



Universiteit
Leiden

The Netherlands

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

Akello-Ayebare, G.

Citation

Akello-Ayebare, G. (2009, May 20). *Wartime children's suffering and quests for therapy in northern Uganda*. Retrieved from <https://hdl.handle.net/1887/13807>

Version: Corrected Publisher's Version

License: [Licence agreement concerning inclusion of doctoral thesis in the Institutional Repository of the University of Leiden](#)

Downloaded from: <https://hdl.handle.net/1887/13807>

Note: To cite this publication please use the final published version (if applicable).

Chapter Fourteen

Concluding remarks

Introduction

This ethnographic study set out to examine children's suffering and quests for therapy in the context of an ongoing civil war in northern Uganda, with an aim of generating recommendations so that their 'right to health' can be met. In this concluding chapter, I extract the main insights which this study generated from the preceding chapters and illustrate how I formulated some of the propositions in this thesis. I will also reflect on the epistemological issues and this study's theoretical and methodological approaches. Since suffering is an illness experience whether due to infections or emotional distress, this study will examine main insights in these illness categories. Children confronted their suffering, through use of medicines and other coping mechanisms. In analyses, I will examine the efficacy of children's approaches in minimising their suffering, what was appropriate-given the context in which they lived and also propose approaches concerning how prevalences of infectious diseases and emotional distress would be minimised. The themes analysed cover commonness of infectious diseases, children's focus on curative approaches in management of infectious illnesses, the importance of preventive approaches in the control of infectious diseases, children's quests for therapy for emotional distress, policy and intervention agencies' approaches in healthcare, epistemological issues in this study and reflections on theoretical and methodological approaches in this study. I will start with an analysis of children's differential mentioning of the health complaints which affected them by narrating mainly experiences with illnesses of infectious nature.

14.1. Commonness of infectious diseases

In general, infectious diseases, or complaints which were clinically- or self-diagnosed as infectious diseases, constituted the highest proportion (85%) of the illness burden among children. Thus I examined one of the major findings of this research, asking why wartime children so readily discussed their illness experiences resulting from episodes of infectious diseases, which in some cases became epidemics. I propose that children readily shared their experiences with infectious diseases because they are acute, primary, and cause a rapid deterioration of the bodily condition. Experiences with infectious

diseases need immediate attention. Children's discussions further imply that they were making explicit what their healthcare needs and priorities were. This finding is consistent with a skewed focus on the management of infectious diseases as opposed to war related emotional distress within the biomedical sector (professional sector in Uganda) of the pluralistic healthcare system. In addition, at the time of this study, the popular sector (where sick children accessed herbal medicines and prescription-only pharmaceuticals) and the professional healthcare system had avenues whereby complaints with experiences of infectious diseases could be systematically presented and addressed. Children's perspectives could be an indication of the high prevalence of such infections, and the fact that they are life threatening.

In light of the latter argument, commonness is interpreted as a concept constituting a triad of sub variables, namely priorities, frequencies/prevalence rates, and effects of the existing healthcare discourse. Children mentioned largely infectious diseases as common health complaints which affected them because (1) they are considered priorities by the children due to the deterioration of their bodily condition as a result of these diseases; (2) prevalence and incidence rates of these infectious diseases are high and they reoccur frequently in the same child; and (3) in children's experiences there is no place within the existing healthcare system and discourse for presenting other 'common' illness, such as the complex emotional distress directly related to the war.

The context in which the children who participated in this study lived was characterized by poor living conditions, congestion and overcrowding, abject poverty, a lack of basic necessities including clean water and food, and insecurity. This context provided opportunistic conditions for infections and re-infections with disease causing organisms. In this thesis I have given examples of how scabies, cholera, and eye infections were experienced as easily preventable yet widespread and problematic epidemics among wartime children because of the context in which they lived. It was discussed how scabies affected mainly children in displaced primary schools and night commuters' shelters. In fact, scabies was frequently referred to by displaced people as *baghdad* – both a euphemism for night commuters' shelters and for a disease of dirty people. Indeed, children who spent nights in night commuters' shelters often appeared dirty. However, there is substantial evidence that many of the dirty children were unable to practice hygienic living due to a lack of basic necessities such as living in a spacious environment,

having a bed to oneself, and access to adequate washing facilities, extra clothing, and even soap (let alone the special medicated *Protex* soap). These conditions indicate the wider socio-economic factors which predisposed night commuters to an epidemic of such an infectious skin disease.

Although throughout the thesis I mention that concerted efforts to address these broader socio-economic issues would constitute an effective way of controlling infectious diseases, the children themselves mainly used short term, curative approaches, accessing pharmaceuticals and herbal medicines to minimise their suffering. I will now shed more light on such curative approaches.

14.2. Children's focus on curative approaches in the management of infectious illnesses

Findings suggest that for health complaints of an infectious nature – and indeed psychological suffering – children used pharmaceuticals and herbal medicines to restore normality. The pharmaceuticals children used included antibiotics (28%), psychopharmaceuticals (16%), antipyretics (15.6%), antimalarials (14.4%), and Benzyl benzoate (8%). At the time of this study, ill individuals could readily access pharmaceuticals including prescription only medicines such as antibiotics and antimalarials. At state aided health centres, clients would be given pharmaceuticals if the hospital pharmacy had them. It was common also for clients to be instructed to purchase their own medicines from private sources when the hospital's stock of medicines had been distributed out. The quality and quantity of medicines sick people accessed from private healthcare providers was determined by the amount of money they had. The availability of medicines as commodities not only provided quick solutions in the symptomatic management of illnesses by children, but children were also thus exposed to various dangers such as misuse, over-use, and even dependency on pharmaceuticals. For example, I have discussed how children, healthcare workers, and persons who sold medicines readily purchased, prescribed, or sold antimalarials for symptoms of *koyo*, *abaa wic*, *lyeto* and *malaria madongo*. In effect, there was an over-use and misuse of antimalarials because it was not possible to do blood smears to ascertain the presence of malaria parasites. In addition, this study has shown that some symptoms which children self-diagnosed as a malaria episode in fact signified emotional distress. I will analyse this issue further below.

During this study, the main approach of frequently seeking medicines to treat illnesses appeared to be but a temporary solution. I have reported that re-infections were a common occurrence among children. For example, during the time when the scabies epidemic was rampant, especially in night commuters' shelters and displaced primary schools, some children told me how they had used *Opele* (Benzyl benzoate) and had recovered. However, they would again contract scabies from a neighbour at the night commuters' shelter with whom they shared a mat and blanket. I could give more examples about the dangers of infection and re-infection with pathogens responsible for cholera, malaria, tuberculosis, and eye infections, due to the context in which the children lived.

