Impact of small arms insecurity on the public health of pastoralists in the Kenya–Uganda border regions

Kennedy Agade Mkutu

Abstract Small arms must be considered as a public health problem, but quantifying the public health impact of small arms is difficult and studies are sparse in areas of conflict. This study considers the remote cross border area between Kenya and Uganda where pastoral conflict in the form of cattle raiding with the use of small arms has escalated in recent years, and where health facilities are scarce. Hospitals and clinics in Karamoja, Uganda, and West Pokot, Kenya were visited by the author, to collect any available data on small arms injuries. Interviews with hospital staff helped to provide further insight into the statistics. Statistics showed that most injuries were sustained during raiding, though worrying incidences of injury among noncombatants and young children were found. Many serious injuries and limb fractures were documented, likely to have some long-term implications for pain, growth, disability, and livelihood. Deaths and injuries are likely to be significantly underestimated by the statistics, due to problems of transport, insecurity, deaths prior to arrival, admission fees for some facilities, and fear of reporting injuries due to the criminal element. Police statistics support this conclusion. The situation appeared to be worse in Uganda as opposed to Kenya, but cooperation between the two countries is needed since pastoralists readily cross the borders both to raid and to attend clinics and hospitals.

Introduction

In May 2001, on the border of Kenya and Uganda, I went to attend a peace-building meeting between rival pastoral groups. While travelling, our car approached a group of men, carrying a wounded Pokot man on an improvised stretcher from Karita, Uganda to Kachiliba, Kenya 37 km away. The man had been shot in the thigh, it was said, in cross fire during a cattle raid.
A month later, Dr. Marina Anghileri the medical superintendent of Matany hospital in Karamoja District, Uganda was ambushed together with the primary health care unit at Nakichumet (Uganda). They were on their way for support supervision and outreach activities to Lobulin health unit. Three young Karamojong karachunas (warriors) stopped their vehicle at gunpoint and demanded money. Since they did not have much, the warriors were not pleased, and they shot some bullets on the ground in the direction of the car to scare them. Fortunately they did not injure the people inside the car or damage the car. However, this incident significantly intimidated the doctor who could not understand how those she was helping could turn against her.

These stories are not unusual as this article demonstrates. Small arms and light weapons have intensified conflict in pastoral areas in recent years and had a devastating impact on lives and health, in a situation where health services and infrastructure are already extremely sparse. This article explores the impact of small arms from a public health perspective in the pastoral cross border areas of Kenya–Uganda, contributing to the growing collection of literature on violence and armed criminality in pastoral areas.

Pastoral conflicts and SALW

Pastoralist communities live primarily in arid or semi-arid areas, where the main sustainable livelihood is livestock rearing, requiring mobility to access water and pasture, especially during droughts. Land alienation and restriction of pastoralists by successive colonial and...
post-colonial administrations has increased competition and vulnerability of pastoralists and threatened this way of life.

Small arms and light weapons (SALW) is often used to mean all type of firearms, including revolvers and self-loading pistols, rifles and carbines, sub-machine guns, assault rifles and light machine-guns. However, the term refers to “any weapons that can be carried or transported and managed by a single person” which includes hand grenades, land mines and small surface to air missile launchers [73: 24].

Pastoral conflict in the form of raiding is not a new phenomenology but a feature of the pastoralist societies of North Eastern Africa and the Horn of Africa in general. In areas of great political instability, as in the northernmost regions of Uganda, Kenya and the countries to their north, raiding has been experienced on a massive, even devastating, scale in the recent past. Even in the more politically stable regions like Kenya, raiding appears more virulent due its integration into the liberalized market based economy and the influx of small arms. Raiding is a customary activity among pastoralists, which has been explained both as an in-built cultural tendency and an economical coping strategy that was regulated by the elders. Pastoralists may raid as a means of expanding grazing lands, restocking livestock and obtaining cattle for bride price. Traditional cattle rustling was less violent than today. Elders from the affected communities sanctioned raids and mediated peace. They could identify stolen herds and direct the return of livestock. Deaths were compensated with extra cattle from the killer’s clan and the killer had to be cleansed before entering the homestead. Importantly the weapons of choice were spears, arrows and bows.

‘Traditional conflicts’ have become increasingly destructive and less manageable. Raiding has intensified throughout the region with constant clashes between the Pokot and Turkana, Pokot and Marakwet, Samburu and Turkana in Kenya, the Karamoja and Iteso, the Karamoja and Dodoth, and the Karamoja within themselves in Uganda. The conflict has moved beyond limited inter-communal rustling as it has become embedded in wider criminal networks serving national and regional black markets. The integration of raiding into the free market economy has transformed it into a well organised and coordinated big business, run by external “invisible” racketeers and businessmen, which ultimately depletes the communities of their cattle and hence their livelihoods. As noted by Heald [27: 106], “it is yet another feature of the informal economy and of the widespread corruption of the modern state.”

Several authors have commented on how the new technology of small arms has catalyzed the change. Pastoralist communities now provide the largest market for small arms from local circulation and from areas in the region undergoing civil wars such as Somalia, Sudan, Northern Uganda, Ethiopia and Eritrea. The predicament of conflict in the

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1 Abbink [1], Mkutu [45, 46, 48, 49], Anderson [3], Quam [63], SNV/Pax Christi [69], SNV [68], Knighton [34], Bollig [7, 8], Walker [75], Dietz [14], Lamphear [35], Cappon [11], Fukui and Turton [18], Niamir-Fuller [53], Ndagala [52], Novelli [54, 55], McCabe [41].
2 Field interviews done by the author in 2000–2004; Mkutu [45, 48], Pkalya et al. [61], SNV/Pax Christi [69], SNV [68], Niamir-Fuller [53], Mkangi [43], Belshaw and Malinga [6], Lamphear [35], Gulliver [25], Odegi Awundo [58], Pazzigalia [60].
3 Mkutu [44], Novelli [54], Niamir-Fuller [53], Heald [27], Hendrickson [30], Gulliver [25], Riamriam [64], SNV/Pax Christi [69].
4 Mkutu [45]: for the agro pastoralist in Tanzania see Bukururu [10], Abrahams [2], Anderson [3], Tornay [71].
5 Mkutu [45, 46, 48], SNV [68], SNV/Pax Christi [69], Gomes and Mkutu [19], Mirzeler and Young [42], Quam [63], Knighton [34], Walker [75], Belshaw and Malinga [6]. Noveli [54], Heald [26, 27], Tornay [70].
6 See Heald [27, 28], Mkutu [48].
7 Belshaw and Malinga [6], Mirzeler and Young [42], Ocan [57], Muhereza [51], Knighton [34], Fleisher [16, 17], Heald [26], Mkutu [44–46, 48, 50].
Horn Africa is that one country’s conflict invariably overflows to another because of same ethnic groups straddling the porous borders on both sides and the reality is the pastoralist will cross from one border to another with arms.11

