infections, curative approaches can be risky when dealing with emotional problems: they give false hope to sufferers through minimising their physical symptoms; they give an impression that the continual use of pharmaceuticals may eventually produce a 'magic bullet' to relieve their suffering; they obstruct an attitude whereby emotional suffering is viewed as processional, in that sufferers must acknowledge that in certain instances there will be only gradual healing, even without medicines; and they serve to obscure the vision of sufferers regarding the core issues at stake. Until individual sufferers and intervention agencies reach a level where they recognise that analgesics, antibiotics, and tranquilizers are *not* a particularly helpful strategy in dealing with their problems, there will be continued abuse, misuse, and over use of pharmaceuticals.

Focus is currently on symptoms and not on underlying causes. However, if core issues are to be addressed, it may necessitate a complex, holistic approach. For example, firstly, the conflict itself, and the fact that people live in fetid, overcrowded camps, will need to be dealt with. Complex social relations will also need to be looked at, such as the fact that children have been the victims of gender based forms of violence, and that ex-combatants are both victim and perpetrator in one. Such holistic approaches might include both indigenous and professional ways of addressing emotional distress, but more importantly, there might be a need to view attempts to minimise suffering as *healing processes* and not an end in themselves. This conflicts fundamentally with existing notions where individuals frequently engage in various quests for therapy concurrently in attempts to alleviate their suffering or to find a cure. I propose that finding a cure in one or several processes might be possible; however, for now I only see short term ways of minimising emotional suffering and not procedures to find complete cures. In reality, some procedures are more useful than others. I suggest that major attempts must thereby be made to promote psychological wellbeing taking into account people's own perspectives, needs, and priorities.

Photo 2 The plant *atika* (Labiate species)



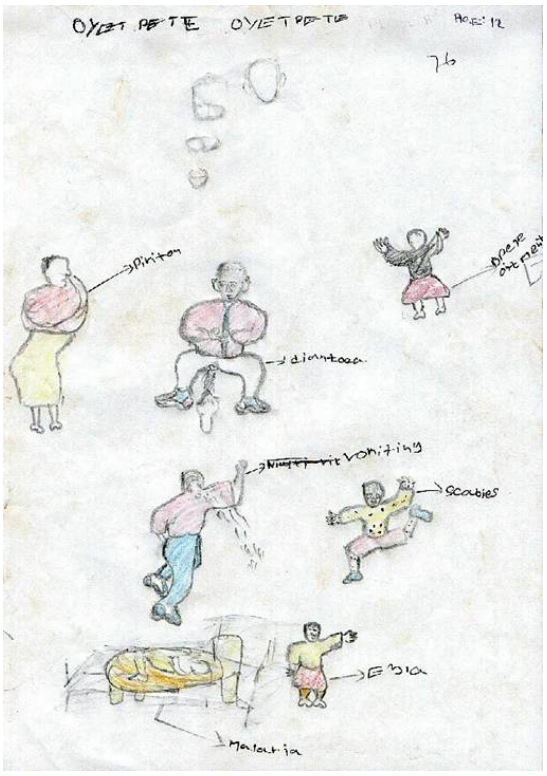


Illustration 3
Common illnesses experienced in a one-month recall

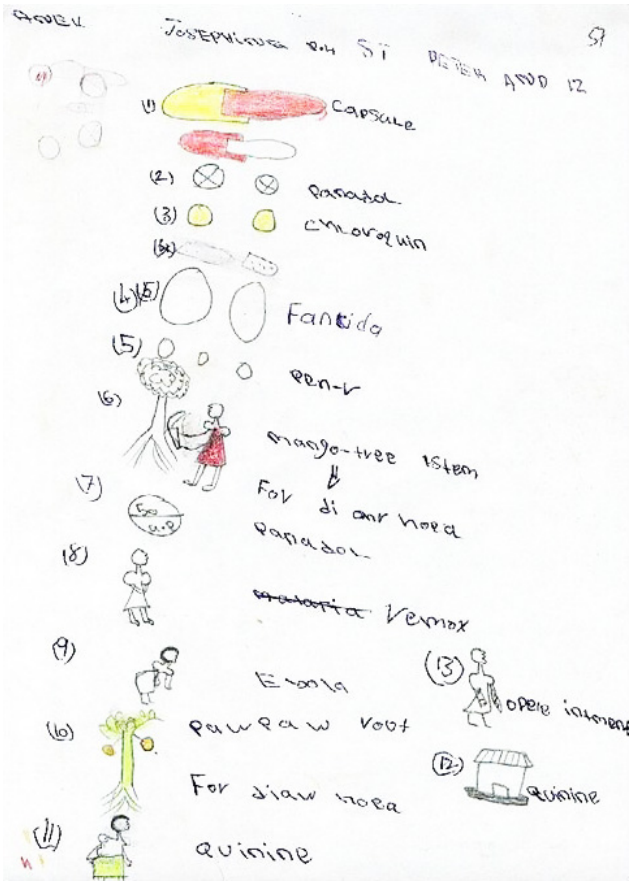


Illustration 4
Common medicines used in a one-month recall

PART IV

REFLECTIONS AND CONCLUDING REMARKS

The content in Part IV is presented in three chapters. After presenting in Part III the health situation of wartime children, as perceived by the children themselves in the context of a market oriented, adult centred, and pluralist healthcare system, I now present a critical analysis of two insights from my ethnographic data. The first insight, discussed in Chapter 12, focuses on children's reluctance to discuss their psychological distress. In Chapter 13, I then reflect on various experiences which occurred during fieldwork involving an attempt at bridging the gap between what the children themselves identified as needs and the healthcare service providers' approaches to ensuring children's wellbeing. In the closing Chapter 14, I will present concluding remarks about children's suffering and quests for therapy.

In Chapter 11, I mentioned that children in northern Uganda did not readily discuss their psychological distress, which they frequently presented in the form of somatic complaints. For many years, the issue of somatisation or the presentation of psychological distress as physical bodily complaints by people in non-Western countries has been an important issue for transcultural psychiatrists. The rationale for presenting a critical analysis of somatisation in this concluding section is mainly to add clarity to this crucial debate, and my premise for presenting a different viewpoint is drawn from experience-near data. I specifically draw from children's own perspectives, and the contextual approaches they took in minimising psychological distress, in order to shed light on this issue. In particular, I reflect on the issue that silencing distressed children and expressing psychological distress in bodily complaints appeared to be a suitable coping mechanism for this community at the time of study, where many people had to confront various severe experiences. However, these coping mechanisms in turn had many health consequences, a theme discussed in Chapter 12.

Throughout this discussion I refer to contextual as opposed to cultural approaches for minimising suffering, in order to transcend exoticization and to suggest that I privilege children's viewpoints. In referring to contextual approaches, I also avoid the frequent implication that culture is a bounded thing. I contextualize rather than culturalize to sug-

gest the fluidity of culture, and more precisely to regard culture as an adaptation and to propose that the children's behaviour was very much influenced by the broader socio-economic factors with which they lived and not simply their 'culture'. In addition, I avoid confusion in reference to 'culture', as has been the case with classical anthropology and other disciplines, whereby it is implied that a difference in 'culture' with the West – which is seen as normative – implying that the 'culture' being discussed is at an earlier stage of development.

12

Silencing distressed children in the context of war: An analysis of its causes and health consequences

In this chapter I aim to answer the question of why children were generally reluctant to discuss their experiences of an emotional or psychological nature, and there were indications in this research that children often present their psychological suffering in the form of physical complaints. Adults too did not readily share their psychological distresses with researchers, intervention agencies, or people representing healthcare institutions. This non-readiness to discuss psychological distress, I argue, has repercussions for the way children and adults who have experienced emotional distress present and deal with such problems, so I will analyse the causes and health consequences of this issue. In the discussion, I will reflect on the value of silencing as a coping strategy and of its health consequences.

This chapter first provides a case study followed by some children's narratives, which picture the severity of their emotional distress and how they presented it. These narratives also aim to give an impression of the context of these children's lives, which was characterised by high rates of exposure to extreme events such as deaths, child abductions, various disease epidemics, gender based violence, and a severely damaged social fabric. Finally, the narratives depict the various approaches children have for dealing with the distress. After this, key informants' viewpoints and the institutional processes which have led to the silencing of victims of emotional distress will be presented, followed by an analysis of the empirical data.

Children's suffering and critique of public expressions of emotional distress

In this section I present children's perspectives on the various causes of distress, and how they dealt with them. In particular, attention is given to the issue of the silencing of sufferers as a coping strategy. I will first present a detailed case study of fifteen year old Okello. Thereafter, I will present other children's narratives suggesting attempts to conceal emotional distress, the community's reward for people who suffer in silence, and the health consequences of this phenomenon.

Case study: Okello's presentation of and coping with emotional suffering

One of the children I frequently interacted with in 2005, and with whom I had thus developed a good rapport, was Okello, a then fifteen year old boy. One day he told me that the worst thing that had happened to him was his mother re-marrying and not his father's death as I would have expected. His father had died in an LRA ambush on Kitgum-Gulu highway in 1995, when he was about five years old. After this incident he continued to live in good peace with his mother and two siblings. However, in 2000, when he was ten years old, his mother re-married to a retired soldier who had lost his wife to HIV/AIDS. Okello narrated his experience as follows:

> This man (this was how he generally referred to the new husband of his mother) is the source of all my sufferings. After two months of marriage with my mother this man ordered her to find me somewhere else to live. He told my mother that I was too old to share a hut with them. My mother took me to my aunt's place. There, I was mistreated. My aunt told me she had no more money to pay for my school fees. I had to stop going to school. She sometimes refused to give me something to eat, and often she sent me to sell foodstuffs in the market and bring all the money to her. I escaped from my aunt's home after one year and went against my mother and her husband's wishes to stay with my mother. Since I came back to Kirombe, I sleep in the neighbouring Pentecostal Assemblies of God Church. My mother said that *jal magwoko wan ni* (the man who houses us) will not be happy with my coming back.
>
> When I came from my aunt's home, I found everything we had had been sold by this man. All the businesses of my mother had collapsed. Previously she sold paraffin, salt, sugar, and other household items in a small shop close to home, but the business had collapsed. We had a bicycle before, and this man had misused it 'til it was beyond repair. This man also sold our World Food Programme (WFP) card to his debtors, hence making it difficult for us to receive WFP food rations. He had also sold all my mother's pigs and she has never seen where the money went. Of late, my mother has resorted to a business of pottery. Still, this man tells her about the many debts he has to pay, and she subsequently gives him all the money.
>
> When I came back, I borrowed money from my friends to start a small scale business of selling boiled eggs, paraffin, and salt. Each time this man borrowed money from me, he never paid it back. I stopped doing this business because I did not have money anymore. Lately he is always having diarrhoea and is very sickly. I also feel sick. I have not been well for five months now since I always have strong headache. It starts with something very painful moving around my head and body. By the time it returns to my chest and head, I feel a lot of chest pain and headache. At first I used to take two tablets of Hedex and it would go. These days, even when I take three Hedex and Action tablets, it only reduces. Shortly afterwards I feel the same headache again. Since the problem is becoming worse, and my mother also has the same pain, we have resorted to going for prayers at Pentecostal Assemblies of God.

Children's views about Otika and his public expression of emotional distress

In order to explore children's experiences of emotional distress and their perspectives on its appropriate management, I presented a vignette about a boy called Otika (see below) to groups of between seven and fourteen children aged ten to fifteen years, fol-

lowed by a discussion of the story. In seven discussion groups, viewpoints were elicited from girls and boys separately.

Vignette: The story about fourteen year old Otika

> In Kanyagoga there was a boy called Otika. He likes staying alone. He does not easily laugh, even when other boys talk about funny things. Wherever he sits he is always touching his cheek. His face looks like that of someone who has been crying. Sometimes, when he is sitting alone and you greet him, he does not answer. He keeps on looking very far away while touching his cheek. Otika cries very often when he is seated alone, even though no one has beaten him. When asked why he is crying, he says nothing has happened to him. Sometimes he denies that he had been crying. Sometimes he does not want to eat. His sisters told us that he keeps on telling them that it is useless to live. Otika says that he does not sleep well. When he goes to his bed at night, he keeps on turning on every side of the bed, sometimes 'til morning. Some nights he just decides to sit outside at night.

After the vignette had been read out, children were asked whether they had similar experiences, and if yes, how they dealt with them and what advice they would give to Otika. Typical answers gathered from several such discussions are presented below. They are exemplary of the silencing of emotional suffering that occurred within northern Uganda during the civil war.

In one focus group discussion, a twelve year old boy, Ocan (or Innocent Jimmy), spoke extensively about the vignette, while eight other children nodded in agreement, sometimes laughing or adding to what he said:

> Otika has *can* (emotional suffering) and *cwer cwiny* (sadness/bleeding heart) due to the death of his father, but he is disturbing people for nothing. He needs to be told how other people have seen and experienced worse things than him, yet they do not behave like he does. For example, there is a woman in Cereleno who has lost all her children, but she is strong. She does her work normally, talks to people, and it is only when people begin to talk about LRA rebels and how they have brought about suffering that she can cry. Still, she first goes and locks herself in her hut.
>
> If Otika cannot sleep, he should be given *yat nino* (medicines for sleep). This should be done by about four o'clock in the evening so that by the time it starts getting dark he is dizzy, drowsy, and too drunk with these medicines. In that case he will be able to sleep throughout the night without tossing about or opening the hut to go and sit outside. Otika should be beaten, even for his constant crying. It irritates people for him to keep on crying and showing people his *can* [from the context this implies individual emotional pain which could become collective emotional suffering or social pain]. If his mother has money, she can take him to Kampala or any town and show him nice things, promise to buy for him cars, mobile phones, or anything which attracts his attention. However, she should trick him, saying that she will do this only if Otika stops misbehaving.
>
> But importantly, Otika could be told about people in the army and rebel groups, how they suffer; sleeping in the bush, having nothing to eat, and that anytime they can be attacked and killed. He should be told that he would be taken there if he continues disturbing people. Otika should even be happy that he had known his father. Most children here in Gulu do not even know who their fathers are. It is something to celebrate if you have at least lived with your father for a short period.

Twelve year old Ocan had insisted to me that his name was Innocent Jimmy and that he did not have another name. His mother had been raped by several soldiers while in captivity, became pregnant, and had wanted to terminate the pregnancy but was advised against it. After she gave birth to Ocan, she had disappeared with another soldier. When Ocan reached primary school age his grandmother registered him at school as Innocent Jimmy. After various attempts to find out his Acholi name, he reported to me one morning with the name Ocan. He mentioned, however, that he did not care much if he was simply known as Innocent Jimmy.

A thirteen year old boy, Oketch, added to the discussion by sharing his experience:

> I lost both parents to abductions and LRA killings. Within a few months, my elder brother also died in a motorcycle accident. I have since then become like a father and mother to my younger sisters. There are many times when we do not have food to eat. Twice we have been told to leave the huts where we were staying due to our inability to pay monthly rent. In both cases, the hut owners just threw away our belongings while insulting us. If Otika thinks he has the most severe forms of suffering, he should contact me. How can he refuse food when there are so many people who do not even have anything to eat?

Apio, a fourteen year old girl, also gave an account of the source of her own severe emotional distress. Nevertheless, she stressed, she had to be strong:

> I had to be strong when my mother became mad due to *malaria madongo*. Children in the Abili camp frequently laughed at us, saying my mother was not ashamed anymore of walking naked where people were. I and my younger brother Bernard suffered a lot during that time. My father took us to close relatives, neighbours, our step mother, and even our aunt, but they all mistreated us. That is how my father rented a hut for us in Layibi. In Layibi we have many problems but I never sit down to cry or refuse to eat food! I can have *par madong*o (deep painful thoughts), *can dwong ataa* (deep emotional pain), and *cwer cwiny* (sadness), but I cannot show it to people. I sometimes simply close myself in the hut in order to cry about all these problems.

Fifteen year old Omony discussed his views on Otika's suffering, and his own experiences of severe emotional distress:

> Being a boy also makes Otika's frequent crying and talking about his suffering so annoying. If there are many girls who have *can dwong ataa* but are not crying all the time, how annoying is it for a boy to keep on crying! [Here the other eight children laugh, and they request me to show them where Otika lives].
>
> For me, the saddest moment this year was when our hut was accidentally burnt down. In it were the harvested crops, all the money we had earned, clothes, and utensils. I almost reached the stage of Otika, but I had to be strong. This is because people even praise you if you can ignore your problems and not disturb them with misery. I think it is because so many people have seen problems with this war that even when someone dies, they spend there a very short time and then go about their business. Some time back a neighbour in Kirombe lost his two year old child due to diarrhoea, but as she kept on weeping, other people were asking her to get up and prepare for them something to eat.

On one hand, the above narratives give a brief impression of what children experienced and how they suffered from it, and on the other hand they also show how the overt expression of such suffering by Otika was actively condemned by the children themselves. In some instances they expressed irritation and disregard for other people's emotional distress. From the case study and the discussions with children several themes emerge that are related to the value of keeping emotional distress out of sight of others. Being silent about one's emotional distress was apparently associated with strength, and showing it in public was a sign of weakness. Showing weakness in public was shameful mainly for boys and men, but it also applied for girls and women. By showing one's emotional distress in public, others were confronted with it, which means that they were burdened by it as well. Everybody was suffering, and seeing another person's distress reminded them of their own losses and grief. Therefore to show one's grief in public was inconsiderate to other people's losses, and amounts to misbehaviour. Such misbehaviour was met with condemnation, ridicule, or even punishment. Grieving in public when others did not openly express their distress could also mean belittling the grief of others. In that sense, displaying emotional distress in public amounts to a form of boasting.

Silencing children taking care of sick close kin and suffering effects of sexual violence

Children who had to take care of kin sickly with HIV/AIDS suffered from specific problems. Four of the six such children that participated extensively in this ethnographic study frequently complained of persistent headaches and pain in the body. Fifteen year old Akwero often stated how "I do not feel very sick, but my head keeps paining me when I think of what will happen to me when my mother dies". Here is how she discussed her experience of *can* (emotional pain) and *can dwong ataa* (deep emotional pain):

> I am always absent from school because I have to take care of my sick mother. Sometimes it is because she coughs the whole night and often vomits out blood. I need to be awake and keep cleaning her. When she has diarrhoea and she fears going out in the dark alone, I stay awake to help her. When there is no paraffin at home, and I have to keep helping her at night, it is very difficult to take care of her. Even washing dirty clothes and bathing her is difficult when we do not have soap. Sometimes *pii loya* (I am discouraged) when I sit down to think about what will happen to me after her death. I feel deep emotional pain (*awinyo can dwong ataa*) if I think of these things.