In essence, the most effective way for the children to avoid getting scabies, for instance, was not only to avoid situations where they were exposed to contagion (e.g. from those already suffering from the disease), but also to ensure that their own environment was not a breeding ground for disease causing organisms. The latter spells out a preventive approach to scabies infection. While this study recognises that preventive approaches constitute the most effective ways of dealing with infectious diseases, it is proposed that for the children who participated in this study, such preventive measures were impossible to implement, while it was suitable or fitting for them to engage in short term curative approaches, given the context in which they lived. Engaging in curative approaches was the best they could do to minimise their suffering, because the children who participated in this study lived in camps, night commuters' shelters, congested suburbs within Gulu Municipality, and attended displaced primary schools characterised by poor sanitation, congestion, the presence of those already infected with various contagious pathogens, and a lack of sufficient basic needs. In addition, due to insecurity, children had little choice but to live in these institutions for their own safety. In light of this, it is hardly comprehensible how such children could engage in preventive methods of infectious disease control and management.

Importance of preventive approaches in the control of infectious diseases

Preventive approaches in the control of infectious diseases imply that the people at risk should avoid being exposed to disease causing organisms. This could be through breaking the life cycle through which the pathogens are transmitted. For example, since cholera pathogens are transmitted through an oral-faecal route, people at risk should practice hygienic living, good sanitation, and avoid contact with *Vibrio cholerae*. This study argues that such an approach would be preferable to a more curative management

of cholera, where the people affected or those in danger of contagion use medicines.

Further, it would also be preferable for children to prevent infections and re-infections with *Tubercle bacilli*. However, in this study, I examined the context in which the child called Okello, who had tuberculosis, lived. The sick boy lived together with his four siblings in one hut, and they shared household utensils and other basic things. The child in question is believed to have contracted tuberculosis when he was the primary caretaker of his sick mother, who had contracted tuberculosis as an opportunistic infection secondary to HIV/AIDS. At a dilapidated structure at GRRH where such patients were admitted, patients and caretakers had to provide their own food and medicines. Given the above scenario, I conclude that the broader socio-economic context in which these children lived made it impossible for them to engage in effective preventive approaches in dealing with infectious diseases.

I have therefore only analyzed (short term) curative approaches in dealing with infectious diseases. They are short term because the children's approaches are limited to attempts at finding a cure and minimizing suffering, regardless of the fact that preventive methods are long term and more effective in dealing with infectious diseases. I cannot at this stage envisage a phenomenon where children can intervene in order to 'make infectious diseases a history'. Although the World Health Organisation emphasizes the importance of early diagnosis and effective biomedical treatment as one of the key factors in preventing high levels of malaria related deaths in Sub-Saharan Africa (WHO 2005:9), this study argues that curative approaches might be efficient but not effective. Emphases on curative approaches in healthcare provision amounts to offering sub-standard care to those mainly afflicted with infectious diseases in the context of armed conflict.

14.3. Children's quests for therapy for emotional distress

Although the children who participated in this study were reluctant to discuss their severe experiences during armed conflict (see analysis of this phenomenon in Chapter Twelve), when certain approaches were employed – including holding workshops to discuss severe experiences and medicine use in wartime, using vignettes, and conducting individual interviews – the children disclosed various forms of psychological suffering and revealed the core causes.

Extraordinary events which children experienced included loss of close kin, sexual violence (sometimes predisposing them to infections with HIV/AIDS), child abductions,

living in child headed households, loss of property, living in misery, and abject poverty. The children who experienced such extraordinary events frequently expressed their distress in terms of stomach aches, something invisible but painful moving around the body, persistent headaches, *cen* (evil spirits), *tipu* (spirits of close kin or harmless spirits), *can* (emotional pain) and *can dwong ataa* (deep emotional pain). In extensive follow-up of the children who disclosed their severe experiences, they told me that they dealt with *cen* or *tipu* by using medicines for sleep, joining the armed struggle, applying *atika* to incisions on the forehead with the help of an *ajwaka*, and through regular participation in healing services. Children engaged in income generating activities such as fetching water for sale, doing *leja leja* (farm labour), and seeking material support from NGOs in order to access basic needs, however children were often turned away since many NGOs usually channelled any assistance to their beneficiaries through partner NGOs and not directly to individual children.

Evidence suggests that displaced children used Piriton and Valium as remedies for sleeplessness. In a region where medicines are readily accessed over the counter based on the symptom experienced, it is easy to access medicines for sleep. This scenario is facilitated by the limited control measures regarding the distribution of pharmaceuticals. The general trend in Gulu at the time of the study is that pharmaceuticals were accessed as commodities, where individuals' purchasing capabilities significantly predetermined the quality and quantity of medicines accessed.

The taking of pharmaceuticals constitutes a curative approach to emotional distress. Another type of curative approach to psychological suffering, which was mainly implemented by intervention agencies, was counselling. Counselling is a trauma focussed approach intended to ensure wartime children's mental wellbeing. It is argued that through story telling, promoting creative plays, singing peaceful songs, and doing traditional dance, children will be able to relieve their trauma, and thus move on. In Chapter Thirteen I demonstrate how there was a basic conflict between the contextual approaches adopted by the children to deal with their emotional distress, and the approaches introduced by national and international agencies.

Further, this study has presented reflections on the issue as to why displaced children were reluctant to discuss their emotional distress, or only discussed them in somatic idioms. It is argued that given the context in which many people had to deal with the consequences of being exposed to extreme wartime suffering, silence was a suitable

approach for minimising psychological distress. During my fieldwork, both professional and indigenous approaches silenced distressed sufferers, often by telling them of how someone else with comparatively worse experiences had successfully confronted them and carried on with life ‘as normal’, and did not constantly express their misery to others. In the displaced persons’ camps and various suburbs in Gulu Municipality, people rewarded those who did not express their distress or exhibited a stoical façade. Other coping strategies were a general disregard of others’ psychological suffering, ridicule of the victims of violence (including sexual violence), and sometimes blaming of the victim. The approaches in dealing with psychological distress had nevertheless led to the adoption of legitimised body complaints as an expression of the same distress. For example, distressed people often complained of stomach aches, persistent headaches, something painful moving around the body, and *cen*. One health consequence of this phenomenon was that both sufferers and healthcare providers focussed on the body, and administered analgesics, antimalarials, and sometimes antibiotics. Since the core causes of the distress remained unaddressed, the results are a persistence of somatic bodily complaints.

