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

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Chapter Thirteen

An evaluation of healthcare services' provision in relation to children's perspectives

Introduction

The second goal of this study was 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 was a neglected emphasis on integrating 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.

13. Findings

13.1. 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)[48] 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

48 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.

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 addition, 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 straight 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. I will return to this issue shortly.

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. This study has 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.

13.2. 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), Medecines Sans Frontiers (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 the time of this study 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 in this study 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 institutions. 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 which 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[49] . 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 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.

13.3. 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

49 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.

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 One and Chapter Twelve, 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 at the time of this study to provide *psychosocial* [50] 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 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 north west 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

50 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.

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[51,52] . 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.

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

[51] The Daily Monitor May, 4, 2006: Northern, pp 9.

[52] 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).

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 this thesis calls 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 response 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[53] was an international, non-political, non-partisan organisation employing staff in 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

[53]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 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).

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.

13.4. 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 in this study demonstrate that children of primary school age are in need of complex healthcare interventions to address infectious diseases and emotional 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 this study has proposed that it is appropriate for children to engage in curative approaches addressing infectious diseases given the context in which they live, 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 in this study 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 this study has 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 this study 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 this study has found mainly failed intervention projects, 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.