Children taking care of close kin sickly due to HIV/AIDS were frequently absent from school due to admissions to hospital or because of their responsibilities helping the sick person at home. Such children lived in fearful expectation of the death of their kin. This was evident in statements they commonly made concerning what would happen to them if their parent(s) died. However, it was only during home visits, and when they collected food items at World Vision's food distribution points, that they talked about their problems with caring for their sick kin. In primary schools, HIV/AIDS was discussed as a sexually transmitted disease, and anyone who disclosed their status or suggested that they had a close kin who was sick was stigmatised, either as sexually promiscuous themselves, or because they were taking care of sexually promiscuous sick kin. Unlike in the school context where children ridiculed those who took care of kin sickly due to HIV/AIDS and sometimes discriminated against them, at food distribution points the children who were present had a commonality among them – they all took care of a kin member sick with HIV/AIDS. Thus these children were specifically targeted there for various counselling sessions organised by World Vision for its clients in the antiretroviral therapy programme.

Another type of experience that led to deep emotional distress, but which was very difficult to discuss, was sexual violence, in particular rape. Only when children were asked if they knew or had heard about incidences of rape of other children was it possible to discuss the issue. For example, one fifteen year old girl narrated how her friend was 'attacked' by three boys on her way to one of the night commuters' shelters:

> Just last week, my friend who works for the staff at World Vision was delayed at home. Her caretaker had many visitors, so she had a lot of work to do. Instead of leaving home by seven o'clock, she left after eight o'clock in the night. On her way, three boys [students from the neighbouring secondary school] ran after her and raped her. They ordered her to go to the shelter afterwards. She reached the shelter very late and feeling sick, but did not tell any of the administrators. She simply went to bathe and later slept. She only told us, her friends, because she knew we would not tell anyone. People in Bardege can just keep pointing fingers and talking about you if they hear such stories that boys 'attacked' you.

One Sunday in October 2005, while attending prayers at Christ Church, I was seated with a girl of about fifteen years. She told me her name was Angella. She had been quiet throughout the church service, even when choruses were sung, sitting intently and

simply observing what was going on. At the time when the reverend called for people who needed prayers, Angella first stood up to go, then hesitated and sat down again. When I inquired as to why she did not go to be prayed for, in her response she indicated:

> I do not feel sick but I am not well. Yesterday we were going to sleep in the shelter. It was just seven o'clock but boys attacked us on the way. They stoned us. I am feeling pain all over me and also stomach ache. I am not sick but because of bodily pain I need prayers.

After a second thought, Angella went to be prayed for. Although the girl never made explicit that she had been raped, her mention of stomach pain alludes to this. Some girls expressed in a non-somatic way distress as a result of gender based violence by telling me about their nightmares where huge men wanted to rape them.

Children extensively discussed with me the dangers 'young girls' experienced when they went to dance at night. They were often lured by big men, especially soldiers, to have sex with them. When they refused, soldiers and policemen simply took these girls by force. Nobody would intervene since the soldiers could easily shoot at rescuers. Children were convinced that reporting rape to the authorities would not lead to action against perpetrators. The general impression I gained was that the authorities downplayed the complaint and preferred that victims themselves address the issue of rape.

The silencing of victims of gender based violence was multifaceted, involving disinterest in reported cases, the ridicule of victims, disregard of their emotional distress, and sometimes the blaming of victims. In addition, stories of suffering related to stigmatised sexually transmitted diseases or sexual violence show that public expression of one's distress in such circumstances brings to the fore ambivalent ideas about accountability. Openly showing one's distress in such cases means admitting to having been part of something in which one is considered compromised or partly accountable (for instance rape) or for which a stigma applies.

Key informants' perspectives and institutional processes which led to the silencing of distressed children

- State and institutional processes

It was a known fact that girls who spent nights at night commuters' shelters were sometimes waylaid by soldiers, night commuting boys, and security personnel. One evening I observed a sobbing girl of about twelve years approaching Noah's Ark night commuters' shelter. Five boys, about her age, followed closely while laughing. When I inquired what had happened to the girl, she disclosed how she had been 'attacked' by these boys. I contacted the nurse and centre manager, however they showed disinterest in taking any action, and expressed surprise at my involvement, stating how "such cases were common", and besides the boys had already run away. One of the centre managers outlined his position, and Noah's Ark policy, as follows:

> It is up to the girls to make sure they move from their homes before dark. What is more, Noah's Ark's mandate is only to provide a place to spend nights. Noah's Ark cannot engage in such issues, including ensuring the safety of children when they are outside the shelter.

The coordinator of Noah's Ark also disclosed how less than half of the children turned up at the shelter on days when the discotheques in Gulu Municipality were open throughout the night. She discussed how it was risky for young girls to go to discotheques because older men readily took advantage of them, including raping them. There was no way to address such cases when these girls exposed themselves to them.

In 2005 UNICEF reported that over fifty percent of displaced women and girls in Pabbo camp had been victims of rape and other forms of gender based violence. The various stakeholders produced mixed reactions in response to this UNICEF report. The district army spokesman called a press conference to categorically deny any army involvement in gender based violence, including rape. There was even militaristic harassment of research assistants in this study, with soldiers forcing them to make public apologies for their infamous research findings. At the Gulu District Security Committee level there was total silence about the high number of incidents of gender based violence, which were rarely addressed. At best, general statements were made by individuals, not by the committee; for example, one key officer in the security committee discussed during interviews how "it was women's own responsibility to take care of themselves and avoid situations which might expose them to rape". In comparison to Pabbo camp, conditions in Gulu Municipality were conducive for such crimes since girls and boys commuted to night commuters' shelters in the dark when various security personnel were stationed within the municipality, and there was no strict follow-up concerning regular attendance of children at the shelters.

Another example comes from the case presented in Chapter Eleven of the thirteen year old girl who repeatedly sought medical attention at Gulu Regional Referral Hospital (GRRH) over a one year period in 2005 for stomach ache. The ultimate diagnosis of hysteria and the administering of a false IV did not solve or minimise her problem, which had direct links to an episode of gender based violence. I believe this to be an exemplary case, bringing to the fore the effect of silencing distressed people. The victim adapted legitimate idioms which were mainly physical symptoms to present the issue at stake within the healthcare sector, only to end up with the pharmaceuticalization and trivialisation of her problem.

• Professional counselling and NGOs' approaches to expressions of emotional distress

During the second phase of ethnography there were frequent radio advertisements in Gulu for people with psychosocial suffering to seek free help from Caritas. Caritas was only one of numerous NGOs in Gulu that offered counselling to ensure the wellbeing of war-affected people. In the same vein, such NGOs conducted numerous sensitisation seminars, radio talk shows, and individual and group counselling sessions.

From the children's narratives above, it is clear that Omony met the criteria for counselling at Caritas because of his persistent lack of sleep, disturbances by *cen*, and living in abject poverty and misery. With his permission, I took Omony to Caritas for counselling; this is how Omony discussed his experience with a professional counsellor:

> The counsellor told me that she also suffered like me. She comes from a similar family like mine, but for them they were nine children compared to only five of us. Unlike me, she was the oldest in that family. When her father died, she was still very young, younger than me, but she managed to take care of her siblings. Sometimes she would absent herself from school to take on 'jobs' in order to secure basic needs. She told me that I should know that there were numerous people with problems just like or more than mine. She further discussed how the *cen* of her late father constantly disturbed her but she called the Catholic Charistmatics to pray for her and drive away the *cen.* That was how she solved that problem. She told me to try out the same procedure. But again she recommended that I tell my mother to organise for the *guru lyel* (last funeral rites) ceremony.

Ultimately, Omony's assessment of the procedure was as follows:

> These people [in reference to the counsellor] know how to talk to others. They can make you laugh even when you have a problem. The lady who talked to me even mixed the talk with dancing and

some ululations. She also told me about her life which is very similar to mine. She, however, persisted with the problem 'til she studied and reached where she is!

In order to gain more insights into the process of the professional counselling of children, on behalf of the school administration of two displaced primary schools – St Peters Bwobomanam and St Kizito Alero-Cuku – I invited counsellors from Caritas to conduct a session. Three counsellors from Caritas tackled topics including the challenges of living in displaced persons' camps, the causes of nightmares and how to deal with them, and the problems of growing up.

One counsellor first stated that he resided in Lacor camp, just like most displaced children, and he was therefore better placed to tell them how to deal with their challenges. It produced a difficult scenario because one child immediately asked him which camp he meant, since at the time there was no camp in Lacor. All people who had lived in Lacor camp had been relocated to Unyama camp in 2002, and now there was only a night commuters' shelter at Lacor hospital for children below eighteen years. The counsellor shifted the discussion without answering, saying that he still had enormous knowledge concerning children's difficulties and how to solve them, which was why he had come to advise them. Using a question and answer technique, he inquired into the emergence of the new phenomenon of child headed households, as stated in the invitation letter, and other issues to enable him to assess the children's lives. By observation, there was a visible lack of enthusiasm from the displaced children concerning what he was 'teaching' them. A substantial proportion of children preferred to talk or play with each other, or simply to look at him as he laboured to solicit responses.

The topic which was discussed extensively in this group counselling session was nightmares. In a dream analysis, one counsellor elaborated on the causes of nightmares, and how to avoid or deal with them. Nightmares are 'playbacks' of events experienced, seen, heard, or thought about by individuals. According to the counsellor, the events in conflict zones which make children have nightmares include the killings and shootings of people by both the LRA and state army, but also include the fact that children watch violent videos, and discuss the deaths of close kin and other frightening episodes. The advice given to the children was that it was 'normal' to have nightmares, and that people who had violent dreams should be left and not woken up or interrupted.

In the same counselling session, another graduate counsellor extensively discussed the problems of growing up and adolescence, much to the children's amusement. First he sent away more than three-quarters of the child participants, since they were still 'too young' for the theme. Those who remained behind preferred, however, to ask him questions about how to address problems such as lack of school fees and lack of money to buy food, and whether there were material needs which would be given to children in child headed households if they went and told them to 'counsellors' at Caritas.

In sum, the approach taken by the counsellors was to redefine children's problems as a lack of information, and to normalise their experiences so that they would not worry so much. Although the intended effect of the counsellors' session was that the children should start to view their problems of nightmares as normal, among the Acholi people dreams are given meanings. For example, when a child is constantly confronted in a dream by his/her deceased kin demanding *guru lyel*, it means there is a need to conduct such a ceremony so that that child will no longer be disturbed by the spirits. It is therefore tantamount to ridicule by the counsellors to describe such dreams as 'normal' playbacks and 'nothing to worry about'. Counsellors told the children about others who had

experienced more complex problems, which seemed to imply that the children had no right to complain and led to a reinforcement of children's silence.

During the planning session of one international humanitarian organisation which I observed, aimed at discussing projects organised for displaced persons over a five year period, one project – promoting the peaceful co-existence of people in communities – included varied sensitisation seminars to train beneficiaries. The planners argued that because people in the target communities had lived in a conflict zone for twenty years, they did not know anything about the issue at hand. In other words, they lacked information about the core causes of their suffering and how to deal with them. I envisage that Okello and the other children who shared their emotional experiences above would be potential target beneficiaries, and that in workshops, sensitisation seminars, and short courses – which were a common occurrence in Gulu during the armed conflict – they would be trained in various thematic issues pertinent to peace, and psychosocial and general wellbeing. They would also be trained in how to identify and 'help' a traumatised person overcome their severe experiences through counselling.

From the descriptions above I may conclude that the techniques of counselling distressed children as generally practiced in Gulu at the time of this study greatly reinforced the themes that I identified in children's own views and strategies regarding the expression of emotional distress. Although no doubt well meant, and perhaps fuelled by the way professional counsellors were trained, their own experiences with suffering, and their reluctance to display their emotions, it is clear that their efforts of normalising, trivialising, and redefining their problems into a lack of information did not do justice to the experiences of the children and to the children's felt needs.

Indigenous and religious healers' perspectives on expressions of emotional suffering

Indigenous perspectives

In this general climate of the widely shared need, both among children and adults, to suppress the display of grief and emotional distress, the extent of suffering was clearly so great that true suffering in silence was virtually impossible. There were various attempts by people to communicate their emotional suffering, couched in legitimized somatic idioms. That is how anger, frustration, and depression were expressed as all over body pain, especially in the heart, persistent headaches, and as something painful moving all over the body.

One way in which a substantial number of children addressed their suffering and emotional distress was through the use of painkillers, medicines for sleep, and *atika* plants. For example, in Apio's narrative of having nightmares and disturbed sleep, she gave this account:

> When I was still in the bush, the younger soldiers were often used as spies. One day we were told to go and find out which shops had more things at Kitgum town so that when we attacked at night we would go directly to those shops. In one of the shops was a man who sold nice clothes, toys, and food stuffs. I asked him how much a cloth cost and he told me a high price. He did not want to reduce it. At night I led our group to that shop. After taking all we wanted, the commanders did not know what to do with that man. I killed him on my initiative. Since that night, the *cen* of that man disturbs me. In some nights or even during day, he comes with a gun and sharp knives to kill me. In such times I scream in my sleep. Each night I burn *atika* branches on a partially broken pot. I crush its seeds and leaves to smear on my head and mat. I have also placed branches of *atika* at my doorpost and window.

Other narratives suggest the use of *yat nino* (medicines for sleep) to minimise emotional distress. In Part III of this thesis, I discuss that such an approach is but short term, and core issues remain unaddressed and symptoms may recur thereby leading to the over-use of pharmaceuticals. The efficacy and long term benefits of such short term curative approaches are questionable. Here then is a negative effect of short term curative approaches in dealing with emotional distress; at best, the problems may recur, and at worst, the sufferer may simply disguise the same persistent problem in other legitimised somatic idioms, thus blurring or even preventing adequate solutions to their suffering.

If there were any attempts to actively alleviate individual and community distress, then they were quite subtle. Sufferers were told about people with comparatively worse experiences, reflected in children's comments such as 'there are people with more problems than you'. Children or indeed adults who stoically confronted or concealed their suffering were rewarded with appreciation and praise. It was apparently preferred that individuals suffer in silence. For example, in one of the children's narratives above, it was indicated that many people expressed a disregard for one unfortunate woman's emotional distress; some mourners instead demanded that she stopped weeping and prepare a meal for them. While I have shown that if people frequently wept simply because they remembered an extreme event which they had experienced, their suffering would be unbearable, I suggest that in this context, it would be appropriate for mourners to recognise and validate the bereaved woman's grief.

Religious healers' approaches

One place where people converged to let out their grief and suffering was in churches. During one morning service at Christ Church in Gulu Municipality, the reverend called forward people who needed prayers for their physical, social, and emotional problems; more than half of the congregation (about fifty to eighty people out of approximately one hundred) went to be prayed for. An interview was organised with the reverend about the recent introduction into the Protestant Church services of sessions to pray for the sick. She disclosed that people frequently came to church, even during week days, to request for prayers. People also gave testimonies about the prayers 'working for them' when they had problems of persistent pain in the body, headaches, and other complaints. She mentioned how the majority of people she prayed for (over seventy percent were women and girls) often had problems such as headache, bodily pain, stomach aches, pain in the chest, and other problems which were pain related. These somatic complaints are attributed to the consequence of the active silencing of sufferers of emotional distress; but as it was then, even the reverend could hardly tell why over seventy percent of her clients had such complaints.

One day in November 2005, fifteen year old Okello was for once visibly happy. I inquired into what had made him happy. He disclosed that he had recently been for three days of prayer and fasting at the Pentecostal Assemblies of God church. The pastor had prayed for him as well, instructing him to forgive all those whom he was holding in his heart. He had subsequently forgiven 'that man' for all he had done to them, and was indeed feeling much better. What is rather disappointing is that one week later, Okello had the same complaints of body aches; in fact, his pain was worse. Could this be because in the main focus to minimise Okello's bodily aches, and in partially addressing his hate without the attendance of the new husband of his mother in the prayer session; hence leaving the structural factors causing the emotional distress intact,

the problem was only partially solved? Could it be that ordering Okello to forgive 'that man' and call him uncle constitutes an even more complex way of silencing him and neglecting the core issues at stake? For example, Okello's anger towards that man was part of his experience; his hate, his anger, and his addressing such an experience, would require a focus not only on his body pain but also his social and economic wellbeing. I also recognise the fact that Okello's own failure to deal with his negative emotions through forgiveness, although justified, fundamentally contributed to his persistent body aches. Perhaps Okello needed to be told by the pastor that his hate and anger are negative feelings destroying not only himself, but also the people he interacted with. Additionally, the man Okello identifies as the main cause of his distress could be invited for some of the prayer sessions and advised about his behaviour.

Christians from Pentecostal churches had reservations concerning the use of *atika* plants for emotional distress. For example, Okello and all other saved children interviewed vehemently denied ever using herbal remedies. This is how Okello argued out his position:

> I used to use herbal remedies such as leaves of eucalyptus plants for cough, roots of Sodom apples for diarrhoea, and other herbs, before I was saved. My mother would collect them from the bushes in case anybody was ill at home. When I got saved, the pastor told us that we should no longer use such medicines. He said that it was because it is Satan who gave people knowledge concerning those herbs. It is in using these herbs that people 'welcome *cen*' to disturb them. For example, the pastor said that if a saved person uses *atika* plants, or plants which people put or burn in their huts, that attracts *cen*, and they will be increasing the chances of attack.

It is noteworthy that displaced children who used *atika* plants mentioned that they were 'driving off' or 'warding off' *cen* and not 'attracting *cen*' to their huts. One girl specifically discussed how she was presently able to sleep without the disturbance of the *cen* of a huge man wanting to rape her because she frequently burnt *atika* plants in her hut.

Religious healers conducted deliverance sessions for psychological sufferers. For instance, during one narrative by eleven year old Abonga, and during the deliverance sessions which I attended with two families which had sick kin due to HIV/AIDS, the pastors always instructed them to repent of their sins, and sometimes they drove away the *cen* which caused such suffering; at other times, they admonished sufferers to forgive or release those people they were holding in their hearts. The sufferers were thereby expected to leave their heavy burdens of hatred, lack of forgiveness, and grudges at the cross of Christ and be set free, and encouraged instead to take on the light burdens of love, forgiveness, and peaceful co-existence.

