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Dollars for Drugs?
An Exploration of the Bamako Initiative as an
Appropriate Intervention for Meeting Women's Health Care Needs in Kenya

by

Donna Chiarelli, B.A.

A thesis submitted to the
Faculty of Graduate Studies and Research
in partial fulfilment of
the requirements for the degree of

Master of Arts

The Norman Paterson School of International Affairs

Carleton University
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The undersigned hereby recommend to the Faculty of Graduate Studies and Research acceptance of this thesis submitted by DONNA L. CHIARELLI, in partial fulfilment of the requirements for the degree of Master of Arts.

Maureen Appel Molot

Maureen Appel Molot, Director
The Norman Paterson School
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F. Mackenzie

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Abstract

The Bamako Initiative (BI) is an Africa-wide primary health care strategy based on the supply and sale of essential drugs supported by UNICEF and the World Health Organization. This thesis explores, through a case study analysis of the Sigoti Location Bamako Initiative site, whether Kenya's Bamako Initiative is appropriate for women: namely, whether it integrates women's voice into its design, through women-centred definitions of priorities, and whether it incorporates mechanisms for women's empowerment, enabling women to exert greater control over their health development. Experience from Sigoti suggests that where community-financing of health care is incompatible with local realities, the BI is less than successful in meeting women's broad health care needs. The Sigoti BI site was characterized by uncertainty and conflict between various key actors because they lacked the requisite knowledge, negotiating skills, and above all, resources, to manage their BI site effectively.

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There are many people whose support, guidance, and caring have enabled me to persevere and take pride in this project. Most importantly, I thank the Sigoti community for their warmth and participation. The enthusiasm with which they participated in the study, and their eagerness to strengthen their health care program, in spite of the magnitude of problems they faced, served as a constant inspiration for this work.

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Thanks also go to Dr. Hezron Oranga, my supervisor in Kenya, and the African Medical and Research Foundation (AMREF). I hope that the information gained from this study will contribute to their understanding of gender issues in decision-making in the Bamako Initiative.

I express my gratitude to my supervisor, Dr. Fiona Mackenzie, whose positive feedback and guidance at each stage of this process certainly boosted my confidence, and meant that my thesis experience was a positive one. I also thank my advisor, Dr. John O'Manique, whose comments and perspective were much appreciated.

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List of Acronyms

AMREF	African Medical and Research Foundation
BI	Bamako Initiative
CBHC	Community-Based Health Care
CHW	Community Health Worker
DDC	District Development Committee
DHMT	District Health Management Team
MCH	Maternal and Child Health
MOH	Ministry of Health
NGO	Non-Governmental Organization
PAR	Participatory Action Research
PHC	Primary Health Care
PR	Participatory Research
PRA	Participatory Rural Appraisal
RRA	Rapid Rural Appraisal
TBA	Traditional Birth Attendant
TOT	Trainer of Trainers (Trainers of CHWs)
UNICEF	United Nations Children's Fund
VHC	Village Health Committee
WFPA	World Federation of Public Health Associations
WHO	World Health Organization

planning and maternal and child health, particularly in countries characterized by high fertility rates (Jacobson, 1993; Raikes, 1989; Uyanga, 1990).³ The frequently quoted statistic that over 500,000 women in the South die each year from pregnancy-related complications has drawn attention to the dangerous role of reproduction for women in these countries.⁴ Health "experts" have prioritized the relationship between fertility and reproductive health, so to speak. It is the perception of a high correlation between high fertility rates and maternal mortality⁵ which has served as the justification for the widespread implementation of family planning and maternal and child health programs in the South (World Health Organization, 1992a; World Health Organization, 1992b).⁶

Generally, the assumption has been made that if women alter their reproductive behaviour such that they have fewer children, space births adequately, and do not have

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³ It is difficult to place the narrow conceptualization of women's health into a specific time period. The 1980s in particular were associated with the broadening of the conceptualization of women's health (Edström, 1992; WPFA, 1986).

⁴ Edström, 1992; Freedman & Maine, 1993; Graham & Campbell, 1992; Ostergaard, 1992; Sundari, 1992; Uyanga, 1992; and Winikoff, 1988 are examples of documents which include this statistic.

⁵ Maternal mortality refers to death while pregnant or within 42 days of termination of the pregnancy (not including incidental or accidental causes). The majority of maternal deaths are caused by haemorrhage, infections, toxemia, obstructed labour complications from spontaneous or induced abortion, and anemia. Maternal morbidity refers to disease or infection directly related to pregnancy or childbirth (For a detailed description see Koblinsky et. al., 1993: 38).

⁶ The focus on family planning and women's reproductive health has reflected more than the inadvertent absence of consideration of gender differentials in health beyond the difference in biological composition of men and women. It has also reflected the neo-Malthusian and ante-natal ideology associated with international development agencies and some national governments (e.g. Uyanga, 1990, World Bank, 1989). Rapid population growth is thought to constrain development efforts (eg. World Bank, 1989; World Bank, 1991). Action to reduce high fertility rates through the promotion of modern contraceptive methods has been seen as acceptable if linked to improvements in "women's health" (Kabeer, 1992). Huda Zurayk (1994: 7) notes that family planning as a policy instrument for reducing fertility in developing countries came before a "health rationale" for family planning. While the international discourse on women's health currently recognizes the underlying causes of women's ill health associated with poverty, sex discrimination, and lack of access to income, priority is still placed on the use of family planning as one of the most effective ways to promote development (see for example, World Health Organization, 1992a).

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1.2 Towards a Broad Conceptualization of Women's Health

Strategies aimed at improving the health of populations in the South must be understood in the broad context of the "international development establishment."² As the health sector is a target of international development strategies, health development has been influenced by both national and international perceptions of what constitutes good health and what obfuscates or facilitates the process of attaining it (Oakley, 1989: 1). Just as mainstream definitions of development have shaped Southern development strategies over the past four decades, mainstream conceptualizations of women's health issues and concepts of gender and development have shaped health interventions which target women as primary beneficiaries (Price, 1992: 50).

Health interventions targeting women have historically been developed in response to a narrow conceptualization of their health. The assumption that women's health is primarily a function of their reproductive and child rearing roles has guided research and development efforts. Interventions targeting women have invariably prioritized family

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² By "international development establishment," I refer broadly to international institutions such as the World Bank (WB) and the International Monetary Fund (IMF), in addition to the plethora of UN agencies and international development assistance agencies of Western governments involved in the development process in the South. Historically, these institutions' conceptualizations of what constitutes development have played a role in shaping the nature and process of development interventions in the South (Zaidi, 1994: 1385).

more ethically comfortable engaging in an analysis which would critically examine the assumptions of an internationally conceived model, than restricting my analysis to understanding local level gender dynamics and their implications for program effectiveness.

I have made an active effort throughout the entire research process to work within a feminist participatory research framework. Through a case study analysis of the Sigoti Location BI site, I examine the validity of implicit assumptions that have guided the development and implementation of the BI. Feminist case studies usually consist of a fully developed description of a single event, person, organization, group or community. Case studies defy the social science convention of seeking generalizations by looking instead for specificity, exceptions and completeness (Reinharz, 1992: 164). My analysis is based on an exploration of women's and men's experience with the Sigoti BI. By giving voice to those who have formerly been unrepresented in the international health discourse (those who are the key participants and beneficiaries of health programs), I hope to produce an understanding of the complex social and political dynamics which influence the effectiveness of community-based health interventions which target women.

The purpose of this chapter is to delineate the assumptions which have guided the analysis of the BI. In section 1.2 I examine critically the narrow conceptualization of women's health which has formed the basis for health interventions targeting women. In section 1.3 I describe a holistic approach to women's health, and demonstrate that women-centred definitions of priorities are integral to this approach. In section 1.4 it is argued that a true commitment to women's health requires the incorporation of strategies

for women's empowerment into the design of interventions. In section 1.5 my thesis question is introduced -- is the Bamako Initiative an appropriate intervention for women? The section defines an appropriate intervention as one which incorporates women's voice, and includes mechanisms for women's empowerment. The section concludes with a chapter breakdown detailing the structure of my analysis of the Bamako Initiative.

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children too early or too late in life, then reductions in maternal morbidity and mortality will logically follow (WHO, 1992a). Yet high maternal mortality and morbidity statistics have been disproportionately linked to high fertility rates in absence of sufficient consideration of how women's daily activities influence both the reproductive and other aspects of their health (World Health Organization, 1992a; International Center for Research on Women, 1989). While it is true that decreased fertility will inevitably lessen the lifetime risks to women associated with pregnancy and childbirth, family planning is only one component of a solution to a complex problem. Maternal morbidity and mortality statistics, which are the key indicators of women's health status, reflect the outcome of a complex network of social, political, economic, environmental and cultural factors which determine women's total well-being in a specific context (Brems and Griffiths, 1993; Jacobson, 1993; Koblinsky et. al., 1993). In reference to maternal mortality, Susan Brems and Marcia Griffiths assert that

...[women] may put a higher priority on less dramatic but more chronic and frequent ailments that undermine the quality of their daily lives -- illnesses in which both incidence and duration are high, translating into high prevalence (1993: 262).

Thus, of crucial importance is not only the availability of family planning (for those women who make an informed choice to practice contraception), but also the reduction of the underlying factors which contribute to maternal health problems. Kathleen Merchant and Kathleen Kurz (1993: 81) report that poor nutritional status, and specifically, pre-existing anemia, contributes to at least three quarters of the major causes of maternal mortality (hemorrhage, infection, and obstructed labour), and is directly linked to maternal morbidity. Women's risk of death from hemorrhage and infection is

significantly reduced when they are adequately nourished (1993: 81). According to Belkis Giorgis (1983: 37), "the enormous wastage of human life in Africa is caused by the synergistic effects of malnutrition and infections." To the extent that women's nutritional status is related to food insecurity, sex discrimination regarding food entitlements, access to safe water, income and education, the simple relationship between high fertility and high maternal morbidity and mortality becomes weak at best (Edström, 1992: 42; Nightingale et al., 1990: 117).

The relationship between high fertility and high maternal mortality also loses significance with the argument that factors such as physical stature, age and parity, or preexisting conditions such as diabetes and hypertension are poor predictors of the development of obstetric complications among women. Lynne Freedman and Deborah Maine (1993: 156) agree that women with these factors are at higher risk for developing complications, but assert that the majority of high-risk women will still have normal deliveries (1993: 156). The great majority of maternal deaths are preventable by good obstetric interventions (Edström, 1992; Fraser and Meli, 1990; Freedman and Maine, 1993; Raikes, 1989), and access to maternal and obstetric services has been associated with maternal mortality in a negative and highly significant relationship (Edström, 1992: 42). The mere distance to adequate health services itself is often responsible for women not receiving the medical attention they require to save their life (Edstrom, 1992: 43). Lynne Freedman and Deborah Maine advocate strongly for increased access to emergency medical care to treat the most common life-threatening obstetric complications in the South (1993: 154). Hence, access to family planning services represents only one

issue in relation to women's total reproductive health needs, and may be of little priority to women (Welbourn, 1992).⁷

Maternal and child health claims to offer a broader perspective on women's health. Wendy Graham and Oona Campbell state that "maternal health encompasses positive or negative outcomes -- physical, social or mental -- in a woman from any cause related to childbearing or its management" (1990: 18). Yet maternal mortality and morbidity remain the key indicators used to measure maternal health. These statistics have been criticized as weak indicators of maternal health, as their sole focus on the short-term physical outcome of childbearing fails to comprehend maternal health holistically, as in the above definition. Further, the use of maternal mortality statistics has been questioned for its focus on the outcome of births rather than on the health of the mother. Lifetime risk associated with pregnancy and childbirth is more woman-centred, treating the woman as subject, but is rarely used in policy documentation (Edström, 1992: 44).

Women's health advocates have also opposed the tendency in maternal and child health programs to focus on the effect on the child of the mother's health status, rather than on the health of the mother herself (Raikes, 1989; Kabcer, 1992a; Edstrom, 1992; Winikoff, 1988). A clear example of the prioritization of the child is Meredith Turshen's finding that in a recent document related to maternal and child health, nine out of ten risks associated with human reproduction cited by UNICEF, WHO and the World

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⁷ It is not my intention to discount the importance of family planning services as one component of women's total health needs. Access to information concerning women's bodies, and the right to choose the number of children born as well as to plan families without government interference is supported by women's health advocates in the North and South (Annual National Council on International Health Conference, 1991). Rather, it is the intention here to illuminate the disproportionate attention that family planning has received in light of women's total health care needs.

Bank were related to the child's health, and only one -- maternal mortality -- was related to the health of the mother (1992: 16).⁸ The peripheral attention maternal health receives is also reflected in the failure of countries to report on maternal health indicators. According to WHO statistics, while 50 out of 52 countries report on infant mortality, only 5 out of 52 report on maternal mortality (cited in Kabeer, 1992a).

1.3 A Broad Definition of Women's Health is Woman-Centred

Support is growing for broader and more critical gender sensitive analyses of health which reflect the daily lives of women (Brems and Griffiths, 1993; Edström, 1992: 48, Raikes, 1989).⁹ It is increasingly recognized that maternal and child health and family planning programs which prioritize women's health needs according to their role in biological reproduction fail to incorporate effectively issues of poverty and social status which lie at the root of the poor health status of women in the South (Graham and Campbell, 1992; Gottschalk and Teymour, 1993; Paolisso and Leslie, 1995). Van der Kwaak (1991, in Koblinsky et al., 1993:33) offers a broad conceptualization of woman's health, defined as "her total well-being, not determined solely by biological factors and

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⁸ The risks affecting children noted in the document include diseases transmitted sexually to the fetus; abortion (as a cause of fetal death); stillbirths (in women over forty); unattended home births (as a cause of perinatal death); neonatal death; malnourished infants; and a subsequent pregnancy within one year, which increases the first child's mortality risk by 75% (Turshen 1991: 213).

⁹ Gender sensitive research is now more commonly applied to health issues which were formerly considered to impact men and women in the same way (e.g. mental health, AIDS, malaria and other tropical diseases, etc.) (see for example, Mulindi, 1992a, 1992b International Center for Research on Women, 1989). While it is beyond the scope of this thesis to incorporate the issue of AIDS into my analysis, because strategies to address AIDS were not incorporated into the Sigoti Location BI program. But it is important to note that "the outbreak of AIDS in Africa is a challenge to the physical survival of whole communities" (Mulinde, 1992a: 53)). While urban populations have been impacted most heavily by the AIDS epidemic in Africa, the spread of AIDS to rural areas has translated into large numbers of deaths among rural women (Mulindi, 1992a: 53). As Sobbie Mulindi notes, there are several complex socioeconomic, cultural, and behavioural factors which place women at a substantially higher risk than men of contracting AIDS in Africa (Mulindi, 1992b: 211). Lack of incorporation of gender-specific strategies to address the AIDS epidemic in rural areas represents a weakness in health interventions which target women.

reproduction, but also by effects of work load, nutrition, stress, war and migration, among others." In many cases these factors have a differential health impact on men and women (Thomas, 1985: 177; Welbourn, 1992). For example, WHO estimates that 80% of all diseases are related to unsatisfactory supplies of water (Ostergaard, 1992). In East Africa, women's daily and direct contact with water makes them particularly susceptible to water-related diseases. Further, poor nutrition and lack of food lead to anemia, exhaustion and a general wearing-down, particularly as women continue to perform heavy manual agricultural work in addition to all other household tasks throughout pregnancy and lactation (Raikes, 1989: 448).

A gender-sensitive understanding of women's health recognizes the synergistic effects that women's relationship to biological reproduction, production and social reproduction¹⁰ have on their health status (Raikes, 1989). It is built on the assumption that lack of access to health care, or access to inappropriate care unreflective of self-defined priorities, is a product of marginal social, political, economic, and geographic status, in addition to poor organization of peripheral groups (Green, 1991: 747; Turshen, 1991: 216). Interventions which take account of women's triple roles may be geared as much towards redressing the marginalization of women through improving their socio-economic status as they are to health care provision in the narrow sense. As Alice Welbourn (1992) notes, lack of access to income and food insecurity have generally been identified by women as their key priorities; therefore, increasing women's access to

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¹⁰ Women's roles in production generally refer to either paid labour or unpaid labour which represents "productive" work, such as agricultural work on subsistence or cash crops. Social reproduction refers to those activities which ensure household survival, such as collection of water and fuelwood, cooking, caring for ill family members, etc.. (Raikes, 1989).

income, credit facilities, small-scale enterprise, appropriate technology, and increasing political representation of women may prove to have a greater impact on their total well-being than the provision of health care services alone (Bell and Franceys, 1995; Ojanuga and Gilbert, 1992).

