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USING LIFE HISTORIES TO EXPLORE GENDERED EXPERIENCES OF CONFLICT IN GULU DISTRICT, NORTHERN UGANDA: IMPLICATIONS FOR POST-CONFLICT HEALTH RECONSTRUCTION

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ABSTRACT

The dearth of knowledge about what life was like for different women and men, communities and institutions during conflict has caused many post-conflict developers to undertake reconstruction using standardised models that may not always reflect the realities of the affected populations. There is a need to engage with and understand the life experiences, transformations and social concerns of people affected by conflict before, during and after the conflict in order to develop



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appropriate and context embedded post-conflict reconstruction strategies. This article discusses how life histories were deployed to explore how the 20-year conflict in northern Uganda transformed people's lives. It presents how 47 men and women lived, experienced and remembered the war in northern Uganda, and the implications for health care reconstruction. By focusing on what the respondents considered major life events in their narratives of war experiences, the article shows how through using life histories, the respondents were empowered to narrate in their own voices their experiences of war; how gender and power(lessness) shaped their experiences and their 'situatedness' within the conflict and thereafter; and the implications this has for post-conflict health reconstruction. The life history method enabled the researchers to surmount the subjective nature of narratives of war and its after effects, permitting the researchers to construct a picture of how experiences and challenges to well-being, health and health care seeking changed through time and what needs to be done to ensure post-conflict development prioritises the multiple health care needs of those most impoverished by the war.

Keywords: Uganda, conflict, life histories, gender, health

KNOWLEDGE AND REALITY IN RESEARCH: EPISTEMOLOGY AND THE CASE FOR LIFE HISTORIES

Judging the authenticity and validity of knowledge lies at the heart of epistemology and epistemological debates. Evolving multiple epistemologies (e.g., those linked to subjectivism and constructionism) continue to challenge objectivism, and other paradigms in the knowledge generation industry. The debate about power relations in research continues, with discussions on multiple realities; who is best placed to talk for the researched; and how best to represent their different and evolving views, experiences and perspectives. The focus on power relations has seen the emergence of critical analysis of how issues of race, gender, poverty, age and class intersect and play out across the life cycle to influence research findings.

Within this debate an interest in transformative research methods that aim to empower research participants has emerged. The transformative paradigm emphasises both ethics and partnership in research: being sensitive to people's cultures, power relations and building relationships of trust between the researchers and the researched is critical (Mertens 2012). This is seen as imperative if research is to challenge the status quo and promote social justice (Mertens 2012). This paradigm calls for the researcher(s) to investigate meanings from the view point of the researched, exploring how the research participants construct knowledge, and what the significance of the constructed meanings is in the given context. It calls for the investigation of how this meaning varies across groups and how it is layered depending on the position of a given individual or group. Such sensitivities influenced our choice of life histories in understanding people's health care seeking and expenditure, during both conflict and

post-conflict northern Uganda. Specifically our research sought to answer the following questions:

1. How do people construct their experiences of health care seeking and expenditure during and after conflict?
2. What meanings do people construct out of such experiences?
3. How do these constructions of meanings and experiences differ by gender?
4. How suitable are life histories in capturing these meanings, and empowering people to transform their lives?

Life history interviewing is a qualitative method of data collection in which the respondents are asked to document their life over a period of time. It is a personal account by the respondent of the respondent's life, in the respondent's own words (Shacklock and Thorp 2010). Accordingly, they tend to be selective, contingent upon remembered events that are amenable to being told, be they fact or fiction (Atkinson 1995 in Shacklock and Thorp 2010). According to Goodson and Gill (2011a), this relates to the distinction of 'life as lived and life as told'. How the story is told, then, is at the discretion of the individual respondent.

How have life histories been used?

There has been a growing interest in, and use of life histories, to capture experiences and perceptions of oppressed or subaltern voices that may have been unheard and/or need situating within a particular context. For example, life histories have been used to explore the experiences of lesbian teachers and their coping strategies in specific situations (Sparkes 1994); and to capture black American women's experiences of mental illness and strategies used to cope and improve their lives (Solsulki, Buchanan and Donnell 2010). Life histories have also been used to explore experiences of infertility in Malawi (Hemmings 2007); fertility and social status in South Africa (Harrison and Montgomery 2001); critical events regarding HIV in Malawi (Yajima, Van Huis and Jiggins 2010) and gender, conflict and vulnerability in Burundi (Seckinelgin, Bigirumwami and Morris 2011). All these studies highlight the importance of context (social and metaphysical) to people's life experiences, especially of 'subaltern' positionality, and the importance of culturally appropriate methods and interventions in dealing with them.