In effect, during healing services children were led into a process of confronting destructive emotions, and it was suggested that if they surrendered these emotions to Jesus, in return they would walk away with constructive emotions. However, this was not enough to free the children of the effects of structural inequity, injustice, and social suffering they experienced at the time of the study.

Discussion

In the children's narratives above, evidence suggests that most of those who experienced emotional distress suffered in silence. Commonly, attempts to express and disclose individual psychological suffering were met with indignation, disregard of children's emotional distress, and often the citing of others' comparatively worse experiences. I believe that the aggrieved were actively silenced for the purposes of making suf-

fering bearable, and in order to avoid being faced with a society which constantly expresses distress with an unbearable excess of sadness, bitterness, frustration, bereavement, and anger. As the children frequently put it, people should keep silent about their personal suffering or else they "would be seen crying for nothing, just because they had remembered some of the suffering in their lives in the recent past, or anything bad which had ever happened to them".

However, as empirical evidence suggests, children who experienced psychological distress frequently complained of bodily aches and pains. Children and indeed adults with these bodily aches and pains frequently used analgesics, medicines for sleep, antibiotics, and *atika* plants, but nonetheless their body aches always recurred. Subsequently, data suggests the over use and abuse of pharmaceuticals and herbal medicines. While these medicines were vital in providing short term symptomatic relief, recurrences of the same symptoms reflect a misguided approach to managing emotional suffering, and the focus on bodily symptoms shows that there were limited attempts to address the core causes of psychological distress. I will return to this shortly.

This chapter proposes that children expressed their psychological suffering in somatic idioms because it is only somatic suffering which is considered legitimate. Data also shows that the indigenous and professional procedures designed to deal with such suffering in Gulu actively silenced them. Silencing took many different forms. I can discern it as a specific contextual expression and dealing with problems at the individual or social level which goes further than just emotional distress. It has symbolic, political, and social dimensions. Children themselves form part of it and frowned upon explicit emotional expressions. They were both victims and 'victimisers'.

The way in which episodes of gender based violence, including rape, were regarded or managed in Gulu during the time of the study similarly amounted to the silencing of victims. It is not only that local legal structures and administrators showed little interest in following up such cases, but also that in the very communities where these incidents occurred, the victim was instead blamed or ridiculed for it. Therefore, in the main, these acts constituted ways of silencing the victims of sexual violence, which subsequently made it quite difficult to assess.

Since it is my contention that redefining wartime people's complex problems as a lack of information is a way of silencing them, I believe that sensitisation seminars organised by NGOs for people in conflict zones, to tell them about trauma and its symptoms, amount to the silencing of the aggrieved. In effect, I suggest that this redefinition of children's emotional suffering – caused by having to take care of terminally ill kin – into problems of being sinful, or lacking information, amounts to the act of silencing them. In a large part, the emotional problem is rated as an individual or bodily issue and not a socio-economic one, and thus the fundamental problems underlying suffering are neglected or actively ignored.

It is a basic premise in this discussion that the target beneficiaries have agency. Children are able to name their problems, deal with them themselves, and are able to suggest ways in which they could be better addressed. For example, during extensive interaction with displaced children, evidence suggests that they were able to identify the core problems of their own and others' emotional distress, and their reactions during a workshop to sensitise them – their insistence on talking about issues of poverty, for instance – show their need to have the fundamental problems underlying their distress addressed.

This chapter therefore questions whether the approach of silencing of victims, and externally conceived psychological interventions, are effective in the context of wartime Gulu in terms of alleviating psychological suffering. In particular, I have sought to shed light on the active silencing of victims as an attempt to make the individual's or community's emotional suffering bearable. In contexts where a substantial proportion of people have recently been exposed to severe events, it may be the best of all possible ways to cope. In short, there may be sense in the idea that showing one's suffering to others will lead to more suffering. Further, I have linked the general indigenous practice of downplaying or trivializing suffering to the explicit silencing of sufferers as-it-were by professional counsellors in Gulu at the time of this study. The common denominator which underpinned such silencing by both professional counsellors and people who had to confront the consequences of extreme events is in telling the victim about their own or others' comparatively worse experiences, and highlighting how they had managed to 'work through' them. The only difference between professional counselling and indigenous active silencing, I argue, is that professional counsellors made it explicit that their approach was a therapeutic procedure.

The analyses in this chapter are not, however, consistent with the dominant explanations for why people in non-Western societies express their mental or psychological distress in somatic idioms, which mostly place emphasis on cultural differences or 'culture', or on not 'knowing' psychological illnesses in the Western sense (Mechanic 1972: 1132; Kleinman 1977, 1980: 76; Lin 1983: 105-107; Drakapoulou 1985: 40; Van Dijk 1998: 245). For example, Mechanic (1972: 1134) proposed a 'cultural formulation' which added several important factors to the general case formulation for a psychological health assessment, thereby allowing the clinician a framework for understanding the patients' cultural identity and cultural explanation of illness, the cultural factors in the psychosocial environment, and the cultural elements of the relationship between patient and clinician, in a bid to comprehend why patients present their emotional suffering in somatic idioms. Kleinman (1977, 1980: 76) demonstrated that among Chinese populations, and indeed for the populations of many developing countries with predominantly agrarian cultures, depression manifests itself with somatic symptoms – 'somatisation' – unlike among general American population categories who label depression as a psychological problem. In a similar vein, Lin (1983: 106) suggested that Korean folk etiological beliefs centre on anger as the precipitant of numerous illnesses, and case reports frequently discussed a diagnosis of depression engendered by negative life circumstances and expressed by patients as somatic complaints. Further, Van Dijk (1998: 245) presented several stereotypes, including that Moroccans and Turks are unable to handle the distinction between body and mind and do not know psychological illnesses in the Western sense; and that the vague somatic symptoms and physically felt pains which the Mediterranean patient presents could have a psychological cause apparently beyond his/her comprehension. Emphasis in this instance is placed on cultural differences, and far less on similarities (see Fabian 2002: 1-35).

In short, a focus on culture – and the framing of 'culture-bound syndromes' to describe the psychological distress of people from non-Western countries – has had a limited positive effect on enhancing understanding of the sufferers' plight. The stereotypes, in short, epitomize what Van Dijk (1998) calls 'culture as an excuse', and have led to the failure of both medical practitioner and patient to adequately address the issues at stake. Drakapoulou (1985: 40) demonstrated well the effect of relegating the expression of psychological suffering in somatic idioms to culture. He nicely states that

"the social worker regards culture as an obvious cause of all misery and is thus released from the task to absorb himself in suffering of the patient". And Van Dijk (1998: 246) states:

> Too often cultural differences and language problems are used as alibis. The care provider keeps clean hands. The problem lies with someone else. The culture of the help seeker functions as a 'comfortable' explanation for the inadequacy of the service. The care provider cannot get hold of the symptoms; he cannot interpret them and bring about a cure or alleviation of the problem. He does not succeed in passing on his view on the nature of symptoms. His feelings of impotence and frustration are softened and camouflaged by the cultural label.

During this study's data collection process, I did observe how diagnosis was made at outpatients' clinics in four health centres in Gulu. In the main, clinical officers focused on physical complaints and readily attributed them to malaria. In Chapter 5, I gave an example of a distressed child whose frequent presentation with headache ended with a clinical diagnosis of malaria despite the fact that he had at one time made it clear that he "did not think his headaches and body pains were due to malaria". While it is true that contemporary medical training has a major emphasis on the germ theory and physical health, it is also true that there was no specific place in most health centres in Gulu where psychological distress could be presented and addressed. It is possible that this phenomenon subsequently prompted distressed people to adapt and present their suffering in somatic idioms. Helman (2001: 80) and Van Dijk (1998: 247) attribute patients' somatic presentation of psychological suffering to the general focus by professional healthcare workers on objectively demonstrable physical changes in the body's structure and function, which can be quantified by reference to 'normal' physiological measurements.

This chapter, however, suggests that the silencing of sufferers by both professional and indigenous healthcare providers contributes substantially to the presentation of psychological suffering in somatic idioms. A similar explanation is given by Van Dijk (1998), who asserts that the general practitioner and migrant are faced with the joint task of reaching a workable definition of the situation. They must try to reach an agreement on what is wrong. As a result of differences in explanations and expectations, an interaction develops in which the body becomes the arena of assistance. There is a marginal communication whereby one party is trying to present the physical symptoms as clearly as possible and the other is constantly looking for symptoms of illness. In the search for the correct way to express his/herself, the migrant will use what he/she considers the language of the practitioner: the language of the body and pain. Because the psychological (and/or psychosocial) aspect is considered taboo, the practitioner sees his possibilities restricted to medico-technical procedures aimed at the body (Van Dijk 1998: 248).

In psychopathology there are psychological and somatic diseases, and Holmes & Rahe (1967) and Kleinman (1988) have demonstrated that psychosocial stress can produce either psychological or physiological disease, or both. It is possible that experiences with severe events have caused the physical pains in war-affected children and indeed adults in Gulu. In addition, it is argued in this chapter that the silencing of distressed children leads to the adoption of legitimised somatic idioms in order to communicate distress, thereby giving the impression that there is a low prevalence of psychological suffering. For example, take the narratives above, which present various physical health complaints symptomatic of psychological suffering: perhaps it is because such suffering is not new in this context; perhaps people are not courageous enough to listen

to, label, confront, and deal with such suffering; perhaps it is not yet useful to pay attention to such suffering since the community, the legal or administrative systems, and other sufferers will not respond to pleas for help to solve the issues at hand. Needless to say, the community and institutional and district administrators' reluctance in dealing with the core causes of distress in the general population reinforces the expression of emotional suffering in legitimized somatic ways and in turn serves to blur and simplify the core issues.

In the pharmaceuticalization of complex problems as part of the quest for therapy, I see dimensions of pragmatism which propel persons to engage in any activities which might minimise their suffering, albeit only on a short term basis. While these short term approaches are implemented, the search for likely concrete solutions is blurred by the communication and identification/diagnosis of the problem as being in the body(psyche), yet the core causes of the distress are likely to be social, economic, and political in nature.

It is proposed in this chapter that when sufferers do actually start to make deliberate attempts to identify the specific core causes of their psychological suffering, and implement procedures to address them, these approaches will contribute to the healing and minimising of somatic expressions of psychological suffering. Put differently, it is only in correctly identifying the sources of psychological distress and appropriately addressing them that the high prevalence of physical complaints symptomatic of psychological suffering can be minimised in Gulu.

I recognise that expressing one's distress or discussing the extreme events people were exposed to either in public or to a therapist, is one way that people can give meaning to their experiences, enabling them to leave the past behind them; but indeed, in Gulu both professional and indigenous procedures silence people experiencing emotional suffering. Perhaps, as noted earlier, silencing distressed people was the best way to cope at the time of this study. In Akello *et al*. (2006) we gave an example of how one former child soldier exposed herself to various forms of backlash and violence as a result of freely sharing her experiences during captivity. Concerning the paediatrician's diagnosis of hysteria in the case of the young girl with stomach ache, I cite Szasz (1974: 230) who put it this way: "those who want to deal with the so-called hysterical patients must therefore learn not how to diagnose or treat them but how to understand their special idiom and how to translate it into ordinary language". In the case study of this girl, the administering of a false IV (intravenous fluids) suggests a neglect of her emotional suffering. I suggest that it could have been more appropriate to view the girl's persistent presentation of stomach aches as an essential distinctive feature of a hysterical disorder, whereby a dysfunctional bodily state is substituted for a personal problem (for example sexual violence). Subsequently, an approach to address the physical and psychological consequences of being exposed to sexual violence would be the more effective way of assisting this girl in escaping her anxiety.

Conclusion

In sum, due to living in context where people had been exposed to various forms of violence and living under dire circumstances, both children and adults' distress levels were high in northern Uganda. However during my research both adults and children were reluctant to discuss their distress. Findings suggest an active silencing of people in distress by both the community and professional healthcare givers. I argue that there are

causes and health consequences due to silencing distressed children. Whereas silencing distressed people made coping more bearable, the immediate effects of this phenomenon include over-use of pharmaceuticals, expression of the distress in somatic complaints and blurring of core causes of distress and a focus on the physical body. I however suggest that openness and talking about the distress and its likely core causes will lead to concrete addressing of it and finding last solutions to people affected by war. Nonetheless I am aware of the limitations of the context in which the respondents lived – circumstances which might not facilitate redressing of core-causes of distress including, poor social networks, high prevalence of stressors, poor legal structures and that people whose role is to protect civilians are at the same time perpetrators of violence.

13

An evaluation of healthcare services' provision in relation to children's perspectives

In attempts to generate policy recommendations so that children's 'right to health' is met, I interpret children's right to health as the extent to which they can access healthcare services of the highest possible quality that are consistent with their needs and priorities. During my fieldwork, in a context where there were various interventions intended to ensure children's wellbeing, I did present to the various healthcare institutions what the children themselves identified as priorities and needs. It is this chapter's objective to share my experience with disseminating children's own perceived needs and priorities over the course of my fieldwork. I will examine my experiences of bridging the gap between children's healthcare needs and existing interventions under two thematic areas, namely (1) the state-led healthcare services for children of primary school age, and (2) the humanitarian agencies' healthcare interventions to ensure the wellbeing of wartime children.

I will use 'target population' interchangeably with 'beneficiaries' to imply the dynamics and positioning of wartime children in relation to healthcare service provision. Although the major healthcare service providers frequently referred to their target population as beneficiaries, I find that the word beneficiaries mostly focuses on the passivity of the recipients of such services. The reality is that the target population actually engaged with the ideas and services provided. In some cases, there was no response to calls by service providers to receive particular services like counselling, while in other situations the services were insufficient; children often sought a path to wellbeing in the popular sector where they accessed pharmaceuticals and herbal medicines or participated in healing services. Thus when I consider the experiences of the population which

was the focus of my ethnographic study, 'target population' is more suitable. However, for service providers, the term beneficiary is appropriate in reference to the children in wartime because they were viewed as passive recipients, and there were limited efforts to integrate their perspectives into the services provided.

This chapter is organised as follows: I will first analyse the dynamics of the state's provision of healthcare services to children of primary school age in northern Uganda. My experiences with presenting children's perspectives to humanitarian agencies and NGOs will then be presented. In the analysis, I will evaluate why there were limited successes in state and NGO implemented projects in terms of meeting vulnerable people's healthcare needs and priorities.

State and humanitarian agencies' service provision

State implemented school healthcare programmes

At the time of this study, policy documents about the healthcare of children of primary school age had clear objectives and guidelines on how they would be implemented at local level. On three occasions during the second phase of fieldwork, starting July to December 2005, Gulu DDHS distributed de-worming tablets to primary school children within Gulu Municipality. Girls aged thirteen years and above, frequently called girls of reproductive age, who attended primary and secondary schools, were vaccinated against tetanus. In addition, the District Health Office (DHO)[1]organised various forums in which children in primary and secondary schools were sensitised about HIV/AIDS and on how to avoid infection.

It is noteworthy that during my fieldwork, there were many children out of school. This was because of the high drop-out rates from school due to insurgency, teenage pregnancies, and because some children were heading households and taking care of their siblings or sick kin. In effect, in addition to the narrow focus in healthcare service provision, there was already a group of out-of-school children whom the existing healthcare policies and interventions neglected.

In examining children's perspectives on their healthcare needs and priorities, children named experiences with diseases such as (self-diagnosed and clinically-diagnosed) malaria, diarrhoea, infections in the respiratory system, wounds and injuries, and various forms of psychological suffering. Further, children frequently named a lack of material needs such as food, shelter, and scholastic materials; and for those taking care of sick kin due to HIV/AIDS, they mentioned the need for assistance in taking care of the sick. In short, children's healthcare needs and priorities were so much more complex than what was addressed in policy documents.

In light of the above, I set out to investigate in detail why there was a gap between children's own expressed needs and those documented at policy level and implemented at district level. I posed questions to key healthcare planners at Gulu DDHS. In response, the coordinator of the Child Healthcare Unit mentioned how "With this war not only are children of primary school age exposed to malaria, but everybody is. In addi-

[1] In late 2007, the name District Health Office (DHO) was adapted in public service documents to replace District Directorate of Health Services (DDHS). I will sometime use DHO to recognise this change. I still also use DDHS because the name change was a political issue, since personnel, policies and guidelines in healthcare service provision remained the same and the records which I refer to are still under the name DDHS.

tion, children of primary school age are exposed to any illness which affects adults". In connection to my inquiry, the District Director of Health Services at the time of this study mentioned how "In planning for healthcare services, the district aligned budgets with mainstream national healthcare budgets". This is regardless of existing data about what healthcare needs and priorities the target population identifies.

As stated in the problem statement, the areas of emphases in terms of promoting the wellbeing of children of primary school age are consistent with what the international level institutions suggest as suitable for school health programmes. In effect, Uganda's national healthcare policies are adapted from the World Health Organisation, the United Nations Children's Fund, and the World Bank. Consequently, the Ministry of Health does not meet the health needs of the most vulnerable categories among its target population: children above five years old who are not under adult care, such as children in child-headed households in displaced person's camps and villages. Humanitarian agencies do not meet these needs either.

It is important to note that due to the economic powers and donor demands, at the time of this study, policy makers and officials at the Ministry of Health hardly engaged with the policies regardless of the issue that what would be implemented did not meet the needs of the target population. One such example was in 2005 when the Malaria Control Programme at the Ministry of Health (MOH), adapted the policy of promoting use of Coartem as the first-line drug for malaria. I have argued that Coartem was very expensive for the communities in Uganda and that providing it at no cost in the first phase of implementation of the policy might generate other kinds of malaria-resistant pathogens difficult to deal with.

Humanitarian agencies' service provision

During my fieldwork, northern Uganda had experienced over twenty years of armed conflict, and it was still on-going. There had been a phenomenal influx of NGOs into this conflict zone with the main objective of alleviating people's suffering. For example, one international aid agency – the World Food Programme (WFP) – intermittently supplied food aid to various camps and sometimes to primary schools, an intervention wartime persons looked forward to since they were displaced from their livelihoods. World Vision, the United Nations Children's Fund (UNICEF), the Norwegian Refugee Council (NRC), the International Committee of the Red Cross (ICRC), the World Health Organisation (WHO), the African Medical and Research Foundation (AMREF), Gulu Support the Children Organization (GUSCO), Médecins Sans Frontières (MSF), Save the Children in Uganda (SCiU), Noah's Ark, and Caritas, among other NGOs in Gulu, had major project elements focusing on providing psychosocial support to people in conflict zones through counselling and sensitization seminars. Occasionally, basic material needs would be supplied to vulnerable people by the national and international humanitarian agencies.