Thus, the central issue in approaching women's health holistically is conceptualizing both health promotion activities and considerations of ill health in terms of the fit between women and their environment (Welbourn, 1992). There is now a widely recognized need for information about context-specific factors that present health risks to women, and that present barriers to women in protecting their health or seeking care from health professionals (Paolisso and Leslie, 1995: 60). Different solutions are required to meet the health needs of women depending on the demographic, epidemiological and socio-economic context in which they live (Paolisso and Leslie, 1995: 59). Women residing in rural communities in Africa have distinct health priorities from women living in urban areas or different regions (e.g. Raikes, 1989). Further, the local context within countries produces differential health risks.

A wealth of knowledge exists related to factors that present health risks to women and pose barriers to access to care.¹¹ There is general agreement over certain key measures to improve women's health, such as gearing interventions towards nutrition concerns,

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¹¹ Barriers to access to care which have been identified in the women's health literature include: 1) conflict with essential daily activities, including employments, water and fuel supply, food preparation, and childcare; 2) poor understanding of health problems and failure to recognize symptoms; 3) lack of information about available health services; family resistance to travel outside the home; cultural distance from clinic settings and personnel; lack of cash for bus fares, clinic fees and drugs; reluctance to be examined or treated by men; inappropriate clinic scheduling, including the separation of related activities such as family planning and child health; lack of privacy at clinics; and insensitive clinic staff, not trained to address women's health problems (Leslie et al., 1986; WFPA, 1986: 40).

parasite and infection control as well as maternal health problems.¹² While this knowledge is necessary to inform the development of health programs, it is insufficient in understanding how context-specific relationships between and among biological, physiological, psychosocial, economic, political, cultural, generational, developmental and lifestyle issues interact with health issues. Information regarding how these relationships manifest themselves in a particular context must also underlie the health development process (e.g. Welbourn, 1992; Brems and Griffiths, 1993).

A major weakness in the development of health interventions has been the failure to incorporate local knowledge in their design. Health planning at the international level has been characterized by the implementation of blueprint models across the globe which take account of underlying social and economic factors that contribute to ill health, but that tend to hold the local environment constant (Brems and Griffiths, 1993: 270). The blueprint model carries with it the implicit assumption that the same factors impact on health in similar ways in different contexts. The central idea behind incorporating local knowledge is to move from a situation in which generalizations about the importance of various social forces to health are made, to a situation in which insight is gained into how those forces interact with health and disease, such that people can be empowered to combat negative forces impinging on their well-being, and take control over their own health development (Yach, 1992: 604).

As the conceptualization of women's health has broadened over the past decade, there

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¹² Strategies which have historically targeted women include nutrition programs, provision of nutrient supplements, price subsidies and controls, food fortification, home gardening, nutrition education, parasite and infection control, family planning, maternal health, and surveillance of high risk women (WFPA, 1986: 45).

has been a concomitant push for population-based studies in the South which understand health needs from the perspective of women themselves, including both users and nonusers of formal health services (Brems and Griffiths, 1993; WHO, 1992a). Incorporating women's voice into definitions of priorities is increasingly seen as a necessary prerequisite to the formulation and implementation of interventions whose goal is to improve women's health status (Welbourn, 1992). Lise Ostergaard asserts that

in order to include women fully as a target group in primary health care -- in terms of their total scope of life and not only with regard to reproductive problems -- health staff need to be sensitized to perceiving the role and status of women in a given area. Although women may be illiterate, or uneducated with respect to health prevention measures, women should be recognized in their own right as potential carriers of a wisdom that the specialist needs -- a vital, valid, and down to earth knowledge of their own reality, deeply rooted in their own culture and in their own life experience (1992: 52).

Thus, knowledge of what women perceive to be their greatest health problems, what they understand to be the origins of their health problems, what they perceive as potential solutions (either within or outside the formal health system) and what constraints they face in protecting or promoting their own health is an essential starting point from which appropriate interventions can be developed.

The World Federation of Public Health Associations (WFPA) calls for a gender-sensitive approach to health interventions which understands women's health holistically, reflecting their daily life experience. It requires the collection of information from local women, with a view to producing a complex understanding of women's key health concerns and constraints to their well-being, including:

- health conditions that mainly or solely affect women;
- chronic or asymptomatic conditions for which women rarely seek treatment;
- their own sense of community priorities;

- their daily activity patterns and how they affect personal and family health;
- their educational levels and access to communications media;
- their economic and productive activities, both inside and outside the family;
- their access to resources such as food and income;
- allocation patterns within the family;
- decision-making patterns within the family;
- their reactions to the quality, content, and convenience of available primary health care services; and
- religious and cultural factors affecting women's health (WFPA, 1986: 28).

Unfortunately, incorporating local women's knowledge has rarely been a guiding principle in the development of health programs (Winikoff, 1993). The result has been the development of ineffective interventions which fail to impact positively on women's health status. Where health care services exist in the South, evidence of their underutilization and inappropriate use by women is sufficient to show that they have been relatively misguided in addressing women's priority needs (International Center for Research on Women, 1989).

Perhaps the single most important reason for this outcome is the peripheral status women have been accorded in the health development process (Jacobson, 1993: 24). Women have rarely been involved in making key decisions in the formulation of health policy and programs in macro arenas due to their poor representation in international health organizations and national ministries of health; or in developing and managing local health care interventions in micro arenas due to their subordinate status to men in local settings (Brems and Griffiths, 1993: 256; WHO, 1992a).¹¹ Women have essentially been objects or targets of health interventions, with little or no involvement

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¹¹ As will be seen in Chapter Three, women have rarely been involved in decision-making capacities in local health programs reasons including and beyond their subordinate position to men. The structure and organization of national health systems, and the problems associated with implementing internationally-conceived models at the local level also perpetuate women's marginal participation.

in defining priorities or shaping the course of health development. The following section proposes that the development of effective interventions for women requires the incorporation of strategies for empowerment. It is argued that only through the incorporation of women's voice into the health development process will interventions adequately address women's self-defined priorities.

1.4 Women's Health Meets Empowerment

The previous section illustrates two important points. First, women's health status is a product of a complex network of factors, both including and extending beyond their biological composition; poverty and low social status lie at the root of women's ill health. Second, women's peripheral role in the health development process has been associated with the failure of health interventions to take account of this complex network of factors, resulting in programs which are inadequate in addressing women's total health needs. What these points illuminate is the growing recognition of the inseparability of women's health issues with issues of empowerment. The international health discourse now commonly refers to the need to incorporate women's health issues with strategies for their empowerment (e.g. World Health Organization, 1992a, 1992b, 1985). The World Health Organization is increasingly vocal about the relationship between women's position in society and their health:

...in the 1990s approaches to women's concerns will need to shift from the sidelines of development to a concerted initiative to bring women into the mainstream; to promote the role of women as agents of change; to make their health and social needs a top priority; and to equip them with equal access to information, technical and economic resources, skills, education and opportunities -- not only to benefit women in their own right, but to benefit all people and future generations (WHO, 1992a: 2).

Health in this sense is situated within the overall context of the development process, whereby people are empowered to lead economically productive and socially satisfying lives (WHO, 1978: 14). Empowerment is a process whereby women increase their capacity to exert control over their lives and their health (Jacobson, 1993).¹⁴ Peggy Curlin and Ann Tinker refer to the quality of women's lives as an indicator of their ability to develop and maximize their potential. They state that

....women must be empowered by training, education and participation to seek prevention and treatment of diseases which maim and kill them (Curlin & Tinker, 1993: 2).

Health interventions which incorporate issues of women's empowerment must inevitably address questions of power-sharing and influence, recognizing and bringing into the mainstream a group that has hitherto been excluded (Goulet, 1989). The empowerment approach recognizes that women's capacities, abilities and strengths are situated within political and economic structures which on the one hand favour men, and on the other, place supremacy on the western biomedical model (Price, 1992: 50; van

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¹⁴ A comprehensive agenda for women's empowerment to effect improvements in women's health is outlined by Jodi Jacobson (1993: 24-25). The actions prescribed over the long-term are: 1) enforce or enact where needed legislation to improve women's status--regarding inheritance laws, property rights, marriage contracts, divorce laws, abortion laws, etc...; 2) promote efforts to expand female education and reduce female illiteracy; 3) address women's specific needs in employment and economic development by promoting women's savings schemes, and providing no or low-collateral credit, extension services, training and material inputs; 4) increase food security by investing in women farmers; implement policies that improve the nutritional status of women and girls, and expand nutrition education; 5) promote the development, extension and popularization of appropriate labor-saving technologies to ease women's work burdens. Ensure women's access to water and other essential resources, and develop information and education programs to encourage key family members, such as husbands and in-laws, to assist with household chores; 6) require the collection and publication of gender-disaggregated data on socioeconomic indicators by all governments and international bodies; 7) establish baselines for vital indicators of women's health and well-being, and use these to measure progress within five-year intervals, including measures of female literacy, numbers of women in the formal employment sector, and the share of women decision-makers; 8) encourage research on the socioeconomic factors influencing health care seeking behaviour, compliance rates, attitudes, and women's decision-making processes, their perceptions and views.

der Geest et al., 1990, 1026). Empowerment entails the transformation of dependence-based power relations, for which the point of departure is the incorporation of women's voice into the health development process.¹⁵

F.M. Mburu argues that the skewed sharing of educational resources plus the traditional structures which favour males perpetuate women's peripheral status. A cycle persists whereby men have the means to consolidate and hence accumulate knowledge, which is translated into power. As power is a tool for decision-making, "to the extent that women are largely excluded from the power-sharing process they will remain on the receiving end, dependent on the goodwill of men" (Mburu, 1986: 786).

Women are also dependent on a rigid and hierarchical health system which prioritizes biomedicine (Zaidi, 1994). Susan Brems and Marcia Griffiths call for a reconciliation of the agenda of international health experts with that of the local women international health programs propose to serve. Reconciliation is based on the assumption that the benefits of biomedicine, with its effective drugs and treatment, must be tempered with an interest in and respect for local knowledge of needs, appropriate types of programs and resources (1993: 261).

Incorporating women's voice in the health development process is political -- it necessitates a redistribution of power, creating space for women to determine choices in life and to influence the direction of change, through the ability to gain control over crucial material and non-material resources (Moser, 1989: 18). It implies that women's

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¹⁵ This notion of women's empowerment borrows from theories of power for women espoused by Nancy Harstock (1990) and Biddy Martin (1988). Women's struggle for empowerment is considered in terms of both specificity - local struggle manifested in daily activity or resistance, and structures - systematically unequal relations of power.

participation must be what Goulet (1989) refers to as authentic -- a situation whereby true decision-making power is located in non-elites. Only when women break out of their silence and "win their right to speak" can the structures which maintain their dependence, and consequently limit the effectiveness of health interventions, begin to be transformed (Freire, 1985: 72).

1.5 Is the Bamako Initiative an Appropriate Intervention for Women?

The Bamako Initiative is a strategy to accelerate the implementation of primary health care (PHC) in Africa which targets women and children. It is designed to encourage maximum community involvement in primary health care through the provision of basic essential drugs and supplies and the development of a revolving fund which, with support from the district and higher levels, will ensure self-reliance and sustainability for health care. One of its goals is the promotion of gender equity in terms of both increased access to essential health care of women and children, and increased involvement of women and the most vulnerable groups in the community in decision-making aspects of the initiative. This push for greater involvement of women in the design and implementation of PHC in Africa is part of the general trend towards linking primary health care with issues of women's status (e.g. World Health Organization, 1985, 1992a, 1992b).

This thesis explores, through use of a case study analysis, whether the Bamako Initiative is an appropriate intervention for women in Africa. The above sections delineate the assumptions which have guided the analysis of my thesis question; namely, that an appropriate intervention has two key interrelated characteristics: effective

integration of women's voice into its design, through women-centred definitions of priorities; and incorporation of mechanisms for women's empowerment, such that women hold true decision-making power, thereby influencing the structure and direction of the intervention.

The remainder of this thesis is divided into five sections. Chapter two critically examines the primary health care approach, and illuminates the historical constraints which have precluded PHC from being a force for empowerment for communities. Chapter three examines the historical treatment of gender in the PHC discourse, and illuminates the constraints women have faced in participating in PHC programs, by virtue of their gender.

Chapter four provides the methodological framework which guided my fieldwork in Sigoti, and describes the research process. Chapters Five and Six constitute the analysis of the Bamako Initiative. Chapter Five situates the Sigoti Location BI in its international institutional context, and describes the Kenyan BI's organizational structure, delineating the ascribed roles of the various actors. The chapter includes an exploration of BI discourse, and its implications for community empowerment. Chapter Six explores the local level response to the BI in the Sigoti community, and builds on fieldwork conducted in Sigoti between January and May, 1995. My analysis attempts to understand the source of the virtual collapse of operations of the Sigoti BI. Chapter Seven presents conclusions based on the case study analysis. Implications for primary health care policy are discussed, and potential directions for change explored.

Chapter 2

Primary Health Care Discourse: What it Reveals and Conceals

2.1 Introduction

The purpose of this chapter is to delineate the conceptual issues which have guided the case study analysis of the Bamako Initiative (BI), a strategy to accelerate the implementation of primary health care (PHC) which specifically targets women and children. An implicit assumption of the BI is that the PHC approach is an effective means to increase survival and improve the quality of life of rural populations in Africa. Community ownership and management of the BI pharmacy is the BI's defining characteristic, and is intended to act as a catalyst for community involvement in and access to a wide range of PHC activities defined by the community, in collaboration with the ministry of health. Whether the BI is appropriate, effectively incorporating women's voice and strategies for women's empowerment into its structure and design, is the focus of analysis in Chapters Five and Six.

My analysis is situated within four key (non-distinct) bodies of theory. The first two are the general PHC literature, and the literature on local participation in development initiatives. A critical examination of PHC theory and practice will illuminate the constraints which have historically limited the potential of PHC to act as a catalyst for empowering the communities it intends to serve. These issues are the focus of this chapter. The third and fourth bodies of literature, to be discussed in the following chapter, are the literature on gender and development and women's health. The BI must be understood in these contexts, as it is a community-based initiative with community

participation central to its design, and specifically, as it promotes women's full participation in this process to meet their health needs more effectively.

Section 2.2 introduces the PHC approach, and describes the rationale which has led to the assumption that PHC is a progressive intervention which attempts to meet health care needs of the majority in the South. A typology of participation which has characterized the PHC discourse, based on two distinct views of the objectives of participation, is described. Section 2.3 discusses the contradictions associated with PHC as an internationally conceived health care model which emphasizes local participation. Section 2.4 introduces the community-based health care model as one whose design reflects goals of empowerment. This sets the context for the following chapter, which illuminates a key theoretical shortcoming of PHC models in general, and community-based models in particular. Their typically androcentric approach has precluded effective incorporation of empowerment goals for women, who as a distinct group have historically been marginalized in the PHC process.

2.2 Primary Health Care: The Effort to Bring Health to All

Since the culmination of a global health conference at Alma Ata in 1978,¹⁶ international bodies such as the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) have espoused the view that poverty is the world's most serious carrier of ill health (WHO, 1979). There was growing concern that the

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¹⁶ WHO and UNICEF convened a conference in September, 1978 at Alma Ata, USSR to discuss the challenges associated with attacking ill health at its root, poverty. The outcome of the conference was the development of principles to guide the establishment of primary health care. The primary health care approach challenges many of the fundamental concepts of health and medical care which have dominated western-style health policy (Rifkin, 1980: 4).

"fruits" of large-scale modernization initiatives were failing to reach the rural (and urban) poor population in countries of the South. Expansion of state financed, hospital-based curative health care, characteristic of the health system of most post-colonial governments, was recognized as expensive and inadequate in reaching the majority of the population (Zaidi, 1994: 1388).¹⁷ Lack of emphasis on preventive care (e.g., sanitation, proper hygiene, proper nutrition, immunization, etc.), which can conceivably alleviate the most pressing health concerns in the South, reflected misplaced priorities on the part of national governments (e.g., Mburu, 1981). The PHC approach advocated by WHO and UNICEF attempted to address health issues holistically, making connections between ill health and local conditions in the South. PHC was defined as

essential health care made accessible to individuals and families in the community by means acceptable to them, through their full participation, and at a cost that the community and the country can afford (WHO, 1978).

Eight principal components of PHC identified by WHO include: nutrition, safe water, sanitation, maternal and child health and family planning, immunization, prevention and control of locally endemic diseases, health education, and appropriate treatment for common diseases (World Health Organization, 1979).

