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among the Acholi, Northern Uganda

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Aloysious Nnyombi MSc

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LIST OF ACRONYMS

ACTs	Artemisinin-based Combination Therapies
AIDS	Acquired Immune Deficiency Syndrome
AMR	Antimicrobial Resistance
APPEAR	Austrian Partnership Programme in Higher Education and Research for Development
ART	Antiretroviral Therapy
AU	African Union
CRC	Convention on the Rights of the Child
HC	Health Center
HIV	Human Immunodeficiency Virus
HSMF	Holy Spirit Mobile Forces
IDP	Internally Displaced People
IMF	International Monetary Fund
IOM	Infant Oral Mutilation
ITNs	Insecticide Treated Nets
LRA	Lord's Resistance Army
MA-MEDANIH	Master Programme Medical Anthropology and Research for Development
MoFPED	Ministry of Finance Planning and Economic Development
MoH	Ministry of Health
MoPS	Ministry of Public Service
NDA	National Drug Authority
NGO	Non-Government Organization
NRA/M	National Resistance Army/Movement
NU-HITES	Northern Uganda Health Integration to Enhance Services
NUMAT	Northern Uganda Malaria AIDS and Tuberculosis Programme
OeAD	Austrian Agency for International Cooperation in Education and Research
OPD	Outpatient Department
PEPFAR	US President's Emergency Plan for AIDS Relief
SAPs	Structural Adjustment Programmes
TBA	Traditional Birth Attendant
TCM	Traditional and Complementary Medicine
TMG	Therapy Management Group
UBOS	Uganda Bureau of Statistics
UCDA	Uganda Christian Democratic Army
UPDF	Uganda People's Defence Force
UPDM/A	Uganda People's Democratic Movement/Army
VHT	Village Health Team
VSLA	Village Savings and Loans Association
WHO	World Health Organisation

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CHAPTER 1: INTRODUCTION

This dissertation focuses on a topic of significant interest to anthropology: health, illness, and healing in Africa (Evans-Pritchard, 1937; Feerman & Janzen, 1992; Whyte, 1997; Mogensen, 2000; Langwick, 2011, 2015). The topic has been attended to from various perspectives, with earlier ethnographic texts interrogating the logic of local health beliefs (Horton, 1967). In his ethnography on witchcraft, oracles, and magic among the Azande, Evans-Pritchard (1937) demonstrated that witchcraft was a means to explain and respond to ill health. Being ill or not was then tied to a supernatural frame that could be accessed and understood when one consulted with the oracle. Such classical texts present key threads of thought that still influence some anthropological body of work. They demonstrated the need to study the cultural patterns underlying the local beliefs about health.

The growth of structural-functionalist scholarship brought about a fundamental shift from cultural logic to the contribution of the health system to the ordered whole. The interest then was how health and healing systems sustained the social system of which they are part. Turner's (1968) study among the Ndembu in Zambia found that healing rituals served both current needs and Ndembu traditions. These not only addressed bodily malfunctions but also attended to psychological troubles and social ruptures.

Subsequent anthropological work gave precedence to the interpretation and meaning of African health systems. This body of work attends to African medical systems as “cultural systems” that construct unique forms of illness and produce distinctive forms of medical behaviour (Kleinman 1973; Good & Good 1981; Good, 1994). Langwick's (2011) study on African healing in southeastern Tanzania found that individual suffering has an intimate connection with social tensions. Therefore, indigenous healing meant taking a spiritual orientation to amend one's relationship with other beings. However, among biomedical practitioners, bodies were understood as distinct from the spirit and mind. Disorders were being treated through the ailing body.

Ethnographic studies that place interpretation and meaning at the centre of analytical interest have been critiqued for attending to culture as being independent of broader political-economic forces (Moore, 1993). This gave birth to anthropological work that extends the scope of analysis to material conditions in which people's meanings are situated. These have been able to show how global and national political, economic, and socio-structural frames influence differences in the quality of health (Singer, 2004; Fassin, 2013; Panter-Brick & Eggerman, 2017). Meek's (2023) study on fugitive science in Tanzania attributes the growth of adulterated pharmaceuticals to neoliberalism, structural adjustment policies, debt, and racial capitalism. Adulterated pharmaceuticals, then, are a marker of decades of neoliberal deregulation and privatisation that have pushed the Tanzanian government into the recurrent underfunding of the health sector (Meek, 2021; 2023).

Currently, research on African health is approached from two strands – the interpretive and critical stances. Increasingly, this separation has been understood as counterproductive (Dressler, 2007). Thus, some studies utilise both theoretical constructs to accurately depict reality. This study utilised both theoretical frames to provide an understanding of local health practice. It particularly attends to a local disease-causing agent called Te Lak "under the tooth" among the Acholi people in Northern Uganda.

Te Lak is an important idiom often referenced when the community speaks about health and health care for infant children. It is common for mothers to cite Te Lak when an infant experiences symptoms of a disease. In conversations with fellow parents, mothers whose infants have persistent symptoms, such as high body temperature or convulsions, are asked if they have considered seeking treatment from a Te Lak specialist. Women in communal spaces (such as markets and farmland) share their experiences caring for children who contract diseases caused by Te Lak. During clinical encounters, the mother's explanations of disease causation include Te Lak and emphasise the importance of providing timely care to avert the possibility of death. Some healthcare professionals sometimes discuss the possibility of Te Lak causing diseases, and some refer patients to Te Lak specialists for care. Other healthcare professionals view Te Lak and related practices as harmful and attribute a proportion of infant morbidities and mortalities to practices mothers engage in when they seek care from Te Lak specialists. When conducting

healthcare outreaches in hard-to-reach areas, healthcare professionals address beliefs connected to Te Lak and explain how these stop mothers from seeking care for common childhood diseases such as malaria and pneumonia. In a Pentecostal church, preachers occasionally refer to Te Lak and cite biblical verses to demonstrate that associated practices are ungodly.

It is evident that Te Lak is a daily concern for the community. It is also clear that competing narratives argue for and against the local disease-causing agent. The "pathogen" is placed along the disease-causing continuum and associated with distinctive symptoms. The symptoms are addressed within a local health care system managed by a group of local specialists trained to address ill health among infant children. The specialists possess local health knowledge passed on from one generation to the other through training and apprenticeship.

There is also a group of persons, mainly hospital practitioners, who place Te Lak along a continuum of beliefs that cause harm to infant children. This line of thought is mainly informed by the global discourse on harmful traditional practices affecting children and women. These persons argue that participation in practices related to Te Lak is a violation of a child's right to good health. They point out the horrific experiences that infant children endure as the local specialists attend to them. Further, they estimate the proportion of children who have lost their lives following treatment for symptoms related to Te Lak. They also argue that prioritising care from local specialists results in delays in seeking care from the professional health system, ultimately leading to death (Atim et al., 2018; Wordley & Bedi, 2019). As a result, there is an urgent call to eliminate Te Lak and associated practices. This discourse has created a general perception that engagement in Te Lak is immoral (Atim et al., 2018).

I argue that these competing narratives shape the micro-politics of health and healing in post-conflict communities in Northern Uganda. In the field sites I visited, when local law enforcement officers detain mothers and local practitioners for engaging with Te Lak and associated practices, the elders in the community protest such acts and cite the ignorance of enforcement officers of the prized local medical knowledge. The contestation between two critical community leadership structures creates a social struggle over who is right.

I also argue that these contestations disrupt local ideas and practices on infant health. Nonetheless, this does not erase the perception that Te Lak is a threat to the health of infant children. What happens is that the local populace weighs the contestations against what their local medical culture suggests. The communities find sense in some of the ideas presented, which creates areas of consensus. This, for example, results in treating symptoms associated with diseases caused by Te Lak with therapies common to the professional medical system (Lock & Nguyen, 2018). Also, there are ideas that they strongly disagree with. For example, the argument that Te Lak and associated therapies lead to child morbidity and mortality contrasts sharply with the local population's opinion that such therapies support the child achieve good health.

It is important to note that these competing narratives tend to obscure the crucial economic and political factors that underlie Te Lak. Those who view Te Lak as a harmful traditional practice tend to apportion blame to the community's local customs for the infant's poor health. These fail to contextualise the existence of Te Lak within the historical, economic, and political processes that might explain the infant's suffering. Similarly, community members who classify Te Lak as a specific entity responsible for child morbidity rarely attribute the child's continued poor health to existing inequalities. They instead interpret the continuity of symptoms as a matter of misdiagnosis. They re-diagnose the symptoms and, at this time, exclude the earlier said cause, thereby moving far away from explanations that can attribute the persistence of poor health to existing deficiencies.

I argue that having a complete understanding of the continued popularity of Te Lak also requires the interrogation of how the local disease category is embedded in historical, socio-structural, economic, and political factors and their resulting inequities and inequalities. Mogensen's study on the social course of Te Lak among the Jop'Adhola in eastern Uganda provides essential insights into this matter. This study reveals that the local health beliefs and associated practices are "a way to express experience with poverty and the instability Uganda has gone through". Thus, Mogensen concludes that Te Lak can only be understood "as part of a larger social, political, and economic context" (Mogensen, 2000, p. 332).

The field sites that I collected data from experienced a 20-year civil conflict that started in 1988 and ended around 2008. The conflict had severe effects on the health system, including the destruction of the healthcare infrastructure and the killing and migration of health workers (Olushayo et al., 2015). The post-conflict period has been characterised by the rebuilding of the health system to improve health. However, several health inequities still exist, with some having their roots in the violent conflict, while others are related to other factors, including the privatisation policy (Musoke, 2016).

The privatisation policy was informed by structural adjustment reform processes. These were a set of economic policies and reforms required by the World Bank and the International Monetary Fund (IMF) to receive loans and debt relief. Privatisation was employed to deal with economic imbalances, promote growth, and stabilise economies. In the context of Uganda's health sector, this resulted in reduced spending on health and promoting the privatisation of health services (Coburn et al., 2015; Thomson et al., 2017).

There is a predominance of private health enterprises in the field sites visited. Caregivers are often referred to these facilities when public health centres run out of stock of essential medicines. Notably, getting hold of these medicines is not a given since service users often do not have enough money or have no money to purchase the supplies. This demonstrates how difficult it is to implement a privatisation policy in post-conflict places where people live on subsistence means.

These inequalities structure practices around seeking care from local specialists. Parents who choose professional medical institutions as the first option of care, in the end, find themselves in traditional care facilities. The experience of the inadequacies of the professional medical system pushes parents to traditional care spaces. The shortages undermine the strengths of the outsider's argument that traditional care practices cause harm to the child. In the end, seeking care from Te Lak specialists is not a matter of choice but rather could be about what is available.

Local health specialists are often blamed by law enforcement officers and experts from the professional medical systems for misguiding mothers on infant health. I am keen to find out how the local health practitioners respond to this blame. Of specific interest is how the specialists embed their arguments in the existing socio-economic possibilities. I interrogate how they relate their decision to treat children to the unavailability of other viable livelihood opportunities. This provides insights into how the practitioner's engagement with the practice is not only about the maintenance of good health but also about meeting one's daily needs and those of their family.

As I have argued, Te Lak can be looked at as a local disease-causing agent embedded in Acholi customs. It is also a phenomenon that lays bare existing inequities and inequalities. Therefore, attempts to understand its continued dominance on health and healing require an understanding of its cultural co-founders and political and economic conditions that increase the possibility of parents visiting spaces where Te Lak is understood as a “pathogen”.

By approaching this study from this point of view, I demonstrate how local customs, structural inequalities, and inequities lead to Te Lak's dominance in the health and healthcare discourse. This then supports the interrogation of various central questions: Why does Te Lak continue to be an idiom of distress even after the conflict? Why is Te Lak attributed with different meanings by different stakeholders? What does Te Lak tell us about the various political and economic inequalities common to the field sites visited? Why do practices that have been labelled as harmful continue? And what can anthropology teach us about practices like Te Lak?

1.1 The Te Lak Phenomenon

Te Lak, two Acholi¹ words that mean “under the tooth”, is bio-medically known to be unerupted primary canine tooth buds (Iriso et al., 2000) that become visible when canines sprout in infants (Stefanini, 1987; Accorsi et al., 2003; Kemoli et al., 2022). The Acholi identify the buds as "pathogens" that cause malaria, diarrhoea, pneumonia, and other childhood diseases (Accorsi et al., 2003; Gollings & Longhurst, 2013; Girgis et al., 2015).

This understanding transcends several other communities in different African countries (e.g. Sudan, Tanzania, Ethiopia, Chad, etc.) and among African migrant populations. In France, for instance, parents of African descent shared with the physician that their children would die if tooth buds were not treated (Khonsari et al., 2009). In Israel, the prevalence of missing primary canines and dental defects was greater among offsprings of Ethiopian immigrants than in native Israelis (Davidovich et al., 2013). In the United Kingdom, a mother of African ancestry disclosed that treatment of Te Lak was common among immigrant populations (Dewhurst et al., 2001).

In Uganda, Te Lak transcends almost all ethnicities. The different ethnic groups refer to the “disease” category differently. The Langi refer to it as Gidog, the Baganda refer to it as Ebinyo, Ebiino among the Banyankole, Bino among the Basoga, Lake Jo Marak among the Japadhola, and Ikela or Icela among the Itesot (Accorsi et al., 2003; Garve et al., 2016). The English-speaking communities commonly refer to it as False Teeth (Stefanini, 1987; Mogensen, 2000). Notably, it is common for the different ethnicities to make claims that Te Lak originated from the Acholi (Cobbs, 1972; Sebudde, 2006).

Communities assign Te Lak different causal attributes. There are claims that all children are born with Te Lak. Some hold onto the view that an unborn child could contract it when the pregnant mother steps on one that has been extracted or when she eats corn. Others attribute it to the bewitching of pregnant mothers (Rawal, 1988; Kubukeli, 1999). Mogensen (2000), however, notes that people are always reluctant to point out its immediate causes, probably because they are not known.

¹ Acholi language is a southern Luo dialect spoken by the Acholi people in northern Uganda.

There are several therapeutic options meant to prevent or cure Te Lak. The treatments are also understood as a measure to treat or prevent serious childhood diseases (Mogensen, 2000; Kemoli et al., 2018; Musinguzi et al., 2019). Kwanyo Te Lak "extraction of tooth buds" is considered to be the most effective (Welbury et al., 1993). The healers make a unilateral or bilateral cut on the jaws to remove the bud (Kemoli et al., 2022). Reports show that the procedure is crude and traumatic (Wandera & Kasumba, 2017; Wordley & Bedi, 2019; Anjum et al., 2022). The healers use fingernails or sharp instruments such as hot needles or knives, sharp pointed chisels, sharp bicycle spokes, razor blades, sharp pointed nails or locally made clippers or tongs (Johnston & Riordan, 2005; Tirwomwe et al., 2013). After the operation, herbs or locally prepared medicinal powders are rubbed on the wound (Iriso et al., 2000). Dentaïd², a Non-Government Organization (NGO), has recently coined the term "Infant Oral Mutilation" to refer to the practice of extracting Te Lak.

A review of existing studies indicates differences in the frequency with which the procedure is performed across communities. Atim et al.' (2018) study in selected slums of Makindye, central Uganda, found that 90.3 per cent of the households had a child that had undergone canine bud extraction, 12.1 per cent of whom reporting that this had been performed by a dentist. In Nyakagyeme sub-county in western Uganda, 8.1 per cent of the households reported having a child that had gone through the practice (Musinguzi et al., 2019). In NorthWest Ethiopia, the prevalence stood at 86.8 per cent and this was highest among first-position children (Teshome & Assefa, 2019). Among the Maasai Mara in Kenya, 61 per cent of the adolescents interviewed had been exposed to infant oral mutilation (Kemoli et al 2018).

² Dentaïd is a United Kingdom (UK) charity that works to improve the world's oral health. It operates within the UK and Overseas. The charity is involved in fluoride advocacy, school oral health projects, and initiatives that provide toothbrushes and toothpaste to deprived communities.

Evidence suggests that the proportion of the population engaging in Kwanyo Te Lak among the Acholi has tripled over the years. The most recent survey I know of that aimed to establish the magnitude of the practice in Uganda showed a 55.1 per cent prevalence in Gulu³ district (Tirwomwe et al., 2013), a prevalence rate that is much higher than the 16.1 per cent reported by Pindborg in 1969.

To date, there is no agreement on the circumstances that trigger Kwanyo Te Lak. Some scholars argue that the practice results from a long-term evaluation of a child who has encountered severe problems during his or her development and whose growth has not been satisfactory. The decision to perform the procedure is thus a response to recurring episodes of diarrhoea, vomiting and or fever (Mogensen, 2000). Weiss (1996), on the other hand, argues that confirmation from a healer that Te Lak exists in the child's gum prompts the procedure. Gollings & Longhurst (2013) also opined that having or not having diarrhoea or fever is not that important. The development of tooth-like substances earlier than expected prompts the extraction practice.

Kwanyo Te Lak varies much from other recognised culturally based dental modifications, such as ritual tooth ablation among the Dinka and Nuer tribes of South Sudan (Willis et al., 2005; Willis et al., 2008). It is performed with a perceived medical benefit (Davidovich et al., 2013), practised on infants who cannot consent to the practice (Kubukeli, 1999; Johnston & Riordan, 2005), and lastly, it often has severe health consequences (Edwards et al., 2008).

The practice has been identified as a significant social and health problem (Kemoli et al., 2021). Gollings & Longhurst (2013) refer to the practice as an inappropriately practised iatrogenic belief with consequences that can ultimately lead to further ill-health and even the child's death. In St. Mary's Hospital Lacor, a faith-based hospital found in Gulu District, an average of 100 admissions a year due to the procedure were recorded, with 21 per cent of these cases resulting in the death of a child (Holan & Mamber, 1994). Another study reported that the practice had the third highest "disease" specific fatality rate after meningitis and malnutrition (Iriso et al., 2000). There have also been reports in countries other than Uganda of deaths resulting from Kwanyo Te

³ Gulu District is a district in the Northern Region of Uganda. It is one of the districts that hosts the Acholi people.

Lak. Mosha's (1983) study in Tanzania reported that 10 of the 124 children who had undergone oral mutilation died.

Other health consequences attributed to the practice include psychological trauma, infections (such as tetanus, osteomyelitis, septicaemia), death following uncontrolled bleeding, inflammations (e.g. pharyngitis, tonsillitis), transmission of bloodborne diseases (including human immunodeficiency virus) and dental defects (namely dental displacement) (Atim et al., 2018; Wordley & Bedi, 2019; Kemoli et al 2022; Anjum, 2022).

Other measures taken to treat Te Lak or prevent its occurrence include applying the root of a plant on the gums of a newborn and the mother's breasts for one week. Alternatively, a pregnant mother could wear a small package of herbs around her neck until her baby is born, or a newborn baby could wear a string of white beads and white shells around its wrist till two years of age (Rawal, 1988). The healer could also make a small cut on the tooth buds and administer a herbal solution (Mogensen, 2000).

The locals argue that Western medicine does not cure Te Lak (Gollings & Longhurst, 2013). Local healers are thus considered and consider themselves the only specialists in preventing and curing the condition (Rawal, 1988). The local practitioners are respected older women, family members or anyone knowledgeable about Te Lak (Kubukeli, 1999; Johnston & Riordan, 2005).

1.2 Teething and Health in History

In this section, I examine biomedical science engagement with teething to present important threads of thought on the phenomenon. Attention is given to the classification of teeth as a specific clinical entity responsible for child morbidity and mortality.

Throughout history, the opinion of medical practitioners was that there was a relation between teething and morbidity. For example, Hippocrates, a Greek physician commonly referred to as the Father of Medicine (Yapjakis, 2009), argued that a teething child would have to experience itching of the gums, contract fevers, diarrhoea, and convulsions. This happens when the child develops the canine tooth of the upper jaw. Also, it is common among children who are fat and constipated. Further, he noted that the child who goes through a more difficult teething period grows better than one with lesser difficulty (Hippocrates, 440 BC).

Paulus Aegineta, a Greek surgeon known for writing the first medical encyclopedia (Gurunluoglu & Gurunluoglu, 2001), suggested that at the time of dentition, that is, about seven months, the gums of the child are inflamed, and the child could convulse at times (Rendle-Short, 1955). Thomas Phaer, a physician, and polymath who published the first English book on medical care for children (Bowers, 1999), advised that at about the seventh month or less, the child will grow teeth but also experience several diseases, pains, swelling of the gums and jaws, fevers, cramps, and complete or partial muscle paralysis. He also noted that children who grow teeth earlier than others go through this phase with much ease (Phaer, 1530).

Medical scientists also suggested that breeding teeth in children exposes more danger to the child than countless calamities do to the child's mother (Harris, 1689). It was opined that a man aged 90 had more chance of living for a year than a newborn baby having teething problems (Edmonds, 1835).

In 1896, a comprehensive account of how teething leads to child mortality was provided. It was argued that "when the development of the tooth proceeds more rapidly than the overlying tissues is absorbed, we have local inflammation, the secretions become much increased, and pressure on

the nervous and vascular supply involves the whole system. As a result, the child becomes wakeful, restless, and fretful and refuses nourishment; the alimentary canal becomes more active, diarrhoea follows, and if relief is not given, relaxation of the vital forces follows, and we have nausea, vomiting, convulsions, paralysis and not infrequently death" (Foster, 1896 pg. 569).

There were several reports on child mortalities resulting from teething. The London bills of mortality for a period of thirty years (1629-1660) reported teeth (and worms) as one of the diseases that were contributing to the greatest number of deaths among children (Rendle-Short, 1955). Between the years 1728-1764, it was reported that 1.4 per cent and 3.5 per cent of childhood deaths in Kilmarnock and Glasgow, respectively, were due to teething (Creighton, 1891 in Duffin et al., 2017, pg. 184). In 1732, John Arbuthnot, a physician extraordinary to Queen Anne (Aitken, 1892), also explained that the symptoms (e.g. inflammations, fevers, convulsions) resulting from the irritation of the delicate nervous part of the jaws resulted in above a tenth of child deaths (Arbuthnot, 1732). New evidence showed that teething led to fewer deaths as the years went on. In 1910, only 1,600 deaths in England and Wales were caused by teething, compared with 5,016 in 1839 (Ashley, 2001).

It was only in 1748 that alternative views on the role of teething in child morbidity and mortality emerged. In his essay on "Nursing and Management of Children," William Cadogan advised that teeth are not what it is thought to be and are never as fatal to children as has been advanced (Cadogan, 1748). Thirty-five years later, George Armstrong published an essay on fatal infant diseases. To some extent, he agreed with Cadogan as he thought that not all deaths attributed to teething were caused by it (Armstrong, 1783).

Cadogan and Armstrong's opinion on teething did not go un-criticised. Michael Underwood, an English physician, and surgeon who gave the first known description of childhood diseases (Dunn, 2006), strongly disagreed with his colleagues' perspective. He argued that teething still poses much danger to children and, if unattended, can be fatal. Underwood urged fellow physicians to provide equal attention to ensure that teething did not result in more deaths (Underwood, 1835). Henoch, a director in the department for children in the Royal Charity Hospital, also cautioned writers like Cadogan and Armstrong not to dismiss or take the ideas of

the forefathers in medicine lightly. He advised that teething cannot only be understood as a physiological condition; it is also a disease-causing agent (Henoch, 1889).

By 1894 more dissenting views on the relation between teething and morbidity or mortality emerged. Barret, in his presentation to the First District Dental Society of New York, openly rescinded his earlier take on teething – “I had from time to time read in dental and medical textbooks, and the current professional literature, of the terrible mortality due to the advance of dentition and had accepted some of the conclusions without question. However, when I came to reflect more deeply upon the matter and consider the physiological and pathological principles involved, I became convinced that there was an error somewhere. In the address to which I have alluded, I attempted to show that the advance of the teeth was not the principal cause of the diseases which swell the death rate in infancy”. Barret argued that dentition is never a cause of significant mortality but rather one of the factors in human development. He informed the medical community that children developed diseases at that time because they were almost defenceless due to poor immunity (Barret, 1894 pg. 200).

Throughout the early centuries, several treatment options for teething were recommended. Soranus of Ephesus, a Greek paediatrician, opined that one could use a hare's brain. This option remained popular until the 17th century. Alternatively, Soranus suggested that one can apply hen's fat, dog's milk, cow's butter, and marrow specifically from the thigh. Also, Oribasius, a court physician that wrote complete work on Medicine in Seventy books and friend to the Emperor of Julian, advised that if a child's tooth is coming out of the gums with much difficulty, one should smear the gums with cyperus, butter, and oil of lilies. Further, Aetius of Amida, a Greek physician and medical writer, asked parents to spread one of the following on the child's neck; the root of colocynth in a gold or silver case, a bramble root, a tooth of a viper, particularly a male viper set in gold or a green jasper (Greenhill, 1870; Still, 1931; Ashley 2001).

It was only in the 16th century that Ambroise Pare, a French army surgeon (Drucker, 2008), introduced a unique treatment for the teething problem. He asked his fellow surgeons to lance the gums with a lancet and discouraged surgeons from just doing a superficial incision. Instead, asked them to cut the gum deep until the lancet penetrated the growing tooth. Also, he asked

them always to incline the incision outwards to avoid cutting tissues connecting to the permanent and temporary teeth (Pare, 1575 in T. E. C., 1981).

Lancing was prevalent till the 20th century. It was performed to prevent several illnesses caused by teething (McIntyre & McIntyre 2002; Royal Pharmaceutical Society, 2008). Walter Harris, a Gloucestershire physician, would also advocate for the use of lancing. He was, however, concerned that many surgeons were performing it poorly. He advised that surgeons should always use proper instruments like a penknife with a thick blade rather than a lance that practitioners like Francois Mauriceau, a French male midwife, advocated for (Harris, 1689).

There were differences in opinion on the number of times a child's gum can be lanced. John Hunter, a Scottish surgeon (Palmer, 1835), advised that one could lance the baby's gums up to ten times. Marshall Hall, an English physician, physiologist, and early neurologist (Rosner, 1998), suggested that he rather unnecessarily lance a child's gum 199 times than omit it once. He instructed his students to perform the procedure before, during, and after the teeth had appeared. To him, one could do it twice a day if possible (Hall, 1844 in Ashley, 2001 pg. 5).

The 17th and 18th centuries saw a persistent crop up of syrups marketed to heal all diseases resulting from teething. These syrups were not absent of controversy as many had ingredients that had a fatal impact on children. Syrup of white poppies common between 1700 and 1740 had narcotics as one of the ingredients. Mrs Winslow, on market till the 19th century, contained morphine, and several cases of children falling into a coma, becoming addicted, or on given occasions dying were being reported. Woodward's Gripe Water contained alcohol, while Steedman Soothing powders contained mercury (Royal Pharmaceutical Society, 2008).

By the mid-20th Century, many conditions that were thought to result from teething were being accurately diagnosed as specific clinical entities (Wake et al., 2000; Macknin et al., 2000). As a result, teething preparations were increasingly formulated to provide relief for specific symptoms in teething infants. These included paracetamol-based preparations that are still popular in the 21st century (McIntyre & McIntyre, 2002; Royal Pharmaceutical Society, 2008).

1.3 Global Discourse on Te Lak

There is consensus amongst intergovernmental bodies and governments on Te Lak. The phenomenon has been categorised as a harmful traditional practice embedded in values and beliefs that have been in place for generations (OHCHR Fact Sheet No.23) and a form of violence against children (International NGO Council, 2012; Plan, 2012).

Harmful traditional practices have been a matter of great concern to the United Nations since its early years. On 17 December 1954, the UN General Assembly declared, by resolution 843 (IX), that certain customs (such as child marriage, denying widows access to their children), ancient laws and practices relating to marriage and family were inconsistent with the principles in the 1948 Universal Declaration of Human Rights. All states were urged to abolish such customs, ancient laws, and practices (UNGA 90, 843 (IX), 17 December 1954).

In the 1980s, the issue was taken up by the Sub-Commission on the Prevention of Discrimination and Protection of Minorities of the then Commission on Human Rights and its working group on Traditional Practices affecting the Health of Women and Children (United Nations, 2009). In 1984, the Commission adopted its first resolution on traditional practices affecting the health of women and children (UNCHR, 1984/48, 13 March 1984). In 1988, the first rapporteur on harmful traditional practices was appointed. In 1994, the Sub Commission adopted a plan of action to eliminate harmful traditional practices affecting the health of women and children. Since a plan of action was laid down, the Commission (now the Human Rights Council) regularly reviews the progress made regarding eliminating these practices. Since then, harmful traditional practices have been a regular item on the Human Rights Council agenda (International NGO Council, 2012).

It is widely reported that harmful traditional practices inflict many forms of violence against children, such as physical, sexual, emotional, or mental violence. Protecting children from this kind of violence is a Human Rights imperative and has been recognised by international and regional Human Rights standards (Plan, 2012). The Convention on the Rights of the Child under

Article 24(3) and the African Charter on the Rights and Welfare of the Child under Article 21 require State parties to identify and take all effective and appropriate measures to end traditional practices prejudicial to children's health. In a bid to draw attention to the earlier commitment made by State parties to combat and eliminate harmful practices against children in Africa, in 2013, the African Union (AU) commemorated the Day of the African Child under the theme "Eliminating Harmful Social and Cultural Practices Affecting Children: Our Collective Responsibility". The intent was to provide an opportunity for AU member states to reflect on the lived realities of children who go through the different harmful social and cultural practices and remind them of their commitment to respect, protect, promote, and fulfil the children's rights and welfare issues (African Union, 2013).

Uganda ratified the Convention on the Rights of the Child (CRC) (on 17 August 1990) and the African Charter on the Rights and Welfare of the Child (on 17 August 1994). The ratification of the CRC was followed by forming a "Child Law Review Committee" to assess all laws on the welfare of children and establish their level of alignment with the Convention. In 1997, the government passed the Children's Act Chapter 59, which was later amended in 2016. Section 7(1) of the Act states that "a person shall not expose a child to any customary or cultural practice that is harmful to his or her health, wellbeing, education or socio-economic development". Paragraph 3 provides punitive actions. This person shall be liable to a term of "imprisonment not exceeding seven years or to a fine not exceeding one hundred and sixty-eight currency points or both".

In response to the global call to eliminate harmful traditional practices, the Uganda government is working towards strengthening the regulatory framework for Traditional and Complementary Medicine (TCM) products and practices (MoH, 2015). In a similar vein, global health partners, notably the World Health Organisation (WHO), are supporting the government in realising this goal. The WHO developed an overarching framework, the WHO Traditional Medicine Strategy 2014-2023, that guided member states in formulating proactive policies and implementation plans that enable health sectors to work closely with TCM practitioners.

Notable in the government's efforts to regulate TCM products and practices is the distinction borne within the realm of traditional medical practice. The Second Uganda National Health Policy calls for the support and promotion of good and relevant aspects of traditional medicine. Products and practices, including Te Lak, have been categorised as unhygienic. Indeed, efforts are directed toward eliminating these products and practices through health promotion, education, enforcement, and preventive interventions (MoH, 2010). Health education programmes focusing on extracting tooth buds have been implemented in some rural communities and health facilities (such as St. Mary's Hospital Lacor, Gulu district and Kisiizi Hospital in Rukunguri district) in Uganda. The programmes were delivered through discussion workshops and radio broadcasts (Iriso et al., 2000; Jamieson, 2005).

1.4 Anthropological Viewpoint on Te Lak

Te Lak, like other bodily practices, has been intensely moralised. This has generated a moral debate framed in the language of rights and culture. The global formulation of rights argues for a universalised body that must be applied uniformly across countries. Te Lak and similar bodily practices are looked at as practices that contrast with the universal body image. The rights discourse explains this differentiation as hinged in culture, thereby placing culture in opposition to rights (Cowan et al., 2001).

Anthropologists identify the rights discourse theorisation of culture as largely essentialist. It assumes that people have a discrete, bounded, and homogeneous culture with relatively fixed meanings (Brightman, 1995; Lock & Nguyen, 2018). Bodily practices, like Te Lak, are then attended to as coherent and shared within the community, and persons who engage with Te Lak are looked at as irrational individuals who do not reflect much on what they are doing (Geertz, 1988; Rosaldo, 1993; Gruenbaum, 2015). Anthropologists take a fundamental shift from such conceptualisation. They dismiss the idea of cultures being discrete. They argue that cultures overlap (Strathern, 1997). For example, research has shown that bodily practices like Te Lak are being carried to Western countries by migrants, places that are far away from where such practices originate (Davidovich et al., 2013).

Culture also works in context with other formations, including colonial, imperial, regional, and global formations (Fischer, 2007). For example, Khamasi's (2015) study in Kenya shows that what is defined as female circumcision in Gikuyu-land is an overlap between the local customs and schooling, Christian churches, the anti-FGM agenda that has its roots in the colonial times and being pushed forward by women activists, the global treaties especially the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and its domestication through the Prohibition of Female Genital Mutilation Act in 2013.

Ethnographies have shown that the idea of culture being homogeneous is inadequate. They have been able to demonstrate that cultures are disputed within a group. People who hold a different perspective contest the usefulness of cultural practices that others engage in. Their access to global formations brings about new forms of consciousness, agency, and subjectivities (Lock & Nguyen, 2010) that are negotiated considering the dominant culture. This creates contradictory views on various normative practices in the community. These differences in viewpoints on practices may bring about a cultural clash as various categories of people comment on the correctness of the practices (Sabatello, 2009).

Anthropologists also move away from the rights discourse's relatively fixed meaning of bodily practices as harmful to explore the various ways in which people use Te Lak to make sense of the world (Cowan et al., 2001). Te Lak could have its roots in how African communities used to symbolise bodily processes and conditions. Certain aspects of teething were associated with symbolic pollution and signs of disorder (Weiss, 1996). For example, the Jop'Adhola in Eastern Uganda used to remove four lower front teeth. They believed that the child could never grow up or become healthy unless the teeth were removed. In other communities, healthy teeth were an important marker of transitioning from a helpless person to a social member of the community. Te Lak, thus, symbolised a blockage to this transition (Mogensen, 2000).

Just like in female genital mutilation practising communities (Boun et al., 2023), engaging in Te Lak grants power to women as mothers of sick children but also as local health practitioners – something that is uncommon in patriarchal societies. Young mothers are assigned the role of monitoring the health of their child, including the initial diagnosis of the health condition. Upon

realisation that the child is unhealthy, they are afforded a space where they present the issue to the extended family or their spouse and are listened to. They also contribute to the decision on where the condition could be addressed and have the power to seek care on their own. This accords them greater independence and enables them to be listened to, present their views, express discontent with their spouse if not supportive, and interact with health professionals. Female local practitioners who treat Te Lak probably wield a higher power than the young mothers. They are listened to by the male clients, and their advice is acted on. The male clients recognise their power and implement the actions they have recommended (Weiss, 1996; Mogensen, 2000).

The meanings that anthropologists focus on are ever-changing, partly or in their entirety (Weiss, 1996; Gruenbaum, 2001; Boddy, 2007). For example, Khamasi's (2015) study among FGM-practising communities in Kenya shows how female circumcision moved from being a practice that is out of the gaze of the community to something that was celebrated with lots of ambience. At this point, there was less concern about the scars that the girls were to live with. Women were looked at as clean, beautiful, and mature for marriage. The incoming of anti-female genital mutilation campaigns coupled with formal education, migration, modern and liberal religions, urbanization, and political pressure brought about changes in the understanding of a woman, from being viewed as a marriage tool that has to be cleaned through FGM to a woman of substance, a successful mother, loving wife, responsible daughter and a sister; one that does not have to be circumcised.

Anthropologists are critical of the rights literature that places the relationship between rights and culture in binary opposition. From such a perspective, rights are seen as superseding Te Lak and similar practices, while at the same time, bodily practices are viewed as prohibiting the attainment of universal rights. Approaching research from such a position deters the exploration of key questions of how rights are connected to other aspects of social life, including Te Lak. This presents research gaps around how bodily practices are shaped by the rhetoric of the right, including adaptations and contestations and how these bodily practices shape the universal categories of rights, especially how they are implemented (Cowan et al., 2001).

Research that has attempted to explore this relation shows that local therapeutic economies continue to evolve as sites for interaction between folk, popular and professional medical systems. With the embracement of microbiology and human rights across the globe, there continues to be a moral struggle concerned with the elimination of unhygienic and harmful traditional practices. This is being done largely through the rolling out of biomedicine and the enactment of laws. In effect, there are emerging assemblages of the global, national, and sub-national within the local worlds, and these are interacting with local institutions, the social world, and identities (Lock & Nguyen, 2018). In this process, newly diffused ideas, knowledge, behaviours, technologies, and material goods are appropriated and actively transformed to 'fit' with the cultural horizons of their new localities (Fullwiley, 2004).

Anthropologists also move away from the rights explanations that attribute the continuity of Te Lak and other bodily practices to culturalism. They rather look at the bodily practices as cultural processes that mask the different power relations that perpetuate inequities and injustices that have more explanatory power for holding such practices in place than cultural beliefs (Cowan et al., 2001; Anderson-Fye, 2012). Mogensen (2000) shows that Te Lak is not only an affliction among children, but also it is a practice that hides larger structural issues. It is an expression of the collective trauma of war and violence, as well as subsequent poverty and socioeconomic stress. Also, La Tosky's (2015) study on the lip plates of the Mursi, a Surmic ethnic group in Ethiopia, speaks to the misrepresentation of harm that the global actors engage in. La Tosky shows that the harm does not lie in the lip plates but rather in the lack of basic medical services that the Mursi people endure in the face of life-threatening diseases, including malaria and pneumonia.

1.5 Outline of the Dissertation

This dissertation is organised into ten chapters. Chapter 1 introduces the dissertation by articulating the key research questions that are being addressed by the study. The chapter also presents existing literature on Te Lak and its associated practices. Further, it provides a historical perspective on teething to illustrate earlier biomedical science classification of teeth as a specific clinical entity responsible for child morbidity and mortality.

Chapter 2 describes the social and cultural anthropology theories underpinning the research project. In particular, the chapter discusses the anthropological theorisations of cultural constructivism, critical anthropology, and structural constructivism. It highlights the inadequacies and limitations of cultural constructivism and critical approaches to present a strong argument for integrating these perspectives when studying local disease categories.

Chapter 3 describes the context and methodology of the research. It provides information on the Acholi ethnicity and their marginalisation, characterised by colonialism and conflict. It also discusses the research process, including field entry, data collection methods, study participants, and data analysis.

Chapter 4 examines parents' experiences following the onset of affliction among infant children to show meanings recollected and conclusions drawn regarding disease aetiology and appropriate health care. Further, it describes the experiences of parents when they finally seek care. The different healthcare trajectories are recorded to understand how professional healthcare access challenges exacerbate the risk of engaging with Te Lak practices.

Chapter 5 illustrates how the expertise of persons knowledgeable of treating diseases caused by Te Lak is built. It addresses several questions to understand the complexities of becoming an expert in treating such diseases, including: How are these persons selected? How do they get to know the different medicines that treat these diseases? What similarities and differences exist among the different people who acquire this knowledge? What places is this expertise built?

What therapies are these persons trained in? What process do they go through to be initiated as healers?

Chapter 6 presents narratives on the social roles and identities of the Te Lak healers. By exploring the various roles, the chapter documents how healers manage the multiple roles and how these roles complement or conflict with one another. Further, the chapter examines how healers embody their healing identity and the circumstances under which they forfeit or negotiate this identity.

Chapter 7 describes the exchange practices of healers to show how healing, on the one hand, is transformed into an object of trade as it intertwines with the money market and, on the other hand, how healing embraces the qualities of a gift. It also explores how the different exchange practices mediate relations between healers and their clients. Finally, it attends to how healers creatively use money and gifts to maintain their lifestyle and social status.

Chapter 8 focuses on how caregivers weigh public health and local explanations of risk presented by Te Lak. It also explores how the popular discourses on harm structure everyday life, the various meanings that are at play when a child contracts Te Lak, and conflict and negotiations that happen, the type of institutions and expertise that count in the community, the type of medicine that is efficacious, and the threats that deserve attention in this community.

Chapter 9 interrogates the different change processes that result from the local campaigns meant to eliminate Te Lak. It specifically looks at the alternative practices, knowledge and institutions that are being fronted by the local campaigns to understand how they are being integrated into the everyday, specifically how they co-exist, compete, and interrelate with already existing practices, knowledge, and institutions.

Finally, chapter 10 presents a final discussion and conclusions. It summarises how local customs, structural inequalities, and inequities lead to Te Lak's dominance in the health and health care discourse. It also presents the theoretical and programming implications of the findings.

CHAPTER 2: THEORETICAL FRAMEWORK

This dissertation studies cultural ideas and practices on Te Lak and the systematic inequalities that shape the experiences of children diagnosed with diseases thought to be caused by Te Lak. I draw on anthropological theorisations of cultural constructivism, critical anthropology, and structural constructivism to explore the cultural distinctiveness and structural inequalities surrounding the "pathogen". I particularly highlight the inadequacy and limitations of cultural constructivism and critical approaches to present a strong argument for integrating these perspectives when studying local disease categories like Te Lak.

2.1 Cultural Constructivism

The cultural constructivist approach attends to medical systems as cultural constructs with underlying local notions, concepts and models that generate symbols, meanings, events, patterns, and relationships (Kleinman, 1980; 1995; Gaines, 1991). The symbols, meanings and relationships created could be the same for a group of people or vary primarily where social actors rely on different folk theories (Janzen, 1983; Good, 1994). Moreover, these constructions are not necessarily static as they could change as one is introduced to "alternative positions, organisational forms, and emergent new technoscience" (Fischer, 2007, p. 43).

This body of knowledge examines medical systems in terms of people's lived experiences. One of the analytical tools used to understand these experiences is the explanatory models framework. This supports one in eliciting the sufferer's explanations of the aetiology, time and mode of symptom onset, pathophysiology, course of the disease, and treatment (Kleinman, 1980). These explanations are in constant motion as sufferers get to interact in different contexts and experience various medical systems. The sufferers are presented with often contradictory explanations on disease (Good, 1994). This pushes them into a struggle of making sense of their affliction and rethinking disease aetiology (Kirmayer & Bhugra, 2009).

In this dissertation, I am interested in the explanations that the caregivers provide when infants contract diseases thought to be caused by Te Lak and the evolving meanings when the illness episode continues and how this informs the treatment preference and eventually the outcome of the treatment. I am also interested in how caregivers describe the symptoms that demonstrate the presence of Te Lak and how this shapes their perception of illness severity, effectiveness, and cultural appropriateness of methods of treatment, and how this then informs their interactions with healthcare providers. I also focus on how knowledge of other medical explanations of disease is borrowed and integrated to make sense of the symptoms, guide health-seeking behaviour and inform treatment decisions.

To move beyond clinical realities – the focus of the explanatory models – cultural constructivists employ the narrative analytical tool to capture people's reflections on their lived experiences. These are engaged to tell their story of how the everyday unfolded when they contracted the illness. They offer personal accounts of the onset of the illness, the initial and confirmatory diagnosis, treatment-seeking journeys, and their experiences with treatment, how this affected their daily life, including their social interactions, support systems, and adjustments they had to make. In this process, they link their past and present experiences, teasing out continuities and changes within a given time frame (Götsch & Palmberger, 2022).

I use the narrative tool to capture the experiences of caregivers from the point when they realise that their child is unwell to the point of seeking care and regaining good health. I am interested in how they interpret the journey from unwellness to wellness, how they use this experience to co-create and sustain identities of being a child, mother, or local practitioner, the social relations that they develop and how this differs from one caregiver to the other. I am also interested in points where the caregivers decide not to speak. These are important moments as they point to important realities that have to do with one's socialization, moral values or social norms around health and health-seeking. I also use the tool to illicit experiences with different illness episodes experienced by the same or different children. Documenting these experiences helps me to capture the continuities and discontinuities in health and health-seeking.