Although one of the priority needs for the Acholi people since 1986 is that the armed conflict should stop so that they can go back to their livelihoods and live in peace, in Chapter One it was discussed how the state has employed peaceful means together with armed attacks against the LRA, but with only limited success. In major national and international emergency aid circles, the accent was on working within mandates, being a-political and non-partisan. One key informant's viewpoint – articulated below – may serve to reflect the generally espoused position taken by humanitarian agencies. This is how she frequently explained their position:

> We are here as a non-partisan, a-political, humanitarian emergency aid NGO. We are obliged to alleviate the suffering of people in conflict zones. As an institution, our main mandate is to help traumatized children work through their distress by distributing footballs to registered clients, organizing creative plays, traditional dances and games competitions. The war itself should be stopped by Ugandans themselves.

Presence of NGOs in Gulu district to alleviate the suffering of people in conflict zones

While the expected results of the high representation of local and international NGOs in Gulu district at that time would be that the targeted population received tangible benefits and that their suffering was alleviated, the outcomes were in reality negligible. In a large part, Acholi people continued to live in fetid, overcrowded camps, frequently experiencing intermittent epidemics of easily preventable and manageable infections such as scabies, cholera, and eye infections. In addition, at the time of the study, people had to deal with the fear of impending attacks by the LRA, child abductions, hunger and malnutrition, gender based violence, and living with uncertainty.

One of the unintended consequences of the high presence of NGOs in Gulu Municipality was the subsequent high cost of living. In general, commodity prices were higher in Gulu district in comparison to other rural districts countrywide. This in itself attracted small scale traders, some of whom relocated from the capital Kampala to Gulu due to the presence of a substantial number of humanitarian workers with high purchasing capacities.

In addition, there was general conflict between the civil service employment sector and NGOs. For example, the District Education Officer complained during interviews about the difficulties in retaining teachers in primary schools since NGOs always recruited them as field staff where they were promised better wages. Subsequently, it was difficult to improve school performances because of inadequate numbers of teaching staff.

Functioning within mandates as a limiting factor to project successes

While investigating NGO functioning in Gulu, it was observed that some of them had notices at their gates strictly prohibiting researchers and journalists from entering their premises. It was clear that they considered themselves to work within their mandates and objectives; mandates which were preset guidelines for NGO intervention. Whereas many NGOs had comprehensive guidelines on paper, at the implementation stage activities were frequently limited to counselling and sensitization seminars to promote awareness about the common problems of traumatized people. As findings suggest, the healthcare needs and priorities which children identified were not consistent with NGO approaches and preset guidelines. Here are my proposed analyses:

(1) There was a profound conflict of priority interests between humanitarian agencies (NGOs) and the Acholi people. I mentioned above that for the Acholi people, stopping the armed conflict in order for them to go back to their communities and livelihoods was a fundamental priority: in contrast, NGOs' top priority was to ensure the wellbeing of people in conflict zones.

(2) NGOs functioned only within their mandates. There were limited attempts to integrate beneficiaries' perspectives into the preset guidelines.

(3) The process of presenting beneficiaries' perspectives to intervention agencies was like going against the tide created by broader political, social, and economic in-

stitutions. My attempts to bridge the gap between children's expressed needs and healthcare interventions only drew attention to what was already known, yet there were deliberate efforts to avoid them.

(4) There were ideological guidelines regarding NGO functioning, including being a-political and non-partisan in situations of armed conflict, which put their interventions in a precarious position. For example, being a-political means that intervention agencies will mostly speak out and document tragedies mainly where their own staff are injured, and rarely against the dangers which their beneficiaries are exposed to. Being a-political also means distributing aid, for example food, to both armed groups and to the people injured by the fighters.

Exemplary planning workshop to alleviate children's suffering over a five year period

In one workshop that I attended, held in a prestigious hotel in Gulu town, and organized by Save the Children in Uganda (SCiU), the aim was for project partners to draft an action plan for projects to be implemented in the coming five years. Project partners to SCiU included primary school teachers, representatives from sub-projects including Rural Focus Uganda (RUFO), SCiU night commuters' shelter, Gulu Support the Children Organization (GUSCO), and other minor school sub-projects. Noticeably, there were no children representatives in this planning session.

During interviews with the then northern region SCiU coordinator about the absence of children partners, his answer was cautious, but mainly pointed to the difficulties in dealing with children:

> These projects are for children, but we have not inquired into their ideas because it is difficult to deal with children. In general children require special techniques to interact with them, and most of us are not technical in that area. That is why we invite primary school teachers to give us perspectives from children.

In this strategic planning workshop a technical team from Kampala gave presentations drawing from five projects which were consistent with International level SCiU projects. These ranged from peace building, child protection, raising awareness, and the counselling of people in conflict zones. Project partners were later requested to make contributions for project design by mentioning activities they may implement, within the mandates of SCiU.[2] I inquired of one coordinator of a primary school project how they implemented such complex projects focusing on the promotion of peaceful co-existence and the mental wellbeing of children, mainly through sensitizing children about the topics of peace, distributing costumes to children for traditional dance, singing peaceful songs, and peace building through organizing war affected youth's participation in debates on topics of peace. She discussed her experience as follows:

> I have been the coordinator of the SCiU project in my school for three years. It is very difficult to coordinate the activities they tell us. We are instructed to organise debates on topics of peace, and also to compose peaceful songs. It is almost impossible to get children to remain behind when schools close at four o'clock in order to do such activities. Some children stay very far from school and they

[2] By observation, there was a clear sense of un-equal power relations between the team from Kampala head office and SCiU partners. During plenary sessions where the partners contributed to the activities in project design, the four experts took turns to inspect what they were doing, reminding them of which activities are relevant for counselling traumatised children. One of the team members mentioned how, it is not possible for SCiU to go beyond its mandate.

> need to be home early since it is dangerous to travel home in the evenings. Other children are simply not interested. The issue is, the monitoring officer from SCiU Kampala often comes at any time to see what you have done with the costumes already donated to the school. In that case we often request the teacher in charge of the music and drama club to teach one child a peaceful song for presentation. It would be better to give the school SCiU club money for piggery and small-scale agriculture instead of costumes for creative dances and peaceful songs. It is income generating activities which will be useful for the children, some of whom are orphans or live in child headed households.

The above conversation clearly stipulating the difficulties in implementing SCiU projects, and spelling out beneficiaries' priorities, were relayed to the northern region coordinator of SCiU projects. The coordinator, in defence, gave this account:

> SCiU functions within its mandates. Funding for projects are drafted on a five year term basis. At the moment we mainly have projects to promote peace building and child protection. These are to be implemented through debates on topics of peace, promotion of awareness seminars, organising children to sing peaceful songs, sensitizing people about the importance of peace and counselling. Often we are not able to implement projects which are beyond our mandates.

An effort to bridge the gap between NGO activities and children's needs

In extensive assessments of children's experiences, children frequently made explicit their needs and priorities. Children mentioned lack of basic needs, food, scholastic needs, house rent, fear of abduction, being exposed to injuries due to landmines, and the difficulties of taking care of kin sick due to HIV/AIDS. Subsequently, I made a written request outlining children's needs and presented it to UNICEF, the Norwegian Refugee Council, World Vision, and SCiU. The rationale for selecting these NGOs was that in their mandates, their main stated objectives were to ensure the wellbeing of children in conflict zones. There was no need to present a request about children's priorities to War Child since it had already made its mandates clear: War Child aimed to strengthen children's resilience through verbal and non-verbal expression of thoughts and feelings, using age appropriate creative activities such as songs, sports, role play, art, debates, and music. At the time of this study, children associated War Child with the distribution of footballs to registered clients and organising games competitions at district level.

In response to a request about children's needs, one official whom I contacted at UNICEF mentioned how UNICEF did not recognize projects from academics, nor did it work with children as project partners. UNICEF's partners were other NGOs based in Gulu. In addition, UNICEF's mandate, as spelt out in the 2005 project framework, was to facilitate the counselling of former child soldiers. This was despite the fact that it was approaching almost a year in which there were no child soldiers rescued at the warfront by the Ugandan Peoples' Defence Forces. It was surprising to me that UNICEF did not acknowledge or attempt to integrate children's perspectives into their mandates, when children were their main beneficiaries. Another surprising issue to me was that NGOs frequently recommended or engaged in researches to elicit their beneficiaries' needs. In this case, the academic had already done the research, but UNICEF chose not to acknowledge the data.

What then is the field evidence that UNICEF needs to improve its service provision? Concerning UNICEF's project framework for 2005, UNICEF promoted the reintegration of former child soldiers through GUSCO by providing funds for traditional cleansing ceremonies. UNICEF also conducted various researches to find out the problems which wartime people faced. In Chapter 1 and Chapter 12, I referred to a study by UNICEF (2005) regarding the prevalence of gender based violence in Gulu district.

Such researches on political issues put UNICEF in a delicate position concerning their claim of being a-political; yet UNICEF started a discussion on the political issue of gender based violence, including sexual violence, by documenting the main perpetrators. At the time of publishing parts of the UNICEF study (2005) in the local media, there were various attempts by UNICEF officials to distance the organisation from the study. The field coordinator based in Gulu referred all people with questions about the study, including top officials from the state army (the UPDF), to the research assistants. Officials from UPDF tracked down and demanded that research assistants make a public apology for their infamous findings. In effect, as long as various NGOs remained a-political and non-partisan, there was a sense of continuity and normal interaction with both the state and the LRA. It appears that an attempt to ensure the wellbeing of their beneficiaries by addressing what the vulnerable people themselves describe as needs and priorities was problematic.

The same written request concerning children's priorities and needs was presented to the coordinator of SCiU. The coordinator's response was as follows:

> SCiU has no project element to pay school fees or meet these basic needs for children. Such projects are difficult to get funding for since no donor would like to give money to ventures which are difficult to sustain. Money for house rent as a request also falls outside our jurisdiction. In child protection, SCiU may only facilitate cases of crime reported by children to ensure legal action. I will contact another officer to inquire if SCiU can meet other demands presented by children.

Upon inquiry concerning his assertion that SCiU had no capacity to pay for school fees – despite the fact that the handbook [see IRC, CRS, Care, AVSI, SCiUG, USAID (2005: 16, 76)] reflecting the SCiU project framework stipulated that SCiU would meet the school expenses of vulnerable children – the SCiU coordinator gave this response:

> That project framework was drafted in partnership with other NGOs we work with. Therefore, there is flexibility such planning accords to us. This is because we can decide that other institutions deal with those issues which we do not have experience in. It was, however, unfortunate that no institution opted for paying school fees. In general, a project to meet the scholastic needs of children including school fees is difficult to implement. This is because there will be problems of sustainability of such projects since very few donors would like to fund them. United States Agency for International Development (USAID), the proposed major funding institution for school fees, had already cut down their finances towards this cause.

Save the Children in Uganda responded to the written request which I presented to its coordinator about children's needs three months later by giving each of the twenty-four children in child headed households a blanket.

World Vision responded four months later to a request I made on behalf of the children by giving each child one pen, four exercise books, and three pencils. When I made it clear that these children specifically needed these scholastic materials during the school semester, the answer was that they could still use these items in the coming semester. Another issue which surprised me in my attempts to bridge the gap between children's needs and NGO activities was the length of time it took beneficiaries to access necessities from these self-reported 'emergency aid' institutions. The point here is that children's needs varied according to various time frames, activity schedules, and whether they lived within Gulu Municipality or in displaced persons' camps. Whereas children needed the scholastic materials during the school semester, if received after the semester had finished the materials would instead be sold or disposed of. Seven of the twenty-four children, who had done the national examination to mark the end of primary school education, were not even sure whether they would proceed with formal education the next year. In effect, I linked the children's prioritizing of immediate short

term needs to their living in a context of uncertainty. I believed that their immediate short term needs would be regarded as such by emergency aid institutions, and that there would be a timely response. However, it seems to me that the emergency aid institutions I contacted were in fact bureaucratic organisations which were to some extent not well adapted to contexts of emergencies. For example, at the Norwegian Refugee Council, the coordinator at the children's desk indicated that they were willing to help the children, however all requests must first be approved by UNICEF, their principal partner. By this time I already knew UNICEF's position.

In short, my contribution of providing the emic views of so-called beneficiaries met with various forms of resistance exerted by the existing structural, political, and economic powers' definition of what is appropriate in situations of armed conflict, and for people in low income countries. Bridging the gap between children's needs and priorities and those of NGOs was a tedious process, which sometimes provoked negative impressions on my part about the presence of NGOs in northern Uganda whose major objectives were of ensuring the wellbeing of people in conflict zones, yet their proposed beneficiaries continued to be exposed to various forms of suffering. In addition, although there was a gap between children's needs and most of the NGO activities, children's needs were not static. Children named mainly material needs, and mostly their choices were influenced by the context of uncertainty in which they lived. Take the example of exercise books above; if the children were assured of pursuing their education, perhaps their need would be met regardless of the timing of the intervention. However, after completing primary school, no child could tell with conviction that they would pursue their education any further. There is another category of needs which children identified, which have long term effects including enabling children to access their own immediate requirements such as shelter, safety, food, and water themselves. For example, children spoke of the need for a cessation of armed conflict so that they could return to their livelihoods. Meeting their long term needs, which could even enable the children to provide for their own short term needs, could constitute a comprehensive intervention. I could not, however, engage NGOs with this issue because NGOs were a-political, non-partisan, and not directly mandated to deal with armed conflict.

I mentioned earlier that humanitarian agencies were based in Gulu in 2004 to 2005 to provide *psychosocial*[3] support to vulnerable war affected people. The beneficiaries ranged from primary school teachers, children, community (read displaced persons camp) leaders, and counsellors. Some of the approaches used in interventions were sensitisation seminars and workshops in which people were taught how to identify traumatised children. One primary school teacher at St Peters Alero-Cuku displaced primary school instead pitched the importance of being trained to become a counsellor and on identifying traumatised children as a way to enhance his chances of being employed by one of the NGOs. Many primary teachers interviewed frequently argued how "Traumatised children are only those who were formerly abducted. These were easy to

[3] I highlight psychosocial well-being, because there is a profound conflict in addressing trauma - which is an individual's intrapsyche world, yet claiming to ensure social well-being. Social well-being encompasses economic and socio-political well-being of societies. Ensuring well-being of societies is therefore a more complex intervention as opposed to ensuring well-being of a collection of independent psychological beings in societies.

identify since they were introduced to primary schools by either GUSCO or WVCFAC [former child soldiers' rehabilitation centres]".

Sensitizing children about scabies, gender based violence, and malnutrition

At the time of this study, Noah's Ark was the largest night commuters' shelter. In large part due to the fact that many people were sharing limited shelter facilities characterized by poor sanitation, this shelter was struck by an epidemic of the infectious skin disease scabies in 2004. In response, Noah's Ark administrators and counsellors carried out sensitization seminars for the affected people about the importance of hygiene and using medicated soaps, including Protex. The centre manager particularly mentioned the need for giving extra sensitization seminars to children who appeared very dirty each evening when they came to the shelter. One such child, Ojok, was interviewed about his apparent laxity in his personal hygiene, culminating in the worst form of scabies. Ojok explained his condition in these words:

> These days I live alone in Laliya camp (about 7 kilometres northwest of Gulu town). I live alone because my parents in Opit left me there thinking it is a safe area from LRA abductions. Since it is dangerous to go to Opit to ask my parents for money, at the moment I do not have money even to buy food. How can I buy that that expensive soap Protex?

In one discussion with Noah's Ark coordinator about the likelihood that some children, severely affected by scabies, may need more than sensitization seminars or counselling for recovery, her response summarily reflected the non-readiness to go beyond Noah's Ark mandates of providing shelter to night commuters, and conducting sensitization and counselling. Fortunately, in Gulu MSF's intervention during August to September 2004 involved the dipping of children in a mixture of Benzyl Benzoate, thereby controlling the readily preventable scabies epidemic. The epidemic was only controlled rather than eradicated because night commuters were still at risk, especially of re-infection due to new members, other predisposing factors, and because the opportunistic conditions for infectious epidemics were left intact.

Further, there were nightly awareness/sensitization seminars for girls who spent nights at Noah's Ark. The seminars addressed topics of safety and gender based violence, including rape. In the seminars girls were counselled to report to the shelter early to avoid exposure to attacks and sexual violence, and about the dangers of interacting with people infected with HIV/AIDS.

Further, the World Food Programme (WFP) launched a maternal, child health, and nutrition programme in Gulu district in May 2006. The head of the WFP office in the district, Mr Amolat Pedro, disclosed that the programme would help reduce malnutrition in Uganda through educating mothers on maternal, children's antenatal, and post antenatal care.[4,5] In educating the mothers, however, WFP would be providing a less than effective solution to the problem of malnutrition of an impoverished population displaced from their livelihoods and mainly dependent on food supplies from the WFP at the time of this study.

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[4] The Daily Monitor, May, 4, 2006: Northern, p. 9.

[5] Contemporary literature however challenges intervention designs to sensitise or educate beneficiaries since other influencing factors could be of greater impact. Such factors suggested include poverty, poor living conditions and insecurity (Farmer 1999; Summerfield 1999: 1449).

Whereas it was a common practice to sensitize people confronting various afflictions and predisposed to various health dangers, during my fieldwork this approach contributed minimally to addressing such problems. The example below about disseminating information to the people at risk of contracting cholera will shed more light on my argument.

Other healthcare institutions' sensitization of the predisposed to cholera

In Gulu, numerous healthcare intervention agencies designed varied awareness messages about the spread, prevention, control, and management of cholera (to and by) persons in conflict zones in August to October 2005. Numerous sensitisation seminars were organised in camps and hotels to reinforce the dissemination of awareness messages about cholera. The District Health Coordinating Committee, headed by the DDHS, was overwhelmed by signposts, placards, radio announcements, and proposed sensitisation seminars about cholera from institutions including MSF, AMREF, UNICEF, WHO, AVSI (The International Service Volunteers' Association), UNICEF, and ICRC, to mention a few examples.