Community participation was considered to be a central component of primary health

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¹⁷ S.A. Zaidi notes that the health care system in most countries in the South still provide inappropriate services that are disproportionately urban, and are characterized by the following salient features: inequitable access by region and social class; curative care orientation, with primary or preventive health care a recent phenomenon which has been appended to the system without much thinking or structural change; hospital based; disproportionately urban, with few and rudimentary facilities in rural areas; doctor oriented, with the health pyramid inverted with doctor-auxiliary ratios in the order of 5 or 10 to 1; a curriculum and educational value system which gives far more priority to surgical and medical skills with little emphasis on community medicine, often resulting in a substantial brain drain to the West, and due to the curative bias, there is a very high dependence on drugs, often provided by foreign pharmaceutical companies which are in a position to influence prices and health policy (1994:1388).

care. The perpetual cycle of poverty and poor health in the South was attributed by development planners to the peripheral status in the development process of local populations, who at best were acting as beneficiaries of initiatives for which they were "targets" (Rifkin, 1990: 4). It was believed that only if those who most needed health care participated in its delivery would there be any impact on the diseases afflicting them, and only through community involvement would there be any assurance that culturally acceptable care would be available to underserved populations (Rifkin, 1990: 3).

Emphasis on participation in health was part of a parallel shift in the general development discourse in which local participation and development of local capacity were seen as crucial to successful development initiatives (Oakley, 1989). The promotion of "participation" of local communities in a range of rural development activities (e.g. agricultural development, water and sanitation projects, infrastructure projects, health etc..) became a major thrust in the activities of non-governmental organizations (NGOs) in their shift away from relief efforts, and towards efforts to address what were perceived to be the fundamental problems facing marginalized groups - lack of access to resources, and lack of voice in the development process (Oakley and Marsden, 1984). Community participation, variations of which are to be discussed below, was seen as the central means by which the local population could reap the benefits of development efforts. It was in this context that the "Global Health for All Strategy," whose basis was Primary Health Care (PHC), was formulated in the late 1970s.

Almost two decades after its inception in 1978, PHC continues to be promoted as an

essential means to improve the quality of life of the majority of people in the South (WHO, 1993). Yet despite significant progress in PHC initiatives over the past decade and a half, the nature of participation at the local level has been less significant than had initially been envisioned. WHO, in its most recent evaluation of the Global Health for All strategy, asserts that "the means for effective community health action and control which can be built into community functions in a sustainable manner are still to be found" (1993: 157). This has been the case for the community at large as well as those groups in most need of appropriate services, but least likely to have access to or knowledge about them - rural women (Jacobson, 1993).¹⁸

The PHC approach is riddled with contradictions, both in theory and practice, which have historically set parameters around the nature and substance of participation, and which raise questions about the goals of participation. These contradictions must be understood within the overall context of the political economy of health. What transpires at the local level is the result of the interplay of power and interests among not only women and men with diverse experiences at the local level,¹⁹ but also a broad range of institutional and personal actors, including international lending institutions, professional medical associations, pharmaceutical companies, government health and development

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¹⁸ For the purposes of this paper, gender is the privileged category of analysis. By no means should this imply that all rural women have been marginalized in the same manner through the PHC process. To use "rural women" as a single defining category for analysis assumes that the social relations which determine women's reality are uniform within, and even between communities in the South. In fact, every woman's experience is determined by a complex web of social and material relations, arising out of both her unique personal situation, as well as broader structural factors related to her race, ethnicity, socio-economic status, and gender. Gender is privileged here in an effort to understand the common ways in which women as a group have been marginalized, as a direct result of their participation in society as females.

¹⁹ Men and women have diverse experiences by virtue of their socio-economic status, age, membership in community leadership positions, etc.

agencies (McPake et al., 1993; Singer, 1989). These actors can either hinder or facilitate positive structural change at the local level. By positive structural change I refer to the empowerment of individuals and groups in communities through the redistribution of health knowledge, resources and decision-making capacity to the periphery. The remainder of this chapter critically examines the role of these actors in PHC development, with a view to illuminating the constraints which have precluded the capacity of PHC to marry health with empowerment. The community-based health care model is introduced as one approach to PHC which attempts to mitigate these constraints. It is necessary first to delineate what would be entailed in an empowerment approach to PHC.

2.2.1 PHC - A Force for Empowerment?

Numerous different conceptions about the nature and content of participation have characterized the development literature, but ideas converge around the active role that people must play in making development decisions, the requirement for increased access to resources and knowledge to satisfy locally-defined needs, and equitable allocation of benefits received from development efforts (Oakley, 1989: 2). Where ideas diverge is in their assessment of the overall goal of participation. Two distinct views about the objectives of participation have historically characterized the PHC discourse. One sees participation as a means by which to deliver better health services. Its premise is that health can be improved if health budgets are increased, the existing health system is extended and the community is encouraged to participate in health activities (Rifkin, 1980: 9). The second view assumes that none of the above activities will have a lasting

impact on the health of the majority without a transformation of structures which perpetuate ill health. Participation is therefore seen as a means by which to change the existing social, political and economic structures that deny access of the poor to health care (Rifkin, 1980: 9).²⁰ These views have given rise to a number of interpretations about the form that participation in PHC should take. But generally speaking, these can be summarized according to three basic types of participation referred to in the PHC discourse: participation as contribution, participation as organization, and participation as empowerment (Woelk, 1992: 420).²¹

2.2.2 Typology of Participation in PHC

Contributive participation involves the community in implementing pre-determined programmes and projects through contributions of labour, cash or materials, and as such represents a means to an already identified end goal. Activities to be undertaken are generally determined by planners to whom the members of the community have to refer for advice (Rifkin, 1990: 14). Networks of local community health workers (CHWs) trained by health professionals in basic health preventive and promotive measures, and in some cases, in treatment of common diseases, are the key implementors of PHC.²²

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²⁰ The introduction to this thesis delineates the assumptions which have guided the analysis of the BI. It was argued that only through a transformation of structures which perpetuate women's subordination will lasting improvements in women's health be realized. This paper therefore supports the second view.

²¹ Receiving benefits has also been referred to as a form of participation, but is generally passive, and therefore not included in this typology (Rifkin, 1990: 14).

²² The skills these workers require vary widely throughout the world, depending on the particular form of primary health care being provided (WHO, 1978: 9). Community health workers in East Africa are usually frontline health workers trained for specific, essential tasks. They are usually members of the community they serve, and are chosen by it (yet in many cases, selection of CHWs is the responsibility of an elite minority in the community). CHWs are given support by a hierarchy of paraprofessional and professional health workers. Ideally, CHWs should be accountable first to the community they serve, and

Their participation tends to be contributive, as they usually represent extension workers with little involvement or authority in planning or managing PHC (Mburu, 1994: 884). Community-financing of health care (e.g. through user fees or annual fees for services or drugs) is also an example of contributive participation (Thomason, 1994).

Participation as organization involves the creation of appropriate structures to facilitate participation. Village health committees involved in the definition of community needs and monitoring of health activities have historically been the key type of local level organization which aids in the implementation of PHC projects (Matomora, 1990). Committees generally facilitate the collection of health-related information in the community, and oversee the work of community health workers. Both contributive and organizational participation require the use of community resources, with a view to making health care service provision more effective and culturally appropriate (e.g. van der Geest, 1993). To the extent that parameters around activities to be undertaken are defined from above, and induced or promoted by some external agent,²³ they mirror the view that the objective of participation is a means by which to deliver more effective and appropriate health services.

Empowering participation reflects the second conceptualization, that structural transformation is a necessary precursor to long-term improvements in health of the majority. It requires that groups and communities, particularly those which are poor and marginalized, develop the power to make real choices concerning health care services,

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second to the staff who support them (Mburu, 1994).

²³ External agents inducing or promoting participation PHC are generally staff of national ministries of health, non-governmental organizations or international health agencies.

through having an effective say or having control over these programmes. This form of participation focuses on the process of participation as an end goal, through which confidence and solidarity among rural people are built up (Oakley and Marsden, 1983). It is both an active and dynamic form of participation, responding to local needs and changing circumstances (Rifkin, 1986: 242). Contributive and organizational participation are therefore necessary, but not sufficient conditions for empowerment.

An empowerment approach to PHC implies that participation is not simply a component of a health care delivery system, it is a strategy to effect long-term improvements in quality of life of the majority. It represents what Susan Rifkin refers to as "the context in which a health care program develops" (1980: 5). Empowering participation demands a sustained, bottom-up process which moves progressively from micro to macro spheres of action (Goulet, 1989: 168).²⁴ As a result, it does not necessarily begin with a pre-conceived set of quantifiable targets or objectives (Oakley 1989: 11). This point is crucial, as it has been argued that it is not possible to build broad, self-sustaining community participation through health service activities alone. Health care is frequently of secondary concern to more pressing income and food-related priorities, and communities may prefer to organize activities around these priorities (Rifkin, 1990: 243).

Inherent in this approach is a commitment to redistribute power, such that people who traditionally have not been included participate fully in the process. It requires that those

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²⁴ Goulet asserts that alternative development strategies centring on "goals of equity, job creation, the multiplication of autonomous capacities and respect for cultural diversity all require significant participation in macro arenas" (1989: 177). An example of community involvement in macro arenas in PHC might be representation at the district level.

who have had a monopoly on a certain kind of power (generally knowledge and resource control in the case of health) must forfeit this monopoly (Rifkin, 1986: 243). The main objective of health professionals interested in empowering participation is to engage in a dialogue with local populations in order to help people become more conscious of health-related problems, and to provide them with the capacity to exert control over their environments in an effective manner (Oakley, 1989). This entails a participatory process, represented by an interchange of views about how to solve a mutual, agreed upon problem by community members and professionals (Maguire, 1987). Ultimately, the relationship between health "experts" and the local population is to be reciprocal in nature, such that people's knowledge, practices and beliefs about health are "married" with professionals' knowledge and beliefs about good health practices. It is expected that through mutual cooperation, the most effective health interventions can be developed and implemented (Matomora, 1989: 1083). Susan Rifkin asserts that programs which fall short of these goals evolve in a traditional context, whereby "the professionals give advice, give services and give everything but power of decisions and thus, the potential of realizing human development" (1980: 120).

It is important to note that a participatory process cannot occur in a vacuum. It must be nurtured and supported with adequate resources (both material and human). Arthur Brownlea argues that only if sufficient resources of the right kind are at the disposal of potential and actual participants, can participation truly enrich individuals and enhance the prospects of better decisions and better outcomes (Brownlea, 1987: 607). He asserts that participation which is not adequately and appropriately resourced is "simply

tokenism...[doing] nothing to alter the knowledge balance, the skills balance, and the power balance in the community" (1987: 607).

Despite the objective of participation in PHC as a means to build autonomous capacity of the community, the nature of participation which has historically characterized PHC initiatives has been limited to the first two types, contribution and organization, and has fallen short of empowerment goals. Communities have participated primarily in receiving benefits, undertaking health activities, and making decisions related to how to raise money for activities that planners have decided upon (Rifkin, 1990: 28). Goals of transforming social structures which perpetuate inequality and ill health have failed to represent the driving force of the PHC process. One of the key factors influencing this outcome has been the administrative culture and political economy of health care, which supports a top-down flow of policy, information and resources throughout the bureaucratic levels of the system (Singer, 1989; Stone, 1992). Each higher level sees itself as superior to and more knowledgeable than lower levels. The next section illuminates the inherent contradictions of "the international health establishment"²⁵ which have historically precluded the development of truly empowering PHC initiatives.

2.3 PHC and the Political Economy of Health

As noted in the introduction to this chapter, the point of departure from which PHC has been conceived has been the international policy actor level, through organizations

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²⁵ By "international health establishment" I refer to international lending institutions such as the World Bank, and international agencies such as WHO and UNICEF which set global health policy. Both influence national health system development in the South. It has been argued that in exchanges between donor agencies and recipient countries, the donors' priorities predominate (Zaidi, 1994: 1389).

such as WHO and UNICEF (Banerji, 1992; Stone, 1992). The call for community participation in health by these agencies is riddled with contradictions, originating from their positions as both international advisors on global health and disease, and as mainstream international organizations whose policies reflect dominant political and economic ideology at another (van der Geest et al., 1990). PHC, like any other policy conceived of at this level, incorporates these biases.

2.3.1 Omniscient WHO and the Prestige of Biomedicine

At the international level, the World Health Organization sees itself as *the* knowledgeable partner in health in its relationship to countries of the South. John Peabody has attributed the omniscient character of WHO to a legacy of intermittent successes²⁶ over a period of 45 years of operation. These successes have conferred upon it two key myths - first, that WHO is a politically neutral, technical agency that sets an international standard of social justice by improving health; and second, that WHO is uniquely qualified to improve health in vast and diverse contexts whose populations are plagued by poverty and disease (1995: 736).

These myths have driven the tendency of WHO (and UNICEF) to formulate global health strategies. Underlying these strategies is the assumption that despite its composition of numerous countries with diverse local contexts, the South as a monolithic entity is characterized by certain basic health problems. The result is that new policies conceived at the international level have often been promoted without sufficient regard to the particular setting in which they are being introduced (Zaidi 1994: 1389). Not only

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²⁶ The eradication of smallpox, for example, is a frequently quoted success of WHO (WHO, 1993).

have these strategies tended to be technocratic and dependence-producing through their use of pharmaceutical companies and health experts, but they have also been launched by countries without the collection of specific epidemiological, sociological, administrative and ecological data which would lend support to them (Banerji, 1992: 175).²⁷ A key example in the context of women's health is the importance international agencies place on incorporating family planning into PHC programs, despite the relative indifference with which family planning programs have been received at the local level in several contexts (Welbourn, 1992).²⁸

This outcome can be directly linked to the process which has historically characterized definitions of health status and health care needs in the South. Generally speaking, health status and health care needs have been defined and shaped by health "experts" under the framework of Western biomedical models (Singer, 1989: 1194).²⁹ It has been

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²⁷ D. Banerji (1992: 176) uses WHO and UNICEF's promotion of its expanded program on immunization in India as an example of such a program. He asserts that this program does not reflect the most pressing health needs of the Indian population, and was promoted and implemented prior to the collection of epidemiological and sociological data which would lend support to the program.

²⁸ This is often the case when international lending institutions with population concerns, such as the United States Agency for International Development or the Family Planning International Agency, for example, incorporate and prioritize family planning in the spirit of PHC. In four Kenya PHC projects reviewed in an earlier paper, these donors pushed for intensified promotion of family planning, using the number of new family planning acceptors as the measure of program success. The case studies were Mburu, 1989; Deboer and McNeil, 1989; Jacobson et al., 1989; and Johnson et al., 1989. The key point to note is that these measures of success were identified at the donor level, and not by the intended beneficiaries of the initiative. In effect, women were targets of initiatives that did not necessarily reflect their key health priorities. Family planning has been shown to be a rather peripheral health concern in one district in Kenya, where poverty, disease and malnutrition were identified as underlying reasons for rejecting contraception (K'Okul, 1991).

²⁹ Although the WHO employs staff who bring a wealth of experience from a range of geographical and cultural contexts, the ideal of a diverse staff does not exist in so far as staff have been educated through use of Western models viewed through a medical lens; particularly when staff work in a rigid organizational structure with little incentive to offer solutions arising from non-traditional perspectives (Peabody, 1995: 737).

characteristic of health experts at the international level to "define which social groups should be seen as a priority, determine to what extent their needs should be satisfied and identify how this should be done" (Price, 1992: 50). Although international health professionals have stressed the importance of understanding the perspectives of the populations they intend to serve, it has been argued that their work as outsiders who are concerned with rural development, but are neither rural nor poor, has influenced the questions asked and the conclusions reached about the health status and needs of a given group of people (Stone, 1992).³⁰ Their tendency to take biomedicine at face value has resulted in the displacement of local medical traditions based on self-help (van der Geest et al., 1990). Further, it has masked the political and economic functions which biomedicine serves, including both profit making and social control (Singer, 1989: 1195).

It has been argued that the medical profession is a major domestic political obstacle to radical change necessary in medical strategy or policy (Green, 1991: 748). The prestige of western medicine and the "cult of pill-popping" has been used as a solution to a wide range of problems, including fatigue and diarrhoea, clouding the underlying reasons for ill-health, and frequently obscuring or replacing indigenous methods of healing (Cottingham, 1983: 153). The result is creation of a demand for chemically-based drugs, often provided by foreign pharmaceutical companies which are in the position to influence prices and health policy (Zaidi, 1994: 1388). The global prestige

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³⁰ Over a decade and a half ago, Susan Rifkin cautioned that the efforts to overcome professional resistance in both the local and national scene may be better used directly to attack poverty by introducing income-generating activities. She stresses that a community-based health program considers improved health as one means of improving the community's life-style and sense of ability to control its destiny; it, therefore, sees health services as a possible, but not the only, entry point for community participation programs (Rifkin, 1980: 121).

of western biomedicine has perpetuated the emphasis placed on expensive, curative care in the South, which does little to improve the general condition of rural populations in a sustained way (Mburu, 1981; Zaidi, 1994).