This theoretical branch also contends that medical systems are founded on inter-subjective relations between the sufferer, healers, family, friends, spirits, and ancestors. These relations are dynamic as they are "constructed, destructed or reconstructed" in a single disease episode, resulting in a plurality of disease trajectories (Jackson, 1998, p. 8).

The various persons interacting with the sufferer have been referred to as the therapy management group (Janzen, 1978; Olsen, 2017). These are persons whose opinions matter to the sufferer and are instrumental during diagnosis, selection and evaluation of treatment and provision of support. They are brokers or are intermediaries between the incapacitated persons and the available medical options (Janzen, 1987). John Janzen, in his classical ethnography in lower Zaire (current Democratic Republic of Congo), reported that when someone contracts a disease and is incapacitated, maternal and paternal relatives and, at times, friends and associates take on the responsibility of initial diagnosis of the symptoms to establish the cause of the disease. They then decide whether this is a disease for the hospital or other available medical systems. If the condition is attributed to the existing social tensions within the community, then mystical healing is sought so that the healer resolves the pollutants in the body. The decision-making process is, however, non-linear. There could be disagreements among the relatives on whether a disease of God or Man attacked the sufferer. The decision to seek care only happens when there is consensus on the type of disease that has attacked this person. However, conclusions about symptoms of the disease could change when the relatives finally seek care from the healer, who could make a somewhat different diagnosis (Janzen, 1978).

In this dissertation, I am interested in understanding the network of persons that coalesce when a child gets ill, whose opinions matter and at what point it does matter. This is important because one's view might be important at all stages of diagnosis, selection, and evaluation of treatment or not. This can then explain who is usually involved in each stage and why their opinion matters.

The therapy management group's decision to seek care from a given healer demonstrates the efficacy of the given medicines and the power of that individual to heal. It also says a lot about who has the power to heal in a particular community. When the group decides to seek care from the hospital, and the sufferer regains good health, the group takes notice and appreciates the

importance of hospital care. However, the situation is different when the bodily affliction persists. Then, hospital care is viewed as non-viable, strengthening the perception that some diseases cannot be treated in biomedical spaces (Olsen & Sargent, 2017).

Cultural constructivists' inquiry around these shifts in healthcare-seeking decisions has shown the different treatment pathways for the same disease episode. For example, Olsen's study among the Asante in Ghana analyses personal medical histories of ageing men and women suffering from stroke, hypertension, and problems due to high blood pressure. Patients who viewed viruses, bacteria and diet as possible explanations for their afflictions chose the hospital as the first option of care. However, when the sufferer felt that progress towards good health was slow, an alternative course of action was sought, informed by a different understanding of the body. Opting for alternative care also happened when the sufferer contacted a therapy management group that held onto an understanding of the body different from the biomedical one (Olsen, 2017).

Cultural constructivists attend to ethnomedical systems as unfinished. Of particular interest has been how communities integrate foreign elements into their medical repertoire, often being able to assign symptoms of disease in scientific terms. Important to note is that foreign concepts do not annihilate local medical concepts and constructions (Olsen & Sargent, 2017).

Studies informed by this perspective have shown how the local population appropriates and actively transforms medical technologies, giving rise to meanings different from those the originators hold. These are transformed to fit within the cultural horizons of the new localities (Lock & Nguyen, 2010). For example, Müller-Rockstroh's study on the appropriation of Ultrasound in Northwest Tanzania shows the multiple constructions of a medical technology transferred from the Netherlands to a local hospital in the South. The technology became a skilling device for medical students, pregnant women thought of it as a pregnancy test, and midwives thought of it as a device they consulted at a last resort (Müller-Rockstroh, 2012). Fullwiley's (2004) study in Senegal showed that many physicians thought that genetic testing implied selective abortion for people with sickle cell. In this study, I am interested in how the

medical technologies common in government health centres are adopted by the local practitioners treating Te Lak.

2.1.1 Criticism

There have been several criticisms that have been laid against the cultural constructivist approach. First, it is argued that the approach exclusively focuses on local meanings and interpretations within localised health contexts, leaving no room for attending to the social, economic, political, and historical processes. Second, the relegation of the structural processes implies the inattention to the political structuring of the local meanings that the cultural constructivists are interested in (Keesing, 1990; Baer, 1996; Panter-Brick & Eggerman, 2017). Third, focusing on micro-level explanations creates an impression that individuals and their beliefs are responsible for structuring life experiences (Singer, 1989). This creates an illusion that people's culture is to blame for infant children's situations, not the structural processes.

There is criticism laid towards the analytical tools utilised under this theoretical body. There are concerns that the explanatory models' framework is limited to the individual experience of a single disease episode (Frankenberg, 1980; Young, 1982). It is also argued that the framework seeks out the aetiology, time and mode of symptom onset, pathophysiology, course of the disease and its treatment, but fails to capture the broader contextual meanings (Garro, 1994). Further, it is noted that the variations in explanatory models of the sufferer and doctor are attributed to cultural differences, thereby neglecting the political structuring of meaning in a clinical setting (Singer, 1990, 1995; Scheper-Hughes, 1990).

2.1.2 Conclusion

Nevertheless, this body of work guides me in exploring the meanings various social groups attach to Te Lak. This supports an understanding of how Te Lak becomes visible to local people and outsiders. It also provides essential insights on why people act the way they do when a child contracts symptoms attributed to Te Lak. However, whilst guiding me in understanding the above aspects, this approach does not take me far into getting to know how Te Lak is produced and reproduced by structural inequalities. Consequently, I cannot tease out how political and economic processes interact with local meanings on Te Lak to shape the life world of infant children and their families. To achieve this, I take on a critical approach that guides me in attending to the hegemonic ideologies and structures of power that underlie Te Lak and its associated practices.

2.2 Critical Approach

This theoretical branch places health, disease, and healing analysis within global and national political, economic, and socio-structural frames (Singer, 2004; Fassin, 2013; Panter-Brick & Eggerman, 2017). This represents a significant shift from micro-level ethnographic analysis to structural inequalities as determinants of disease, access to health systems and human suffering (Baer et al., 2003; Kutalek & Prinz, 2007).

Studies that take a critical stance have a special interest in the continuity of local categories of health, despite the proliferation of biomedicine. They demonstrate how this is shaped by large-scale forces. The structural influences determine when one can access care, who can access diagnosis and treatment, and the quality of treatment. Access then is defined by the availability of diagnostic equipment, the capacity of the health worker, and the availability of hospital medicines and supplies. The unavailability and inadequacies mean that the population could fail to regain good health, opening paths for seeking care from alternative medical institutions (Farmer et al., 2006). In this dissertation, I am interested in how access to spaces where Te Lak is known as a disease-causing category makes treating Te Lak viable and meaningful.

The large-scale forces then turn local categories of health into legitimate concerns for the communities. This then positions the local practitioners as professionals who have a role to play in maintaining the health of people. Their regime of knowledge and practice is strengthened as it is recognised by the local leadership, who make it known that they make an important contribution to the community. The communities subsequently add such information to their repertoire of knowledge, consequently informing people's decisions and perceptions about health (Witeska-Młynarczyk, 2015).

Critical anthropologies take a keen interest in Foucault's assertion that “where there is power, there is resistance” (Foucault 1978: 95). This provides conceptual tools that support studying local population resistance to global formations, ideologies, and practices. For example, Adeline Masquelier's study in Dogondoutchi, Niger, investigates the people's resistance to the WHO-sponsored campaign to eradicate Polio. Resistance campaigns were founded on rumours that the vaccine was meant to lower the Muslim population. It was also thought that the ulterior motive was to inject people with the Polio and HIV viruses. The conservative Muslim clerics strengthened the hostility and suspicion against the vaccination campaign. Malam Awal, a Sufi cleric, argued that government and partner organisations had a hidden agenda of converting Muslims to Christianity and further seeing that they adopt western values. This pushed his followers into rallying against the well-intended public health campaign (Masquelier, 2012).

Jack Ume Tocco reported similar findings in his study among the Muslim communities in northern Nigeria. Tocco studies the local people's perception of the Antiretroviral Therapies (ARTs) programme funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the United Nations Global Fund to Fight AIDS, Tuberculosis and Malaria. The side effects of ART strengthened the local understanding that biomedicine did not have a cure for HIV and that the promise of getting better was in Islamic prophetic medicine. Consequently, communities chose prophetic medicine over the highly publicised ART treatment (Tocco, 2014).

This theoretical body has also demonstrated how global agendas and ideologies shape local health realities (Panter-Brick & Eggerman, 2017). There has been a particular interest in how neoliberal reforms influenced Africa's social course of disease (Pfeiffer & Chapman, 2010). For

example, Chapman's ethnography on reproduction in central Mozambique shows how structural reforms transformed social relationships surrounding reproductive practices, including virginity reviews, seduction fees, bridewealth payments, and childbirth assistance. This intensified the commodification of reproductive practices and gave birth to new strategies for managing risk during pregnancy (Chapman, 2004). Pfeiffer's ethnography in Mozambique also demonstrates how neoliberal reforms strengthened the role of African independent churches in addressing accusations and fears of witchcraft and witches (Pfeiffer, 2002).

Critical anthropologists are also interested in documenting the epistemic violence resulting from the politics of knowledge. They look at how global ideologies are integrated into the national legal and policy frameworks and how this determines what is knowable and desirable in the local world (Simmons, 2012). Of particular interest is how persons who subscribe to the local forms of knowledge attend to these new realities and the kind of socialities that come about as they go against new forms of knowledge (Hardon & Moyer, 2014). In female genital-cutting communities, the global positioning of the practice in opposition to moral principles and standards of human behaviour has pushed the practice out of the gaze of outsiders. Among the Tapeth of Uganda, the celebrations before and following the cutting have been minimized, the associated rituals have been abandoned, it is now common for the cutting to be done at night, the places for cutting have changed to bushes and gardens, and some families cross into Kenya to have their child cut and only return when they have fully healed (CCFU, 2023). This is done to avoid the legal sanctions that came into place with the passing of the Prohibition of Female Genital Mutilation Act of 2010.

2.2.1 Criticism

Cultural constructivists have problematised the critical approach for attending to biomedicine as the only authoritative medical system and overlooking individual agency and locally constructed meanings. They argue that the focus has been on the larger socio-cultural worlds, which provides an impression that natives are passive beings with little or no access to agency (Gaines, 1991). Critical anthropologists, however, argue that they place the locals at the centre of their inquiry

and attend to their agency. The difference is that they emphasise how local realities intersect with global and national political and economic factors (Upton, 2019).

2.2.2 Conclusion

This body of literature supports me in moving away from the micro-level meanings and interpretations of Te Lak to the structural processes that shape health practices surrounding this local category. This pushes me to question whether the “pathogen” is a result of decades of marginalisation endured by the Acholi people. The occurrence of Te Lak can then be understood as a product of people being pushed into marginal positions where infant children can hardly access good health care. Studying the local disease-causing category then supports us in understanding who has access to hospital care and who does not. It also helps us know how often parents with infant children access hospital care and why children fail to regain good health even when hospital care is prioritised.

2.3 Structuralist-Constructivist Approach

Anthropology, like other social science disciplines, has been dominated by theoretical divisions, including the structuralist (social life as a product of structural inequalities) and constructivist (representations of social life) divide (Bourdieu, 1988; Roseberry, 1988). This dualism has been organised as separate or opposed to the other with the intent of achieving scientific credibility. This is seen in the works of Gaines (1991) on cultural constructivism and Baer's (1997) response to the cultural constructivist critique.

However, some responses to the critical anthropology critique are urging scholars on either side to engage in dialogue, given that the two theoretical approaches share commonalities. They also re-echo that the end goal of critical anthropology is to synthesise “the macro-level understandings of political economy with the micro-level sensitivity” (Singer, 1989, p. 181). This argument implies that concepts in either theoretical branch can be incorporated into the other (Baer, 1990).

Increasingly, anthropologists are taking the suggestion that both theoretical branches must be in dialogue seriously. Several ethnographic texts demonstrate within their work the importance of diffusing ideas and concepts from either branch. Lock and Scheper-Hughes (1996) argued that the study of human suffering should consider the cultural constructions and structural forces that affect the human body. Farmer also argued for an “an interpretive anthropology of affliction, attuned to how history and its calculus of economic and symbolic power impinge on the local and the personal, and how it might yield new understandings of culturally evolved responses to illness, fear, pain, hunger, and brutality” (Farmer, 1988, p. 80). Vonarx (2007) posited that explanatory models are incomplete without critical anthropology. Kleinman et al.'s (1997) approach to social suffering has both an interpretive orientation and broader social structures. Mogensen (2000, p. 332) found that health practices are both a “cultural construction that generates meanings to the community and political construction that brings into being intersecting micro and macro power relations.” Massé's (2007) study on social suffering in the French Caribbean concludes that comprehensive anthropology requires the integration of culture and politics. Forsyth's (2015) study in tropical Bolivia highlights the interplay of knowledge of the vector, ethnomedical treatment, and structural factors in shaping the understanding and management of Chagas disease.

As demonstrated, there is growth in the literature that is arguing for the combining of the constructivist and the structuralist perspectives, with each approach having an equal voice (Dressler, 2001). This supports the analysis of “the experience of social agents and the objective structures that make this experience possible” (Bourdieu, 1998, p. 782).

Some studies that take on this combined approach are interested in firstly documenting collective meanings for an individual sufferer and their therapy management group. They then take a keen interest in recording the experiences of the sufferer when they start interpreting and acting on the meanings to lay bare the political and economic constraints that coerce the sufferer to a given behaviour, social spaces, understanding of the body and access to health systems, namely folk or biomedical systems (Bourdieu, 1990; Dressler, 2007). This experience can vary from person to person seeking similar healthcare options (Bourdieu, 1988; Mogensen, 2000; Massé, 2007).

There is also a particular interest in how shared cultural constructs create social structure and the role of structures in creating meanings (Dressler, 2007).

By situating this study in the structural-constructivist approach, this dissertation pays attention to the presence of a local disease-causing agent, Te Lak, in a post-conflict community with a long history of marginalisation. The ethnography takes a keen interest in the thought processes that parents engage in when infants present with disease symptoms to show the meanings attached to the symptoms and their interpretation to finally decide whether the child has contracted Te Lak or not. In exploring this process, I record the different concepts of disease that caregivers refer to when making the decision. With the proliferation of biomedical knowledge in the study sites, attention is given to how scientific concepts inform decisions.

The interpretative processes the parents engage in are attended to as variable to show the constructions and reconstructions that happen throughout a single episode of disease. By recording these processes, I show how parents who earlier made conclusions that the child was suffering from a disease that is handled in a hospital engage in further diagnosis and end up deciding that the affliction is to be handled by local healers experienced in treating diseases caused by Te Lak. Careful attention is given to the contribution of the parents' reference networks and intersecting biomedical discourse to the shifts in understanding the infant's symptoms. By recording these processes, I show the local understanding of the anatomy of an infant's body and how emerging external discourses remake this. I am also able to demonstrate the existing struggles for the meaning of disease in a local social world.

Further, this ethnography examines how diseased infant bodies are managed within this local social world. Eliciting such narratives is vital in revealing the different medical systems that attend to infants with poor health, specifically the plurality of options for treating Te Lak. It also reveals the negotiations mothers engage in when deciding on the system where they could seek health care. Of particular interest is how mothers negotiate existing social norms that require that an infant presenting with unique symptoms is attended to in a local health system and not any other. By documenting how mothers navigate these processes, I show the inter-subjective

realities that occur when disease happens. I am also able to interrogate how health care decision-making constitutes processes meant to manage various social norms on infant health care.

This dissertation also examines how local experiences with disease are embedded in global discourses on biomedicine, harmful traditional practices, and Christianization to find out how these discourses transform the local knowledge systems on Te Lak. By attending to this fact, I am also able to interrogate how the intersecting discourses trigger moral and ethical conflicts in the community. Of particular interest are processes of othering that happen, particularly to parents who seek care for Te Lak and the healers who intervene to address Te Lak. Attention is given to the new identity that the parents and healers embody and how they navigate the different health care systems, considering this new identity. Due attention is also given to the resistance that the parents and healers engage in following the global actors' insistence that the practice puts infants at risk of harm. By interrogating these processes, I show the new kinds of sociality and subjectivities that emerge when parents and healers assert their visibility in the face of incoming global discourses on Te Lak. I am also able to show how Te Lak becomes a basis for the blame and exclusion of mothers and healers.

This ethnography further records the caregivers' experiences when they start acting on knowledge of infant health and health care to show the broader global and national political and economic factors that shape health care behaviour. By documenting these processes, I am able to show how these factors result in plural health care seeking, as mothers can access one health care system and not the other at one point. The experience could be different at another point in time. I am also able to demonstrate the structural constraints that mothers face when they seek care from the hospital and how this pushes them to the healthcare systems where Te Lak is treated.

This dissertation also investigates the local politics of change driven by global agents in religion, education and biomedicine. The locals' resistance to the outsiders' agenda to eliminate the practice is of particular interest. I capture the arguments the locals are putting forth and their source of support when they stand against the different global agents.

2.4 Concluding Remarks

This chapter presents the theoretical approaches that informed this research. Although conventional anthropological literature posits constructivist and structuralist approaches as separate and contradictory, I consider these approaches complementary. The constructivist perspective helps us draw out the various meanings attached to Te Lak and how they support people to interpret their experiences and guide their actions (Geertz, 1973; Ortner, 2016). The structuralist body of work introduces an equally important perspective that supports me in exploring how Te Lak could be a product of the 20 years of civil war, the global campaigns on ending harmful traditional practices, poor investment in health care and the privatisation agenda (McEwen, 2005). These approaches draw me towards different but equally important phenomena that cannot be neglected if one is to have a comprehensive understanding of Te Lak.

CHAPTER 3: CONTEXT AND METHODS

In this chapter, I describe the social and political history of the field sites that I visited to lay bare the various marginalisations that the Acholi people have had to endure. I also present, in detail, the research process including field entry, data collection methods, study participants, data analysis, challenges experienced during data collection and how these were addressed.

3.1 The Acholi – Community at the Margins?

The Acholi are among the ethnicities that form present-day Uganda. However, their origin has been a point of contention among scholars. Some argue that they migrated from Rumbek in South Sudan. Others disagree with that position. They claim that Rumbek was the second or third diffusion point. To them, the Acholi originally lived in Egypt, were forced to migrate southwards by the Arabs, and finally settled in northern Uganda (Langlands, 1971; Amone, 2014).

Before colonial times, the Acholi lived under separate, distinct, and independent chiefdoms numbering up to sixty, with the Rwot as the political head. The chiefdoms never had a strong army and used elementary weapons such as clubs, bows, and arrows for protection until close to 1900, when the chiefdoms secured more than 20,000 guns. The lack of military strength made the chiefdom susceptible to external attacks. From about 1850 onwards, the Arab slave dealers from Cairo began to venture into Acholi-land. They did make surprise attacks on villages, usually at daybreak. In searching for slaves, other valuable animals such as oxen, goats, and sheep were taken (Kasozi, 1994; Amone & Muura, 2013).

The British colonial incursion into Acholi-land was slow and tedious (Atkinson, 1994). It lasted for more than 50 years. At the very beginning, the British were not directly involved. Instead, they used agents like explorers, missionaries, and the Turko-Egyptian administrators who controlled Egypt and Sudan (Amone, 2014).

The Acholi people were only subjugated in 1910. The British introduced two political and administrative units to replace about 60 Acholi chiefdoms – West Acholi and East Acholi, with headquarters in Gulu and Kitgum, respectively. River Acwa separated these. With this development, the Acholi chiefs lost their power and privileges (Atkinson, 1994). In 1937, a decision was made to merge the West and East Acholi districts into a single administrative unit, the Acholi district, with a commissioner based in Gulu. As a result, the former autonomous chiefdoms of the Acholi were reduced to the status of sub-counties (Hannes, 2012). The creation of the Acholi District gave rise to a single Acholi ethnic identity.

The Acholi were marginalised in many ways during the early British colonial rule. There was a common perception that they were of an inferior order, naturally lazy and had little to contribute to the development of the colonial economy (Odoi-Tanga, 2009). Nevertheless, the colonial government designated the Acholi district (and other parts of present-day northern Uganda) as a labour zone. The decision was based on the presumed natural qualities of the Acholi (Hannes, 2012). The people were to take on casual manual work in central and eastern Uganda, popularly referred to as productive zones, where cash crop production flourished.

This had implications as the British concentrated infrastructural developments (e.g. roads, schools, health facilities) in the productive zone (Barongo, 1987; Kabwegyere, 1995). The people only found solace in joining the army (Refugee Law Project, 2004; Allen, 2006). Soldiering became a source of prestige, employment, and identity for young males, thereby replacing other potential economic opportunities (Veale & Stavrou, 2003; Sanghamitra & Elliot, 2012).

No industries, large plantations, or improved roads existed in Acholi land during the colonial period, yet the British had introduced taxes and monetised the economy. This pushed the Acholi to seek casual work in present-day central and eastern Uganda (Allen, 2006). Even when cash crops were introduced, the situation did not alter much. The natural conditions only favoured crops like cotton and tobacco, which are labour-intensive and harvested annually. Also, cotton prices dropped after World War II, making the investment non-viable (Amone & Muura, 2013; Amone, 2014).

The socio-economic and ethnic divisions that were popular during the colonial period were reified even further after Uganda gained independence (Allen, 2006). Like the British, the post-independence governments preferred to rule by creating divisions, taking advantage of tribal rivalries, and planning and executing conflicts. This set the stage for tribalism, national disunity, and mistrust, ultimately resulting in armed conflict. It was during President Obote's first rule that the divisions were first taken advantage of. In 1967, Obote's administration decided to abolish all kingdoms and exiled the King of Buganda to the United Kingdom. The Acholi council highly praised Obote for his decision (Dolan, 2009).

It is said that this was the start of the present narrative that the people from the north (including the Acholi) are violent. The narrative became firmer when political heads (like Milton Obote, Idi Amin, and Tito Okello) from the north committed atrocities on fellow Ugandans. During the 1981-1986 bush war that brought the current president Yoweri Kaguta Museveni to power, it was highly publicised that the people from the north were committing atrocities in the Luweero triangle. This might explain the revenge killings that happened every time a leader from the north was overthrown from power (Refugee Law Project, 2014).

The National Resistance Army/Movement (NRA/M) government came into power in 1986 after the overthrow of Tito Okello, an Acholi. It is thus not surprising that the Acholi planned and executed several insurgencies against the new government. Unfortunately, the government did counter the insurgencies in a similar manner, resulting in a civil conflict that lasted over 20 years in northern Uganda (Finnström, 2003; Refugee Law Project, 2004; Dolan, 2005; Allen, 2006).

The Uganda People's Democratic Movement/Army (UPDM/A) held the first armed struggle against the NRA/M. UPDM/A mainly consisted of former national army soldiers who had migrated back to northern Uganda (Human Rights Watch, 2005; Latigo, 2008). They launched their first armed struggle in August 1986. The UPDM/A registered success which saw the NRA move to the towns of Gulu and Kitgum, leaving the villages to the UPDM/A. However, this only fuelled atrocities as neither army had control over the other. With the lack of a decisive win among the two camps, the two decided to engage in peace talks. These began on October 31,

1986, and were only fruitful on June 3, 1988, when the two parties signed a peace agreement in Pece Stadium, Gulu town. This ended the conflict between the two parties and led to the integration of the UPDM/A into the National Resistance Army [NRA] (Lindemann, 2011).

Alice Auma Lakwena, a self-proclaimed Acholi prophetess, led another insurgency against the new government between 1986 and 1987. She formed the Holy Spirit Mobile Forces (HSMF), which came in to fight the abuses that the new government was committing. Lakwena claimed that she had spiritual powers from River Nile and was on a mission to liberate the people of God from the NRA. At first, the movement used stones and prayer to fight the NRA as they believed supernatural beings were protecting them. The movement was defeated, and its leader was exiled to Kenya. Alice's father, Severino Lukoya, picked on from where his daughter had left off and led what was called the second Holy Spirit Movement. The movement later ceased to be as Severino surrendered to the NRA government. It should, however, be noted that not all his followers gave up on the cause. Some joined Joseph Kony, who led the Uganda Christian Democratic Army (UCDA). In 1991, Joseph Kony changed the name of his movement to the Lord's Resistance Army (LRA). The army comprised not only the followers of Alice Lakwena but also soldiers of the armies that the NRA had defeated. Joseph Kony claimed that he had inherited the spirits once possessed by Alice Lakwena (Allen, 1991; Doom & Vlassenroot, 1999; Human Rights Watch, 2005).

Joseph Kony's armed struggle began in 1987. He claimed God had sent him to destroy evil forces like the NRA/M. He also alleged that he had come to teach God's Ten Commandments. Kony's insurgency grew popular in some communities, and at one point, the elders blessed his struggle. Nonetheless, the NRA/M government saw this as a real threat to their tenure in power and counteracted the surging popularity by forming several local militias to fight the LRA. This forced the LRA to revise its tactics. It would start committing atrocities against civilians. They killed, beat, abducted, forcefully recruited adults and children, sexually abused girls and boys, and destroyed civilian property (Human Rights Watch, 2005; Refugee Law Project, 2014).

Not all atrocities against civilians were committed by the LRA. It is also reported that the government had its share. The government's response was not only violent to the LRA but also to the civilians (Dolan, 2009). The 2005 Human Rights Watch report indicates that the 11th Uganda Peoples Defense Forces (UPDF) battalion stationed in Cwero (one of my field sites) was torturing and killing people. Civilians who were thought to be rebel collaborators were detained in pits. The soldiers had also raped and performed other forms of sexual violence on women and girls (Human Rights Watch, 2005).

The LRA insurgency forced the sitting government to forcefully relocate people into what was called “protected villages,” commonly known as Internally Displaced People's (IDP) camps. The forced encampment began as early as 1988 when civilians in Gulu district were asked to leave their homes and move to camps in Pece Division, Gulu municipality and Bungatira Sub County within 48 hours. Some reports indicate that even before the ultimatum elapsed, the NRA (now UPDF) started to torture and kill civilians. Men were raped; the soldiers defecated on people's food and burnt people's houses (Refugee Law Project, 2014).

The Acholi people were confined to the camps. They could not move far (stayed within one-kilometre distance) due to the fear of rebel attacks or being labelled rebel sympathisers (Latigo, 2008). Children and youth of school-going age could not continue with school, nor did they have alternative activities that could keep them busy. They were left to engage in self-destructive practices like drinking alcohol and having unprotected sex (Paul, 2010). Unplanned and unwanted pregnancies were on the rise. Diseases, including HIV, were spreading rapidly (Amone, 2014). Persons who lived in the IDPs described them as “places of restriction, danger, humiliation, disempowerment, moral degeneration, terrible living conditions”. Those who grew up in camps have been referred to as the “missing generation” as it is said that they cannot “compete on an equal basis with those across the country who were never displaced” (Refugee Law Project 2014, pg. 27).

The civil conflict did not leave the health care system unscathed. Most of the health facilities were destroyed and remained dysfunctional without supplies. Health workers fled to neighbouring towns and countries (Carlson, 2014). Multilateral and bilateral donors became key players in the health sector and were predominantly camp-based (UNICEF, 2007). The 2007 Health Services Availability Mapping survey showed that none of the Health Centres (HC) at levels III and IV met the recommended staffing norms. One doctor was serving 11,318 persons in Gulu town. In the three districts of Gulu, Kitgum, and Pader, up to 49 per cent of health facilities experienced stock-out for tracer drugs in the first quarter of 2006 (Olushayo et al., 2015).

The Acholi people have since moved out of the camps to their villages. By 2010, more than 90 per cent had resettled in their areas of origin or new locations. However, the return process was challenging since there were still land mines. The people also had to deal with border conflicts with the people of South Sudan and “cattle raids from the neighbouring Karamoja sub-region” (Norwegian Refugee Council, 2010, p.8). Not all people have successfully resettled and reintegrated into their communities. This is due to household labour constraints, asset deprivation, the poor state of social service facilities in return areas, land disputes, and widespread conflicts in this region (Refugee Law Project, 2014).

Access to health care was and remains particularly challenging. Government health services were concentrated in district centres, with international NGOs and churches providing minimal health care outside district centres. The government committed up to 22 per cent of the national budget for local government services, including health, to districts affected by the conflict. However, a 2004 parliamentary report found that large amounts of these allocations went unspent due to the inability of government staff to engage in routine work. By then, only 60 per cent of the health worker posts were filled. In addition, the District Health Management team was incapacitated to take on its supervisory role (Parliament of Uganda, 2004).

The different deficiencies in the social service systems informed the government of Uganda's decision to introduce policy and programme interventions meant to support the war-affected communities in Northern Uganda. This included the Northern Uganda Malaria, AIDS, and Tuberculosis Programme (NUMAT), which ran from 2006 to 2011. This was meant to expand access to and utilisation of HIV and AIDS, tuberculosis, and malaria services in the different districts of Northern Uganda. The government passed the first Peace, Recovery and Development Plan (2007 – 2010) to develop the health infrastructure (MoH, 2010; Matsiko, 2010). In 2012, the Northern Uganda Health Integration to Enhance Services (NU-HITES) project was launched. This would run up to 2017. The project aimed at making health services in Northern Uganda more widely available and of good quality by strengthening the health workforce. The Ministry of Public Service passed a Hard to Reach Allowance Policy (2010). The intent was to attract and retain adequate numbers of skilled and capable personnel. A total of 24 districts were designated as hard to reach, including all six districts of the Acholi sub-region [Gulu, Pader, Kitgum, Amuru, Nwoya and Lamwo] (MoPS, 2010).

3.2 Health Care in Northern Uganda

Health care in Uganda is delivered through the public and private sectors. The private sector consists of private not-for-profit organisations, private health practitioners and traditional and complementary medicine practitioners. These receive technical support supervision from the Ministry of Health⁴ and District Health Team⁵.

The public health system is made up of national and district health systems. The national health system includes National and Regional Referral Hospitals. The district health system comprises district general hospitals and health centres classified as Health Centres II, III and IV. The classification depends on the administrative region served by the facility. Health Centre II serve a parish, Health Centre III serves a sub-county, and Health Centre IV serves a county (Turyamureba et al., 2023). At the village level, there are community health practitioners known as the village health team.

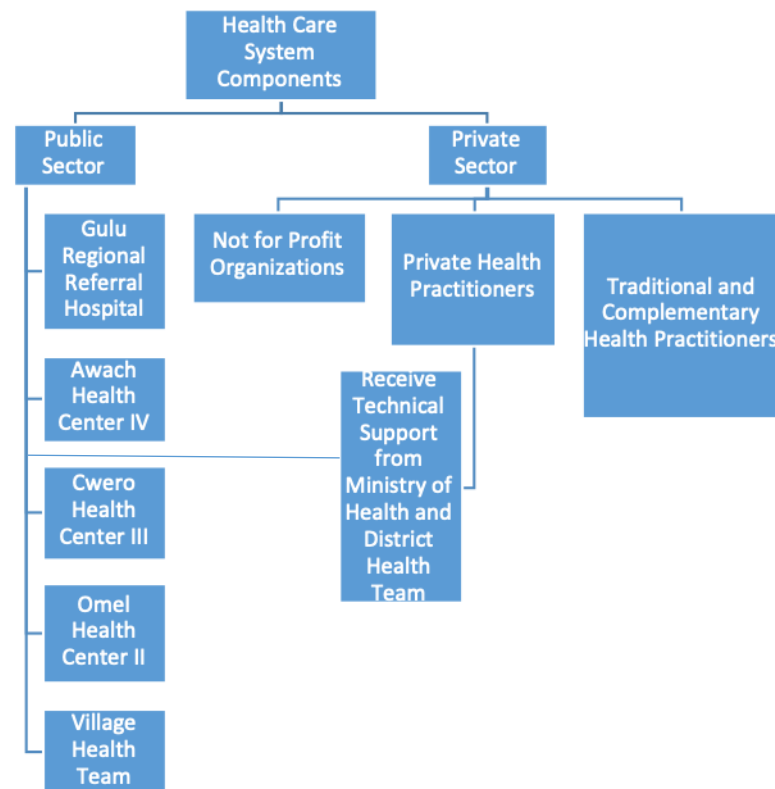
⁴ The Ministry of Health is a government body set up with the mandate of stewardship and leadership of the health sector.

⁵ Is a health management structure at the sub-national level.

The district health care system works on a referral basis. If a health condition cannot be addressed at one level, one is referred to a facility at the next level. The village health team is the first point of contact for the population. They provide basic health education and initial treatment for common diseases. Health Centre II provides community-based preventive, promotive and outpatient curative services. At the next level is Health Centre III, which provides all services offered at Health Centre II and maternity, inpatient health services and laboratory services. Health Centre IV provides all services offered at Health Centre III, plus emergency surgery and blood transfusion services. At the district level, there is a hospital which, in addition to the services provided at Health Centre IV, has specialised clinics such as those for dentistry. Gulu district does not have a district hospital; however, it hosts a regional hospital whose catchment area goes beyond Gulu district. Regional referral hospitals offer specialist services such as psychiatry, ear, nose and throat, ophthalmology, and dentistry (Tashobya et al., 2018; Chen et al., 2021).

The sources of financing for health care are public and private funds, including out-of-pocket expenditures, development partners and voluntary health insurance. Uganda has consistently allocated between 5% and 9% of the national budget to health. The country does not have a national health insurance scheme, and less than 5% of the population has some form of insurance (WHO, 2023).

Figure 1: Health System Structure in the Field Sites Visited



Developed by the Author

The readiness capacity of health facilities to provide general services is at 60 per cent (MoH, 2023). This could be explained by the thin health worker human resource in Gulu district. Data shows that only 242 personnel (including 68 clerical staff) serve a population of about 270,000. A further review of staffing norms shows that some facilities have lower staffing levels. For example, staffing in Omel HC II (located in my field site) is about 66 per cent. These are six personnel, including two clerical staff, with the enrolled midwife being the most qualified (MoH, 2020). According to the Uganda Scheme of Service for the midwifery cadre, the enrolled midwife holds a certificate in midwifery (MoPS, 2017). Also, there is a low bed capacity in the government facilities, leading to a high bed occupancy rate. For example, Awach Health Centre IV has a bed occupancy rate of 289 per cent. Stock out of medicines is common in Gulu district. 54.1% of villages in Gulu report at least one stock out of Amoxicillin, while 66.2% of villages report at least one stock out of Artemisinin-based Combination Therapy (ACTs) (MoH, 2023).

There is a high disease burden in the Gulu district. The infant mortality rate is 28.9 per 1,000 live births, under-five mortality is 40.6 per 1,000 live births, and there are 121 hospital admissions per 1,000 population (Ibid, 2023). The Uganda Demographic and Health Survey (2016) provides critical information that can further support the understanding of the disease burden in Gulu district (although data provided is at the regional level). It shows that, in the Acholi region, 9.1 per cent of children under 5 presented with acute respiratory infection symptoms; 49.1 per cent of children under 5 had a fever two weeks preceding the survey; 70.8 per cent of children aged 6-59 months were classified as having anaemia, with 3.9 per cent of these having severe anaemia; 15.2 per cent of children aged 6-59 months were classified as having vitamin A deficiency; and 62.8 per cent of children aged 6-59 months were classified as having malaria (UBOS & ICF, 2018).

3.3 Context of the Research

This research project was born out of the decision by the Austrian Partnership Program in Higher Education and Research for Development (APPEAR) to integrate PhD grants in a partnership project titled "Master Program Medical Anthropology and Research for Development" (MA-MEDANIH) between the Medical University of Vienna (Austria) and Gulu University (Uganda). It was envisaged that students from the partner institutions should contribute to the implementation and sustainability of the cooperation.

The MA-MEDANIH partnership project ran from 2012-2016. The project aimed to implement a master's course in "Medical Anthropology and International Health" with a "strong focus on an innovative curriculum as well as international and national partnerships. The course enables students with a background in medicine, social science, science, and the arts to benefit from an interdisciplinary partnership and curriculum. It is combined with a strong needs-based research commitment in the local communities."⁶

⁶ Gulu University. Programme for Master of Medical Anthropology (M-MAH). Faculty of Medicine. Department of Mental Health. September 18, 2013.

I got to know of the call from Professor Paul Bukuluki. I was finalising my Master's (MA) studies at the University of Gothenburg, Sweden. I managed to submit a project proposal on “Culture and disability; a focus on culture influence on treatment-seeking behaviour and health systems response for children with hearing loss in Pader District”. On June 21, 2013, I received an email from APPEAR notifying me that the selection board had discussed my application in Vienna and that I had been awarded an APPEAR grant.

Later that year, I met with my supervisor, and one of the issues we discussed was the study topic. We concluded that I should focus on a local disease-causing agent, Te Lak, since it was often associated with common childhood diseases, namely, malaria, pneumonia, and diarrhoea. These diseases are responsible for most mortalities in children under 5 in Northern Uganda (MoH, 2018). We agreed that the study was more relevant to the MA-MEDANIH partnership project since it addressed one of the most pressing health problems in Northern Uganda.

We did share our experiences with the local disease-causing agent. My supervisor had had interactions with health workers in the districts of Mbarara and Gulu on the same issue. She was surprised by the high number of mothers reporting to the health practitioners that their children were suffering from diseases caused by Te Lak. She attempted to interact with one of the popular Te Lak specialists in Gulu town, but the specialist declined to open up. Te Lak was not new to me either. It is commonly known as Ebinyo (bad teeth) in my local community. I had heard stories from relatives and friends of children who had died after contracting Te Lak. By then, my childhood friend had just started working in a government health facility and told me that parents seek care after extracting Te Lak from their child's gums.

3.4 The Ethnographic Approach

Ethnography is a special methodology that "suggests that we learn about people's lives from their perspective and within the context of their own lived experience" (O'Reilly, 2005, pg. 84). This methodological approach allowed me to overtly participate in the daily lives of individuals who engage with Te Lak for about ten months. I cared for sick children, I did seek health care from health facilities, clinics, and drug shops within the field sites, I took part in community cleaning

exercises under the campaign to prevent malaria, I regularly visited communal markets, I accompanied Te Lak specialists to local bars, I attended funeral rites of children that reportedly died from Te Lak, and I took part in health care outreaches conducted by government health workers. I tried as much as possible to participate in the daily lives of the people in my field sites. As I participated in their lives, I was keen to observe and listen to what was happening. When something of interest was discussed, I asked the individual to explain more about the issue. In cases where I was not satisfied with the response, I looked for that individual on yet another day for more clarity on the issue. Indeed, I engaged the people formally and informally on their daily life experiences, which I had previously observed or experienced myself. I took pictures, especially when I thought they depicted the people's perspectives about Te Lak. I collected plant species that local specialists use when handling cases of Te Lak, and I shared a homestead with a specialist in order to have an understanding of what it means to be a healer in these communities. At the end of the fieldwork, I had collected "rich, sensitive, and credible" information on Te Lak and health care in general in the two rural communities in Gulu district (O'Reilly, 2005; Hammersley & Atkinson, 2007; O'Reilly, 2012, p. 11).

Drawing from what I have explained in the above paragraph, I agree with O'Reilly, who finds ethnography to be "more of a theory about how research should be conducted than a recipe for techniques that can be employed. It draws on a family of methods, usually including participant observation, in-depth interviews, and conversations. It gains its understanding of the social world through involvement in the daily practice of human agents, and it involves immersion in the context, building trust and rapport with agents, and recognising the complexity of the social world. It does not attempt to reduce this complexity to a few statistical or typological representations" (O'Reilly, 2012, pgs. 10 & 11).

My immersion into the people's daily lives was not as merry as I have described above. I had to struggle with my biases as a foreigner to the land. Truthfully, I grew up hearing that people from northern Uganda were violent. Whenever my siblings hit me, my parents or relatives cautioned them not to be as violent as people from northern Uganda. The community I grew up in had an army barracks, and thus, there was a high presence of military men on the streets. It was an everyday talk that most soldiers were from northern Uganda. I was always told to run away when

I met someone in a military uniform. Whenever I annoyed my mother, she threatened to take me to the barracks, so that I would be "eaten up" (translated from my mother tongue).

I went to schools that were dominated by people from the southern part of Uganda. The students often made fun of people from northern Uganda. I admit I occasionally ridiculed the Northerners and thought it was okay. I am a Muganda by tribe, and there is a common saying that "omuganda takola bwa asikali" literally translates as "A Muganda can never seek employment as a night watchman". This saying has ties to the divisions that the colonialists created. The southerners were recruited into the civil service, while the people from the north were part of the army. This still holds as people think that individuals from the north are best suited to the realm of security.

Growing up, I had a predetermined idea of who a northerner is. When I joined Makerere University as a bachelor's student, I met several people from northern Uganda. I became friends with many of them. I realised that I was wrong about who they were all along. I even started getting into arguments with people who negatively viewed them. When I was in my third year, the faculty of Social Work organised a study trip to Gulu. I could not miss out on this trip. I quickly contacted my parents to ask for permission. They did agree but asked that I take care of myself. They advised me not to loiter around alone as I could be abducted. I took their advice seriously since that was when the civil war ended, and we occasionally heard about abduction cases. Well, I did travel to Gulu. I expected to find a town with grass-thatched houses, no tarmac roads and no electricity. I was so surprised at what I found in Gulu town. It was as developed as my hometown, Masaka. Later in the night, we were taken to a pub called "Buganda Pub". After that night, my perception of the people from the north changed.

I did my MA studies in Social Work and Human Rights. Whenever I attended lectures on human rights, I reflected on the discriminatory ideas that other people from the southern part of the country and I hold concerning people from the north. It is then that I swore a personal oath never to discriminate against my fellow Ugandans. Therefore, when I got into the field, I was confident that I did not hold onto any bias toward my study participants. However, I was surprised when a single unfortunate event happened during my fieldwork. I, along with the other people, was by the evening fire. We retired to our huts at about 21:00 hours only to find that they had been

burglarised. We tried to look around for clues on who could have broken into the hut, but our efforts were not fruitful.

The following day, I attended a family meeting where the mother was being blamed for not taking the child for treatment of Te Lak. My interpreter kept translating the proceedings, but all I could think of was how irrational the elders were. Reflecting on my discussion with my research assistant after attending the meeting, I could tell I was biased. I took sides with the woman who was being blamed for not taking the child for "treatment". I did not give myself a chance to listen to the elder's arguments. Instead, I took them to be bullies. I remember telling my assistant that these elders were being abusive. For days, I struggled to be an outsider who listened and never judged the behaviour of my study participants. One day, my assistant asked me why my behaviour towards my study participants had suddenly changed. I responded "they stole my property". However, I silently added that I knew they were violent people. Why should I be surprised? It was then that I realised that my earlier preconceptions about people from the north were haunting me. I decided to take a few days off from fieldwork to deal with my psychological troubles. I called one of my social research mentors and explained what had happened. Our conversation led to a discussion on the importance of self-awareness of biases and assumptions throughout the data collection process. This was particularly helpful because it helped me reflect more on my role as a researcher and the importance of managing other identities that might bring about role conflict.

The significance of being self-reflexive (Berger, 2015) cannot be underestimated, since I had to deal with the moral implications of the extraction of Te Lak from infants' gums. The communities of practice and education I had previously been part of find engagement with Te Lak immoral. These, consciously or unconsciously, have a decisive influence on the way I perceive my participants and the research questions to pursue. This required that I continuously reflect on such popular conceptions and how they could affect the research relationship that I developed with my participants and the research questions I were to analyse. This enabled me to move away from asking questions about the harm Te Lak presents to infants to focus on the meanings that those who engage with the practice draw from the various events associated with

Te Lak. This was important in showing the unexpected paradoxes that provide a more comprehensive understanding of the practice and change that outsiders can build on.