Currently it is estimated that there are more than 160,000 small arms in circulation in the hands of civilians in Karamoja alone.12 Research in October–November 2004, suggested the numbers were much higher.13 Cold war politics through the sponsoring of conflicts in the Horn (Sudan, Ethiopia and Somalia civil wars and Ethiopia–Eritrea and Uganda–Tanzania wars) is largely responsible for the provision of arms into pastoral areas.14 Another significant event in the small arms story was the storming of the Moroto barracks by the Karimojong during the 1979 defeat of Idi Amin, yielding around 60,00015 weapons, which diffused into the Ugandan and Kenyan pastoral communities, unhindered by the porous boundaries.

The Karimojong and Kenya Pokot indicate current sources of arms to be Sudan, Ethiopia and Somalia. Also the presence of rebel groups/militias like the Lords Resistance Army (LRA),16 the Allied Defence Force (ADF) and the Toposa militia operating in the North accommodated by their relatives and some supported by the states has supplied arms to the pastoralists.17,18 Today sources include the capture of arms from rival pastoral groups as noted by one elder in an interview, “As you are raided lives are taken, the number of guns in the areas is reduced due to the several deaths. But in the raiding county, the arms are increased hence the rotating of arms.”19 Official security forces are another source through arms being sold by undisciplined soldiers. A related issue is the arming of informal security forces20 or para-military groups, who are poorly regulated and poorly paid/not paid, such that many use their small arms for their own ends, or desert with their weapons, having been trained in military skills to teach others. In the context of escalation of raiding violence and poor management by the state, the need for human security drives individuals to purchase their own arms from traders, by the sale of cattle.21 This may then further escalate conflict.

11See for example the military operation to flush our Ethiopian Oromo liberation front (OLF) rebels in Moyale Kenya. The conflict is spilling arms into Kenya. See Kenya Times 18 June 2004. http://kentimes.com/18jun04/nwsstory/news22.html. See also Daily Nation 18 June 2004 “Search for Ethiopian rebels is stepped up.” Seven guns and 70,000 bullets, landmines and grenades have been recovered from the armories belonging to OLF. See more in Mkutu [46, 48].
12Mkutu [48], SNV/Pax Christi [69].
14Makinda [38–40], Kinsella [33], Porter [62], Lefebvre [36], Lyons [37].
15Muhereza [51], Mirzeler and Young [42], Belshaw and Matlinga [6], Mkutu [45, 46, 48], Gomes and Mkutu [19], Ocan [57], Quam [63], Patman [59].
16IRIN, 3 February “Amnesty and Peace groups urge International Criminal Court to probe government army too”.
17Note that for many years Sudan government armed, trained and sheltered the LRA [Lord’s Resistance Army] in its territory and gave them the means to commit their crimes.
18See for example IRIN 8 September 2003. “The Uganda government admitted using militia groups to fight the Lords resistance army.”
19Interview elder Koritantoyo Nakiliro, 2 February 2003.
20This include the vigilante groups and militia and warriors.
21See Mkutu [46, 48]. On arms flows in the entire North Rift region. See SNV/Pax Christi [69], Gomes and Mkutu [19] on vigilante on the cross border areas.
Small arms and public health

Various authors have commented on the significance of small arms related injuries, referring to the problem as a “scourge” [9: 48]; a “global epidemic affecting civilians” [65]; as a “preventable health problem” [78, 79]; and an “international public health hazard” with violence as pandemic [76]. Cukier [13] notes that ultimately the effects of weapons are a health issue, and a public health approach is important...careful analysis would lead to understanding of causes and effective pathways for intervention. Cohen [12: 720] notes on providing nomadic people with healthcare that delivering the treatment also poses great problems, though she does not note the significant issue of small arms insecurity.

The Small Arms Survey [67] quotes figures from its 2001 edition, largely derived from WHO. It gives a figure of 500,000 deaths per annum related to small arms violence worldwide. However the survey admits that data from developing countries, particularly the Middle East and Africa is less available. Arya [5: 990] notes “the capacity for collecting consistent, reliable, and relevant data is limited by various cultural, economic, infrastructural, and logistic factors even in developed countries not at war” GoK [21] states that approximately 17,000 cases of violence against individuals were carried out in 2003. This constitutes murder, rape and assault, but there is no indication of numbers of firearm violence. The Ministry of Health for Uganda Annual Health Sector Performance Report has very little on the impact of armed violence on the community [23]. The Poverty Reduction Strategy paper (PRSP) 2001–2004 notes the importance of internal security on economic development, mentioning the proliferation of firearms as a problem to be tackled. It states however that poor use of statistics and research has hindered the fight against crime and insecurity. Matters to do with arms and raiding are regarded as security issues by state authorities and often no official statistics are available. Jackson et al [31: 64] note “There is a shortage of information on the impact of armed violence on development. Government personnel in affected countries are reluctant to highlight the problems associated with armed violence.”

This data small arms injury is part of PhD fieldwork done between 2000 to January 2005 and research done for the Netherlands Development Agency in 2005. It suggests that the impact of small arms have been profound for communities in terms of individual deaths and suffering of people and their families, and potential economic disruption. As observed by the Small Arms Survey [66: 155], “Amidst all of the debate about controlling the proliferation of small arms, there is a glaring, fundamental omission – the human face.”

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23 Government of Kenya Economical Survey [21]: 44
25 Mkutu [48]
26 SNV [68]
27 Research and policy tends to focus on supply-related issues such as the production and the mismanagement of stockpiles, inter-state transfers and illicit trade, technical aspects of weapons tracing, marking, collection and destruction, and on legal or normative regimes designed to stop the flow of weapons. See SAS [66]: 155.


Study area

The Kenya–Uganda border area is a largely arid and semi-arid area, best suited to pastoral activities. It is marked by an escarpment, which is 500 m above the general plain and runs the entire length of the border. The border area is 933 km long with only three border posts! There are numerous passes, which for a long time have provided means of communication between ethnic groups along the border. It is through these passes that cattle raids are frequently carried out. The region is dominated by a number of hill ranges. The Charangani hills that rise to 11,300 ft (3,444 m) to form the highest non-volcanic point in Kenya: on the Ugandan side, there is Mount Komerimeri. The areas also suffer from inaccessibility due lack of infrastructure due to nearly 4 decades of marginalization.