The introduction by WHO and UNICEF of the concept of PHC in the late 1970s was a conscious attempt to avoid some of these trappings, through its emphasis on an intersectoral approach to health. Among the principles adopted at Alma Ata, the following ones express the growing disenchantment with the privileging of biomedicine:

- western medical care is not the only efficacious type of health care;
- medical professionals are not the only people capable of giving medical advice and treatment;
- health cannot be isolated from other development policies and agencies;
- the most sophisticated technology does not necessarily provide the best care;
- the doctor/patient ratio does not necessarily indicate the quality of care available;
- and
- decentralized health planning and institutions are better able to respond to local health problems (WHO/UNICEF 1978; cited in Rifkin, 1980: 4).

Not only did the introduction of PHC broaden the approach to health in the South, but it also placed emphasis on incorporating intimate knowledge of the local context. Yet despite this policy emphasis, WHO and UNICEF, as the most knowledgeable partners in health, continue to set the parameters around both the needs of the people and the range of possible means of meeting them (Banerji, 1990; van der Geest, 1990; Zaidi, 1994).

A WHO document outlines the rationale for community participation in PHC in the following terms:

- 1) health patterns can be more radically improved by preventive than by curative measures; therefore, the adoption of health-promoting behaviour by rural communities with respect to sanitation, environmental hygiene and food consumption would lead to a more rapid improvement in health than by increasing investment in services alone;
- 2) misuse and underuse of services would be mitigated if those who need the

services were involved in planning their development and application;
 3) untapped community resources could be used to make health care more accessible and acceptable, particularly to the poor and underprivileged; and
 4) people have both the right and the duty to be involved in decisions about activities that affect their daily lives (Rifkin, 1990: 10).

These ideas about the benefits of participation carry with them certain assumptions about locally-perceived needs and the cycle of poverty characteristic of the South. Points one and two, taken together, assume that if the type of health services offered and the process through which they are provided reflect culture, in its broad ideological and behavioural context, then adoption of healthy behaviour will ensue and services provided will be more effectively utilized (Stone, 1992: 409). Problems related to poor hygiene and malnutrition are grounded in inappropriate behaviour, rather than systemic poverty and inequality. The major effort is therefore directed towards persuading people to abandon traditional beliefs and practices in favour of modern practices based on the biomedical model (Zaidi, 1994: 1387; Stone, 1992: 409).

Yet it is widely acknowledged that "rural people in the South, like people everywhere, are overridingly interested in good curative services and are not very interested in receiving health education or preventive medical advice" (Stone, 1992: 410). Evidence suggests that where modern curative services are accessible, affordable and effective, they are used (Stone, 1992: 410-411). Curative care is perceived as a quick and effective means for overworked and underfed community members to continue with their daily activities for survival. While health promotion and preventive activities may be valued in rural communities, they may represent an unaffordable luxury. Expecting communities to devote their time and energy to health promotion and prevention

represents an ideal goal to be strived for over the long-term, but cannot be assumed to reflect the immediate priorities of community members, who may be struggling to generate income and provide food for themselves and their families.³¹ It is safe to say that participation in health promotion and preventive activities will only lead to more rapid improvements in health if there is a concomitant transformation in structures which perpetuate poverty (van der Geest, 1994: 1035). Lack of adoption of "healthy behaviour" must be understood in this context.

Further, while it is almost universally acknowledged that health programs must be culturally sensitive, and reflect the community's self-defined needs, it has been argued that too much emphasis on culture has hidden the influence that political and structural factors have on health programs (Stone, 1992: 409). Factors such as the global political economy, international and national political will, government administrative and technical support to programs, decentralization of decision-making and local power struggles also influence the effectiveness of PHC (van der Geest et al., 1990). The emphasis on how health systems and programs are structured, and how local power struggles are played out leads not to an image of the poor as being tradition-bound, but instead as being constrained by lack of power (Stone, 1992: 415).³²

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³¹ From my discussions with women in Sigoti, it was clear that health promotion and preventive activities were highly valued. However, availability of drugs was a pressing concern for them, because as a means to control morbidity, it allowed them to continue with their heavy workloads. One might ask then, why not simply direct efforts to extending curative services, which tend to be disproportionately urban, to rural populations in the South. The push for PHC developed out of recognition that curative care is not only inaccessible to the majority of people in the South, but it is also an expensive short-term solution to preventable health problems. The key question being raised here is whether a traditional PHC program is an appropriate lead intervention which can effect sustainable improvements in the standard of living of rural populations. To give one example, will nutrition education be effective if those responsible for purchasing or growing food do not have income, or access to land on which to grow food?

³² This tendency to ignore how interrelations of power influence local responses to health projects seems

The third point identified above assumes that the "community" possesses untapped resources in the form of money, labour or time which they wish to devote to health-related activities. However, the assumption of untapped "community" or "family" resources has to a great extent come to mean women and their unpaid labour (Mburu, 1986: 785). The assigning of women to yet another unpaid, unrecognised job has been seen as placing an extra burden on women, often with little positive developmental impact on their lives (WFPA, 1986: 36). This issue will be discussed in depth in the following chapter.

Further, it is assumed that community resources will be channelled in a way that effectively incorporates the interests of even the most marginalized groups and members of the community. This assumption is problematic. Despite the widespread acknowledgement that communities do not represent homogeneous groups with similar interests, goals and resources, health planners continually fail to look for and define community diversities, power groups and basic social, political and economic inequalities (Matomora, 1989; Oakley, 1989). Experience reveals that broad-based participation has rarely characterized PHC initiatives, as local power struggles and domination by elites (overwhelmingly, though not exclusively, men) have been shown to limit the extent to which marginalized groups participate, and hence benefit from, PHC (McPake et al., 1993). A failure to articulate the complexities involved in developing broad-based

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to be part of a general trend in "development" work, whereby planners fail to take account of the embeddedness of development projects in local political struggles. James Ferguson has pointed to this problem in the context of an integrated rural development project undertaken in Lesotho, in which planners saw both government and the project as "neutral instruments of development, providing technical solutions and social services to the rural poor" (Ferguson, 1994: 87).

participation simplifies the concept of participation to the detriment of individuals and groups who are typically marginal to the process. It marks the political nature of both participation and health care, and ignores the original conceptualization of PHC as "the key to achieving an acceptable level of health throughout the world, an integral part of social development *in the spirit of social justice* [my emphasis]" (WHO, 1978: 7).

Finally, the assertion that communities should participate in PHC programs because "people have both the right and the duty to be involved in decisions about activities that affect their daily lives," assumes that health-directed activities which form the components of PHC are a priority in the daily lives of the community. While this may be a correct assumption in some contexts, it has been shown to be false in others, and cannot be applied universally to the South (Rifkin, 1990). What these points illuminate is the potential discrepancy between WHO's interpretation of participation and local realities. WHO and UNICEF advocate participation for reasons conceived of at the international level. Participation is seen as a means to improve the health of populations -- that is -- it is a component of an effective health intervention, one whose basis is PHC. In effect, WHO and UNICEF, through their universal promotion of PHC, have privileged health as a priority of the people and have defined a range of possible means of attaining it (Stone, 1992: 411).

This is especially true of WHO and UNICEF's more recent push for a limited number of specific pre-selected interventions, in an effort to address seriously issues of cost recovery in PHC implementation (Kabeer, 1992). This is generally referred to as selective PHC, and focuses to a great extent on family planning and child survival

components of PHC. The underlying rationale is that resources are not adequate to address all problems so a lead intervention must be identified (Brems and Griffiths, 1993: 257). Malcolm Segall argues that such efforts do not account for the desire on the part of local health structures to assign a greater priority to certain interventions over others, according to their particular circumstances (Segall, 1987: 282). In effect, it precludes the possibility of participation as a slow, sustained process that empowers people to make choices they deem most relevant to their own lives. The push for selective PHC not only reflects the supremacy placed on the international health establishment in defining needs, but also reflects WHO's and UNICEF's status as mainstream international organizations whose policies mirror dominant political and economic ideology.³³

2.3.2 The Politics of the Mainstream

The world economic climate of the past decade has led to two important trends in the practice of development -- the drive for economic efficiency, and a concomitant push for cost recovery, leading to emphasis on welfare financing and provision of services by communities (Bell and Franceys, 1995: 1172). Structural adjustment programs and stabilization policies which generally require a reduction in government expenditure on social services have had a direct effect on the health sector - as ministries of health are being asked to find ways to make the health sector accommodate to a contraction of resources (Zaidi, 1994: 1391). WHO has adopted the language of structural adjustment:

...structural adjustment programs in many developing countries continue to imply

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³³ UNICEF, however, has been inclined to retain a more integrated approach, in which community participation is developed through a number of community development activities in addition to health services, including food production, nutrition, water and sanitation, education and income generation. UNICEF has therefore given a broader meaning to "health" in PHC (Rifkin, 1990: 3).

tight government control over expenditures on health and social services, often to the detriment of poorer populations who depend on government services. The health sector will have to make prudent use of the available resources by cutting down misplaced allocations, sharpening priorities and implementing policies and strategies that improve effectiveness and reduce waste (WHO, 1993: 150).

As S. Zaidi maintains, the policy debate in the health sector "shifts markedly from demand-oriented questions on what the population needs and what would be feasible and effective to meet those needs, towards supply-oriented questions of what is affordable and cost-effective" (1994: 1391). In effect, the responsibility to reallocate resources in an effective manner is placed at one level on individual national governments, and at another, on individual communities, to accommodate to an inequitable global economic order. WHO and UNICEF, as mainstream international organizations and global policy-makers, remain immune from political considerations (Morgan, 1990: 241).

At the 42nd World Health Assembly, member states were urged "to maintain political commitment to reduce the inequities among the different population groups" (WHO, 1993: 42). Ingredients for success were identified as

government political, social and financial commitment; strong management capabilities for implementation; well-oriented, trained and committed health personnel; decentralization to district/local level; community involvement in local decisions; sustained financing; and widespread deployment of affordable technologies (WHO, 1993: 46).

Lynn Morgan argues that the recent emphasis by international agencies on national political will focuses analytic attention on the individual country, thus concealing the crucial role played by the agencies themselves in determining the health policies of the South (1990: 233). She asserts that the emphasis on political will obscures the relationship between poverty, underdevelopment and disease, and minimizes the adverse

impact of economic crisis. This effectively shifts the burden of poverty and illness away from inequitable global economic relations and onto impoverished governments (1990: 240).

It is not surprising that during the same period there has been a re-affirmation of the importance of community involvement in the delivery of health services. The concept of participation continues to be regarded by WHO and UNICEF as a magic bullet through which improvements in health can be realized (Zaidi, 1994). Increasing recognition by WHO and UNICEF of constraints which limit effective participation in PHC programs has not led to a reevaluation of the use and value of participation in PHC; rather, it has spurred research directed to finding ways to improve the effectiveness of participation (WHO, 1993).³⁴ At the 42nd World Health Assembly, WHO recognized the need to accelerate the implementation of PHC, and asserted that the people-centred approach to PHC must prevail (WHO, 1993: 148). Yet the conceptualization of participation has shifted, placing more responsibility on communities to meet their health care needs, both financially and in terms of more active forms of participation. In 1978, WHO defined participation as:

a process whereby communities, families and individuals assume responsibility for their own health and welfare and develop the capacity to contribute to their own and their community's development (WHO, 1978: 20).

In 1993, explicit attention to empowerment is clear:

There is a need to empower people with information, ideas and responsibility, and to encourage free expression of concern and individual and community action to solve health-related problems (WHO, 1993: 148)....communities should be

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³⁴ Works by Peter Oakley (1989) and Susan Rifkin (1990) are examples of such research efforts.

involved in assessing their health situation, defining the problems, planning priorities, implementing activities, and monitoring and evaluating their own programs....mechanisms are needed based on clearly defined objectives, mutual interest, good understanding and collaboration (WHO, 1993: 51).

At first glance, the shift towards empowerment in WHO discourse appears to be a progressive development; however, it is somewhat paradoxical that nations and communities are being called upon to take responsibility for their own health, amidst growing concern that "as long as there are situations of gross poverty and inequalities, where groups, communities and nations are disempowered, PHC in the long term has little chance of succeeding" (van der Geest, 1994: 1035). Notably absent from the above statement is the need to empower people with *resources, a necessary condition for empowerment* discussed in section 2.2. PHC is a social justice issue that calls for the reallocation of resources and the uplifting of the poor (Muhondwa, 1986: 1250).

Perhaps the greatest contradiction associated with WHO's emphasis on national political will and community empowerment is its inattention to its own role in addressing one of the basic principles adopted at Alma Ata: that health is political (WHO/UNICEF 1978; cited in Rifkin, 1980: 4). Remarkably absent from PHC policy documentation is the articulation of participation as a means to break down inequitable political and economic structures which deny access of rural populations to health services. Responsibility to deal with the global economic crisis is placed outside of the international arena, and instead on national governments, communities and individuals. It has been argued that community participation was made a pivotal strategy because it satisfied the political and ideological need for a cooperative, non-confrontative approach to address issues of poverty and inequitable distribution of wealth (Woelk, 1992). Lynn

Morgan argues that international agencies justified community participation in health

more because they wanted to reinforce the symbolic identification of "health" with "democracy" than because they knew that community participation would improve health status. Foster [1987; cited in Morgan, 1990: 212] writes that within WHO evidence was carefully selected to support the *a priori* assumption that community participation was a very important element in building PHC at local levels (Morgan, 1990: 212).

A key example is Costa Rica's experience with PHC. Its renowned success in meeting health care needs of rural populations has had little to do with community participation, and more to do with the national allocation of health resources and the structure and organization of rural health services (Morgan, 1990: 211). The promotion of community participation in health by international agencies ignored a long history of nonparticipatory rural health programs. Further, they overlooked the long history of community involvement in health care through indigenous healing and health enhancing behaviour. As a result, participation in "modern" health in Costa Rica failed to materialize, but perhaps not for the worst (Morgan, 1990: 218).

National political will and beneficent health systems are certainly required in efforts to develop empowering health strategies for rural populations in the South, and will be discussed below. But the above point illustrates the tantamount need for international political will in the development of empowering health strategies. At a forum discussion held at the 18th Annual National Council on International Health in Arlington Virginia, the action agenda for the 1990s included a section entitled "What We Want - Voices from the South." The agenda called for a substantial political and economic commitment from the international sphere, in the form of

- durable arrangements for the transfer of resources;

- reductions in, if not cancellations of, the debt burden;
- direct investment to meet capital requirements;
- favourable trading terms and better prices for primary commodities like coffee, tea, and cocoa;
- small and medium scale joint ventures to create jobs;
- sustainable strategies for the use of natural resources; and
- investments in the development and dissemination of appropriate technology to reduce women's work burdens (in Jacobson, 1993: 6).

The agenda implies that unless radical changes are made to the current global economic system, poverty and ill health in the South will prevail. These issues tend to get played down, if not ignored, in WHO and UNICEF policy documents. This point is not meant to place responsibility for a structural transformation in the global economic order on WHO and UNICEF. But it does point to the incongruity between WHO's setting policies in the spirit of social justice and empowerment of people while simultaneously masking the disempowering forces at play at the international level which limit the capacity of PHC to achieve its goals. International agencies truly committed to the original principles of PHC defined at Alma-Ata must themselves be political in their efforts to effect positive structural change.

Thus, the "international health establishment," in its effort to promote participation in PHC delivery, has been less than successful in acting as a catalyst for empowerment of local communities through PHC initiatives. Its interpretation of participation as a means to deliver pre-defined health services more effectively (particularly in the case of selective PHC), compounded by lack of international political will to articulate the need for positive structural change at all levels, have been key reasons for this failure. Should this imply that PHC and participation have no merit as a global movement? No; certainly the principles put forth at Alma Ata and the concept of empowerment are

admirable guidelines towards which nations should strive. The key argument here is that the true spirit of a broad, democratic and empowering health strategy is contradicted by distinct parameters around which the local context is enabled to respond. National governments, in their attempts to secure resources for health, must conform to donors' priorities. As a result, local perceptions of different approaches and priorities are often bypassed, limiting the prospects for empowerment (Zaidi, 1994: 1389). Despite the international health establishment's articulated appreciation of diverse local contexts, its pre-defined objectives which form the basis for funding allocations preclude its ability to respond in a flexible manner to this diversity. As Susan Rifkin notes, if participation is to develop from within and be self-sustaining, programs must use planners and agencies as resources, not directors (1990: 245).