I also had to deal with identity as a man who was working in a field that is dominated by women. I was raised in a patriarchal society. In my early years, my parents socialised me into gender roles meant for boys. I was also dressed as a boy and often reminded never to buy blue shirts as this colour is meant for girls. I was severely beaten for being found cooking. My sisters would also burn me when they found me near a saucepan. The communities in which I conducted this study are also patriarchal. Most of my experiences as a child are similar to what young boys are being socialised in. One of the key roles that is assigned to women is that of seeking health care and caring for sick children. Given that I took on the role of a participant-observer, I at times offered to take sick children to the health facilities on the parents' behalf. These were times when they had competing priorities. In most cases, mothers right away declined my offer. They explained that this was not a role for men in this community. This explains the gossip that I overheard when I took one of the children. One of the health facility workers affirmed to the other that indeed I was a foreigner in the land. There were times when we had to meet young women in their homesteads. In most cases, it took time to receive consent from the male spouse, allowing us to speak to their wife. The man has absolute power to make decisions in the home, including deciding who speaks to the spouse.

The ethnographic approach requires the researcher to engage in the field long-term. The intention is to understand what it is like to live in such a community (Hoey, 2014). As earlier mentioned, fieldwork lasted over ten months. However, the said period does not include the preparatory activities I engaged in. I planned to begin the first fieldwork phase in April 2015. I, however, decided to push the start date to May 2015. I utilised that month to learn how to conduct ethnographic studies practically. There was a group of PhD students who were utilising this approach. Two of them were my former lecturers at Makerere University. I visited their field sites a couple of times. They did caution me not to come along with a motor vehicle. I was told that the participants would immediately treat me as a foreigner and that it would be hard for the community members to accept me as a native.

Nevertheless, my time within those field sites was beneficial. I learnt the art of conducting informal interviews and how to note down what one has collected from such interviews. The students also guided me on how to draw theoretical memos from the interview notes. I was also advised to keep a field diary where I would write my reflections on the data collection process and any other personal matters. Midway through April, I got an opportunity to conduct fieldwork in Gulu municipality. I right away took on this opportunity. The fieldwork lasted a week. This helped me to settle in Gulu town. It also mentally prepared me to start my fieldwork.

Because I was not conversant with the Acholi language, I recruited a research assistant and a translator. Both were Acholi (ethnicity), and Acholi is their first language. The research assistant then held a bachelor's degree in social sciences from Makerere University. She also had a good understanding and experience in conducting qualitative and ethnographic studies. The translator was a fresh university graduate with a bachelor's in social work and social administration from Makerere University. She had written her dissertation on "Community Health Resource Persons".

I moved with the assistant and translator in the day-to-day collection of the data. The assistant asked the questions, and the translator translated to me the interview proceedings. I, from time to time, wrote down probes on a piece of paper and handed it out to the assistant. I also took it upon myself to learn the Acholi language – by the end of fieldwork, I could construct a sentence in Acholi. Furthermore, I always ensured that I exchanged pleasantries with the participants in the Acholi dialect. It is through this that I created rapport with the participants. I should note that some respondents were conversant with the English language and thus could directly interact with them.

The first phase of fieldwork ran from May to September 2015. The first week of this phase mainly consisted of introducing myself and seeking permission to conduct fieldwork in Gulu district from the district officials. After getting the necessary permission, I travelled to my field sites. My first order of business was to introduce myself to the local chairpersons and inform them about my intent to stay in their communities. They advised me on how best to get in touch with the potential study participants. These engagements with the local authorities and other

personnel facilitated successful entry into the field sites. The second phase of fieldwork ran from March to mid-August 2016. This phase involved further data collection, addressing the gaps and clarifying previously collected data.

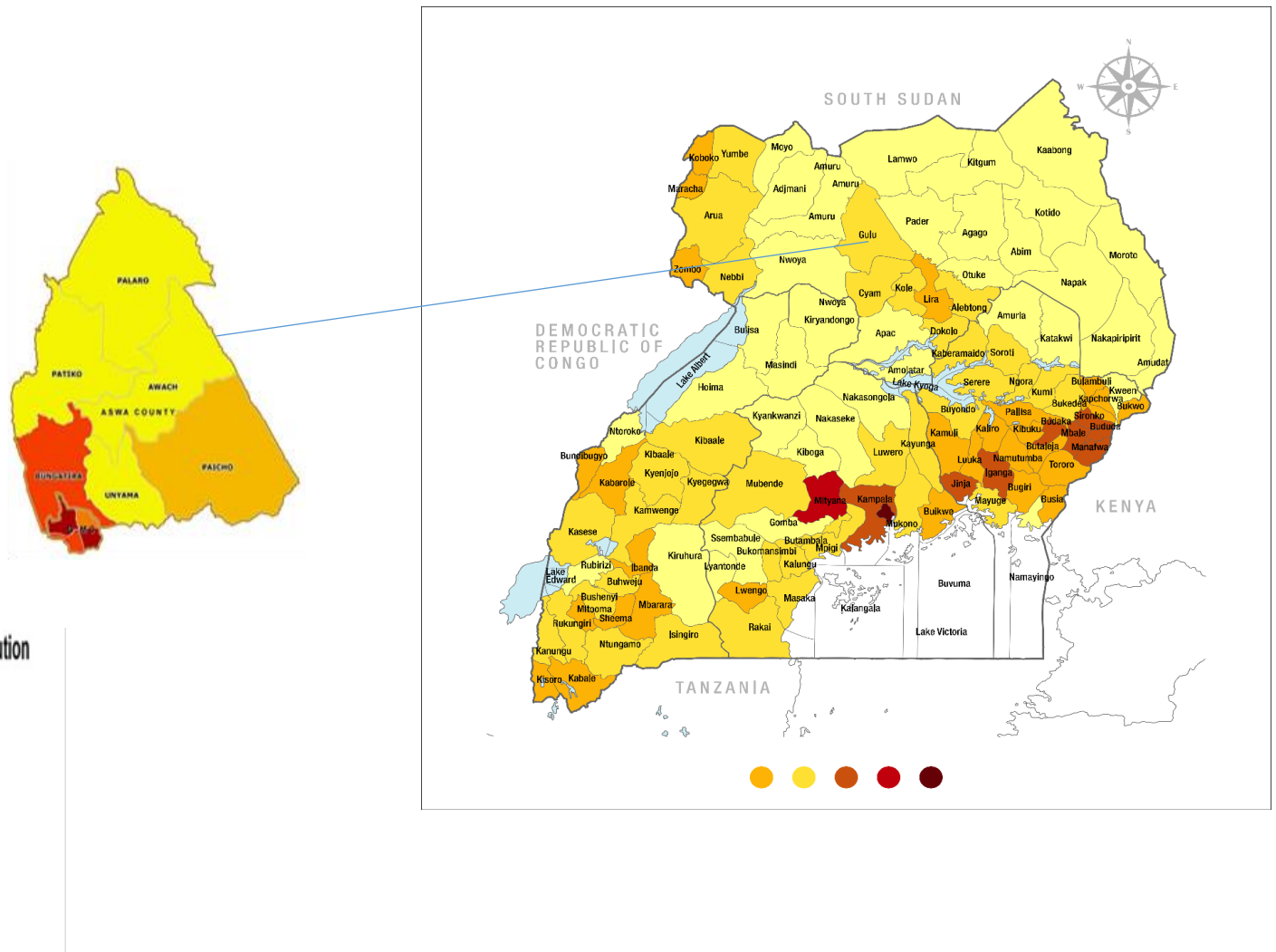
3.5 Field Sites

One of the requirements set by the PhD grant-awarding institution was that the project had to be carried out in Northern Uganda. Therefore, I chose to conduct the study in Gulu district, one of the 30 districts that make up Northern Uganda. This is because the most recent study I know of on the prevalence of Kwanyo Te Lak in Uganda indicated that the prevalence is highest in this district (Tirwomwe et al., 2013). Gulu district, along with the other six districts of Agago, Amuru, Nwoya, Lamwo, Pader, and Kitgum, hosts the Acholi ethnicity.

The communities within which data collection happened were chosen under the direction of the District Health Officer, Gulu district. My interest was to work in communities which hosted IDP camps. It was agreed that I would work in Paicho Sub County in the parishes of Pagik and Omel. Pagik parish hosted Cwero IDP camp, which was locally known as Teyapacola. Omel Parish hosted Omel Apem IDP camp.

By 2014, Paicho Sub County had a total population of 24,488 people. 19.9 per cent of the population aged 6-12 years were not in school. 16.7 per cent of the population aged 10-19 years had been married. 11.8 per cent of persons aged 0-17 years were orphans. 41.5 per cent of households were 5 kilometres or over from the nearest public health facility. Only 45.8 per cent of households had access to safe water. 22.5 per cent of households did not have a toilet facility, and 22.3 per cent of households had less than two meals a day (UBOS, 2017).

Figure 2: Map of Uganda showing Gulu District



Source: Uganda Bureau of Statistics, 2017

3.6 Study Participants and Their Selection

A wide array of participants were recruited for the study. These included local council leaders, Te Lak specialists, caregivers of children that have gone through the treatment of Te Lak, caregivers that do not believe in Te Lak, Village Health Team (VHT) members, health unit management committee members, health workers in the government health facilities of Omel HC II and Cwero HC III, health workers in private health facilities, elders at family and community level, a trainee healer, and a church leader. These participants were selected purposively and through snowball sampling. As a result, 69 (56 female and 13 male) participants participated in this study. The tables below provide details on who took part in the study and the selection criteria.

Table 1: Selected Te Lak Specialists/Healers

Unique identifier	Sex	Therapy	Number of years spent as a healer	Selection Criteria
Specialist_01	Female	Kwanyo Te Lak	15	Number of years spent as a healer & type of treatment offered
Specialist_02_01	Female	Herbal	8	Number of years spent as a healer & type of treatment offered
Specialist_03_06	Female	Herbal	40	Number of years spent as a healer & type of treatment offered
Specialist_04_02	Female	Herbal	4	Number of years spent as a healer & type of treatment offered
Specialist_05	Male	Kwanyo Te Lak	65	Number of years spent as a healer & type of treatment offered
Specialist_06_03	Female	Herbal	3	Number of years spent as a healer & type of treatment offered
Specialist_07	Female	Kwanyo Te Lak	30	Also holds position of a traditional birth attendant

Specialist _08	Female	Kwanyo Te Lak	2.5	Number of years spent as a healer & type of treatment offered
Specialist _09	Male	Kwanyo Te Lak	26	Healer and part of the village health team
Specialist _10_04	Male	Herbal	50 plus	Number of years spent as a healer & type of treatment offered
Specialist _11	Female	Kwanyo Te Lak	32	Number of years spent as a healer & type of treatment offered
Specialist _12	Female	Kwanyo Te Lak	3	Also holds position of a traditional birth attendant
Specialist _13	Female	Kwanyo Te Lak	28	Also holds position of a traditional birth attendant
Specialist _14	Female	Kwanyo Te Lak	9	Number of years spent as a healer & type of treatment offered
Specialist _15	Female	Kwanyo Te Lak	30	Number of years spent as a healer & type of treatment offered

Table 2: Caregivers who have had their children treated for diseases caused by Te Lak

	Sex	Age	Selection Criteria
Caregiver_01	Female	18	Willing to have other children treated by healers
Caregiver_02	Female	33	Currently using western medicine to treat Te Lak
Caregiver_03	Female	29	Born again Christian, no longer takes the child to the Te Lak specialist. Uses Western medicine to treat Te Lak.
Caregiver_04	Female	31	Willing to have other children treated by healers
Caregiver_05	Female/1	25	No longer seeks treatment for the Te Lak specialists
Caregiver_06	Female	40	Willing to have other children treated by healers
Caregiver_07	Female	22	Willing to have other children treated by healers
Caregiver_08	Female	25	Stopped seeking care from healers because they were reusing sharp instruments
Caregiver_09	Female	27	Willing to have other children treated by healers

Caregiver_10	Female	24	Willing to have other children treated by healers
Caregiver_11	Female		Willing to have other children treated by healers
Caregiver_12	Female	32	Born again Christian, no longer takes child to Te Lak specialist; Stopped seeking care from healers because they were reusing sharp instruments
Caregiver_13	Female	39	No longer takes children for treatment of Te Lak
Caregiver_14	Female	19	Willing to have other children treated by healers
Caregiver_15	Female	32	Willing to have other children treated by healers
Caregiver_16	Female	32	Willing to have other children treated by healers
Caregiver_17	Female	40	Born again Christian, no longer takes child to Te Lak specialist.
Caregiver_18	Female	28	Willing to have other children treated by healers
Caregiver_19	Female	35	Willing to have other children treated by healers
Caregiver_20	Female	27	Willing to have other children treated by healers
Caregiver_21	Female	24	Willing to have other children treated by healers
Caregiver_22	Female	38	Willing to have other children treated by healers
Caregiver_23	Female	34	Religious healing
Caregiver_24	Female	30	Willing to have other children treated by healers
Caregiver_25	Male	30	Willing to have other children treated by healers
Caregiver_26	Male	38	Willing to have other children treated by healers
Caregiver_28	Female	31	Believe in Te Lak but resists from using local treatments
Caregiver_29	Female	32	Willing to have other children treated by healers
Caregiver_30	Female	26	Willing to have other children treated by healers
Caregiver_27	Female	27	Willing to have other children treated by healers
Caregiver_31	Female	32	Willing to have other children treated by healers

Table 3: Government Health Unit Committee Members

Number	Position
1	Chairman Health management committee
2	In-charge, cleanliness
3	In-charge, finance

4	Chairman Health management committee
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Table 4: Other Participants

Category	Number of participants	Selection Criteria
Elders	2	Keepers of cultural knowledge
Church leader	1	Play a crucial role in the campaign against Te Lak
Government health workers	2	Play a crucial role in the campaign against Te Lak
Caregivers that do not believe in Te Lak	2	Against the idea that Te Lak is a disease causing agent
Two Kal ⁷ (millet disease) healers	3	Treat an illness that has similar signs as those of Te Lak
Village Health Team members	5	Serves as initial point of contact for primary health care
Local Council Leaders	3	Lowest level of political authority; Legitimize the treatment practice
Trainee healer	1	Receiving specialized training in the treatment of Te Lak

⁷ Two Kal is a common “disease” category associated with symptoms of common childhood diseases e.g. malaria, pneumonia, diarrhea. It is treated by making small cuts on the chest and back and thereafter removal of fat which is commonly referred to as millet by the locals.

3.7 Data Collection Methods

Ethnographic Interviews

Ethnographic interviews are interviews where researchers have "established respectful, ongoing relationships with their interviewees, including enough rapport for there to be a genuine exchange of views and enough time and openness in the interviews for the interviewees to explore purposefully with the researcher the meanings they place on events in their worlds" (Heyl, 2001, pg. 369).

These interviews take an unstructured, in-depth format with people from a particular culture or who share specific experiences. The ultimate objective of taking on such interviews is for the researcher to learn from the respondent instead of imposing an external frame of reference (Spradley, 1979; Jupp, 2006).

I conducted ethnographic interviews with Te Lak specialists, caregivers of children who have had their children undergo treatment for Te Lak, caregivers who do not believe in Te Lak, Two Kal specialists, elders, local council leaders, and a trainee healer. I developed several interview guides targeting the different respondents before the beginning of fieldwork. My supervisor and the MildMay Research and Ethics Committee reviewed these guides, and the Uganda National Council of Science and Technology later approved them. The guides only included open-ended questions. This allowed the participants to interpret the questions in various ways, giving me several opinions, thoughts, and reflections on a similar issue. These were, at times, contradictory. The respondents were also prompted to answer with stories about the past and future. I collected unexpected responses, which gave me a deeper understanding of the practice and new insights or topics to focus on in the subsequent interviews. The task at hand was to have a proper understanding of what was happening in the local world of my participants, and indeed, the open questioning technique allowed me to collect information on the people's world views on Te Lak and more widely on child health within the community.

At times, the interviews were arranged. I, my research assistant, and translator, visited the potential respondent and sought an interview. If the participant did not have adequate time to talk to us, we asked that he or she advise on the preferred interview date and time.

There were instances where I opportunistically turned conversations into an interview. This often happened when I attended social engagements in the community. For example, there was a time I took part in the community cleaning exercise. I did find a gentleman who was conversant with the English language. We began by sharing pleasantries. He subsequently asked why I was participating in an exercise meant for permanent residents in the community. The more we talked, the more we delved into child health issues and the local disease-causing agent, Te Lak. We had talked about a lot, but still, I felt there was more to talk about. I thus requested that we meet again to discuss the issues at hand.

The practice of interacting with a participant more than once was common. We made several returns to the participant's home, mainly when we wanted to get his or her view on a topic that had emerged during interviews with other participants. It could also be about something that we observed in the community. Having several opinions about a similar matter assisted me in having a more detailed and in-depth description of the issue.

Field Diary

I did keep a field diary. The diary helped me think about my "own role in the research process", my "own history and biography, decisions I "make and how". It was where I logged "many things I thought did not seem relevant at the time of hearing about, seeing or thinking about them, yet turned out to be relevant at some later stage". The diary enabled me to empathise with my participants "as I reflected on my apprehensions, ambiguities, surprises, and joys" (O'Reilly, 2005, p. 70). I wrote many things in the diary. There is no hardship I faced that I missed writing about. The misery that came about with the data collection was all scribbled down.

That aside, the diary helped me reflect on my position in the community as a researcher and how this affected the data quality I collected. There were times when I felt my presence was instigating fear among the respondents. This happened in the first months I tried recruiting Te Lak specialists into the study. Most viewed me as an outsider who probably came in to spy on their work, eventually report to the authorities, and subsequently get them arrested. Writing down these experiences helped me think more critically about the issues. I then devised ways on how best I could approach them, how they could accept me as a researcher, and how I could change their general perception of me.

Participant Observation

Participant observation is one way in which the gap between the ideal, what people say should be the normative practice and the real, what happens, is most clearly identifiable (Nelson & Wright, 1995). In this study, I took up the role of participant-observer since I was fully integrated into the study participants' lives. I adopted a peripheral type of membership since it was ethical to only observe and interact closely with people under study and not participate in treating Te Lak. However, I did observe and took notes on naturally occurring interactions and conversations among caregivers within their social world.

Participant observation requires that one gains access to the study group. This was not an easy task at all. The war between the government of Uganda and the LRA ended over a decade ago. However, most of my study participants still held memories of what happened. Earlier in the conflict, the rhetoric was that the LRA was trying to liberate the people in the north from the southerners. The LRA later grew unpopular as it no longer represented the desired cause of liberating the people. The friction between the northerners and the southerners has not been resolved (Refugee Law Project, 2014). There is a general feeling of captivity among the population. Within such categorisation, I happen to be a southerner.

Whenever I met people in the first days of fieldwork, they strangely looked at me. My assistant always told me that she was often approached and asked if I had come to buy land. She constantly laboured to explain to them that we had come to conduct research. This is not

surprising because when the war ended in 2006, there were several cases related to land grabbing. It was also a popular talk in the community that southerners were buying all the land in the northern region. I had to find ways how I could change people's perceptions of me. Fortunately, I was staying on a farm owned by one of the most respectable persons in the community. Many people came around to offer manual labour. These later happened to be part of the study. I started engaging in activities around the farm. I, at times, engaged in hoeing. I prepared meals for the people who visited the farm. I also made sure that I served the meals. As a result, people's attitudes toward me started to change. It was at this time that they were willing to listen to me. I did explain to them what my intentions were. I built a relationship with them, and they later helped me observe what was going on in their lives. They no longer saw me as a stranger, and thus they started acting naturally around me. They had gotten used to my presence in the community. In a nutshell, I did so to immerse myself "into the life of the locals and tried not to be noticed, so that they can carry on with their lives as usual" (Eriksen, 2015, p. 34).

I did, however, realise that my engagement with people who came to offer labour on the farm did not capture all categories of people I was interested in. My first attempts with Te Lak specialists were not fruitful. They were not willing to be part of the study. Some told me that they were no longer treating Te Lak. So, I had to plan to gain access to this category of participants. I consulted with the local council chairpersons of Omel A and Omel B. I asked them to identify the most respectable specialists in their communities. I also asked them to spare a few minutes of their time and introduce me to them. They obliged, and this facilitated my entry into their lives. I then decided to work with these specialists first. I, at times, was asked to accompany them to social gatherings. At these gatherings, I met other specialists, at times those I had approached earlier. I was introduced to these specialists, and a request was made to accord me some time. This built the foundation on which the specialists accepted me as a researcher, one interested in collecting information on Te Lak and not one to persecute them for engaging with Te Lak. These interactions drew a path for me to participate and observe what was going on in the lives of the specialists.

However, I should note that gaining access to participate and observe the participants' lives was not done at one point. I had to often renegotiate my entry into their lives depending on the activity I intended to participate in. For example, I had built a strong relationship with a given family. We regularly interacted because the family head could speak my mother tongue. There was a time a family meeting was called. The intent was to collect money to meet the child's health care costs. I struggled to convince the family head that I needed to participate in this meeting. This is not the only time I had to renegotiate access to participate in the participants' lives. This was unique each time I had to do so.

I laboured to access the study participants' lives right from the start of fieldwork because I did not want to miss out on capturing behaviours and practices that, at first sight, seemed strange to me. If I had delayed gaining access to the participants' lives, I would probably have settled into the community and gotten used to what was being done.

I also created a log of daily childcare practices for one of my study participants. This was done for one month. My initial thinking was that the mother would fill in the log herself. However, this was not possible because she was illiterate. Thus, it was agreed that each day, we would interact with her so that she could tell us how her day was, mainly concerning childcare. I did choose this parent because her story was unique. She was a mother to 5-month-old twins who had just undergone Kwanyo Te Lak. Days after undergoing the procedure, the mother complained of the persistence of symptoms of the disease.

In-depth/ Focused Interviews

I also carried out in-depth or focused interviews with a church leader, health unit management committee members, government health workers, and VHT members. These directly or indirectly play a crucial role in child health in the community. Most of the interviews happened towards the end of the fieldwork. The respondents were chosen to respond to issues raised during the ethnographic interviews. For example, there were claims that health workers punished caregivers who reported to the health facilities with children who had undergone Kwanyo Te Lak. There were also concerns about the quality of health care provided at health facilities.

Therefore, I needed to approach the actors in the government health facilities, namely VHTs, health workers, and health unit management committee members, to record their perspectives on the people's concerns. The caregivers also often reiterated that the church leaders had influenced their decision to stop seeking care from Te Lak specialists. It was, therefore, essential to collect the views of the church leaders on Te Lak. The responses collected from the caregivers and specialists primarily directed the interview with the church leader.

Document Review

This has been a continuous process throughout the research project. The first review was undertaken after the supervisor and I chose a study topic. Te Lak is popularly referred to as false teeth by the scholarly community. I searched for this and other terms in different journals: Social Science and Medicine, Medical Anthropology Quarterly, African Health Sciences, East African Medical Journal, Uganda Medical Journal, and Culture Medicine and Psychiatry, among others. Throughout the writing process, I have reviewed different texts, including ones that had been archived, particularly on teething and health. In addition, I collected new items and anything else of interest that I thought would inform me more about the topic at hand.

Note Taking

I was able to collect rich information from the participants. For every arranged interview, I noted down the responses given by the participant. The interview was also recorded on a voice recorder. After the interview, I sat with the research assistant to transcribe the audio recording. After every phase of fieldwork, I handed over the audio recordings and the transcripts to another person well-versed in the Acholi language to cross-check and see if the transcripts were representative of what the respondent talked about. This was helpful because I was able to capture everything that the respondent said.

The practice was different for the informal interviews. I usually moved with a small notebook that would easily fit in my trouser pocket. When a conversation turned into an interview, I carefully listened to what the respondent said. Moments after the interview, I sat down with my

assistant and, at times, the translator (that is, if we had moved with her) and noted what the respondent was talking about. However, at times, we could hardly remember his or her views on a particular issue. If at all that happened, we arranged an interview with the respondent to capture the views in their entirety. Additionally, whenever I observed something of interest or went through an experience relevant to the study, I quickly brought out my notebook and wrote it down. These notes were later typed out in a Microsoft Word document.

3.8 Data Analysis

The data analysis process took an iterative-inductive process (O'Reilly, 2005). This was ongoing right from the start of the fieldwork. Whenever I collected data, I reflected on it to see how I could build it further. I sought clarification where needed. Where necessary, I returned to the informant to get more details about a single event that he or she talked about earlier. As more and more data were collected, I started categorising the data into themes, for example, child healthcare-seeking behaviour. I started to think about the kind of data I was collecting more broadly to see if there were issues of interest that I could follow up on that could make up additional themes. A single response from an informant directed me towards collecting a mass of information that made up a theme, e.g. the theme on the position of specialists in the community was borne from a simple response from one participant who said, "I am of great importance in the community".

The keeping of a field diary facilitated this process. This is where I noted down the different intellectual ideas that randomly came about. Sometimes I would sit under the mango tree and observe something that would trigger my intellect. I then excused myself, that is, if I was interacting with a couple of people, and moved to my hut to write down and reflect more on what had come to my mind. At times, this took a formal process. An issue could come up, but I could not easily relate it to the study. I then sat down and thought more about it. I, at times, consulted other researchers to get their opinion on the issue. In instances where they went through such an experience, they were in a position to guide my intellect. The researchers sometimes asked me to consult scholarly articles, though I only managed to do so after the first phase of fieldwork. This

is because I could not access amenities like power and the internet. In conclusion, this exercise directed me to decide on the kind of data I could collect.

After the fieldwork's first phase, I travelled back to Vienna, Austria, for the winter semester. I also moved along with draft transcripts. Within the first month, I reviewed the scripts, sorted the data into categories and drew initial conclusions. I then presented the emerging findings to my supervisor and the seminars I attended. This was helpful. I got a lot of feedback on the data, but I also realised that I had not fully covered some aspects. There were questions that I could not answer at the time. I followed up on these questions in the second fieldwork phase.

The more I read the scripts, the more I realised that there were issues I had not followed up on. I also started to question whether the translator was translating verbatim. I felt there were some gaps in the data. Then, I decided to share the voice recordings and draft transcripts with another person to cross-check and see if the scripts were representative of what the informants had said. Indeed, when this person sent in the first scripts, I realised that some information had been left out.

Data collection and analysis were also simultaneous within the second phase of fieldwork. After fieldwork, I had a big batch of information to manage. I did utilise the computer program ATLAS.ti version 8 to facilitate this process. This program was beneficial because I could sort the data into meaningful categories. This process provided me with the initial ideas on the chapters I could write and the different sub-sections that could go under each chapter. After this process, I started describing the understandings of my informants under each chapter and sub-section. The more descriptions I made, the more I refined the chapters and sub-sections. I then extracted quotations from the transcripts to support the descriptions. At the end of this process, I had study findings categorised under different chapters.

Subsequently, I had to explain the findings. I re-read the findings and noted down the issues that I could explain. I also looked for inconsistencies which needed explaining. Several concepts arose from the field. As I earlier noted, the specialist talked about her position in the community. I also found out that specialists and their clients engage in exchange practices. These concepts

guided me in making sense of the findings. I further reviewed the literature to establish existing evidence on these different concepts. I then looked at how my data complements or contradicts the existing evidence. At the end of this process, I had discussed the findings in light of the existing literature.

3.9 Ethical Considerations

This study targeted caregivers of infant children as well as health practitioners. Both caregivers and practitioners were invited to participate in this study regardless of their status, age, or gender.

The benefits and risks of participating in this study were explained to the participants. The benefits were that caregivers' and health practitioners' participation would contribute to increased understanding of the child health care landscape and continuity of Te Lak in post-conflict areas of Pagik and Omel parishes in Gulu district. Information provided would also contribute to the development of more context-specific interventions meant to reduce the incidence of Te Lak and its impact on the lives of infant children.

The risk of participating in the study was that the participants could feel uncomfortable with questions being asked and the time spent answering the questions. I thus came up with a plan to support participants in distress. I trained the research assistant and translator on working with vulnerable children and families, particularly on markers of distress and effective response.

I made it clear to the research team that cases of abuse might occur and that we have a responsibility towards participants who may disclose information that suggests that they may be at risk of harm. I explained that in such situations, disclosure rather than confidentiality applies. This meant that at the consent stage, the research team must inform the potential participants that all information will be confidential unless there is a risk of, or one is experiencing harm. They were advised that any suspected cases were to be reported to the researcher first. I would then inform the Community Development Officer, a government worker responsible for receiving cases and taking case management actions.

We also had discussions with community leaders to understand existing power and gender dynamics. This was meant to determine if the participation of some categories of people in the study brings about safety concerns. I found out that male spouses held decision-making power within the household, including decisions about participating in research activities.

Since some of my female study participants were married, I found it essential to inform the male spouse of my intention to contact the wife. In my interaction, I did explain to them who I was, what the study was about, who was involved, and why the partner qualifies for this study, who will have access to the data, and what will happen to the data. This engagement set the stage for my assistants and me to have a private conversation with the participants without interference from the spouse.

The safety of the research team was paramount. This meant training the assistant and translator on personal safety and safety measures they can take. We agreed that we shall not undertake interviews in any situation in which we feel uncomfortable or unsafe. We always informed our neighbours of our plan for the day, specifically the area within which we were to conduct interviews. We also visited the local council leadership and informed them of our stay in their area of jurisdiction. This was done so that we do not face suspicion and mistrust from the community.

Ethical approval and permissions were obtained from MildMay Uganda Research and Ethics Committee (reference number: 0402-2015) and the Uganda National Council for Science and Technology (reference number: SS 3759). The committees approved the ethical considerations of the study, particularly the informed consent process. The Chief Administrative Officer of Gulu district, the sub-county chief of Paicho sub-county and local council chairpersons of villages visited provided additional permission to conduct the research.

The approved informed consent was translated into the Acholi language to support better comprehension. It described the purpose of the study, the procedures to be followed, and the risks and benefits of participation. Potential participants were informed that their participation is voluntary, and they can decide to leave at any time without any consequence. They were

informed of the procedures for ensuring their confidentiality, including: the use of unique participant identification numbers instead of names on research products, and maintenance of data in password-protected folders and in locked filing cabinets. A master list linking study participant identification numbers to a given participant was maintained. The list was kept in a password-protected data file, with access restricted to researchers. The master list was used in situations where there was a need to identify a participant from whom we needed to collect additional data. The participants were also informed of the limits of confidentiality, particularly the legal obligation to report cases of abuse or risk of abuse.

The informed consent process provided potential participants with the opportunity to ask questions and have the questions answered. All participants were given the researcher's contact number and the contact number of the ethics review committee to answer questions about the study or their rights as human subjects. Caregivers and health practitioners who declined participation were not included in the study. All participants were offered a copy of the informed consent form.

It is important to note that informed consent was not limited to a practice of just signing the consent form, but was treated as part of the daily fieldwork process. I interacted with most of my informants in different spaces. It could have been a health facility or in the informant's home. The fact that the informant allowed me to participate in an activity in his or her home did not imply that he or she was comfortable with me being part of his or her health-seeking journey. I then had to seek verbal consent.

The research assistant and translator were trained in the ethical treatment of human subjects and on procedures to protect the safety and identity of human subjects in this study. The training ensured that the staff are skilled at avoiding intended and unintended disclosure of information. They were also trained on other topics such as adherence to the research proposal and quality assurance.

Throughout the data collection process, participants' safety and protection were carefully monitored. All participants participating in the study were deemed to be at risk at any point in time, and research staff were on the lookout for any indication of abuse, exploitation, or neglect. We worked within the existing government structures to report all suspected cases of abuse. These were reported to the Community Development Officer. The officer is mandated to investigate and monitor the progress of all reported social protection matters. Once these concerns are substantiated, they may take measures to assist the person, refer the person to protective services and/or initiate action for long-term social protection.

CHAPTER 4: QUEST FOR GOOD HEALTH

4.1 Introduction

Anthropological studies on health have shown that culture defines local aetiology and disorder categories (Massé, 2007), providing a framework through which patients and therapy management groups make diagnostic decisions and treatment choices. In addition, the ethnographies reveal the negotiations that people engage in when they start acting on their choices, thereby making visible the intersecting structural impediments (Allen & Storm, 2012; Nielsena et al., 2016).

In this chapter, I examine parents' experiences following the onset of affliction among infant children to show meanings recollected and conclusions drawn regarding disease aetiology and appropriate health care. I pay particular attention to how these meanings are reconstructed when mothers interact with groups of people in a homestead, community, and or medical spaces.

I also investigate the decision-making processes that parents engage in to provide insights into the categories of persons entrusted to make health care decisions and the circumstances under which this responsibility shifts. By interrogating these processes, I also show the tension and cooperation involved, demonstrating health care's relational and moral dimensions. Finally, I examine the experiences of parents when they finally seek care. The different healthcare trajectories are recorded to understand how professional healthcare access challenges exacerbate the risk of engaging with Te Lak practices. This analysis situates healthcare seeking and delivery within broader structural contexts.

4.2 Signs of Te Lak

Caregivers I closely worked with always observed how well their children were growing. They were always concerned when the child presented signs indicating a probable presence of Te Lak in the gums. There are several, and some are unique to given caregivers. The child could refuse to breastfeed, could bite the breast, and shake their heads while breastfeeding, the child keeps

crying, could convulse, has a high body temperature, have a dry and warm mouth, itching gums, have a heating sensation in the back of the head, position his or her head backwards, rub gums onto nipples, the skin turning yellowish, spitting of breast milk, and vomit. Some were unique as a single person mentioned them. The child gets frightened when touched. The mouth will always be open, and saliva will flow out of the mouth – interpreted to mean that Te Lak is growing.

While I recognize that the participants' explanations of signs are culturally significant, it is equally important to note that these signs are categorized differently within the biomedical health system. Some signs like biting the breast, itching gums, and crying are part of the normal dentition development phase. Also, signs like yellowish skin, convulsions, vomiting and high body temperature indicate potential health concerns.

The presentation of malaria and diarrhoea in children also points to the presence of Te Lak. To my respondents, this kind of "malaria" and "diarrhoea" differs from that discussed in the biomedical facilities. A child with this kind of "malaria" bites the nipples of the mother and shakes his or her head while breastfeeding, the child's mouth and back of the head are warm, and the child is pale. A child with a type of "diarrhoea" caused by Te Lak will be passing out stool that is green in colour.

Yes, malaria caused by Te Lak brings about warmth in the child's mouth but also, since the nerve under Te Lak is connected to the back of the head – the back of the head will also be warm – Caregiver_11

The one caused by Te Lak makes the child pale, and the back of the head will also be warm – Specialist_03

Malaria caused by Te Lak is different because when the child is breastfeeding, the child bites the nipples and shakes the head, but in normal malaria, the child does not bite the nipples – Specialist_05

You first feel the back of the head; you know Te Lak is connected to the back of the

head. If it is warm, then you know that it is Te Lak causing malaria – Specialist_11

One of my respondents believed malaria spread through mosquito bites is relatively new. She was confident that it was only Te Lak that was causing malaria in the past. The respondent told me that they sometimes find it challenging to differentiate the kind of malaria the child could have contracted. Thus, they have difficulties seeking care in the right health care system.

Those days we did not have this kind of malaria that is around. We only had malaria that Te Lak was causing. Today when the child gets ill, it could be malaria caused by Te Lak or the other type. At times you might fail to differentiate it and take the child to the health centre, but when you see that the child is not getting better, you have to look for a Te Lak specialist to treat your child – Caregiver_11

The signs of Te Lak are several, and these do not present in the child at once. Presentation of given signs (e.g. positioning the head backwards, skin turning yellowish) often does not preempt checking children's gums for the presence of Te Lak. Even when the caregiver decides to diagnose the child further and finds out that Te Lak is in the gums, he or she might not attribute the child's poor health to Te Lak. It is only when the child has difficulties with doto chak (breastfeeding) that the caregiver would be greatly concerned about Te Lak.

What usually worries us is the child shaking her head while breastfeeding. Have you ever seen a child disapprove of what the parent is offering? Shaking the head is more of a gesture showing that the child disapproves of taking the mother's breast milk. By the way, she not only shook her head but also would breastfeed for a minute and then withdraws her lips from my tits. The child was not feeding at all, and by that time, a child can only feed through breastfeeding and not in any other way – Caregiver_23

I later learnt that doto chak is of concern to the family of a new mother right after birth. Family members toil to ensure that a mother has enough breast milk, and any condition that disrupts proper doto chak would be distressful. In case the mother of the child dies, a call for help is made to any close family member who has a breastfeeding child also to feed the orphan child, and if

there is not any, ajwaka "traditional healer" is called upon to perform rituals on one of the girls in the family that enables her to produce breast milk. To my respondents, doto chak is not all about feeding the child and relieving the mother of pain caused by breast milk but also helps with child spacing and preventing a child from habitual greed.

As soon as a newborn child is born, especially if it is a first child, I give the mother hot water with tea leaves. I also give her porridge made from millet and malakwang (leafy green vegetables) prepared with salt and tomatoes. Malakwang is a sour vegetable, and it helps to melt the solid substance found in the woman's breast into milk. I also massage my daughter's breast to ensure the breast milk is liquefied. I then ask my daughter always to take warm water, eat soupy meals, and eat malakwang and porridge to produce and maintain breast milk. If she fails to produce enough breast milk, I can collect a plant called gwar-gwar (local herb), boil it as a whole and then she could drink the liquid that comes out of it. If I fail to get that plant, especially in the dry season, we buy cow milk. The problem is that it is not easy to get that milk. If I fail, I prepare porridge and mix it with oddi (a mixture of Sesame and ground nut paste). However, it would be good if my daughter was able to breastfeed. You know doto chak is much more nutritious and healthier, and the child becomes productive when taken. Breastfeeding is not just a matter of a mother giving her child doto chak for a couple of years; and it serves several other purposes. When a child breastfeeds, the mother is relieved of the pain she goes through for holding excess breast milk in her breasts. Breastfeeding practices also save the child from being a glutton. When a mother of a newborn has any meal, she is asked to carry her baby so that if the child is hungry, she feeds as the mother eats. One can also use breastfeeding as a birth control mechanism. When a mother breastfeeds, her monthly cycle delays and thus can only conceive when the child is old enough. We expect someone to breastfeed her child for up to two years. Well, some go on and breastfeed their children to about three years. In circumstances where the baby's mother either died during or after labour, I summon all my other daughters and ask them to volunteer and take care of the newborn orphan.

When one of them does, I invite ajwaka, who brings with her some local herbs known as yat chak (milk herb). She does mince it into parts and put it into a calabash. Ajwaka then swings a white hen, which he holds by the legs, around the calabash, four times. After that, she gets a razor blade, breaks it diagonally to produce a sharp edge and asks the young woman to carry the child on her lap. She then makes minor cuts on her chest just above the breast while uttering out these words: "Please (she mentions the name of the deceased), provide your child with breast milk through this young woman (she mentions her name). We want your child to grow up strong and healthy". Ajwaka then applies the local herbs, and it is expected that the breast milk will come into the sister's breast within 6-12 hours. She then breastfeeds the baby until it is old enough to discontinue breastfeeding. Also, if the mother of the child dies when there is a breastfeeding mother in the home, I ask that mother to breastfeed the newborn orphan. We then do not have to call on ajwaka to perform the other ritual I have told you about – Interview with Female Elder.

Many respondents told me they often ignore Te Lak's presence in the child's gum until the child starts having difficulties breastfeeding. When this happens, the caregiver rushes to seek care for Te Lak so that the child can again breastfeed without difficulty. They fear the child would die if he or she took long without breastfeeding.

When the child fails to breastfeed, that child eventually dies. Who would want her child to die? No one, so that worries us a lot. You immediately have to seek health care at that time – Caregiver_23

4.3 Who Diagnoses?

Acan (pseudonym) gave birth to her first child in 2012. Her husband was training with the Uganda Peoples Defense Forces (UPDF)⁸ at the time, so he had left her in the care of his parents. She was thankful for the support she received from her in-laws. She did not think that she could have managed the first weeks of motherhood if it was not for their help.

Her child started presenting with minor illnesses in the first month. She sometimes had diarrhoea and a running nose that healed without medication. The illnesses were, however, on and off and worsened with time. Episodes of diarrhoea became persistent, and the mucus was coming out of her nose more often. Finally, it reached a time when the child's body got hot during the day. She later confessed that it never came to her mind that Te Lak had led to these illnesses.

First-time mothers, like Acan, are often not knowledgeable about how illnesses thought to be caused by Te Lak present in children. Many had heard about Te Lak but had no experience caring for a child with illnesses known to be caused by Te Lak.

At first, I was not aware that it was Te Lak that was affecting the health of the child. She had malaria, diarrhoea, and fever, but it did not come to my mind that it could be Te Lak causing this. I was a young woman who had heard about Te Lak but had never had a child whose health was deteriorating due to Te Lak – Caregiver_21

I thought that the child just had a fever. I had no idea that Te Lak was causing the fever. I knew about Te Lak, but I had never seen a child whom Te Lak had attacked. To my surprise, I was told that it was Te Lak that was disturbing the child – Caregiver_20

Acan had given birth at Cwero HC III. She was asked to take her child for immunisation at six weeks. She indeed did so. The health worker noticed that the child was unwell. She asked that Acan takes the child to the clinician before she left. The clinician asked for the illness history and

⁸ UPDF is the armed forces of Uganda.

subsequently prescribed medicine. Acan offered medicine to the child for two days, not three, as the clinician had prescribed. She did not need to give her more medicine since she was getting better. A week later, the child contracted diarrhoea again.

I interacted with first-time mothers who had also received health care from government health centres, community drug distributors, and drug shops before their relatives or peers told them their children had contracted Te Lak. They made a similar complaint that their children never got better after administering the medicine.

I went to the village health worker and explained the child's condition. She gave me Panadol and asked that I give the child a tablet per day for three days. By the end of the three days, the child had not improved – Caregiver_05

I bought Panadol and coartem and gave them to the child. After some time, I realised that there was no improvement in the child's health – Caregiver_20

Yes, I did. I did go to Apem HC II, and I did receive medication. I was given orals (oral rehydration salts) plus Panadol meant to reduce the fever. The fever reduced, I think the Panadol did help, but the diarrhoea continued – Caregiver_04

I took the child to the hospital thinking it was all about fever – the child had a high fever, and he kept crying. When I took him to the health centre, I was given treatment for malaria, which I gave the child until it finished. There was no improvement – Caregiver_01

Acan's child's health condition worsened as the days passed. The child's body was hotter than it had ever been. The diarrhoea was so severe. The child had also stopped breastfeeding. Her in-laws at that time had spent several days away from home. She decided to go to her parent's home to talk to her mother about the child's condition. Her mother told her the child could have been infected with Te Lak. She opened the mouth of the child to confirm her suspicion. She concluded that the child had Te Lak. Similarly, several other caregivers I talked to reported that their

mothers or mothers-in-law advised that the child contracted Te Lak.