The border as it is today was established in 1926, during the colonial period. From Sudan in the north, two thirds of the border is adjacent on the Uganda side to the Karamoja cluster, with Sebei and non-pastoralist Teso and Bugisu in the southernmost part. On the Kenya side there is the large district of Turkana in the north, then West Pokot and Trans-Nzoia districts, with Sabot and Western Kenya in the southernmost part. Agricultural Luhya people occupy Trans-Nzoia and Western Kenya. A few groups straddle the border including the Sebei, Teso and Pokot, which complicates issues of national and international security. The study is concerned with Karamoja and West Pokot, being the main areas of insecurity.

Karamoja region, is a semi-arid area covering approximately 27,200 km². It encompasses 11 different ethnic groupings with similar dialects with a small number of quite distinct. The main Karimojong tribes are Matheniko, Pian, and Bokora. Others are the Pokot, Tepeth, Nyakwae, Jie, Dodoth, Ik (Teuso), Napore, and Labwor. West Pokot is and is inhabited mainly by Pokot peoples. The district has a sizeable portion added to Kenya from Uganda in 1966, but the presence of the Kenya government was not felt in the area until 1972. The area remains marginalized today.

The conflict has various unique or interesting characteristics. Firstly it is severely affected by small arms insecurity and was chosen in order to obtain pronounced evidence of impact, though by definition this meant some areas were too dangerous to access. Secondly both Karamoja and West Pokot are areas where there is a porous international border located away from major urban centres. Thirdly the conflict is not only across borders but in Karamoja it is between “cousins” which is unusual amongst pastoralists.

Fourthly the conflict is a national problem affecting non-pastoralists such as Teso, Lango and Acholi in Uganda, while the Kenyan Pokot and Turkana affect agro-pastoralist Marakwet and non-pastoralist Trans-Nzoia. Lastly the conflict takes a regional dimension when the either the Pokot or Karimojong ally together to launch attacks another group in Sudan or even Kenya.

28Karamoja and Sebei in Uganda and Pokot, Turkana and even Transzonia in Kenya.
29West Pokot and Karamoja was part of the Eastern Province of Uganda until 1926, parts of the Eastern Province of Uganda including West Pokot was moved to Kenya by the British government.
30Kotido (2), Moroto (2) and Nakapiripirit (1) see http://www.health.go.ug/health units.htm.
31The expectation is the Kuria in Kenya who rustled cattle from within see Heald [28, 29]. For the Pokot it is illegal to rustle cattle from within.
Health facilities in the cross border area

The estimated population for Karamoja in the most recent census was 955,245 served by five hospitals. Moroto District has two hospitals for 171,000 people. There is a government district hospital 30 km from the Kenyan border, which is poorly equipped and staffed by nurses and a doctor. Moroto also has Matany Mission Hospital, which is 80 km away. It is 120 km by road from the border. It is supported by the Italian government and is well equipped. It can be accessed by air, only through Mission Aviation Fellowship six seater planes, which is largely impractical for serious injuries. Five out of the 14 small clinics in Moroto: Nadunget, Loputuk, Kangole, Ngoleriet, and Lotome were visited since they are the first recipients of many victims of small arms. These clinics range from those run by a nurse and a midwife to a few with at least 1 medical officer and lab technician.

In Nakapiripirit people are still confronted with the inability to access health services and use health care facilities. Nakapiripirit district has one small hospital for 154,000 people. Amudat Mission Hospital (AMH) belongs to church of Uganda and is located on the border of Kenya and Uganda. It has two medical doctors seconded by Medecins Sans Frontières and a local doctor. There was no operating theatre during the most recent visit in 2003. More serious cases are referred to Kapenguria in Kenya. Data from 11 small health facilities in Nakapiripirit was then obtained from Tokera Hospital (a government facility with no equipment). There are 15 of these in total, and they can often offer little such that patients will often be recommended to attend Moroto and Matany. The centres are the first port of call for many (though for some, they will still first try traditional healers), and are therefore very representative of the situation on the ground.

Kotido District has two hospitals, serving 596,000 people. Kananwat mission hospital has similar facilities to Amudat, but unfortunately no data could be obtained from there. In Kaabong district to the north there is Kaabong mission hospital, but the insecurity between the Jie and the Dodoth has made it inaccessible for the majority of the injured and also the researcher. Forty-four other very small facilities existed.

There are three types of health facilities in Kenya, hospitals, health centres and health sub-centres including dispensaries and mobile clinics. Dispensaries and health centres are the first contact facilities for most people seeking medical care. Based on the Kenya Human Development Report, UNDP [74], use of health services is determined by absolute access to service, distance travelled or cost incurred to access the services, relative access to service, the crowding and waiting time at the clinics and availability of medical services.

West Pokot in Kenya, a district with a population of 350,000 is served by Kapenguria district hospital, which is 45 km from Amudat in Uganda (The doctor in Amudat noted that Ugandans will cross the border to get to this hospital). It has around 2–4 doctors. There is

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32Based on the final results of the September 2002 National Population and Housing Census, Kotido District, which includes the newly created district of Kaabong has a population of 605,322 (302,206 males and 303,116 females). Moroto District has a population of 194,773 (98,145 males and 96,628 females). Nakapiripirit has a population of 155,150 (78,284 males and 76,866 females). These figures are questionable, how can a population increase from nearly 300,000 (1991) to nearly one million in 2003?. See Mkutu [48], Chapter 1 UBOs [72]. However, increase from 1991 figures to current figures is question see Mkutu [50].


34Kabongo became a district this year; initially the district headquarters for the region was Kotido.

35GOK [20].

36Interview Stephen Kaadu, 20 June 2001
also Ortum Catholic Mission hospital, which has around two doctors. There are other district hospitals in the north rift region, though the terrain and remoteness means travelling would be extremely difficult. Kitale hospital is 30 km away in Trans-Nzoia district, and Eldoret hospital is 80 km in Uasin Gishu district. Kapenguria is able to deal with most admissions.