Researching post-conflict health system reconstruction

Rebuilding health systems in a post-conflict setting such as northern Uganda can never be an apolitical process, given their poorer economic and health indicators, which predated the war but influenced the initiation of the war, its continuation, how it was conducted, the protagonists involved and the time it took to conclude it. Moreover,

health systems often entail a plethora of actors and activities, including biomedical, popular, folk or traditional approaches to health care (Kleinman 1980).

Hence, attempts to rebuild a health system will be influenced by power relations, which in turn are shaped by historical, regional and social inequalities. Questions of legitimacy emerge regarding who rebuilds the health system, especially if those rebuilding it are foreigners. With what knowledge are they acting? And with what degree of sensitivity to the local context – are they simply transplanting standardised templates of post-conflict reconstruction or using templates tailored to context?

Similarly, the research which feeds into these processes has to be locally grounded, bearing in mind historical and social sensitivities and complex power relations. Researchers are in an advantaged position, with the power to construct and label research subjects, subsequently informing the reconstruction effort. Researchers too, in all contexts but arguably particularly in post-conflict contexts, need to be mindful of the power they wield and their own biases. There is no such thing as a ‘view from no-where’ and researchers need to be mindful of their own positionality and experiences and how these shape the research endeavour.

SETTING THE CONTEXT FOR LIFE HISTORIES IN NORTHERN UGANDA

This study was undertaken in Gulu District, the regional headquarters of northern Uganda, and it was one of the districts that faced the brunt of the 20-year northern war between the government’s National Resistance Army (NRA) and Joseph Kony’s Lord’s Resistance Army (LRA). The conflict caused many people to abandon their homes and make their way to internally displaced people’s (IDP) camps. Most IDP camps in the Acholi sub-region were located in Gulu, making it the base for the war and post-war reconstruction effort, characterised by a mushrooming of different types of non-governmental organisations, involved in different types of socio-economic and humanitarian activity. Although most camps were destroyed and people were required to return to their homes when the war ended, many chose to remain on the periphery of Gulu town.

According to the Gulu District Local Government Statistical Abstract 2012/2013 (GoU 2012/2013), Gulu District has an average population of 407 500 people and a population density of 111.5 persons per square kilometre. Although it is the most urbanised district in the northern region, most people (80%) rely on agriculture for their survival, growing mainly cereals such as millet and sorghum. School enrolment is male biased, with 42 304 boys enrolled compared to 34 800 girls. With regard to health, malaria remains the biggest cause of morbidity and mortality. It is the leading killer disease among children under the age of five years accounting for 27% of all causes of death, while acquired immune deficiency syndrome (Aids) is the leading cause of death among adults (18%). The human immunodeficiency virus (HIV) prevalence rate

was reported to have declined from 14.4% in 2009 to 11% in 2011 among antenatal attendees, while the national prevalence was 6.4%. Maternal mortality was 354/100 000 live births in the population and the infant mortality rate stood at 132/1 000. According to the Uganda Demographic and Health Survey (UDHS) 2011 (Uganda Bureau of Statistics 2011), the total fertility rate for the North was 6.3 births per woman, similar to the national figure of 6.2 births per woman.

While generating district specific information to support responsive planning, the Gulu District Local Government Statistical Abstract 2012/2013 (GoU 2012/2013), as with most statistical abstracts, captures a summary of socio-economic data, focusing on measurable aspects of the sectors considered fundamental for development. With regard to health, only statistically measurable indicators, such as maternal mortality, HIV and malaria prevalence, and fertility rate, are measured. Other critical aspects which cannot be easily captured statistically, such as psycho-social aspects of health, are left out.

With the end of the war the government of Uganda embarked on reconstruction to enable the north to catch up with the progress in other parts of the country. The government developed the Peace, Recovery and Development Plan (PRDP) for northern Uganda (GoU 2007), which became the blue print for post-conflict reconstruction, spelling out how accelerating progress in northern Uganda would be achieved. The overall goal of the PRDP is 'To consolidate peace and lay a foundation for recovery and development in Northern Uganda' (GoU 2007).

With regard to health, the strategic objective of the PRDP is to reduce morbidity and mortality from major causes of ill health, through a strategy of constructing more health facilities to increase the percentage of the population living within 5 km to the nearest health facility, improve service delivery and public health education (GoU 2007). However, the health focus and indicators remain the same as the national ones.