So, the child continued presenting these signs for some time, and it was only when my mother-in-law saw the child that she advised that Te Lak was affecting the child. If it were not for my mother-in-law, I would not have realised at that moment in time that the child was suffering from Te Lak – Caregiver_04

I had no idea what Te Lak was and how one could tell that it was Te Lak disturbing the child. My mother-in-law knew, and she is the one who suggested that Te Lak be treated. She is an elder, so I think that is why she knew about Te Lak – Caregiver_14

By then, I was staying with my parents. They had a nearby hut. So my wife regularly interacted with my mother, and she noticed that the child was not feeding well. She then said that it was Te Lak affecting the child – Caregiver_26

My mother-in-law then came to me and said that I was giving the child the wrong treatment. She held the child, checked her gums, and said Te Lak was disturbing the child. I asked her what Te Lak was because I knew nothing about it. She said, 'it is a thing in the gums that was causing the fever' – Caregiver_16.

It is possible that earlier on, a first-time mother could have received similar advice regarding the cause of the child's illness but could have ignored it as she did doubt their wisdom. Only when an elder provides similar counsel is when the mother heeds to the advice.

The child's grandmother diagnosed the child with Te Lak, but even before that, my peers had already told me that my child had Te Lak. I, however, had doubts about what they were saying.

Interviewer: Why?

Response: They are the same age; how could they have known something I did not know

about? I did not trust their word – Caregiver_18

Acan gave birth to her second child in December 2014. The child contracted similar illnesses within the first month. She was at the time aware of Te Lak as a probable cause of such illnesses. She checked the gums for Te Lak the moment her child contracted the first episode of diarrhoea. She noticed something white in the child's gum, and not as big as the one her mother found in her first child. Acan and other mothers I talked to can attribute illness to the presence of Te Lak in the child's gum when they have subsequent births.

I only had trouble knowing it was Te Lak with my first child. He had diarrhoea and fever, but it never came to my mind that it was Te Lak causing this. When I had my second born, I knew much about Te Lak. When the child got sick, I immediately checked his gums, and indeed I saw Te Lak – Caregiver_04

I never knew it was so easy to find out. You can also do so. You just have to open the child's mouth and see if Te Lak is in there – when my other children got sick, I just checked their gums – Caregiver_11

That notwithstanding, a confirmatory diagnosis can only be made by a Te Lak specialist. The child can only receive treatment if the specialist confirms the presence of Te Lak in the child's gums. If the specialist thinks otherwise, he or she will further diagnose the child to ascertain the probable cause of the illness.

4.4 Treatment Trajectories

Acan was instructed by her mother to seek care from a Te Lak specialist moments after diagnosing the child with Te Lak. Acan followed her mother to the home of the Te Lak specialist. The specialist asked her if the child's father had agreed to have the child treated and if she was able to meet the treatment cost. She told the specialist that the child's father had not been around for months and that she was not able to meet the charge. Acan's mother informed the specialist that she had come along as an elder and could decide on behalf of Acan's husband. She

also promised to provide the specialist with millet for her treatment services. The specialist proceeded and checked the child's gums and confirmed that the child had Te Lak. She, however, advised that they come back tomorrow for treatment as it had started getting dark.

Other first-time mothers had a similar experience of being instructed by their in-laws or parents to seek care. In particular instances, the child's grandparent could be a specialist and proceed with the treatment procedure.

I did not know that Te Lak was making the child ill. The child's grandmother told me so – she carried the child, and I followed her, and we went to the practitioner – Caregiver_13.

When my mother-in-law saw the child crying now and then, it was not ordinary at all. She knew the child had Te Lak and told me we should go to his brother for treatment. We got his place, and he agreed to treat the child – Caregiver_12

I stay at my mother's house, and she is a Te Lak specialist. The child was constantly ill. She checked the child's gums and realised that the child had Te Lak. She then said to me that she would extract it, and if she did not, it would further bring health problems to the child – Caregiver_01

Many first-time mothers told me they were not involved in deciding to seek care from a Te Lak specialist. Some were not certain whether the elder had correctly diagnosed the child. They, however, thought it wise to keep silent. Being outspoken is interpreted as going against the advice of an elder. Such behaviour is punishable.

I did not agree to take the child for Kwanyo Te Lak, but I just followed what my mother-in-law told me. I remember she said that the child had to be taken for Kwanyo Te Lak – she also said that many children do suffer because of Te Lak – Caregiver_13

I was not involved in any way in making such a decision. It was my mother in law that made such a decision. She saw the child crying endlessly and said it was time to extract

the child's Te Lak. I asked where we could find that person, and she said just by the river, and we went to his place – Caregiver_12.

At that time, I had no idea what they were talking about. I abided by what I was told and took the child to an old lady to extract the Te Lak. When elders say something, you must abide by what they say – Caregiver_19/1.

But can you even ask such of your mother-in-law? That – why are you sending me to that particular practitioner? You would be insulting an elder – that would be an insult to an elder. You can be punished for that. They can call other family members, discuss your issue, and then decide on the kind of punishment. You could be beaten – Caregiver_05

I asked caregivers about the treatment practices they had engaged in before seeking care from Te Lak specialists. I found out that many mothers who no longer stay with their mother-in-law or parents and those who are not first-time mothers had delayed seeking care from Te Lak specialists. Instead, they continuously sought care from available health centres, drug shops, and community drug distributors. Many were only compelled to have their children undergo treatment for Te Lak as the illness episode continued.

My child was two months by then. It was at that time that she started getting fevers. My friend asked if I had taken the child to a Te Lak specialist to remove Te Lak. She told me that the child needs to have his Te Lak removed. I disagreed with her. I had taken the child for treatment at the health facility, but there was no improvement. I, at times, went to the drug shop and asked for treatment for fever. When I reached, I told them my child had a high fever. They provided the drugs, but the child never improved. I tried the health facility and the drug shop, but my child did not get better. I have visited these institutions about 2 to 3 times, but the child never improved. I then decided that it was about time that child went through Kwanyo Te Lak. The fever had persisted. I tried several treatments to try and reduce the fever, but still, the child did not improve. Then I had to accept what she had proposed. So, we went and had the child's Te Lak extracted – Caregiver_02.

Before removing Te Lak, I went to the hospital, where the child was put on a drip, and tablets were also given, which did not stop the high fever, diarrhoea, and vomiting. The doctors then advised me to go back home, saying that the child would develop other illnesses if he stayed in the hospital. They told me to provide the child with the drugs they had given me and only come back if there was no improvement. The child did not improve, and we decided to take the child for Kwanyo Te Lak. I know I had been advised to take the child back if he did not get better, but that was the second time I sought care from there, and the child never got better. So, it was time for Kwanyo Te Lak – Caregiver_22.

When such happened, the caregivers came to believe in the popular saying that Western medicine never cures Te Lak. Their peers or relatives had earlier told them that, however much one goes to a health facility, the child never gets better, as they do not have medicine to cure illnesses caused by Te Lak. It is thus not surprising that many were hopeful that my research findings would help develop a cure that will be used in health centres.

When the child contracts Te Lak, he will never heal with medicines provided in health centres, I know you will not believe what I have said, but you go and ask parents. They will go to health centres, the child will feel a little better and then within a few days, she will fall sick again, and they will never get better – Specialist_01/1

My child was one and a half months. She developed a high fever. I gave the child medication, but there was no improvement. I was told that if you see that the child is not responding to the medication, then you just know that the child has Te Lak – Caregiver_16

The problem is that even if you go to the health centre for treatment, the child never responds positively to this treatment. The child never heals. So, the only alternative you have now is to let the child go through Kwanyo Te Lak – Caregiver_03

4.5 Persistence of Ill Health in Children

The practise of self-prescription is common in this therapeutic community. Drugs can easily be purchased from the available drug shops since the attendants rarely ask for a prescription note from a health worker. The parent's decision to use a particular drug is informed by his or her past therapeutic experience with a given disease. The parent could also be advised by his or her peer on the type of drug to use. It is common knowledge within the community on the type of drug to administer when the child presents with given signs. The case narrative below provides a deeper insight into self-medication.

Question: Did you seek out care and treatment before going for Kwanyo Te Lak?

Response: No, I did not. I just went to the drug shop and bought Panadol.

Question: Did you go with the child to the drug shop?

Response: Yes

Question: So, how did you know that Panadol would help?

Response: We are supposed to give a child Panadol when she has a fever

Question: Who told you that?

Response: Even when you go to the hospital, that is what is given. You will only be given coartem if the child has malaria. My child did not have malaria at that time. She only had a fever – Caregiver_09

Caregivers often do not provide medicines to children as prescribed by the health worker. Not all prescribed medicines are dispensed at government health centres. On given occasions, caregivers leave the facility without any prescribed drug. Drug supplies often run out of stock. The

caregivers are advised to purchase the drugs from the drug shops. However, the caregiver may be unable to afford the drugs. They sometimes decide to purchase part of the dosage and promise the drug shop attendant that they will return when they get the required money.

Author: When you went to the health centre, did you receive all the medicines that had been prescribed?

Response: No, I did not

Author: What did they provide?

Response: I do not even remember. They gave me one drug and asked me to buy the other.

Author: Did you buy the other drugs?

Response: By then, I did not have the money, so I did not buy the drugs. Nevertheless, later on, I got the money. I ploughed someone's land, and he paid me. I went to the drug shop, but my money was not enough. I pleaded with the attendant. She said she could sell me part of the dose, and then, when I get more money, I could come back and take the rest, which is what I did. When I reached home, I gave the medicine to the child, but she did not get better.

Author: Did you go back to buy the remaining tablets?

Response: That was after some days, I think after a week. I went and bought them and gave them to the child, but still, the child never got better. That is when I decided that the child should go through Kwanyo Te Lak – Caregiver_02

Some fail to purchase the drugs and resort to offering the child the only drug provided at the government health facility if at all they got any.

Author: Tell me about that encounter with the health worker?

Response: I got into the room, and she asked for the book⁹ and started asking what was wrong with the child. I told her she had a fever, and then she noted something in the book. She said they only had Panadol around and asked me to buy coaterm from the trading centre.

Author: Did you buy the medicine as recommended?

Response: I did not have money – coaterm is an expensive but good thing. I had received one of the drugs that had been prescribed, so I was hoping that the child would get better. Days passed, but the child was not getting better. That is when my mother-in-law told me about Te Lak. By then, the fever was so severe – the entire body was hot.

Author: Could the child continue to be ill because you did not give her the coaterm?

Response: Maybe, but still, she would have improved a little because I had given her the other medicine – Caregiver_16

It is true that, at times, caregivers receive all prescribed medicines. However, many caregivers did not provide the child with the total dosage. They stop providing the child with medicine when he or she shows improvement. The remaining drugs are kept until the child, or another child in the household, falls sick. This is done in anticipation that they could fail to get medicine in future.

Some parents do not give their children all the medicine. Then, when the child feels better, the parent will not give the child the rest of the medicine.

⁹ This is a book where treatment history of the patient is written.

Author: What does she do with the rest of the medicine?

Response: She keeps it. You know, there are times when you go to the health facility and fail to get medicine. So, it is better to keep some so that when you do not get the medicine, you have somewhere to start.

Author: Does that mean the child will not have a complete dosage?

Response: Yes, but it is better than nothing. There are times when you do not have money and cannot get to the health centre. It could be that the child gets ill at night and you cannot access care, so you use the available medicine – Caregiver_06.

It is common for a caregiver to share the dispensed drugs among her children or with the neighbour's child—the caregiver checks for any available home medicine when a child falls sick. If there is not, he or she goes to the neighbouring household to ask if they have any medicine. Notably, the caregivers are reluctant to seek care because of the different health care access challenges they are bound to meet when they do so.

I was fortunate that my neighbour gave us some medicine that he had kept; if that was not the case, I do not know what could have happened. It was nighttime – I do not think any facility was open. My neighbour saved my child from death – Caregiver_25.

If I have money, I go to a drug shop; if I do not, I pass by my friends' homes and ask if they have any drugs I could give my child. We usually keep some medicine, and they cannot refuse to offer it to me because, in the following months, they could be in need, and I am the one in a position to help – Caregiver_17.

Sometimes I go to my neighbour and see if she has some medicine; if she does, she gives me some. If she does not, then that will be trouble. You start thinking of the distance to Apem, the time you will spend at Apem, and how you will get to Apem – Caregiver_10.

I learned of the local understanding that when one twin child falls sick, the other twin child will also develop a similar illness, even though he or she does not present with any signs. Some caregivers do take both children to the health facility for care. The health worker provides a dosage for a single child and explains to the caregiver that the other child is not sick. However, the caregiver does not take the health worker's advice and shares the drugs with the children. This is also common in the folk medical system. Te Lak specialists told me that they treat both twin children, even if one of the twins presents with an illness thought to be caused by Te Lak. I was told that whatever happens to one twin would happen to the other twin.

Ocen was the sickly one. He had several illness episodes. However, that does not mean that Opio did not receive care. Both twins must get treatment at once, even though one does not present signs.

Question: So, health workers provided medicine for both children

Response: No, the health worker refused to give Opio medicine, so I gave each child half of a tablet so they could share. You know you must handle twins with care. What is done on one twin must be done on the other. There is no way I could only give Ocen medicine – Caregiver_27.

Many caregivers utilise drug shops; indeed, many prefer accessing health care from drug shops rather than health care centres. This decision is informed by the healthcare access challenges associated with health centres (e.g. long distances and drug stockouts).

It is better to go to the drug shop, it is nearby, a few minutes away, and most of the time, that person is around. Even if you get ill at night, you can knock on his door and get the necessary care – Caregiver_04.

The medicine is available, unlike in the government facility, where you can find no drugs. So instead of spending money on transport and then reaching the facility, they tell you that there is no medicine and that you must buy it from the drug shop – you go to the

drug shop at once, you would have saved money – Caregiver_03/1.

However, many drug shop attendants did not have any qualifications in medicine. For example, there was a drug shop I visited a couple of times. I got to know that the person running the shop never completed primary school. She had difficulties counting out change, yet I gave her small money notes of 1000 Uganda shillings (less than 1 euro) on two separate occasions. Some of my respondents were hesitant to seek care from drug shops because they doubted the attendants' capacity to provide quality health care. One told me of a friend's experience who had a miscarriage as a drug shop attendant gave her the wrong medicine.

I am not too fond of drug shops, so I take them to Cwero Health Centre. One day my friend was pregnant, and she developed severe malaria; she went to the drug shop and received treatment that was not proper for a pregnant woman, and then that very night, her condition worsened, and she was taken to Cwero Health Centre. The medicine she was given started affecting the pregnancy, and she had a miscarriage. She was worked on, and after getting a little better, the health worker asked where she had got the first treatment. When she was told, she asked if we had the phone number of the owner of the drug shop. We did, and we gave it to her. She called him and asked why he had employed incompetent people. She was so furious – Caregiver_11.

They cannot know what medicine to recommend for which illness. Unfortunately, some of the drug shop attendants never attended any medicine course. They just know the names of the drugs but do not know what they heal. Sometimes they offer the wrong medicines that would not restore the child's health. So, I prefer going to the health centre because the health workers are educated in the health field – Caregiver_24.

My respondents were confident in the medical capacities of health workers in government health centres. However, they did not know that the health workers possess several human resource capacity deficiencies. During my interaction with the respondents, I learned about the gaps in disease diagnosis. Some respondents noted that health workers never asked about their treatment history, yet others talked of symptomatic diagnosis rather than testing for malaria. I observed

health workers carrying out medical roles beyond their medical training on several occasions. In one of the integrated community-based outreaches I attended, the nursing aide and nursing assistant diagnosed and made prescriptions. The security guard attached to one of the health centres I visited dispensed drugs to the patients. A nursing assistant headed one HC II facility during the ten-month and two-week fieldwork. Though not trained in midwifery, she took on the responsibility of assisting women's deliver as the health centre did not have a midwife.

The health workers I talked to expressed concerns about the challenges people face in maintaining proper hygiene and sanitation practices. They noted that many households do not have latrines, resulting in open defecation. However, it was observed that the communities make an effort to put in place makeshift solutions for waste disposal, such as digging holes in the anthill.

I have seen you in this community for some time now, and what I will share with you might not be new to you. As you move around some of these places, you shall find feces disposed of. In some places, this is around the home and places where children usually play. From our training, we know that possibilities of contamination are high but also given that hand washing is not common, these children get in touch with fecal material but are unable to clean their hands and thus the material being consumed which eventually might lead to contraction of disease – Female Government Health Worker

The health workers' other concern was the drinking water quality within the different households. On the first day I got into the field; I was offered lunch at the farm, where I would stay for the following months. A jug of water was brought along with the food. I used it to wash my hands, and I did notice a gentleman nearby shaking his head. My assistant told me I was using drinking water to wash my hands. I was surprised since it had taken me minutes even to decide if it was safe enough to clean my hands. To my eyes, the water was dirty. I later learned that all water for domestic use, including one for drinking, was being drawn from a flowing river near the farm. Not a single time was water for drinking boiled during my stay at this farm. Male respondents said they did not consider this their responsibility, as this is traditionally a feminine role. The female respondents recognised that water preparation was expected of them; however,

this task requires collecting additional wood fuel, which has recently been scarce to find due to deforestation. Several women and men, however, expressed scepticism about boiling water collected from natural resources, mainly streams. They argued that boiling the water would destroy its natural qualities.

Indeed, thirty of the thirty-one caregivers (who had their children treated for Te Lak) that I interacted with reported that they do not boil drinking water. Many did not see any reason to boil the water since it looked clean to their eyes. Many were collecting water from boreholes. One caregiver told me that on the day the borehole was commissioned, the government official told them they should be thankful to President Museveni for bringing clean water to their community. She thus saw no reason for boiling the water since she was told it was clean.

I am not the only one who was told. You go and ask around. They will tell you the same thing. The day that borehole was commissioned, someone – I think he was from the government- said that we now have peace, and Museveni has started working. He said that he had started by giving us clean water. When you look at it, you get to see spotless water – Caregiver_19

Mothers recognised that breastfeeding is important. However, they noted that they at times do not have enough breast milk. They attributed this to the inability to have enough food that would help in creating the breast milk. They reported that they at times feed their young children (below six months) a mixture of water, tea leaves and sugar. At times, they cannot afford sugar and thus feed them only water and tea leaves. One day, one of the mothers came by the farm where I used to stay to offer labour. When the feeding bottle ran dry, she came by and asked for water from one of the workers. She was asked to draw some from one of the jerry cans. She did so and then add tea leaves to the bottle and proceeded with feeding the child. The water in the jerry can had been collected from a flowing stream at the end of the farm.

Government health workers reported that there is periodic community-wide distribution of insecticide-treated nets (ITNs). Also, pregnant women receiving antenatal care from Cwero HC III are provided with ITNs. They were however concerned about the wrong or non-use of the

ITNs. I observed ITNs being hanged over seed beds, and some being cut into pieces to be used as a sponge for bathing and washing utensils. The caregivers had various reasons for not using the ITNs. They explained that they had difficulty breathing when they slept under the nets. One caregiver reported that since the war had ended, it is possible that the government was looking for a way to kill them and that they had found insecticide nets as a viable option. They explained that this was not new since the same government had forced them to live in IDP camps and was responsible for some of the deaths that happened in their communities during the war with the LRA. Others explained that they get horrible dreams when they sleep under the insecticide-treated net related to the atrocities earlier committed by government armed forces.

I did get the net, and it is the doctor that gave it to me. So, I returned home and hung it as the doctor had directed me. That night I dreamt about the day these rebels came to my home and cut off my brother's fingers – that was the last time I slept under it and will never do so again – Caregiver_15/1.

I once visited the home of one of my respondents. We had in the past interacted at the farm as she now and then came by to hoe the land in exchange for food. We walked for close to an hour to her home. The paths were too narrow, with long grass at the sides. She used to stay a few meters away from river Acwa. The surroundings of her home were bushy. She lived in a hut with her co-wife and four children. The husband at times visited them. He spent most of his time with his other wife in Gulu town. Unlike the co-wife, my respondent did not have a mattress to sleep on. She laid a single bed sheet on the floor and shared the space with her two children. She had hanged an insecticide net over the bed sheet. The net was filled with holes. Part of the wall of the hut they used to stay in had fallen. The space outside the hut door was being used for cooking. It is not only my participant and her children that stay in such an appalling shelter. Many more families in the communities I stayed have severe challenges with shelter. Health workers, I interacted with cited poor shelter conditions as one of the reasons for the high prevalence of the disease, mainly malaria.

4.6 Health Care Access Challenges

I interacted with many individuals who wished that parents could seek care from the available health facilities. They ask caregivers to always seek care from government health facilities.

I always tell my people that God has blessed us with a health centre. Therefore, they should always utilise that facility. There is no reason they should opt for anything else that God has not blessed. By seeking care from these facilities, we are fulfilling God's command. He told us to fill the world, but how would we do that if children die now and then in the hands of those people. Going to the health center helps, as the child will get better – Interview with male Church leader.

Indeed, some caregivers have even come to believe that Te Lak can be treated in biomedical facilities.

Te Lak can now be treated in the health centre. You go there, and the health worker will give you coaterm. The child will then get better –Caregiver_28

However, these days there are many ways of treating Te Lak. You can take the child to the health centre to get medication if the child is ill. The health workers will take care of the child until the child heals – Caregiver_08

However, the caregivers decry the several health care access challenges, some of which I did observe. I was at one of the retail shops when I saw two men carrying a woman who was in pain from the look on her face. To my surprise, they went past the government health facility straight to a drug shop whose legal jurisdiction stops at dispensing drugs. Moments later, a woman passed by me carrying a child with an open wound. She still sought care from the same drug shop. I kept wondering why people were not utilising services from a health facility accredited by the Ministry of Health. When I asked the owner of the retail shop why this was happening, he said, "The woman who runs that drug shop is well-behaved; she is not like the health workers in health centres".

This stirred my interest in finding out more about why people may not prefer to seek care from government facilities. There was a day I took a sick child to the health centre. I reached the health facility a few minutes past 10 o'clock and found many patients seated at the triage waiting for the health worker to come and attend to them. I saw the health worker in the distance attending to her garden. I also heard voices at the back of the building. I decided to go and talk to the people at the back. When I asked why they were not attending to us, the lady angrily responded that they do not take instructions from me. She asked that I go back, sit down, stay calm, and wait for the health worker. I was told she was still busy. I laboured to tell her of the laws governing health centres and how everyone has a right to access care, but all fell on deaf ears. She would respond:

"I can tell you are not from this community. With time you will get to know how things go on here. I advise you to go and sit; the health worker will come and attend to you. She is still attending to her garden¹⁰."

The health worker came later, and the first thing she asked was why we had come late. She said that she had earlier opened the facility, but no one had come. She later attended to the child and prescribed medicine. However, not all medicines were available. I was asked to buy coartem from a drug shop. Unfortunately, I found the drug shop closed. The attendants to the neighbouring shops told me that the owner opens in the late afternoon. It was the rainy season, so she attended to her garden first. The attendant finally opened the shop two hours and thirty-three minutes later.

¹⁰ A garden is a piece of land where food is grown.

Indeed, when I asked my respondents about the different health care access challenges they meet, some talked of the short opening hours of health facilities.

You cannot access care from a health centre at that time. The health workers do not work at night. However much you knock by their doors, they will not open – Caregiver_17

There was one day I went to the health center around 1:00 pm, and we were seated out with other people, but the health workers had closed themselves in, and yet they saw that we were around seated on the verandah – afterwards, they said that the health centre was closed – that they had finished working. Imagine 1:00 pm, and they had stopped working, yet the health facility rules do not permit such. It must be open till late. That would mean somebody has to come back the following day – Caregiver_24.

On 24th June 2015, I was part of an integrated health care outreach. A mother came with her child as health workers were leaving the health centre compound. She was barefoot, had much dust on her legs, sweat was rolling down her forehead, and she wore a sad face. The child was crying out loud. When the health workers saw her, they all ran into the vehicle and asked the driver to drive off. I later understood that the health workers were not certain whether they were able to provide effective care since some essential medicines were out of stock.

My respondents shared similar experiences.

Some two years ago, a pregnant lady had gone to deliver at the health centre, but only one person was willing to help her when she arrived. When this person called for help, no other health worker came out. It then happened that the woman delivered the baby from outside. The lady who refused to help was fired from her job. There are many experiences I could talk about the health centre. You could get to the health centre early, but leave later without being attended to. Some sleep on the floor, but the health workers never care to cater for them. Some reach a point of death when no one is bothered. There is another experience I could share. There was a time I went to the health facility. I found the Local Council

chairman at the facility. The facility was open, but there was no one to attend to us. The chairman decided to go to the staff quarters to see if there was any health worker that could come and attend to us. When the health worker saw him, he ran and hid behind the staff quarters. The chairman never saw him, but I did see him run. The chairman came back and said there was no one. We all sat out there waiting for anyone to work on us. Later, I saw a pregnant woman seated by the staff quarters. I went and asked her where the health care worker was. She told me that most likely, he is in the maternity ward. I went to the maternity department but saw no one. I joined my other colleagues, and we sat as we waited for the Dr. in the end, we decided to go home – Caregiver_05.

A friend shared with me her experience. She had gone to seek medical attention at the health centre. She found a health worker; good thing she is no longer working there. She said she would work on a few patients and asked that the others leave and come back the following day. She left, but the child's condition worsened at night, and the child was rushed back to the health centre, but it was closed by then. She went back home and had to come back early in the morning. By then, the child was so weak, and they had to call an ambulance to take the child to the main hospital – Caregiver_06.

Lack of enough supplies is yet another challenge. There was a day I escorted an older woman to the government health facility. She was diagnosed with severe malaria, and the clinical officer asked the nurse to administer quinine. Unfortunately, there was only one quinine vial at the facility, yet her dosage required three vials. I was asked to go to the trading centre to buy these vials. I visited the first, second, and third drug shops, but they did not have it in stock. The fourth drug shop I visited had a few vials in stock, but the attendant was only willing to sell them off if the sick person was a pregnant woman or child. She said, "What is left is for emergencies, pregnant women or children". She advised me to go to Gulu town, which is about thirty-two kilometres from the trading centre.

My respondents would tell me of similar experiences.

I have many experiences but let me share with you what happened last year. This child was eight months old by then. I went to the health centre. The child was in a terrible condition. You could think that he was about to die. When the health worker came by, she found me with the other two mothers. She told us that, unfortunately, she had a single dosage that could cater for only one child. She added that she had to choose who would get the treatment. She decided to choose a child she thought was in a worse situation. She did not pick my child, which meant that the other mother and I would not be attended to, imagine. My child was severely off, and all she had to say was that there was no medicine for us. I went back home with no single tablet, not even Panadol – Caregiver_05.

The most annoying thing about seeking care from a health centre is that you are unsure if you will return with medicine. If there is no medicine, you are expected to buy it. Well, it is not only I that do not get medicine, but many of us – if I were the only one, then that would be worse, but it is a general problem – Caregiver_13.

My respondents also complained about the small number of government health workers. This implies that staff must take on multiple treatment roles, resulting in delays in accessing health care.

The problem with that health centre is that there is the only person who diagnoses, prescribes, and dispenses drugs. So, you find that one takes much time at the health facility – Caregive_18.

The health facility has few staff. You could reach the facility and find that only one person is diagnosing and prescribing. You will find only a single person in the lab and only one dispensing. At times you could find one person taking on two roles. We have continuously asked for more workers at this facility. They took a blood sample from me yesterday, but I never got the results. They asked me to go back on Monday. He said that

he had many samples to test – Caregiver_11.

My respondents also attributed poor access to difficulties in finding transport to the different health centres. Many respondents were staying far away from the nearest health facility. For example, one requires transport services if he or she has a sick child. In most cases, the caregivers cannot meet the cost of transport and thereby delay seeking care or opt to use alternatives nearby.

There was a time when my child fell sick in the middle of the night, and it was raining. We started moving from here to the health centre in the rain. When we reached Cwero, we decided to go and seek treatment from the clinic, not the health centre. We woke up the owner of the clinic, who gave us medication and then on the following day, we went to the health centre. Unfortunately, they could not help us, and we were referred to Lacor hospital. Getting to Lacor was a struggle because we had to foot the bill for transport – Caregiver_17.

One of my assistants resided in the staff quarters of one of the government health facilities, which happens to be within the same compound as the facility. Therefore, I did ask her to write a short report on her observations on health care service provision at the facility. When I opened the report document, I noticed that she had titled it "challenges" and talked of drug stockouts, short opening hours and poor staffing among others. The excerpt below is picked from her report.

Challenges

1. Poor hygiene and sanitation in and around the health centre. This is most common in the Outpatient Department (OPD) department. It is all littered. The latrines are all covered with human waste.
2. There are limited drugs both in the OPD and maternity. This comes about as the Ministry of Health delays in delivering medicine. As a result, most patients do not complete their medication. This has fuelled negative attitudes towards healthcare-seeking.

3. Another big challenge is that there are limited or few medical personnel at the health centre. New staff were sent to the health centre; however, the ministry only sent pregnant women. They went on leave a month later. This left the health centre in the care of just the 'In charge', 'the Lab technician', a 'midwife, 'the Record manager', a clinician managing the OPD (does all the diagnosis and prescriptions), and two security guards.
4. The health centre should have about 20-26 staff, including the support staff, security guards, the midwives, the laboratory technician, the Village Health Team [VHT], the Nursing assistants, the Record manager, and the In-charge. Nevertheless, from May to date [23/06/2015], the facility has been operating with only 8-10 staff.
5. Short opening hours. This is the biggest challenge. However, I realised that health workers would still be in their houses by 10:00 am, yet the patients would have already filled up the OPD and closed early.

4.7 Health Care Practices Opted for after Receiving Care from Local Specialists

Some of the caregivers I talked to told me their children regained good health after receiving treatment from local specialists.

The child improved significantly after Kwanyo Te Lak. When Te Lak was removed, the child felt better right away. I breastfed the child and could not even feel the hotness of her mouth as before. The child would later start playing – Caregiver_02.

However, I discovered that these caregivers had continued to provide children with the medicine they received early on from health centres, drug shops, or community drug distributors. They still had hope that the medicine could cure the child. Therefore, some thought it was suitable to comply with the health worker's directive of administering the total dosage.

Author: Did you continue giving the child the medicine – the coaterm and Panadol – did she take her third dose on the third day?

Response: Before I left for town, I gave her the medicine. She was in a terrible state, my dear friends. However, as a parent, I was worried that one must take medicine to get well, but I was still hopeful that it could help.

Author: And on that day, you still went for Kwanyo Te Lak?

Response: Yes, are you a parent?

Author: No

Response: Then you cannot tell what we go through as parents with sick children. All you hope for is for your child to get well. You must try this and that. Even though she was not getting better, I felt that she would improve once I gave her the last dose. However, I also had the idea that my mother-in-law could be right. She told me how she treated her son with Te Lak, and there was no way I could escape it. It was a norm within their family. So, I had to do it. The good thing is that she got better.

And the elders say that when a child is taken to a health facility, treated and does not get well, that child should be taken to a Te Lak specialist for treatment because it is Te Lak that is affecting the child's health – Caregiver_18.

Some caregivers told me their children fell sick again a few days after the procedure. A couple of them were advised that their children had contracted the Two Kal (literally translated as millet disease, another local disease category with symptoms of malaria and pneumonia; i common among children and adults) or had both Te Lak and Two Kal at the time Te Lak was treated. As a result, the caregivers were asked to seek care for Two Kal.

They then added that I should hurry and seek treatment from the Te Lak specialists. The child's grandmother carried the child and took her to a practitioner who treated her. The child was in good health for some time and later became ill again. She had a high fever, and this time around, her grandmother said that the millet disease had attacked the child. She took the child for treatment – Caregiver_10.

No, I did not. The child was well for some time. After some weeks, the child fell ill again, but we did not take her to the health centre. I was advised that the child had Two Kal, not treated within the health centres. The grandmother of the child still took the child to a practitioner who worked on the child – Caregiver_03.

I told the specialists about the complaint from caregivers that children never get better after undergoing treatment. They explained that the specialist could have performed the treatment procedure poorly in such cases. They advised that in such instances, the parents should go back to that specialist to amend what he or she did wrong. They also argued that it is possible that the cause of the disease was never Te Lak.

When the child continues to be sick, then you will get to know that the sac in which Te Lak is kept was not removed; also, it could be that the fever is being caused by something else and not necessarily Te Lak; usually, when I work on the child the fever reduces, if Te Lak is the one responsible for the fever there and then the fever reduces – Specialist_08.

I did come across several caregivers who had sought care from the available biomedical facilities a day or days after having their children treated by Te Lak specialists. They explained that there are various causes of childhood diseases. They were certain Te Lak had been dealt with and had to see that the other causes were also dealt with.

There are many causes of illnesses, my friend, not only Te Lak. I know that the illness Te Lak had caused had healed because the moment the child had her Te Lak extracted, she

began breastfeeding, which was dealt with. So now we had to find out what else was bringing illnesses to the child – Caregiver_07.

4.8 Discussion

Communities identify Te Lak with given signs. From a biomedical perspective, some of these signs relate to the normal functioning of the body [e.g. saliva flowing from the mouth] while others could indicate pathology [e.g. high body temperature] (Hutchison, 2016).

The nomenclature used to refer to some signs is borrowed from the biomedical system. As such, biomedicine helps caregivers classify symptoms that indicate the presence of Te Lak in children. Although similar terms are used, caregivers' explanations of what this means differ from the biomedical meaning. For instance, the terms malaria and diarrhoea are used not as specific disease entities but as symptoms of Te Lak. Just like in biomedical spaces (AL Hosni et al., 2023), the different signs indicate the severity of the infant's condition. The decision to act or delay treatment then depends on the signs the infant child presents with. The consciousness of the caregivers shifts from inaction to action when signs that indicate severity are present among children, for instance, failure to breastfeed.

First-time parents often lack the diagnostic awareness required to identify Te Lak. Instead, they primarily rely on biomedical theories of disease to draw meanings from the symptoms the infant presents with. This facilitates seeking care from available biomedical facilities (Good, 1994). In instances where infants are unresponsive to medicines provided in these spaces, caregivers consult older women who often happen to hold onto cultural theories that attribute disease to Te Lak. These women introduce first-time parents to new diagnostic processes and healthcare practices (Gupta et al., 2015; Lynch & Cohn, 2016). At this point, mothers can seek care from local practitioners who intervene in diseases caused by Te Lak.

When parents have subsequent childbirths, they are knowledgeable of several disease-causing theories. The decisions they make following the presentation of illness in infant children are informed by these various theories (Schrempf, 2011). Notably, knowledge of Te Lak as a

disease-causing agent does not replace scientific notions of disease. Mothers still perceive scientific explanations as authoritative. Biomedical spaces, in many instances, remain the first option of care, though frequently inaccessible or not meeting the required standards of quality. Only when the illness persists, or the child presents with similar symptoms following treatment completion, can the mother choose to seek care from spaces where the disease aetiology is attributed to Te Lak. In some instances, multiple healthcare options are utilised concurrently. The simultaneous use of medicines provides a viable explanation as to why some mothers report the efficacy of Te Lak extraction or rubbing herbs on gums.

The emergence of symptoms associated with Te Lak does not always lead to seeking care from the local healers. This decision is at times influenced by interpretations of symptom severity and perceived urgency for medical intervention. When symptoms deemed minor manifest, parents interpret the condition as uncomplicated and assume the primary role of managing the illness. Their response often includes the use of biomedical treatments while carefully observing the child's health. However, when symptoms suggest progression towards severity, the case is treated as an emergency, and immediate medical attention is sought.

It is a common practice for parents to seek care from indigenous medical spaces when illness persists, or when reinfection occurs following treatment from the biomedical system. At this point, mothers engage in the re-diagnosis of the illness and, at this time, exclude the biomedical cause (Muela et al., 1998; Feierman, 2000). Even after seeking care from the Te Lak specialists, the illness may endure, prompting the continuation of the iterative diagnostic cycle. The caregiver could choose to return to the biomedical facility or seek care in alternative therapeutic spaces (Ross et al., 2011; Andrews et al., 2013).

Seeking care from Te Lak specialists is closely tied to the recurrence of illness. This practice is reflexively constituted within the socio-cultural and structural complexities of everyday lives (Tae, 2017). For example, this is evident in the local populations' continued practice of self-medication, despite their lack of formal medical training. This practice has been reinforced by the widespread availability and informal circulation of pharmaceutical products through multiple channels, including households, community drug distributors and local drug shops.

While communities have access to these medicines, uncertainty persists regarding their correct usage. Their engagement with biomedicine is shaped by the local epistemologies sitting at the intersection of indigenous medical practices and experiential learning, especially following interactions with the formal biomedical system. This hybrid landscape informs treatment behaviour, often characterised by underdosing and misapplication of biomedicines. Parents may administer an incomplete dosage that was previously set aside, anticipating potential stockouts of medication at government health facilities. Alternatively, they may purchase an incomplete dosage due to financial constraints. This dynamic demonstrates that under-dosage cannot only be explained as an aspect of knowledge, rather it reflects broader economic challenges.

Caregivers struggle to decide whether health should be prioritised over other needs. They could decide to purchase part of the dosage but fail to secure money to get hold of the remaining dose (Whyte et al., 2004). This is often compounded by the overpricing of medicines in the drug shops. For example, the Global Fund subsidises the antimalarial medicine to about UGX 3,500 (0.8 Euros)¹¹ (OIG, 2016). Yet, the drug shops in the field sites I visited were selling a dose of artemether-lumefantrine (coartem) at UGX 8,000 (2 Euros), more than double the recommended price. This is embedded in the absence of drug pricing policies or price regulatory mechanisms in Uganda (MoH, 2015).

Under-dosages can also be explained by drug-sharing practices driven by stockouts of medicines, long distances to health facilities, with over 41.5% of the households five kilometres or more to the nearest public health facility (UBOS, 2017), and local medical norms on treating twin children.

The problem of providing medicines in low dosages could have been minimised if drug shop attendants had insisted on asking for prescription notes from medical doctors or clinicians. However, they do not enforce this practice because they are deeply integrated into the social network of the community. Their close integration allows them to understand the context and the

¹¹ 1 euro is equivalent to 4000 Uganda shillings.

different societal expectations of a physician. In this relational dynamic, social relations with the caregivers influence the treatment encounter more profoundly than the treatment guidelines. As a result, they assume the role of a diagnostician and prescriber, while the attendant dispenses the required medication (Geissler et al., 2000).

One of the key consequences is the increased preference for traditional sources of health (Allen et al., 2017; Chang et al., 2020). The findings from this study align with these broader trends. Mothers who cannot access quality care choose alternative healthcare spaces that attribute aetiology to local disease-causing categories, such as Te Lak.

The recurrence of illness could also be linked to the increased use and misuse of antimicrobials, which results in antimicrobial resistance (AMR) (Chandler et al., 2016; Pearson & Chandler, 2019). There have been several studies on AMR in Uganda. Anguzu and Olila (2007) report that pathogenic bacteria were resistant to gentamicin, ciprofloxacin, and ceftazidime. Kitara et al. (2011) also found that *Staphylococcus aureus* infection was resistant to Methicillin. There are also reports that AMR is on the rise worldwide (United Nations Environment Programme, 2023).

AMR to antimalarial medicine is not new in Uganda. In 2004, the country decided to use Artemisinin-Based Combination Therapies (ACTs) as the first-line drug for uncomplicated malaria (Nanyunja et al., 2014) due to microbial resistance to chloroquine. However, the Uganda government has not successfully crowded out chloroquine from the market (Kibira et al., 2021). Although there are efforts to ensure universal access to ACTs, artemether-lumefantrine (AL) and artesunate-amodiaquine (AS/AQ) have been associated with a risk of recurrent parasitemia, though AS/AQ treatment has fewer recurrences than AL treatment (Yeka et al., 2016).

The Government of Uganda is implementing nationwide programs aimed at preventing the recurrence of mosquito-borne illnesses through preventive measures such as insecticide-treated nets (ITNs). Findings show that these commodities are often not utilised, and in other cases, used beyond their intended purpose (Dunn et al., 2011; Sangare' et al., 2012). What stands out is how the civil conflicts and the perceived role of government in the harm inflicted during the conflicts have influenced people's uptake of ITNs. For example, participants reported difficulties in

breathing, which they interpreted as a deliberate action by the government to target the Acholi ethnicity. Similar findings have been reported by Nnko et al. (2012) in north-western Tanzania, where the low uptake of ITNs was influenced by people's engagement with the political and economic landscapes of the country.

A study by Okot-Okumu and Otim (2015) on the quality of drinking water in some districts of Uganda, including Gulu, revealed that shallow wells, unprotected springs, and surface water were high-risk water sources. The authors reported the presence of faecal coliform bacteria in these water sources responsible for increasing the risk of diarrheal diseases, typhoid, cholera, and other waterborne infections. The study findings show that drinking water was being fetched from similar water points, yet boiling was uncommon. This was primarily attributed to limited access to wood fuel and the added burden on women, who are responsible for collecting firewood. Studies have also reported on the relationship between faecal disposal and the incidence of disease among children under five years in Northern Uganda (Auma et al., 2024). Findings show that open defecation remains prevalent in the field sites. However, some community members have taken the initiative to implement makeshift solutions to address the sanitation challenges.

Caregivers primarily opt to access the closest public health facility. There are occasions when the desired course of treatment does not proceed as planned or is delayed, particularly if one cannot afford the transport cost, lacks suitable means of transport, or is afraid of the stresses associated with long distances to health facilities. When mothers finally access public health facilities, they are expected to purchase prescribed medications from drug stores, wait for extended periods before seeing health workers, and interface with a demotivated workforce.

Such healthcare inequities have been widely reported on. These have been categorised into supply-side (related to the health system itself) and demand-side (associated with the end user) challenges (Dowhaniuk, 2021; Vallières et al., 2021). As has been shown by other studies (Zakumumpa et al., 2016), inequities related to the motivation of public health workers are embedded in the poor work environment characterized by a thin workforce attending to a large patient volume, lack of equipment (mainly laboratory equipment) and absence of cadres of the health care workforce namely physicians (Zakumumpa et al., 2016; Obua et al, 2017). This

pushes health workers into alternative means of survival, mainly farming. Attending to one's garden during work hours is an appropriate way to respond to the economic hardships one experiences.

Drug shortages have been mainly attributed to poor planning, prioritisation, and forecasting (BMAU, 2015). Public health workers interviewed provided similar explanations. However, participants' narratives provided deeper insights into conditions that lead to poor forecasting, mainly unpredictable seasonal rainfall trends and attendant increases in disease incidence. These realities undermine the planning, prioritisation, and procurement process. The different access challenges imply that service delivery is never guaranteed in public facilities (Chandler et al., 2013; Nannini et al., 2021).

Often, similar access challenges are experienced for different disease episodes. This informs the caregivers' understanding of future possibilities of accessing public and private health care. Mothers anticipate that the child will not be able to access quality care in the future. The risk of being unable to access care is the basis for the parents' understanding of the past and the present (Eddy & Hart, 2012). This has serious implications for health behaviour. For example, it critically shapes practices related to drug adherence. As previously noted, mothers make calculated decisions to store drugs for future use when the child shows slight improvement, resulting in incomplete dosages. It is also true that such expected risk informs the decision to seek care from alternative healthcare systems, including spaces where Te Lak is viewed as a disease-causing category.

CHAPTER 5: BECOMING A TE LAK HEALER

5.1 Introduction

Anthropologists have long been interested in how local health knowledge is produced, legitimised and preserved across generations (Laplane, 2015; Nichols-Belo, 2018). This chapter builds on this anthropological tradition by examining the different journeys healers take to become knowledgeable about treating illnesses perceived to be caused by Te Lak. By paying attention to the cultural, symbolic and structural dimensions of this journey, the chapter interrogates the role of human and non-human agents in transmitting this knowledge, explores how the different rituals that the trainees are introduced to build their authority, examines the spatial and temporal dimensions of Te Lak healing knowledge and explores the exclusivity and social hierarchies involved in selecting trainees and how structural systems are challenging such hierarchies.