Gulu District Health Office, assisted by some of the NGOs with emergency healthcare package kits, ensured that a surveillance team managed cases at emergency cholera centres. The surveillance team recorded those who recovered and those who succumbed to this fatal infection. In summary, the Gulu district strategic healthcare plan for 2006-2007 cautiously reported the devastating effect of cholera, resulting in the treatment of over 1,000 cases in camps (Gulu DDHS 2006: 14). At Pabbo camp, an over crowded, fetid camp with poor sanitation and its entire population living in poverty and misery, polythene bags donated by AVSI were used to construct an emergency cholera management centre. That is how, for over five months while the cholera epidemic raged in northern Uganda, people were sensitised, taught, blamed, and counselled about cholera. In effect, and as discussed in Part III, the context in which the people at risk lived made it impossible to implement awareness messages about *Vibrio cholerae.* It is possible that making people aware of the dangers of coming into contact with the pathogens was important information, and that they could minimise the risk of being exposed to infectious agents. However, the fact that it took such a long time to control the epidemic is evidence that other concerted efforts, such as the provision of clean water, shelter, and sanitation facilities – such as when Pabbo camp was decongested into smaller camps – was a more effective approach. The latter approaches are consistent with what I call addressing the wider socio-economic factors linked to the spread and high prevalence of infectious diseases.

World Vision Centre for Formerly Abducted Children (WVCFAC)

At WVCFAC former child soldiers were received and Christian approaches to counselling were implemented to enable them re-live their lives. Rescued ex-combatants who were injured were treated at the centre clinic, and some were admitted at Lacor Hospital. Pregnant girls who were rescued were retained at the centre until they gave birth. In general, former child soldiers were counselled and thereafter reintegrated into communities. Children were counselled and reintegrated as victims. Children's kin were in the meantime sensitized about the innocence of former child soldiers, and their need to help ex-combatants re-live a normal life. However, at the time of this study, children in primary schools reported that former child soldiers' had escaped to Labora farm, located about seven kilometres on Gulu Kotido highway, because of the exclusion, slander, and

threats of retribution they experienced from the very same sensitized communities. In late 2006, Labora farm was closed, but re-opened in 2007 with a focus on teaching vocational skills to ex-combatants and youth in northern Uganda who were unable to pursue secondary school education due to lack of funds.

I met some reintegrated child mothers who preferred to live in Gulu town and attend vocational courses at Noah's Ark because of the rejection and slander they received in the communities which believed they still had links with their LRA 'husbands'. In extensive ethnographic investigation into former child soldiers' life worlds, children and ex-combatants disclosed particular disturbances by *cen* (evil spirits) (see Akello *et al*. 2006 for more details). Former child soldiers exhibiting symptoms of *cen* might signify that they had not worked through their traumatic experiences. It suffices to mention here that although it was expected that communities that were counselled and sensitized accepted reintegrated ex-combatants, this outcome had not been realized. And does the issue of the community's rejection and non acceptance of ex-combatants reflect a need for more sensitization seminars? In short, it appears that NGOs' activities of counselling and sensitization seminars amounted to giving less effective solutions to complex problems in wartime. Nonetheless, WVCFAC was instrumental in bridging the gap between the former child soldiers and the communities which previously totally avoided them, to a level where they could find their own living space within Gulu Municipality.

Gulu Support the Children Organization (GUSCO)

One of the key partners to SCiU and UNICEF was GUSCO. This partner institution mainly carried out traditional counselling with formerly abducted children prior to their reintegration with their kin. Traditional counselling here is used in reference to rehabilitation, and carrying out indigenous Acholi ceremonies such as stepping on an egg and other rituals including animal sacrifice to ensure the cleansing of former child soldiers. At GUSCO, counselling was also conducted through creative dances, singing peaceful songs, and elderly women were employed to do *wang oo* (stories of long ago around a fireplace) to enable the traumatised former child soldiers to relieve their memories of extreme events. Ultimately, the foregoing activities were also meant to ensure the mental wellbeing of ex-combatants. At GUSCO, ill or injured ex-combatants were treated and pregnant or child mothers were given health and material support.

To be sure that former child soldiers were accepted as innocent victims, communities and close kin were sensitized about the innocence and traumatization of former child soldiers, thereby promoting people's awareness about the issues at stake. In July 2005, during an in-depth interview with SCiU's northern region coordinator, he disclosed how out of the three hundred ex-combatants reintegrated into their communities, none of them had been traced during follow-up visits three months later. The ex-combatants had fled, mainly to Labora farm, others had re-joined armed struggle, and some preferred to live in areas farther from their sensitized communities and close kin for fear of retribution.

Caritas' persistent invitations and radio announcements for free counselling services

During the months of July-December 2005, there were announcements over local radio stations including Mega, Choice, and Radio Maria FM for people in Gulu to go to the NGO Caritas for free counselling services. It was argued that people in Gulu had been exposed to many extreme events, and therefore they needed to be counselled in order to ensure their psychosocial wellbeing. My visits to Caritas to assess the community res-

ponse to the radio announcements showed that virtually no persons sought the free advice.

The professional counsellor at Caritas gave conflicting views concerning this lack of response to the announcements inviting people for counselling. Her first response suggested that people lacked information about the importance of counselling. Therefore, she featured regularly on Radio Maria and Radio Mega FM to sensitize people about counselling. In those sessions, she urged people to "Come to Caritas counselling centre for free advice", but to no avail. In another session, her discussion assumed another tone:

> It is because these people, especially ex-combatants who are the major target group for our services, are so much used to material handouts. That is why they cannot envisage the importance of counselling. In my community visits to assess why child mother ex-combatants never report to Caritas for counselling but only asked for material support, I can only conclude that the respondents are unexpectedly tuned to material assistance instead of psychological needs. This could be because the girls, having stayed in captivity, were used to free material things. They were therefore dissatisfied with whatever support offered to them, which was less than the materials they grabbed.

If there was a limited response and resistance to attending counselling sessions by the very people, including children, who have been subjected to various forms of misery and hardship, then it is likely that Caritas' beneficiaries have different perspectives concerning how to address and confront their suffering than Caritas itself.

ICRC initiatives to ensure the wellbeing of people in wartime

In September 2005, the International Committee of Red Cross (ICRC) representatives took it upon themselves to sensitise different people, including children, in displaced primary schools about their presence in Gulu and their mandates. At one displaced primary school where I attended the sensitisation seminar, one twelve year old boy discussed what he knew about the Red Cross, upon inquiry by the ICRC facilitator:

> It is a group of people in Gulu who drive very huge vehicles carrying large flags. On their big white flags is a red cross.

The facilitator of the sensitisation session solicited for additional contributions, including asking if children knew where the ICRC offices were located. Here is another response from a thirteen year old child: "Red Cross often participated in district and national day celebrations through hiring an entire tent on their own and displaying the huge white flag with a red cross". Subsequently, the facilitator explained to the children their mandate and why they drove about with their flags. In short, he stated that the ICRC[6] was an international, non-political, non-partisan organisation employing staff in

[6] On the world Red Cross, Red Crescent day Piccolo – the ICRC communication delegate in Kampala highlighted what made ICRC unique among actors and institutions working in the north of the country to alleviate their suffering. He suggested that, as an institution mandated by States party to the Geneva Conventions of 1949 to protect and assist persons affected by internal or international conflict, ICRC worked for the faithful application of International Humanitarian Law that sets the rules to be observed and enforced during armed conflicts. They had therefore established their base in the north for this purpose and also that they should understand the conflict better. That the confidential dialogue they engage in develops in-line with its principle of neutrality, which prevents the ICRC from taking sides. Within their mandate and neutrality, ICRC delivered material support to hospitals and health centres and to train community medical personnel in the districts of Gulu, Kitgum and Pader. In early 2006 they donated equipment for the surgical theatre to Anaka hospital in Gulu district. In 2005 ICRC carried out malaria prevention campaign having distributed 40.000 insecticide treated mosquito nets in IDP camps where ICRC works. ICRC delivered non-food items to victims where huts were accidentally burnt

war zones to save lives. The flags were a protection for their staff since they warned all warring sides not to attack people in such vehicles, since that would be a criminal act.

At the end of the sensitisation session, the official welcomed the children to pay 1,000 shillings each (about 0.5 euro) to him so that he could register them as members of the ICRC. To the teachers and adults present he recommended that they register with a type of membership where they paid between 5,000–20,000 shillings (approximately 2.17–8.69 euros). Registered membership to ICRC would therefore help them to access tangible benefits from the Red Cross Society, mainly through being employed as volunteers to distribute non-food items when the institution secured them.

Collecting money from the impoverished people whom an NGO has come to help sent forth a confusing signal. This was partly because only a handful of children were able to raise the membership fee, but also because some children had to borrow the required fee for membership, expecting an improvement in their livelihoods through being employed by the ICRC. Seven months later, none of their promises were fulfilled by the Red Cross in terms of giving registered children their membership identity cards or employing them as volunteers.

To shed more light on the preceding point, I will add that one primary school teacher expressed his anger during interviews about his membership experience with the ICRC. He indicated making a remittance 20,000 shillings (8.7 euros) in the year 2000, though he had declined to renew his membership in 2005 since the five years he had paid for were expired. The teacher in his own words:

> I was very annoyed when after five years of paying 20,000 shillings, I had not got anything from Red Cross. I had paid for the best type of membership knowing anytime they would call on me to be employed or to distribute the non-food items in the camps. This never happened because at their offices there are always a group of youths mainly related to senior officers there. These are the people they recruit as volunteers whenever there is chance. Such chances are even very rare. I therefore stormed the office to demand for my money back. Since that day, the staff there fear me, but the good thing is that they organised quickly to refund my money. Now when they come to register members, I just look on since I know what they are up to. They just exploit the poor persons and I think they are making business with our money.

Evaluating the impact of state and NGO provision of healthcare services

The objectives for this chapter were to discuss my experiences of presenting to NGOs and other healthcare service providers what children regarded as their needs and priorities, and why people in the conflict afflicted region of northern Uganda continued to be exposed to various forms of suffering despite the presence of state structures and humanitarian agencies to ensure their wellbeing.

Results suggest that the state of Uganda, in addition to spending its limited income primarily on defence, has its provision of healthcare services guided by global – not local – policies. For children above five years, the state did not engage in critical reflection concerning what would be suitable for their healthcare. While it is true that in other contexts, such as in resource endowed countries, children of primary school age are a 'healthy group', results demonstrate that children of primary school age are in need of complex healthcare interventions to address infectious diseases and emotional

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down by fires such as in Pabbo, Padibe, Acholi Bur and Pader trading centre (Piccolo G.L. (2006) "Making audit of ICRC role in war-torn northern Uganda" in The Daily Monitor, May 8, 2006: 12)

suffering. In addition, as a consequence of limited state spending in healthcare, there was subsequent dilapidation of infrastructure and generally poorly motivated professional healthcare workers, most of whom had to flee to safer areas of the world due to the prolonged civil war in northern Uganda.

Since the state's provision of healthcare services was guided by global policies, its focus was too narrow in terms of meeting children's needs. It appears that global healthcare policies are directed with limited interest to fund such projects in developing countries. It could be that the healthcare policies and projects implemented are meant only to complement the state's role in providing healthcare to its citizens. The state's sole dependency on such policies therefore reflects its own inadequacies and inappropriate priorities in healthcare spending. Moreover, due to budget shortfalls, Uganda relies mainly on donor funds for health sector planning. Therefore, Uganda had little choice but to be guided by global policies for its health sector at the time of this study. Closely connected to the above point is the idea that global policies are sometimes imposed on developing countries. For example, since the mid 1980s when Uganda adapted Structural Adjustment Policies (SAPs), even pharmaceuticals have become commodities in the market. Although I have proposed that it is appropriate for children to engage in curative approaches addressing infectious diseases given the context in which they lived, the dangers of the availability of such medicines as commodities has also been widely discussed.

Further, the national constitution obliges the state to protect and provide health services to its citizens. One of the concrete ways in which the state could improve the dire contexts in which people in northern Uganda live is in ending the civil war so that Acholi people and other ethnic groups can resettle in their communities and return to their livelihoods. In their communities, Acholi people were known to be self-reliant, hardly exposed to infectious epidemics, engaged in various indigenous approaches to minimise their emotional distress, and were able to access their daily material needs. In Chapter One I mentioned how the Acholi sub-region used to be the food basket of Uganda, but that with the civil war it was mainly Acholi people who were reduced to settlement in camps and subsequent dependency on World Food Programme rations. In addition, findings have shown that this context of uncertainty influenced Acholi people's approaches to dealing with their daily challenges in various ways. For example, although children mainly managed their commonly experienced illnesses in the popular sector, it was through short term curative approaches. Children resorted to simple somatic curative approaches even for complex forms of suffering.

This brings me to the issue of my attempt to bridge the gap between children's needs and priorities with those of the NGOs. It has been discussed above that communicating beneficiaries' needs and priorities to the humanitarian agencies felt like going against the tide; I met various forms of resistance and to some extent hostility. I believe that the intervention agencies were already aware of their beneficiaries' needs, but their hands were tied as their functions were guided by pre-set mandates. It also appears that humanitarian agencies have limited budgets. Therefore, adapting to the viewpoints of their beneficiaries (whose needs were not static), would be costly. Perhaps it is better to operate within limited mandates and objectives rather than stretching beyond a project's budget, which will again lead to failures. But then again, looking at the way NGOs operated, and the overt impression put across about expenditures for workshops, I believe it could have been possible to move beyond simply sensitizing people at risk and implementing sub-standard healthcare projects, if the beneficiaries' perspectives were taken

into account. However, as I have demonstrated, NGOs had pre-set guidelines about providing psychosocial support, and the mandates were not consistent with beneficiaries' priorities or needs. And often, what was on paper was different from what they implemented. However, a few NGOs made an impact in the communities with their presence and project activities. NGOs including Save the Children, World Vision, ICRC, UNICEF, NRC, GUSCO, Caritas, AVSI, War Child, WHO, AMREF, and MSF provided some basic needs, promoted awareness about complex wartime issues through sensitisation seminars and counselling, and sometimes provided material needs.

Empirical data about the sensitising of people at risk of infection from cholera and scabies epidemics suggest the limitedness of this approach in promoting wellbeing. According to Chambers (1994), top-down approaches risk failure since beneficiaries find them less useful. If development experts such as Chambers (1994), Weiss (2000) and Lieten (2003) recommend that beneficiaries identify and prioritise their needs in project design, then SCiU and indeed a substantial number of NGOs' approaches to alleviating wartime people's suffering are not consistent with contemporary development approaches. This chapter proposes micro-macro level approaches in project planning, suggesting that by integrating the experience-near perspectives of the target population regarding what is relevant for healthcare interventions would ensure greater project success. For example, if children identify and prioritize material needs as ways of alleviating their suffering, then it would be appropriate to integrate such perspectives into projects planned for them.

Another proposition in is that emergency intervention should not be a prolonged process. There were numerous aid agencies in Gulu which had been stationed there for a long time, some of them for a period approaching twenty years at the time of this study. Twenty years is not a short time. This clearly undermines the claims of offering simply short-term emergency aid to ensure the wellbeing of people in conflict zones.

It is possible that the target population's needs and priorities might be too costly to implement. Take for instance the ending of armed conflict: how much in terms of additional financial costs would that entail, for an institution which has established its offices in Gulu only to carry out the counselling of traumatised people and sensitization about their problems? Are donations even available for such projects? Perhaps, however, an immediate redress of the core issue of armed conflict would have minimised the huge expenditures made in a prolonged emergency intervention. This argument likely suggests that it might be a donor preference to fund short term, inexpensive ventures, including counselling and sensitisation seminars, as opposed to major interventions to alleviate vulnerable people's suffering.

What hangs in the balance now, and what I will question, is the genuineness of this interest – to ensure the wellbeing of people in conflict zones – of the very people who report this as their main objective. Could it be that an experience-distant definition of suffering is quite different from an experience-near stance, and that this is why we have numerous seemingly experience-distant interventions to alleviate suffering in wartime Gulu which hardly meet the needs and priorities of the target population? Perhaps that is why mainly failed intervention projects were found, which offer only simple solutions to complex problems in wartime. If interventions in this context left a lot to be desired, I propose that the so-called beneficiaries should view these interventions simply as alternative approaches to their suffering. In effect, they need to come to terms with the fact that they are obliged to deal with their daily challenges themselves, rather than rely

upon external help, much as the external help could constitute part of a holistic approach to their well-being.

Having said that, I recognise that interventions in a contemporary emergency aid situation pose problems regarding the dangers of investing in a conflict stricken area. Such dangers include the fact that structures can easily be the target for attacks and demolition in gunfire exchange, and that even where there is investment, people will not necessarily utilise these facilities due to the insecurity which such visible investment attracts. The points provided still link to the basic question of an urgent need to inquire into beneficiaries' needs and priorities before establishing emergency aid institutions. And if the priority of the beneficiaries' was to end armed conflict as early as 1986, then the issue of a fear of investment in conflict would not even arise two decades later. In connection to the foregoing argument, I recognise that interventions in line with vulnerable people's priorities and needs might not attract donors due to their high costs. The argument was summarily put in the question of sustainability.

Conclusion

The empirical evidence above suggests that healthcare interventions to promote the wellbeing of people in wartime have yielded limited success.

(1) State implemented projects are guided by external healthcare and financial institutions such as the World Health Organisation, the World Bank, and the United Nations Children's Fund. I agree with Farmer's (2003) assertion about structural violence and violation of human rights in the provision of healthcare services. There is conflict between attempts to redefine what is essential for children above five years in developing countries, and what these children's healthcare needs and priorities actually are. Having said that, I must make it clear that aid itself – including healthcare aid – cannot and will not sustainably meet the needs and priorities of people affected by civil war, or the needs of the recipients of aid. Therefore I propose that the Acholi people themselves, even when living in a hugely disempowering context, need to innovate appropriate approaches towards alleviating their suffering, and must view interventions by the state and NGOs simply as an alternative approach to their end.

Further, I suggest that the state of Uganda should put a limit on the asymmetrical investment in ammunitions. The funds could then be invested in healthcare and other development projects. Dilapidated and non-functioning healthcare structures could be renovated, and equipped and trained personnel could again have confidence living and working in northern Uganda. The redirected funds from the Ministry of Defence could also be used to remunerate poorly paid healthcare professionals.

(2) Although there was a high representation of humanitarian agencies in this conflict zone, all with the main objective of alleviating the suffering of vulnerable people, humanitarian agencies functioned only within preset mandates. Such preset mandates only occasionally addressed beneficiaries' actual needs and priorities.

