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

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Part III

Children's suffering and quests for therapy

In Part III of this thesis I focus on children's suffering and quests for therapy. I analyze 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 this study. 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 Four 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 (N=165) children aged nine to sixteen years, of whom eighty-eight (n=88) were boys and seventy-seven (n=77) girls. I will then extract from this quantitative overview data about infectious diseases and 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.