Overall, this chapter explores how the presence of a local disease-causing agent, Te Lak, creates an epistemic community that preserves prized local knowledge through generations. Additionally, it examines how the practice of treating Te Lak-related illnesses serves as an alternative pathway to formal education, enabling practitioners to attain professional identity and social status within their communities.

5.2 Selection of Trainees

I met Atim (pseudonym) a few days after her 15th birthday. She is the daughter of one of the most accomplished specialists in the field sites I collected data. I learned that her grandmother and two sisters are also experts in treating diseases caused by Te Lak. Atim dropped out of school in 2013, aged 12. She was tired of having to walk for hours to and from school. In addition, she was fed up with having to study on an empty stomach as school authorities were not providing any meals. At one point in our conversation, she talked of the likelihood that the children she attended school with could have dropped out too. After dropping out of school, her mother consistently asked for help whenever she treated children with Te Lak.

Unlike Atim, her mother never attended formal school. She had spent most of her childhood completing care roles, collecting wood, fuel and water, taking care of the farm, completing other roles expected of women and girls and helping her mother when attending to a child with Te Lak. Her brothers were expected to herd cattle. They spent weeks in the wild, looking after the animals. She is the only one among her siblings who eventually became a Te Lak specialist. I learned she was actively engaged in treatment much younger than Atim.

When Atim dropped out of school, her mother thought of training her in the art of treating Te Lak. However, she was unsure whether Atim was interested in becoming a Te Lak specialist. Nevertheless, she was put to the test as she regularly asked for assistance when handling children with Te Lak. As time passed, Atim started volunteering to help with some treatment roles. To the mother, this indicated that she had developed an interest in this trade. Only then did she decide to train Atim in the art of treating Te Lak.

Most of the specialists I interacted with explained that they only decide to recruit someone for a traineeship if that person demonstrates interest in becoming a Te Lak specialist. They, however, added that the availability of that individual is also crucial. For example, several specialists desired to train their children but could not since they were engaged in other activities, particularly attending school.

I select someone who has time to learn and assist me; it is hard for me to train my children because they do not have time to learn, so they never assist me – Female Specialist_12.

I started at an earlier age because I was the younger girl at home and my other sister was older than me, so my mother decided to teach me first because I was not busy like my bigger sister who was doing garden work but later one of my big sisters had interest and learning, and she started at an older age – Female Specialist_11.

In my discussion with a specialist who uses herbs to treat Te Lak, I learned that she only selects girl children for the traineeship. She advised that boy children never have the time to learn the art of treatment. She was also doubtful that they would accord the trade the respect it deserved.

To only my daughters because they are the only ones I think should administer the herbs, the boys always do not have an interest in such things, and when training them, they will undermine it – Female Specialist_04_02.

The specialist frequently re-evaluates the decision to retain someone as a trainee. The specialist assesses the trainee on several grounds and only decides to move on with one who has a couple of these attributes: hardworking, brave, strong-hearted, not money-minded, and one with a consistent interest in learning the treatment procedure.

Yes. One should continue showing me that she still has an interest. She should be hardworking, and when I ask her to do something, I expect her to do it there and then. That person should also not be money-minded because treating Te Lak is not about making money but helping people – Female Specialist_12.

The interest matters. I will stop teaching you if you are no longer interested. You know, Kwanyo Te Lak is not easy at all. One will find it hard to extract Te Lak if not trained well. One could even kill the child. So, I must see that one is still interested in becoming a Te Lak specialist – Female Specialist_08.

I gave birth to 7 children, five girls. They were all helping me out, and I thought we all would become Te Lak specialists. However, as time passed, I realised some were not that brave. They were fearful, yet treating Te Lak needed someone who was strong-hearted. So, I told them they could no longer come around when I treat children. Imagine sending someone for Pen V (penicillin V potassium), and she spends 30 minutes. I could not tolerate such. That is being lazy. If one can spend 30 minutes on such a small thing, how many minutes would she have spent extracting Te Lak? So, I decided to let her do other things, go to the garden, like that – Female Specialist_01.

I did interact with two specialists who did not think that their recruitment into traineeship had anything to do with their character, as they did not have any interest in becoming Te Lak specialists. They instead thought that it was circumstantial. One was recruited since she was the only one in close contact with the specialist, who was losing his eyesight. The other had a sick child, and the trainer asked that she observe and learn how Te Lak is treated. The treatment procedure was simple, involving using herbs to treat Te Lak.

My father-in-law started losing sight, and he could no longer see well. That is when he decided to teach someone; he had lost his wife, and I was the only one around to take on the practice. So, he showed me the medicine and took me through the procedure. Ever since then, I have been carrying out the procedure – Female Specialist_06_03.

You know my child was ill, and I had decided to take her to a health centre. As I was going, she asked for the child so that she could check for Te Lak, I did give her the child, and she diagnosed for Te Lak after she asked that I go and get a herb and since I had seen her pluck the herb before it was easy for me to find it, she then asked me to pound it and then put it in the pot and then put it on fire. Afterwards, she asked that I add kedo atona (salt), and after it cooled, I started rubbing the herb on the Te Lak – Female Specialist_02_01.

If a specialist does not choose a trainee, he or she is chosen by divine power or spirit. This was particular to specialists skilled in herbal therapies.

One day I had a dream in which Rubanga (god) asked me to help people. During the dream, I was shown the medicine to use – Male Specialist_10_04.

I worked closely with fourteen Te Lak specialists. Twelve of these were women, and all apart from one had been recruited by their parents. One of the two male specialists I interacted with had been selected by divine power.

Four of the five specialists who use herbs to treat Te Lak I talked to had received traineeship after childhood. The one specialist who received a traineeship during childhood had been trained by her mother.

It all started when I was about 10. At that time, it was my mother who used to do it. Whenever she was to work on someone, she would send me to collect the herb, and the time reached when I was asked to apply the herbs to the gums. So that is how I began applying the treatment. She took me through all that is required of one to carry out the procedure. So I got to know the time it can be done, the different rituals involved, why one has to do them, and how much medicine one should apply onto the gum for Te Lak to heal – Female Specialist_04_02.

Two of the five herbal specialists told me they had received treatment instructions from supernatural beings. Their traineeship had taken place through a dream. One of the specialists had a history of receiving treatment instructions from supernatural beings. Her traineeship in treating Te Lak was not her first. The other specialist was a desperate parent looking for a cure for a disease that had attacked his child. He later received a visitation from a spiritual being that instructed him on how to treat the illness.

You know "god" gave me the ability to use herbs ever since I was young, I think at about ten years, from then till now I have been doing quite a lot of traditional medical treatments, apart from Te Lak I also treat the hunch back, I give an individual some herbs, and one gets cured, when people's chest swell I also do treat them, I also treat measles. I have so many herbs that cure several illnesses. No one taught me but "god". If "god" gives you that gift, he then shows you a lot - "god" showed me the herb to treat Te Lak through a dream. On the day I had this dream, I stood up from my bed, went to the bush and got to see the herb which cures Te Lak, "god" then asked me to help his people with Te Lak, to use this herb to treat Te Lak – Female Specialist_03_06.

I had a dream and was shown which herb to use and where I could find it. The person in the dream told me to make a small cut before applying medicine and that I would hear some slight noise when I cut. That is when I know that the cut is deep enough and can now apply the herbs – Male Specialist_ 10_04.

5.3 Therapeutic Treatments Trained in

In this section, I present the local practitioners' narratives on the different treatments they engage with to provide the reader with an understanding of the kind of medical knowledge passed on to the apprentices. The therapies include Kwanyo Te Lak, rubbing herbs on the child's gum or making an incision on the gum and applying herbal solutions.

5.3.1 Kwanyo Te Lak

Kwanyo Te Lak is a treatment procedure involving the extraction of Te Lak from either the lower gum or the lower and upper gums. The decision on where Te Lak is to be extracted is informed by either the treatment history of Te Lak within a given family or the expertise of the specialist. Some specialists are only skilled in extracting Te Lak from the lower gum.

There were differences in opinion among Kwanyo Te Lak specialists on the recommended age at which the procedure should be done. However, they all agreed that the procedure should be done in the first months of the child's life. Carrying out the procedure after the mid-months of the first year of the child's life was discouraged for a couple of reasons. One of the specialists advised that it would be as if one were breaking a child's tooth by that time. Another specialist cautioned that at this time, one extracts the tooth and not Te Lak. The child also fights, placing the practitioner in a position of performing the procedure poorly.

The Te Lak must be removed within the first month when the child is still young. For example, when my granddaughter gives birth today, the following day, the Te Lak is removed. By that time, the child will not have any illness, which will also mean that she will not get sick because Te Lak will have been removed – Male Specialist_ 05.

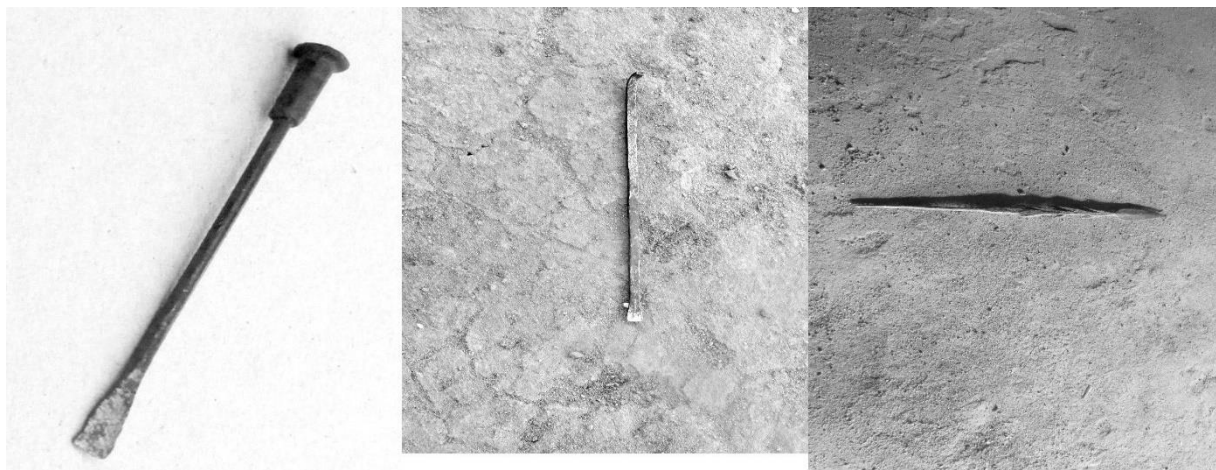
You see that child of mine, I did remove her Te Lak at two weeks. When Te Lak is removed earlier, the operation is more effortless; it is even possible to remove Te Lak on the second day after birth. Children are born with this Te Lak; if Te Lak is removed at a later stage, at about nine months, it will be so painful, so it is better to be removed at an early stage – Female Specialist_ 11.

Removing Te Lak in children between 2 – 5 months is easy. After five months, it becomes harder to remove the Te Lak. By five months, natural teeth would have started to grow, so you will be removing natural teeth, but not Te Lak – Female Specialist_ 12.

Treatment Procedure

The specialist starts by assembling all the equipment and supplies that he or she needs when treating the child. This includes calabashes, gloves, clay pots, wash bowls, water, herbs or penicillin V potassium, and a "siliki". A "siliki" is a sharp object the practitioner uses to cut the child's gum. This could be made from a metal of desirable size, preferably a bicycle spoke, a nail, or a metal bar. Alternatively, the practitioner uses the tip of an arrow.

Figure 3: Tools Used to Make Incisions on the Gum Made Out of a Bicycle Spoke, Metal Bar and Arrow



The author took the photo.

Before or after assembling all these materials, the specialists collect one of the following herbs to be applied after extracting Te Lak. It could be nyek mon (*Bidens pilosa*) or belwinyo (*Lantana camara*). These herbs grow in the wild. It is easier to find nyek mon; however, the specialists prefer to use belwinyo since it is more effective. Some specialists prefer to use medical and household supplies other than herbs. They use penicillin V potassium¹² drug, iodine, salt, sugar, or a tip of a matchstick. Often, the specialist and caregiver share the responsibility of acquiring such supplies. The supplies used when performing the procedure are stocked by the specialist. The caregiver must then acquire supplies to nurse the child further at home.

The salt or sugar used on the day of extraction is mine, so when the parents take the child back home, they use either salt or sugar, which is available to them – Female Specialist_11.

I have penicillin V potassium. For the first application onto the wound, I use my own and then the parents are asked to buy their own, which they use later. If I have iodine, that is what I use, I put it on the cotton, and then I apply it on the wound – Female Specialist_01.

After assembling and preparing all tools, supplies, and equipment, one needs to carry out the procedure, the specialist treats the child. If the specialist is going to treat twins or a child who was born with feet or hands first, then it is required that a sign of the cross is drawn either on the chest or chin of the child/children. This is a sign of respect for children born under exceptional circumstances. It is said that once this sign is drawn, Te Lak shall quickly come out of the child's gum. The sign is drawn by the child's mother or children using ash.

To some specialists, it matters which twin child is treated first. Therefore, these specialists treat the firstborn twin first (Opiyo if it is a boy or Apiyo if it is a girl), and then the latter twin will be treated next (Ocen if it is a boy or Acen if it is a girl). This is because the firstborn twin is taken

¹² This is an antibiotic commonly sold in drug shops in the communities.

to be the elder. Therefore, being treated first accords him or her respect that comes with being an elder sibling in a family.

The specialist then asks anyone present, preferably the child's mother, to hold the child. The child is carried in a position that not only makes it easy for the specialist to operate on the child but also limits movement. This person sits on the ground with legs straightened or on a chair with an inclined back. The child then sits on the lap of that person with his or her legs straightened and with the back of the child against the chest of that person. That person holds the hands of child with his or her left hand and uses the right hand to hold the forehead of the child.

I used to hold the children when my father was carrying out Kwanyo Te Lak. First, I would sit down on the ground with my legs straightened up, and then the child would sit on my thighs with her back and head laid back on my body; I then use my left hand to hold the child's hands and then use my right hand to hold the child by his forehead, my father then opens the child's mouth and remove Te Lak – Female Specialist_07.

The specialist then picks a "siliki", opens the mouth of the child with his or her hand and makes either or both a vertical and horizontal cut on the part of the gum where Te Lak is. It could be a single cut if the "siliki" is sharp enough or multiple if the "siliki" is blunt. The specialist then inserts the bent part of the "siliki" into the cut made and scoops out Te Lak, a "maggot" under Te Lak and the sac in which the Te Lak “grows”. I asked the specialists to describe what Te Lak, the sac, and the maggot look like. They likened the shape of Te Lak to that of a tooth. They described a sac as smooth, slippery and filled with blood. They described a maggot as a pointed thing that grows under Te Lak, and once put on the ground, it moves back and forth. The specialists emphasised the need to have the sac and maggot removed. They cautioned that the child stays sick if it stays in the gum. When asked how the sac affects the child's health, the specialists did not give me a direct answer but compared the danger a placenta poses when it stays in a mother's body after birth.

At this point, the child's caregiver is called upon to come to the space where the treatment is taking place if the caregiver is not brave enough or strong-hearted enough to stay when the procedure is being done. The caregiver is shown what has been extracted, the Te Lak, the sac, and the maggot. This gives the caregiver hope that the child will get better as the cause of the disease is dealt with. If the procedure is done as a preventive measure, then the caregiver is confident that the child will not suffer from any disease caused by Te Lak.

The specialist cleans the child's gums with water, a piece of cloth, or bare hands. After cleaning the gums, the practitioner applies medicine to the wound. This could be iodine, penicillin V potassium, sugar, salt, a tip of a matchstick, belwinyo, or nyek mon. The iodine, sugar, and salt are applied to the wound in their pure form. Penicillin V potassium is crushed into powder and applied to the wound. The tip of a matchstick is put on fire, and immediately the fire is blown off. It will then be crushed and applied to the wound. The leaves of belwinyo are crushed and mixed with water; salt is sometimes added. It is the mixture that is applied to the wound. The leaves of nyek mon are plucked off the branch and squeezed in between the palms until a liquid comes out. It is the liquid that is applied to the wound.

The child's mother is expected to come along with the child to be treated. She is supposed to breastfeed the child right after the medicine is applied to the wound. The specialists believe this allows the medicine to spread fast throughout the whole body. The other reason is to help the child swallow the blood so that it does not choke him or her. It is believed that breast milk also stops blood from oozing out of the wound.

This helps the child take the applied medicine with the milk to spread all over the body. Breast milk also stops the bleeding; thus, the child does not choke on the blood oozing out of the fresh wound – Female Specialist_07.

The specialists administer the first dose of medicine and give directions to the caregiver on the quantity of the medicine he or she is supposed to apply to the wound in the subsequent days. They also recommend the dose, dosing interval and treatment duration. This is unique for each medicine. Specialists prescribing a similar medicine also recommend a different dose regimen.

The difference in recommended regimen is explained by the specialist's perception of the effectiveness of the medicine. His or her perception is informed by his or her past contact with a particular medicine, his or her earlier recommendation and feedback from the caretaker, and the directions received from the trainer/mentor. The age of the child is also critical. It is understood that a child between zero and two months heals faster than one who is older. Therefore, the dosage would be shorter.

It depends on when the child's Te Lak is removed because when they remove it early enough, it does not take long, other than when the child is older. However, removing it a week after the child has been born is better so that it heals faster, and one uses less medicine – Male Specialist_ 05.

The specialists who administer a single dose often advise the caregiver to gently rub the cheeks of the child with a damp cloth, especially the part adjacent to the gum where Te Lak was extracted. This must be done until the wound heals.

I also ask the parents to use a warm cloth and pass it by the cheeks of the child, especially adjacent to the part of the gum where Te Lak was removed. They could also clean the wound with cotton wool or a piece of cloth. The warm cloth nurses the swollen wound to heal faster – Female Specialist_ 13.

In the proceeding days, the parents can use a warm piece of cloth and place it on the cheeks of the child, just adjacent to where the Te Lak was removed in the morning and the evening – Female Specialist_ 07.

Before disposal of Te Lak, the sac and the maggot, the specialist informs the caregiver that he or she will dispose of them. The specialist proceeds to do so, and when he or she gets back, he or she shows the caregiver the utensil or calabash as confirmation that they have been disposed of. Sometimes, the caregiver asks the specialist not to dispose of them but rather hand them to her so that she can take them home. This often happens when only the mother of the child seeks care.

She must go with what has been extracted from the child's gum and present it to the husband and elders in the homestead. If any household member had doubts about the existence of Te Lak, this is the opportune time to show that person what Te Lak looks like. If the child's mother came along with an elder, preferably the mother-in-law, it would not be necessary to carry the waste back home. The elder would have witnessed the treatment procedure and confirmed that Te Lak was extracted.

Afterwards, I show the parent the Te Lak and later throw it away, far in the bushes where the hens cannot find it. After throwing it away, I return to the parents and show them that I have indeed thrown away the Te Lak – Female Specialist_07.

After removing the Te Lak, I wrap it in a piece of paper, and the parents can take it home, in case there is one who needs to see it, or in case the mother moves with the child's grandmother, then I will throw it away – Female Specialist_13.

I can throw it anywhere; if somebody wants to take it home, they can. For example, last week, a lady took the Te Lak home to show her husband because the husband was against removing the Te Lak, but if someone does not want to take it, I throw it away because it is of no use – Male Specialist_05.

To one specialist, the wastes must be thrown deep in the bush. It should be far away so that the chicken cannot find it to peck at it. It is believed that once they peck the Te Lak, the child's wound will not heal fast. Other specialists do not hold the same view. They throw the waste anywhere. Others dug holes in the ground or by the ant hill and buried the waste. One could also dispose of the waste in the pit latrine.

5.3.2 Rubbing Herbs on Gums

Diseases caused by Te Lak are also treated or prevented by rubbing herbs on the part of the gum where Te Lak is. The treatment can only be applied in the first four months, beyond which one is advised to seek other treatment options. The medicine is applied to the upper and lower gums, and the treatment is offered at one point.

One of the herbal specialists took me through the art of treating childhood diseases caused by Te Lak with herbs. I was taken to the nearby bushes to collect a medicinal herb, which she referred to as "albahina". She dug the herb out of the soil and asked that I break off the root of the herb. When we got back to her home, she picked a calabash, a grinding stone, and a cup of water from the hut. She cleaned the calabash and the stone, washed off soil from the root, pounded the tip of the root on a grinding stone and subsequently placed it in the calabash. She did pour a small amount of water into the calabash. She then asked my assistant to carry the child and sit in the doorway of a hut. She held a hen by its legs and swung it around the medicine thrice. This is done so that the medicine is free of the evil spirits that get into it. She explained that the procedure is done at the time when evil spirits are leaving this world to rest, and so they get into the medicine. The swinging of the hen over the medicine cleanses it. The specialist advised that when treating twin children, he or she must use a single hen to enchant the medicine. This is because twins are one child.

The specialist then got hold of the child, placed her in a breastfeeding position, and demonstrated to me how one should rub the root onto the part of the gum where Te Lak is. She advised that one should never forget to give the child the water poured into the calabash. The specialist also advised that the parent must return for two consecutive days for the other dose of medicine if it is a boy child. Suppose it is a girl; the caregiver returns for three more days. She recommended that the specialist administer the subsequent dosage to ensure that the child has completed treatment. This might not be the case if one trusts the parents with this responsibility.

5.3.3 Making an Incision and Inserting Medicine

Diseases are also treated by making an incision on the top of the lower gum where Te Lak is and then inserting herbal medicine. A "siliki" is used to make the incision. Just like Kwanyo Te Lak and rubbing of herbs, this therapy could be preventative or curative. The difference is that this treatment can only be done in the lower gum. The specialists in this therapy recommend that the treatment procedure be administered in the first three to four days after the child's birth. This is the time at which the medicine is most effective. They also advised that it must be administered in the morning or evening when the weather is not hot. It is believed that treating the child when the weather is hot further deteriorates the child's health condition.

It is either done early in the morning or evening, but not during the day. I do not do it during the day because it is hot, the sun is out, and this would kill the child. In addition, the sun worsens the child's condition, especially the high fevers – Female Specialist_03_06.

Early in the morning and late in the evening, when there is little sunlight, because during the day it is hot, and the heat increases the child's illness – Male Specialist_10_04.

The case narrative below provides a deeper insight into the treatment procedure.

Question: Take me through the process of preparing the medicine?

Response: I do pound the root of that herb. I also grill the leaves of that herb over fire and rub them between my hands until they produce some liquid substance. I then mix the two, the grilled leaves and the root.

I did not tell you that one must wash the herbs. So, as I said, when I am done with the grilling of leaves and pounding of the root, I now have a mixture of the two. I then put a saucepan of water. I let the water boil a little and then put leaves of malakwang. I let them boil until they turn yellowish. When they do, I add leaves of anuna. I let them boil

for some time, and then finally added the mixture of the grilled leaves and pounded the root into the saucepan. I let it boil for some more time. After that, I took it off the fire and let it cool down. I then ask the mother of the child to carry the child.

When working on twins, I get ash and draw a sign of the cross on their chest. If I do not do this, Te Lak may never heal and can quickly swell within the child's mouth. Before applying the medicine, I use a 'siliki' to cut the top of the gum and then afterwards apply the medicine. When a cut is made, blood oozes out. Subsequently, a white substance will come out of the tooth. Only after the blood and watery substance have come out can I apply the medicine so that the Te Lak can receive enough medicine. The child will also drink some of the medicine. You can also smear some medicine on the back of the child's head – Female Specialist_06_03.

5.4 Duration of Traineeship

This is unique for each Kwanyo Te Lak specialist. It is represented by the period from when the child starts as a helper to the time when he or she has his or her first treatment encounter. It is primarily determined by the trainees' level of bravery, consistency in displaying interest in becoming a practitioner, and strong-heartedness. It can, however, be determined by unforeseen events, for example, when the specialist is sick, and thus the trainee is asked to carry out the procedure under the guidance of the specialist, or the specialist might be away, and the caregiver asks the trainee to carry out the procedure. If such unplanned events do not happen, the traineeship period ends when the trainer is convinced that the trainee is brave enough and strong-hearted to carry out the procedure.

I started carrying children, and it got to a time when I started operating on children. It was a long time because I started carrying children when I was about ten years old, and I started removing in 2013 and spent about 17 years as a trainee – Female Specialist_08.

Four of the five herbal specialists had received training for a shorter time when compared to their colleagues and Kwanyo Te Lak specialists. Some specialists' traineeship duration was equivalent to a dream length.

One herbal specialist had a long traineeship duration that could somewhat be equated to that of Kwanyo Te Lak specialists. It took her years to become a Te Lak specialist; however, the training content was different as the trainee was treating Te Lak during this period, which is not the case with Kwanyo Te Lak specialists.

5.5 Healer Initiation

A successful first treatment encounter symbolises the initiation of a Kwanyo Te Lak trainee into a specialist. The first treatment encounter was unique for each specialist I interacted with. It is, at times, part of an initiation ceremony. The decision to hold such a ceremony lies in the hands of the trainer. The trainer decides if he or she is hopeful that the trainee is ready to become a specialist. The trainee is expected to conduct the procedure on his or her child so that if he or she carries out the procedure poorly, he or she hurts his or her child. The spouse of the trainee is present during this ceremony and supports the idea that the trainee's first treatment encounter is with their child. A handful of other relatives could also attend the ceremony. The trainer only initiates the trainee as a specialist when he or she carries out the procedure correctly.

The case below illustrates the initiation ceremony.

One day, my father came to where I was sitting and told me I was a strong-hearted woman. He brought my child to me and asked that I remove her Te Lak. He then threw a bicycle spoke on the ground. He asked that I pick it up. I did pick it up. I asked my father to help me hold the child, but he refused. He said, "You have been observing how I have been carrying out the procedure. Sometimes I do not ask you to hold the child, so carry the child on your own". That was not the problem, but I was to operate on my child. I was nervous, and if I failed to carry out any step properly, I would have killed my child. It would be my fault. So, I had to be brave and carry out the procedure on my child. I did it

well, and my father was impressed with how I did it. He then said that the child's parents should give me something in return as a sign of appreciation whenever I do it. Afterwards, I was given some items I would use when carrying out the procedure; I was given a calabash, two gourds, a bicycle spoke, and a coin.

Probe: Who else was around that day?

Response: My aunties and uncles were around

Probe: Did your husband agree to the idea of having your first treatment encounter with your child?

Response: My husband agreed that I operate on the child. He did accept he was around on that day – Female Specialist_07.

The practice of having trainees treat their children during the first treatment encounter was reiterated by other specialists.

They all had to start with removing Te Lak from their children so that when they do it poorly, they do kill their children. So, I first gave them the "siliki" I used to use, and later on, I made one for each of them. So, they have their own now – Male Specialist_05.

The decision for the trainee to have the first treatment encounter is often reached when the trainer thinks that one is ready to do so. However, there are instances where the trainer is forced to ask one to carry out the procedure even though he or she doubts one's competence. For example, the trainer could be sick and thus not in a position to carry out the procedure. The trainer will be present as the trainee treats the child and instructs him or her, which is not the case with treatment encounters as part of the initiation ceremonies.

The first time I did extract was on my child. She had a dry mouth and a fever, and she would shake her head when I was breastfeeding her. I took the child to my mother, who said Te Lak had attacked her. On that day, my mother was not feeling well and feared that she would not do it well; she then asked that I remove the Te Lak. She had already sharpened the siliki, I cut the child's gum, and a small white maggot came out of the gum. Afterwards, she commended me for the excellent job done, and she encouraged me to keep doing so since she was already turning weak – Female Specialist_12.

Ideally, the decision for one to have a first treatment encounter must be made by the trainer.

On that day, some lady brought her child, and my mother told me to prepare the herbs, and I did, and instead of her removing them, she told me it was my turn to remove them, and I made a cut horizontally on the gum then vertically, and I scooped out the teeth quickly – Female Specialist_11.

In reality, this might not be the case. The first treatment encounter could happen when a child's caregiver seeks medical attention, only to find that the specialist (trainer) is not around. The child's caregiver suggests that the trainee treat his or her child. This often happens when the child is in a severe state and needs emergency treatment. The caregiver makes a desperate decision as there is no alternative. The trainee is hesitant to carry out the procedure and only agrees if he or she is given assurance that he or she shall not be blamed if something goes wrong.

There is a particular lady who is still alive today. She had a son. When she came home, she found that my husband was not around. The other specialist she could go to stayed near river Acwa. It was far. She then asked that I remove the Te Lak. She said she would not blame me even if I did it poorly. Even if the child dies, she will not blame me. She insisted that I remove the Te Lak. Since the 'siliki' was home, I proceeded with the procedure – Male Specialist_05.

The way I started removing Te Lak. It all started when a particular lady took her child to a certain Mzee to treat the child. What the Mzee did was cut the child's gum. However, he never extracted the Te Lak as one is supposed to. The mother of the child then said, "My friend. Your grandmother used to remove Te Lak when you were young, and you were the one who used to hold the patients; I want you to remove my child's Te Lak. I replied, "I have never done such a procedure in my life, and I fear extracting Te Lak. Then that lady and her husband said, "Please, we want you to do what you can do. We will not blame you if what you do results in the death of our child." I said no problem, but I did not even have an instrument for extracting Te Lak. The lady's husband then helped me and made me a siliki. Because the child's parents had given me the go-ahead and were not to blame me if, in the process, the child died, the moment that I held the siliki and made a cut on the gums, within minutes, I had scooped out the Te Lak – Female Specialist_14.

One trainee refused to heed the caregiver's request to treat the child. His trainer had died before she could initiate him as a specialist. He told me that the spirit of his trainer appeared to him and urged him to take up the new role of the specialist. The trainee, however, had doubts about whether he was competent enough to carry out the procedure. He persistently turned down treating the child until the spirit of his trainer descended in the form of an image and expressed her disappointment with his actions. It is only then that he agreed to treat the child.

My mother died in 1984. She was a Kwanyo Te Lak specialist and had previously trained me to treat Te Lak. She died during a shootout. I was also shot thrice. When I was in the hospital, I had a dream. My mother came to me and told me that I should help people the way she used to help them. She told me people would come to me for help when I returned home. She asked that when they do, I should help them. I had a similar dream later that day. I reported to the army when I was discharged from the hospital. I was posted to Lira and then later transferred to Gulu. Months later, I decided to desert the army and return home. A day after getting home, a lady came home seeking help. She said, "Your mother used to help us, so you should also help us". I told her I did not know how to carry out the procedure. She insisted, but I still told her I could not help her. I then stood up and went to my room. As I sat on my bed, I saw my mother. She asked me why

I was not helping people. She seemed angry. She then disappeared. At that time, I felt something pushing my head. I stood up and got the bicycle spoke that my mother used to use, and then I went to the bush to collect herbs. Afterwards, I got the bicycle spoke. I closed my eyes and then opened them afterwards. I opened the child's mouth wide and extracted the Te Lak – Male Specialist_09.

One specialist decided on her own to begin treating Te Lak as the trainer had been called upon to offer his services elsewhere.

During Milton Obote's regime, Te Lak was seriously killing the children of army men. They came to our home and picked up my husband. They came with an aeroplane and airlifted him to Cwero. I thought he was being taken for a few days, but this was not the case. He was to train with the army and become the person in charge of treating Te Lak. He later came back home. When Idi Amin came into power, he also came for him. This time around, he was taken to Mengo. At that time, many people were coming home seeking his services. I then decided to start helping these people – Male Specialist_05.

The initiation of individuals trained in herbal therapies is unique from that of Kwanyo Te Lak specialists. Traineeship, for persons who received treatment instructions through a dream, ends the moment the dream stops. The other trainees only became specialists when they became independent of their trainers, mainly through marriage.

5.6 Discussion

Te Lak healing, like other African healing systems, remains deeply rooted in local epistemologies. Humans or 'non-human' (spirit) entities pass on Indigenous medical knowledge to trainees through physical interaction or a spiritual experience. The different engagements with humans and non-humans signify a transition in healers' identities and their legitimisation in the community (Green et al., 2020). Humans offer training in therapies involving surgical procedures, while non-humans provide instruction in herbal therapeutics. These findings align

with research on other African communities, where spirits are regarded as gatekeepers of herbal knowledge that pass down the sacred treatment knowledge (Emeagwali & Shizha, 2016).

The spiritual encounters in the Te Lak healing tradition offer a unique perspective on the transmission of Indigenous medical knowledge. Unlike traditional medical systems in central Uganda, where trainees experience multiple spiritual engagements (Sekagya et al., 2024), in this context, the apprentices experience a single spiritual encounter where they receive detailed instructions on preparing and applying the herbal remedy. At that moment, the healer's body becomes an epistemic site where healing knowledge is revealed and mastered.

Te Lak knowledge transmission follows a structured, top-down approach. The trainees are handpicked by accomplished healers following criteria based on lineage and considerations such as availability, interest, and gender. A similar model is observed among traditional health practitioners in Madagascar, where experienced healers select trainees based on trusted lineages and specific traits (Pierlovisi & Pourchez, 2014).

Lineage plays a crucial role in the selection of trainees. Most specialists I interacted with were descendants of healers treating illnesses perceived to be caused by Te Lak. Additionally, many had siblings skilled in the healing tradition and were either training their children or were hopeful of passing on the knowledge later. Earlier studies have shown that this structured transmission preserves the family's healing legacy and positions the healers as both custodians of sacred knowledge and guardians of the family healing legacy (Ouma, 2022).

Similarly, gender plays an important role in determining access to and transmission of Te Lak healing knowledge. As the case has been in other study areas (Hicks & Liddell, 2023), the matrilineal line of traineeship is more common than the patriarchal one. This may be attributed to the fact that traineeship happens in the domestic sphere, a place where communally sanctioned feminine roles are enacted. The dominance of the matrilineal line of traineeship may be attributed to the unique authority that comes with being a healer. Unlike many other feminine roles, being a healer grants women power and recognition (Popper-Giveon & Weiner-Levy,

2014). Men are reluctant to disrupt this sort of influence because it aligns with caregiving roles traditionally associated with femininity.

The decision to train girls reflects a strategic effort to maintain matrilineal authority and preserve their social and economic autonomy. However, the dominance of formal education is challenging this preference. Healers are reluctant to train girls who are pursuing education. It is thought that they do not have enough time to commit to the training. In addition, the healers think that they would not give the healing tradition the kind of respect it deserves. Notably, the healers are adapting to these realities by waiting until one drops out of school. In other instances, they opt to train boys. Similar insights have been reported by research in the Eastern Lake Victoria region in Uganda. Ouma (2022) shows that the matrilineal line is increasingly being challenged as younger generations migrate to urban areas seeking education and employment opportunities.

For some trainees, the selection process continues until completion of the initiation rituals. The key considerations at this point relate to the trainee's moral, relational and technical aptitude. There is careful observation of one's character. The trainers are intentional in gauging their interest in the trade and the respect they accord to the indigenous medical knowledge.

This exclusivity criterion limits the transmission of Te Lak healing knowledge to a specific group of people sharing similar traits. Earlier studies have demonstrated that such selectivity plays a crucial role in ensuring the continuity of healing knowledge within trusted networks. It also safeguards the sanctity and integrity of the healing knowledge and consolidates the healer's authority (Marques et al., 2021; Usure et al., 2024). The restriction of healing knowledge to specific families and groups strengthens social stratification within the community. That said, this stratification is being challenged by the intersecting structural systems, such as education. Nevertheless, training continues to be regarded as a credible alternative to formal education that provides children with skills critical to developing a professional identity in the community. It is particularly common for children who drop out of school to be recruited as trainees, offering them a pathway to social and economic integration in the community.

The healing knowledge offered to the trainees encompasses technical, spiritual and relational dimensions. The healers do not only focus on building one's skill in treating Te Lak but also

focus on the cultural, spiritual and moral principles of healing. The technical aspects relate to the precision and proportionality in the preparation and administration of treatments. Trainees are instructed on administering a suitable amount of medicine to the infant to avoid further complications or disease persistence. The intention is to maximise the effectiveness of the drug while at the same time minimising risks that come with overdosage. This demonstrates the specialists' "understanding of the dialectical relationship between quantitative and qualitative proportionality when injecting foreign substances" into the human body (Camara, 2014, p. 30; see also Horden & Hsu, 2015). This is similar to the practice in the professional medical system, though there are differences in the level of precision.

The moral dimensions of the training relate to the delivery of healing that is ethical and accessible to the community. This involves learning about how healing practices align with the cultural values of the community. On the other hand, the spiritual dimension supports the trainees to learn spiritual laws and conduct rituals. Aligning healing practices with spiritual laws and cultural values fosters community trust in one's healing abilities (Read et al., 2023).

The healing tradition is deeply embedded within specific temporal frameworks. The treatment practices are periodized, often timed to align with daily and life stage cycles. The trainees are instructed of the time of the day they should treat the child, ensuring alignment with specific spiritual and physical energies. This is also the case with Tanzanian healing traditions, where healing happens in the morning to tap into the cleansing and renewal energies related to the morning time (Langwick, 2011). Other studies have identified dusk and dawn as liminal periods during which healing practices are aligned with spiritual energies (Bigger, 2009).

The periodization of treatments is also informed by the life stages. Trainees are told of the recommended age at which one should have their child treated. This often coincides with key development milestones where infants are more vulnerable to disease. This kind of knowledge is influenced by the local understanding of the anatomy of the human body, specifically on the different development vulnerabilities. Previous research has shown that the scheduling of treatments in alignment with daily rhythms and life stage cycles enhances the efficacy and legitimacy of the healers (Berhe et al., 2024).

The transmission of healing knowledge happens across multiple spatial dimensions, both physical and metaphysical spaces. It could be in a homestead. This provides a controlled and private environment for the transmission of healing knowledge. The trainer at this point has total control over the learning process. It is also in this space that spiritual laws related to healing can be observed or where rituals pertinent to the learning process can be performed. This private space then creates a secure setting for technical, moral and spiritual development. In such a place, a trainee embodies their evolving role from a trainee to a unique social agent with the responsibility of safeguarding sacred healing knowledge. However, during initiation, the homestead is turned into a communal ritual site where the healer's expertise is validated and legitimised in the presence of the public.

The other dimension where training happens is dreams. This is a liminal space where non-humans interact with humans. At this point, dreams are a portal to sacred healing knowledge (Bakow & Low, 2018). These spatial dimensions further strengthen the exclusivity related to the Te Lak healing tradition. Individuals who stay in the same homestead as the healer and those who have spiritual visits are more likely to have access to this sacred knowledge.

Traineeship and initiation are separate processes, mainly where the training relationship is with a human being. The initiation process symbolises the transition from trainee to healer and admission into a large network of healers. The specifics of initiation vary across different therapies, and even individuals trained in the same therapeutic practice may undergo distinct initiation processes. Notably, initiation involves undertaking symbolic acts that test the trainees' technical, moral, and spiritual readiness to take on the healing role. For example, the trainee could be asked to perform the procedure on his or her child. This is meant to emphasise the importance of taking a cautious approach when offering treatment, but also to demonstrate their ability to embody the sacred responsibility of healing within the community. Initiation, in other instances, involves encounters with non-human entities that facilitate the transformation of the individual into a healer.

CHAPTER 6: SOCIAL ROLES AND IDENTITIES OF TE LAK HEALERS

6.1 Introduction

This chapter interrogates the diverse social roles of persons skilled in treating illnesses perceived to be caused by Te Lak. The exploration of the different roles provides information on how healers manage the multiple roles and how these roles complement or conflict with one another. Further, the chapter examines how healers embody their healing identity and the circumstances under which they forfeit or negotiate this identity. This supports the analysis of the social and professional pressures that they experience when they identify themselves as healers. Particular attention is given to the pressures exerted by biomedical practitioners and their embeddedness within global power hierarchies. Focusing on these pressures offers insights into how healers maintain their healing identity.

This chapter is anchored in anthropological theory that argues for attending to people's being-as-becoming to show the "unfinishedness of human subjects and lifeworlds" (Biehl & Locke, 2017, pg. x). Human lives, from this perspective, are understood to be incomplete, emerging, evolving, and shifting, shaped by multiple cultural systems and political and economic forces (Biehl & Locke, 2017; Ralph, 2017; Petryna, 2017). By showing the shifting set of relations and constant reworking of the lives and worlds of healers, I show the multiplicity of identities and roles that persons initiated as healers hold and argue that anthropological texts that only identify them as healers do not provide a complete and whole account of their lives.

6.2 Uneasy Relationship with Individuals and Institutions that Promote Biomedical Practices and Authority

Te Lak specialists recognised the presence of biomedical health care practitioners and their critical role in providing health care to those afflicted. However, they quickly mention that they hold onto specialised knowledge unknown to the hospital practitioners. They narrate how these practitioners have had to seek care from them when their children contract diseases caused by Te Lak. This was reiterated by some caregivers who made a plea for developing a cure for Te Lak that can be used in biomedical facilities.

Like I told you earlier, I was taken to Lira. There were many doctors in the room. They were asked to search for Te Lak but did not find it. I laughed at them. It was my turn, and I showed them the Te Lak within no time. They know nothing about Te Lak. In the past, some doctors have come to me for help. I have treated their children. I am the expert – Female Specialist_07.

There was a day when he (army general) came to my home and picked me up, he took me to his home in town, he had also called some other doctors, he then asked other doctors to check if his child had Te Lak. They all opened the child's mouth, they inserted their fingers, but in vain; they did not find the Te Lak. Then I was asked to check for Te Lak, and I showed them Te Lak. One of the doctors around said that I was a witch doctor. I told him I am not a witch doctor, I am only a Kwanyo Te Lak specialist. I then proceeded and removed the child's Te Lak, and the child became fine. After some time, I was called again as his other child had also got Te Lak. The time my husband was away, I mainly treated the children of soldiers. – Female Specialist_12.

The specialists told me that it was common practice for some hospital practitioners to refer infant children to them when diagnosed with diseases caused by Te Lak. However, the practice is never reciprocal. The specialists reiterated that they do not refer clients to biomedical practitioners since they lack the requisite expertise to handle such cases. They noted that they only refer cases to fellow local experts in treating diseases caused by Te Lak. This is common when a child requires a therapy that one is not skilled in. It might also happen when one performs the treatment procedure poorly and requires a more skilled healer to attend to the child.

I did, however, find out that there are instances where some specialists decide to refer children to biomedical facilities. It is common for one to abstain from treating a severely ill child. This is out of fear that the child could die during the treatment encounter, which may attract the attention of law enforcement officers who could arrest the practitioner.

At times, parents delay bringing these children to us. By that time, the child is badly off, so sick, I can treat her, but there is a possibility that she will die days later. When the police find out, they will arrest me, so I will send her to the health centre because even if she dies, no one will come after the health workers – Female Specialist_13.

Individuals and institutions that promote biomedical practice and authority often target the specialists. The most vocal are the health workers in government health facilities and church leaders. Some individuals have gone to the extent of labelling specialists as killers. They argue that the procedure they perform is responsible for many deaths among children. They are also responsible for the delays in seeking health care, which increases the risk of a child's death. However, members of the local 1 council, the lowest administrative and political unit elected by village members and responsible for community development, of Omel Apem and Omel Kuru I interacted with, disagreed with how Te Lak specialists have been labelled.

Is it bringing any problems? No, it does not. Do children get better after treatment? Yes, they do. If the government is discouraging its practice, it should come up with better alternatives, but they have not offered anything. So, it is right for it to continue – I see no problem – Interview with Local Council 1 committee member.