With the end of the war and the departure of humanitarian agencies, an opportunity arose for new health providers to establish their private health facilities, to fill the void. This increased the number of private health providers, creating a complex interplay of government and non-government (private) providers. Private providers here include drug shops and pharmacies,¹ clinics,² faith-based private not for profit hospitals,³ and private hospitals.⁴ There are also specialized providers, such as The Aids Support Organization (TASO) for HIV specialised care. The emergent health care market, requires money to access. All facilities charge fees, ranging from the nominal to exorbitant fees depending on the ailment, and the nature of the facility. This is a sharp contrast to the conflict period when humanitarian agencies provided free health care services to people in IDP camps.

Sampling sub-counties for life histories

Within Gulu District, four sub-counties were selected. These were Paicho and Unyama sub-counties which represented the rural sub-counties, while Layibi and Bardege

represented the urban sub-counties. From these, four villages were selected: Wii Layibi from Layibi, Keyi from Bardege, Omel from Paicho, and Agung from Unyama. The rural urban mix was chosen based on the premise that comparing the rural and urban, and richer and poorer groups would enable a rich comparison and support generalisability to other districts.

The process of using life histories in northern Uganda

In the current study, 47 heads of poor households (each aged 45 years and above) were asked to mark significant life events over the three key phases of before, during and after the war, to document changes in their households' ability to cope with household health care costs over the three time periods. This included highlighting what they considered to be significant life events, health events, treatment sought, cost, what was paid and what was foregone to pay for health care. While many studies have documented the effects of war on populations, using the life history approach meant that we left it to the respondents to determine for themselves what events they considered significant and to share these with us. Similarly, the choice of what determines health, treatment and cost of care were left to the respondents to define and articulate: this was considered more empowering than choosing for them. Having told us their life experiences, they went on to give us their expectations of what good health care meant and recommendations for reconstruction. That way, we ceded some of our power as researchers to the participants to tell their own story other than just reproducing knowledge as part of the post-war research industry.

Of the 47 household heads, 26 were females and 21 were males. The unit of analysis was the household, which in the study referred to residential unit(s) whose occupants commonly shared meals, undertook productive activities and decision making. The household head referred to the socially accepted leader of the residential unit(s).

Each life history was conducted by a pair of researchers, one interviewing and the other recording both manually and electronically. After introducing the study, the respondents were asked to narrate the story of their life as far back as they could remember, from whichever year, as long as it was before the war. For each phase, they identified their major life event, why they considered it significant, and what memories they attached to it. For illnesses, they named the illness, the treatment sought, where treatment was sought from, how much was paid and the treatment outcome. As they narrated their life story, the researcher in charge of recording drew the timeline, matching the events with the years (if the respondent could remember it) and the outcomes. In addition to the lifelines drawn, the results of these life history in-depth interviews were transcribed, translated from Acholi into English, and analysed thematically using Atlas ti software.

KEY FINDINGS

The presentation of key findings reflects the key themes that emerged during the analytical process and they are particularly pertinent to the post-conflict reconstruction from a gender perspective. We first outline the prolonged experience of war and its implications, the impact of war on gender, and men's specific experience of war.

Not one war, not one experience

The northern Uganda war is often portrayed as a single 20-year war protracted by Kony's LRA (Dolan 2009). But from the life history accounts of different respondents, it was clear the war in northern Uganda was fought in different phases, with different experiences for those caught up in it:

During the insurgency (*Cilili*), ... from 1989 until about 2000 we did not leave this place ... So when they came and took my things is when we knew we have to leave this place because if they came back this time they would kill us. It was that robbery by the army and we feared for our lives ... And also the Kony (rebels) group. Let me say it was from the first rebel group (that was Lakwena)⁵ up to when the Kony rebels came. We went to the town, opposite the bus park. We stayed almost 5 years in Gulu town; it was 5 or even more years. (68-year-old man)

... In that year [1992] the insurgency intensified and even here in Layibi we could not stay and it went up to 1996 which was the worst year, ... people could not sleep at home so we started looking for where to live again. We started sleeping in Sacred Heart School where my sister was teaching but during the day we would come back home here in Layibi and at night we go and sleep there. In 1996 I also gave birth to another baby. In 1997 we went back home because the insurgency had reduced, we started sleeping at home again. ... But in 1998 coming to 1999 we again ran because the rebels came back, ... this time with even more ruthlessness. We again ran and rented a house in go down. That time you could not sleep at home because when they came they would move in every house ... Because it was now difficult to just stay at home my husband went back to school to train as a teacher ... I gave birth to another child in the year 2001. We stayed in Gulu and my husband started drinking so heavily and life became very difficult with frequent issues of domestic violence. ... in 2006 August I gave birth to another child who is now our last born. That was the same year that my husband's mother also died. (50-year-old woman)