2.3.3 Hierarchy Flows Down -- Not Up

Limitations to an empowering health strategy are not restricted to the international sphere, however, as the bureaucratic and administrative hierarchy of health systems flows down to national, district and local levels. "Global health for all" was based on the premise that all components of national health systems would have to be organized as a coherent whole oriented towards a common goal - "a purposeful system" (Kleczkowski et al., 1984: 45). Primary health care was seen as an integral component of such a system, within which it should play the central role as the main point of entry and main channel of delivery; in other words, the goal was to reorient national health systems towards PHC. On a global scale, reallocation of national health resources has been a difficult process, with such factors as lack of realistic resource planning, lack of criteria

for more even distribution, lack of motivation of health personnel to work at peripheral levels, and insufficient resources, hindering the necessary redistribution (WHO, 1993: 44). Further, national health systems have fallen prey to the same contradictions characteristic of the international level, delineated above.³⁵ It has been argued that central planners have historically considered the local population to be, if not outright "ignorant," then at least in great need of outside education, advice and guidance (Stone, 1992: 414). The dominance of western-trained health professionals is not exclusive to the international sphere. The harshest critics of community participation have seen it as "a means of control and manipulation of the people, the supposed beneficiaries of the process of participation, by politicians, bureaucrats and technocrats" (e.g. Zaidi, 1994: 1389). Broad access PHC, unlike issues such as land reform or peasant self-organization, has rarely been seen as directly threatening by elites, particularly where little change in the structure of power relations has resulted from its implementation (Green, 1991: 745). Thus, the illusion that health is immune from political considerations flows down from international to national and local levels (Morgan, 1990: 241).

PHC programs have rarely been located within what David Werner refers to as a community-supportive environment. He defines community-supportive programs or functions as

those which favourably influence the long-range welfare of the community, that help it to stand on its own feet, that genuinely encourage responsibility, initiative,

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³⁵ Muhondwa, 1986; Brownlea, 1987; Justice, 1987; Ritkin, 1986, 1990; Oakley, 1989; van der Geest et al., 1990; Green, 1991; Price, 1992; Stone, 1992; and McPake et al., 1993 have illustrated this point.

decision-making and self-reliance at the community level, and that build upon human dignity (Werner, 1980: 94).

Community-supportive programs therefore foster an empowerment process, as delineated in section 2.2. Peter Oakley asserts that criticisms of previous health development strategies based on community participation focus on four main reasons for their failure:

- 1) failure to encourage people to think or act for themselves in attempting to solve their health problems, impelling them to rely upon external sources for action and solutions;
- 2) failure to provide adequate training, which led to the inability of local people to maintain the services that had been set up, and a resulting inability to sustain local resources and knowledge;
- 3) community contributions of resources and [labour] to health projects and programs have not been met with active community involvement in their design and implementation;
- 4) conflict between health-directed needs, as determined by the health service and medical profession, and health-related needs, such as housing, water and sanitation, as determined by the local people themselves; has often resulted in an incompatibility between the two sets of needs, and a concomitant lack of community interest in externally promoted health programs (Oakley, 1989: 5; paraphrased).

PHC seen in this light can hardly be considered to have sustained, or even elicited initially, empowering participation. Instead they have been characterized more by community-oppressive situations, which

...while invariably giving lip service to aspects [of a community-supportive program], are structured and carried out in such a way that they actually encourage greater dependency, servility and unquestioning acceptance of outside regulations and decisions; those which, in the long run, are crippling to the dynamics of the community (Werner, 1980: 94).

There is growing appreciation that the degree to which national policy responds to local aspirations and needs, the degree to which the civil service has been decentralized, the degree of organization at the local level, and the degree to which communication takes place between the centre and the periphery at both local and national levels

determine the effectiveness of participation, and whether its goal is to act as a mechanism for empowerment.³⁶ Also important in either hindering or facilitating participation are factors related to the health development process, referred to by Susan Rifkin as "action" factors. These include: how community needs are assessed; how community organizations are developed; how programs are managed; how financial and human resources are mobilized; how leadership is developed; and how the problems of marginalized groups, especially the very poor, are dealt with (Rifkin, 1990: 16-17). These factors interact in a complex way, and highlight the difficulties associated with developing frameworks for empowerment. Each level of organization is characterized by struggles for power, status and access to resources, all of which influence how community health activities and services are planned, delivered and utilized and how and to what extent local participation is actualized (McPake, 1993; Stone, 1992; van der Geest, 1990).

Despite the problematic associated with devising frameworks for community participation, both within the health sector and beyond, efforts continue to be directed towards developing strategies that lead to a positive interaction of the above factors, such that communities are empowered. In the field of health, strategies whose goal is to enable marginalized groups to have an authentic voice in the direction of health development have come to be referred to as community-based or managed (Matomora, 1989; Oakley, 1989).

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³⁶ Fraser & Meli, 1990; Green, 1991; Raikes, 1989; Rifkin, 1990; Oakley, 1989; van der Geest et al., 1990 are some examples.

2.4 Community-Based Health Care: How is it Different?

Community-based health care (CBHC) implies that ownership and control of a health intervention ultimately rests with the community (UNICEF, 1991). It extends beyond PHC interventions which attempt to provide essential components of primary health care in a rural setting, but fail to locate true authority or decision-making power with the community itself.

The CBHC approach parallels community management models which have been applied to a variety of development initiatives and disciplines, including water and irrigation, natural resource management, and provision of essential drugs to treat community members through PHC programs (Bell and Franceys; 1994; Korten, 1986; UNICEF, 1991). Generally speaking, the term community management is applied only when management processes involve broadly distributed control within the community, and involve strengthening and broadening the local base of effective resource control (Korten, 1986: 3). The assumption that communities are well able to organize and manage change is central (Matomora, 1989; Bell and Franceys, 1995: 1172).

As with any intervention designed to alter the prevailing power balance, community-based health programs carry with them the implicit assumption that conflict situations are inevitable. The development of a community-supportive environment, and culturally and socially acceptable strategies to deal with conflict is therefore integral to the design of community-based health care programs (Rifkin, 1980: 119). This requires a concerted effort by planners, health professionals and health agencies first, to share information, and collaborate with community members in clearly defining tasks involved; and second,

to ensure that communities possess or obtain the resources required to fulfil their tasks (Rifkin, 1990: 26).

David Korten (1986) has identified certain principles of a community management approach which facilitate empowerment of communities, and lead to more effective and appropriate interventions. He uses the National Irrigation Administration in the Philippines as an example of a successful community management endeavour, characterized by a true commitment from a range of actors to facilitate community empowerment. He points to several factors which contributed to the effectiveness of the program:

- 1) assistance to each individual community group is designed and managed as a discreet project activity with its own specifications and timetable responsive to the particular situation of that group, based on a careful study of existing practices, technical capacities, resource availabilities, and power structure;
- 2) the emphasis is on community control and management of the resource, and every aspect of the project intervention is geared to this outcome, including legal confirmation of resource ownership and legal recognition of the resource management group as an autonomous body with legal rights
- 3) actual project design does not take place until the beneficiaries are fully prepared to make their needs and preferences known, and once completed, is not implemented until formally accepted by an association of the beneficiaries;
- 4) organizing takes account of and works within existing structures to the extent possible, while building member strength from the bottom-up to insure broadly-based participation by the actual producers and avoiding domination by traditional leaders;
- 5) incentive systems within the agency are structured so as to strengthen the accountability of the project staff to assisted groups; and
- 6) systematic, long term attention is given to debureaucratizing agency systems and procedures, developing its capacity to work flexibly as a service agency in support of local resource management groups (Korten, 1986: 12, paraphrased).

Community-based health care adopts these principles, in theory. Importance is placed on decentralization of decision-making, devolution of power, attention to distinct interests of groups and individuals in the community, and definition of priorities by the

community, in collaboration with health staff. The community-based health care model is therefore an attempt to redress some of the historical contradictions which have precluded PHC from becoming an empowering strategy for communities. The Bamako Initiative is one such strategy.

But even the community-based health care approach, in theory, has shortcomings. What is not articulated explicitly above is how differences along gender (and to a lesser extent, class) lines, as important determinants of local power structures, are dealt with. This is an especially crucial oversight in the context of health development, where women have historically been marginalized, and their particular needs not accounted for. As Patricia Maguire notes (1987; see Chapter 4, Methodology), participatory frameworks which are sensitive to gender must articulate how women are impacted at each stage of the participatory process. Failure to explicitly problematize gender represents an essentially androcentric approach, and may result in failure to effectively incorporate women into the empowerment process. The following chapter discusses the historical gender biases of PHC embodied in community-based health care approaches.

Chapter 3: PHC Discourse and the Gender Variable: Conceptual Issues

3.1 Introduction

Chapter One located women's health issues within the overall context of the development process. It was asserted that health interventions truly committed to effecting long-term, sustainable improvements in women's quality of life must be concerned not only with traditional women's health issues related to their reproductive roles, such as maternal morbidity and mortality, but also with women's self-defined priorities. Sustainable improvements in women's health were seen as inextricably linked to their empowerment, where empowerment was defined as a process through which women increase their capacity to exert control over their lives and their health. Increased access to information and resources, skills development and ability to exercise choice through authentic decision-making in health development was seen as integral to the empowerment process.

Primary health care has been widely recognized as a potentially forward-looking health strategy for women, because of its intersectoral approach and focus on empowering individuals and families through the health care process.¹⁷ Meredith Turshen refers to PHC as

a democratic health system -- one whose basic elements include equitable distribution of food, water, sanitation, preventive health services, curative medical care to men, women, and children of all social classes in rural and urban areas, and entails a process as well as a provision of services -- ie. a reversal of the usual top-down planning process (Turshen, 1991: 208).

PHC has been assumed to be of particular benefit to women for four main reasons.

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¹⁷ See for example, Koblinsky et al., 1993; Edstrom, 1992; Ojanuga & Gilbert, 1992; Ostergaard, 1992; Turshen, 1991; Hart et al., 1990; Rifkin, 1990; Leslie et al., 1986; Mburu, 1986; and WFPA, 1986.

First, its goal is to increase accessibility of health care to all through a redistribution of resources to the social periphery. Second, PHC is assumed to account for women's broad health needs, including and extending beyond their reproductive health needs.³⁸ Third, the PHC approach prioritizes the provision of health information and education, which has been seen as a tool for women to exert greater control over their lives and health (Merchant and Kurz, 1993: 83). It is assumed that self-care knowledge about health empowers people to make appropriate choices to maintain their health and respond to illness (Hilderbrandt, 1994). Finally, the central role of participation in PHC is seen to be an acknowledgement of the capacity of individuals to take action to improve their health, and indicates a commitment to finding alternatives to dependence-based health interventions (Rifkin, 1980).

Thus, PHC embodies a health strategy that could conceivably contribute to improving women's health by increasing their access to health-related resources and encouraging their full participation in the health development process. Women could influence the direction of health care to their benefit through their integral role in identifying priorities. These priorities would no doubt be reflective of women's daily life experience, and would necessitate collaboration between among sectors.

As Chapter Two illustrated, however, primary health care has generally fallen short

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³⁸ Reproductive health needs are assumed to be considered because maternal and child health and family planning usually form a central part of PHC. The share of health budgets going to primary health care has therefore been used as a proxy for commitment to maternal health (Edström, 1992). But PHC also attempts to address health issues holistically through an intersectoral approach. In this sense, women's broad health needs, which are a function of the context in which they live, are assumed to be considered. As this chapter will illustrate, however, the broad health needs of women accounted for in the conceptual framework of PHC have not necessarily been defined as priorities by local women themselves.

of acting as a catalyst for, or contributing significantly to, community empowerment. Despite PHC's broad-based and democratic definition, its practice at the local level has been guided by dominant health and development ideology, and constrained by rigid and hierarchical health systems which prioritize the biomedical model. In an analogous sense, dominant gender ideology has shaped the structure and organization of PHC programs. Just as parameters around the nature and scope of PHC programs have been determined from above, so have parameters been set around women's and men's "proper" roles in the PHC process. This has had specific implications for local women involved in PHC implementation, particularly with respect to their role in participatory processes. Generally speaking, the potential of PHC to contribute to women's empowerment has to date not been realized (e.g. Ostergaard, 1992; Koblinsky et al., 1993; Paolisso and Leslie, 1995).

Through an examination of the treatment of gender in the PHC discourse, and by building on the literature on both gender and development and women's health, this chapter will illustrate the historical biases which have resulted in the marginalization of women from "authentically" participating in, and hence, benefitting from PHC programs. The constraints to empowerment discussed in Chapter Two are broad-based and have impacted on communities-at-large, affecting men and women in more or less the same manner. It is my purpose here to illuminate further constraints to participation which have impacted mainly on women, as a unit of analysis, by virtue of their gender.³⁹ My

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³⁹ Certainly women have had diverse experiences with PHC, both among and between communities. As discussed in Chapter One, women's lives are characterized by different contexts, resulting in varying constraints to their participation in and access to PHC programs. The extensiveness of these constraints is a function of household and community decision-making patterns, women's particular socio-economic status,

analysis of the Bamako Initiative must be understood in this context, because as a PHC strategy which aims specifically to increase survival and improve the quality of life of women and children, it relies on the participation of women (as beneficiaries, as health care providers, and as decision-makers) to achieve this end. Whether BI discourse, and its practice in one community, have incorporated or alleviated the historical constraints facing women in planning, implementing and managing PHC is central to my analysis in Chapter Six. Section 3.2 illuminates the gendered division of responsibility inherent in the conceptual framework of PHC; and grounds this division in dominant gender ideology, which has guided the development of social policy initiatives in the South. Section 3.3 discusses the implications of conceptualizing primary health care activities in relation to women's and men's traditional roles, particularly how it has precluded women from articulating their health interests through the PHC process. Section 3.4 looks specifically at how women's absence from decision-making fora which influence health policy has effectively disempowered them, and has reinforced traditional power structures which are skewed in favour of men.

3.2 Gender Ideology in Social Policy: Progressive for Women?

Since the official acknowledgement of primary health care as a global health strategy in 1978, assumptions about traditional gender roles have guided the substance of PHC programs and the process by which they have been designed and implemented. At that time, a gendered analysis of health care needs consisted primarily of separating women's

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ethnicity, geographic distance to health services, work burden, and other factors. This does not, however, negate the usefulness of gender as a privileged unit of analysis in this thesis. This chapter will identify those constraints that are common for most women involved in PHC programs, specifically deriving from their social, political and economic relationship to men.

reproductive health needs from those of the general population. Health needs not linked to reproduction were generally not subject to a gendered analysis, because they were assumed to impact on men and women in the same manner (Raikes, 1989; Kabeer, 1992a; Ostergaard, 1992; Welbourn, 1992).⁴⁰ As a result, women were targeted in maternal and child health and family planning interventions in the context of PHC. These interventions were invariably planned from above,⁴¹ and generally failed to incorporate women's voice into their design and management (Ojanuga and Gilbert, 1992: 615; WHO, 1992).

While participation of both men and women was actively encouraged in WHO policy documents, participation was understood in terms of a distinct gendered division of responsibility. WHO saw an important role for men in the PHC process, based on their predominance in public leadership positions:

It is important to encourage men, too, to take a greater interest in health, and to help them realize that they can contribute by shaping the community health system, as well as by taking part in practical undertakings (WHO, 1978: 34, my emphasis).

It was understood that local men in the community would organize and manage PHC (WHO, 1978). The implicit assumption in PHC, as in other social policy initiatives, was that since women were part of male-dominated households, their interests would be

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⁴⁰ As discussed in Chapter One, gender differentials in health are not solely related to biological differences between men and women, but are a factor of the particular social, political, cultural, economic and environmental context in which they live (Kabeer and Raikes, 1992; Ostergaard, 1992). In many cases, these factors impact on men and women in different ways. For example, men and women frequently have different susceptibilities to tropical or sexually transmitted diseases, and are exposed to different occupational health risks (Mulindi, 1992a, 1992b; Paolisso and Leslie, 1995). Carol Vlassof notes that women's domestic responsibilities frequently make them more susceptible than men to health problems such as respiratory diseases and back pain (Vlassof, 1994: 1251).