Around four health centres, five clinics and 36 dispensaries in total exist in the district. Amukuriate Mission Health Centre is located in the North of the district, 20 km from the Kenya–Uganda border. Data for Amukuriate Mission Health Centre was extracted from the Amukuriate dispensary and mobile clinic in Alale, West Pokot. The centre was well staffed with nurses, being a missionary centre, but an interview with the nurse revealed that they did not have a doctor or operating theatre. The Catholic Church runs the centre, and as a result the local bishop is well respected and influential in the area. Two other missionary clinic sites were also visited, but they were not in operation. Smaller private clinics were visited but they did not keep records. The government clinics have few resources and hence are rarely used. In the 1990s, a wave of neo-liberalization swept Africa, and most hospital services were privatised by the state, which led to understaffing in government hospitals. Given the remoteness of pastoral areas with the infrastructure, the only providers who went to these areas were missionaries.

In these institutions, access to the records was allowed. The author perused the records available for all admissions over the 4 years from 2001–2005. Information was extracted on gunshot wounds and other injuries classified by the centres as being due to “domestic violence,” noting sex, age, date, area of origin, what was the type of injury and by what means was it sustained (if available). In some of the small dispensaries, where records were not as completely kept, the information classification was unclear, particularly with regard to what was meant by domestic violence, (i.e. whether firearms were involved). Some centres did not have data for the entire time period. Public health information often is not available because of the sensitivity of patient information in health and social care. Therefore, names and addresses were removed to reduce the chances of anyone identification of a record, only summaries were obtained, rather than detailed records. Other methods used to obtain data include in-depth interviews with hospital staff, local leaders and the community. Participative observation was also used.

Interpretation and limitations

The data was analysed for trends in demographic information, such as age and sex of victims and comparison of numbers of gunshot wounds with other types of trauma. From these data, as well as from discussions with the staff at each clinic, inferences were made about the magnitude of the problem of armed violence in pastoral areas. They give some indication of the nature and prevalence of small arms injuries. though figures must be considered in relation to the size of the districts, and in light of the fact that “hot spots” were chosen.

However the figures may be an underestimation since not all hospitals could be accessed and deaths soon after combat would not feature in hospital data. Also as noted in interviews with the medical staff, four reasons prevent pastoralists especially Karamoja from bringing the injured to the hospital. Firstly is the cost, since people that attend Matany are those rich enough to travel the long treacherous journey and pay the mandatory charge of 200,000

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37The ratio of doctor to patient in West Pokot is 1:84. This is 528 in a population of 337,870 people. West Pokot Annual report 2002–2008, 2002:8
38For an extensive write up on the methods see Mkutu [48] chapter 1.
UgSh (for injections, antibiotics and to discourage raiding.) Secondly, in a government hospital one is required to have a P3 form from the police station, stating the cause of injury before treatment. As noted in an interview with the clinical officer at Loputuk clinic,39

The guns in the violence are not intentional. In Loputuk you have to pay 5,000 UgSh for a continuous trauma treatment, while in Moroto you have to get a P3 from the police stating how you were hurt, therefore, fear of charges makes people not come to hospitals. So people treat themselves locally. People only come when it is septic40

Thirdly, there is the issue of distance and transport to reach medical care. After the completion of my research interviews in Alale, I was shocked to come to the car and see a big crowd. I wondered what blunder I had done. On approaching the car, I discovered the crowd of nearly 20 people all wanting a lift to Kapenguria due to lack of means on the Alale-Kapenguria road. Some of the people were the sick who could not be treated at Amukuriate and they had been referred to Kapenguria District hospital. One lady told me that she had been trying to get means to Kapenguria for the last 3 weeks.

Lastly, the pastoralists may sometimes prefer to use the local medicine men, emuron (Karimojong) or werkoyon (Pokot) to treat them rather than come to the hospital, since they are culturally more trusted and feared and also will not report perpetrators to the police. I was unable to obtain information from any emuron, though attempts were made in all areas. I did interview one in Amudat, but he was unwilling to provide any information.

Results

Table 1 collates available data from all the centres over 8 years, giving data on total number of patients. It demonstrates where possible, total injuries, mortality, women and children (under 16). Extra data from Kapenguria, which was available from 1990, is given later. From the data one can see the impact of small arms on communities from the health perspective. There are some ‘hotspots’ seen particularly in Karamoja clinics, which have astoundingly high figures. It should be noted that people in larger centres may have been counted twice since many of them were referred from smaller health centres and there is a small chance some female children may have been counted twice as both children and female (Figs. 1 and 2).

Individual centre analysis

Moroto

The original data indicated the date of injury, which is valuable information since injuries frequently occur in clusters and indicate when raids took place. Additionally the data demonstrated hot spots by indicating the village from which victims originated. See Table 2. Some comments may be made to concur with this data. Rupa seems to have many

39If it is reported that the enemies made the injury the cost is 100,000 UgSh. But if a warrior is shot during raiding the cost is 200,000 Uganda Shillings. Interview medical officer, Name withheld, Moroto 27 November, 2004
40Interview Peter Lodonga, Nursing assistant Lopotuku dispensary, 29 September 2004
patients, despite being located 2 km from the army barracks and near the police station. Rupa is not a *kraal* area, so this supports anecdotal evidence that guns are used outside of raiding activities, in brawls fuelled by drinking. Rupa is known to be a high producer of local brew or *ekwete*. Raiding and banditry in Lorengwat declined due to the creation of vigilantes in 1995; however, it has begun again recently. The Resident District Commissioner Peter Ken's car was ambushed and burned in 2002, and on November 21, 2002.

### Table 1 Gun related injuries in hospitals and health centres 2001–2004

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<tr>
<td>Amudat Mission Hospital</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Total</td>
<td>–</td>
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<td>9</td>
<td>10</td>
<td>17</td>
<td>11</td>
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<td></td>
<td>12e</td>
</tr>
<tr>
<td>Women</td>
<td>–</td>
<td>–</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td>Deaths</td>
<td>–</td>
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<td>–</td>
<td>–</td>
<td>2</td>
<td>–</td>
<td>–</td>
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<tr>
<td>Nakapiripirit Clinics41</td>
<td></td>
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<td></td>
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<td>Total</td>
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<td>2,420</td>
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<tr>
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<td>11</td>
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<td>1</td>
<td>1</td>
<td>–</td>
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<td>–</td>
<td>–</td>
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<tr>
<td>Children</td>
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<td>–</td>
<td>1</td>
<td>1</td>
<td>–</td>
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<tr>
<td>Kapenguria District Hospital</td>
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<tr>
<td>Total</td>
<td>6</td>
<td>19</td>
<td>23</td>
<td>18</td>
<td>17</td>
<td>–</td>
<td>–</td>
<td>–</td>
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<tr>
<td>Women</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td>Deaths</td>
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<td>3</td>
<td>0</td>
<td>0</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td></td>
</tr>
</tbody>
</table>

Matany Mission Hospital, DDHS Nakapiripit, Moroto Hospital and dispensaries, Kapenguria district Hospital, Amukuriate Mission Dispensary 2001–2004

a Children defined as under 18

b Data collection started between Jan–Oct 2001 and went on until 2004 in all clinics except one, where collection stopped in 2002.

c July to October

d July 2002 to May 2004

e January and February only, there was a large raid.