The war begun from Awach ... What made me leave Awach was, 'Karimojong' cattle rustlers came and raided cattle from people. After that there was war between the NRA and Lakwena, there was insecurity so all of us fled from home. We went to Gulu. But I said I am going back home (Agung) ... The war was intense after our hut was burnt ... We all went and sought refuge in a place called Lukome St. Martin in the school ... From there the situation worsened, we could not bear it, so we sought refuge in Gulu ... While in Gulu the situation subsided so we came back home [Agung]. After that the government said that 'You should leave the village within forty eight hours.' If by that time you were still there they would kill you. They had pitched camp all over this place. If they got you they would send you away forcefully. So a camp was built in Onyama and everybody sought refuge in Onyama till the war ended. (63-year-old woman)

The historical lens provided by life histories revealed the experience of conflict from the perspectives of different older women and men. The illustrative extracts above show that there were several protagonists in the northern war: the Karimojong cattle rustlers, Alice Lakwena's Holy Spirit Movement, Kony's LRA and the government soldiers (NRA); and three significant periods within the anti-war effort. The first period was in the early 1990s when people were ordered to leave their homes within 48 hours, most ending up in schools and mission bases. This led to displacement but not camps. This was followed by a lull when people returned to their homes. The second episode – the fresh outbreak of war in the mid-1990s – led to the formation of IDP camps in the villages, to which villagers were required to go. The third episode was in the 2000s, when camp infrastructure was well established and services provision improved. The life histories highlight the ongoing, fluid, fluctuating and devastating nature of the war across genders and generations and its impoverishing nature. Each of the periods identified has gendered ramifications for women and men as explored in the following sections.

Gendered experiences of war

From the different accounts, there were variations in people's life events, including death, abduction, marriage, divorce, giving birth, getting jobs, poverty and impoverishment, financial hardship, economic opportunity, dropping out of school or joining school, displacement and night commuting:

... when this war begun he [husband] had just gotten a job and started working in Kampala. From Kampala he was posted to Khartoum [Sudan] but me I came home in Gulu. ... he stayed there for some time that we lost communication, for three years. I thought it was their kind of job – ... But later some man came from Khartoum and told me that my husband had died in Khartoum. At that time we were here with my in-laws and his parents. ... My brother-in-law started mistreating me and the children ... They [in laws] became so greedy for the things we returned with from Kampala saying they were their brother's. So they started to remove the things from me. I tried to resist but he took it by force so it became too much for me. So, it was hard that I went to the office of the Red Cross in Gulu for help. I told them what I was going through ... In 1993 I could not take it any more so my people came and took me home. The Red Cross took me to Lira. They took me with two of my children and others (four) remained with their grandmother. (54-year-old woman)

... I lost my children during the LRA insurgency, two of them died during the insurgency and they were already big boys. In 1990, I fell ill only once but it was a very serious illness. ... We had to run and we were in the camp in Bungatira *Coopee* and I was brought to the government hospital in town where I recovered and that was the last time I fell seriously ill. I do not know the year ... The Karimojong took my cattle. By then, my children were already fully grown up ... It must have been 1991 ... I am still suffering from it up to now. (87-year-old man)

By 1989 my life was not easy ... my wife had passed away, following my parents ... I was just forced to marry ... I went to the camp in Acet here in Gulu district, we were forced to go there by the government. 1995 was a difficult year. People it is painful to talk about death in this discussion ... [Silence] In around 1995 my son died when he was abducted by the rebels ... He was only 15 years old. We had just stayed for a year at Acet Camp. In that same year [1995] I also lost my brother. (56-year-old man)

From the above, people had several experiences which affected them negatively. It is also clear that gender affected what was reported as a major life event, how people experienced it and how they coped with it. For example, for women, widowhood compounded their war suffering, bringing upon them further loss of property, displacement and family disruption. Meanwhile, men highlighted their inability to take charge of their families and property as was customarily expected of them, exhibited in the following ways: failure to seek medical help for fear of abduction; loss of children to abduction; and loss of property, particularly cattle to rustlers.