These local council members recognise and respect the specialists' role. However, one of the members was hesitant to blame the individuals attacking the specialists. He confided in me that he once had similar thinking until a time when Te Lak attacked his child. He had declined to have his child treated for diseases caused by Te Lak. He had to go against his mother's advice as he thought that Te Lak and its associated practices were engaged in by those that are backward. For the next month, he sought care from Omel Apem health centre II, but the disease persisted. It was only then that he accepted to have his child treated by a Te Lak specialist. He told me that his child only got better after Kwanyo Te Lak. That is when his take on Te Lak changed. He now sees that his children are treated the moment they are diagnosed with diseases caused by Te Lak.

My child would be dead if it were not for mego (elder). I was just like them, thinking that people who believe in Te Lak are backwards, those who did not attend school. I

remember I was staying with my mother. I had just dropped out of school and decided to marry. My parents had given me a hut to stay in. That is where we raised our first child. So, there was a day my wife told me that the child had contracted Te Lak. I almost beat her up. I was so furious. She had also attended school, so I thought she would not believe in such. The next day my mother called me and asked why I wanted to beat up my wife. I guess she had told her. I told her she believes in stupid things. I remember my mother saying, "My son, I am older than you are. We have been doing certain things within our family, and I do not think you can run away from them". I did not take her word seriously and told her my child would be taken to Omel (Omel health centre II). My wife took her there, but the child never got better. I started thinking about what my mother had told me. I began to believe that Te Lak was in my blood and had passed it on to my child. I then talked to my mother. Imagine I knelt, asked for forgiveness, and told her I wanted my child to be treated for Te Lak. She forgave me, and they took the child for treatment. The child got better. So, I laugh at whoever despises these specialists. They do not know what Te Lak is – Interview with Local Council 1 committee member.

The specialists do have the support of the community, the village, and clan elders. Some specialists were part of the council of elders in their families—the elders' guide members of a community, a village, or a clan on the Acholi customs. Indeed, I was always asked to consult elders whenever a respondent was not knowledgeable about a particular issue. For example, the elders mediated the forgiveness and reconciliation process for one of the specialists who had taken part in the Holy Spirit Movement, which was a militant rebel organisation against the Uganda government from 1986 to 1987, as elaborated in chapter 3. The elders advised the people in attendance that they had more to gain than to lose if they accepted her back into their community. Earlier, she had explained to the elders that she was skilled in treating diseases caused by Te Lak and was willing to attend to children at no cost.

I am not shy about my past. You have probably heard from people that I was a follower of Lakwena. You do not look surprised, so I think someone told you. The army was looking for us; I remember Lakwena had fled then. I said to myself, 'Why should I continue with the fighting?'. I decided to come back to my family. The problem was that

everyone knew that I was with Lakwena. Some thought we had killed our people, which was not the case. The only way I could get back into the community was to go to the elders and ask that I be accepted.

I met with elders within my family, but they said they could not handle it. They then contacted the elders of our clan. The elders called me. Some were bitter. They asked that I tell them what I did when I was with Lakwena. I told them I was not a fighter. I was mainly cooking food for the men. Some did doubt whether I was telling the truth, yet I was. They then asked me why I deserved to be welcomed back. I told them many things – looking after my family and the sort, but they were not convinced. Then one of the elders who knew my mother asked if she had taught me how to treat Te Lak.

I said yes. She then asked if I remembered how to do so. I still said yes. She then told the rest of the elders that I would be helpful since I knew how to treat Te Lak. Some were not convinced. I then told them I would do it at no cost. That is when they agreed. I was then told that a community meeting would be held where I would confess all my wrongdoings and ask for forgiveness from the people. That happened. The people were angry, but the elders told them that I was willing to treat their children with Te Lak at no cost. I think that is why I was forgiven – Female Specialist_14.

I met many caregivers who appreciated the role Te Lak specialists play in ensuring that children live longer and healthier lives. I was told that many people had died during the civil conflict that took over 20 years. They were now embarking on seeing that they re-populate their communities. Many men worried that their property (particularly land) would be encroached on if they failed to have as many male children as possible. Many had decided to have as many wives as possible to realise their goal within no time. Women are conversant with this fact and are expected to do all they can to see that children live healthily. The biggest impediment to realising their goal is the recurrent child mortalities. The specialists are appreciated for their role in minimising these mortalities.

I have seen you a couple of times with Mego (elderly woman). It is good that you two are working together. As elders of this community, we are confident that something good will come out.

Author: What do you mean?

Response: Ohh, you are like other people. Do you mean you do not know how important she is in this community? We always thank our ancestors for sending us such a woman. Hmmm. Let me tell you. You would not find this enormous number of people within this community if you came just after the war. We lost so many people. So many of our people were killed by Kony¹³. After the war, we elders asked our people to produce as many children as possible. The intention was to be as many as we were before the war. We are somewhere now but still, look at all this land. No one is using it. I have so much land and imagine most boy children were killed during the war. Nevertheless, now I have married two young women. Ohh, why are you laughing? I am still strong. Let me tell you. I have so far one boy child. The other is a girl. I have told my wives that I need other boy children, and I know they will give me more. You know these are the children that will stay on my land. My land shall be stolen if I do not have as many as I can.

Author: So why are you grateful for having Mego within this community?

Response: Ehh, you know I sometimes talk a lot and forget what I was saying. She is the one who treats our children when they are sick. We would have lost many of them if it were not for her. She has just treated my boy child recently. He is now well – Interview with an elder.

¹³ This is elaborate in chapter 3

6.3 New and Expanded Roles in the Field of Health

A specialist was recruited as a Village Health Team (VHT) member, a team that serves as the initial point of contact for primary health care. VHTs are non-professional volunteers who provide basic healthcare services (including managing simple cases of malaria and diarrhoea), health education and referrals. The selection of VHTs involves nominations by community members based on their qualities and willingness to serve. After community nominations, the selected individuals are vetted and approved by the district health team. Once approved, they undergo a series of trainings provided by the Ministry of Health or partner organisations. However, this healer was uncertain about the selection process and unaware of who had chosen him to be part of the team.

I worked closely with this specialist, and he occasionally conducted home visits where he interacted with families on a wide range of health issues (e.g. hygiene and sanitation, drug adherence). The excerpt below, taken from a conversation between the specialist and family, highlights key roles he fulfils.

Specialist: How are the children?

Response: The children are doing well

Specialist: I was last here when we were registering people who would receive nets (ITNs). Did you get the net?

Response: Yes, I did

Specialist: Could I have a look at it?

Response: The problem is that the children refused to sleep under it. Whenever I would hang it, I would find it on the ground, so I chose not to hang it anymore, and when my

sister came to visit, I gave it to her. She told me her children have no problem with sleeping under it.

Specialist: Do you know that you are putting your children in danger?

Response: But they were getting sick even when they used to sleep under the net, so I did not see any difference

Specialist: That is because you used it poorly. By the way, last week you came for medicine. Do you still have the packet where the medicine was?

Response: Yes, you told me to keep it, and I did (proceeds and picks the packet)

Specialist: You see, I told you. The medicine is still in (the practitioner shows me the packet with four tablets still in).

Why didn't you give the child all the medicine?

Response: Respondent keeps quiet.

Specialist: I always tell you to give the child all the medicine but do not know what is wrong with you. Ahaaa, I asked that you put up a latrine last time I came by. Did you do so?

Response: Ahaaa, for that, you have to ask my husband, I told him about it, but he has not responded yet.

On other days, this specialist managed malaria in children under five. He diagnosed, prescribed, and dispensed medicine. At times, he offered the first treatment and then referred the patients to a government health facility. He often visited the health facility to interact with the VHT coordinator about the state of child health in the community he serves. He was expected to

submit a report on cases handled and those that he referred. Mothers often referred to him as ‘doctari’ (doctor). He did take pride in being called so.

Indeed, we are doctors, we have worked a lot to see that children are healthy, that is why people come late at night to seek care, they know that at that time the health facilities are closed, and we are the only ones who can help them out. Some of the VHTs offer family planning services. Though I was not chosen to do so, I believe one day I will also be taken on. I shall have become a real doctor then. We are doctors. We spend days walking all over the community, visiting people's homes to find out if they are well. The difference between them and us is that they pay them, and we are not paid – Male Specialist_09.

This specialist understood the government health workers were spearheading the campaign against Te Lak. He, however, disagreed with them as he argued that he should not go against his dead mother's request to help children who contracted Te Lak. He also dismissed the health worker's argument that Te Lak and malaria are the same. He explained that the two had different signs. He believed he was better placed to tell the difference between the two since he had received training to handle both. He also told me that there are children who lose their lives in health centres as health workers fail to realise that they have Te Lak.

Yes, I know what my colleagues from Cwero say about Te Lak. I expect that since they did not get a chance to be trained in treating Te Lak. I told you about how I started treating Te Lak. I had refused to treat people, but my dead mother never stopped appearing to me. So, I also have that obligation to help children who have Te Lak. I also help those with malaria. When the child refuses to breastfeed or if the child attempts to breastfeed and keeps shaking their head, I get to know that he has Te Lak and not malaria. Some children die because doctors treat them for malaria, yet they do have Te Lak, so if they were not hostile towards us, I would tell them about Te Lak – Male Specialist_09.

Three specialists from the many I talked to are traditional birth attendants (TBAs). One of them told me that she had received training on maternal health from Red Cross. The other two had also received training but were unsure who had trained them. Nonetheless, health workers in government facilities knew that they were TBAs and occasionally picked up gloves from the health centres. The three women preferred administering treatment for diseases caused by Te Lak in the first days after a child is born.

I also assist women in delivering. I like it more than Kwanyo Te Lak. I usually advise the women I have helped during delivery to treat their children as early as possible. Children are born with Te Lak, so it can be treated as early as the first days after birth – Female Specialist_07.

Other specialists that I interacted with also treat several other childhood diseases. For example, those trained by supernatural beings, yet again or had earlier had a dream in which they received other treatment instructions. There are also simple procedures that the specialists teach themselves (e.g. treatment of boils).

It is common for a Te Lak specialist to also be skilled in treating Two Kal (millet disease). To my respondents, Two Kal is as common as Te Lak among children. It is believed that these local categories are responsible for most infant deaths. They share signs (e.g. fever, malaria, and convulsions). Two Kal is treated by cutting Kal (millet) from the child's chest, his or her back or the back of the foot. Treatment for Two Kal is often sought when a child who has just been treated for diseases caused by Te Lak continues being ill. It is thought that the specialist could have misdiagnosed the disease, or Te Lak and Two Kal could have attacked the child at once. Some children receive treatment for both on the same day.

The specialists are often consulted on different aspects of child health. I did observe these consultations on several occasions. One of the practitioners was part of a peer farming group. One day, her peer asked about Two Lango (skin rash) and how she could treat it. Another practitioner worked in a marketplace where she sold vegetables. There was a time when one of her peers asked her about the treatment for diarrhoea. The specialists not only provided advice on

how to treat these ailments but also provided advice on how to prevent such ailments. Discussion with the parents show that they often adhere to this advice.

Some Te Lak specialists recommend biomedicine for diseases, especially diarrhoea and Two Lango. There is a mother of twins who had for the last month been providing ciprofloxacin to her children on almost a daily basis. She divided a single tablet into two, crashed them into powder and gave each child his share. She had approached one of the specialists in the past as her children persistently had diarrhoea and had contracted Two Lango at the time. The children had undergone Kwanyo Te Lak in the past. She was advised to use ciprofloxacin. She bought the medicine from the nearby drug shop and gave it to her children as instructed. Only then did the children stop having diarrhoea, but Two Lango never healed. She was happy that she had found a cure for diarrhoea but was still anxious about finding one that could heal Two Lango. She went back to the specialist, and this time around, she was advised that she had to provide the child with ciprofloxacin daily for Two Lango to heal. From that day, she laboured to see that she procures and provides medicine to her children.

This is Ocen, and the other is Opio. They have not been so severely off, only that I do not have enough breast milk. They persistently had diarrhoea for some time, but we were advised to use Cipro (ciprofloxacin). They also have Two Lango (she unbuttons the shirt of one of the children and shows me the skin rash). We were also told to use Cipro. They no longer have diarrhoea, but the problem is with Two Lango. I went back to Mego and told her that the child was not getting better. She asked how long I had given the child Cipro. I told her once. She told me that is why the child was not getting better. She told me I was supposed to give the child the medicine daily. So that is what I am doing these days. I try to see that I give these children Cipro as much as possible. The problem is that my husband sometimes does not give me money to buy the medicine, but I try to see my children take medicine – Caregiver_27.

The twins' mother was asked to stop providing the children with medicine when she saw they were improving. This recommendation was also common among other specialists. There was a day when I found a specialist blaming her daughter for being irresponsible, as she had decided to

give her child a third dosage of the malaria drugs as instructed by the health worker, yet the child was feeling better. These specialists believe that any slight improvement indicates that the swallowed drugs have started working, and there is no need for one to swallow anymore. To them, it is more important to keep the rest of the medicine so they can be sure of having medication when the child or any other child falls sick.

Never continue providing the child with medicine when you see her getting better. You will be wasting the rest of the medicine. The medicine you would have given her is enough; you just have to give it a day or two, and it would have cured your child. You can then keep the rest. Our children fall sick often; we always need to have that medicine around – Female Specialist_07.

The specialists recommend and use western medicine when they fall sick. One day, my assistant and I met a specialist by the road. She was coming from her garden. She looked sickly. She did ask us to help her carry her hoe and cassava as she could not manage to do so anymore. She told us that she had a bad headache all night long. She was dizzy at the time. We had to stop on several occasions so that she could take some rest. She did not find any reason to seek care since she had taken the remainder of the medicine prescribed for her child. She was not sure of the name of the medicine. We later found out that she had taken ciprofloxacin.

6.4 The Private Lives of Healers

Several female specialists whom I talked to were married. These women were expected to perform gendered roles, such as caregiving and domestic roles. There was a day I scheduled an interview with one of the specialists in Lapuda at 17:00 hours. I found the specialist grinding millet into flour. It was only after 20 minutes that she had some time to talk to us. Minutes into our conversation, the husband came to where we were. He greeted us and asked why we were talking with his wife when she was supposed to cook for him. We explained that she had agreed and assigned one of the daughters to cook the flour. I looked at the wife, hoping she could back us up, but she kept silent. He would add.

It is my wife's responsibility to prepare a meal for me. I do not want my daughter to take her place as a wife in this household. So please stop whatever you are doing and let her go on with preparing my food.

One of the women specialists was in a polygamous marriage. She was the second wife. My assistant and the practitioner grew close and started sharing their private lives. She once jokingly asked her why she would allow getting married to a man that had a wife. Her response was precise "I am like any other woman". Her co-wife position was challenging as she believed that the husband favoured the other wife. This was often a source of argument for the couple. One day she narrated her ordeal to me.

I do not understand why he lets his other wife leave when it is time for tilling and planting. If she were around, she would have tilled our land as I went out to look for money that could help us as a family. I am sure she will return when the rains are over, and this man will allow her in our house. I do not understand why he does so. She is very lazy. Imagine she left her children here, and I must fend for them. She never goes with her children. When she is around, she does nothing and rarely helps me prepare food for the family. All she does is eat and eat. I wonder what this man likes about her – Female Specialist_04_02.

This, however, does not stop her from treating her co-wife's child when he or she contracts Te Lak. She did believe that her troubles with her co-wife should never be a reason for denying the child a healthy life. She is attentive to the health of all children within the household and always advises her co-wife on what to do when the child falls sick.

One specialist is married to a health management unit committee member of one of the health facilities in my field sites. The committee manages the general administration of the health unit, advises, and monitors the use of finances, and works towards improving communication with the public. The committee member advised that his wife only handles people who have failed to heal after seeking care from the health facility.

Author: How common are traditional health practices within this community?

Response: They are not as common as they were. I only know of two specialists, and one happens to be my wife.

Author: What role do folk healers play in this community's medical system?

Response: My wife helps people with mental problems. She also helps people with chest-related ailments like millet disease and those with diseases caused by Te Lak. She also works on legs that swell. Nevertheless, she only does this if someone seeks care from a health facility and fails to get better. That is when she comes in – if you fail to improve, then she works on you – Interview with Health Management Unit Committee Member.

The specialists engage in popular livelihood activities within their communities. These are diverse and generally fall in the realms of agriculture and business. Every specialist I interacted with was engaging in agriculture as a subsistence farmer and a labourer on someone's farm. It is common for a specialist to offer labour at a farm owned by an individual who previously sought care from the specialist. The specialists are paid between 2000 to 3000 Uganda shillings (less than 1 euro) to dig a four-by-ten-meter piece of land. This is paid daily, weekly, or monthly. Some, however, opt to be paid in kind. It could be cassava, millet, or any other type of food that the landowner possesses. The food given would be equivalent to the amount owed.

There was a specialist who was part of a peer farming group. She was recruited into the group by someone who had sought care from her. The group consisted of 5 women. These women dig as a group on every member's piece of land. The specialist was happy to have been introduced to this arrangement as she could now prepare her land for planting before the rainy season. She was also happy that she could now cultivate more land acreage and harvest much more produce.

It has been two years since I joined those women. I used to see them dig together, but it never occurred to my mind why they were doing so. One day, I passed by where they were, and one woman stopped me. She told me that she suspected her daughter could

have malaria caused by Te Lak. We agreed that she would bring her child later in the day. She did bring the child. Before she left, we talked about why they work as a group. She told me that I should try it out. I agreed. It has been two years since I joined. The good thing about it is that we can prepare our lands early before it starts raining. I also now have food because they helped me dig a bigger piece of land – Female Specialist_07.

Some specialists were engaged in the retail business. For example, two female specialists are in the bar business. They make and sell local beer made of millet and water. There was also a specialist who was moulding clay pots for sale. The specialists who are paid in kind (with food items) after labouring at farms sometimes sell off part of the food. This was common when a given specialist did not have any money at hand to cater for other emerging needs. It was also common for specialists to sell off almost half of their agricultural harvest. It is never a preferred choice but rather a response intended to secure money to cater to ever-emerging needs.

Many specialists constantly struggle to meet the needs of their families, particularly food and health needs. As a result, specialists occasionally asked me to assist them in meeting some of their household needs. However, this was not particular to specialists but also to the caregivers I worked with.

I find it hard at times to feed these children; there are times when we have only one meal a day. I am struggling to fend for them. These days' children get sick often, and finding medicine is quite hard. You can go to the drug shop and get medicine, but sometimes you do not have money. You can go to the health centre, but it is far away from here. I need money to pay the motorcycle rider – Female Specialist_04_02.

Some specialists were part of the Village Savings and Loans Associations (VSLAs). These are associations where members are expected to make weekly contributions to the savings fund. This money was being loaned out to members at a low interest. I took part in one of the VSLA meetings. The members discussed many issues, including contributions and loan repayment default. The specialist was one of the members that had defaulted and were tasked to explain why she had not made contributions for the past weeks. She explained that she had not treated

anyone in the past weeks and had not earned any extra income from her other engagements. She kindly asked that she pays in the coming weeks since she was about to harvest her agricultural produce.

6.5 Discussion

Te Lak specialists position themselves as having an advanced understanding of child health compared to biomedical practitioners. This differentiation is strengthened when biomedical practitioners seek care from Te Lak healers. However, legal sanctions impose significant constraints on this stratification. For example, healers are forced to refer critically ill children to biomedical facilities to mitigate the legal risks that come with the death of the child in a non-state-sanctioned medical space. This underscores the healer's ability to adapt in the face of adversity. At that moment, the healer is cognisant of the law and bases their decision on legal provisions rather than the locally prized medical knowledge. These adaptations demonstrate that specialists are influenced by the institutionalised authority established through the public health legal framework. In such instances, the legal systems reinforce the dominance of biomedical authority (Cloatre, 2019).

Nevertheless, community-level power structures play a crucial role in empowering Te Lak healers to challenge biomedical dominance. Their support aligns the healer's role with community expectations of a health expert. By reinforcing the healer's role as a trusted health expert, these structures align with community expectations, enabling Te Lak healers to resist biomedical marginalization (Camara, 2014).

Te Lak specialists hold diverse roles that cut across traditional and biomedical systems. One of the male healers was recruited to the village health team, the lowest-level cadre of Uganda's health system. Several female healers were trained as TBAs through the global safe motherhood campaign.¹⁴ Some are trained in treating other locally defined disease-causing pathogens. The

¹⁴ The Safe Motherhood Initiative was introduced by the World Health Organization in 1992. The overall objective of the initiative was to train birth attendants in evidence-based early pregnancy risk detection and referral protocols for high-risk pregnancies.

coexistence of traditional and medical roles highlights the adaptability and resourcefulness of Te Lak healers within the community. This integration not only strengthens their influence in the medical realm (Witeska-Młynarczyk, 2015) but also enables them to navigate the dominance of biomedical authority (Biehl & Locke, 2010).

Beyond the healthcare domain, the specialists participate in agriculture, business, and social support activities in the community. The activities within these social fields mirror the livelihoods of the clients (Camara, 2014). In assuming these non-medical roles, the healers disrupt the traditional healer-client power hierarchies as they depend on their close neighbourhood for resources or support. In such cases, the healer's authority may not be recognised, as the social relationship is no longer rooted in the healing expertise.

The relationship between Te Lak healers and biomedical health practitioners is marked by tension and contestation. Biomedical practitioners commonly utilise narratives that frame local healers as unscientific or even harmful (Akol et al., 2018), reinforcing the global power structures that position biomedicine as the sole authoritative health system. However, Te Lak healers and elders counter these narratives by highlighting their role in supporting communities in their reproductive abilities, particularly in repopulating their land after years of civil war. This seems, however, to be in contrast with findings about reproductive rights among female adolescents (Bakessiima et al., 2021, 2023). These studies suggest that there is interest among female adolescents to use modern contraceptives. The healers' assertion that they support reproductive abilities illustrates a broader understanding of health beyond its physical aspects, contrasting with the more clinical approach to health. While their perspective is culturally significant, it diverges from global health objectives that prioritise reducing child mortality through scientifically proven interventions.

CHAPTER 7: DYNAMICS OF EXCHANGE

7.1 Introduction

Anthropological literature on health and healing is interested in monetary and gift exchanges practiced in care relationships. The ethnographies examine how these practices are shaped by cultural, economic and moral structures. Van Dijk & Dekker (2010) edited volume explores the commodification of health and healing across various African societies to show how traditional healing is increasingly influenced by market forces. On the other hand, Krah's (2019) study on the cultural economy of healing among the Maprusi people in Northern Ghana, shows that traditional healing is deeply embedded in a system of gift exchange. The ethnographies illustrate the dual nature of exchanges that happen in healing, as both socially significant gift and a commodity gradually shaped by monetary systems.

This chapter focuses on the “micro-processes of exchange” that emerge in Te Lak treatment encounters (Panella & Thomas, 2015, pg. 4). It examines how these exchanges position Te Lak as both an object of trade and as a gift embedded in cycles of reciprocity (Marques, et al., 2021). By attending to these dual aspects, the chapter analyses the physical, social, and symbolic aspects of money and gifts exchanged to illustrate the emotional and moral complexities inherent in the enactment of exchange practices. Finally, the chapter attends to how healers creatively use money and gifts (Guyer, 2018) to maintain their lifestyle and social status.

7.2 Payment for Treatment Services

Most of the Te Lak specialists I interacted with levy a charge for their services. This is one of the issues discussed in the first consultative meeting between the specialist and the caregiver. The intent of holding such a meeting is to agree on the terms of treatment. In instances where such a meeting is not held, it is plausible that the caregiver knows how much a given specialist charges. The specialists prefer to be paid in monetary form. This is within the range of UGX 2,000 (5 euro cents), and UGX 7,500 (1.9 Euros) for each child worked on. However, they ask for a single

charge when treating twin children. This is because they do believe that twin children are one person.

I know you have been interacting with Akello (pseudonym). I did attend to her twin children. Twin children are not like any other child; they are different – when we met at first, she was worried that she would not get the UGX 15,000 to pay me. That is why she had taken long without coming to me. However, I told her my sister Ocen and Opio are one child. You do not have to pay UGX 15,000. You just come with UGX 7,500. She was happy. She went back home to look for the money – Female Specialist_07.

In-kind payments, particularly agricultural produce, are also accepted. This should be of good quality and a given quantity. This could be ground nuts, sesame, millet, beans, cassava, or pigeon peas. This form of payment is common after harvest. The specialists also accept chicken in return for their services. This should be a hen, not a cock since a cock cannot reproduce. They also accept household items (e.g. sugar, a bar of soap).

Some specialists have a fixed price for their services. When paid in-kind, they expect someone to offer items equivalent to the money they often charge. They always reserve the right to value the items brought. The specialist can ask for additional items if he or she thinks the item (s) brought is not equivalent to the amount of money he or she charges.

There was a time I requested a Kwanyo Te Lak specialist to demonstrate how she makes a "siliki" and prepares the herbs she uses. The specialist agreed but requested that I offer something to compensate for her time. She did not specify the charge, so I had to decide what I could take. I asked around, and many people suggested that I take paraffin and maize flour. Indeed, this is what I took. I did offer her the items after taking me through the craft of making the "siliki" and preparing the herbs. However, she was displeased with my offer and asked that more be provided. She said that what I had brought was not worth her time and asked that I give her an extra UGX 5000 (1.3 Euros). When I asked her about how much she charges and how she reaches that charge, she had this to say.

You can either come with 7,500 (UGX) or a hen – one cannot just bring any hen to me. I should be pleased when I look at this hen.

Probe: What do you mean?

Response: One day, some lady brought me a hen that looked so bad. I think it was about to die – she probably picked it since she knew it would not last long. I knew she had many hens at home, so I refused to accept such a hen. I like hens that are good-looking, one you look at and right away think of eating chicken – when I looked at what she had brought, I could have sold it at 2,000 (UGX), but I wanted something that I could sell at about 7,000 – Female Specialist_07.

She also told me that she asks her clients to put the money on a coin that her mentor gave her on the day she was initiated into a healer. She was given several items of that day (a calabash, two gourds, a bicycle spoke, and a coin). The money is placed on the coin so that other parents can bring their children for treatment.

Some specialists had a flexible price for their services. They were open to negotiations with the caregivers. They are often observant of other factors when deciding how much one should pay. Their decision on the amount to be charged could be reached after considering the state of the local economy. They would charge a higher price if there was enough money in circulation. This is at the time when community members have just sold off their agricultural produce. Some specialists charge urban dwellers more than those that stay in villages. It is presumed that they have better access to money. These specialists also tend to charge a caregiver that has sought care from them for the first time more. This client will pay less if he or she becomes a regular customer.

I attend to children within Oluwa but also go to Cwero to treat children. When someone comes to my home in Oluwa, she will pay 3,000 (shillings). When I go to Cwero, the parent has to pay more. The people in Cwero have money. They are not like those in Oluwa – Female Specialist_13.

Well, now people are poor, you go to the bar and see if you will find that many people. Even those that are there do not pay. They only promise the attendants to pay later on. So, for now, I ask for 3,000 (shillings). However, about two months ago, people had money. You find them drunk early in the morning. They had just sold off their harvests. That is the time I charge more. Anyone that needs my services comes with 5,000 (shillings) – Female Specialist_04_02.

She could ask for about 5,000 (shillings) or more. Those women tend to charge more when it is your first time to seek care from them. However, if you become a regular client, they charge less – Interview with Local Council 1 committee member.

The payment could be remitted after treatment, or the parents could make a promise to pay later. This happens when the parent cannot meet the cost at that time. The parent will negotiate with the specialist, and the two will agree on when the payment can be made. Sometimes the specialist has to wait for months before he or she is compensated. This is common when an in-kind payment is agreed on. For example, the specialist would have been promised payment after a harvest. There are, however, times when harvests are so poor, especially if the community experiences a long drought. The specialist will have to wait many more months before any payment is remitted to him or her.

We attend to many people not in a position to pay at that time – we talk as older adults and agree. You know things are not as easy as they are where you stay. I did agree with my neighbour. He begged that I work on his child. I did agree, and he promised to give me lapena (cow peas) after harvest. I had seen his garden of lapena and was confident he would get some good harvest. Unfortunately, a month later, the lapena started to dry up. It was shining a lot at that time. I looked at the garden and could not believe I would not have a share of the lapena. I now must wait; I know he will plant Lapena again; it will rain, he will plant it – Male Specialist_09.

Some specialists do not accept later payments at all. Notably, most such specialists had spent less than five years as healers. They told me how people often fleeced them in their early days as healers. Their mentors had also had similar experiences. They did not want to go through a similar ordeal. When caregivers come to them for care with the promise of paying later, they always ask them to try some other specialists or go home and only come back for care when they get the money or items to offer in return for health care. One specialist advised that later payments contradict their communal norm of offering something in return for service received.

I do not treat those children, and if the parent cannot pay me at that time, then she better finds another person that can treat their children. Then, if the child is not so sick, she can go home, look for the money, and afterwards come back. Let me tell you, my mother was a soft-hearted person. Women would come to her and explain all their problems and then ask that she works on the child – they promised to pay later. However, those women never paid my mother. This also happened to me when I had just started. So, I learned that I could not trust these women who came to me crying for help. If you want me to treat your child, come with the money – Female Specialist_11.

If someone comes and asks that I do it now and that he would pay later, I never accept. According to our tradition, we are expected to offer something in return for a service given. It could be money or something else. It is hard for one to refuse what someone has brought, some bring sugar or a bar of soap, and practitioners accept, it is hard to refuse what a sick person has brought, but you must come with something – Female Specialist_07.

I indeed came across women that had been forced to postpone treatment as they did not have anything to offer as payment. Instead, they were angry at their husbands for failing to meet their children's health care bills.

When I reached home, I told my mother-in-law that the practitioner asked for some money, and if I could not get the money, I could take a hen. She told me that I had to wait for his son. He was the one supposed to give me the money. When he returned at night, I

told him the child had contracted Te Lak, and we needed to take her for treatment. He said he did not have money. Imagine! That he did not have money. Nevertheless, he came home smelling alcohol—these men. So, I had to wait for days – Caregiver_09.

One caregiver decided to borrow from a VSLA so that his child could receive treatment for Te Lak. Other parents decided to go and hoe someone's land to get money. One parent asked the owner of the land to offer cassava as payment since he was only willing to pay him at the end of the month. The parent then approached the specialist and asked that she accepts cassava as compensation for her service.

It happens, and one can understand why they do so. You know they buy "silikis" and Pen V, so we also must have the money to pay them. We met and talked, and she said she could not treat my child if I did not have money. The good thing we had in the past started an association with other people in the village. So, I went to the chairman and asked that my loan application is accepted. The chairman knows how bad Te Lak is. So, he did not delay. He asked the treasurer to give me the money. I then took the child for treatment – Caregiver_25.

Hmmm, it was a long story – I came back late in the evening, and my wife told me that Mego (elder) had refused to attend to the child. I did not sleep well that night. I kept thinking about where I could get the money. Finally, my wife advised that we go and dig at Onono's farm. I did not like to but had no choice. So we went, and he gave us a piece of land. When we were done, we asked for the money, but they told us we would be paid at the end of the month. Oh, my wife started crying. We had made a wrong decision. She then asked him if we could be given cassava. He said it was okay. I turned to her and asked why she was asking for food now. She told me that she could offer it to the specialist. Well, we took the cassava. Surprisingly, she accepted the cassava – Caregiver_26.

There is a specialist who only accepts later payments from caregivers who stay within her close neighbourhood. Those who do not stay within are expected to make on-spot payments since it

would be hard to follow them up if they do not honour their promise. However, if the child is severely sick, the specialist is not concerned about whether the caregiver is able to pay or not. Instead, priority is given to saving the child's life. This practise is common among many specialists. Some were not accepting any payment (even when the caregiver had it at hand) until the child regained good health. They are, at the time, unsure if the child will regain good health and thus see no need to receive payment.

When someone is from a distant place, that person must give me that money immediately. Those that stay within, for them, it is fine. If they take longer to pay me, I can quickly knock on their door.

Author: Let us assume this individual you cannot trust with debt comes with a severely ill child. What would you do?

Response: That is quite different. I cannot chase away that parent. I forget about the money and see that I am helping the child. The parents I am talking about seek my services when the children are not sick or when the sickness is not that bad. I do ask those to leave until they get the money – Female Specialist_03_06.

When I see a child vomiting with a yellowish body, I do not even think about the money. I rush to my house, pick the calabash, go to the bush, and collect belwinyo (tick berry) if I do not have Pen V (penicillin V potassium) and work on that child. I do not ask for payment from the parent – yes, even if that parent has the money at that time. I ask him to keep it and only give it to me when the child gets better.

Author: Why?

Response: We are paid to help children to get better. When a child is in such a condition, you cannot be sure if they will get better as you can be when treating children, not in a similar condition – Female Specialist_07.

Some specialists go on to treat the child even though they are not sure that the caregiver would pay later. The prime interest of these specialists is for children to regain good health. They described children as innocent beings who should not be denied services because their parents failed to meet a charge. One of these specialists disagreed with me when I suggested that what they are given is a form of payment. She preferred that I look at it as a gesture of appreciating their work.

The service we offer is about helping the child. I cannot refuse to work on a sick child because the parent has not brought anything. What wrong would the child have done? Why would I punish the child? It is not like they are paying us; they appreciate what we have done. Even if they do not appreciate it, I know God appreciates – Female Specialist_06_03.

That cannot stop me from treating the child. Life is more valuable than money, soap, and sugar. My mother asked me to help people within her community just like she did when she was alive. So why would I chase someone away because of money? I cannot – Male Specialist_09.

One of these specialists does not remind the parents of their promise of offering something in return for the service offered. To him, this was not a debt. Instead, it is a token of appreciation that one has to offer at their own will. Indeed, he had no problem assisting such a parent if he or she sought care again. His priority is to fulfil his mother's (trainer's) wish that he continues helping children as she once did.

If the parent does not have anything to offer in return, I operate on the child. I never remind her that she promised to offer something in return. I never make demands. I know of so many people that have never brought what they promised, but I cannot tell them to. I had a dream, and my late mother told me to help children. That means I should not prioritize the money. Even if such a parent comes back looking for help, I would still attend to her child – Male Specialist_09.

Some specialists repeatedly complained of parents that failed to pay them within the agreed time. A few had lost hope of ever being paid. They had asked the parents to do odd jobs as compensation for the earlier treatment services. Some resolved to report such matters to the local council one authority. The members of the authority call on both parties to discuss the matter at hand. Negotiations ensued, and a new payment period was agreed upon in all cases I learned about. This time, the agreement is put in writing and witnessed by a member of the local council one authority.

Quite many. Even those women that stay down there have not paid me yet. I have now told them to collect firewood and bring it to me. If they do, I will forget about their debt with me – Male Specialist_05.

They do not want to pay, yet they beg you to help them. So, I decided to report the case to the chairman. She had promised to bring the hen and the money in January. The chairman called us. She was asked why she had refused to pay me. She said her husband was living with another woman, and she had not seen him. However, she was lying. I told the chairman that I had seen him around a few times. The chairman then asked her to write in his book that she would pay me next month. She wrote what the chairman asked and put her name at the end of the text. I am waiting to see if she will pay me – Female Specialist_04_02.

There was a specialist who never engaged caregivers in a conversation on what to offer in return for the treatment service. She did not have a specific price for her services or expected anything in return. However, she understood the token was often passed on to her as an act of recognition that she had performed the treatment procedure well. I would get to know that she conducts voluntary treatment follow-ups to see if the child is well whenever the parent decides not to offer a token of appreciation.

I do not have such conversations with the caregivers. I used to, but I no longer do. All I do is help people. If someone appreciates your work, he can give you anything. I do not even ask for hens. If someone thinks I deserve a hen, she could give me one. When

someone does not offer something, I get concerned. I keep asking myself whether I did treat the child well. What I do is I go to their home and check on the child. I could have performed it poorly— Female Specialist_06_03.

Three specialists were offering free treatment services. One had agreed to offer free treatment services in exchange for forgiveness from the community for her engagement in the Holy Spirit Movement, an armed struggle against the current government led by Alice Lakwena. The second specialist explained that his call is to help children and not to gain from their misery. The third specialist was only handling her children and her relatives' children. She explained that her motivation for being a Te Lak specialist is not to earn an income but rather to be able to avoid expenses she would incur when someone else treats her child.

My services are free. Guess you have already forgotten what I told you – that is what I promised the people in this community. They only forgave me because I agreed to treat their children at no charge – Female Specialist_15.

I only treat my children. At times my aunties send their children. I do not ask anything from them. I like it because I do not have to take my children to someone else for treatment. I can use the money that I would have paid for something else. We have many needs; we need the money— Female Specialist_02_01.

7.3 Reaping from the Art of Treatment?

Some specialists found the practice to be lucrative. Indeed, they smiled when I asked them about the material benefits they had gained as Te Lak specialists. One would confess that that is one of the reasons why she decided to pass on the art to his child, grandchild, and stepson. Her son was happy that he was going through traineeship. He was hopeful that he should also earn a lot from the practice as his mother did so that he could support his family.

I was able to complete S.4 (lower secondary level) because of the money she earns from treating Te Lak. I am also hopeful that I will also be able to support my children so that

they attend school. Te Lak is common. For each child, I will be charging 5,000. I treat about ten people monthly; I would have earned 50,000 (shillings). That is some good money. There are a few people that can earn that in a month.

This specialist told me how she had invested the money that she had received from the caregivers. She had bought hens for rearing. The hens reproduce, and she only sells off the cocks. It was only when the stock of hens got to 100 that she sold them off. She then invested the money she got in tomato growing. It is through tomato sales that she earns some good money.

I did not just keep the money in my pot as many people in this community do. Whenever I get paid, I buy a hen or two of them. You never know someone might be so badly off, and you get a good deal. That went on for years. Whenever they reproduced, I would keep the hens and sell off the cocks when they matured. I aimed to have about 100 hens. I knew I could sell them off, get the money and start the tomato business. Someone had told me that it is a good business. So that is what I did, which is why I have a tomato garden. So far, I am not complaining; been able to earn – Female Specialist_13.

Two herbal specialists were skilled in a therapy that required using a hen to cleanse the medicine offered to the child. This was done to send away evil spirits that could have gotten into the medicine. The specialists expect the caregiver to come along with the hen and leave it behind after treatment of the child. These specialists had a good number of hens. These could easily be seen loitering around in their homesteads. They do sell off some to meet their daily needs. The parents that prefer this therapy also must pay money for the service they would have received.

I do own many chicken. You look all around my house. You will see the chicken. They are mine. When the parents tell me they want to treat their children, I tell them they must come with a hen. You know we usually conduct this procedure at a time when the evil spirits are leaving to rest, so we need to swing that hen over the medicine so that we chase away those spirits. I hold the hen by its legs and then swing it around the medicine as the parent is seated in the doorway. Afterwards, the parent leaves the hen behind – she also must pay for treating her child – Female Specialist_04_02.

Some caregivers who had decided to stop seeking care from Te Lak specialists thought that some specialists were well off. However, they argued that the only reason specialists claim that they treat Te Lak is to continue earning money but not because the therapies they administer work.

People like me have realized that these practitioners want to make money, nothing else. They claim that Te Lak causes illnesses, yet it does not. I did not treat my child's Te Lak, but they are alive – Caregiver_21.

Some specialists disagree with those that think that the treatment practice is lucrative. They told me that the money they are paid is spent on the same day on the ever-existing household needs, especially medical treatment, and food. Some use the money as a top-up for the child's school fees. These specialists kept wondering why people think they gain a lot from treating Te Lak. They reminded me that the caregivers often cheat them.

People think I know you could also be thinking that we earn a lot from treating Te Lak. This is not the case. Last week I treated the child. I got paid, but I went to Apem to buy salt immediately. We also did not have soap. Days later, my husband fell sick. I had to pay for transport to the health centre. The money was not even enough. We had to walk when we were coming back home – Female Specialist_11.

We use the money we get on that day if you are lucky enough to attend to a child whose parents are willing to pay you on that day. Unfortunately, we earn nothing. Some of those parents do not pay us. They promise they will bring the money but do not – Female Specialist_12.

I learned that, at times, specialists choose to attend to activities other than treating the child. For example, the specialist and caregiver agree on a day, and time the child will be treated, but the specialist fails to honour the appointment. In all cases, the specialist had chosen to attend to an activity that was better earning.

Some woman asked me to come and assist her child in delivering, so I had to leave, and you know one can be given a goat after assisting a woman to deliver, so I had to leave. Akello had to wait. We have now agreed on a new date. I will treat the children on Friday
– Female Specialist_07.

7.4 Discussion

Unlike other healing traditions (Lanoue, 2023), some Te Lak healers offer treatment without expecting compensation. This practice is common among healers compensating for past transgressions, for example, participation in armed conflict against their people. In such situations, healing becomes an act of moral restitution rather than a transactional exchange. Several healers value receiving gifts, not as compensation but as a recognition of their authority and expertise (Peebles, 2015). Often, their commitment to providing treatment is based on the desire to improve community health rather than material gain.

Monetary transactions are gaining prominence among some healers. Some have a fixed price for their services, while others adopt a more flexible approach. They do adjust costs in response to local economic conditions, charging more when agricultural income increases, especially after harvest seasons. Increasingly, gifts are becoming commodified with healers assigning monetary value to the items received. In instances where the gifts do not equate to the expected cost of treatment, clients are required to provide additional compensation. This reflects the growing influence of the money economy on the healer-client relationship (Ahmed et al., 2023).

Notably, the increasing commodification of the healer-client relationship is shifting the priorities of some healers. They are moving away from their traditional healing obligations and focusing more on income-generating activities. Dini's (2024) study on Somali traditional healing shows that such dynamics underscore the challenges healers face in balancing spiritual and community roles in increasingly monetised societies. The need for economic survival introduces pressures that justify prioritisation of other activities that are more economically viable.

Compensation for treatment services can be made immediately or deferred. When made on the spot, the transaction resembles a short-lived market exchange which are one-time transactions without long-term obligations. However, when deferred, this establishes elements of trust, debt,

and repayment obligations between the client and the healer. The two forge an ongoing trusting relationship based on the parties' verbal agreement.

Specialists who require on-spot payment sometimes deviate from this principle. This is common when treating children in their immediate community. Notably, this is not exclusively voluntary. Demand for on-spot payment implies denial of care for children. The community perceives this as an abdication of their social responsibility and erodes their credibility as unique social agents. By forgoing demands for immediate compensation, the specialist maintains their social position in the community (Thomassen, 2015).

When payment is deferred, the healer-client relationship transforms into one of trust and obligation. Agreements to pay later create relationships of debt that are socially mediated and reliant on verbal or written promises. Failures to honour these promises often involve broader community interventions, such as mediation by local authorities or the creation of formalised contracts (Bolt, 2014). These deferred exchanges reinforce existing hierarchies and dependencies, particularly when clients must borrow money or rely on male providers to meet payment obligations.

Exchange practices have the potential to create social stratifications within the community. This is common when caregivers who cannot afford treatment are excluded from care. Such stratifications strengthen social inequalities, forcing caregivers to pursue alternative treatments or delay care until that point when they can afford the healer's demands. Such exclusions undermine traditional moral obligations (Guyer, 2018) that require healers to always support children to regain good health.

There are shifts in perception of healing from a moral obligation to a professional occupation. Many healers treat compensation charges as important for sustaining their role as providers in a family and enabling investment in other ventures. This trend has attracted new entrants to the profession and strengthened the commitment of healers to train successors within their lineage. Notably, this has deepened the connection between healing practices and economic logics (Latour, 2014; Tae, 2017).