⁴¹ Reasons for failure of PHC programs to incorporate the local population fully into the planning process was discussed in Chapter Two.

reflected in the interests of their husbands or fathers (Oakley and Marsden, 1983: 10).⁴² Similarly, the health needs of the whole community would be accounted for through men's role in shaping PHC programs (Kabeer, 1992b). Thus, planners' attempts to stimulate community participation generally began with "selling" the PHC concept to the local leadership, which were almost always male (WFPA, 1986: 33).⁴³ Local leaders or elites (also usually men) were then recruited to participate in organizational and managerial capacities in PHC programs (WFPA, 1986; Rifkin, 1990; Stone, 1992; McPake et al., 1993).⁴⁴

Conversely, women were mobilized into the PHC process based on their intimate connection with health issues through their roles as providers of health care to the family:

In most societies, women play an important role in promoting health, particularly in view of their central position in the family; this means that they can contribute significantly to primary health care, especially in ensuring the application of preventive measures (WHO, 1978: 34, my emphasis).

The possibility that women, as primary health care providers and consumers, could effectively shape the health system did not figure into this conceptualization of PHC. No

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⁴² Henrietta Moore asserts that the control and allocation of resources within the household is a complex process which has to be seen in relation to a web of rights and obligations (1990: 56). She notes that if we assume that pooling and sharing characterize all intra-household relations (including the sharing of information) we obscure the real nature of those relations and preclude any possibility of enquiring into how they actually work (Moore, 1990: 55).

⁴³ This is certainly true in Kenya, where, with the exception of women's group leaders, local leadership positions are almost exclusively the domain of men (Thomas, 1989; World Bank, 1989).

⁴⁴ While this has been the general manner through which PHC programs have been introduced in the community, this process has not only been the result of gender biases of planners. Planners have tended to go through existing leadership structures in order to avoid alienating existing elites, and running the risk of creating conflict within the communities (Rifkin, 1990: 31). Conflict is generally avoided when community leaders feel the introduction of a health care initiative will not disrupt the status quo (Green, 1991). As discussed in Chapter Two, community participation was made a pivotal strategy because it satisfied the political and ideological need for a cooperative, non-confrontative approach to address issues of poverty and inequitable distribution of wealth (Woelk, 1992).

value was placed on incorporating women's voice into the PHC process, such that women could share decision-making power, influencing the direction of a health intervention. The exact nature of how this gendered division of responsibility has been translated into practice, and its implications for women, will be discussed in the next section. First, it is important to ground this division in its historical ideological context, which is by no means unique to PHC.

Gender ideology inherent in the conceptual framework of PHC mirrors that of other social policy initiatives in the general context of development (Kabeer, 1992b: 5). By the late 1970s and early 80s, these initiatives were subject to increasing criticism by women in development (WID) specialists for their tendency to marginalize or exploit women. Two streams of critiques pervaded the WID literature: one focused on economic development initiatives, and the other on social policy initiatives.⁴⁵ Both attributed women's peripheral status in development policy to the inappropriate use by planners of a western model of the household: a nuclear family characterized by a male head and primary breadwinner, and a woman responsible for domestic needs of the family (Moser, 1989; Kabeer, 1992b: 4). This conception of the household derived from both the dominant economic model which assumed the idea of a "self-interested, free-floating economic man, competing in the market place," and the dominant social model which assumed women to be "altruistic mother[s], embedded in the moral domain of household and community" (Kabeer, 1992b: 4). Where productive activities of women and children were acknowledged, they were interpreted as secondary assistance to the male

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⁴⁵ Examples of these critiques are Boserup, 1970; Rogers, 1980; Sen & Grown, 1985; and Young, 1986.

breadwinner (Kabeer, 1992b: 4). Mathew Lockwood attributes the invisibility of women in the economic model to the ultimate source of gender identity, social convention. Gender identity is mystified, and placed outside the "rational" sphere of economics (Lockwood, 1992: 10). Rather than attributing the outcomes of this conceptualization to natural social processes; however, he grounds them in a definite economic history (Lockwood, 1992: 10).⁴⁶

WID critiques were either directed at attempts by planners to increase the economic productivity of the "household" by targeting incentives at its assumed primary breadwinner, the male head, or at the outcomes of planners' implicit assumptions about "the community" in social policy initiatives. The assumption that women were more "naturally willing" to undertake work in the interests of family and community resulted in their mobilization into labour-intensive volunteer or underpaid development activities, in the spirit of community participation.⁴⁷ The legitimization of women's volunteer or underpaid community work by planners has frequently been linked to its attachment to the "nonproductive" and "natural" social world, or domestic sphere, which is given no value in the dominant economic model (Kabeer, 1992b; Elson, 1991; Moser, 1989: 1801).

Critiques illuminated the detrimental outcomes for women of these assumptions;

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⁴⁶ Mathew Lockwood draws an interesting analogy between the treatment of gender and comparative advantage in elementary trade theory. A country's comparative advantage is assumed to be derived from its natural resource endowments. With both comparative advantage and gender, naturally defined categories are placed outside the economic model, despite the fact that they are both grounded in economic history (1992: 10).

⁴⁷ In Kenya, for example, women provide an estimated 80% of the self-help labour for the community (WFPA, 1986: 36).

name . discrimination against them in labour and credit markets;⁴⁸ gender-specific copying of behaviour, which tended to first, restrict women from benefitting from or engaging in "high value" activities (those generally related to some form of "production," requiring training and access to resources such as credit, land or technology); and second, perpetuate asymmetric rights and obligations within domestic groups (Lockwood, 1992: 10). The unpaid community work of women was often labelled as exploitive because of its tendency to provide women with increased knowledge, while doing little or nothing to improve their severe economic and time constraints (Kabeer, 1992b: 5).

As a social policy initiative, PHC has certainly served as a forum through which women's traditional gender roles have been reinforced, and women's unpaid labour has been tapped in the spirit of community participation (Leslie et al., 1988: 308). As such, it has fallen prey to similar criticisms. The next section discusses the historical impact on women of PHC programs which have been based on the organization of primary health care activities around women's traditionally ascribed roles.

3.3 WHO and the Discourse on Gender: Women Feed, Men Lead

The conceptual framework of PHC, which linked "health" directly with women's traditional roles, guided the development of PHC programs that would enable women to carry out their domestic tasks in a more effective manner. A clear example of WHO's

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⁴⁸ An example of discrimination against women in agriculture is Kathleen Staudt's 1978 case study of the Kenyan government's promotion of high-yielding hybrid maize. She documented the productivity losses that were a result of extension staffs' false assumption that innovative farmers were mainly male. She concludes that denying access to credit and extension services to capable groups because of norms which support male preferences eroded the long-term productivity of women farmers, undermined their autonomy as economic actors and lowered governmental capacity to raise agricultural output (Staudt, 1991: 452; cited in Kabeer, 1992: 4).

location of women's roles in PHC within the sphere of their domestic roles is found in a 1987 WHO document entitled *Women as Providers of Health Care*. The document points to the following reasons for involving women in health activities:

- 1) women have a traditional and natural role in providing health care;
- 2) opportunities provided for communicating with other women during the course of normal domestic tasks ensure that much valuable information is passed on;
- 3) women frequently have stronger community roots, especially in developing societies where men may migrate to urban areas in search of better-paid work..ensures continuity in health activities;
- 4) many of the traditional activities of women, such as the collection of water, the provision and preparation of food, the rearing of children, reflect aspects of the intersectoral approach to improving health; and
- 5) women's organizations that already exist in many communities provide a ready-made structure for the participation of women in health-promoting activities (Pizurki et al.; cited in Rifkin, 1990:7).

Thus, successful PHC implementation depended on women's involvement. Women tended to be mobilized to participate in four of five main capacities in which community members have participated in PHC programs: as recipients of health education, as providers of labour in the construction and maintenance of health infrastructure, as volunteer community health workers, and as financiers of health care, through contributions of funds to pay for minor forms of treatment (Hart et al., 1990; Rifkin, 1990). Women's increased time commitment was seen as necessary to ensure the provision of more and better food, safe water; the appropriate development and utilization of sanitation facilities; and the application of preventive maternal and child health measures, including breastfeeding, immunization and family planning (Leslie et al., 1986). The fifth main capacity, namely, organizing and managing PHC through involvement on local health committees, has generally been the domain of men (WFPA,

1986; Rifkin, 1990; Stone, 1992; McPake et al., 1993).⁴⁹

Disapproval of the notion of self-help in PHC was already surfacing in the early 80s because of its lack of long-term vision for improving women's quality of life:

[Self-help] can come to be viewed as a means for governments to withdraw all attempts to provide health care services, with significant consequences for women. Unless sex-typing of roles in a family is rooted out, it will only mean an extra burden on the woman of the house...the assigning to women of yet another unpaid, unrecognised job in the home can have nothing to do with development (Cottingham, 1983: 148).

This criticism of PHC has prevailed into the current decade, as few structural or substantive changes regarding women's and men's involvement have been made in PHC initiatives (e.g. Ostergaard, 1992; Koblinsky et al., 1993; WHO, 1992; Mhloyi, 1994).⁵⁰

Chapter One suggested that a process leading to long-term, sustainable improvements in women's health will likely be hindered if women are not enabled to articulate their particular health interests through their involvement in PHC. An empowering health strategy was seen to recognize that women's capacities, abilities and strengths are situated within political and economic structures which on the one hand favour men, and on the other, place supremacy on the western biomedical model. Sally Green and Cathy Baden

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⁴⁹ While different types of community organizations have been responsible for overseeing PHC activities, the main form has been village health committees (also referred to as community health committees, which are established specifically for community health programs (Rifkin, 1990: 8).

⁵⁰ As discussed in Chapter One, the discourse around women's health issues has changed substantially over the past two decades. WHO is now quite vocal about making women's health and social needs a top priority, and promoting the role of women as agents "by equipping them with equal access to information, technical and economic resources, skills, education and opportunities" (WHO, 1992a: 2). In practice, change in this direction has been slow. Development and health interventions still rarely take into account, nor help change inequalities in gender responsibilities for child care and household maintenance (Mhloyi, 1994: 16).

argue that the focus on women's traditional roles effectively cements women's interests as those determined by their position within prevailing gender divisions of labour and does little to change the status quo (Green and Baden, 1995: 94; Mhloyi, 1994). They assert that women who are targeted for participatory activities because of their domestic roles must at the same time be enabled to articulate their own interests, such that gender interests do not go unrecognized (Green and Baden, 1995: 94).⁵¹ If PHC is to represent an empowering health strategy for women, this implies that women have real influence over the content and direction of a health intervention. Women must actually play an active role in deciding what health programmes they think should be undertaken, and planners assist them by providing the knowledge and/or resources to enable these activities to be pursued (Rifkin, 1990: 14).

In practice, however, PHC has not fulfilled these objectives. The gendered division of responsibility in PHC has precluded PHC from becoming a health strategy through which a secure support base is built for women, or through which women have been enabled to articulate their own health interests. Women's recruitment into primary health care activities has derived from the assumption that primary health care is a pressing "practical need" for women in the South (Moser, 1989).⁵² Because a great deal of

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⁵¹ While Sally Green and Cathy Baden argue this point in the context of water resource management, the point is also applicable to social policy initiatives on a more general level, and to PHC in particular.

⁵² Women's practical needs are those formulated "from the concrete conditions of women's experience, in their engendered position within the sexual division of labour, and deriving out of their practical gender interest for human survival" (Moser, 1989: 1802). Women's practical needs therefore tend to focus on the domestic sphere, on the community's survival needs, and on income earning activities grounded in their traditional roles in the family (Moser, 1989: 1802). They differ from women's strategic gender needs, defined as "those needs which are formulated from the analysis of women's subordination to men, and derive from the strategic gender interest identified for an alternative more equal and satisfactory organization of society than that which exists at present, in terms of both the structure and nature of

women's practical needs derive from their requirements to provide for their families and communities, they tend to be associated by both women and policy makers with "women's needs" (Moser, 1989: 1802).³³ The identification of the various components of PHC with women's needs essentially located the responsibility of dealing with ill health within the domestic, or "nonproductive" sphere. Social, political, and economic relations, and cultural rules which govern the effectiveness with which women can fulfil their domestic responsibilities were placed outside the conceptual framework of PHC.

An illustration of how this conceptualization has translated into practice in the development of PHC initiatives is given by Naila Kabeer (1992a). She states that in the past, national and international policy making bodies have operated as though there were two different groups of women in the South, those with reproductive responsibilities who were the target of health and nutrition projects, and those with productive responsibilities, who were targets of agricultural and income generation projects (Kabeer, 1992a). Independently devised strategies have been approached without considering the overall time demands on or articulated needs of women. For example, nutrition policy and food policy have most often been treated separately at national and international levels, but would undoubtedly be more effective if integrated (Ostergaard, 1992). Strategies to improve women's skills in the production, storage and processing of food may be less effective than if tied to issues of land tenure and access to credit, or if no

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relationships between men and women" (Moser, 1989: 1803).

³³ This also stems from the fact that labour related to meeting a family's requirements for human survival has come to be identified with women's labour, regardless of whether that labour is hired or family (Mburu, 1986: 785).

account is taken of changing demands on women in agricultural production, which impact on women's capacity to produce food.⁵⁴ In an analogous sense, access to and proper use of clean water is directly related to effective and equitable water resource management, and women's time;⁵⁵ and construction and use of latrines are factors of government and "community" resources and commitment, household income and household decision-making patterns.⁵⁶

Thus, failure to consider the social and economic relations which govern provision of food, water and health care to families has been a weakness in the conceptual framework of PHC. This point is certainly not intended to obscure the reality that women's health priorities are linked strongly to their self-defined practical needs for human survival (Moser, 1989: 1802; Kabeer, 1992b: 35). Women's health advocates generally agree that if strategies which target women because of their relation to domestic activities derive from their own articulated interests, and are accompanied by measures which enable women to build a secure support base, women will profit through time saved and better health status for themselves and their families.⁵⁷ Further, where community

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⁵⁴ Alanagh Raikes has pointed out that women's increased participation in agriculture in East Africa, deriving from their increased involvement in cash crop production and continued responsibility for food production, has in many cases decreased both the quantity and nutritional quality of food intake among household members, including both children and women. She notes that many studies have documented increasing rates of malnutrition and pre-harvest hunger (Raikes, 1989: 454).

⁵⁵ For example, women may be furnished with the knowledge that water must be boiled for safe consumption, but this knowledge cannot be operationalized if not accompanied by extra time to boil water, and access to enough fuel required for boiling.

⁵⁶ Through my discussions with members of the District Health Management Team in Kisumu, I was informed that it cannot be assumed that presence of a latrine in a household implies its use by all members of that household. In some cases, only the male head is entitled to use the latrine.

⁵⁷ Some examples are Raikes, 1989; Kabeer, 1992a; 1992b; Ostergaard, 1992; Price, 1992; Welbourn, 1992; Koblinsky et al., 1993; Vlassof, 1994; Green and Baden, 1995; Paolisso and Leslie, 1995.

participation represents an extension of women's ascribed gender roles within the family, it can offer women a measure of autonomy from male authority within the household and can help furnish them with powers of negotiation with men (Kabeer, 1992b: 12).

The important point to illuminate here is that health planners have frequently prioritized the historical gender division of labour and responsibilities as the sole criterion for allocating resources to PHC programs, and have utilized women or women's organizations as a top-down means of delivering externally-defined programs (WFPHA, 1986; Brems and Griffiths, 1993). No real attempt has been made to understand the complex social relations that impact on women's health, and particularly how male influence over both community and domestic resource allocation will affect whether a development intervention targeting women proceeds or is sustainable (Bell and Franceys, 1995: 1174)⁵⁸. As Henrietta Moore notes, regardless of the success or failure of group income-generating activities, the benefits which individual women gain from the income they produce depends largely on their ability to negotiate intrahousehold relations (Moore, 1990: 162). In the context of rural Africa, the development view of the household as a monolithic pooling unit has obscured the impact that structural factors, such as continued high rates of polygyny and marital instability, have on expenditure and

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⁵⁸ A good example of the importance of involving men, or considering their influence over the success of health interventions is demonstrated in a document from the National Council of Women of Kenya which states: "We see it as a matter of urgency that widespread educational seminars be organised, aimed at Kenya's adult male population. The educated youth in Kenya do not need to be persuaded as to the merits or the necessity of Family Planning. We must ensure, however, that the prejudice of fathers, based on ignorance, does not get transmitted into the children. The fathers must be educated. It is also very important for us to realise that the majority of women in this country do not make the decisions or are not in a position to do so. In many instances they will go by what their husbands say or think. We see it as crucial that men are educated on this subject. We should also consider the publication of Family Planning Education materials that are aimed specifically at the male population" (in Kenya Woman, 1978; cited in Cottingham, 1983: 154).

decision-making patterns in the household. Husbands and wives frequently maintain separate expenditure patterns (Blumberg, 1989: 15).⁵⁹ Income under women's control has been shown to be most often spent for children's nutrition and the family's basic needs, especially among women with provider responsibilities (Blumberg, 1989: xvi). The failure by planners to observe decision-making in particular settings has obscured the importance of involving men in health activities that have traditionally been the responsibility of women, leaving little scope for transforming the status quo (Kabeer, 1992b: 28).⁶⁰

As Chapter One contended, knowledge of what women perceive to be their greatest health problems, what they understand to be the origins of their health problems, what they perceive as potential solutions (either within or outside the formal health system) and what constraints they face in protecting or promoting their own health, is an essential starting point from which appropriate interventions can be developed. To many women the availability of credit facilities, access to small-scale enterprise and political representation are as important as their involvement in social service provision (Bell and Franceys, 1995: 1175). WHO now recognizes that the proportion of women in policy

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⁵⁹ Henrietta Moore describes relations within the household in many African societies, particularly in East and West Africa, in terms of an exchange, rather than a pooling of resources. She suggests that wives, and to a lesser degree, husbands, are obliged to engage in "family labour" for each other. Family labour is generally unpaid, and conflicts often emerge between spouses as they attempt to balance the demands of family labour against those related to their individual endeavours (Moore, 1990: 56). She stresses that relations of exchange are frequently skewed in favour of males, who hold greater social status or power within the household (Moore, 1990: 59).