Men as victims of war

The dominant narrative in most gendered accounts of war portrays men as perpetrators and women as victims of war. Even when men experience war as victims, this is still constructed within the masculinity paradigm, not as an aspect of weakness. But life history accounts of northern Uganda in men's own words and experiences highlight men as victims, who also suffered shame, humiliation, weakness and helplessness:

My son, just only two things stick out for me: the sodomy I endured and how we left home going to the camp. We were chased from our homes in a very bad way, we only survived by God's grace, it was not a good experience at all. Also there was a time we were abducted by the government army and they tied us with ropes and they were pouring on us red peppers [red chilli powder] just direct on our faces. We just escaped death narrowly. I cannot remember the year. But I think it was April 1991. It happened from Aswa County in Bur-Coro by the government army, unbelievable ... We were first taken to Lukome Primary School where we were tortured too much and later to Bur-Coro. From Bur-Coro we really suffered ... We were displaced first to Pwong Dwongo, ... then we came back home. In 1990 I lost another child. My first born is now 40 years old. In 1990 I produced a girl ... In 1993 I produced a baby boy but unfortunately he died, after about three years. ... Am sorry but let me take you back a bit if it is allowed. In 1990 my son called Ojok died in Lacor Hospital ... They just told us he was having little blood in his body and also anaemia ... they asked me to give my blood which I donated for my son. (70-year-old man)

... it was the famine and also the way the soldiers treated us by sending us in the war front when we did not have guns. Life was hard; we were living in abject poverty. It was until 1994 that is when we went to Acet camp. [Silence] ... We narrowly escaped abduction. My last [third] wife was abducted twice and she only escaped. That was in 1998. That was for only one night when they were made to shell the groundnuts and released. Each time she was kept for one night

and she returned. In 1998 my son whom I had left studying in Gulu town was abducted from Palenga and stayed for one year ... he returned in 1999. His name was B. C. [Silence] ... There was nothing and I went back to town. I moved back with my children who were at the age of abduction to town and also my son B. C. who had just returned thinking if he was abducted again, they would kill him for escaping. In 2007, that same year when my wife fell sick, my daughter in law fell sick and died. That same year we left Acet camp and moved to Omel Apem, still in small camps. Now in 2008 I left Omel and came back home and resumed with my normal life at home and everything was okay. In 2009, the second wife of my son whose first wife had died in the camp, fell sick. She was taken to Gulu hospital and died. (60-year-old man)

In 1989 ... my wife left me and ... I lost so many of my relatives. My brother died, he was my elder brother. I also lost two sons of my late brother ... One of them was beaten by the rebels (*Cilili*), he was a student at Layibi. One was 15 years old. He was the youngest and still in school at Layibi College. The rebels came and abducted him from home and beat him but later left him to die ... The last one died of HIV. At that time HIV had just started and we did not know ... In 1990 the army robbed me. They took many things, mostly household things ... We feared for our lives. It was now dangerous to live at home at that time. During that year after I was robbed, I was sick. I suffered from bladder infection. By that time, my wife had already left me, because of other small issues, like getting money, it was very difficult to get money, until that boy whom I paid school fees for started helping me and he did that till around 2005 and then unfortunately that very boy died. We went to the town, opposite the bus park. In 2001 we had another death occur in our family. Another boy [nephew] died; he had gone to train for kick boxing. (68-year-old man)

2005 was the year when I was abducted by the rebels. I was in the bush for five days then I escaped and came back home. They let me carry one of their injured combatants and I walked with him in the bush. By the time I came back I did not have any energy left in me. It was Mr. W. O. who came and picked me, because I could not walk at all, this was from Bobi barracks ... They [rebels] had been shot from Layibi College here, and as they were escaping they found me sleeping in my house and they just arrested me. Then when I came back I went to the barracks in Bobi. By the time I arrived home, I found that people, my relatives had organized my funeral, because they had got word that I was killed. Some of my relatives were looking for my body in the trails of the rebels. Meanwhile, I had also escaped, so people were confused about my fate. Actually there was a grave ready for my body; all was set for my burial. It was the worst experience. In 2006, I was re-arrested. This time they made me carry their luggage like beans and many other things. We reached a certain place and they started looting. That is the time when I threw that luggage down and again I escaped. When I returned, I was very angry and I joined the local vigilante group to protect my village and that is how we defeated the rebels and stopped their attacks on the village. I stayed in the vigilante group the whole of 2006, 2007 ... Then in 2008 my wife conceived and gave birth to my sixth child. (46-year-old man)

In 1994, when I was teaching is when I was captured and taken captive as a luggage carrier. That time they were killing teachers. I even got a wound while in captivity. They hurt me. That is the problem I got. After that, I escaped in 1996. I came and reached Gulu. I found my family in Gulu. I never went back to our home in Lukome, which is found in Bungatira Sub-county. I continued to stay in Gulu. Starvation was a major problem. In 2005, I got sick. I suffered from

TB. They found wounds in my lungs. Two in the right hand side and one in the left hand side. I treated it from Lacor. I got better and up to now am living with no pain, except for remains of the scars of the wound that I got while in captivity, it is the one that at times pains. [Silence] ... (54-year-old man)