In effect, much as I recognise that there are no simple ways of dealing with psychological distress, I critique the existent curative approaches, especially those focusing on the physical body. My argument is that a focus on the body blurs the core causes of distress and prolongs or even increases the severity of psychological distress. I will come back to this. Nevertheless, this study recommends that it is better for distressed persons and indeed people dealing with other chronic illnesses to still engage in the short term curative approaches to minimise their suffering, as they often provide an unintended cure, an issue to which I now turn.

Unintended cure realized through quests for therapy for emotional suffering

In Part III I coined the term ‘unintended cure’ to signify what is achieved by caretakers’ and sufferers’ persistent quests for therapy for chronic illnesses. I suggest that there is some form of fulfilment achieved, including a resigned attitude about the suffering or coming to terms with an inability to solve the issue at stake. Unintended cure therefore encompasses a triad of care for the ill individual, an engagement in various existing ways of restoring normality, and subsequent acceptance of the inability to solve the problem. This qualifies as an unintended effect of the quest for therapy because the intention is to find a remedy, for instance from *cen* and persistent headaches. However, failure to find a

remedy through the various curative approaches which the children mentioned still leads to a kind of cure. To put it differently, failure to deal with the symptomatic presentation of emotional suffering itself is still a better state for the persons engaging in quests for therapy than a complete lack of attempts to deal with the issue at hand.

Such a resigned attitude, acquired after various (failed) attempts at a quest for therapy, relates to children's analyses of all the procedures they engaged in, even those for chronic conditions like *can* (emotional pain) and *can dwong ataa* (deep emotional pain), exemplified by their conclusion that *can en cango kene* (this suffering heals itself). In effect, the children were hinting at the achievement of the unintended cure, suggesting that they realise that some forms of suffering might need less interference in terms of pharmaceuticals or medical attention. It is also better to leave affected individuals to devise their own approaches towards minimising *can* or *can dwong ataa*, thereby allowing them to come to terms with their suffering. Just allowing the sufferer to deal with such problems themselves constitutes a call for minimal interference by stakeholders, where standard practice is that short term curative methods are employed to alleviate suffering. The dangers associated with short term curative approaches are that the suffering may in fact be made worse, since individuals are discouraged that the various approaches they are implementing are not necessarily solving the problem in a more concrete way. Sufferers are pushed further into oblivion regarding knowing what is appropriate, what is acceptable, and what can be practically implemented given their individual context. The latter spells out the limitations of a dominant focus on the trauma effects of war, which is often the approach adopted in conflict zones. Nevertheless, when a health complaint is viewed as social processional suffering, an individual sufferer may not need to engage in short term processes which leads to over-use of pharmaceuticals for their condition.

Collective or social processional suffering and quests for therapy

I coined the concept social processional suffering to describe a phenomenon whereby some forms of suffering take on dimensions outside of the affected individual. Examples of this include: (1) where the ill individual's condition directly affects the close kin and his or her society; (2) where the suffering has no particular loci of reference, and various methods exist to manage it; and (3) where there is a need to view chronic conditions as processes of suffering, which may or may not have the outcome of healing. Regarding the latter, engaging in various procedures (holistic approaches) to deal with chronic wartime

emotional suffering may lead to the gradual minimising of its symptomatic presentation.

However, depending on the duration which an individual or society has experienced an extreme event, even holistic approaches may not minimise suffering. An example I will give here is when children frequently concluded their severe narratives by saying, “Even when you are given everything, there is no way to enjoy such a life”. In fact, a chronic form of suffering like *cen* (spirit possession in this context) is unique in terms of being an exemplary form of social processional suffering, because not only does its symptomatic presentation affect societies as opposed to only individuals, but also the process of finding a therapy should not only focus on the sick individual but also the entire society, or all individuals closely engaging in this process. In addition, if a child experienced *cen* at school, not only would the individual sufferer be affected, but their classmates and teachers as well. Subsequently, when children reported communal or collective organisation occurring to visit the *ajwaka*, I can see a societal or collective quest for therapy and collective healing, though sometimes such a community may again face disappointment. In other words, for chronic suffering which may affect not only an individual but also his or her social network – a phenomenon called social processional suffering in this study – there is a need to view the process in the quests for therapy as vital not only for the individual sufferer, but also for the society, thereby leading to individual and collective healing or at least an unintended cure.

In fact, it appears that the best approach in dealing with complaints symptomatic of emotional suffering might be in acknowledging the suffering and subsequently providing a conducive environment through which the healing may slowly take place. By conducive I refer to exhibiting restraint in determining the amount of time such a healing process should take, engaging in various contextually appropriate approaches – or what sufferers themselves consider as effective ways to minimise such suffering, enabling the distressed people to talk about their suffering, and learning how to address them without silencing them. This means listening to and acknowledging the sufferers’ narratives, and where possible, steps must be taken to address the core social causes of the problem. The foregoing argument is not consistent with both the indigenous and professional approaches of dealing with emotional distress in northern Uganda at the time of this study. Although I argued that silencing sufferers could have been the best way to cope in the context where there were virtually the entire population had to deal

with severe experiences, I propose that the approach of encouraging open communication and discussing of the severe experiences will be one of the ways of addressing emotional distress in post-conflict context.

Other approaches to dealing with psychological suffering

Some indigenous approaches to address core causes of distress recommended by Latigo (2008:101) include enabling the aggrieved to access traditional justice. In the Acholi region, traditional justice mechanisms are *Culo Kwor* (compensation), *Mato Oput* (drinking of bitter roots), *Gomo Tong* (bending the spear), *Nyono tong gweno* (stepping on an egg), and *Moyo Piny* (cleansing the area). Latigo (2008:108) proposes that the conflict in northern Uganda has revealed that there is a rich body of traditional systems of law and justice that reflect the principles of conflict management, with both retributive and restorative elements. In restorative justice, the objective is to reintegrate the perpetrators back into their communities and reconcile them with their victims. Reconciliation is promoted through a process of establishing the truth, eliciting confessions, reparations, repentance, and forgiveness. The precursor for all these processes of societal recovery is acknowledgement of the issues. Forgiveness opens the way for individual and collective healing. Such insights were not, however, obtained from the child respondents, but mainly reflect adult viewpoints on dealing with emotional distress. If they constitute part of the holistic approach towards managing wartime distress then their effect needs to be explored in another study.