---

41 Source District Department of Health Services Nakapiripit, 2003

42 See SNV [68]
warriors attacked two army detachments near Moroto. In the exchange of fire, the military people were defeated and several soldiers were killed.\footnote{Observations in the field, 19–23 November 2003 See Mkutu \cite{Mkutu2006, Mkutu2008}, Gomes and Mkutu \cite{Gomes2009}, SNV/Pax Christi \cite{SNV/Pax Christi2006}. for vigilante formation in Karamoja.} One soldier told the researcher in an interview that he only just survived by the mercy of God.\footnote{Peterken former Resident District Commissioner. Interview, Nakapiripirit, Uganda, 26 January 2003.}

The original data gave names of those admitted from which it was clear that two of the patients were treated twice, with a few months between admissions. This shows how hospital data might identify ringleaders and used for early conflict warning, though there may be ethical problems with this since it may deter those who need help, and strengthen the position of emurons to whom they will go instead, who are also the same people who bless the raiders. Hospitals are not currently required to submit data on criminally related injuries to identify villages where there is trouble. Interviews with hospital staff in another area noted that many victims are also perpetrators.\footnote{Dr Kaadu, Stephen, former Doctor at Amudat mission hospital Interview Amudat, 18 June 2001. Also Dr. Motanya, David, former Ministry of Health in charge, Kapenguria District Hospital, Interview, Kapenguria, August, 2002.}

Clinic data is interesting, because it may represent the situation on the ground more accurately. In this instance it should be considered alongside hospital data as some clinics are quite near to the hospital, this may explain why the figures for the clinics are not always very high. Unfortunately police data for the area to assist with interpretation of the figures was not available, since the security of Karamoja is managed by the army.\footnote{SNV/Pax Christi \cite{SNV/Pax Christi2006}: 34–45, Mkutu \cite{Mkutu2006}.} Some interesting data was available from clinics on injuries classified as “domestic” allowing comparison to be made with the gunshot wound figures, which are much less. However, it is not entirely clear how the injuries occurred in these statistics and whether or not some small arms violence may have been involved. Interviews elsewhere have suggested that sometimes gunshot injuries are classified as domestic accidents if they were carried out at home.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{gunshot_wounds_in_morotoclinics_2001_2004.png}
\caption{Gunshot wounds in Moroto clinics 2001–2004}
\end{figure}
Matany

Matany is interesting because it receives the worst cases from elsewhere in the four districts, provided they can access the hospital, therefore it gives insight into how severe some injuries may be. Sites of injury were also given and are discussed later. The large catchment accounts for the high numbers of injuries, though Matany itself is still an insecure area. Although there is no data for 2001, when the researcher visited Matany in June, there were 17 gunshot victims in the hospital.

Amudat

Interviews with the superintendent of Amudat Mission Hospital indicated that due to high payment costs for those admitted; many preferred to go to Kapenguria hospital across the border in Kenya, as it is free and has better facilities. This may explain low figures here. Transport for those referred to Kampala or Mbale is problematic due to the costs of travel. Air travel is safest but costs 78 Pounds Sterling to Kampala. Interviews with doctors from Medecins Sans Frontières indicated that those who travel by road have to go via Kitale in Kenya to get to Kampala due to the insecurity on the Namalu-Mbale and Namalu-Nakapiripiriti roads. Twelve people with gun injuries were admitted in January and February 2003, and interviews with the medical personnel indicated that they were Uganda People Defence Force (UPDF) soldiers from the Karita (Pokot) fight.

Fig. 2 Domestic injuries in Moroto clinics 2001–2004

Gender and Age of Domestic Injuries in dispensaries in Moroto

<table>
<thead>
<tr>
<th>Dispensaries</th>
<th>Men</th>
<th>Boys</th>
<th>Women</th>
<th>Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kangole</td>
<td>40</td>
<td>30</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Ngoleret</td>
<td>20</td>
<td>30</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Kideto</td>
<td>25</td>
<td>30</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Nadunget</td>
<td>25</td>
<td>30</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Loputuk</td>
<td>25</td>
<td>30</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Lotome</td>
<td>25</td>
<td>30</td>
<td>20</td>
<td>10</td>
</tr>
</tbody>
</table>

47 Due to a road ambush of the supervisor at Matany, and because a big raid had just taken place, she was so upset that she refused to release any data.

48 Superintendent of Matany Hospital. Interview, Matany, 20 June 2001. On the day of the interview a big had taken place and 17 warriors had been brought to the hospital.

49 The hospital charged 20,000 Uganda shillings before they would touch any one admitted with a gunshot wound. The purpose was to discourage cattle raiding.

50 Interviews in June 2001, and also interviews at Amudat, 27 January 2003. Interview with a Solider based in Nakapiripirit noted that over 1000 people have been killed due to banditry on the Namalu-Moroto road.

51 Nurse, name with held, Interview, Amudat Hospital, 27 January 2003.
Nakapiripirit clinics

Over 18 months the number of victims recorded with gunshot wounds in the clinics in Nakapiripit was an astounding 5,000 persons with 1,041 sustained during raids (see Fig. 3), yet it is not even a centre of pastoral small arms conflict. This has to be questioned but the data was collected first hand from the centres. The researcher was not aware of any reason why figures should have been doctored and had requested the staff in various clinics/hospital to verify. They may be accounted for by the dangerous locality.

Figure 4 shows a breakdown of the contexts in which trauma incidents to place. Staff claimed that the ‘accidental’ gunshot wounds were often domestic incidents where arms were used. However, when the people came to the clinics they claimed, “It was an accident.” Notes from field observations, mainly in Nabilatuku, revealed that domestic violence involving arms was often related to the brewing of local beer. Interviews in the community confirmed that sometimes shootings were caused by ‘a small quarrel,’ which resulted in the warriors using their guns, especially when under the influence of alcohol. This was clearly confirmed by the medical superintendent for Kapenguria Hospital in Kenya who noted:

Often, I think, it is just squabbles at home and they happen to use guns in their squabbles accidentally. Or a person will be fiddling with it and it goes off and probably injures somebody.