(3) Experience-near based researches may contribute relevant and desirable ideas for project design. This is an approach where interventions are guided by what beneficiaries identify as their needs. However, these ideas may be difficult to implement, because: (i) they might necessitate a complete change of focus in emergency intervention, from alleviating suffering in 'conflict zones' to taking concerted efforts to

address the armed conflict itself; (ii) the latter, in the main, are expensive projects which raise issues of sustainability from donors. Such ideas in project design are likely to attract limited emergency funding; and (iii) emergency aid institutions, on the other hand, are guided by their focus on being urgent, short term, a-political, non-partisan, and non-profit institutions.

(4) Perhaps it is the right time for war-affected people in northern Uganda to focus on their own resources and attempt to address their own needs and priorities. The approach of defining and addressing their own needs, including the management of common illnesses in the popular sector, appears to yield desirable results other than reliance on the state and humanitarian agencies in alleviating their suffering.

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Concluding remarks

Examining children's suffering and quests for therapy in the context of an ongoing civil war in northern Uganda was done with an aim of generating recommendations so that their 'right to health' can be met. In this concluding chapter, I extract the main insights generated from the preceding chapters and illustrate how I formulated some of the propositions. I will also reflect on the epistemological issues, theoretical and methodological approaches. Since suffering is an illness experience whether due to infections or emotional distress, I will examine main insights in these illness categories. Children confronted their suffering, through use of medicines and other coping mechanisms. In analyses, I will examine the efficacy of children's approaches in minimising their suffering, what was appropriate-given the context in which they lived and also propose approaches concerning how the prevalence of infectious diseases and emotional distress would be minimised. The themes analysed cover commonness of infectious diseases, children's focus on curative approaches in management of infectious illnesses, the importance of preventive approaches in the control of infectious diseases, children's quests for therapy for emotional distress, policy and intervention agencies' approaches in healthcare, epistemological issues, reflections on theoretical and methodological approaches. I will start with an analysis of children's differential mentioning of the health complaints which affected them by narrating mainly experiences with illnesses of infectious nature.

Commonness of infectious diseases

In general, infectious diseases, or complaints which were clinically- or self-diagnosed as infectious diseases, constituted the highest proportion (85%) of the illness burden among children. Thus I examined one of the major findings of this research, asking why wartime children so readily discussed their illness experiences resulting from episodes of infectious diseases, which in some cases became epidemics. I propose that children

readily shared their experiences with infectious diseases because they are acute, primary, and cause a rapid deterioration of the bodily condition. Experiences with infectious diseases need immediate attention. Children's discussions further imply that they were making explicit what their healthcare needs and priorities were. This finding is consistent with a skewed focus on the management of infectious diseases as opposed to war related emotional distress within the biomedical sector (professional sector in Uganda) of the pluralistic healthcare system. In addition, in the popular sector (where sick children accessed herbal medicines and prescription-only pharmaceuticals) and the professional healthcare system had avenues whereby complaints with experiences of infectious diseases could be systematically presented and addressed. Children's perspectives could be an indication of the high prevalence of such infections, and the fact that they are life threatening.

In light of the latter argument, commonness is interpreted as a concept constituting a triad of sub variables, namely priorities, frequencies/prevalence rates, and effects of the existing healthcare discourse. Children mentioned largely infectious diseases as common health complaints which affected them because (1) they are considered priorities by the children due to the deterioration of their bodily condition as a result of these diseases; (2) prevalence and incidence rates of these infectious diseases are high and they reoccur frequently in the same child; and (3) in children's experiences there is no place within the existing healthcare system and discourse for presenting other 'common' illness, such as the complex emotional distress directly related to the war.

The context in which the children lived was characterized by poor living conditions, congestion and overcrowding, abject poverty, a lack of basic necessities including clean water and food, and insecurity. This context provided opportunistic conditions for infections and re-infections with disease causing organisms. I have given examples of how scabies, cholera, and eye infections were experienced as easily preventable yet widespread and problematic epidemics among wartime children because of the context in which they lived. It was discussed how scabies affected mainly children in displaced primary schools and night commuters' shelters. In fact, scabies was frequently referred to by displaced people as *baghdad* – both a euphemism for night commuters' shelters and for a disease of dirty people. Indeed, children who spent nights in night commuters' shelters often appeared dirty. However, there is substantial evidence that many of the dirty children were unable to practice hygienic living due to a lack of basic necessities such as living in a spacious environment, having a bed to oneself, and access to adequate washing facilities, extra clothing, and even soap (let alone the special medicated *Protex* soap). These conditions indicate the wider socio-economic factors which predisposed night commuters to an epidemic of such an infectious skin disease.

Although throughout the book I mention that concerted efforts to address these broader socio-economic issues would constitute an effective way of controlling infectious diseases, the children themselves mainly used short term, curative approaches, accessing pharmaceuticals and herbal medicines to minimise their suffering. I will now shed more light on such curative approaches.

Children's focus on curative approaches in the management of infectious illnesses and emotional distress

For health complaints of an infectious nature – and indeed psychological suffering – children used pharmaceuticals and herbal medicines to restore normality. The pharma-

ceuticals children used included antibiotics (28%), psycho-pharmaceuticals (16%), antipyretics (15.6%), antimalarials (14.4%), and Benzyl benzoate (8%). During my fieldwork, ill individuals could readily access pharmaceuticals including prescription only medicines such as antibiotics and antimalarials. At state aided health centres, clients would be given pharmaceuticals if the hospital pharmacy had them. It was common also for clients to be instructed to purchase their own medicines from private sources when the hospital's stock of medicines had been distributed out. The quality and quantity of medicines sick people accessed from private healthcare providers was determined by the amount of money they had. The availability of medicines as commodities not only provided quick solutions in the symptomatic management of illnesses by children, but children were also thus exposed to various dangers such as misuse, over-use, and even dependency on pharmaceuticals. For example, children, healthcare workers, and persons who sold medicines readily purchased, prescribed, or sold antimalarials for symptoms of *koyo, abaa wic, lyeto* and *malaria madongo*. In effect, there was an over-use and misuse of antimalarials because it was not possible to do blood smears to ascertain the presence of malaria parasites. In addition, some symptoms which children self-diagnosed as a malaria episode in fact signified emotional distress.

The main approach of frequently seeking medicines to treat illnesses appeared to be but a temporary solution. Re-infections were a common occurrence among children. For example, during the time when the scabies epidemic was rampant, especially in night commuters' shelters and displaced primary schools, some children told me how they had used *Opele* (Benzyl benzoate) and had recovered. However, they would again contract scabies from a neighbour at the night commuters' shelter with whom they shared a mat and blanket. I could give more examples about the dangers of infection and re-infection with pathogens responsible for cholera, malaria, tuberculosis, and eye infections, due to the context in which the children lived.

In essence, the most effective way for the children to avoid getting scabies, for instance, was not only to avoid situations where they were exposed to contagion (e.g. from those already suffering from the disease), but also to ensure that their own environment was not a breeding ground for disease causing organisms. The latter spells out a preventive approach to scabies infection. While I recognise that preventive approaches constitute the most effective ways of dealing with infectious diseases, it is proposed that for the children, such preventive measures were impossible to implement, while it was suitable or fitting for them to engage in short term curative approaches, given the context in which they lived. Engaging in curative approaches was the best they could do to minimise their suffering, because the children lived in camps, night commuters' shelters, congested suburbs within Gulu Municipality, and attended displaced primary schools characterised by poor sanitation, congestion, the presence of those already infected with various contagious pathogens, and a lack of sufficient basic needs. In addition, due to insecurity, children had little choice but to live in these institutions for their own safety. In light of this, it is hardly comprehensible how such children could engage in preventive methods of infectious disease control and management.

Importance of preventive approaches in the control of infectious diseases

Preventive approaches in the control of infectious diseases imply that the people at risk should avoid being exposed to disease causing organisms. This could be through breaking the life cycle through which the pathogens are transmitted. For example, since cholera pathogens are transmitted through an oral-faecal route, people at risk should prac-

tice hygienic living, good sanitation, and avoid contact with Vibrio cholerae. I argue that such an approach would be preferable to a more curative management of cholera, where the people affected or those in danger of contagion use medicines.

Further, it would also be preferable for children to prevent infections and re-infections with Tubercle bacilli. However, I examined the context in which the child called Okello, who had tuberculosis, lived. The sick boy lived together with his four siblings in one hut, and they shared household utensils and other basic things. The child in question is believed to have contracted tuberculosis when he was the primary caretaker of his sick mother, who had contracted tuberculosis as an opportunistic infection secondary to HIV/AIDS. At a dilapidated structure at GRRH where such patients were admitted, patients and caretakers had to provide their own food and medicines. Given the above scenario, I conclude that the broader socio-economic context in which these children lived made it impossible for them to engage in effective preventive approaches in dealing with infectious diseases.

I have therefore only analyzed (short term) curative approaches in dealing with infectious diseases. They are short term because the children's approaches are limited to attempts at finding a cure and minimizing suffering, regardless of the fact that preventive methods are long term and more effective in dealing with infectious diseases. I cannot at this stage envisage a phenomenon where children can intervene in order to 'make infectious diseases a history'. Although the World Health Organisation emphasizes the importance of early diagnosis and effective biomedical treatment as one of the key factors in preventing high levels of malaria related deaths in Sub-Saharan Africa (WHO 2005: 9), I argue that curative approaches might be efficient but not effective. Emphases on curative approaches in healthcare provision amounts to offering substandard care to those mainly afflicted with infectious diseases in the context of armed conflict.

Children's quests for therapy for emotional distress

Although the children were reluctant to discuss their severe experiences during armed conflict (see analysis of this phenomenon in Chapter 12), when certain approaches were employed – including holding workshops to discuss severe experiences and medicine use in wartime, using vignettes, and conducting individual interviews – the children disclosed various forms of psychological suffering and revealed the core causes.

Extraordinary events which children experienced included loss of close kin, sexual violence (sometimes predisposing them to infections with HIV/AIDS), child abductions, living in child headed households, loss of property, living in misery, and abject poverty. The children who experienced such extraordinary events frequently expressed their distress in terms of stomach aches, something invisible but painful moving around the body, persistent headaches, *cen* (evil spirits), *tipu* (spirits of close kin or harmless spirits), *can* (emotional pain) and *can dwong ataa* (deep emotional pain). In extensive follow-up of the children who disclosed their severe experiences, they told me that they dealt with *cen* or *tipu* by using medicines for sleep, joining the armed struggle, applying *atika* to incisions on the forehead with the help of an *ajwaka*, and through regular participation in healing services. Children engaged in income generating activities such as fetching water for sale, doing *leja leja* (farm labour), and seeking material support from NGOs in order to access basic needs, however children were often turned away since many NGOs usually channelled any assistance to their beneficiaries through partner NGOs and not directly to individual children.

Evidence suggests that displaced children used Piriton and Valium as remedies for sleeplessness. In a region where medicines are readily accessed over the counter based on the symptom experienced, it is easy to access medicines for sleep. This scenario is facilitated by the limited control measures regarding the distribution of pharmaceuticals. The general trend in Gulu at the time of the study is that pharmaceuticals were accessed as commodities, where individuals' purchasing capabilities significantly predetermined the quality and quantity of medicines accessed.

The taking of pharmaceuticals constitutes a curative approach to emotional distress. Another type of curative approach to psychological suffering, which was mainly implemented by intervention agencies, was counselling. Counselling is a trauma focussed approach intended to ensure wartime children's mental wellbeing. It is argued that through story telling, promoting creative plays, singing peaceful songs, and doing traditional dance, children will be able to relieve their trauma, and thus move on. In Chapter 13, I demonstrate how there was a basic conflict between the contextual approaches adopted by the children to deal with their emotional distress, and the approaches introduced by national and international agencies.

Further, I have presented reflections on the issue as to why displaced children were reluctant to discuss their emotional distress, or only discussed them in somatic idioms. It is argued that given the context in which many people had to deal with the consequences of being exposed to extreme wartime suffering, silence was a suitable approach for minimising psychological distress. During my fieldwork, both professional and indigenous approaches silenced distressed sufferers, often by telling them of how someone else with comparatively worse experiences had successfully confronted them and carried on with life 'as normal', and did not constantly express their misery to others. In the displaced persons' camps and various suburbs in Gulu Municipality, people rewarded those who did not express their distress or exhibited a stoical façade. Other coping strategies were a general disregard of others' psychological suffering, ridicule of the victims of violence (including sexual violence), and sometimes blaming of the victim. The approaches in dealing with psychological distress had nevertheless led to the adoption of legitimised body complaints as an expression of the same distress. For example, distressed people often complained of stomach aches, persistent headaches, something painful moving around the body, and *cen*. One health consequence of this phenomenon was that both sufferers and healthcare providers focussed on the body, and administered analgesics, antimalarials, and sometimes antibiotics. Since the core causes of the distress remained unaddressed, the results are a persistence of somatic bodily complaints.

In effect, much as I recognise that there are no simple ways of dealing with psychological distress, I critique the existent curative approaches, especially those focusing on the physical body. My argument is that a focus on the body blurs the core causes of distress and prolongs or even increases the severity of psychological distress. Nevertheless, it is recommended that it is better for distressed persons and indeed people dealing with other chronic illnesses to still engage in the short term curative approaches to minimise their suffering, as they often provide an unintended cure, an issue to which I now turn.

Unintended cure realized through quests for therapy for emotional suffering

In Part III, I coined the term 'unintended cure' to signify what is achieved by caretakers' and sufferers' persistent quests for therapy for chronic illnesses. I suggest that there is

some form of fulfilment achieved, including a resigned attitude about the suffering or coming to terms with an inability to solve the issue at stake. Unintended cure therefore encompasses a triad of care for the ill individual, an engagement in various existing ways of restoring normality, and subsequent acceptance of the inability to solve the problem. This qualifies as an unintended effect of the quest for therapy because the intention is to find a remedy, for instance from *cen* and persistent headaches. However, failure to find a remedy through the various curative approaches which the children mentioned still leads to a kind of cure. To put it differently, failure to deal with the symptomatic presentation of emotional suffering itself is still a better state for the persons engaging in quests for therapy than a complete lack of attempts to deal with the issue at hand.

Such a resigned attitude, acquired after various (failed) attempts at a quest for therapy, relates to children's analyses of all the procedures they engaged in, even those for chronic conditions like *can* (emotional pain) and *can dwong ataa* (deep emotional pain), exemplified by their conclusion that *can en cango kene* (this suffering heals itself). In effect, the children were hinting at the achievement of the unintended cure, suggesting that they realise that some forms of suffering might need less interference in terms of pharmaceuticals or medical attention. It is also better to leave affected individuals to devise their own approaches towards minimising can or *can dwong ataa*, thereby allowing them to come to terms with their suffering. Just allowing the sufferer to deal with such problems themselves constitutes a call for minimal interference by stakeholders, where standard practice is that short term curative methods are employed to alleviate suffering. The dangers associated with short term curative approaches are that the suffering may in fact be made worse, since individuals are discouraged that the various approaches they are implementing are not necessarily solving the problem in a more concrete way. Sufferers are pushed further into oblivion regarding knowing what is appropriate, what is acceptable, and what can be practically implemented given their individual context. The latter spells out the limitations of a dominant focus on the trauma effects of war, which is often the approach adopted in conflict zones. Nevertheless, when a health complaint is viewed as social processional suffering, an individual sufferer may not need to engage in short term processes which lead to over-use of pharmaceuticals for their condition.

Collective or social processional suffering and quests for therapy

I coined the concept social processional suffering to describe a phenomenon whereby some forms of suffering take on dimensions outside of the affected individual. Examples of this include: (1) where the ill individual's condition directly affects the close kin and his or her society; (2) where the suffering has no particular loci of reference, and various methods exist to manage it; and (3) where there is a need to view chronic conditions as processes of suffering, which may or may not have the outcome of healing. Regarding the latter, engaging in various procedures (holistic approaches) to deal with chronic wartime emotional suffering may lead to the gradual minimising of its symptomatic presentation.

However, depending on the duration which an individual or society has experienced an extreme event, even holistic approaches may not minimise suffering. An example I will give here is when children frequently concluded their severe narratives by saying, "Even when you are given everything, there is no way to enjoy such a life". In fact, a chronic form of suffering like *cen* (spirit possession in this context) is unique in terms of

being an exemplary form of social processional suffering, because not only does its symptomatic presentation affect societies as opposed to only individuals, but also the process of finding a therapy should not only focus on the sick individual but also the entire society, or all individuals closely engaging in this process. In addition, if a child experienced *cen* at school, not only would the individual sufferer be affected, but their classmates and teachers as well. Subsequently, when children reported communal or collective organisation occurring to visit the *ajwaka*, I can see a societal or collective quest for therapy and collective healing, though sometimes such a community may again face disappointment. In other words, for chronic suffering which may affect not only an individual but also his or her social network – a phenomenon called social processional suffering – there is a need to view the process in the quests for therapy as vital not only for the individual sufferer, but also for the society, thereby leading to individual and collective healing or at least an unintended cure.

In fact, it appears that the best approach in dealing with complaints symptomatic of emotional suffering might be in acknowledging the suffering and subsequently providing a conducive environment through which the healing may slowly take place. By conducive I refer to exhibiting restraint in determining the amount of time such a healing process should take, engaging in various contextually appropriate approaches – or what sufferers themselves consider as effective ways to minimise such suffering, enabling the distressed people to talk about their suffering, and learning how to address them without silencing them. This means listening to and acknowledging the sufferers' narratives, and where possible, steps must be taken to address the core social causes of the problem. The foregoing argument is not consistent with both the indigenous and professional approaches of dealing with emotional distress in northern Uganda. Although I argued that silencing sufferers could have been the best way to cope in the context where there were virtually the entire population had to deal with severe experiences, I propose that the approach of encouraging open communication and discussing of the severe experiences will be one of the ways of addressing emotional distress in post-conflict context.

Other approaches to dealing with psychological suffering

Some indigenous approaches to address core causes of distress recommended by Latigo (2008: 101) include enabling the aggrieved to access traditional justice. In the Acholi region, traditional justice mechanisms are *Culo Kwor* (compensation), *Mato Oput* (drinking of bitter roots), *Gomo Tong* (bending the spear), Nyono *tong gweno* (stepping on an egg), and *Moyo Piny* (cleansing the area). Latigo (2008: 108) proposes that the conflict in northern Uganda has revealed that there is a rich body of traditional systems of law and justice that reflect the principles of conflict management, with both retributive and restorative elements. In restorative justice, the objective is to reintegrate the perpetrators back into their communities and reconcile them with their victims. Reconciliation is promoted through a process of establishing the truth, eliciting confessions, reparations, repentance, and forgiveness. The precursor for all these processes of societal recovery is acknowledgement of the issues. Forgiveness opens the way for individual and collective healing. Such insights were not, however, obtained from the child respondents, but mainly reflect adult viewpoints on dealing with emotional distress. If they constitute part of the holistic approach towards managing wartime distress then their effect needs to be explored in another study.