... I was captured and beaten many times. Then in 1989 the soldiers of the government captured me and many other people ... and put us in the quarter guard here and then later took us to Luzira [national maximum security prison in Kampala] ... claiming that we were rebels. We stayed in Luzira for 3 months then later they released us after finding out that we are not rebels. But I stayed in Luzira. When we came back the camps had started ... I went and stayed in Unyama camp ... because our temporary home was in Unyama. So we had to come and get food from here. You struggled and sometimes if you met the Kony soldiers they mistreated you in any way. The government soldiers also; when the women came here, they would collect women and gather them in a school in Bur-Coro and some in Lukome and mistreat them, beat them and rape them ... I also lost two brothers who lost their lives while under my care. We buried them in a certain home in the camp there; because bringing them here was impossible. (59-year-old man)

From the foregoing stories, men experienced rape, starvation, suffering when loved ones died, abduction, joined and served in the army, were vulnerable to both HIV and desertion by their wives. This implies that the discourse of war and the interventions following wars need to cater for both male and female survivors of violence. Otherwise, males will continue to suffer in silence. And the absence of interventions means negative practices such as gender inspired violence continue unchecked.

IMPLICATIONS FOR POST-CONFLICT HEALTH RECONSTRUCTION

From the different narratives of war illustrated in the life histories above, it is clear that people experienced suffering, death, vulnerability, humiliation, poverty, starvation and variations of helplessness. This suffering was not reduced to one gender, although gender roles and relations structured and shaped the different kinds of experiences older women and men endured. From this, those constructing the health care system need to be cognisant of a number of aspects.

Hard choices: Investing in the hardware or software of health systems?

The ongoing Ebola epidemic with its wide reaching repercussions in West Africa has highlighted the importance of resilient and responsive health care systems that respond to community needs. Ebola has manifested itself particularly in post-conflict states, in both the current (Sierra Leone, Liberia and Guinea) and previous (Northern Uganda, DRC) outbreaks, demonstrating how the implications of war can have far-reaching consequences.

In northern Uganda, the post-war effort has arguably paid much more attention to the hardware of health infrastructure (building clinics) over the software of health approaches (supporting and retaining human resources for health and ensuring appropriate training to best support women, men, girls and boys traumatised by war). There is obviously a need to rebuild health infrastructure post-war (Kruk et al. 2010), and the reconstruction effort in northern Uganda has focused on increasing the numbers of health centres built or renovated and housing for health workers. However, the experiences and issues raised in the life histories clearly illustrate the need to go beyond constructing facilities. The post-conflict health intervention needs to be cognizant of what people suffered, how they suffered, their framings of suffering and best approaches to address pain and suffering. This calls for both preventive and curative services, available within both communities and health centres to enable community healing.

Improved livelihoods key to health care coping

Two dynamics that characterise health care access in post-war northern Uganda are an emerging health care market and an impoverished population. As the life histories clearly demonstrate war is impoverishing, given that many people lost their animals and employment. While the health care system has both public and private providers, money is required to purchase medicines and other requirements, even in public facilities. While the government is committed to providing free primary health care in its many facilities, these tend to be basic and drugs are often in short supply, unlike the situation that pertained before the war, or during the war in IDP camps where health care services were generally free.

These days the costs are high, those days the costs were low and then drugs were in surplus and they would never get out of stock. But these days when you go to the hospital you hear, 'there are no drugs in stock go and buy your own drugs'. What if you do not have money, what are you supposed to use for buying these drugs? ... It is costly. (63-year-old female)

Now it is those who can afford who get the best treatment. When you go to the hospital the doctor will see you and prescribe the drugs. Then you go to the pharmacy and you are told we do not have the drug you are supposed to get. So they tell you to go to the drug shop and buy or any other clinic and what they do not know is that you do not have money. So now what used to be free, you pay for it. (62-year-old female)

Meanwhile, the facilities that are well stocked and have enough health care workers are the private, fee-charging diagnostic facilities that emerged after the war. So, on encountering inadequate care in government facilities, many are forced to go to private facilities where they have to pay.

Men's health matters

In addition to the above, there is a need to pay attention to men's health care needs. Most literature assumes only women have war-related health care needs, and this in turn underpins the emphasis on maternal and child health services. But the life histories illustrate the multiple impacts on men's health too. In addition to physical illnesses, such as bladder infections, HIV and wounds, there were clearly articulated psychosocial needs arising from the suffering and humiliation they suffered at the hands of different groups of combatants. Such suffering included being raped, being tortured, losing property, watching on as one's spouse or family member was physically and sexually violated, losing children and relatives. To many males, this challenged the very basis of their masculinity, as they failed to protect themselves and their families. Men's health needs need to be provided for, to address both the physical and psychological needs, and subsequently end the cycle of violence.