This is a new understanding of the impact of small arms and how the presence of arms in the home and community can lead to indiscriminate disordered violence. It shows the picture in local villages, since many would not travel to a major hospital due to distance and the criminal nature of the activity that produced their injuries. Novelli speaks of one of the fights between Karamoja and the UPDF after which he saw 300 dead bodies left for the

Table 2

<table>
<thead>
<tr>
<th>Village</th>
<th>Year gun injuries most problematic</th>
<th>Approximate distance from Moroto (km)</th>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rupa/Army Barracks</td>
<td>Throughout</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>Nabilatuk</td>
<td>2000–2001</td>
<td>80</td>
<td>14</td>
</tr>
<tr>
<td>Nakimisitae</td>
<td>1999</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Lorengdwat</td>
<td>1999–mid 2000</td>
<td>40</td>
<td>8</td>
</tr>
<tr>
<td>Nadunatau</td>
<td>Unknown</td>
<td>Unknown</td>
<td>7</td>
</tr>
<tr>
<td>Nadunget</td>
<td>Unknown</td>
<td>Unknown</td>
<td>6</td>
</tr>
<tr>
<td>Tokera</td>
<td>Unknown</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Kidepo</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Nakapiripirit clinics

53Various sources from Kangole, Moroto, Namalu and Amudat, Uganda. See SNV [68]. Note that the Lutheran World Relief is trying to assist women in Nabilatuku to buy grain to sell But most of the women invested their money in local brew as it gives them better returns. See for example Daily Monitor 2 June 2003. http://www.monitor.co.ug/archives/2003main/jun/news/0602/news8.php. It notes that waragi (local beer) drinking has heightened insecurity is and therefore a cause of deaths in the area.
54Motanya, David, Interview, Kapenguria, 22 May 2001.
vultures. As noted in an interview with the Local council Chairman for Kotido “in Karimojong culture men killed in battle are not buried but left to in the bushes to rot.”

Amukuriate

The original data for this centre gave the dates of admissions with clusters of admissions indicating raids. Interviews indicated the factors leading victims to attend. “Sometimes they come, and some times they do not, due to fear of explaining the cause of gunshot wounds.” However, when they realize they are in danger, they end up coming for treatment. Some periods of the year during droughts, admissions of people with gunshot wounds increase drastically, which implies that more raids are taking place. The ages of the victims are commented on in the discussion.

The nurses noted that they treat many people with gun wounds, but the most serious wounds are referred to Kapenguria district hospital (KDH), which is 173 km away. A Catholic Father said, “The area is completely cut off, and it is difficult to get essential services or important things to survive.” Florence, a nurse who has worked with the clinic for 8 years, noted, “The local clinic does not have a surgery to operate on serious cases; it is forced to refer them. By the time the patients arrive in Kapenguria, they are probably dead.”

It was also mentioned that if local people were needed to give blood, it would have to be carried in refrigerated cars, which are not available, or be donated on site in the remote areas (Table 3).

Kapenguria

Kapenguria figures show a small trickle of injuries over 5 years. However Police data shown in Table 4 below, show 521 deaths due to small arms over the same period in West Pokot, so the injuries which make it to hospital, are really the tip of the iceberg! (However some would rather travel to Ortum) A long-term doctor at Kapenguria District hospital noted,

In West Pokot we have several small arms and most of them are actually unlicensed. This usually you can get from the fact that if you take a walk you would see...
pastoralists herding their cattle carrying at least a gun. That means on average for every herd of cattle, there is at least a gun which herdsmen are walking around with.... It is not everywhere in this country you walk or you go around and you just see somebody carrying a gun. On top of that you have guns that are licensed those given to homeguards...According to the doctor, “a month would not end without them having a raid victim.” A month will not end without a raid occurring where there is loss of life, major loss of life and animals.59

Police are commonly accused of being ineffective and poor at record keeping, however this problem is variable, and dependent on resources to move in dangerous areas. Their data is clearly of some use in representing the degree of the problem. Police data can also give more specific information on events. For example, there was a raid in Morita on 25th January 2000 where 1,500 cattle were stolen, nothing recovered and in the process 17 people were killed, 11 of which were children, and nine people were injured.60 This degree of violence is not in any way represented by the hospital data for that area which only picked up nine injuries that year. Post-mortem data (collected differently from admission data) was also available, see Table 3, which did not indicate this either (Table 5).

Analysis

Comparison of the figures between centres is difficult because of the different factors which determine presentation of injuries to health facilities. Remoteness and transport, security of roads, facilities in health centres, seriousness of the injuries cost of attendance and requirement for a certificate from the police, and the use of traditional healers will all be issues determining attendance. Some comments may be made however. Referral centres will see more injuries and worse injuries. Local clinics may see more injuries due to being the first point of contact. The cost of attendance may lead to smaller number of injuries being dealt with.

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59Interviews Medical Superintendent Kapenguria District Hospital, Kapenguria, August 2002. The District commissioner concurred and not that at least in a month there is always one or two raids with many people injured. Interview Kapenguria, August 2002

Gender and age data

The data demonstrates that most patients are men, with Fig. 5 noting the age group from 18–30 in Amukuriate. It is also important to note that nearly a quarter are below 18 in this small centre. This at least suggests that raiding is the main cause of injury, and men younger than 18 are raiding. This was confirmed by interviews with hospital staff. It is important to note that in pastoral societies initiation into manhood is done on an “age set” system, in the early teens and the western definition of adult is rather arbitrary in this context. However there are also some girl children and very young children injured, suggesting crossfire and interviews

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>Women</th>
<th>Children</th>
<th>Male</th>
<th>Female</th>
<th>Male</th>
<th>Female</th>
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</thead>
<tbody>
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<td>0</td>
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<td>0</td>
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<td>1997</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>1998</td>
<td>9</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>3</td>
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<td>2000</td>
<td>8</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 3 Post-mortems carried out in Kapenguria for gunshot wounds 1996–2000

Source: Kapenguria Hospital health records and information 1996–2000

16 year old victim of gun shot wound, Mkutu Nov 2004.
noted that sometimes young boys are targeted to be shot since they are the future raiders and security of the community.\textsuperscript{61} It must be noted that an injured child is more likely than an adult to be taken to hospital when wounded.