It is important to note that the traditional mechanisms mentioned in the preceding paragraph were practical for intra-Acholi crimes where one individual committed one atrocity against another person or group of people within clans of the Acholi ethnic group, and where there were clear perpetrators and victims. At the time of this study, however, the prolonged civil war had affected also the Langi, Madi, Iteso, and other ethnic groups to varying degrees. In addition, there were complex scenario(s) involving child abductions where victims themselves were forced to carry out atrocities, or did so on their own initiative. It was common to find one individual who committed many atrocities, even against his own kin. These were not atrocities which traditional mechanisms of justice were designed to address. However, the basic principles underpinning the traditional mechanisms of reconciliation might lead to healing of the aggrieved. This is because the

principles of conflict resolution among the Acholi are intended to create reconciliation by bringing the opposing sides together through the intercession of elders, leading to the acceptance of responsibility and an indication of repentance.

Another concluding insight in this study is that wartime children need to view the state and international organisations' presence in Gulu as an alternative approach, or part of the holistic approach, to alleviate their suffering. Recognising that the major responsibility to minimise their suffering lies within themselves will also help people affected by war to avoid becoming dependent upon the state and intervention agencies, or even blaming them for their hardships. Generally speaking, people affected by war living in developing countries need to understand that sustainable solutions to their suffering must be innovated and implemented by the affected people themselves. Whereas in a situation of ongoing insecurity the engaging in short term curative approaches to minimise psychological suffering is a suitable approach, with the hoped-for cessation of armed conflict and resettlement in their communities, the people of northern Uganda will need to engage with their past experiences and challenges in order to move on sustainably.

They could start with short term approaches including accessing pharmaceuticals for infectious diseases, but gradually they will need to engage in activities to prevent infections, perform contextually suitable ceremonies to deal with bereavement, forge new social networks, perform *guru lyel*, acknowledge others' suffering, participate in healing services organised by Pentecostal churches, and devise possible means for dealing with their daily challenges. If deprived children engage with their own challenges they will not only be motivated to devise various means to minimise their suffering, but also there will be a consequence of appreciating externally based interventions as an alternative approach to their wellbeing. In Part III, I demonstrate how children frequently accessed pharmaceuticals in their quests for therapy for common health complaints. And whereas the children proposed various concrete ways of minimising their distress, the dire context in which they lived prevented them from implementing such approaches like *guru lyel*, going back to their villages, resettlement, and engaging in income generating activities. In light of this, I propose restraint on the part of intervention agencies, particularly in the way they communicate their objectives to their targeted population, which often had the effect of instilling in children's minds that they could easily access solutions from wartime intervention agencies.

14.4. Policy and intervention agencies' approaches in healthcare

The Gulu District Directorate of Health Services (DDHS) was the implementer of state healthcare policies in the area where this study was conducted. In Chapter Thirteen I mentioned how in late 2007 the DDHS was renamed the District Health Office, but that their mandates remained unchanged. Concerning policy issues focussing on the provision of healthcare services to children of primary school age, this study has critiqued the narrow focus on de-worming, oral hygiene, and vaccination of girls of reproductive age. The premise for this critique is based on what children themselves identified as their healthcare needs and priorities.

Further, the DDHS in Gulu implemented curative approaches for and promoted awareness of infectious diseases and emotional suffering. When the district experienced epidemics of an infectious nature, including cholera and scabies, the DDHS was overwhelmed by awareness messages designed by various intervention agencies based in Gulu at the time of the study. People at risk were sensitized about various infections, how the pathogens were transmitted, how to avoid becoming infected, and informed that they should ensure that the sick are taken for medical attention at designated emergency centres. Awareness messages were disseminated through sensitization seminars, placards, t-shirts, and local media, especially radio stations. Findings in Chapter Thirteen show how various intervention agencies sensitised people about the trauma effects of war, and proposed that girls should avoid conditions which could expose them to sexual violence. Regardless of the two approaches taken by the DDHS and NGOs, there was nevertheless a persistence and recurrence of epidemics and psychological distress. Subsequently, this study critiques the narrow approaches of simply giving medicines to the sick and promoting awareness among those at risk as a strategy to manage and control common infectious diseases. This is because the dire socio-economic context in which those people targeted with the information lived limited their abilities to implement the information about the diseases. Addressing the broader socio-economic causes of infections (preventive approaches) constitute more effective ways of managing and controlling infectious diseases. However, if the district DDHS activities are facilitated by a very small budget, and they are constrained to align their service provision within what is defined at the national and global levels, then the main task of ensuring wellbeing and meeting health needs still falls upon the Acholi people themselves.

Concerning modes of addressing psychological suffering, the perspectives of the target population were not consistent with intervention agencies' approaches. In a large part, humanitarian agency projects ignored the holistic character of the impact of the war on people, such as the erosion and disintegration of social groups and the social exclusion of direct victims of human rights violations. The conflict affected people were often left to themselves, and where there were attempts to address children's suffering, emphasis was on their traumatisation within a narrow psychological discourse. While it is possible that wartime children did need psychological help, they identified and prioritized food, household utensils, scholastic materials and school fees, lack of shelter, difficulties in taking care of their sickly kin, and a need for protection against LRA abductions and gender based violence. Most of children's material, social, and psychological problems are interlinked. Social and material problems may lead to psychological problems, while psychological problems may lead to social problems. Focussing on the inner psychological problem was found not to be effective in alleviating children's distress in Gulu.

As discussed earlier, it is possible that if war affected people viewed the state and other healthcare intervention agencies as an alternative approach to alleviating their suffering, there would be less dependency on their activities. Nevertheless, intervention agencies always communicated their mandates to suggest that NGOs were obliged to ensure children's wellbeing. Therefore, I suggest that intervention agencies need to reframe their objectives to clearly state that they can only offer an alternative approach to alleviating wartime suffering, and that much of the responsibility to minimise wartime suffering falls upon the war affected people themselves. This could help the target population to emotionally prepare to deal with their daily challenges, thereby minimising dependency. In addition, when the target population resist or suggest different approaches through which their needs might be addressed, their ideas must be acknowledged and not pathologized, as it was during my fieldwork. In effect, saying that NGO intervention is only an alternative approach to alleviating people's suffering will (1) help the people targeted to appreciate the additional services they receive from intervention agencies, and (2) ensure that the intervention agencies are not overwhelmed with constant demands by the vulnerable people.

The dependency of the children's mindset which believes that NGOs will solve most of their problems in my view could further be checked by allowing only a limited

number of NGOs to implement their objectives in conflict zones. What is more, if so many NGOs wish to implement their activities in one region, there needs to be an institution to coordinate such activities to ensure maximum effect and minimum overlap, and further to monitor activities and verify whether what is implemented is what was promised. The duplication of activities by intervention agencies was especially visible at times when Gulu experienced epidemics of infectious diseases. In sum, having a coordinating institution to moderate and approve various healthcare interventions in Gulu would have been useful not only to avoid duplication of activities which sometimes bordered on competition, but also would ensure that the target population will not have gained the impression that with the presence of so many institutions, their problems will be addressed according to their needs, while the very institutions they looked upon faced their own challenges.