Importance of mental health services

Most post-war health interventions focus on rebuilding health services and the immediate causes of disease and mortality: there has been a lot of attention paid to curative and maternity services. Where prevention services are provided it is those that can be easily verified, quantified and with immediate benefits, such as vaccinations and HIV prevention services. However, the accounts of many who experienced the war call for more attention to be paid to mental health services. Talk of feeling 'foolish', 'emptiness', suffering unexplained joint pains, body weakness or illnesses that medics could 'not see' were indicative of people somatising distress. Often, these were blamed on the suffering they endured (be it rape, loss of loved ones, abduction or abducted loved ones, loss of cattle, etc.). Men were sometimes deserted by their spouses while women suffered violence at their spouses' or in-laws' hands, including being driven out of their homes. All these caused untold suffering, which many are yet to recover from. So, while the gains of maternal and preventive health are to be celebrated, there is need to step up mental health services. This is particularly important in a community where many have struggled to find closure. Here, unlike South Africa (Gade 2013), there has never been a truth and reconciliation commission.

Revamping health care is key to national transformation

In many of the life histories, the respondents' narratives of suffering were tied to their identity as Acholi people. Many questioned why they as Acholi had to suffer, and asked why other Ugandans let them suffer like this. While most of Uganda has experienced war, this may not be easily comprehended by people who suffered either in an IDP camp in northern Uganda or within their village. Therefore, for people to heal, there is need for community counselling, to take them through what they suffered, to show them that

what happened to them could and has happened elsewhere and is not linked to their Acholi identity. This could be followed by a national dialogue on war, conflict and its after effects. If put together with other wars that have occurred in Uganda, it would help the people of the north to know that what happened to them was not restricted to them. And that together, we should fight to end wars and conflicts, rather than to perpetuate them through revenge.

Reflections on the life history method

The use of life histories enabled women and men to tell their experiences of war and the implications for health in their own words, using their own terminologies and concepts and approaches to discussing time. Indeed, personal experiences are used to mark time and narrate events: marriage, birth, death, abduction or changes in livelihood. These life histories enable us to observe lives as socially constructed, providing insights into how society constructs, considers and values the issues narrated. However, using life histories to explore personal narratives of war is not without its challenges:

Moving towards an empowering process: Research ethics as process

The empowering potential of life history research has generated debate, given the inherent ethical issues relating to life histories. On the one hand, there is Gill (2005, 2007a) in Goodson and Gill (2011a) who argues that life histories, in their ability to be both an ‘intervention and an interruption, provided an opportunity for change’, which would not have been possible with other methods. On the other hand, there are Goodson (1995) and Sike et al. (2003), both cited in Goodson and Gill (2011a) who caution against hyping the empowering potential of life histories, as the evidence was not robust and in view of the ethical issues concerned, particularly the ‘crisis of representation’ and the ability to generalise.

Nonetheless, they all agree that life histories can be therapeutic, as people are given an opportunity to tell their stories and experiences. Through situating the events in context they enable respondents to identify, discuss and locate social meaning to events (Goodson and Gill 2011b). Life histories give participants the power to decide what to talk about, and how to frame discussions: this is critical in contexts where people have been through extreme personal and social hardship and where, as Uvin (2009) argues from the Burundian context, there is ‘the risk of retraumatizing people, especially as we had nothing to offer in terms of services or support’. In post-conflict Burundi, Seckinelgin et al. (2011: 5) found that people wished to talk about their experience: ‘a) many people told us that no one was interested in their stories; b) it was a way of resisting simple victimization which also removed their agency’. This is in line with Goodson and Gill (2011a), who argue that life histories can enable social imagination, because if an event occurred in a historical time period, it can be historically located. From the life histories,

respondents were able to reflect and make plans with regard to seeking health care. Other than simply lamenting about how difficult it is to get medicines, they were able to imagine a life of self-sufficiency, basing on what their recollections of their past was (a life with animals and income). While the extent to which their dreams would come to fruition is debatable, at least, by giving them an opportunity to reflect, they were able to dream about a better future in both financial and health terms.