It is notable that the AK47 is a very easy weapon to use, such that it can be wielded by a child and lethal shots rattled off in an arc of destruction. The following story was told in Natarumurum, Rupa while in the field.

Three young boys aged 14–16 were drinking with others. As they enjoyed their beer, they were singing their songs of bulls (songs of giant warriors who have killed). However the young boys did not know how to kill. So, they decided to go and try. They travelled to Nakajat and hid and waited. The first people that appeared were three girls from Leyia primary school. The children were carrying remnants of their lunch. As they were going they asked them whose children they were. The three girls aged 8–12 responded and the boys opened fire. 2 of the girls died instantly and the other was brought to Moroto hospital where she died in September 2004. The Tepeth community, from where the girls came, followed the footmarks of the killers. Meanwhile the Local council 3 and some cadet staff from the army were also looking for the killers of the girls as were the Rupa community from where the boys came. They caught the boys still drinking. The boys had smeared themselves with red clay (sign of cleansing). They were arrested and kept in one of the army detaches. The next day the community of Rupa handed them to Tepeth. The army had intervened and wanted the boys to be prosecuted by the police. But the people grabbed the three boys and threatened to shoot the army. After being handed to the community of Tepeth, just before they reached the point where they killed the girls, they shot them, even the third boy who was innocent. This was during the period of disarmament.\textsuperscript{62}

The tragedy of this story is that the society has become so militarised that even children can get their hands on a gun and take life before they understand what life is.

The percentage of the injured who were women was between 13–25\% in the centres, though again the centre with the largest figures did not segregate for gender. There is no particular difference between the rural and referral centres. It must be considered that women may be less likely to attend due to lack of escorts since men are moving with the cattle. This leaves women vulnerable, and women give accounts of attacks and rapes from enemy raiders

\begin{table}
\caption{Number of people killed from 1997–2000}
\begin{tabular}{cccc}
\hline
Year & Deaths &  \\
  & Men & Women & Children & Total \\
\hline
1997 & 115 & 12 & 6 & 133 \\
1998 & 114 & 1 & 4 & 119 \\
1999 & 35 & 18 & 13 & 66 \\
2000 & 180 & 12 & 11 & 203 \\
\hline
Total & 521 &  &  &  \\
\hline
\end{tabular}
\end{table}

\textsuperscript{61}Interview Alale, August 2002, Interview of warriors in Panyangara Oct 2004.

\textsuperscript{62}Interview Edison Achia, Moroto 2 October 2004.
at these times. A 15-year-old girl in Loputuk told the researcher her story of insecurity with raiding of kraals.

10 years ago we were in kraals in Lorengedwat. The raiders came and raided our kraal. Both men and women were raided. I ran aimlessly, following people, not knowing where to go as the bullets were just raining. The enemies succeeded in taking our cows.

An interview with a woman from Lotirir mothers group shared the experience of her neighbour:

She went to collect firewood. The raiders found her. She was found undressed, raped several times. They went with her for a long distance and she was abandoned in a strange village she did not know.

Vulnerable groups who cannot defend themselves are represented in Matany, partly by virtue of it being a referral centre. From the original data there were 12 people over the age of 60 injured, (three over age of 70) though it is worth noting that age is usually estimated in pastoral culture, four of these were women. The elderly have less capacity to heal and may be more disabled by the injuries (It is ironic that in the western world the commonest cause of a fractured femur in an older woman is osteoporosis, yet here we see a woman of 59, with the same injury from gunshot!). In the past it was a serious matter to harm an older person but it might be that this is changing.

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Table 5  Details of children injured and killed

<table>
<thead>
<tr>
<th></th>
<th>Total recorded injuries/deaths in under 18s 1996–2004</th>
<th>Total recorded injuries/deaths in under 5s</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moroto hospital</td>
<td>5</td>
<td>4</td>
<td>1 boy killed aged 4 months</td>
</tr>
<tr>
<td>Moroto clinics</td>
<td>16</td>
<td>8</td>
<td>10 year old killed 7 in Nadunget clinic</td>
</tr>
<tr>
<td>Matany mission hospital</td>
<td>52</td>
<td>9</td>
<td>1 child aged 3 years shot in the jaw</td>
</tr>
<tr>
<td>Amudat mission hospital</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nakapiripirit clinics</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amukuriate mission clinic</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kapenguria hospital</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kapenguria hospital</td>
<td>2</td>
<td></td>
<td>Boys aged 6 and 12 killed</td>
</tr>
</tbody>
</table>

*a Some centers may have counted children as under 16s

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63 SNV [68].

64 Interview young girl of 15 in Loputuk 29 October 2004.

65 Interviews Lotirir mothers group, 1 October, 2004
Deaths

Deaths were documented in all centres except two, again valuable information from Nakapiripirit was not given. Sixty-two deaths in hospital were noted in all since 1996, however as noted previously other sources show that this in no way represents total small arms deaths. Many deaths may also occur outside of hospital and the seriously injured may be allowed to die due to lack of resources to travel or be admitted (20,000 UgSh in Amudat) or need to produce a P3 form as in Kapenguria.

Deaths may not be accounted for in any official way. Karimojong never bury a person violently killed on the ground that it could bring bad omen and that the relative would even refuse to see the body. In an interview with a late Catholic father and resident since 1970s he noted that: “Among the Karimojong there is the tendency to attribute death to the ‘evil eye’ or to evil dispositions of other people, rather than to natural causes. This is particularly the case of violent death or with deaths of a mysterious origin. For this reason, their body are left were they are, in order to avoid contamination from the same misfortune and also for fear that the dead will take revenge not only against those who caused their death, but also against everybody else.”

Sites of injury

Some injuries documented were very serious. It must be born in mind that this information came from a referral center with full time or visiting specialists and surgeons. Bone injuries are likely to be disabling, and chest, abdominal and neck injuries may be life threatening. One head injury was to a child who was shot in the jaw. A child of 15 was injured in both femurs. Other information closer to the ground on fractured limbs was available too, from Amudat, showing that a quarter of the patients had fractured bones. This was supported by interviews revealing that from 2002 to 2003, most had limb fractures. Such injuries have long-term implications for mobility and livelihood. Many of those who survive an injury will suffer long-term disability. Particularly vulnerable are children whose limbs are still growing, a process that is impaired by fractures. Disability would negatively impact families by diverting scarce family resources and limiting the capacity to work and to survive, further engraining the poverty in the region.

