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

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Chapter Ten

Wounds, injuries, and epilepsy

Introduction

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.

10. Findings

10.1: Quantitative findings: Prevalence and management

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

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 observation, 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 the table above 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 who participated in this study, 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.

Table 10.2: Medicines used in the management of wounds, epilepsy, injuries, 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

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. 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).

10.2: Qualitative findings: Prevalence, severity, and quests for therapy

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

During the first phase of this study 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 willing to participate in this study 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 reintegrated 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.

10.2.2. 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 Eleven.

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 thesis 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.

10.3. 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, at the time of this study 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".

During the first phase of this study, 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 Eleven 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.

10.4. Discussion

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.

10.4.1. 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 in this thesis 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 themselves 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, at the time of this study, 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* at the time of this study, 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 in this study 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 study, 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 for this thesis 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 for this study, 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.

10.4.2. 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 wellbeing 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.