It is important to note that the traditional mechanisms mentioned in the preceding paragraph were practical for intra-Acholi crimes where one individual committed one atrocity against another person or group of people within clans of the Acholi ethnic group, and where there were clear perpetrators and victims. In 2005, however, the prolonged civil war had affected also the Langi, Madi, Iteso, and other ethnic groups to varying degrees. In addition, there were complex scenario(s) involving child abductions where victims themselves were forced to carry out atrocities, or did so on their own initiative. It was common to find one individual who committed many atrocities, even against his own kin. These were not atrocities which traditional mechanisms of justice were designed to address. However, the basic principles underpinning the traditional mechanisms of reconciliation might lead to healing of the aggrieved. This is because the principles of conflict resolution among the Acholi are intended to create reconciliation by bringing the opposing sides together through the intercession of elders, leading to the acceptance of responsibility and an indication of repentance.

Another concluding insight is that wartime children need to view the state and international organisations' presence in Gulu as an alternative approach, or part of the holistic approach, to alleviate their suffering. Recognising that the major responsibility to minimise their suffering lies within themselves will also help people affected by war to avoid becoming dependent upon the state and intervention agencies, or even blaming them for their hardships. Generally speaking, people affected by war living in developing countries need to understand that sustainable solutions to their suffering must be innovated and implemented by the affected people themselves. Whereas in a situation of ongoing insecurity the engaging in short term curative approaches to minimise psychological suffering is a suitable approach, with the hoped-for cessation of armed conflict and resettlement in their communities, the people of northern Uganda will need to engage with their past experiences and challenges in order to move on sustainably.

They could start with short term approaches including accessing pharmaceuticals for infectious diseases, but gradually they will need to engage in activities to prevent infections, perform contextually suitable ceremonies to deal with bereavement, forge new social networks, perform *guru lyel*, acknowledge others' suffering, participate in healing services organised by Pentecostal churches, and devise possible means for dealing with their daily challenges. If deprived children engage with their own challenges they will not only be motivated to devise various means to minimise their suffering, but also there will be a consequence of appreciating externally based interventions as an alternative approach to their wellbeing. In Part III, I demonstrate how children frequently accessed pharmaceuticals in their quests for therapy for common health complaints. And whereas the children proposed various concrete ways of minimising their distress, the dire context in which they lived prevented them from implementing such approaches like *guru lyel,* going back to their villages, resettlement, and engaging in income generating activities. In light of this, I propose restraint on the part of intervention agencies, particularly in the way they communicate their objectives to their targeted population, which often had the effect of instilling in children's minds that they could easily access solutions from wartime intervention agencies.

Policy and intervention agencies' approaches in healthcare

The Gulu District Directorate of Health Services (DDHS) was the implementer of state healthcare policies in northern Uganda where this study was conducted. In Chapter 13, I

mentioned how in late 2007 the DDHS was renamed the District Health Office, but that their mandates remained unchanged. Concerning policy issues focussing on the provision of healthcare services to children of primary school age, I critiqued the narrow focus on de-worming, oral hygiene, and vaccination of girls of reproductive age. The premise for this critique is based on what children themselves identified as their healthcare needs and priorities.

Further, the DDHS in Gulu implemented curative approaches for and promoted awareness of infectious diseases and emotional suffering. When the district experienced epidemics of an infectious nature, including cholera and scabies, the DDHS was overwhelmed by awareness messages designed by various intervention agencies based in Gulu at the time of the study. People at risk were sensitized about various infections, how the pathogens were transmitted, how to avoid becoming infected, and informed that they should ensure that the sick are taken for medical attention at designated emergency centres. Awareness messages were disseminated through sensitization seminars, placards, t-shirts, and local media, especially radio stations. Various intervention agencies sensitised people about the trauma effects of war, and proposed that girls should avoid conditions which could expose them to sexual violence. Regardless of the two approaches taken by the DDHS and NGOs, there was nevertheless a persistence and recurrence of epidemics and psychological distress. Subsequently, I critique the narrow approaches of simply giving medicines to the sick and promoting awareness among those at risk as a strategy to manage and control common infectious diseases. This is because the dire socio-economic context in which those people targeted with the information lived limited their abilities to implement the information about the diseases. Addressing the broader socio-economic causes of infections (preventive approaches) constitute more effective ways of managing and controlling infectious diseases. However, if the district DDHS activities are facilitated by a very small budget, and they are constrained to align their service provision within what is defined at the national and global levels, then the main task of ensuring wellbeing and meeting health needs still falls upon the Acholi people themselves.

Concerning modes of addressing psychological suffering, the perspectives of the target population were not consistent with intervention agencies' approaches. In a large part, humanitarian agency projects ignored the holistic character of the impact of the war on people, such as the erosion and disintegration of social groups and the social exclusion of direct victims of human rights violations. The conflict affected people were often left to themselves, and where there were attempts to address children's suffering, emphasis was on their traumatisation within a narrow psychological discourse. While it is possible that wartime children did need psychological help, they identified and prioritized food, household utensils, scholastic materials and school fees, lack of shelter, difficulties in taking care of their sickly kin, and a need for protection against LRA abductions and gender based violence. Most of children's material, social, and psychological problems are interlinked. Social and material problems may lead to psychological problems, while psychological problems may lead to social problems. Focussing on the inner psychological problem was found not to be effective in alleviating children's distress in Gulu.

As discussed earlier, it is possible that if war affected people viewed the state and other healthcare intervention agencies as an alternative approach to alleviating their suffering, there would be less dependency on their activities. Nevertheless, intervention agencies always communicated their mandates to suggest that NGOs were obliged to

ensure children's wellbeing. Therefore, I suggest that intervention agencies need to reframe their objectives to clearly state that they can only offer an alternative approach to alleviating wartime suffering, and that much of the responsibility to minimise wartime suffering falls upon the war affected people themselves. This could help the target population to emotionally prepare to deal with their daily challenges, thereby minimising dependency. In addition, when the target population resist or suggest different approaches through which their needs might be addressed, their ideas must be acknowledged and not pathologized, as it was during my fieldwork. In effect, saying that NGO intervention is only an alternative approach to alleviating people's suffering will (1) help the people targeted to appreciate the additional services they receive from intervention agencies, and (2) ensure that the intervention agencies are not overwhelmed with constant demands by the vulnerable people.

The dependency of the children's mindset which believes that NGOs will solve most of their problems in my view could further be checked by allowing only a limited number of NGOs to implement their objectives in conflict zones. What is more, if so many NGOs wish to implement their activities in one region, there needs to be an institution to coordinate such activities to ensure maximum effect and minimum overlap, and further to monitor activities and verify whether what is implemented is what was promised. The duplication of activities by intervention agencies was especially visible at times when Gulu experienced epidemics of infectious diseases. In sum, having a coordinating institution to moderate and approve various healthcare interventions in Gulu would have been useful not only to avoid duplication of activities which sometimes bordered on competition, but also would ensure that the target population will not have gained the impression that with the presence of so many institutions, their problems will be addressed according to their needs, while the very institutions they looked upon faced their own challenges.

Epistemological issues

The main epistemological issue which underpinned the process of data collection, and the knowledge which was privileged in the data analysis and report writing, was my personal involvement in this study. This implies that I acknowledged the importance of shared subjectivities in the assessment of children's suffering. I make it explicit in Akello (2007: 39-58) that consciously or unconsciously, my being an insider and participant observer (more precisely a proximal participant observer as opposed to detached participant observer) had a role to play in the entire research process.

For example, my own childhood experience of living in the dire circumstances of poverty, poor sanitation, hunger, and being an orphan exposed me to various easily preventable diseases and emotional distress. During that period, despite the awareness and experience of the health dangers directly linked to my dire context, it was not possible to practice preventive approaches in the control of infections and distress. The main resort was to short term curative approaches using pharmaceuticals and herbal medicines. Through my experience, I know how the provision of material needs can be more effective in alleviating distress than the trauma focussed approaches which were frequently implemented for wartime children.

Taking care of a close kin member sick due to a chronic illness prior to my fieldwork also contributed to the awareness of an intersubjective experience with the children. I know of the challenges of trying to meet the needs of my sick kin with only a meagre

income, and the stress involved in managing frequent opportunistic infections. I fully understand the emotional pain of taking care of close kin who themselves experienced varied levels of distress and lived in uncertainty of recovering from an illness. I have also lost a substantial number of close kin and friends due to HIV/AIDS and other misfortunes. Therefore I argue that in examining the illness experiences of children, particularly those living in child headed households and/or taking care of sick kin due to HIV/AIDS, I was assessing my own childhood and even my own experiences as an adult. In effect, the knowledge generated and discussed in this book constitutes an intersubjective narrative of the children's and my own experiences. Subsequently, one of my main arguments is that the experiences of the researcher have an effect on the knowledge production process, and determine whether s/he will understand the respondents' perspectives, which questions will be asked, the way information is interpreted, and whether the respondents can recognise and identify with the perspectives in the study outcome.

In Akello (2007), I chronologically discuss my experiences before, during, and after fieldwork. I analyse the various challenges I faced as a researcher who had shared the experiences of suffering with the study participants, and of the existing approaches in dealing with challenges. For example, I discuss the issues of empathic enmeshment and counter-transference. Concerning empathic enmeshment when assessing suffering, I show how I became over involved with the respondents' suffering. I frequently found myself intervening in order to diminish children's suffering, for instance by providing for their immediate needs, meeting their healthcare costs, and sometimes taking care of their sick kin. In my over identification and personalisation of the children's suffering through my introspective assessments, I ran the risk of blurring my burden as a researcher with that of wartime children and instead become a helper. In retrospect, I believe that my being a helper had a therapeutic effect, mainly for my own emotional wellbeing since it would have been more difficult for me if I had neglected the children's suffering. Identifying with children's experiences and sometimes sharing my own hardships was also a methodological approach to exploring their distress. For example, during three workshops exploring extreme wartime experiences and how children minimised them in their quests for therapy, my active participation as an insider was yet another entry point for accessing children's viewpoints and making them comfortable to share their own fears, emotional pain, anxiety, and extreme experiences.

Thus I view over identification and introspective research as an innovative approach for my own emotional wellbeing, a gateway to discussing what children would not readily share with others, and as an entry point to openness and freedom of expression. The latter is especially important for children living in a context of constant repression, silencing, and uncertainty. A context of repression is not only disempowering, it also makes people embedded in this context cautious, even in their daily interactions with others. One of the main health consequences of repression and silencing which I analyse in Chapter 12 is the expression of emotional distress in legitimised body symptoms. The expression of psychological distress in body complaints led to the neglect of the core causes of the distress, and only a narrow focus on the body through administering analgesics, antibiotics, and antimalarials.

Concerning counter-transference, in various moments during my fieldwork I could easily re-experience some of my own severe childhood experiences of lack, hunger, difficult relationships with adults who mainly exploited children, misery, and emotional distress. There was also the danger that I displaced my emotional feelings onto people

who had no links with the original stressor. One example of when I experienced angry emotions and a general ambivalence about my over involvement as a researcher was during a visit to a child's home, where he reported that his aunt who had neglected him and his siblings only a few months earlier had returned to stay with them after three months' rent had been paid. Thirteen year old Oketch further revealed how in addition, his aunt demanded that he spend his nights at the night commuters' shelter since their hut was too small for the entire family. Although this situation was distressing and brought up negative emotions, I believe I would not have been affected so much if, as Wilson & Lindy (1994: 8) suggest, I had taken an optimal distance: considering the clients' story seriously, with an emotional involvement that is embedded in awareness, self-monitoring, and self-reflection. Concerning the latter, Oketch and I would together analyse the issue at stake by putting emphasis on the positive aspects of his relationship with his aunt. This would be possible since I were only interacting with him as a researcher, rather than as someone who would permanently fill the gap between him and his close kin. Much as the relationship with his aunt seemed quite exploitative, Oketch's aunt still exhibited some positive attributes in his life, for example preparing meals for him and his siblings, interacting with guests on his behalf, explaining other aspects of the conflict to him, and sharing her children's belongings with him. In fact, when Oketch and his siblings went back to Pader in early 2007, Oketch's aunt was instrumental in tracing other kin and narrating their life experiences while in Gulu. She also helped Oketch to mark out their ancestral land. In short, in everyday interactions with people, there is bound to be both negative and positive effects, but relationships can only be built by focussing mainly on positive effects of the interaction.

In self-monitoring, I would be in charge of my viewpoints and emotions, especially in such precarious conditions. I would attempt to detach my own experiences from those of Oketch, much as I could acknowledge the emotional effect the scenario exposed him to. I would, for instance, tell him that it is normal to see the situation as distressing. But I could suggest that perhaps he should view this challenge as temporary, since everyone in the family was experiencing hardships. The challenges which his aunt had to confront could still be displaced onto his own experiences, but they must nevertheless attempt to transcend their differences and each of them tries to deal with their individual and collective challenges.

This brings me to my experience of seeking professional help, in an attempt to minimise my own re-experiencing and over-identification with the children's suffering during fieldwork. I sought advice from a university students' counsellor, who mainly told me about others' worse experiences and shared with me vast information covering knowledge, attitudes, management (self-management), purpose, acquisition of skills, assessment of level of achievements, planning, punctuality, staffing, directing, coordination, reporting, and budgeting. During the counselling I was advised against having feelings for the respondents as a researcher and that I should focus on my goal of collecting data and move on. Until the time of writing this manuscript, I am not certain about the impact of the counselling session on my wellbeing. It is not simply that I could not readily implement the information disseminated to me, but also that I found my continual interaction with the children and my acknowledgement of the interspatial or shared intersection of our suffering quite therapeutic in itself. It is possible that the approach of counselling researchers is an effective one for other people, but one that, I believe, has a link with the level of involvement one has with one's research subjects.

In Chapters 12 and 13, I analyse the impact of both indigenous approaches and counselling in terms minimising children's distress. In view of counselling, the children's perspectives also suggest ambivalence about the approach in terms of promoting their wellbeing. In turn, children's narratives suggest various indigenous approaches, which included using *atika* plants, participating in healing services, using medicines for sleep, analgesics, accessing material needs, and mainly stressing that if the war would cease they would be able to minimise their distress by going home where they would be able to perform *guru lyel.* Nevertheless, if intervention agencies propose that counselling is an appropriate approach for alleviating war-affected people's psychosocial distress, then it should be viewed as part of a holistic intervention in minimising wartime distress.

Last but not least, writing this book has been an engaging process for me. In writing draft chapters, I found difficulties in presenting findings in an a-political and detached way. I was frequently advised by readers including my supervisors that I should be as neutral as possible and to avoid taking sides with the wartime children's suffering. With more experience I have avoided as much unclarities as possible when I present both sides of the argument. I have also acknowledged the idea that interventions to minimise wartime people's suffering have both strengths and weaknesses. The sources of weaknesses within the institutions, I argue, could be beyond intervention agencies' capacities to resolve. In addition, I show that regardless of their living in quite a disempowering context, children engaged with their challenges-mostly solving them themselves. I subsequently suggest that given their needs and priorities, and also given the difficulties which institutions which have objectives to ensure their well-being faced, children must come to terms with the idea that they have the main responsibility to ensure their well-being and to minimise their suffering in the way they deem appropriate.

Although I have attempted to organise my insights into various sections and chapters, the outcome must be viewed as a painful attempt to put order and coherence to the issue of suffering. I still remember various conversations with the children where we could not agree on which of the illness categories were more severe. A substantial proportion of children always argued how their illness experiences with malaria, diarrhoea, cholera, tuberculosis, and scabies were the most devastating since they became weak, feared they would die, spent sleepless nights itching, and children from Municipal schools kept abusing them, calling them *baghdad*, and because of the illnesses such children were unable to go to school or engage in income generating activities. However, another substantial proportion of children (including those who fully supported the fact that experiences with infectious diseases were very severe) argued that there is no pain comparable to losing close kin, taking care of a sick parent whose health is gradually deteriorating, living only with your mother since your father and brothers have been abducted and you do not know whether they are alive or dead, and the fear that you yourself might be abducted.

The way this book's content is organised must therefore be viewed as analytical categories with many inter-linkages and very thin boundaries. As an introduction to Part III, I mentioned that in fact, infectious diseases and psychological distress frequently affected one individual concurrently. Sometimes, when children self-diagnosed malaria and subsequently used antimalarials and analgesics, they were at the same time minimising their psychological distress. Therefore the rationale I give for the way this book is ordered is that I progress from the macro-context to a micro-level to show the circumstances in which children were embedded. The contexts also form a red thread through the analyses of results. I then progress to Part III where I first examine child-

ren's experiences with infectious diseases by capitalising on the fact that infectious diseases (which sometimes occurred as epidemics) were an immediate need, and children's discussions suggested varying levels of severity, the rapid deterioration of bodily condition, and generally how experiences with infectious diseases disorganised their relatively stable life worlds. I then present insights about emotional distress, proposing that the children lived in a relatively stable condition of psychosocial suffering. Some forms of psychological distress are severe, but there are no definitive ways of managing them. Nonetheless, children also engaged with such suffering, through curative approaches and other indigenous coping mechanisms, discussed in Part II and Part III.

I therefore attempted to move beyond simply adding knowledge to the existing literature, by also aiming to understand the experiences of the study population. In order to move from knowledge to understanding in research, I believe the approach is to combine both experience-near and detached stances in data collection and analyses. To improve the validity and reliability of one's data, it is proposed that the researcher takes into account the whole individual: their emotions, their core difficulties, their suffering, and perhaps draw on these views when designing healthcare interventions.

It is, however, important to note that most of anthropological studies in Africa reflect a detached assessment of the 'others' experiences. Although the advantages of detached assessments of the 'other' in medical anthropology are documented in contemporary debates, it is also explained that not only will the knowledge produced be racist, historicizing and exoticizing, but further that the people whom such studies claim to represent often critique such studies (see Good 1994; Fabian 2002). And as Fabian (1996: 9) puts it:

> If an anthropologist does not want to use intersubjectivity – that is to actively gain insight into his (her) own not fully conscious part of intersection between him (her) and his (her) subjects, s/he runs the risk of producing mere categories of social artefacts with doubtful historical and intellectual significance.