Fig. 5 Ages of gunshot wound patients in Amukuriate

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>below 18</td>
<td>11.5</td>
</tr>
<tr>
<td>18-30</td>
<td>23.3</td>
</tr>
<tr>
<td>31-40</td>
<td>60.5</td>
</tr>
<tr>
<td>over 40</td>
<td>4.7</td>
</tr>
</tbody>
</table>

66Interview Novelli, Moroto 17 July 2001; See Novelli [55]
Underdevelopment

The lack of medicine in health clinics is partly due to the structural adjustment polices (SAPs) that were introduced in Africa in the 1980s and 1990s by the world bank. Trade liberalization policies were created in the hope that the private sector would be the engine for sustainable development. This compelled governments to slash down public expenditure, doing away with free and subsidised healthcare and adopting market based services backed by cost sharing and use fees [77]. However, investment in insecure and marginalized areas was never a realistic prospect, and this has simply added to the marginalisation and lack of provision for pastoralists.67 The introduction of SAPs has also led to a decline in donor support. Kimalu et al [32: 45] note “more than a decade after its implementation, the cost sharing programme has not fully addressed the problems of the vulnerable and has not promoted access to modern healthcare. Implementation problems and institutional weakness mar the programme and there has not been corresponding improvements in the quality of health care.”

The data highlights the sparse medical facilities in these insecure regions, exacerbated by the fact that insecurity dissuades all but the most determined workers from going there. In West Pokot the people saw the church as responsive to local needs but not the Kenya government. The government responded to the annual malaria outbreak by sending medicines too late, and then to an understaffed government dispensary.68 The health service is heavily reliant on missionary and church help, and the church organisations are well respected in the region. Working with them to build up existing facilities is a sensible and efficient way to improve available health care. Some of the data on the nature of injuries may suggest which would be the most valuable and lifesaving interventions.

The cost of hospital admission is impossibly high for many pastoralists. Matany Hospital started to charge between 100,000 and 200,00069 Uganda shillings to discourage raids while Amudat is now charging 20,000 Uganda shillings. In Amukurirte pastoralists are charged 250 Kenya shillings for dressings. A recent study on medicine prices in Kenya in 2004 notes that some 20 million Kenyans cannot afford drugs out of the country’s estimated 30 million people; just 9.3 million can access the medicines. Only an estimated 23% of the sick do seek either they cannot afford or could not access health facilities. Forty percent of this group do not seek medical service because of lack of money.70 The prices were much higher in Kenya compared to Uganda and Tanzania. However the report found mission hospitals to be cheaper, than both the private and state clinics.71 Government facilities are free, but many are completely without resources. Even an aspirin is hard to come by.

Transport also is a significant problem in the areas studied. Most pastoral areas have been remote and marginalized since colonial times, and suffer from absence of state security, resulting in lawlessness and escalation of inter-pastoral conflict. This further

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67 For details on governance and marginalization in pastoral areas in the north rift see Mkutu [48, 50].
68 Field research Alale, Kenya 2002 see Mkutu [48].
69 Interviews in November 2004 indicated that before you are operated it is now 100,000 and if wounded while in a raid it is 200,000 Uganda shillings.
71 Ibid.
hinders development, since these areas are now becoming no-go areas. The response by state law enforcement bodies has been slow, ineffective, overly forceful, or non-existent. There are no effective polices to address insecurity and the formation of vigilante groups and home guards is leading to additional threats to law and order and increased proliferation of small arms and a major drain on the already fragile public health system.\textsuperscript{72} Pastoral areas are the worst hit by lawlessness. This raises questions about the nature of the post-colonial state in Africa. If the official forces of law and order are demonstrably corrupt and not able to provide security, the implications for public health in rural areas are obvious.

**Conclusion**

Small arms injuries are a national problem, in both countries of Kenya and Uganda. However the situation appears more grave in Karamoja. Other work indicates that small arms violence is more out of hand in Karamoja, due in part to a weakened traditional governance institution which would manage disputes, and recent clashes of the Karamoja Warriors with state security.\textsuperscript{73}

There is a suggestion that charges for health care in Amudat hospital in Uganda led to locals crossing the border into Kapenguria. In other areas people may cross to Uganda because their currency is stronger. Therefore the issue of communities straddling borders has implications for healthcare provision. Additionally there is a need for cooperation between the two countries, particularly if public health statistics were to be used as a conflict early warning mechanism. This poses problems in terms of the ethics of the confidentiality of medical information. Even if hot spots were identified instead of individuals, such information sharing may still threaten the trust of communities, if governments responded with a militaristic approach, as has often happened among pastoralists.

Gunshot injuries are a potent indicator of the humanitarian impact of small arms.\textsuperscript{74} This data demonstrates substantial numbers of people attending the hospitals and clinics in recent years with huge numbers in some local clinics. The data provides a grim picture, but not a full picture. The poor provision and the cost of health care itself means that public health data is not easily obtained, since communities may simply be unable to access any facility at all. Police data over the same time frame has demonstrated much more of a humanitarian impact of small arms. Thus several sources are essential to get a full picture. Thus traditional medicine remains the only choice for many, more research could focus around the numbers presenting to these healers, though is difficult to obtain. Harder still to determine is the mental health impact of small arms. Women have given testimonies of their own fear of attacks and rapes. The story of the children who took up arms against other children is another suggestion of how small arms may be affecting mental health in development. What is currently available in terms of health care in these areas is unlikely to provide for such traumatised people. This may be an area that missionary hospitals could research into, having established trust of the local people.

The data, whilst not exhaustive provides a human face to the growing bank of statistics on small arms. The number of young lives affected and lost from both combat and cross

\textsuperscript{72}Mkutu \cite{45}: 7, Mkutu \cite{47, 48}, SNV Pax Christi \cite{69}, SNV \cite{68}, Gomes and Mkutu \cite{19}, Belshaw and Malinga \cite{6}, Quam \cite{63}.

\textsuperscript{73}Mkutu \cite{46, 48}, SNV \cite{68}, SNV/Pax Christi \cite{69}, Knighton \cite{34}, GoU \cite{24}.

\textsuperscript{74}See for example WHO \cite{78} which argues that they are among the top five contributors to the global health burden among people aged 15–44.
fire, and older vulnerable non-combatants with injuries should galvanise efforts to manage increasing insecurity in marginalized pastoral communities. The poor healthcare infrastructure in the region is not a separate issue, but relies partly on the provision of adequate security.

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