14.5. Epistemological issues in this study

The main epistemological issue which underpinned the process of data collection, and the knowledge which was privileged in the data analysis and thesis writing, was my personal involvement in this study. This implies that I acknowledged the importance of shared subjectivities in the assessment of children's suffering. I make it explicit in Akello (2007:39-58) that consciously or unconsciously, my being an insider and participant observer (more precisely a proximal participant observer as opposed to detached participant observer) had a role to play in the entire research process.

For example, my own childhood experience of living in the dire circumstances of poverty, poor sanitation, hunger, and being an orphan exposed me to various easily preventable diseases and emotional distress. During that period, despite the awareness and experience of the health dangers directly linked to my dire context, it was not possible to practice preventive approaches in the control of infections and distress. The main resort was to short term curative approaches using pharmaceuticals and herbal medicines. Through my experience, I know how the provision of material needs can be more effective in alleviating distress than the trauma focussed approaches which were frequently implemented for wartime children.

Taking care of a close kin member sick due to a chronic illness prior to my fieldwork also contributed to the awareness of an intersubjective experience with the children who took part in this study. I know of the challenges of trying to meet the needs of my sick kin with only a meagre income, and the stress involved in managing

frequent opportunistic infections. I fully understand the emotional pain of taking care of close kin who themselves experienced varied levels of distress and lived in uncertainty of recovering from an illness. I have also lost a substantial number of close kin and friends due to HIV/AIDS and other misfortunes. Therefore I argue that in examining the illness experiences of children, particularly those living in child headed households and/or taking care of sick kin due to HIV/AIDS, I was assessing my own childhood and even my own experiences as an adult. In effect, the knowledge generated in this thesis constitutes an intersubjective narrative of the children's and my own experiences. Subsequently, one of my main arguments is that the experiences of the researcher have an effect on the knowledge production process, and determine whether s/he will understand the respondents' perspectives, which questions will be asked, the way information is interpreted, and whether the respondents can recognise and identify with the perspectives in the study outcome.

In Akello (2007) I chronologically discuss my experiences before, during, and after fieldwork. I analyse the various challenges I faced as a researcher who had shared the experiences of suffering with the study participants, and of the existing approaches in dealing with challenges. For example, I discuss the issues of empathic enmeshment and counter-transference. Concerning empathic enmeshment when assessing suffering, I show how I became over involved with the respondents' suffering. I frequently found myself intervening in order to diminish children's suffering, for instance by providing for their immediate needs, meeting their healthcare costs, and sometimes taking care of their sick kin. In my over identification and personalisation of the children's suffering through my introspective assessments, I ran the risk of blurring my burden as a researcher with that of wartime children and instead become a helper. In retrospect, I believe that my being a helper had a therapeutic effect, mainly for my own emotional wellbeing since it would have been more difficult for me if I had neglected the children's suffering. Identifying with children's experiences and sometimes sharing my own hardships was also a methodological approach to exploring their distress. For example, during three workshops exploring extreme wartime experiences and how children minimised them in their quests for therapy, my active participation as an insider was yet another entry point for accessing children's viewpoints and making them comfortable to share their own fears, emotional pain, anxiety, and extreme experiences.

Thus I view over identification and introspective research as an innovative approach for my own emotional wellbeing, a gateway to discussing what children would not readily share with others, and as an entry point to openness and freedom of expression. The latter is especially important for children living in a context of constant repression, silencing, and uncertainty. A context of repression is not only disempowering, it also makes people embedded in this context cautious, even in their daily interactions with others. One of the main health consequences of repression and silencing which I analyse in Chapter Twelve is the expression of emotional distress in legitimised body symptoms. The expression of psychological distress in body complaints led to the neglect of the core causes of the distress, and only a narrow focus on the body through administering analgesics, antibiotics, and antimalarials.

Concerning counter-transference, in various moments during my fieldwork I could easily re-experience some of my own severe childhood experiences of lack, hunger, difficult relationships with adults who mainly exploited children, misery, and emotional distress. There was also the danger that I displaced my emotional feelings onto people who had no links with the original stressor. One example of when I experienced angry emotions and a general ambivalence about my over involvement as a researcher was during a visit to a child's home, where he reported that his aunt who had neglected him and his siblings only a few months earlier had returned to stay with them after three months' rent had been paid. Thirteen year old Oketch further revealed how in addition, his aunt demanded that he spend his nights at the night commuters' shelter since their hut was too small for the entire family. Although this situation was distressing and brought up negative emotions, I believe I would not have been affected so much if, as Wilson & Lindy (1994:8) suggest, I had taken an optimal distance: considering the clients' story seriously, with an emotional involvement that is embedded in awareness, self-monitoring, and self-reflection. Concerning the latter, Oketch and I would together analyse the issue at stake by putting emphasis on the positive aspects of his relationship with his aunt. This would be possible since I were only interacting with him as a researcher, rather than as someone who would permanently fill the gap between him and his close kin. Much as the relationship with his aunt seemed quite exploitative, Oketch's aunt still exhibited some positive attributes in his life, for example preparing meals for him and his siblings, interacting with guests on his behalf, explaining other aspects of the conflict to him, and

sharing her children's belongings with him. In fact, when Oketch and his siblings went back to Pader in early 2007, Oketch's aunt was instrumental in tracing other kin and narrating their life experiences while in Gulu. She also helped Oketch to mark out their ancestral land. In short, in everyday interactions with people, there is bound to be both negative and positive effects, but relationships can only be built by focussing mainly on positive effects of the interaction.

In self-monitoring, I would be in charge of my viewpoints and emotions, especially in such precarious conditions. I would attempt to detach my own experiences from those of Oketch, much as I could acknowledge the emotional effect the scenario exposed him to. I would, for instance, tell him that it is normal to see the situation as distressing. But I could suggest that perhaps he should view this challenge as temporary, since everyone in the family was experiencing hardships. The challenges which his aunt had to confront could still be displaced onto his own experiences, but they must nevertheless attempt to transcend their differences and each of them try to deal with their individual and collective challenges.

This brings me to my experience of seeking professional help, in an attempt to minimise my own re-experiencing and over-identification with the children's suffering during fieldwork. I sought advice from a university students' counsellor, who mainly told me about others' worse experiences and shared with me vast information covering knowledge, attitudes, management (self-management), purpose, acquisition of skills, assessment of level of achievements, planning, punctuality, staffing, directing, coordination, reporting, and budgeting. During the counselling I was advised against having feelings for the respondents as a researcher and that I should focus on my goal of collecting data and move on. Until the time of writing this manuscript, I am not certain about the impact of the counselling session on my wellbeing. It is not simply that I could not readily implement the information disseminated to me, but also that I found my continual interaction with the children and my acknowledgement of the interspatial or shared intersection of our suffering quite therapeutic in itself. It is possible that the approach of counselling researchers is an effective one for other people, but one that, I believe, has a link with the level of involvement one has with one's research subjects.