⁶⁰ Material inequalities created by factors other than class and gender are also significant aspects of social differentiation. As Naila Kabeer notes, "gender relations are interwoven into this broader set of social relations to structure the division of resources and responsibilities, claims and obligations between different social groups of women and men within any given society" (Kabeer, 1992b: 17).

and decision-making levels in the health sector is indicative of women's equitable participation (WHO, 1992: 31). To the extent that women have been excluded from key decision-making forums in PHC programs which have the capacity to influence the substance of health interventions, women's involvement in PHC has generally been limited to the first, and least empowering form of participation - contributive participation (defined in Chapter Two).⁶¹

The next section illuminates the contradictions inherent in PHC programs which concentrate women in labour intensive health activities, while simultaneously hindering their access to decision-making forums which influence health policy. The result has been the reinforcement and perpetuation traditional power structures which are skewed in favour of men, leaving little scope for empowering women through health.

3.4 Does Energy Times Time Equal Power?

Proponents of participation generally agree that the best indicator of whether participation is purely ornamental or a vital element of strategy is the relative weight assigned to it in the overall development practice of a given society.⁶² If the goal of participation is to enrich the individual and enhance the prospects of better decisions and outcomes, then participation must necessarily transform the knowledge, skills, and power balance in a community. Sufficient resources and an appropriate information base for

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⁶¹ Documents which recognize this include WFPA, 1986; International Center for Research on Women, 1989; Oakley, 1989; Hart et. al., 1990; Rifkin, 1990; Kabeer, 1992a; 1992b; Koblinsky et al., 1993; Leslie, 1992; Ojanuga and Gilbert, 1992; Price, 1992; Welbourn, 1992; Ostergaard, 1992; WHO, 1992; Mburu, 1994; Vlassof, 1994; and Paolisso and Leslie, 1995).

⁶² Some examples are Rifkin, 1990; Goulet, 1989; Oakley, 1989; Brownlea, 1987 and Oakley & Marsden, 1983.

potential and actual participants is required in this process (Brownlea, 1987: 607).

Where attempts have been made to "integrate" women more effectively into the development process, integration was frequently translated into the development of "women-only projects" geared to meeting women's basic needs. Anne Marie Goetz asserts that women's participation in separate projects meant that they continued to be excluded from "higher levels of planning," while providing planners with "alibis to prove their commitment to basic needs priorities without having to deal with the implications of treating women as equal agents in development" (Goetz, 1988: 482).

Historically, government (and international) policy-makers have given little credit or support to women or women's organizations. Women's low social and economic status relative to men's, combined with their frequent lack of educational opportunities, has tended to deter planners from involving women in organizing and managing community activities (Pizurki et al., 1987; cited in Rifkin, 1990: 8; WHO, 1992a). As a result, women's projects have frequently been found difficult to manage, beneficial to limited numbers, and for the most part have had weak institutional ties to local ministries and governments (WFPA, 1986: 34). In the context of PHC, women have rarely been consulted on health issues and frequently lack training opportunities and funding (Vlassof, 1994; Bell and Franceys, 1995; Paolisso and Leslie, 1995). Where women's groups have been mobilized for health, it has primarily been as a means to tap the "ready-made structure for the participation of women in health-promoting activities" (cited above), and generally has not enabled women to influence the content or direction

of PHC programs (Jacobson, 1993).⁶³

Women's involvement as community health workers (CHWs) has in some cases enabled them to increase their autonomy.⁶⁴ Their increased knowledge of health gained through training has accorded them status among the community, and has provided them with powers of negotiation with men in the household (e.g. Johnson et al., 1989; Kaseje and Sempebwe, 1989). Community health workers are in many cases the key providers of health care at the local level, and typically perform a variety of health promotive functions on a voluntary basis. As members of the community, CHWs can assist in the early recognition of health risks, and advise on preventive action. They can also be useful community educators (Mburu, 1994: 883). They can make an impact on community health by reducing the incidence and prevalence of certain diseases, and can refer cases to higher level health facilities.

However, despite the widespread assumptions by planners that CHWs can render health care more accessible and thus contribute to more rapid community development,

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⁶³ Although this has been the general trend, there have been documented exceptions. Susan Brems and Marcia Griffiths have observed that when women work for their health development in groups, the success of their efforts is multiplied because of the additional resources numbers confer. They place importance on involving local women in both management and service delivery positions, and contend that women should be strengthened in their ability to carry out programs, both through personal development and through expansion of the resource base available to them. They illustrate the potential of this approach through use of an example from groups in Bangladesh, which have evolved from an initial focus on savings for income generation to encompass education, legal aid, health education, growth monitoring, collective kitchens, community sanitation, community health assessments and other areas (Brems and Griffiths, 1993: 266).

⁶⁴ PHC programs vary widely in structure and organization; therefore it is difficult, and perhaps misleading, to make generalizations about them. Notwithstanding this, PHC programs in Kenya tend to share similar characteristics, particularly their use of networks of community health workers who live in and "belong to" the community in which they are working. Community health workers in this region tend to be women due to the tendency for the work to be voluntary in nature. Activities engaged in by community health workers vary by program and community, but generally include some or all of the following: distributing contraceptives, educating community members about preventive health measures, and providing basic curative care, as well as basic maternal and child health care (Mburu, 1989).

CHWs have tended to have little real capacity to act on the community's health problems. Community health workers invariably "have little more than a writing pad and an empty stomach," and are frequently out of basic drug supplies (Mburu, 1994: 884). CHWs are expected to be self-reliant and innovative, yet without access to sufficient resources or time to fulfil their task, CHWs are frequently disempowered, "hopelessly unable to transform the living conditions of her community" (Mburu, 1994: 885).

The value planners and communities place on the work of community health workers -- that is, whether CHWs are empowered to carry out their roles as CHWs, through increased knowledge, resources, compensation and influence over the direction of health activities -- is an indication of whether authentic participation of women is sought. (Muhondwa, 1986; Matomora, 1989; Mburu, 1994).⁶⁵ While women may have gained autonomy through their increased knowledge of health issues, their roles as CHWs have generally not enabled them to build a secure support base for themselves or provided them with access to macro forums, through which they could articulate their health interests and concerns.⁶⁶ Community health work tends to be an extra job that individual members of communities engage in addition to their ordinary occupational

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⁶⁵ This term is borrowed from Goulet (1989: --), who refers to authentic participation as a situation whereby true decision-making power is located in non-elites.

⁶⁶ While this is the general trend, there are documented exceptions. For example, in a community-based health care project in Saradidi, Kenya, women who served as CHWs were given the possibility to serve as delegates to the Annual General Meeting at the District level. Participation in the forum provided a form of recognition, status, leadership, decision-making capacity and personal worth not easily tangible to women at the community or broader political levels (Mburu, 1989: 1076). In fact, women operating as figures with public profiles is quite a dramatic departure from the normal expectations of sex roles in Kenya (e.g. Thomas, 1989). As Mburu notes, the extent to which participation of CHWs at the public, political level served as a motivating factor for women's continued participation as CHWs in Saradidi is indicative of women's desire to have a voice in public decision, particularly where their interests are at stake (Mburu, 1989: 1076).

activities (Mburu, 1994; Matomora, 1989).

The expectation that CHWs should fulfil their roles on a voluntary basis has been considered to be both unrealistic and exploitative, given the poor socioeconomic conditions of most communities (Mburu, 1994; Muhondwa, 1986). It is generally agreed that CHWs need a strong economic base if they are to do half of what is expected of them (Muhondwa, 1986: 1254; Mburu, 1994). It is therefore no surprise that CHWs who receive no economic benefit or influence over health have tended to resist marginalization by dropping out of PHC programs, or use their knowledge for their own ends (Matomora, 1989: 1082).⁶⁷ The assumption that CHWs will behave altruistically, in the interests of the community, is problematic. In many cases, women are able to participate in extra work only if it is likely to be in an undertaking that will bring immediate economic benefit rather than long-term advantage (Rifkin, 1990: 8). As F.M. Mburu has observed, "to bleed the poor of the poor for the greater social good defies rational economic reasoning" (Mburu, 1994: 885).

There is also an enormous contradiction associated with recruiting women in labour

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⁶⁷ Numerous examples of strategies of women's resistance to top-down development projects have been documented in the development literature. These include sabotage and general non-compliance, lacklustre participation in participatory schemes imposed from above, non-acceptance of technical advice and inputs; maintenance of shamanism and other spiritual practices which question the hegemony of scientific logic (Connelly et al., 1995: 27). Matomora (1989) documented a case whereby a large church hospital in Tanzania made a failed attempt to "mass produce" 130 CHWs. The method used to train CHWs effectively alienated them from the community and negated the most important and effective characteristic of the CHWs, their identification with the community. CHWs were faced with conflicting expectations. After acquiring increased knowledge during the training, and the reputation of western medicine, they were disillusioned with the low value given to their roles as CHWs by the community. Without compensation or resources to fulfil their roles, CHWs did not fully understand their roles as change agents, particularly because the roles of the CHWs, government and community were not clearly defined. He concludes that although CHWs were selected by fellow villagers, they were not necessarily community-based, at least circumstantially and psychologically. These factors contributed to the eventual drop-out of 77% of the CHWs trained through the program (Matomora, 1989: 1081-1082).

intensive community health work, but failing to consider how their intimate connection to the health of their communities would benefit organizational and managerial aspects of PHC programs. Community health workers gain a wealth of information about women in the course of their routine outreach and clinical activities. They offer valid insights which could help planners become more sensitive to women's opinions and feelings about health services and programs (WFPA, 1986: 31). Further, women involved in PHC implementation are the key intermediaries between the bodies influencing health policy and the target populations, the point at which instructions or suggestions are blocked or passed on to households (Freyens et al., 1993: 353). Arthur Brownlea contends that a key requirement for participation is access to an appropriate information base. Participants must be able to "ask questions and get answers, and to know that those answers represent the true state of the problem being addressed" (Brownlea, 1987: 607). Yet women have generally not gained access to forums in PHC which would enable them to do so. They have rarely constituted participants with an authentic voice at organizational or managerial levels of PHC.

Community participation in PHC has essentially embodied a labour process characterized by an asymmetric gender division of responsibility and resources, and as such has reinforced and perpetuated the existence of traditional power structures which privilege men. Men's dominant role on community health committees has been a means through which they have exerted and maintained control over PHC.⁶⁸ Committees are

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⁶⁸ It is somewhat ironic that WHO has, on the one hand, pointed to the importance of involving women in health because of their strong attachment to the community and intimate connection with health activities, which "ensures continuity in health activities;" but on the other hand, has advocated that men shape the health system by organizing and managing PHC, despite their perceived weaker connection to it.

frequently the community's sole connection to higher levels of the health system, and represent the essential communication and organizational link between communities and the formal health system (Twumasi and Freund, 1985; Brownlea, 1987; Rifkin, 1990). Information regarding prevalent health problems and the development and functioning of PHC programs is related mainly through committees. Arthur Brownlea suggests that in many cases, committee systems may be so complex that "only those who can run with the ideas or the proposals into the final arena actually have the capacity to make a difference to the final decision" (Brownlea, 1987: 605). Thus, with no real access to the PHC committee system,⁶⁹ women's voice has remained absent from decision-making forums and macro arenas.

This outcome cannot be attributed solely to the historical gender biases of health planners, who have tended to go through traditional leadership structures when promoting PHC. It has also been a consequence of the entrenched opposition by men to any radical change in the status or role of women that is seen to give them greater authority, which is characteristic of male-dominated societies where men predominate in public leadership positions (Rifkin, 1990: 8).⁷⁰ Whitehead asserts that where production processes

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community and discontinuity with health activities, especially as they "may migrate to urban areas in search of better-paid work" (cited on page 61).

⁶⁹ In cases where women have been represented on committees, their roles or positions have tended to be peripheral (e.g. McPake et al., 1993; Stone, 1992; International Center for Research on Women, 1989; Kaseje & Sempebwe, 1989). As Arthur Brownlea suggests, it cannot be assumed that women represented on the committee will be enabled to assert their ideas in more macro arenas, such as district or provincial levels of health administration.

⁷⁰ A good example of this is a case study of the harijan village of Zhangar in India, documented by Janet Price. Following the installation of a drinking water supply, women began to raise their voices and identify their own needs. They were dissatisfied with the organizational and operational framework of the project, which institutionalized their roles as wives and mothers and emphasized their economic dependence on men. Janet Price refers to the project as system conforming, reinforcing rather than challenging basic

encompass relationships of interdependence, insofar as this interdependence is based on an asymmetrical, rather than symmetrical, division of resources and responsibilities, gender relations are relations of power as well as difference, and of conflict as well as cooperation (Whitehead, 1991, cited in Kabeer, 1992b: 19). Where women exercise control over particular stages of production or particular products, women are given no real autonomy or equality if the overall terms of exchange and cooperation are against them (Kabeer, 1992b: 19).⁷¹ An example of this is Rae Blumberg's observation that various development projects in Africa present cases in which women were expected to contribute labour but the direct returns went to their husbands (Blumberg, 1989: xvi).

The historical imbalance of power that has characterized the gender division of labour in PHC has precluded PHC from becoming a strategy truly committed to goals of equity (Goulet, 1989). Incorporating women's voice in the health development process is political -- it means that women are enabled to communicate insights and concerns such that others understand what the issues and options are, and where the constraints to their well being, as well as that of their families, lie (Brownlea, 1987: 606-607). This necessitates a redistribution of power, creating space for women to determine choices in

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structural inequalities. Conflict between men and women emerged as their right to raise such issues was questioned. There was a clear attempt by both government officials and village men to prevent women from entering the political arena and to restrict them to the private world of the family, thus re-establishing the public/private dichotomy and restricting women to their normative gendered role as wives and mothers (1992: 54).

⁷¹ According to Naila Kabeer, gender as a power relation derives from social arrangements and cultural rules which provide men of a given social group with greater capacity than women from that group, to mobilize a variety of cultural rules and material resources in pursuit of their own interests: greater access to food, political positions or land; greater physical mobility; lesser responsibilities in terms of self-maintenance or care of the young and the old; a privileged position in terms of command of labour, particularly women's labour; and less confined sexuality (Kabeer, 1992b: 34).

life and to influence the direction of change, through the ability to gain control over crucial material and non-material resources (Moser, 1989: 18).

This is certainly easier said than done. The World Federation of Public Health Associations has observed that in many societies working with groups limited to women may be the only way in which women can learn about their strengths and can share problems frankly with others (WFPA, 1986: 33). But at the same time projects bypassing men may constitute a perceived threat to men's autonomy and authority, creating conflict situations between women and men at both community and household levels (Turshen, 1991). A less confrontational approach to redressing the power imbalance may be to ensure that women create a space for themselves, such that they have a forum through which they can articulate their concerns and interests, and build a secure support base for themselves. Janet Price's case study of a water installation project in the harijan village of Zhangar in India demonstrated that a decision to provide women-only space and time for the staff was one of the most important steps in enabling the women to deal with the personal conflicts aroused by the new role they were taking on:

Regular meetings and longer bi-monthly workshops served as an arena in which women could not only develop new skills and gain knowledge, but more importantly, talk about their lives and the conflicts they were facing. A tradition rapidly grew through which women shared experiences, talked at great length about their life histories, and offered each other support and empathy to deal with both work and personal situations. Contradictions continually emerged as the women staff struggled with their conditioned views and internalized beliefs about themselves as women, their expectations of the state and "experts," and their desire for change (Price, 1992: 56).