The ReBUILD Consortium, under which this research was undertaken, is an international research partnership working for improved access of the poor to effective health care and reduced health costs burdens, through the production and uptake of a coherent body of high quality, policy-relevant new research on health systems financing and human resources for health in post-conflict countries. Central to ReBUILD's operation are the networks with policy makers (local and national). ReBUILD researchers are encouraged to compile a popular version of their research findings for uptake into policy. From these life histories, a number of policy briefs, blogs and videos were produced and shared with local, national and international policy makers.⁶ While we cannot claim that there has been much change, at least we are beginning to see improvements, such as increased availability of medicines in government health facilities. Presentations regarding the need for sustainable livelihoods at household level, as a strategy for improving seeking health care, also attracted interest from the district leaders.

Life histories, then are not only about life as lived and told, but also life as imagined, which can then be leveraged by respondents and their leaders to improve their situations. The ability to imagine, Goodson and Gill (2011a) continue, enables people to exert agency and think of alternative futures which are different from those they experienced and or are experiencing now. This engenders new meanings of the self and the event, as history changes and people can develop new meanings of themselves as historically constructed. The ongoing challenge is in rapport and empathy, in trying to ensure life histories are an empowering process rather than an extractive one, an opportunity for people to share their stories with dignity.

Telling others' stories: Gender, power and positionality

Life histories generate large amounts of data: these 47 interviews generated hundreds of pages of transcripts and many hours of analysis. During the analytical process, there is a need to think critically and carefully about our role as researchers in the research endeavour. As Goodson and Gill (2011a) argue, life histories are a collaborative interpretation between the teller (participant) and the listener (researcher). Which narratives should we include? How much do we highlight suffering (victimhood) and how much do we highlight resilience (survival) in the face of extreme hardship? How can we ensure we are presenting others' stories how they would like to be told rather than 'othering' arguably vulnerable groups? How do we structure the narratives in ways that

highlight gendered realities in a given context without exacerbating gender stereotypes? Both women and men experienced gendered violence, suffering and extreme violence; and we have highlighted this in our analysis but in particular showed the experiences of male vulnerability as these are largely absent in discourse, analysis and the post-conflict reconstruction effort and addressing this is arguably key to both women and men's health.

Ensuring both authenticity and confidentiality

The strength of life histories lies in the depth, detail and nuance of the participants' stories: their own words detailing their own experiences. We ensured confidentiality in the consent process prior to the life histories and need to ensure this is adhered to, raising dilemmas of the richness, depth and detail that can be provided in research dissemination and uptake activities and written outputs such as this paper. We went through each output carefully to ensure confidentiality was not breached, and this is particularly critical with vulnerable groups discussing their experiences of conflict, including for example male rape, within a homophobic context.

CONCLUSIONS

The increased interest in narrative research has seen a growth in methods such as life histories, which aim to capture how people live and relive their lives through narrative. In the research reported on in the article, life history research enabled us to capture how 47 men and women aged 45 years and above experienced the northern Uganda war from their own perspective, and which memories endured most. From the 47 life histories, the most enduring memories from the northern Ugandan context were negative, ranging from death, to sexual and physical violence, sickness, suffering, impoverishment and humiliation. This raises the importance of mental health as a key component of post-conflict health reconstruction. It also raises the importance of considering men's health care needs, in addition to women's. The nuance and depth of life histories bring challenges that need discussing but also bring opportunities to inform the post-conflict reconstruction effort from the perspectives of women and men. Prominently it raises the need for us to focus on the software of health systems – on building holistic, responsive and accessible health care systems that go beyond a focus on the physical rebuilding of health infrastructure.

NOTES

1. Drug shops and pharmacies are often the places where most people go for self-medication, which often involves seeking the free opinion (consultation) of the seller.
2. Clinics varied from the general patient outpost to one which can provide outpatient and

basic inpatient care. They were often operated by health workers. However, they rarely provided advanced specialised or inpatient health care.

3. The private not for profit faith-based hospitals referred to mission facilities, such as St. Mary's Lacor Hospital in Gulu, St Joseph's Hospital Kitgum in Kitgum and St Ambrossoli Hospital Kalongo in Agago District. These provided primary and most of the advanced specialised and in patient health care.
4. One private hospital, Gulu Independent Hospital, was established to provide outpatient and inpatient care, primary and specialised health care.
5. Lakwena refers to the Holy Spirit Movement led by Alice Auma Lakwena which preceded Joseph Kony's Lord's Resistance Army.
6. For examples of these, see: <https://rebuildconsortium.com/>; <https://rebuildconsortium.com/media/1100/ugandaprojectbriefingapril2013.pdf>; <http://healthsystemsglobal.org/blog/54/Life-histories-A-research-method-to-capture-people-039-s-experiences-of-health-systems-in-post-conflict-countries.html>; <http://resyst.lshtm.ac.uk/rings>

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BIOGRAPHICAL NOTES

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