In Chapters Twelve and Thirteen I analyse the impact of both indigenous approaches and counselling in terms minimising children's distress. In view of counselling-as it was

conducted at the time of this study, the children's perspectives also suggest ambivalence about the approach in terms of promoting their wellbeing. In turn, children's narratives suggest various indigenous approaches, which included using *atika* plants, participating in healing services, using medicines for sleep, analgesics, accessing material needs, and mainly stressing that if the war would cease they would be able to minimise their distress by going home where they would be able to perform *guru lyel*. Nevertheless, if intervention agencies propose that counselling is an appropriate approach for alleviating war-affected people's psychosocial distress, then it should be viewed as part of a holistic intervention in minimising wartime distress.

Last but not least, writing this thesis has been an engaging process for me. In writing draft chapters, I found difficulties in presenting findings in an a-political and detached way. I was frequently advised by readers including my supervisors that I should be as neutral as possible and to avoid taking sides with the wartime children's suffering. With more experience I have avoided as much unclarities as possible when I present both sides of the argument. I have also acknowledged the idea that interventions to minimise wartime people's suffering have both strengths and weaknesses. The sources of weaknesses within the institutions, I argue, could be beyond intervention agencies' capacities to resolve. In addition, I show that regardless of their living in quite a disempowering context, children who participated in this study engaged with their challenges-mostly solving them themselves. I subsequently suggest that given their needs and priorities, and also given the difficulties which institutions which have objectives to ensure their well-being faced, children must come to terms with the idea that they have the main responsibility to ensure their well-being and to minimise their suffering in the way they deem appropriate.

Although I have attempted to organise my insights into various sections and chapters, the outcome must be viewed as a painful attempt to put order and coherence to the issue of suffering. I still remember various conversations with the children where we could not agree on which of the illness categories were more severe. A substantial proportion of children always argued how their illness experiences with malaria, diarrhoea, cholera, tuberculosis, and scabies were the most devastating since they became weak, feared they would die, spent sleepless nights itching, and children from Municipal schools kept abusing them, calling them *baghdad*, and because of the illnesses such children were unable to go to school or engage in income generating activities. However, another substantial

proportion of children (including those who fully supported the fact that experiences with infectious diseases were very severe) argued that there is no pain comparable to losing close kin, taking care of a sick parent whose health is gradually deteriorating, living only with your mother since your father and brothers have been abducted and you do not know whether they are alive or dead, and the fear that you yourself might be abducted.

The way the content in this thesis was organised must therefore be viewed as analytical categories with many inter-linkages and very thin boundaries. As an introduction to Part III, I mentioned that in fact, infectious diseases and psychological distress frequently affected one individual concurrently. Sometimes, when children self-diagnosed malaria and subsequently used antimalarials and analgesics, they were at the same time minimising their psychological distress. Therefore the rationale I give for the way this thesis is ordered is that I progress from the macro-context to a micro-level to show the circumstances in which children were embedded. The contexts also form a red thread through the analyses of results. I then progress to Part III where I first examine children's experiences with infectious diseases by capitalising on the fact that infectious diseases (which sometimes occurred as epidemics) were an immediate need, and children's discussions suggested varying levels of severity, the rapid deterioration of bodily condition, and generally how experiences with infectious diseases disorganised their relatively stable life worlds. I then present insights about emotional distress, proposing that the children lived in a relatively stable condition of psychosocial suffering. Some forms of psychological distress are severe, but there are no definitive ways of managing them. Nonetheless, children also engaged with such suffering, through curative approaches and other indigenous coping mechanisms, discussed in Part II and Part III.

This study has therefore attempted to move beyond simply adding knowledge to the existing literature, by also aiming to understand the experiences of the study population. In order to move from knowledge to understanding in research, I believe the approach is to combine both experience-near and detached stances in data collection and thesis writing. To improve the validity and reliability of one's data, it is proposed in this study that the researcher takes into account the whole individual: their emotions, their core difficulties, their suffering, and perhaps draw on these views when designing healthcare interventions.

It is, however, important to note that most of anthropological studies in Africa reflect a detached assessment of the ‘others’ experiences. Although the advantages of detached assessments of the ‘other’ in medical anthropology are documented in contemporary debates, it is also explained that not only will the knowledge produced be racist, historicizing and exoticizing, but further that the people whom such studies claim to represent often critique such studies (see Good 1994; Fabian 2002). And as Fabian (1996:9) puts it:

If an anthropologist does not want to use intersubjectivity - that is to actively gain insight into his (her) own not fully conscious part of intersection between him (her) and his (her) subjects, s/he runs the risk of producing mere categories of social artefacts with doubtful historical and intellectual significance.

It is demonstrated in this study that it is possible to move beyond the detached assessment and analysis of the anthropological ‘other’, to propose ideas suggesting an understanding of the respondent (see more details in Akello 2007:39-58).

14.6. Reflections on theoretical and methodological approaches in this study

This study’s theoretical framework encompassed perspectives of child agency, child vulnerability, political economy in healthcare, gender, and health seeking behaviour. Each of the perspectives complemented, negated, or reinforced the other in the analysis of data about children’s illness experiences and quests for therapy.

Children were approached as social actors and their perspectives have been privileged in this study. In addition, more knowledge has been added to the perspectives on child agency in healthcare including relational, replicational, transactional, and transformative agency. In relational agency, children forge social networks with neighbours, peers, and landlords as a survival strategy. In Chapter Three, I show how children in child headed households acted as child minders for their landlords, fetched water for them, and in return children had their monthly house rent wavered or reduced. In connection to their health seeking behaviour, children inquired from neighbours and landlords which medicines to buy, for instance when they had headaches. In one narrative in Chapter Five, one boy was advised by his landlady to take medicines with warm water due to his frequent vomiting, and this led to his recovery. In Chapter Eleven, the peers of a child who was severely distressed after his hut was accidentally burnt down helped to calm him down and get a job for him at Caritas where he was able to earn money and buy a school uniform for himself. That is how he became normal again. In effect, relational

agency in healthcare demonstrates children's abilities to forge meaningful social networks which were in turn useful in dealing with daily challenges, including when they were ill.