CHAPTER 8: LOCAL PERCEPTIONS OF RISK

8.1 Introduction

Anthropologists are interested in studying local perceptions of risk to show the multiplicity of interpretations of danger, harm and safety associated with disease categories. By paying attention to the heterogeneous understandings, anthropologists highlight why some local disease categories are considered less dangerous by the population despite the presence of public health narratives that emphasise their severity (Nichter, 2016). Ethnographies have interrogated how this understanding is an integral part of everyday life where traditional explanations of illness take precedence over biomedical interpretations (Alaszewski, 2018).

This chapter is informed by the anthropology of risk, focusing on how caregivers navigate and weigh public health and local explanations of risk associated with Te Lak. It explores ways in which local discourses about harm and danger inform the parents' decision about whether to seek treatment for Te Lak or prioritise other concerns. It also examines how this decision is influenced by negotiations within families and communities as well as by ethical and moral considerations.

By paying attention to these processes, the chapter attends to the interplay of public health concerns and what really matters within the community (Kleinman, 2006), uncovering the tensions between everyday priorities and institutional discourses. In exploring diverse viewpoints, the chapter considers how popular and biomedical discourses about risk structure everyday life and influence perceptions of health, medicine, and harm. It also examines how competing discourses coexist and define what kind of institutions, expertise, and medicines are valued in the community.

8.2 Local Narratives on Risks Presented

Akello (pseudonym) was aged twenty-seven by the time I interacted closely with her, never completed the lower secondary level of education, gave birth to her third child in March 2016 at a local health facility and returned to her home in Karackirac on a sunny afternoon of the fifth day of March. I, in the company of my assistant, visited her home later that evening. We found

her bathing the child in a basin full of cold water. This is done out of the perceived need to cleanse the newborn of the 'dirty skin' contaminated by vaginal secretions and blood. From that day till 11th August 2016, we did interact with Akello at least twice a week to find out her child's state of health. The child was often attacked by flue until the third month when she contracted her first episode of diarrhoea. This illness episode went on for three days. Akello suspected that it could be Te Lak that had caused diarrhoea. She, however, had doubts as the colour of the faeces was yellowish and not greenish. As the month was ending, the child contracted a severe fever. Her eyes turned teary as she told me Te Lak had caused the fever. She informed me that she would seek care from a Te Lak practitioner in the following days before the child's health deteriorates to the point that the child fails to breastfeed.

Akello was so annoyed when I suggested she take the child to the government health facility for care. She asked if I was her friend to suggest such a thing. I got to know that her second-born child died, and she is sure it was Te Lak that killed him. By that time, she had decided never to engage in treating Te Lak again. She was at the time attending the Pentecostal church. The church leader had asked them never to engage in any traditional practice. The leader was particularly critical of those parents that have their children undergo Kwanyo Te Lak. He reminded them that Jesus loved children and would never cause suffering to any child. This reminded Akello of what she witnessed when her first child underwent Kwanyo Te Lak. She talked of how loud the child cried and the constant tears that did flow from the child's eyes. She sought care from the government health facility, the community drug distributor, and nearby drug shops when her second-born child fell sick. The sickness was on and off, and the last episode persisted until the child passed. The husband blamed her for the death of their only boy child. He did report the matter to the elders of the family, who deliberated about the matter. Akello told me of how she was scorned for being an irresponsible woman. She was repeatedly asked if she did not know that Te Lak kills. One of the elders slapped and caned her when she explained that the religious leader had asked her not to seek care from a Te Lak specialist. Currently, Akello strongly believes that Te Lak kills.

Many respondents, unlike Akello, had never seen a child with Te Lak die. Indeed, some speculate that Akello could have refused or delayed seeking care from a Te Lak specialist. They would explain that such deaths would happen if they did not have people skilled in treating such diseases.

I have never seen a child die because of Te Lak. That does not mean that it does not kill. Children do not die because we have specialists around treating Te Lak. If we did not have them, many children would have died, probably my children too – Caregiver_10.

Akello shared my proposal of seeking care from a government health facility with her sister. She came by my place and told me of how ignorant I was about Te Lak. She blamed that on the education I went through that subscribes more to Western medicine. She laughed as she commented that biomedical practitioners have found treatments for killer diseases like HIV and AIDS but have failed to find one for Te Lak. Akello eventually had her child treated for Te Lak. Her sister returned to where I stayed and asked that we go together and see how well the child became after undergoing Kwanyo Te Lak. I did agree. When I reached her place, I was asked to carry the child. Akello asked that I feel her forehead and back of the neck to see if they were still hot. She then opened the mouth of the child to show me where Te Lak was extracted.

Several other caregivers told me their children regained good health after receiving care from a Te Lak specialist.

Nevertheless, when Te Lak is removed, the child feels better because the thing that brings pain to the child will have been removed. Even the fever will stop – Caregiver_15.

I cannot explain this, but when the child goes through Kwanyo Te Lak, the child starts breastfeeding again, and the fever goes – Caregiver_17.

One day a parent brought a sick child to my mother. When the Te Lak was extracted, the child began breastfeeding – Caregiver_24.

8.3 Complications and Side Effects

The biomedical health practitioners who came to know of my research interest discussed the different complications and side effects that children go through when treated for Te Lak. They told me how a good number of children that have gone through Kwanyo Te Lak are battling anaemia. The health practitioners often spoke of how they attend to children who are excessively bleeding from their gums. They told me that, at times, they fail to handle the cases as the child required a blood transfusion. They then ask the parents to seek care from a health facility at a higher level, preferably Gulu referral hospital.

Caregivers who do not believe in Te Lak and its associated health care practices told me their friends went through similar experiences. Because of such experiences, they do not at all engage in any practice related to Te Lak.

I cannot; it disgusts me when I think of it. It is not important at all. Let me tell you what my friend went through. You will get to understand why. My friend had been looking for a boy child for many years. The husband even decided to get another wife because of that. However, finally, the woman had a boy child. When the child was about two months old, this lady came to me and said that he had Te Lak and was taking the child to the Te Lak specialist. I looked at her and laughed. I asked her to take the child to the health centre, but she refused. Anyway, she took the child. Hours later, she came back to my home crying. I asked her what the matter was. She told me the child was bleeding so much. I looked and asked myself if I should help her. Nevertheless, she was my friend. So, we went to Cwero (Cwero health center III). The facility was locked then, so we went to a drug shop within the centre. The women managed to control the bleeding but asked us to go to Gulu for further treatment. Now imagine such a thing, you have been looking for a boy child, you get one after so long, but you also want to kill that child. I am not among those who think that way –Interview with a caregiver.

The respondents who believe in Te Lak and its associated practices discussed the several complications and side effects of treating Te Lak. Nearly all complications and side effects were related to Kwanyo Te Lak. Kwanyo Te Lak specialists did admit that there are complications that could arise when Te Lak is extracted. They were, however, quick to add that the kind of training they go through enables them to avoid such occurrences. If it happens, they are able to manage it. They, however, did not dismiss the existence of poorly trained persons who conducted the operation poorly.

That depends on how skilful the practitioner is. I was trained for many years. It took me years and years to treat a child. My father waited until that time he thought I was ready. All that time, I was observing what he was doing. He showed me what to do, and I indeed learnt from him. Even when he thought I could be ready, he first asked me to treat my child. If I did it poorly, I would just have hurt my child. Nevertheless, I did it well, and from then till now, I have treated children so well without hurting them – Female Specialist_07.

I agree. Some people do not know how to extract Te Lak, primarily those who were not trained for long. One could help the mother for some time and think she can carry out the procedure; my friend, it is not that easy. Such a person could cut the child's veins, and the child will bleed badly. It comes out well for us who know how to extract Te Lak, but for those who do not, they might even remove the natural teeth, which may cause more complications – Female Specialist_11.

People talk of the child losing much blood – that never happens when I carry out the procedure. That can only happen when someone is not trained well. That person could have cut a vein, and thus the child loses much blood. If one removes the actual Te Lak, the child will lose very little blood. Nevertheless, even if I by mistake do something wrong, I know how to handle it. I will not be like these people who are not well trained – Male Specialist_09.

The health practitioners from biomedical facilities told me they had heard of instances where children died during Kwanyo Te Lak. In addition, some caregivers that do not believe in Te Lak claimed that they had seen children die as Kwanyo Te Lak specialists treated them. Kwanyo Te Lak specialists were, however, quick to dismiss such claims. They reminded me that they help children regain good health. Indeed, many would claim they would no longer be treating Te Lak if children died.

Yes, I have heard about that, but that is not true. When my mother came to me through a dream, she asked that I help parents whose children have contracted Te Lak. She did not say that I go around and kill children. I have worked on many children, and none has died as I was working on him. If it so happened that will be the end of engaging in Kwanyo Te Lak, why would I engage in a practice that kills children? All I do is help children get better – Male Specialist_09.

I did interact with parents whose children died days after Kwanyo Te Lak. Kwanyo Te Lak specialists agreed that some children die days after the treatment procedure. They, however, did not attribute the cause of death to the procedure. They did claim that the child would have had another disease other than diseases caused by Te Lak at that time. The parents also doubted whether the child's death resulted from the procedure. One asked for my opinion about the matter, but still, she found my answer illogical as she wondered how a procedure meant to assist a child to regain good health results in death.

No, no, no. It is not because of Kwanyo Te Lak. Kwanyo Te Lak does not kill children. If a child dies after the procedure, the child could have contracted other illnesses that were not treated – Female Specialist_12.

We have numerous diseases within our community, and Te Lak is one of them. The parent comes for treatment of Te Lak. I will treat the child, but I could fail to notice that the child is presenting with other signs. It could be that the child has Two Kal¹⁵ (millet disease) So, in the end, I have treated one sickness, yet the child has two. The child could die if the parent does not seek care for the other Two Kal – Female Specialist_13.

A couple of Kwanyo Te Lak specialists asked if I share a similar view with biomedical health practitioners that the therapy they administer leads to the death of children. I told them that I thought so. One specialist then asked, "why is it that parents that have lost their children days after undergoing Kwanyo Te Lak decide to bring their other children for treatment?" Another specialist did comment that these parents even seek care early enough out of fear of losing another child. They concluded that Te Lak never leads to the death of children but rather it helps the child regain good health.

Can the mother seek care from me again if it was I that killed her child? They cannot. They come to me when they find out the other child has contracted Te Lak. They do not want to lose another child. So do not believe in what the doctors say. What we do is for the good of the children – Female Specialist_08.

So, you also think like those people in health centres. We do not kill children. We make children better. Those parents you are talking about always come back when their other child falls sick. Hmmm, who would not come back? Can you choose to lose your other child? They do not die because of the treatment they get. The parents do know that. So, they bring their other children – Female Specialist_11.

I did ask for the caregiver's opinion on whom to blame when the child dies during and after undergoing Kwanyo Te Lak. Many were surprised when I asked such a question, and a couple of caregivers asked me why I thought there was anyone to blame for the child's death. They

¹⁵ Two Kal is a common "disease" category associated with symptoms of common childhood diseases e.g. malaria, pneumonia, diarrhea. It is treated by making small cuts on the chest and back and thereafter removal of fat which is commonly referred to as millet by the locals.

explained that death is natural and reminded me that I would also die someday. One added that when a child dies, God has come to that decision, and man has no control over whatever he decides. Another respondent would remind me that death has no bounds as those attended to in the best biomedical facilities also die.

What to do? She has died—nothing to do about it. You look surprised. You should not be. Why do you have to blame anyone? Haven't you seen people die even when they get care from the best health facilities? They do. You just have to move on with life – Caregiver_25.

It is God to decide on that. So even if they remove Te Lak when a child is meant to die, the child will die, there are children whose Te Lak was not removed, but they still live; it is all about God's decision; that is how he works. We humans do not make that decision. God does – Caregiver_16.

No one is to blame; the child has died; you must take her home for burial. Nevertheless, unfortunately, children die, and I think you know you will also die one day – Caregiver_12.

Many caregivers were concerned about the use of sharp objects during the treatment of Te Lak. They knew that this puts the child at risk of contracting HIV. In addition, they told me that many people within the community had contracted the virus and suspected some specialists could be HIV positive. One told me that this makes him second guess his decision to have his child go through the treatment of Te Lak.

Currently yes. The world is no longer safe. I did produce my children free of HIV/AIDS, but they could get HIV if the practitioner is HIV positive. That is possible if the practitioner does not use gloves when working on the child. They always use sharp objects; if that object pierces the practitioner, her blood will mix with the child's blood. The child will contract HIV. There is no other danger that Kwanyo Te Lak presents other than that – Caregiver_02.

Not all caregivers were conversant with the risk sharp objects pose to the child. I asked the caregiver who disagreed with anyone who thought that the treatment procedures threaten the child's health if he thinks a child can contract HIV during the treatment process. He was surprised that I asked such a question. He did doubt that I knew anything about HIV and how it is spread. He reminded me that HIV is spread through sexual intercourse.

HIV! Do you know anything about HIV? HIV is sexually transmitted. How is it related to Kwanyo Te Lak?

Interviewer: So, you have never heard that HIV can be spread through sharp objects?

Response: No, that is not possible – Caregiver_26.

Kwanyo Te Lak specialists knew that one could contract HIV during treatment. Some (particularly those that double as Traditional Birth Attendants) told me how they had attended trainings where they were told so. Many had heard rumours from within the community of such a possibility. The specialists reechoed that the government discourages people from sharing sharp objects. The specialists were taking precautions to ensure that either party did not contract HIV. Many were not re-using the sharp instruments, and those that did were sterilizing the instruments. Some (mainly Traditional Birth Attendants) told me they were using safety gloves to prevent contracting HIV.

Kwanyo Te Lak specialists and caregivers agree that the treatment has several side effects. Some told me that milk teeth do not grow in the part of the gum where Te Lak is extracted. In addition, some older children did not have permanent teeth in the part of the gum where Te Lak was extracted. One caregiver would claim that if the permanent teeth grow, it grows out of the usual lining of the teeth.

Extracting Te Lak is all about destroying the teeth of the child. Children who have gone through Kwanyo Te Lak take long to have their teeth – some even fail to grow them forever – Caregiver_13.

There will be a possibility that the child's teeth will not grow, or if it grows, they will grow out of the proper lining of the teeth. This happens when the practitioner cuts the nerves that enable the teeth to develop in the gum. Moreover, if one of the teeth grows, it will grow out of the normal position – Caregiver_19.

However, some caregivers and specialists told me that if Te Lak is left to grow in the child's gum, he or she will experience several effects and defects. The child will continue being sick. He or she will also have difficulties chewing when he or she grows up. Throughout his or her lifetime, the child will continuously have pain in the gums. Te Lak will grow into a tooth that will be brownish and will grow in front or behind the natural teeth.

Te Lak will finally grow into a tooth that will be brownish. It is never strong; it is shaky. Ultimately, it could fall out of the gum on its own. The child will also keep suffering from malaria – Female Specialist_11.

It brings many complications in adults. For example, it does not allow one to chew food well, the gum muscles are continuously paining, the Te Lak grows besides natural teeth, with that someone cannot eat well, and when that person takes cold food or drinks his teeth pains – Caregiver_31.

The child that has gone through Kwanyo Te Lak has a wound in the gum. This is not a big concern to the specialists since it takes a short time to heal. They were providing medicine that would heal the wound. One reminded me that they now provide biomedicine (Penicillin V Potassium and Iodine), which is more effective than the herbs. The specialists also informed me that they perform reconstructive surgery if the wounds fail to heal.

Okwaru (wound), our ancestors used to call it okwaru. Some children take about a week or two to heal. If that happens, then it is better to bring the child back. I use the siliki to remove the remains that stop the wound from healing – Female Specialist_13.

It does not take long to heal. It can take at most three days, and the child will be well. However, we do provide the child with medicine. If the parent can afford western medicine, I ask them to buy Pen V (Penicillin V Potassium). That works well. Within a day, the wound would have healed – Female Specialist_11.

The caregivers were, however, concerned about the wound in the child's gum. Some said that it stops the children from breastfeeding well. Others had to forego their daily engagements. Women in this community often work while back nestling their infant children. The specialists, however, advise them not to do so since this would open the wound. The children will also be so restless. This stops them from engaging in some activities, particularly hoeing.

The child does not breastfeed well for the first two days until the third day. I am not saying that the child does not breastfeed; she does better than before the procedure, but this wound makes it hard for her to breastfeed well – Caregiver_04.

It does stop me from engaging in my daily activities. By that time, the child could not be tied to my back. When one does so, the child's gums will hurt, and the child will be in pain. The wound has first to heal for you to do that. If you carry the child in that way, her mouth will swell. So, I had to do away with some activities like digging. I had to take care of the child – Caregiver_02.

You may not even be able to cook because the child would be restless and crying most of the time. I could only do some other work if the child got to sleep. The problem was that the child could not sleep for long – so you could not do a lot. Then, when the child wakes up, all you will do is carry the child. I also could not go to the garden – Caregiver_04.

Many respondents talked about the children's experience of pain when Te Lak is extracted. It was a common talking point for the church leaders. He often asked his followers if they would agree to engage in something that inflicts pain on their bodies. The caregivers were equally uncomfortable that Kwanyo Te Lak is a painful procedure. Many told me of how they ran away from the place where the procedure was being carried out as they could no longer observe their

children go through all that pain. One specialist, however, dismissed their concern as she reminded them that all surgical procedures, including those done in biomedical facilities, involve pain. To her, it is through pain that one regains good health.

You are talking of pain, but have you been to a dentist? If so, you should know that things to do with the mouth and their treatment are crude. You go to Gulu hospital; you will find older women crying as their teeth are extracted. It is okay to have pain. Pain does not kill someone. You must go through pain to get a better life – Female Specialist_12.

Many caregivers did not associate complications and side effects with using herbs to treat Te Lak. Indeed, some were no longer taking their children for Kwanyo Te Lak, but had chosen to use herbs to treat Te Lak. Most of the herbal specialists had similar thinking. They furiously dismissed any suggestion that herbs present complications and effects to the child. One advised caregiver's to desist from taking their children to Kwanyo Te Lak as it puts the child's health in danger.

Nothing happens to the child. It is all about rubbing gently on the gums; the child could take some liquid afterwards. The problem is with the extraction of Te Lak. I ask parents to always come to us. Kwanyo Te Lak is bad. So, the child stays with a wound in the mouth – Female Specialist_04_02.

There are no dangers related to the treatment I offer. The child does not bleed and is never in pain. The use of herbs is easy and does not involve any pain to the child – Female Specialist_03_06.

One herbal specialist, however, disagreed with her colleagues as she explained that the child could be in danger if one provides him or her with an overdose. On the other hand, she advised that children that undergo Kwanyo Te Lak are more likely to experience several complications and side effects than those treated with herbs.

Even if God gives you the ability to treat people and you do it poorly, then you can kill people because you should not give herbs in excess. You should give a little amount proportional to the maggot in the child's teeth. If you give in excess, then you can kill the child. For us who use local herbs, we are like health workers. We know the amount to give out to the child-but a child whose Te Lak is extracted suffers much pain, the wound – Female Specialist_06_03.

8.4 Having other Children Undergo Treatment for Diseases caused by Te Lak

I did ask the caregivers if they would let their other child undergo treatment for Te Lak, given the probable health risks involved. Some caregivers had decided not to take any of their other children to treat Te Lak. These in the past had let their children undergo Kwanyo Te Lak on the premise that Te Lak could kill the child. Some found this untrue as their other children are still alive even though they were not treated for Te Lak. Others had reached that decision as the children went through certain complications or side effects.

I found out that removing the Te Lak is of no importance. They lie to us that your child will die once you do not extract Te Lak. My last two children did not go through it and are still alive. So, my husband advised me that having our children treated is unnecessary – Caregiver_03.

I had to excuse myself from seeing what was happening during the procedure. Finally, I could not take it anymore. It was a terrible experience. After the first child, I did not accept any more. The rest of the children, I said, "Shame on the devil, I will not remove Te Lak again". Even when my other children got Te Lak, I did not treat Te Lak. My other children have not gone through such an experience. Not even the last born – Caregiver_05.

Before that day, I did not know about the procedure done to treat Te Lak. I found out that the procedure brings much pain to the child. It is so painful. I have thus not taken my other children for Kwanyo Te Lak, plus I have not taken them for treatment of millet disease. I found out that they remove teeth – Caregiver_13.

However, many caregivers were willing to have their other children undergo treatment for Te Lak. They were aware of the complications and side effects associated with the therapies (particularly Kwanyo Te Lak), but this did not deter them from seeking care. One would ask me if I would decline to take a particular treatment when I am very sure that it is the only way that I could regain good health.

I know Te Lak brings about fever and diarrhoea. I also know that extracting it is the only way to treat it. So, I must. Would you refuse to take medicine when you know it is the only way to get better? – Caregiver_16.

The caregiver explained that the illness episode would continue if one decided to offer treatment other than that meant for Te Lak. I was told that there are parents that decide to seek care from health centres when the child presents with signs commonly associated with Te Lak. I was advised that these children never regain good health as the treatment does not heal Te Lak. The child's caretaker would eventually seek care from a Te Lak specialist. Other caregivers shared a similar opinion too.

I have seen some parents talking bad about Kwanyo Te Lak. They run to the Cwero (Cwero health centre), but the child never gets better. I look at them and wonder. I laugh at them. Cwero does not have medicine for Te Lak. In the end, they go to a Te Lak specialist – Caregiver_16.

If you take the child to the health centre, that child will never get better. The child could be well for a day or two and fall sick again. When that happens, you have to think of options other than the health facilities, and usually, the elders advise that we go to Te Lak specialists. Fortunately, when Kwanyo Te Lak is done, the illnesses heal – Caregiver_25.

Caregivers willing to have their other children go through treatment told me that siblings must receive treatment without fail if their firstborn was treated for Te Lak. The type of therapy should not be different from that administered to the firstborn child. A child will lose his or her life if the parent decides otherwise.

It is said that once you start extracting Te Lak, the practice must go on and on; otherwise, your children will be in trouble – Caregiver_07.

If Te Lak persistently presents illnesses to my second child, I will have to take the child for Kwanyo Te Lak. I have heard people say that once your firstborn undergoes Kwanyo Te Lak, the rest of the children will have to go through the same – Caregiver_14.

Once you start extracting Te Lak, you are supposed to do the same with the rest of your children. Like me, I started with my first child, which means I must do the same for the rest of my children; if I did not, I would have surrendered my child to death. So, it is culture – Caregiver_22.

Te Lak specialists and caregivers often reiterated that if the firstborn child of a given couple undergoes a given therapy, then his or her siblings must go through a similar therapy. They explained that the siblings would have fed on the same breast, which earlier came into contact with gums, where a given therapy was administered. They advised that a child does not heal if a therapy different from that administered to the firstborn child is chosen.

It depends on how someone has been doing it. If she extracts, she must continue with extraction for all children. If she uses herbs, she must do the same thing on all children – Female Specialist_03_06.

It all depends on the woman's nipples and how she has treated them regarding Te Lak. If it so happens that the first child you have breastfed has her Te Lak removed, then breastfeeding your second child would mean that that child must go through Kwanyo Te

Lak. That is the way it is. However, if it so happens that you did not take your first child for Kwanyo Te Lak but instead used an Acholi local herb, you will do the same with your second child – this happens a day or two after the child is born – Caregiver_02.

All my children have undergone Kwanyo Te Lak; unfortunately, when I try to use herbs or quinine, it can no longer work; Te Lak continues to grow because my first child got treated through extraction. I had refused to take my second child for Kwanyo Te Lak, but I had to. When your first child undergoes Kwanyo Te Lak, the rest of the children also must go through Kwanyo Te Lak. Other therapies will not work – Caregiver_04.

When asked why many respondents could not explain why the child does not heal, they said they were not told why. All they knew was that the child would not get better. A couple of respondents argued that the child would have contracted a type of Te Lak that can only be treated in a specific way.

These children feed on the same breast, meaning the first child breastfeeds on a gum where Te Lak was extracted. When my other children breastfeed on a similar breast, they will contract a similar type of Te Lak which can only be treated by extraction – Caregiver_04.

I know that if one accepts her first child to undergo the procedure, all her children must undergo the same procedure. That is how it is. Therefore, you cannot stop doing it if you have your first child go through Kwanyo Te Lak.

Author: Why is that so?

Response: Children feed on the same breast, so the first child would have used gums that underwent Kwanyo Te Lak to suckle her mother's breasts. Remember, these are the same breasts that her siblings will suckle. Nevertheless, this child would have contaminated the breast with Te Lak, which is supposed to be extracted. So as a parent, it would be best if you treated all your children – Caregiver_18.

The rule of administering a similar therapy to siblings could be broken if a woman breastfeeds a child who is not her own, that had earlier gone through a treatment procedure other than that of her children. It could also be broken if a child feeds on the breast that has in the past been fed on by a child treated differently from that of the child's siblings.

However, if it so happens that a parent breastfeeds a neighbour's child whose Te Lak was extracted, then for her subsequent children, she will also be extracting – Female Specialist_03_06.

My mother-in-law said we should take the child and remove her Te Lak because the child had suckled her breast. They say that once a child suckles the breast of a person who in the past breastfed her children treated with Te Lak, you must have your child undergo a similar procedure. You know, at that time, I did not have breast milk to feed my child. The grandmother of the child decided to help, but unfortunately, in the past, she had fed children that had gums where Te Lak was extracted. So, my child also had to undergo a similar procedure – Caregiver_17.

Some caregivers do believe that Te Lak is a genetically inherited disease. They were confident that children inherit Te Lak from one or both of their parents. They thus should ensure that their children's Te Lak is treated.

I know that my Te Lak was not removed, but the child's father had his Te Lak treated so the child could have more of the father's genes than mine. I also did not have my Two Kal treated, but my child had been treated for Two Kal probably because his father's millet disease was treated – Caregiver_14.

I inherited it from my parents. They also had their Two Kal, and Te Lak treated. I also had my Te Lak and Two Kal treated, so I must do the same for my children – Caregiver_20.

I think Te Lak was in the blood of our ancestors, and we inherited this blood from these ancestors. Let me give you an example; the father of my child is an Acholi, and in his family line, they have been having Te Lak. His children will also have Te Lak, and it is required that this Te Lak is treated. When Te Lak is treated in the family, generations and generations of children and grandchildren must undergo similar treatment. So, it would be expected within this family to treat this, Te Lak. Truthfully some parents do not treat their children Te Lak, and nothing happens to them. That is because their ancestors never engaged in this – Caregiver_18.

One caregiver did not think that the side effects of Kwanyo Te Lak could stop him from having his child treated for a life-threatening disease. He had chosen to preserve life over the temporary pain that the child goes through.

Once Kwanyo Te Lak is done, the child takes about two to three days to heal. You nurse the wound with warm water and salt, and the child gets better. The child will experience pain on the day the Te Lak has been removed. On other days, the child will be fine. So, I will have my other child go through the same. You cannot compare those small things to the loss of life – Caregiver_25.

8.5 Discussion

Multiple competing but co-existing narratives of risk surround Te Lak. These narratives are rooted in both public health and indigenous knowledge systems, illustrating the interplay of indigenous and biomedical thought (Holbraad & Pedersen, 2017). Broadly, the public health discourse argues that Te Lak therapeutics present medical risks. In contrast, healers and caregivers contend that biomedical practitioners overlook dangers associated with not applying Te Lak therapeutics, mainly the risk of infant mortality. This situation illustrates epistemic tension between public health risk assessments and indigenous conceptions of treatment.

This divergence in perspectives carries several implications. It presents a paradox where the perceived risk of treatment and non-treatment are in direct opposition. This results in a double bind where caregivers are caught between the risk posed by Te Lak treatments and the dangers of neglecting Te Lak therapeutics. Consequently, decision-making on appropriate care is delayed. Other caregivers may attempt to navigate biomedical and indigenous systems simultaneously, while others may switch between systems depending on the immediate perceived risk. There is also a possibility of losing trust in biomedical care, especially when caregivers believe that biomedical practitioners are dismissing their concerns. These dynamics place children at risk of receiving inadequate, incomplete or conflicting treatments.

The caregivers recognize some of the biomedical risks highlighted by the public health experts. However, they do not perceive these risks as significant. This is because they are not unique to Te Lak therapies but rather universal across health systems. Additionally, the caregivers and healers highlighted the harm reduction strategies embedded in the Te Lak healing tradition that are in place to mitigate these risks.

There are also risks that they outrightly dismiss, such as the claim that Te Lak treatment results in infant mortality. This contrasts the traditional belief that death is dictated by supernatural forces rather than human action. This local understanding of death reflects deeply rooted systems that prioritize spiritual and social explanations over biomedical ones (Streicher et al., 2023). This understanding holds greater explanatory power that eventually shapes what matters most to caregivers (Panter-Brick, 2014).

Indigenous risk discourse often outweighs the public health discourse. This seems, however, to be in contrast with findings about the institutional dominance of biomedical systems in defining and prioritizing health risks (Dew & Liyanagunawardena, 2023). The hegemony of the indigenous risk perspectives relates to the fact that decisions around care-seeking are deeply moral and relational rather than purely medical (von Scheve & Lange, 2023). When mothers choose to have their children undergo Te Lak treatment, they are not rejecting or disputing biomedical assertions about its potential harm. Nor do they fundamentally disagree with outsiders regarding the risks associated with the practice. Instead, their decision emerges from lived experiences shaped by previous encounters with social and medical norms. Some mothers who previously opted against indigenous therapeutics may have witnessed their child's health deteriorate or could have observed their child die. The death of a child in communities that endured existential threats during the 20-year conflict is often met with social blame and punishments from the community. The punishments often include physical beating, which exemplifies that normative health-related decisions are upheld through gender-based violence. In such a context, a mother's decision to pursue treatment despite known health risks is not primarily medical but moral. Adhering to Te Lak healing then becomes a practical way of mitigating the risk of social scrutiny and accusations of neglect. It is also a means by which female caregivers maintain their authority and status as mothers.

CHAPTER 9: CHANGE PROCESSES

9.1 Introduction

Ethnographies have long been interested in understanding the dynamics of change surrounding practices that have been identified as harmful. These studies explore how local populations comply, resist or adapt to the call by global and national actors to eliminate harmful practices. By attending to these negotiations, these studies highlight how harmful practices evolve (Hernlund & Shell-Duncan, 2007; Glover et al., 2018).

This chapter builds on this anthropological literature to examine the local politics of change surrounding Te Lak. Specifically, it explores the alternative practices, knowledge and institutions advanced by the local campaigns to eliminate Te Lak and their integration into everyday life. Emphasis is given to how the alternative approaches, insights and structures co-exist, compete, and interrelate with traditional practices.

Additionally, the chapter explores the dynamic and fluid nature of Te Lak healing system to highlight their adaptability and responsiveness to the local campaigns. It examines how Te Lak specialists incorporate biomedical logics and materialities into their practice. Attention is given to how these ideas and technologies are reinterpreted within the local frameworks to reflect the lived realities of the communities (Hardon & Moyer, 2014).

9.2 Context for Change

A health worker invited me to one of the integrated health care outreaches they were to conduct in Layongooye in Omel Kuru. Integrated health care outreaches are community-based health service delivery initiatives to remote or hard-to-reach populations where several health interventions are provided in a single outreach session, including maternal and child health, sexual and reproductive health, communicable and non-communicable diseases management, nutrition services and water, sanitation and hygiene education.

Layongoeyeke village is one of the ten most remote and hard-to-reach communities served by the two government health facilities in Omel Parish. Ideally, the outreach must be conducted once every three months, but a year had passed since the health workers last visited this community. People of every age group had come to receive health care. I could notice many children in school uniforms. I later learned that the school authority had decided to let children who thought they were unwell go and receive health care. I did interact with a couple of pupils, and the impression I got was that they were grateful for the opportunity to access care within their community.

The health workers first held a health education session about various issues, including malaria prevention and treatment. During the session, one health worker strongly condemned parents who believed that the cause of malaria was Te Lak. She said to the gathering:

"I am tired of hearing this nonsense from parents that Te Lak causes malaria, this kind of thinking should be done away with. Why would you let your children go through all that pain? However, unfortunately, we must handle those children after they go through those old-fashioned procedures. We are tired of having to talk about Te Lak. You better get it into your heads; Te (teeth) has nothing to do with malaria. When the child falls sick, bring that child to us. We are the experts and not them. They know nothing about malaria."

This was not the first time I had heard a health worker strongly condemn individuals that believe in Te Lak. For example, a midwife referred to Te Lak specialists as killers. She asked that when I know who they are, I should tell her so that she sees to it that they are arrested. I also did attend an antenatal care health education session at a government health facility. The health worker asked the mothers to desist from engaging in traditional health care practices, particularly treating Te Lak. She said to the gathering:

"I know many of you have heard about Te Lak from your neighbours, parents, and husbands, and I am sure some of you took your children to treat Te Lak. They have lied to you that Te Lak causes illnesses in children; unfortunately, you believe in what they

said. I will tell you the truth about what you call Te Lak. There is no way Te Lak can cause illnesses in children. What you call Te Lak are teeth growing in children. Let me put it in simple terms that you can understand. You fall pregnant, and it takes nine months for the child to grow within you; you later give birth to that child. That is when we get to see the child that has been growing in you. It is the same thing with teeth. Teeth first grow within gums. After some time, those teeth will come out of the gums. What you refer to as Te Lak is teeth in their early stage of development. Let me emphasise this; there is no way teeth cause illnesses in children. So please do not believe what those people say, it is a mosquito that causes malaria, and good thing we have given you insecticide-treated nets. So, use them, and if the child falls sick, please do not go to those claiming to treat Te Lak but come to the health centre."

In my discussions with caregivers, I learned that health workers punish caretakers of children who have let their children undergo Kwanyo Te Lak. The caregivers reported that the professional health workers verbally abused parents, and care is denied. It is common for a caregiver to delay or opt not to seek care from health centres when the child has just gone through Kwanyo Te Lak. The repercussions are worse if this child also underwent treatment for Two Kal (millet disease). Discussions with caregivers show that health workers get a razor blade and cut on the carers' body so that he or she gets to know of the pain the child went through.

If you go to the health centre when the child still has that wound, they chase you away, so when the wound has not healed, I do not bother taking my children to the health centre because I will be chased without medication – Caregiver_20.

They would abuse me for doing so. They might even refuse to offer care to the child. Furthermore, if you ever let your child go through the treatment of Two Kal, then that would be worse. A friend I know went with her child to the facility and had just undergone treatment of Two Kal. The health workers were furious, and one got a razor blade and cut the arm of the woman. She then asked her "How does it feel?" – Caregiver_06.

A caregiver expressed her anger at the conduct of health workers towards people that have their children treated for diseases caused by Te Lak. She did assert that the health workers were ignorant of their culture and thus did not know how deadly Te Lak is.

Those health workers are not sensible enough. They do not understand the importance of Kwanyo Te Lak. They do not know that this is part of our culture, and we are supposed to embrace it. If not, we will lose our children to ill health – Caregiver_06.

The caregivers whose children had undergone Kwanyo Te Lak resort to seeking care from drug shops when the wound (okwaru) is still visible in the child's gum. As earlier noted, this is out of fear of the punishment they could receive from the health workers in government health centres. The drug shop attendants do not mind the presence of okwaru in the child's gums.

I just went to a drug shop. I did not go to the health centre. Those in drug shops do not care, but if you go to the health centre and they find out that you had your child go through Kwanyo Te Lak, they will abuse you and might even refuse to work on the child; actually, that is why one has to wait till the wound heals and then that is when they can seek care from the health centre – Caregiver_21.

I did have a hard time convincing Te Lak specialist to take part in this study. The first three specialists I approached told me they no longer offer treatment. One commented that only stupid people still engage in such practice. The fourth specialist was willing to participate but was doubtful whether my intentions were only research related. She was only willing to be part of the research if her son advised her to. Her son did work in Gulu town but occasionally came back over the weekend to see his wife and kids. Eleven days later, I got to meet her son. Fortunately, he could read, so I handed him a letter from the Uganda National Council of Science and Technology that permitted me to carry out this research. Upon the advice from her son, the specialist agreed to participate in the study. Later, the three specialists I approached first also agreed to be part of the study. They earlier thought I was part of the authorities that had arrested one of their colleagues in the past. I later interacted with the specialist, and she said:

Three people came into my home; one was in a police uniform. They asked if Alice (pseudo name) was around. I told them I was the one. They asked if I had recently treated a child with Te Lak. I told them I had. That is when I panicked. A few days ago, I refused to work on this child. The child was too ill. I asked her to take her to someone else, but she insisted. I opened the child's mouth, and the gum was full of puss. I cut the gum, but the bleeding was too much. Anyway, I removed the Te Lak. They told me that is why they had come to my home, and I should follow them to the police. I went with them. When I reached, I was put in a cell. I kept crying; all I did was try and help the child. Fortunately, the child did not die; if she had died, I would still be in prison – Female Specialist_07.

Indeed, the specialists I worked closely with often reiterated that they do not treat severely ill children. This is out of fear of being blamed for the child's death. The other specialist that treated a child in such a state had received orders from the local council chairman. The child later died, but she was not blamed for the death since she was just persuaded to treat the child.

She did bring a child with a high body temperature; when I was trying to remove the Te Lak, the child was not crying, so I decided not to do so, the woman pleaded with me, but I stuck to my decision. Moments later, she came home with the local council chairman. The chairman was furious. He asked why I would refuse to help a child in such a state. I then proceeded and worked on the child, but two days later, this child died. The good thing was it was not my decision to treat the child: no one could have blamed me – Female Specialist_11.

When my supervisor and I visited one of the families I worked closely with, the children's father, who had undergone Kwanyo Te Lak a few months ago, asked that we first pray. In his prayer, he denounced traditional health care practices.

"God, I thank you for this day. It is today that I first set foot in your church. The same day, a white person came to my home. I thank you, God. I came to you, God so that I can change. My family is involved in a lot of cultural practices. I ask that from today I take a

different path. As I take on this journey, I ask that you guide me. Her coming here is a sign that I have made the right choice. Amen."

Just like this gentleman, some caregivers told me how their introduction to Christianity had influenced their decision to stop engaging in traditional practices, including seeking care from Te Lak specialists.

I am now born again and can no longer allow such practices in my family. The pastor says that it is a traditional practice that is outdated. They tell us that as born again, we should desist from involving ourselves in traditional practices – Caregiver_12.

The pastor said that we should not engage in Kwanyo Te Lak. They told us that it is of no importance. It just brings about pain to the child – Caregiver_03/1.

When I got saved, I stopped treating Te Lak. The pastor advised that what we were doing was contrary to what God wished children to go through. So, from then, I stopped taking my children for Kwanyo Te Lak. So, my two last born children have not gone through Kwanyo Te Lak, and the treatment of millet disease, and they are alive – Caregiver_17.

In my interview with the head of a Pentecostal church, I noted a much stronger condemnation of Kwanyo Te Lak. He would cite bible stories and verses that are in opposition to any harm that one can cause to the child. He used the words savage and wolves when talking about people that engage in Kwanyo Te Lak. The narrative below is an extract from the interview.

I hope you have read the bible because I will make many references to it. As you may know, Jesus told his disciples to let the young children come to him. Let me tell you, Jesus loves children; to him, these are innocent beings that everyone should treasure. Now I am hoping you know what those specialists do to the children. They do get a sharp object and cut the gums of the child. Imagine! They are close to savages. They are wolves. They seek to drain blood from our children. Their children cry in pain, but these people never listen to them. They do go from one child to another, inflicting similar pain.

They are merciless. How, how, how can one hurt a child. How can one hurt Jesus' closest friend? In church, I tell my congregation to choose, should be at that moment, whether to follow Jesus or the devil that brings pain to children. Some of the children died because of Kwanyo Te Lak. No one has a right to deprive another of life. Fortunately, our God is a forgiving one. They will be forgiven, but the sooner they do so, the better – Interview with Church Leader.

Some caregivers have stopped seeking care from Te Lak specialists. However, some were still convinced that Te Lak causes childhood illnesses. They have thus found new treatment therapies for Te Lak (e.g. use of Aspirin and quinine).

I am not sure about that but what I know is that my mother told me that in the past, people within their community – that is in Oraya, that is where I was born and raised, used to extract the Te Lak, but these days they no longer do so. Most of them are born again and use quinine tablets to treat Te Lak. All traditional Acholi rituals are not done within Oraya – that is why people do not engage in removing Te Lak; they instead use quinine to treat it – Caregiver_03.

I also have a young child. I used to hear rumours about Te Lak; indeed, I was worried that my child would one day contract Te Lak; I kept asking people around about this illness; I was told about many therapies; some asked me to use tick berry, in the end, I decided that when I am brushing my teeth, I would use a clean cloth to press that part of the gum where Te Lak is, I did not do anything else apart from that, and indeed the baby is fine, I refused to use the local treatments – Caregiver_28.

If you see that the child keeps getting fevers, yet she has Te Lak in her gums – instead of taking her for Kwanyo Te Lak, you could buy drugs like Aspirin and press it on the gums at the point where the practitioner usually removes the Te Lak. You have to grind the tablet and then press it at those positions in the gums. The rest of the particles are poured into the child's mouth, so the child swallows them. This heals Te Lak. For example, I saw my uncle's wife do precisely that. She took her two children for Kwanyo Te Lak, but for

the other children, she just bought the Aspirin, which she pressed onto the gums, and the Te Lak disappeared. Whenever the fever started in her children, she would buy the tablets and press them on the child's gum. The Te Lak would then disappear – Caregiver_02.

Other caregivers have turned to religious healing. So, they do pray for God's intercession.

It is a choice you make; if you believe that Kwanyo Te Lak works, then it works – if you believe in God and pray that he heals your child, then still your child will be better; it depends where and in whom you put your trust, whether in God or a practitioner. I no longer believe in Kwanyo Te Lak; I know God can heal my children – Caregiver_23.

Some caregivers decided to stop seeking care from Te Lak specialists out of fear that the child could contract HIV as the specialists kept using the same sharp object on every child.

I have two other children but did not have their Te Lak treated. You know there are many diseases these days, yet the practitioners use a single "siliki" to work on several children. This means that the child could easily contract HIV if she gets to share the blood of an HIV-positive person – Caregiver_08.

Today people are more careful about Te Lak and millet disease and its treatment. Parents no longer take their children for such practices because of the danger they present to them. No one wants their children to contract HIV. My grandchildren have not gone through Kwanyo Te Lak, and they are fine – they get ill, but we take them to the health centre – Caregiver_12.

I was also told of mothers who had denounced practices surrounding Te Lak on the premise that it is ungodly but later agreed to have their children treated by Te Lak specialists. This happened when illness persisted in children after receiving care from the available biomedical facilities.

Some parents do not remove the children's Te Lak since even before they have not been doing so, also the saved people do not do so; for example, there was a woman who was

saved, and the child got Te Lak, the child was continuously ill, the lady took the child to the hospital and did not heal until they brought the child to me and I removed the child's teeth. There was also a woman who had a very ill child; she took her to hospital thrice, but the child did not heal; then, after I advised the mother of the child to bring the child to me, the mother brought the child, and I found out that the child had Two mi Kal and then I cut it out, and in a few minutes the child was breastfeeding well, playing unlike before, since then she brings all the children to me. If a person has been removing those teeth, she must continue removing them for all children – Female Specialist_13.

9.3 Change in Treatment Practice

The specialists talked of the different changes they had come up with in their treatment practice. For example, a specialist had opted to use safety blades instead of a "siliki". She received the safety blades when she participated in the training organised by Red Cross for Traditional Birth Attendants. She decided to use safety blades when the trainer advised her that the "silikis" were unsafe for use.