It is demonstrated that it is possible to move beyond the detached assessment and analysis of the anthropological 'other', to propose ideas suggesting an understanding of the respondent (see more details in Akello 2007: 39-58).

Reflections on theoretical and methodological approaches

The theoretical framework encompassed perspectives of child agency, child vulnerability, political economy in healthcare, gender, and health seeking behaviour. Each of the perspectives complemented, negated, or reinforced the other in the analysis of data about children's illness experiences and quests for therapy.

Children were approached as social actors and their perspectives have been privileged in the discussion. In addition, more knowledge has been added to the perspectives on child agency in healthcare including relational, replicational, transactional, and transformative agency. In relational agency, children forge social networks with neighbours, peers, and landlords as a survival strategy. In Chapter 3, I show how children in child headed households acted as child minders for their landlords, fetched water for them, and in return children had their monthly house rent wavered or reduced. In connection to their health seeking behaviour, children inquired from neighbours and landlords which medicines to buy, for instance when they had headaches. In one narrative in Chapter 5, one boy was advised by his landlady to take medicines with warm water due to his frequent vomiting, and this led to his recovery. In Chapter 11, the peers of a child

who was severely distressed after his hut was accidentally burnt down helped to calm him down and get a job for him at Caritas where he was able to earn money and buy a school uniform for himself. That is how he became normal again. In effect, relational agency in healthcare demonstrates children's abilities to forge meaningful social networks which were in turn useful in dealing with daily challenges, including when they were ill.

In replicational agency, children use experiential information about medicines, mainly pharmaceuticals, to manage their recurring common health complaints. In Part III, I reveal how I saw children making specific demands for antimalarials in case of headache, or asking the drug seller for Panadol, Chloroquine, Flagyl, or medicines for sleep. During interviews, such children indicated how the medicines they bought were effective in managing their previous illness episodes which presented the same symptoms. Another example of replicational agency is when children used remedies which adults advised them to use for their persistent symptoms, including the use of *atika* plants for *cen,* and demands for *guru lyel*. Replicational agency therefore encompasses experiential knowledge and children's abilities to acquire and implement ideas, whether from peers, adult kin, or intervention agencies.

Concerning transactional agency, which explicates children's disadvantaged position in social relations, I have argued that power relations between adults (especially healthcare providers) and children affected the quality of service provision. In Chapter 5, I gave an example of a child whose frequent presentation with persistent headaches always ended with a prescription for antimalarials, despite his argument that he did not think his persistent headaches were due to malaria. In addition, I show how various intervention agencies with preset mandates to ensure children's wellbeing through trauma focussed approaches neglected children's perspectives about suitable approaches for minimising their distress. Instead, there were various strategies to invite, convince, and sometimes blame children for their inabilities to comprehend the importance of counselling. In short, some healthcare providers' powerful positions in defining and legitimising what is relevant for children's wellbeing to some extent even led to the provision of services inconsistent with children's needs.

In transformative agency, I privileged children's voices as appropriate perspectives in project design. If children identified and prioritised their healthcare needs to include material needs and indigenous approaches in minimising their mental distress, I these viewpoints with high importance. During my fieldwork, I already attempted to communicate children's needs and priorities to healthcare planners and interventions agencies. In Chapter 13, I argue that the latter activity felt like going against strong structural and political forces which define for people in developing countries what they need. In fact, it was like working against the tide and even exposing myself to varying forms of hostility from the Gulu based institutions whose main objectives were supposed to be about ensuring the psychosocial wellbeing of war affected people. Ultimately, children's perspectives did not influence healthcare interventions; it was mainly the broader political, economic, and social structures which determined the quality and quantity of the healthcare services which the children accessed.

Privileging children's perspectives about their own healthcare needs and priorities, and proposing these viewpoints for policy and intervention, is consistent with micro-to-macro approaches in development. Development experts (Chambers 1994; Corbett 1989; Lieten 2003) argue that approaches which take into account the needs and priorities of their target population minimise the likelihood of project failures. In addition, the

political economy and market orientedness of the healthcare system had an impact on the quality and quantity of healthcare services which the children accessed. For example, whereas it was possible for children, depending on their buying abilities, to access various pharmaceuticals for the symptomatic management of common illnesses, ready access to pharmaceuticals exposed children to abuse, misuse, and dependency on pharmaceuticals.

Consequently, children's agency notwithstanding, and with regard to their valid points of view which in fact were frequently neglected due to their age, powerless position, and perceived lack of expertise, I conclude that broader structural forces determined what children's healthcare needs should be and how they would be managed. I therefore reject an over emphasis on children's agency and rather adapt a stance emphasising children's vulnerability in healthcare. I argue, for instance, that the context in which the children lived, characterised by poverty, poor sanitation, congestion, lack of clean water and other basic necessities, predisposed them to infections sometimes presenting as epidemics. That the resource poor who mainly lived in displaced persons camps were more affected by easily preventable epidemics leads me to question the effectiveness of curative approaches and children's agency in the control and management of infectious diseases. Even the context of armed conflict and having to live in dire socio-economic conditions exposes children to various dangers associated with health and healthcare. Since 'healthcare issues' are defined as those which are pertinent to the prevention, diagnosis, and management (including self-diagnosis and self-medication) of forms of suffering – whether due to infectious diseases or emotional suffering – in the context of medical pluralism, I insist that children can be actors in their own right only to a limited extent. This is because broader political, socio-economic, and global influences were crucial determinants for their health and wellbeing.

In Chapter 2, I illustrate with examples from fieldwork the complexities of the pluralistic healthcare system in Gulu at the time of the study. I have described in some detail above that it is in the formal biomedical system where the professional healthcare givers have expertise in diagnosing and managing mainly infectious diseases. In state owned healthcare centres where resource poor people accessed free medical care, there was often understaffing, poor facilities, too many clients, and it was common for clients to only obtain prescriptions for medicines which they had to purchase in the popular sector. I link these inefficiencies to the liberalisation of the market economy and the flexibility of market oriented healthcare, and thus to the proliferation of the popular sector, since most ill individuals resorted to managing their complaints themselves through the use of herbal medicines and pharmaceuticals which they accessed according to their buying power.

Another important insight is in adding clarity to that which constitutes the folk sector. Religious and indigenous healers were specialised healthcare providers in the folk sector since they evoked supernatural powers in diagnosis and therapeutic procedures. For instance, distressed ex-combatants frequently reported to Life Line Ministries and other religious healers who evoked the power in the blood of Jesus Christ to drive away *cen* which caused suffering. Religious healers' activities, however, bordered more on the popular sector since they taught clients in healing services to also evoke the power of Jesus Christ, and showed them that they also had power to lay hands on themselves in healing prayer. However, indigenous healers were mainly secretive, and did not want to disclose even what was in their herbal medicines, nor the meaning of the various procedures, for instance making incisions on the forehead of people disturbed

by *cen*. When performing therapeutic procedures, indigenous healers engaged with supernatural powers. The other commonality in the folk sector was that it was mainly used to deal with chronic conditions, i.e. illnesses which children had already tried to resolve using various pharmaceuticals and herbal medicines without success.

The methodological issues focussed on the suitability of employing child centred approaches in data collection, the importance of triangulating methods, and of the researcher being her own tool in introspective research. Key informants' perspectives were examined since the healthcare system was adult centred and adults were the service providers. Further, for policy discussions with policy makers, figures from quantitative data are a preferred reference point. Therefore, child adapted methods were triangulated with a survey to assess their common illnesses and medicines used. There were limitations to employing some of the methods, for example a survey, particularly in examining illness experiences which children were reluctant to divulge. However, using other approaches including vignettes, introspection in research, workshops about severe experiences in the context of war, and medicines used to minimise such suffering, it was possible also to assess children viewpoints about their psychological suffering while taking into account their nomenclature. The latter argument therefore explicates the strengths of introspective researches and triangulating methods in ethnographic research.

What I need to mention here is that since the inception of this study, I believed (and we were taught in courses focussing on applied medical anthropology) that some healthcare issues around the world persist due to lack of *emic* perspectives. However, having come to the end of this writing on children's suffering and quests for therapy, I would like to stress that the persistence of the healthcare problems and existence of interventions which are sometimes deemed inappropriate in minimising vulnerable people's suffering is not due to lack of *emic* views. Although there are frequent calls for researches in Uganda to ascertain vulnerable people's perspectives about the problems which they face; and it is argued that if national and international institutions including World Bank, World Health Organisation, United Nations Children's Fund, Ministry of Health and academic institutions knew *emic* perspectives, policies would be drafted and informed planning will be done to effectively address them, information generated in rarely utilised. Either wrong information is collected even by some anthropologists, or information reflecting *emic* views is unusable due to their detail and complexity. What is more, project funders ultimately define what will be implemented. My overall concluding remark concerning the latter is that knowing vulnerable people's needs or *emic* views only contributes minimally to healthcare policies and implementation of those policies. In effect, there are more complex issues governing how and when to intervene in solving healthcare issues at stake.

That is why I propose that regardless of the dire context in which children and indeed adults in conflict-affected areas lived, they have no other choice but to bear the major responsibility of ensuring their well-being. Where they identify and prioritise their needs differently from intervention institutions, vulnerable people themselves need to devise ways to resolve or minimise their problems. During my fieldwork, children engaged in quests for therapy for common illnesses which affected them. They were quite resilient despite the lack of proper care for them. The people affected by war in northern Uganda and in general people in developing countries need to come to terms with the idea that regardless of the high representation of NGOs and state institutions whose

objectives are to ensure their well-being, projects which they implement must be viewed as complementary to their own approaches in addressing the issues at stake.

Reliance on outside intervention has many limitations. Whereas the outside interventions are well meant, when core problems are defined without the involvement of the target population, there will ultimately be a fundamental conflict with local priorities. This is because when the process of defining and deciding on which issue to address is mainly defined from outside, what donors are willing to fund will be given priority of the target population's needs.

Having said that, the future of the children who participated in this study (excluding Vicky Ajok who succumbed to chronic renal failure in December 2007), is still in an unpredictable state. Five of the twenty-four children whom I have managed to keep constant communication with were in secondary school at the final stages of writing this thesis. Three of the children, regardless of their desire to join any secondary school, had no funds for it. They subsequently joined vocational institutions where they gained skills in tailoring. I did not succeed in tracing them in order to assess how they dealt with the competition for the few people who needed to occasionally make new clothes for themselves. Whereas the five children in secondary school attended what hardly reflected their dream schools and therefore, their overall target to attain the best formal education possible has been affected, there is a sense of satisfaction that within their limits, and with some help from outside, they have not dropped out of school as the case was for a substantial proportion of children who were enrolled at displaced primary schools.

I have desisted from making direct recommendations to policy makers and intervention agencies concerning how to minimise wartime children's suffering due to various reasons. Firstly, during my fieldwork, I already attempted to suggest to some intervention institutions what children's needs and priorities were. In this book I share my experience with this activity and discussed how the experience was quite a challenge. It was like telling the concerned persons what they already knew, but they were either limited by mandates and therefore they could not do anything about it, or such problems were already defined as too complex by donor agencies. In Chapter 13, I showed how the interventions in healthcare were also defined by the institutions funding these projects.

Secondly, within my own experience of intervening to address some of children's problems, I did create even more complex problems (see Akello 2007). On the one hand, I minimised their suffering, but on the other hand, there were issues which children were exposed to due to my intervention. I am still grappling with the idea concerning how to alleviate a few selected children's suffering who lived in a context where virtually everybody in that community was in dire need. This is not to suggest helplessness, but rather to recognise that caution, flexibility and self-reflection is needed in implementing all the well-meant projects which might alleviate children's suffering. Furthermore, at the time of doing fieldwork, children's needs and priorities were quite fluid. A child's priority at one point was not necessarily the same at another point. What kind of project could be designed – for instance over a five-year period (as often recommended by donors) – to meet such a population's needs? As analysed in this thesis, the fluidity of the needs identified reflect upon the mindset of the beneficiaries. In the context of uncertainty, children were likely to identify immediate needs. Immediate needs fulfill a short-term purpose. Such needs are not static and change frequently. The latter analysis about the fluidity of needs and priorities was also observed in some

projects implemented in an attempt to meet vulnerable children's needs. For instance, in Chapter 3, where I analysed the phenomenon of night commuters' shelters, I discussed how, whereas Noah's Ark provided needed services at the peak of the insurgency in 2004, there was an ambivalence about the role of the three additional night commuters' shelters in 2005. Although the manager of Bukipa night commuters' shelter constructed in 2005 disclosed that he requested for the funds from the Japanese government in 2004 when there was an acute shortage of facilities for children and adults who nightly commuted to Gulu municipality for their safety; in 2005, the very target population preferred staying in camps and villages close to the municipality due to relative safety. The difficulty here is that when the donor funds are earmarked for night commuters' shelters, the money needs to be invested as such. There was also a follow up by the Japanese government and an evaluation concerning whether the funds were put to proper use. Another example is here. In Chapter 1, I discussed how the various development initiatives during civil war by the state in collaboration with the World Bank and the European Union yielded limited success. In large part, the projects which met the donors' requirements were tailored to an emergency situation. Emergency aid projects were short-term in nature. Short-term projects were implemented perhaps due to the context of uncertainty and fears that the situation of armed conflict will have a negative impact if concrete development programmes were put in place. The preceding examples reinforce my argument concerning the need to first find out beneficiaries' *emic* views and ranking the types of priorities identified by the vulnerable people into immediate and strategic needs. Whereas immediate needs are typical of emergency aid needs, they do not empower the target population much as they serve to alleviate their suffering. The strategic needs on the other hand meet long-term needs and the community is empowered to meet their own immediate needs. For a context of civil war, a strategic need would be in cessation of armed conflict so that the affected people could go back to their livelihoods. And indeed, through interactions with the children, they also identified this long-term, strategic need when they expressed a desire for the war to end so that they could go back to their communities. Cessation of armed conflict is the responsibility of the state which is under obligation by law to protect her citizens from dangers of civil war. In Chapter 1, however, I examined the various ways in which the state attempted to bring the civil war in northern Uganda to an end with limited success. However, since we live in a global world, much as the war in northern Uganda mainly affected people within that locality, other countries like Democratic Republic of Congo, Sudan, Kenya and Central African Republic were affected by the civil war. There is therefore a need for a joint effort between the countries directly affected and also from the international community to bring the armed conflict to an end. The preceding analysis is perhaps appropriate for humanitarian agencies too since cessation of armed conflict appears more appropriate in comparison with provision of basic necessities to the displaced people during the prolonged civil war.

Appendix 1: List of Acholi words and phrases

Abaa wic	Headache
Abaa wic lela	Migraines (also persistent headaches)
Ajwaka	Indigenous healer
Aona ki avuru	Cough and flu
Aona opiu	Tuberculosis
Can	Sadness or poverty (distinction is clear per context/sentence in which the term is used)
Can dwong ataa	Deep emotional pain
Cango kene	Heals itself
Cen	Evil spirits
Cwinya cwer	My heart is bleeding [my heart is aching/emotional wound/sadness]
Guru lyel	Last funeral rites
Kec	Hunger
Koyo	Coldness fever]
Kumu	Misery over loss of close kin
Latin kwan	School-going child
Latin lum moo	A certain child soldier
Leja leja	Casual farm labour
Lyeto	High body temperature
Malaria madongo	Very severe malaria
Mony	Soldiers or armed personnel
Morokole	A devoted Christian or a person who is saved
Ot yat	Hospital
Ot yat adit	Gulu Regional Referral Hospital
Ryemo tipo	Chasing *tipo*
Pii loya	I am discouraged [I am overwhelmed]
Tipo	Harmless spirit (also *Tipu* meaning spirits of close kin)
Two	Illness [also disease]
Two tam	Illness of the mind [also brain is not functioning] (Though used in validated psychometric assessments to mean depressive-like-syndromes)

Appendix 2: Questionnaire used in a survey with 165 children

- Names of the child
- Age
- Village of origin
- Primary school
- Class
- Name illnesses you experienced in the recent past, for example in the last one month.
- For illnesses you mentioned above, how did you know that you were ill? [Describe symptoms].
- Name the medicines you used to get better in the recent past, for example in the past one month.
- Where did you get the medicines?
- Did you go to hospital?
- Reasons for not going to hospital?
- How did you know you were ill?
- Herbal medicines used if any
- Did you use all the medicines as you were told to?
- Why didn't you use all the medicines as advised?
- What are the problems you faced in accessing medicines you needed?

Thank you for participating in the study

Appendix 3: Generic names and active ingredients of pharmaceuticals commonly used by wartime children

Pharmaceuticals	**Generic name**	**Active ingredient**
Action	paracetamol, aspirin and caffeine	Paracetamol 300mg and caffeine 50mg, aspirin 600mg
Amoxicillin	amoxicillin	Amoxicillin cryohydrate 250mg or 500mg capsules
Chloroquine	chloroquine	Chloroquine sulphate 150mg
Fansidar	pyrimethamine + sulfadoxine	Pyrimethamine 25mg, Sulfadoxine 500mg
Flagyl	metronidazole	Metronidazole 200mg, 400mg
Gentamycin eye drops	gentamycin eye drops	Gentamycin sulphate 0.3%
Imodium	loperamide hydrochloride	Loperamide hydrochloride, 2mg
Largactil	chlorpromazine	Chlorpromazine hydrochloride 25mg, 50mg, 100mg
Multivitamin	multivitamin	Ascorbic acid 15mg, nicotinamide 7.5mg, riboflavine 500 micrograms, thiamine hydrochloride 1mg, vitamin A 2,500 units, vitamin D 300 units
Opele (sodium benzoate)	benzyl benzoate sodium	Benzyl benzoate sodium 25%
Panadol	paracetamol	Paracetamol 500mg
Piriton	chlorpheniramine	Chlorpheniramine maleate 4mg
PPF	procain penicillin fortified	Procain penicillin 1.8 gm, benzylpenicillin sodium 360 mg
Quinine	quinine	Quinine dihydrochloride 300mg or Quinine hydrochloride 300mg Quinine sulphate 300 mg
Septrin	co-trimoxazole	Sulfamethoxazole and Trimethoprim 480mg
Valium	diazepam	Diazepam 2mg, 5mg, 10mg
Vemox	mebendazole	Mebendazole 100mg

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