In replicational agency, children use experiential information about medicines, mainly pharmaceuticals, to manage their recurring common health complaints. In Part III, I reveal how I saw children making specific demands for antimalarials in case of headache, or asking the drug seller for Panadol, Chloroquine, Flagyl, or medicines for sleep. During interviews, such children indicated how the medicines they bought were effective in managing their previous illness episodes which presented the same symptoms. Another example of replicational agency is when children used remedies which adults advised them to use for their persistent symptoms, including the use of *atika* plants for *cen*, and demands for *guru lyel*. Replicational agency therefore encompasses experiential knowledge and children's abilities to acquire and implement ideas, whether from peers, adult kin, or intervention agencies.

Concerning transactional agency, which explicates children's disadvantaged position in social relations, I have argued that power relations between adults (especially healthcare providers) and children affected the quality of service provision. In Chapter Five I gave an example of a child whose frequent presentation with persistent headaches always ended with a prescription for antimalarials, despite his argument that he did not think his persistent headaches were due to malaria. In addition, I show how various intervention agencies with preset mandates to ensure children's wellbeing through trauma focussed approaches neglected children's perspectives about suitable approaches for minimising their distress. Instead, there were various strategies to invite, convince, and sometimes blame children for their inabilities to comprehend the importance of counselling. In short, some healthcare providers' powerful positions in defining and legitimising what is relevant for children's wellbeing to some extent even led to the provision of services inconsistent with children's needs.

In transformative agency, this study has privileged children's voices as appropriate perspectives in project design. If children identified and prioritised their healthcare needs to include material needs and indigenous approaches in minimising their mental distress, this study regarded these viewpoints with high importance. During my fieldwork, I already attempted to communicate children's needs and priorities to healthcare planners and interventions agencies. In Chapter Thirteen I argue that the latter activity felt like

going against strong structural and political forces which define for people in developing countries what they need. In fact, it was like working against the tide and even exposing myself to varying forms of hostility from the Gulu based institutions whose main objectives were supposed to be about ensuring the psychosocial wellbeing of war affected people. Ultimately, children's perspectives did not influence healthcare interventions; it was mainly the broader political, economic, and social structures which determined the quality and quantity of the healthcare services which the children accessed.

Privileging children's perspectives about their own healthcare needs and priorities, and proposing these viewpoints for policy and intervention, is consistent with micro-to-macro approaches in development. Development experts (Chambers 1994; Corbett 1989; Lieten 2003) argue that approaches which take into account the needs and priorities of their target population minimise the likelihood of project failures. In addition, the political economy and market orientatedness of the healthcare system had an impact on the quality and quantity of healthcare services which the children accessed. For example, whereas it was possible for children, depending on their buying abilities, to access various pharmaceuticals for the symptomatic management of common illnesses, ready access to pharmaceuticals exposed children to abuse, misuse, and dependency on pharmaceuticals.

Consequently, children's agency notwithstanding, and with regard to their valid points of view which in fact were frequently neglected due to their age, powerless position, and perceived lack of expertise, I conclude that broader structural forces determined what children's healthcare needs should be and how they would be managed. I therefore reject an over emphasis on children's agency and rather adapt a stance emphasising children's vulnerability in healthcare. I argue, for instance, that the context in which the children lived, characterised by poverty, poor sanitation, congestion, lack of clean water and other basic necessities, predisposed them to infections sometimes presenting as epidemics. That the resource poor who mainly lived in displaced persons camps were more affected by easily preventable epidemics leads me to question the effectiveness of curative approaches and children's agency in the control and management of infectious diseases. Even the context of armed conflict and having to live in dire socio-economic conditions exposes children to various dangers associated with health and healthcare. Since this study defines 'healthcare issues' as those which are pertinent to the prevention, diagnosis,

and management (including self-diagnosis and self-medication) of forms of suffering – whether due to infectious diseases or emotional suffering – in the context of medical pluralism, I insist that children can be actors in their own right only to a limited extent. This is because broader political, socio-economic, and global influences were crucial determinants for their health and wellbeing.

In Chapter Two I illustrate with examples from fieldwork the complexities of the pluralistic healthcare system in Gulu at the time of the study. I have described in some detail above that it is in the formal biomedical system where the professional healthcare givers have expertise in diagnosing and managing mainly infectious diseases. In state owned healthcare centres where resource poor people accessed free medical care, there was often understaffing, poor facilities, too many clients, and it was common for clients to only obtain prescriptions for medicines which they had to purchase in the popular sector. I link these inefficiencies to the liberalisation of the market economy and the flexibility of market oriented healthcare, and thus to the proliferation of the popular sector, since most ill individuals resorted to managing their complaints themselves through the use of herbal medicines and pharmaceuticals which they accessed according to their buying power.

Another important insight in this study is in adding clarity to that which constitutes the folk sector. Religious and indigenous healers were specialised healthcare providers in the folk sector since they evoked supernatural powers in diagnosis and therapeutic procedures. For instance, distressed ex-combatants frequently reported to Life Line Ministries and other religious healers who evoked the power in the blood of Jesus Christ to drive away *cen* which caused suffering. Religious healers' activities, however, bordered more on the popular sector since they taught clients in healing services to also evoke the power of Jesus Christ, and showed them that they also had power to lay hands on themselves in healing prayer. However, indigenous healers were mainly secretive, and did not want to disclose even what was in their herbal medicines, nor the meaning of the various procedures, for instance making incisions on the forehead of people disturbed by *cen*. When performing therapeutic procedures, indigenous healers engaged with supernatural powers. The other commonality in the folk sector was that it was mainly used to deal with chronic conditions, i.e. illnesses which children had already tried to resolve using various pharmaceuticals and herbal medicines without success.

The methodological issues focussed on the suitability of employing child centred approaches in data collection, the importance of triangulating methods, and of the

researcher being her own tool in introspective research. Key informants' perspectives were examined since the healthcare system was adult centred and adults were the service providers. Further, for policy discussions with policy makers, figures from quantitative data are a preferred reference point. Therefore, child adapted methods were triangulated with a survey to assess their common illnesses and medicines used. There were limitations to employing some of the methods, for example a survey, particularly in examining illness experiences which children were reluctant to divulge. However, using other approaches including vignettes, introspection in research, workshops about severe experiences in the context of war, and medicines used to minimise such suffering, it was possible also to assess children viewpoints about their psychological suffering while taking into account their nomenclature. The latter argument therefore explicates the strengths of introspective researches and triangulating methods in ethnographic research.