There is a day people from Red Cross came to Cwero. I was called on as someone that assists women in delivering. They taught us a lot. We got to know how we can improve on our work. As we were discussing, we were asked what we were using to cut the umbilical cord. One friend talked of a razor blade. One talked of the "siliki", but we disagreed with her as we only use that when treating Te Lak. The lady teaching us asked that the next day we come with the "silikis" so that she could get to know what we were talking about. I came with mine. She said that these are not good for use. She took them. That is when I decided I should use the blades given to us – Female Specialist_07.

Many specialists were no longer using herbs to treat the wound after Kwanyo Te Lak. This is out of fear of the repercussions once caught by the government officials.

I do fear getting caught. The government these days does not allow people to use herbs. That is why I no longer use the herbs – Female Specialist_11.

Most Kwanyo Te Lak specialists had opted to use Penicillin V Potassium other than herbs (blackjack and tick berry) to treat the wound left in the child's gums. I was told that it is more effective than herbs. The specialist crushes the tablet into powder and then applies the powder onto the wound. The Penicillin V Potassium was readily available in the study sites. It can be purchased from any drug shop in the trading centres. Three tablets are sold at 200 Uganda shillings (less than one euro cent).

The specialist that had attended the Red Cross training for TBAs had decided to replace herbs with iodine. She had been advised to stop using herbs when handling mothers that have just given birth. She was asked to use iodine to treat the wound. She followed the advice and learnt that a wound treated with iodine heals faster. She then decided to use it whenever she attended to children with Te Lak. Iodine is not as readily available as Penicillin V Potassium within Karackirac and Apem. However, drug shops in Cwero trading centre commonly stock it.

As I told you last time, I had been part of the Red Cross training. That lady was tough. When she took our "silikis" she also said that if it were possible, she would have taken the herbs; the problem was the herbs grow now and then. Nevertheless, she asked that we do not use herbs but instead use iodine. So, they gave us the iodine. At first, I did not know how good it was but one day, I was tired, so I did not pick the herbs, so I decided to use them on the mother I was attending to. The thing was so good. The mother got well within days. I decided I should always use it when someone has a wound. So now I apply it to the wound of the child. I apply it once, and it works, yet for the herbs, a parent had to apply them for three or four days – Female Specialist_7.

Three specialists had opted to either use salt, sugar, or a top of a matchstick other than herbs. These are supplies that are often used within the homestead. It is a common practice within the communities I visited for one to treat a wound with salt. Indeed, several times I was advised to take a solution of water and salt to treat wounds in my mouth.

There is a specialist who gives the child paracetamol after conducting Kwanyo Te Lak for pain relief. She told me how she learnt about its use from health workers in government health facilities. Her wish was for other specialists to know the importance of giving the child this drug after the procedure.

Whenever I go to the Apem, I am given Panadol. One day I asked the health worker why she always gives me Panadol together with coaterm; she told me that the Panadol helps with the pain I would be feeling. It then came to mind that we always treat children but go back home in pain. So, I started asking parents to come with Panadol when they are coming for treatment. My friend Panadol works. The children no longer feel that much pain after the procedure. So, I think my fellow specialists should start giving these children Panadol – Female Specialist_08.

When I asked the other specialists about their colleagues' suggestion of using Panadol, they did not welcome the idea. They advised that it is unnecessary as the child experiences pain for a few days. One was of the view that children and adults are alike. They can all withstand pain.

Two specialists adopted the use of gloves when carrying out the treatment procedure. One is part of the VHT. He told me he observed and admired health workers in Cwero Health Centre III who wore gloves when handling patients. So, one day, he consulted the midwife about the use of gloves and the associated benefits. Since that day, he has been wearing gloves when treating children with Te Lak.

I was not using gloves before, but I learned about their importance. You know, for us, we are like those health workers in Cwero. We are required to be at the facility at times. However, I could see health workers putting on gloves whenever I was at the facility. I kept wondering why. One day I asked the lady that works in the maternity ward why she always puts on gloves. She told me that one cannot get into contact with germs that are always all over someone's body. So, I got to know that it is these germs that cause diseases. I was happy that I got to know that. So, I went to the drug shop, bought the

gloves, and have since been using them when treating children with Te Lak – Male Specialist_09.

The other specialist (specialist_13) that uses gloves also assists women during pregnancy and childbirth. She had attended a training of traditional birth attendants where they were encouraged to use gloves. She later decided also to use gloves when treating Te Lak. I asked this specialist to demonstrate how one can correctly wear gloves. She did so but with much difficulty. She was worried that the gloves she had bought could be of poor quality or probably expired. It took her about ten minutes to put on a pair of gloves.

It was common for the specialists to use a single siliki on several children, but now, most specialists use a new siliki on each child they attend to. This is out of fear of HIV and its spread through sharing of sharp objects. One specialist did relate the non-reuse of silikis to the practice of disposing of syringes after use in health facilities.

Those days' things were good; we used only one siliki; the siliki would be thrown in the water in which the herb was boiled and then later flattened; after use, it would be cleaned and wrapped in a polythene bag and kept, but these days I do use the siliki once and then throw it away just like in the hospital where one syringe is used on one person because of the fear of HIV, if someone tells me in advance that they will bring their child, I prepare the siliki early – Female Specialist_06_03.

The specialists told me that parents expect them to use a new siliki when handling their children. A local council committee member also told me they always advise the specialists to avoid using the same sharp object on different children.

As local leaders, we always encourage these specialists to take care; we tell them not to reuse silikis; if they do, a child can contract HIV. HIV is common these days, and we do not want it to be spread further – Local Council 1 committee member.

No, I no longer have the siliki that was given to me on the day I was initiated; people ask that you use a new one on every child, so that is why I eventually threw it away – Female Specialist_07.

That notwithstanding, most specialists still use a single siliki when treating twin children. This is because they believe that twins are a single person and thus see no reason for using two silikis.

Twins are born simultaneously; whatever you use on one twin, you are supposed to use on the other. I agree we are not supposed to use the same siliki on two children, but twins are one, not two children – Female Specialist_07.

There was one specialist who, unlike before, possesses two silikis. She would use one on children that are HIV negative and the other on children that are HIV positive. She told me that she learns about the child's status through rumours. The specialists' choice for one of the two silikis will depend on the child's HIV status.

Author: On how many children can a single siliki work?

Response: I have two nails; one is for people who are not HIV positive and the other who is HIV positive

Author: How do you get to know that someone is HIV positive?

Response: People within the community tell me who HIV positive is, and it is no longer a secret that people disclose their status to me – Female Specialist_13.

Some specialists still use a single siliki on every child brought for care. They were conversant of the dangers of such a practice and took precautions by sterilising the silikis. They were confident that the siliki was safe for use once sterilised.

I use a bicycle spoke that is old; I heat it on fire, sharpen it, and then use it.–Male Specialist_10_04.

Well, these days, we are having some challenges as we do have some diseases like HIV that could be spread through sharing sharp objects, but the good thing is the practitioners have responded well to this. They boil the siliki, scrub it and then rinse it before use if any other person comes by the same thing – Caregiver_06.

The specialist who is part of the VHT also uses a single siliki. He told me how it is a common practice in government health centres for health workers to sterilise objects before and after use.

Please do not forget that I am part of the Village Health Team, so I know these things. I also know that health workers boil many objects in hot water and then use them again. I have one siliki but trust me; I boil it before I use it again – Male Specialist_09.

However, I learned that this specialist was unwilling to use another siliki because he had inherited it from his mother, who had passed away. He thought it would be disrespectful if he chose to throw it away.

I use one siliki because it is the one my mother used to use. I cannot change to another one. I would have disrespected my mother – Male Specialist_09.

Some Kwanyo Te Lak specialists had stopped extracting Te Lak from the upper gum. The decision was reached as the procedure often resulted in complications (e.g. severe bleeding) and, at times, death.

You can end up killing the child because the nerves of the upper gum are joined with those of the nose. So, the child can die as the blood will flow to the child's nose; that is dangerous – Male Specialist_05.

Caregivers whose children underwent extraction of Te Lak in the upper gums reported excessive bleeding, which compelled them to seek care from the government health facility moments after the procedure, which is often unusual. There was one caregiver who lost her child hours after the procedure.

I used to stay with my Aunt in Hoima by then; she advised me to seek care from some woman, which I did. The treatment process was frightening, especially when she extracted Te Lak from the upper gum. That is when the child begins bleeding excessively. She hurriedly put some herbs, but the bleeding could not stop. I rushed home with my child, found my husband at home, and he quickly brought out the bicycle and took us to the health centre; it was too late; I had lost my child –Caregiver_29.

Some caregivers whose children had experienced complications or even death after Kwanyo Te Lak decided to try other treatment options, particularly the use of herbs. Their experience with Kwanyo Te Lak did not stop them from believing in Te Lak as a cause of common childhood illnesses. They only found it logical to change to alternative therapy.

Unfortunately, my two children died when their Te Lak was removed. The first child died in hospital days after Kwanyo Te Lak. I took the child for Kwanyo Te Lak, but the practitioner cut the vein. The child did over bleed, and I rushed to the hospital. I reached the hospital, and she was worked on, but days after, she passed on as we could not find blood to be transfused into her. Well, it was God's decision. I also lost my other child. This time around, I went to a different specialist. He performed two different procedures. My child was developing something in the throat and had Te Lak. So, he cut the thing in the throat and extracted the Te Lak. Days after this operation, the child fell ill. The wounds were still fresh by then. I was using the blackjack for nursing it, but it was not getting better. It was taking days and days to heal. I rushed to the hospital, but it was late; I had lost her too. I began to think about Kwanyo Te Lak and concluded that my children could have died because of Kwanyo Te Lak. I have thus chosen to do away with Kwanyo Te Lak. I now use herbs. My other three children have been treated with herbs and are still alive – Caregiver_30.

9.4 Change in Perception towards Reciprocating the Gift of Healing

I did ask the specialists if they would mentor their children into becoming Te Lak specialists. Some were willing to but were doubtful. They explained that the children were attending school and therefore would not have time to learn the art of treating Te Lak. Furthermore, one would add that the children are interested in training for other professions (e.g. medical doctor, teacher) rather than becoming Te Lak specialists.

Not at all, it is because most of the children are in school, and they never see me carrying out the procedure. I doubt they are interested in treating Te Lak since they are never around when I treat the children – Female Specialist_01.

Yes, I can, but the problem is that my children are still young, and in most cases, they are at school, so they do not have time to learn; they are never around when I am carrying out the procedure – Female Specialist_11.

Yes, to any other person but my children, no, because they do not have time to learn and do not assist me.

Probe: What takes up their time?

Response: They are always at school.

Probe: What about when they are on holiday?

Response: Uh, it is hard for someone attending school to be interested in treating Te Lak; they are interested in becoming doctors, teachers – Female Specialist_12.

9.5 Discussion

Public health actors are challenging the legitimacy of a deeply entrenched healing tradition. They are calling for the elimination of Te Lak and its related practices (Wandera and Kasumba, 2017). Unlike in FGC practising communities, where campaigns have been intensive and well-coordinated from the global to the local communities (Van Bavel et al., 2024), in Te Lak practising communities, efforts remain fragmented. For example, dentists from Eastern and Central Africa passed a declaration, “The Addis Ababa Declaration to end infant oral mutilation (Kwanyo Te Lak),” calling on all regional stakeholders to launch public health campaigns addressing Te Lak. However, studies show that awareness raising has mainly happened in dentists' workplaces (Wordley & Bedi, 2019). In the communities visited, this primarily unfolds through ad hoc conversations that often occur when health professionals or religious leaders become aware that a child has undergone treatment for ‘diseases’ caused by Te Lak or when caregivers discuss the possibility that the child’s condition is linked to the local disease-causing category.

Although largely localised, the campaigns reflect broader power dynamics. They reinforce the dominance of biomedical authority and simultaneously marginalise indigenous therapeutic systems. The public health actors position biomedicine as the sole legitimate provider of healthcare and, at the same time, frame traditional healing as risky and harmful. As demonstrated by other studies (Closser et al., 2022), this hierarchical structuring ostracises individuals who attempt to visit or seek care at traditional medical sites. At times, the health workers perpetrate abuse on caregivers with children with visible marks that indicate the extraction of Te Lak. This abusive behaviour results from the implicit biases that health workers have over caregivers that have their children go through Kwanyo Te Lak. Just like it has been reported in other communities, this kind of abuse is overlooked or accepted as a standard practice, and the parents hold onto the expectation that it will happen (Pattison and Kramlich, 2022). This may result in delay in seeking life-saving health care for the ailing infant.

The hierarchical structuring that positions biomedicine at a higher level is strengthened when those who operate within these spaces are prosecuted or made aware of that possibility. This has far-reaching implications for how some healers assert their identities. Some healers are hesitant to publicly identify as health practitioners. In situations where individual's unknown to the healer inquires about their involvement with the practice, they first assess and vet them before acknowledging their role. This vetting process often extends to local power structures and family members in positions of authority to confirm the sincerity of these individuals. Beyond playing a vetting role, community-based power structures challenge the legitimacy of legal sanctions against those engaging with Te Lak. The local power structures sanction healers' practices, arguing that they are part of the cultural heritage (Hörbst et al., 2017) of the Acholi people. Given that local leaders are trusted and respected by the community, their opinion strengthens the credibility and competitiveness of local healers.

Notably, health service users' experience with professional care equally undermines the credibility of the legal sanctions. When biomedical treatments fail to improve an infant's condition, caregivers do not see legal sanctions against healers as protective measures. Rather, they interpret this as a system that disregards the community's lived realities. They view the legal arguments as unreasonable and attribute them to a lack of understanding of local culture. Consequently, caregivers seek care from local healers whose practices and beliefs are aligned with their experiences and expectations. Previous studies have similarly illustrated that public health narratives are judged against personal experiences and collective memories with biomedical facilities (Nichter, 2008; Degafa et al., 2022). Once expectations of care fail, the legal sanctions against healers become counterproductive.

As observed in anthropological analyses of female genital cutting in African communities (Hernlund & Shell-Duncan, 2007), Te Lak healers do not simply comply with biomedical critiques but rather actively engage in negotiation. The fear of losing their identity as cultural and medical experts drives them to modify their treatment approaches. However, this is done without fully relinquishing their traditional epistemological authority (Laplane, 2015). Rather than being displaced, indigenous healers incorporate external critiques in ways that reinforce their legitimacy.

For example, discussions with some healers revealed that they use separate sharp objects for suspected HIV-positive and HIV-negative infants. This followed the comprehensive HIV awareness campaigns run by the Ministry of Health that articulated the role of sharp instruments in transmitting HIV (UAC, 2010). This raised the community's consciousness on the perceived risks of using sharp instruments in medical procedures, thereby shaping new expectations of medical practitioners around their use. By using separate sharp objects, the traditional healers recognized this public health advice. However, the translation of such advice often does not follow scientifically validated medical processes (Patsopoulou et al., 2022). The decision to use separate sharp objects is not based on the testing for the child's sero status but rather on rumour or hearsay.

The findings also show that some traditional healers were opting for the sterilising of their tools before treating infants, and some were disposing of the tools after the procedure. This followed their exposure to biomedical health protocols that speak of sterilisation as essential in destroying all microbial life that results in infections in humans and disposal as important in preventing cross contamination (Rutala & Weber, 2016). Nevertheless, healers with tools that were offered to them during the initiation ceremony have not embraced the practice. In their mind, they perceive that sterilizing or disposal of the tool would undermine its spiritual significance and would be an expression of disrespect to the past healers.

Additionally, the healer's response to biomedical critiques also involves co-opting biomedicine in their treatment regimen. On the other hand, some caregivers opt for religious healing while others simultaneously use biomedical and traditional treatments. Notably, these caregivers continue to perceive Te Lak as the cause of childhood diseases while considering religion or biomedicine as an alternative means to addressing these ailments. Previous studies have posited the blending of biomedical and Indigenous practices as an adaptive strategy that local healers intentionally adopt to maintain their credibility (Elendu, 2024). By adopting biomedical ideas and tools, healers can navigate both legal and social concerns around the safety of Te Lak therapeutics. Similar findings have been reported in Mauritius, where traditional healers align their practice with professional medical regulatory standards to gain legal recognition and social acceptance (Urquiza-Haas & Cloatre, 2023).

CHAPTER 10: FINAL DISCUSSION AND CONCLUSIONS

This dissertation interrogates the disease, healing, and health landscape of selected Acholi communities in northern Uganda. The entry point to examining this landscape is a locally defined disease-causing agent, Te Lak. By focusing on Te Lak, I respond to Scherz's (2018) call for anthropologists to "reconsider their collective research priorities" that majorly focus on biomedicine (Scherz, 2018, pgs. 539 & 543). By employing a structural constructivism theoretical approach, this study situates Te Lak at the intersection of cultural, political and economic powers, illustrating its dominance in shaping health care discourse in the post-conflict communities.

The Acholi recognise Te Lak as one of the causes of common childhood illnesses. As documented in some other African communities (Gutema & Mengstie, 2023), Te Lak is classified as a naturally occurring phenomenon and not due to malevolent actions. Caregivers diagnose Te Lak through observable signs that are understood differently within the biomedical system. For example, salivating is considered a normal bodily function, while signs such as "malaria" and "diarrhoea" indicate pathology (Hutchison, 2016). The terminologies malaria and diarrhoea are borrowed from biomedicine, though reinterpreted to fit into the cultural narratives around infant health (AL Hosni et al., 2023). The incorporation of biomedical terms in traditional epistemology could be attributed to the different public health campaigns under the National Malaria Control Programme, as well as the health education sessions at health facilities that emphasize the role of the vector in the spread of malaria (MoH, 2014). The local population co-opts this knowledge and integrates it into their nomenclature to navigate and reconcile the competing explanations of infant illnesses (Langwick, 2011).

Just as the case is among the Tabwa of the Democratic Republic of Congo, where ill-health is not merely addressed at a symptomatic level but by treating the root cause (Davis, 2000), similar experiences were reported by communities engaging with Te Lak. The indigenous medical response involves either extracting or applying herbal remedies on Te Lak. The identification and understanding of Te Lak as a cause of illness requires knowledge of the indigenous

diagnostic practices. Often, most first-time parents are not exposed to this knowledge, relying primarily on biomedical interpretations to classify the illnesses that the child is presenting with. Consequently, parents seek care from professional health facilities as their first recourse (Good, 1994). In doing so, the biomedical model of the body and health momentarily block the caregiver's access to the indigenous medical space. When biomedical interventions fail, the parents turn to their social network, mainly older women who could be their relatives or neighbours that often introduce them to the indigenous diagnostic practices (Olsen, 2017). These interactions eventually facilitate the first-time parents' access to Te Lak local specialists. Parents with subsequent births, however, develop a more nuanced understanding of childhood illnesses, that is informed by both cultural and biomedical frameworks. This results in a plurality of care-seeking, at times prioritizing biomedical care and moving to traditional healers when symptoms persist.

However, at this time, seeking biomedical care comes along with the burden of managing social expectations that suggest that such ill-health conditions cannot be treated in hospital settings (Tilahun, et al., 2016; Mabetha, et al., 2021). To navigate these social pressures, the caregiver may withhold the perceived cause of the condition to their social network or seek care in secrecy. This is done to avoid social sanctions that can be enacted if one defies local medical beliefs. Notably, this social expectation impacts the way parents interpret the child's progress to better health. Slow progress under biomedical treatment reinforces the cultural conviction that biomedicines do not heal diseases caused by Te Lak. This perceived inadequacy pushes parents to opt for indigenous therapeutics. They often extend the diagnostic process to incorporate alternative paradigms, where illness is attributed to Te Lak. The persistence of the illness suspends the earlier staged biomedical interruptions and allows mothers to access the local healers. In these instances, the traditional system may take precedence over and fully dominate the biomedical system, allowing parents to recognize the expertise and authority of the local healers.

It was observed that some parents co-currently utilize both the professional and traditional medical systems. Studies on African health reporting similar insights argue that, at that moment, practitioners in either system are regarded as "complementary, not contradictory, or mutually exclusive" (Nisula, 1999 pg. 289; Olsen & Sargent, 2017). Among the Acholi, this duality becomes evident when parents continue to offer biomedicines to infants while at the same time seeking care from the local specialists. This does not mean that mothers strip local healers of their identity as experts. On the contrary, they still identify them as such, viewing their workplaces as spaces dedicated to addressing bodily threats. What is occurring, instead, is a strategic use of all available resources to restore the child's health. The ongoing use of biomedicine, alongside indigenous treatments, may contribute to the observed healing of some children, reinforcing the belief within the local community that Te Lak therapeutics are indeed effective. In cases where children do not recover despite ongoing care, caregivers further navigate the medical landscape. These create new relations with other experts who are perceived relevant at that moment. This shift does not necessarily imply that the local treatments previously employed are considered ineffective. Instead, the parents attribute persistent ill-health to inaccurate diagnosis. At that moment, new diagnostic categories are introduced, thereby eliminating Te Lak as a cause. At this point, Te Lak no longer guides the caregiver's movements within the community's medical system.

There are also instances where traditional care permanently blocks one's access to the biomedical facility. This is embedded in the understanding that diseases caused by Te Lak are not to be treated in biomedical settings. This is strengthened by the social sanctions that can be enacted if one goes against this norm. Local healers are regarded as the sole legitimate experts, and the biomedical system is relegated to a secondary or even irrelevant role, reflecting the powerful role of social beliefs in shaping the authority of medical systems.

The plurality of care-seeking extends beyond mere awareness of cultural and biomedical treatment options. It is also influenced by the specific signs the child exhibits. Signs help the parents assess the severity of the child's condition, determining whether it is mild or severe and whether urgent care from a local specialist is necessary. When initial diagnosis indicates a mild condition, professional medical care or self-medication with biomedicine is preferred. When the

child presents with a sign that indicates progression to a severe state, such as the child's inability to feed, urgent care is sought from a Te Lak specialist. These findings challenge earlier literature, which suggests that local therapies are administered as soon as Te Lak is detected in a child's gums (Accorsi et al., 2003; Gollings & Longhurst, 2013).

Te Lak is integrated into the moral fabric of the communities studied, which challenges its common categorisation as a disease-causing agent and harmful practice. Te Lak has much to do with the meeting of ascribed social or gender roles, the exercise of power by elders and local leaders and coping with the effects of the prolonged civil war. These findings align with the work of Lambek et al. (2015) who argue that illness and suffering are situated in moral worlds and can serve vital social functions such as affirming gender roles. In situations where infants are in a critical health state and face a heightened risk of death, access to Te Lak therapeutics involves local leaders that reassure the Te Lak specialist that they will not be held accountable for any adverse consequence, including the child's death, an event that could attract the attention of law enforcement agencies. Additionally, older women support caregivers to navigate decisions related to disease aetiology, care-seeking and selection of appropriate healers.

Engagement with Te Lak is also closely tied to the performance of gendered responsibilities. Mothers are obligated to ensure the health of their children, while fathers are expected to financially support the treatment (Ahun et al., 2024). The decision to seek or withhold care becomes a reflection of how well individuals fulfil these gendered duties. In instances where the responsibility is unmet, mothers can be physically assaulted, while for men, their identity as providers is questioned. This dynamic shows that care-seeking is not only a health decision but also a moral act embedded in the performance of gender roles. Additionally, engagement with Te Lak relates to the broader social obligation to repopulate a community that suffered significant losses during the over two-decade civil war. Fulfilling this responsibility involves seeking care for illnesses attributed to Te Lak to prevent child mortalities.

Te Lak, like other traditional practices, holds generative potential, influencing the social, political, and economic spheres of the communities studied (Mier zu Biesen et al., 2012). As a local disease-causing agent, it facilitates exchange practices that exist at the intersection of moral

economies and commodification. The market logic is transforming the healing tradition into a professional practice meant to support healers in sustaining their livelihood and investment ventures. This has attracted new entrants to the traditional healing field and sustained commitment for the trade to be kept in certain families. The treatment decision is increasingly becoming an economic choice mediated by financial exchange, reflecting that Te Lak healing is no longer solely a moral act. The demand for payment has introduced hierarchies and exclusions, limiting access for those unable to afford traditional care. Notably, this financial barrier creates an opportunity for caregivers to engage with the biomedical system. If structural inequalities are minimised, parents may have a greater opportunity to recognise that childhood illnesses can also be treated within biomedical facilities.

Te Lak also establishes a healing system with trained and certified individuals in the trade. Just as in other African communities, the selection of trainees is based on an exclusive process that considers lineage, interest, and moral aptitude (Van der Zeijst et al., 2021, 2022). The selection process is designed to safeguard the sanctity and integrity of the sacred knowledge by entrusting it to reliable individuals. Female healers dominate the healing system and prioritise training girls to preserve the power and authority that healing grants them within patriarchal societies. However, structural changes, such as formal education, are challenging the selection process, pushing healers to train sons and non-relatives. Often, healers delay training their daughters until the time when they drop out of formal schooling. The agency of the selected individuals is built by either human or non-human entities through technical training or spiritual encounters. The training process takes place within domestic spaces, where feminine roles are traditionally performed, increasing the likelihood of training girls (Matholeni, 2020). The training process is intertwined with the daily cycles, life stages and spiritual energies, ensuring the spiritual and cultural legitimacy of the healing tradition.

Te Lak, like other practices that have been categorised as harmful, is continuously evolving and cannot be fully understood in the traditional framework (Longman, 2015). The healers are cognizant of the criticisms regarding the potential harm of the local therapeutics. They do interpret this critique as a comment on their expertise and credibility. In response, the healers co-opt biomedical materialities into their treatment practices, not as a marker of modernity as has

been shown in other communities (Marsland, 2007), but as a strategic means to address the different fears and expectations of their clients brought about by the criticism. Notably, these materialities are not used for the purpose they were developed, but rather, the healers creatively use them to reinforce their credibility as healers and maintain their professional standing within the local therapeutic landscape (Podolecka, 2016; Scherz, 2018).

Caregivers are increasingly using biomedical therapies to treat illnesses believed to be caused by Te Lak. Similar adaptations were reported in other contexts, such as in Botswana, where biomedicines used to treat tuberculosis were used to treat thibamo, literally translated as “to turn” or “to obstruct,” a distinct disease entity within the Tswana cultural understanding. This typically refers to infants born in an irregular position that leads to ongoing health problems in infancy (Livingston, 2005). Other parents opt for religious healing through prayer, while some concurrently utilise prayer and biomedicines to treat these ill-health conditions. Notably, parents continue to attribute the cause of illness to Te Lak, viewing biomedicine and prayer as complementary tools that can be used to manage illnesses perceived to be caused by Te Lak. This dynamic reflects the complex negotiation between preserving traditional medical norms and responding to biomedical criticism.

Notably, the discourse on eliminating Te Lak is resulting in delays in seeking care from professional medical institutions. Parents are knowledgeable that seeking medical attention while visible marks from Te Lak treatment remain results in their subjection to physical abuse from the health professionals, a practice that prompts them to hesitate accessing formal healthcare. Among the healers, the discourse has had implications on how they navigate their identities, especially if they are interacting with individuals who are new in the community. Often, they deny their involvement with Te Lak, further pushing the practice out of the gaze of the public. This concealment has implications for efforts meant to eliminate the practice. In female genital mutilation practising communities in Uganda, eliminating public celebrations after the cutting and making cross-border journeys to have a child cut in a place where law enforcement is weak or non-existent has made it harder for authorities to track and intervene, allowing the practice to persist (UNFPA & UNICEF, 2019).

The framing of healers as mere perpetrators oversimplifies the complexity of their roles and the multiplicity of identities they hold (Shange & Ross, 2022; Msoka et al., 2025). Some healers were recruited into the state-sanctioned health care system, serving at the lowest tier of the professional health system. By holding medical titles recognised in professional health systems, they occupy a unique position that health practitioners in purely biomedical institutions do not occupy. Their dual affiliation grants them a diverse medical repertoire, which they draw upon to treat both Te Lak and biomedical conditions. This also supports them in navigating the criticism laid forth by purely biomedical practitioners, often through integrating biomedical materialities in their treatment regimens. Notably, their participation in the professional health system makes them less visible to the practitioners focused on eliminating Te Lak, as it does not come to their mind that they are part of the traditional healer network.

The community's engagement with Te Lak can be understood as a practical response to the systemic deficiencies in Uganda's professional medical system. It is common for parents to turn to indigenous health practices when biomedical interventions fail to yield satisfactory health outcomes for their children (Towns et al., 2014; Ngere et al., 2022). Te Lak could be one of the outcomes of the widespread availability of substandard medicines in the country. The Uganda National Drug Authority (NDA) occasionally publishes drug recall directives to importers and local technical representatives of manufacturers. In 2019, NDA recalled Ciproren for failure to comply with British Pharmacopoeia specifications (NDA, 2019). This is a drug that many of the study participants were utilising to prevent diarrhoea in children. Unfortunately, the agency lacks the requisite capacity to enforce such directives. Also, the methods it opts for to engage the community in the process are not contextually relevant. For example, notices on recalled products are posted on their website with a clear message urging communities to avoid their use. This is a resource that only a few in the communities I visited can access. Even when accessed, the interests of this small number of people could be far from the communications from NDA.

Te Lak may also be a consequence of the Ugandan government's low investment in the health sector. For example, in the financial years 2018/19 and 2019/20, the percentage share of the health sector in the national budget declined from 9.2 per cent to 8.0 per cent (MoFPED, 2019). This is way below the 15 per cent target adopted by heads of state of the African Union in the Abuja Declaration on Health Financing. There is a possibility that funding for health will further decline. This follows a shift in the national priorities from social services to the production sector (Nannini et al., 2021). The marginal investment in health becomes even clearer when funding allocations to individual health facilities are closely examined. Cwero Health Centre III and Omel Health Centre II are health facilities that serve communities in the field sites studied. They received direct grants of about 13 million shillings (3,250 euros) and 5 million shillings (1,250 euros), respectively, from the central government in the financial year 2019/20. These funds were supposed to cater for health education, promotion, prevention and curative services, disease surveillance, and facility management across the financial year. The failure of health personnel to consistently conduct outreach services to hard-to-reach communities can be explained by these meagre allocations. Their inability to develop context-specific health promotion campaigns founded on good practices in social and behavioural change can also be explained by the minimal allocations. Surprisingly, even though funding for health remains inadequate, the health sector often does not fully utilize the money allocated. In the 2016/17 financial year, the absorption rate stood at 74 per cent (MoFPED, 2018). This is mainly due to the lengthy public service procurement processes and approval procedures (BMAU, 2018).

The reduction in public health spending can be traced back to the Government of Uganda's implementation of Structural Adjustment Programs (SAPs). These economic policy reforms, mandated by the World Bank and the International Monetary Fund (IMF), aimed at removing excess government controls and enhancing market competition (Mohan, 2009). The reforms led to a reduction in public health expenditure, which in turn compromised the availability and quality of health services, resulting in adverse impacts, particularly on child and maternal health (Thomson et al., 2017). The Government was not in a position to commit a substantial amount of funds to support the expansion of health infrastructure, a consistent supply of medicines and equipment, and the recruitment of the healthcare workforce (Dowhaniuk, 2021; Vallières et al., 2021).

The promotion of market competition has led to a growth of private health facilities that provide services at a cost, whilst the broader economic impacts, including reduced incomes, that the SAPs had led to (Nosrati et al., 2022). This rendered health services unaffordable for the vulnerable populations while simultaneously causing a dramatic increase in Out-of-Pocket medical expenses (Grundmann et al., 2006), currently standing at about 41 per cent – the highest in the East and Southern Africa region (MoFPED, 2019). This severely affects childcare and decreases the use of professional health services (Rezayatmand, 2013), all of which result in reinfections and treatment failures that can push parents to Te Lak healing systems.

10.1 Theoretical Implications

This ethnography has revealed that a complex and thorough understanding of health and disease can only be achieved by interrogating the cultural meanings of illness, the structures of power that shape health outcomes, and the ways these two dimensions intersect. From this perspective, health is not only shaped by culture, but also by how power is exercised throughout the healthcare systems. The implication is that one must pay attention to how illness is interpreted through cultural frameworks and how it is produced or reinforced by broader structural forces. By taking this dual lens, we can understand how practices labelled harmful function as socially meaningful responses to structural violence, historical trauma, or disrupted social orders.

I recognise that the term 'culture' is a contested one, particularly regarding how it is formulated and used as an analytical tool in social research. Anthropological literature has long highlighted how culture has been instrumentalised to mark difference and produce the “Other”, resulting in static and reductive representations of societies (Abu-Lughod, 1991; Appadurai, 1996). This amplifies the perceived differences between the anthropologist and his or her study subjects (Brumman, 1999), ultimately resulting in faulty conclusions (Fischer, 2007). This classical use of the term is in sharp contrast with what characterises social reality: variability, inconsistencies, conflict, change, and individual agency (Brumman, 1999).

This study illustrates the continued relevance of the culture concept when applied in alignment with the dynamic nature of social reality. It is most effective when understood as relational, open, plural, and evolving. Additionally, its applicability extends across all aspects of knowledge, including biomedical knowledge (Lock & Nguyen, 2010). Culture is utilised to demonstrate how post-conflict communities are sites of cultural contestation between traditional and professional medical systems. This then makes visible how newly diffused ideas, knowledge, behaviours, technologies, and material goods are either appropriated, actively transformed to fit with the traditional cultural landscape, or resisted. These contestations determine the meanings the parents attach to the infant's illness. As a result, they can interpret the child's condition, determine the appropriate treatment pathway and social relationships they must develop, and conclude who holds the authority and medical expertise required to address the condition. This shows that the parents' agency is shaped by their embeddedness in cultural narratives, community expectations, and social relationships.

While cultural dynamics are important, this study also illustrates that structural factors come into play when parents attempt to act on cultural narratives and community expectations, eventually limiting the agency of the caregivers. These systemic inequities are embedded in the historical marginalisation that could be traced back to colonial times, as well as the current vulnerabilities shaped by marginal investment in health. This constrains the caregivers, who, despite often prioritising the biomedical system, find themselves compelled to rely on the indigenous medical systems (Gizaw et al., 2022; Yihune Teshale et al., 2025).

These patterns illustrate the importance of both culture and structure when studying illness, healing, and the health landscape, necessitating a structural constructivist lens to fully capture the complexities happening in the health-seeking environment. By attending to both culture and structure, this study underscores the significance of moving beyond the binary framework common to the anthropological discipline towards an integrative approach that situates illness and health at the intersection of agency and social and economic inequalities (Dressler, 2007; Forsyth, 2015).

10.2 Implications for Programmes Aimed at Ending Te Lak

This ethnography has revealed that the continuity of a local disease-causing agent is embedded in social and cultural conventions and a failing professional healthcare system. Existing indigenous medical theories prescribe the kind of health care that mothers must seek when infants present with ill-health conditions. Although some mothers do not agree with such prescriptions, they are unlikely to act on their preferences. This is because of the existing social sanctions that can be enacted when one goes against the norm, for example, being othered or beaten by the elders (Nnyombi et al., 2022). The failure to act can also be attributed to the social rewards that come with abiding by the norms. Women can concretise their identity as a mother and wife in the community. These social rewards and sanctions are held in place by the mothers' social networks (reference groups) that are comprised mainly of older female relatives and cultural and community-level political leaders (Cislaghi & Heise, 2020).

The expansion of biomedical services and evangelism in the field sites has introduced new norms in health care. Mothers who interact in these spaces are expected to seek care from biomedical facilities and additionally say a word of prayer to hasten the healing of their infant children. As a result, some parents seek care from biomedical facilities, others self-medicate with biomedicines, and some engage in prayer. I do attribute the adoption of such health care norms to the change in mothers' social networks (reference groups) and being introduced to social spaces (church and medical facilities) where biomedicine and prayer are approved as credible sources of healing. It is in these spaces that the role of Te Lak in disease causation is questioned. Mothers are introduced to scientific evidence that attributes childhood diseases to vectors, viruses, or bacteria. Similar insights are presented by Lundgren et al. (2019), who show that shifts in reference groups provided young people with alternative scripts for identity and relationships, enabling them to challenge, reinterpret, or reject traditional gender expectations.

The actors in these spaces also discuss the kind of harm that infant children are bound to face when they receive the local therapeutics. The mothers relate to this kind of information since their children could have gone through a similar experience. In church, this is strengthened by the citation of the scriptures and the emphasis that the kind of behaviour they are engaging in is far apart from what the almighty spiritual being expects of them. The biomedical facilities and churches are now safe spaces where mothers can act independently of older female relatives and local leaders. It is in these spaces that mothers come to interact with persons who approve of the kind of normative behaviour that is being advocated for by programmes meant to eliminate Te Lak. Nonetheless, although some mothers engage in the desired health care behaviour, the existing health systems' deficiencies and structural constraints prevent access to quality care.

The above social realities present key issues that programmes meant to end Te Lak have to interest themselves if they are to cause or accelerate change. Human relationships and emotions occupy a central position in engaging with the practice, as has been reported among female genital cutting practising communities in Senegal (Vaitla et al., 2017). Ending the practice can happen when human relationships and emotions are changed.

Evidence collected suggests that mothers are interacting in new spaces with actors who approve of biomedicine as the only viable option to address childhood diseases. Programmes meant to eliminate Te Lak should build on this to further facilitate change in human relationships. There should be a deliberate effort to form groups that bring together women who categorise Te Lak as a disease-causing agent. These groups should be engaged in reflective education sessions that a) enable the discussion and questioning of existing relationships and b) support the practice of new social expectations. This will help in redefining what is appropriate and creating new social relationships that mothers can utilise when their children fall sick. This aligns with the SASA! approach – a community mobilisation methodology developed by Raising Voices in Uganda to prevent violence against women and HIV by transforming power dynamics that drive gender inequality. The approach demonstrates the effectiveness of forming community-based groups as a strategy for engaging in reflective dialogue, the questioning of harmful norms and the practising of new behaviours (Michau & Namy, 2021).

Since health care decisions are relational, the education sessions should also be extended to the male spouses. At first, the men should be met separately. Based on my experiences during data collection for this study, discussions in the community are dominated by men. Having mixed groups at the onset will not be helpful, as the opinions of women will be suppressed. The separate sessions should address the issue of equal gender relations. This will set the stage for interactive sessions where both men and women fully participate. Through these sessions, male spouses should be supported to adopt new roles in matters of health, especially in supporting mothers to seek care from the professional medical system. Similar experiences are reported by the REAL Fathers Initiative, a father mentoring program aimed at reducing children's exposure to violence at home. The program emphasises the effectiveness of initially engaging young men individually before later involving their spouses (Ashburn et al., 2017).

Having a couple of men and women adopt new normative behaviour is not sufficient to cause community-level change. The kind of behaviour that is being targeted is sustained by collective beliefs about what people expect from each other. This means that a critical mass of the population must be reached for any broader change to be achieved. Therefore, there is a need to plan for the organised diffusion of information. Persons who participated in group education sessions and who demonstrate change in health care behaviour should be recruited as community-level change agents and trained on how to spread the message of change to the rest of the community. Further, achieving change would require targeting the entire circle of influence of parents. The opinion of older female relatives, local political leaders, healers, and cultural leaders matters to the parents. These hold power and authority over them and enact social sanctions or rewards. These should be supported to adopt new roles in the field of health that encourage seeking care from the professional medical system (Cislaghi et al., 2019).

The ethnographic material collected shows that some healers prioritise livelihood activities other than the treatment of children with illnesses thought to be caused by Te Lak. This is an opportunity that should be tapped into. The provision of alternative sustainable livelihoods to the healers could motivate them to stop engaging in the treatment practice. The economic strengthening component should be accompanied by educational transformative sessions. These sessions should be able to support the healers to reimagine their role in the community. Similar

insights have been emphasised in research on alternative livelihood programs, which highlights that economic substitution alone is insufficient and must be accompanied by educational support components to effectively reshape practices (Wicander & Lauren, 2014; Mokgobi, 2014). In instances where some of these actors adopt the desired normative expectations, these persons must be utilised as change agents to reach out to other persons in the community.

Given that structural deficiencies common to hospital care limit a parent's agency to act on the desired health care seeking behaviour, childcare actors should actively work towards addressing the various deficiencies. Parents shall consistently seek care from the professional medical system only when the system supports infants (and other persons) to regain good health. To achieve this, development actors should move away from merely planning for the basic biological survival of infant children to also making long-term and sustainable investments in the health sector, such as health infrastructure developments and management support investments that respond to estimated future health demands (Redfield, 2005).

I recognise that the Government of Uganda's allocations to the health sector are reducing and might further decline following the priority shift from social services to production. Being cognizant of that fact, the structural reforms that I am advocating for could focus on more efficient use of existing resources. For example, there should be consideration of training nurses as first-line providers (Hammerstedt et al., 2014) so that they can provide quality emergency care to infant children. The Ministry of Health can also adopt a rural pipeline approach to human resource development to address challenges related to job satisfaction and retention of human resources in rural communities (Kolié et al., 2023). This involves advocating careers in health professions among rural students, prioritising the selection of rural students into programs, and developing a curriculum oriented towards rural health.

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ABSTRACT

This study examines Te Lak, a locally defined disease-causing agent among the Acholi in Northern Uganda, recognised as harmful in global health discourse. Grounded in the structural constructivist theoretical approach, it explores how Te Lak dominates the health care discourse in post-conflict communities. An ethnographic methodological approach guided data collection.

Te Lak transcends its characterisation as a disease-causing agent and harmful practice. It is integrated into the moral fabric of the communities studied. It is a way through which parents meet ascribed social or gender roles, community structures exercise their power and is a practical means through which the community copes with the effects of the prolonged civil war. Te Lak holds generative potential, fostering exchange practices that exist at the intersection of moral economies and commodification, and creates an epistemic community that preserves prized local medical knowledge through generations. The community's engagement with Te Lak can also be seen as a practical response to the systemic deficiencies in Uganda's professional medical system. Parents often turn to Te Lak therapeutics when biomedical interventions fail to yield satisfactory health outcomes for their children. Te Lak, then, is a consequence of the Government of Uganda's low investment in the health sector.

ZUSAMMENFASSUNG

Diese Dissertation untersucht Te Lak, ein lokal ausgeprägter Krankheitsverursacher bei den Acholi in Norduganda, der im globalen Gesundheitsdiskurs als schädlich anerkannt ist. Ausgehend vom strukturkonstruktivistischen Theorieansatz wird analysiert, wie Te Lak den Gesundheitsdiskurs in Post-Konflikt-Gemeinschaften dominiert. Ein ethnographisch-methodologischer Ansatz leitete die Datenerhebung an.

Te Lak geht über dessen Charakterisierung als Krankheitsverursacher und schädliche Praxis hinaus. Es ist tief in das moralische Gefüge der untersuchten Gemeinschaften eingebettet. Es bietet Eltern die Möglichkeit, zugeschriebene soziale oder geschlechterspezifische Rollen zu erfüllen, ermöglicht Gemeinschaftsstrukturen ihre Macht auszuüben, und ist eine Praxis, durch welche die Gemeinschaft die Auswirkungen des langanhaltenden Bürgerkriegs bewältigen kann. Te Lak birgt schöpferisches Potenzial; es fördert Austauschpraktiken, die an der Schnittstelle von Moralischer Ökonomie und Kommodifizierung bestehen, und schafft eine epistemische Gemeinschaft, die wertvolles lokales medizinisches Wissen über Generationen hinweg bewahrt. Das Engagement der Gemeinschaft für Te Lak kann auch als praktische Reaktion auf die systemischen Defizite im professionellen Gesundheitswesen Ugandas verstanden werden. Eltern greifen häufig auf Te-Lak-Therapien zurück, wenn biomedizinische Interventionen keine zufriedenstellende Verbesserung des Gesundheitszustands ihrer Kinder erzielen. Te Lak ist somit auch eine Folge der geringen Investitionen der ugandischen Regierung in den Gesundheitssektor.