What I need to mention here is that since the inception of this study, I believed (and we were taught in courses focussing on applied medical anthropology) that some healthcare issues around the world persist due to lack of *emic* perspectives. However, having come to the end of this thesis on children's suffering and quests for therapy, I would like to stress that the persistence of the healthcare problems and existence of interventions which are sometimes deemed inappropriate in minimising vulnerable people's suffering is not due to lack of *emic* views. Although there are frequent calls for researches in Uganda to ascertain vulnerable people's perspectives about the problems which they face; and it is argued that if national and international institutions including World Bank, World Health Organisation, United Nations Children's Fund, Ministry of Health and academic institutions knew *emic* perspectives, policies would be drafted and informed planning will be done to effectively address them, information generated in rarely utilised. Either wrong information is collected even by some anthropologists, or information reflecting *emic* views is unusable due to their detail and complexity. What is more, project funders ultimately define what will be implemented. My overall concluding remark concerning the latter is that knowing vulnerable people's needs or *emic* views only contributes minimally to healthcare policies and implementation of those policies. In effect, there are more complex issues governing how and when to intervene in solving healthcare issues at stake.

That is why I propose that regardless of the dire context in which children and

indeed adults in conflict-affected areas lived, they have no other choice but to bear the major responsibility of ensuring their well-being. Where they identify and prioritise their needs differently from intervention institutions, vulnerable people themselves need to devise ways to resolve or minimise their problems. During my fieldwork, children engaged in quests for therapy for common illnesses which affected them. They were quite resilient despite the lack of proper care for them. The people affected by war in northern Uganda and in general people in developing countries need to come to terms with the idea that regardless of the high representation of NGOs and state institutions whose objectives are to ensure their well-being, projects which they implement must be viewed as complementary to their own approaches in addressing the issues at stake.

Reliance on outside intervention has many limitations. Whereas the outside interventions are well meant, when core problems are defined without the involvement of the target population, there will ultimately be a fundamental conflict with local priorities. This is because when the process of defining and deciding on which issue to address is mainly defined from outside, what donors are willing to fund will be given priority of the target population's needs.

Having said that, the future of the children who participated in this study (excluding Vicky Ajok who succumbed to chronic renal failure in December 2007), is still in an unpredictable state. Five of the twenty-four children whom I have managed to keep constant communication with were in secondary school at the final stages of writing this thesis. Three of the children, regardless of their desire to join any secondary school, had no funds for it. They subsequently joined vocational institutions where they gained skills in tailoring. I did not succeed in tracing them in order to assess how they dealt with the competition for the few people who needed to occasionally make new clothes for themselves. Whereas the five children in secondary school attended what hardly reflected their dream schools and therefore, their overall target to attain the best formal education possible has been affected, there is a sense of satisfaction that within their limits, and with some help from outside, they have not dropped out of school as the case was for a substantial proportion of children who were enrolled at displaced primary schools.

I have desisted from making direct recommendations to policy makers and intervention agencies concerning how to minimise wartime children's suffering due to various reasons. Firstly, during my fieldwork, I already attempted to suggest to some

intervention institutions what children's needs and priorities were. In this thesis I share my experience with this activity and discussed how the experience was quite a challenge. It was like telling the concerned persons what they already knew, but they were either limited by mandates and therefore they could not do anything about it, or such problems were already defined as too complex by donor agencies. In Chapter Thirteen, I showed how the interventions in healthcare were also defined by the institutions funding these projects.

Secondly, within my own experience of intervening to address some of children's problems, I did create even more complex problems (see Akello 2007). On the one hand, I minimised their suffering, but on the other hand, there were issues which children were exposed to due to my intervention. I am still grappling with the idea concerning how to alleviate a few selected children's suffering who lived in a context where virtually everybody in that community was in dire need. This is not to suggest helplessness, but rather to recognise that caution, flexibility and self-reflection is needed in implementing all the well-meant projects which might alleviate children's suffering. Furthermore, at the time of doing fieldwork, children's needs and priorities were quite fluid. A child's priority at one point was not necessarily the same at another point. What kind of project could be designed - for instance over a five-year period (as often recommended by donors) - to meet such a population's needs? As analysed in this thesis, the fluidity of the needs identified reflect upon the mindset of the beneficiaries. In the context of uncertainty, children were likely to identify immediate needs. Immediate needs fulfil a short-term purpose. Such needs are not static and change frequently. The latter analysis about the fluidity of needs and priorities was also observed in some projects implemented in an attempt to meet vulnerable children's needs. For instance, in Chapter Three, where I analysed the phenomenon of night commuters' shelters, I discussed how, whereas Noah's Ark provided needed services at the peak of the insurgency in 2004, there was an ambivalence about the role of the three additional night commuters' shelters in 2005. Although the manager of Bukipa night commuters' shelter constructed in 2005 disclosed that he requested for the funds from the Japanese government in 2004 when there was an acute shortage of facilities for children and adults who nightly commuted to Gulu municipality for their safety; in 2005, the very target population preferred staying in camps and villages close to the municipality due to relative safety. The difficulty here is

that when the donor funds are earmarked for night commuters' shelters, the money needs to be invested as such. There was also a follow up by the Japanese government and an evaluation concerning whether the funds were put to proper use. Another example is here. In Chapter one, I discussed how the various development initiatives during civil war by the state in collaboration with the World Bank and the European Union yielded limited success. In large part, the projects which met the donors' requirements were tailored to an emergency situation. Emergency aid projects were short-term in nature. Short-term projects were implemented perhaps due to the context of uncertainty and fears that the situation of armed conflict will have a negative impact if concrete development programmes were put in place. The preceding examples reinforce my argument concerning the need to first find out beneficiaries' *emic* views and ranking the types of priorities identified by the vulnerable people into immediate and strategic needs. Whereas immediate needs are typical of emergency aid needs, they do not empower the target population much as they serve to alleviate their suffering. The strategic needs on the other hand meet long-term needs and the community is empowered to meet their own immediate needs. For a context of civil war, a strategic need would be in cessation of armed conflict so that the affected people could go back to their livelihoods. And indeed, through interactions with the children, they also identified this long-term, strategic need when they expressed a desire for the war to end so that they could go back to their communities. Cessation of armed conflict is the responsibility of the state which is under obligation by law to protect her citizens from dangers of civil war. In Chapter One, however, I examined the various ways in which the state attempted to bring the civil war in northern Uganda to an end with limited success. However, since we live in a global world, much as the war in northern Uganda mainly affected people within that locality, other countries like Democratic Republic of Congo, Sudan, Kenya and Central African Republic were affected by the civil war. There is therefore a need for a joint effort between the countries directly affected and also from the international community to bring the armed conflict to an end. The preceding analysis is perhaps appropriate for humanitarian agencies too since cessation of armed conflict appears more appropriate in comparison with provision of basic necessities to the displaced people during the prolonged civil war.