The important point to illuminate here is that policies adopted by governments and

other groups help or hinder a process leading to women's empowerment. Historically, planned social change, generally in the form of top-down "development" interventions, has tended to result "in the exclusion of women from decision-making in emerging managerial and political structures, and/or undermined women's authority, autonomy, and power in existing socio-economic systems" (Moore, 1990: 153).⁷²

My analysis in Chapter Five and Six considers how the Bamako Initiative, as a community-based health intervention conceived of at the international level, has incorporated or alleviated the historical constraints which have limited PHC from becoming an empowering strategy for women. The next chapter describes the research approach, and the research process which has guided my analysis.

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⁷² An example of this was Kathleen Staudt's study of the Kenyan government's promotion of high-yielding hybrid maize, which outlined the detrimental impact on women of discrimination against them in the provision of credit and extension services. As a result, their autonomy was undermined and governmental capacity to raise agricultural output decreased (Staudt, 1991: 452; cited in Kabeer, 1992b: 4).

Chapter 4

Approaching Fieldwork: Tools and Techniques

4.1 Introduction

I was faced with a number of critical issues prior to making a decision to pursue a fieldwork placement as an integral component of my thesis research. I was aware of the numerous tensions and contradictions associated with conducting ethical gender sensitive research in a context different from my own. The purpose of this chapter is to illuminate the process both leading up to my decision to pursue fieldwork, and during my fieldwork in Sigoti - how and why I came to use the particular methods that have given rise to my analysis.

4.2 The Fieldworker's Dilemma

By far the greatest challenge to me in my decision to conduct fieldwork in Africa as a component of my research was the ethical dilemma associated with being a white, western woman of middle class background attempting to make some kind of contribution in the area of international health. I was aware of the rigorous critiques of western feminist analyses of "Third World women" by non-western scholars such as Ifi Amadiume (1987) and Chandra Mohanty (1991). They object to the exploitative nature of many of these works, which have tended to parallel the historically imperialist and racist male academic models characteristic of social anthropological research. These analyses invariably misrepresented southern women as a homogeneous, monolithic and powerless group deemed culturally inferior and universally oppressed. Western feminists were accused of being absorbed in their own particular struggle (Amadiume, 1987: 8)

through their search for a variety of "powerless" groups of women to prove the general point that women as a group are powerless (Mohanty 1991: 57). Patricia Stamp (1986) and Henrietta Moore (1990) are Western scholars who have also exposed feminist anthropologists' distorted interpretations of gender relations which look at difference strictly in terms of inequality and hierarchy. Concepts such as motherhood, family, household and patriarchy understood in Western terms were commonly transplanted and inaccurately applied to the southern context. Patricia Stamp (1986: 24) contends that the use of essentialist categories such as "role" and "position" precludes a dynamic view of change. The result has been little or no account of women's capacity to think or act for themselves.⁷⁴

Chandra Mohanty refers to this process as a "discursive colonization" of Southern women's experience by Western feminist academics which masks the material and historical heterogeneities of their lives (1991: 53). Works written by Southern women have tended to avoid this methodological trap through their embeddedness in the particular context of a single ethnic group, country or surrounding region (Amadiume, 1987: 9). Where these critiques diverge is in their prescriptions for Western female academics. Chandra Mohanty points to the "good, valid" context-specific research that characterizes Maria Mies' study of lacemakers in Narpasur, India:

Mies' analysis shows the effect of a certain historically and culturally specific mode of patriarchal organization, an organization constructed on the basis of the definition of the lace makers as "non-working housewives" at familial, local,

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⁷⁴ Stamp (1986: 24) does point to the work of Schlegel (1977), Sacks (1979), Leacock (1981), Mackenzie (1986, 1988) and others which "attests to the multifaceted nature of power, decision-making, and authority in pre-capitalist societies and undermines the concept of a simplistic dominance/submission dichotomy..."

regional, statewide and international levels. The intricacies and the effects of particular power networks not only are emphasized, but they form the basis of Mies's analysis of how this particular group of women is situated at the center of a hegemonic, exploitative world market (Mohanty, 1991: 65).

Chandra Mohanty is therefore less opposed to the idea of Western female academics studying "Third World women" than she is to the universalistic methods used that have historically misrepresented Southern women's experience. Ifi Amadiume goes further in her criticism. She endorses strongly the call for constructive dialogue between Northern and Southern women, but sees no role for the study of Southern women by Western feminists. She is more inclined to accept a role for Northern women in monitoring the policies and activities of international development agencies and exposing their ethnocentric bias (Amadiume, 1987: 10). Another potential role has been proposed by Shulamit Reinharz, who suggests that feminists wishing to do comparative cross-cultural analyses should support women from countries other than their own in conducting their own research (1992: 120).

My initial enthusiasm for doing fieldwork was quickly brought into perspective when I was faced with issues of exploitation and misrepresentation of Southern women's experience. Further, critiques of the study of international health have paralleled the above as being yet another example of Western academic imperialism which has historically silenced the voices of women in defining needs and identifying interventions (e.g. Ostergaard, 1992). I found locating myself in an appropriate role in the study of international health problematic. While I recognized the importance of exposing ethnocentric and gender biases of international development assistance policies, I felt I could not bring a balanced perspective to this level without having experienced first hand

the socio-political context on whose behalf these policies spoke. Much of the health development literature I had read had been written by Western academics, and works originating in the South had overwhelmingly been written by male academics. Rarely had I encountered works on African women's health issues written by African women.⁷⁴ Never did I come across an account of a community health worker's experience as told by her (most community health workers in Kenya are women),⁷⁵ or a comprehensive qualitative analysis of women's response to and involvement in health care programs, even those that targeted women as primary beneficiaries.

I supported the new emphasis being placed on women's involvement in the design and implementation of health programs as a means to redress the gender imbalance that has historically let female-specific health problems go unnoticed, and precluded women's full participation in the health care process.⁷⁶ This awareness drove my specific interest in issues of gender and local participation in community-based health care programs. But I did not feel comfortable writing about an issue centred on community development in the South without somehow giving voice to those I was supposedly representing. There was a contradiction in exposing the andro- or ethnocentric biases of policies through the

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⁷⁴ Some exceptions are the works of Marvellous Mhloyi (1994), S.A.Z. Mulindi (1992a, b), Miriam Were (1982), and J. Hezekiah and F. Wafula (1989). As the work of these authors is not specifically related to my research question, I have referred to them only briefly in other chapters, where relevant. The first two authors, for example, have written in the areas of population and health and AIDS, respectively. The work of Miriam Were is related to community health, and the work of the last authors identified above was a case study of women's health problems in a region of Kenya.

⁷⁵ I refer here not to "professional" health workers, but to those health workers who have been mobilized at the community level for involvement in PHC activities. They are generally trained in basic preventive health measures and in some cases curative care, and tend to live in and "belong to," the community they serve.

⁷⁶ Chapters One and Three discussed these issues in depth.

predominant use of either Western or male sources. Despite the inherent contradictions associated with conducting research in the South, I was committed to listening to what the people who were experiencing these programs had to say about them. I strongly believed that learning from them directly would deepen my perspective.

With this in mind, I pursued a field placement in Kenya. Through a contact at the International Development Research Centre in Ottawa, I learned of an opportunity to work as a volunteer intern with AMREF on its three-country study (Kenya, Zambia and Benin) of equity-promoting features of the Bamako Initiative,⁷⁷ under the supervision of Dr. Hezron Oranga,⁷⁸ the project leader. He requested that I examine the "role of women and the poorest in decision-making concerning equity-promoting features of the Bamako Initiatives in Kenya," through analysis of a case study of the Sigoti community's BI site in Western Kenya.

I was excited about the prospect of working with a community in Kenya on a study that mirrored my interests very closely. Despite this, I was concerned that regardless of the approach I took, however rigorous and attuned to the trappings noted above, my position as a Western female academic would pervade my analysis and result in an unrepresentative interpretation of women's and men's experience with the Sigoti BI. More disturbing was the knowledge that the community I was assigned to had not asked me to study their BI site, and certainly had not developed the research question for their own purposes. I recognized that I was accountable to a number of different groups in

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⁷⁷ Chapter Five gives a description of the Bamako Initiative.

⁷⁸ Dr. Oranga did not object to being cited in this thesis.

conducting this research, including the Sigoti community, AMREF, UNICEF, my school, and myself. Yet I questioned how this process would benefit the people I was to work with, if at all. How was I to approach the research in such a way as to avoid the use of universalisms through the application of concepts such as "role" "women," "poorest" and "decision-making"? Who would make use of this analysis, and for what purposes?

I searched for research methods that would allow me to answer the research question in terms that I could justify ethically. The only way I could rationalize working in a small community in Kenya was through the adoption of feminist participatory principles in accordance with an alternative approach (described in the following section). I considered my research to be feminist because of its explicit focus on understanding and challenging male bias in the design and implementation of a health care program.⁷⁹ It was also very important to me ethically to use a participatory, non-exploitative approach with the people of Sigoti. Finally, the alternative paradigm corresponded with my personal world view, and I wished to reflect that view through my research approach and analysis.

4.3 Embracing the Alternative Paradigm

The growing body of literature related to feminist methods and participatory research approaches⁸⁰ embraces an alternative social science paradigm which attempts to redress

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⁷⁹ I make this assertion in accordance with Patricia Maguire's definition of feminists as: "social scientists who are challenging the male bias shared by dominant and alternative paradigm social science research and working towards an intentionally feminist, antipositivist research approach" (1987: 77).

⁸⁰ I refer broadly to participatory research approaches as those labelled as participatory research (PR), participatory action research (PAR), participatory evaluation, and participatory rural appraisal (PRA).

the power imbalances that have historically embodied positivist social science research methods. It has been argued that positivist methods reinforce the domination of experts and other ruling groups (Cancian, 1992: 623). Patricia Maguire (1987: 14) describes the alternative paradigm as essentially non-positivist. It rejects the underlying assumptions of positivist research (objectivity, distance, value-free, in search of one "truth"), and stresses the importance of human subjectivity and consciousness in knowledge creation (Maguire, 1987: 19). Alternative paradigm researchers doubt the possibility and usefulness of maintaining distance and suggest that without close, emphatic, interpersonal interchange and relationships, researchers will find it impossible to gain meaningful insights into human interaction or to understand the meaning people give to their own behaviour" (Maguire, 1987: 20). The key principles of feminist methods and participatory research approaches guided the development of my research process, and are illuminated in more detail in the next section.

4.3.1 Participatory and Feminist Methods Converge

Feminist methods grew out of the desire to create ways of knowing which give voice to women and other marginalized groups whose knowledge has historically been subjugated by research informed by the dominant paradigm.⁸¹ They are based on the premise that "different methodologies carry with them specific underlying assumptions which will shape the way information is gathered and the kind of knowledge created"

While these labels convey somewhat different meanings they share some basic principles, which are discussed in this section.

⁸¹ For a review of feminist research methods, see Shulamit Reinharz (1992). She identifies ten common themes that characterize these methods.

(Kirby and McKenna, 1989: 26). The scientific, positivist emphasis on abstract theory and complex quantitative data has been linked by feminists to the production of knowledge that is accessible primarily to experts and power centres, devaluing personal experiences and everyday knowledge produced by non-elite people, who are considered incapable of understanding and controlling their own lives (Cancian, 1992: 623). Feminists attempt to redress this power imbalance in the research process by striving for democratic relationships between researchers and participants, characterized by respect, shared information, openness and clarity of communication, or in the best case scenario, the establishment of rapport (Reinharz, 1992).⁸²

The ideological base of participatory research approaches parallels this perspective. These approaches derive from the perspective that socio-cultural systems contain elements of contradiction, wherein dominant political and economic elites defend and advance their interests, and marginal groups remain invisible outside the arena of policy debates and decision-making (IDRC, 1988: 5). Like feminist methods, participatory research approaches were developed in an effort to redress power imbalances in knowledge creation, and generally embody processes of cooperative enquiry by both researchers and the people who are the focus of the study, involving reciprocal educational processes at every level (Chambers, 1992; Ramphela, 1990; Park, 1992; Feuerstein, 1988; Maguire, 1987).⁸³

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⁸² Shulamit Reinharz notes that the establishment of rapport leads to a non-exploitative treatment of "subjects." However, structural barriers to establishing rapport, including class and race, mean that rapport is generally a fortunate outcome of projects. The establishment of rapport usually requires time and shared interests among researchers and participants (Reinharz, 1992: 240).

⁸³ Participatory rural appraisal (PRA) is used in research and planning in international development

Critical reflection of one's own biases and assumptions is also a key tenet of feminist and participatory research approaches. Sandra Kirby and Kate McKenna stress that the act of interpretation underlies the entire research process. As feminist researchers, they assert that because you bring to your research your own thoughts, aspirations and feelings, as well as your culture, ethnicity, race, class, gender, sexual orientation, occupation, family background, and schooling, who you are has a central place in your analysis (Kirby & McKenna, 1989: 46). Feminist methods are therefore based on the assumption of value-laden subjectivity (Harding, 1991). While Sandra Harding embraces the assumption of value-laden subjectivity of the researcher, she asserts that subjectivity does not preclude the possibility of generating objective knowledge claims. She suggests that where interpretation is rooted in the experience, or standpoint, of research subjects in their particular context, the researcher's analysis is characterized by "strong objectivity" (Harding, 1991). In an analogous sense, researchers engage in participatory processes under the implicit assumption that knowledge created by social scientists is inevitably grounded in their own cultural and ideological standards (Feuerstein, 1988; Park, 1992; Ramphela, 1990). Socio-economic advancement of marginal groups therefore requires new paradigms of inquiry and explanation grounded in their own particular experience and insight (IDRC, 1988: 5).⁸⁴

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projects, and is generally more rapid and extractive than other participatory research approaches, which require a significant length of time to develop relationships with participants. David Mosse notes that in the context of PRA, *rapport* generally describes a relationship of trust, agreement and cooperation between researchers and the subjects of research, but is a very difficult quality to identify. He cautions that in practice, "effective rapport" often represents the set of assumptions that researchers have about the "accessibility" of villagers and the likelihood of effective communication with them, and cannot be assumed to represent a mutual relationship of trust (Mosse, 194: 503).

⁸⁴ However, Alison Goebel cautions against the use of "experience" as an unproblematic concept, and

Feminist methods and participatory research approaches are generally driven by subject matter rather than methods, and will use any cluster of methods needed to answer the questions put forward (Reinharz, 1992; Chambers, 1992; IDRC, 1988; Maguire, 1987). The key aim is to create knowledge which is both accessible to participants and maximizes their participation throughout the entire process. Increasingly, participatory rural appraisal (PRA) techniques have been used to achieve this goal with communities in rural areas of the South, which are frequently the subjects of research or targets of international development projects. PRA generally refers to a collection of rapid information gathering techniques which attempt to be "more reliable and more relevant to community interests than those generated by conventional social research methods" (Chambers 1983, 1991; cited in Mosse, 1994: 498). PRA grew out of a dissatisfaction with anti-poverty biases associated with rural development tourism, as well as a disillusionment with complex, quantitative surveys whose results were often questioned or ignored. It is characterized by informal, qualitative-based rural appraisal techniques.⁸⁵

Finally, participatory and feminist research approaches tie knowledge creation to an

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suggests that the focus of inquiry should be on the processes that produce peoples' varied experiences. She asserts that "without explicit attention to the construction of subjectivity in a particular social and historical context, researchers run the risk of producing subjects that mirror their own interests and beliefs" (Goebel, 1994: 22-23).

⁸⁵ It is important to note that a key difference between PRA and other participatory research approaches is the rapid nature of PRAs. Other participatory research approaches require significantly longer to establish relationships, to define the research framework and question, and to engage in the analysis. PRAs are therefore more elicitive and extractive than other approaches. Because the duration of my research was quite brief (14 weeks), I drew substantially from the PRA literature in developing my research framework. While my intention was not to conduct a PRA, per se, I did base my research on the principles of PRA, which parallel those of other participatory approaches (see Chambers, 1992: 1-5).

agenda of social change, in which learning is coupled with the investigation of social conditions and their transformation (Kirby & McKenna, 1989; Reinharz, 1992; Maguire, 1987; Ramphele, 1990; Park, 1992). Maria Mies asserts that

in the face of extensive poverty and oppression, producing knowledge for knowledge's sake or for some indefinite future application is an exploitative, unaffordable luxury (Mies, 1983; cited in Maguire, 1987: 100).

It is assumed that groups or communities engaged in examining causal relations, processes, consequences and potential solutions are doing so with an intent to act upon the knowledge generated (Ramphele, 1990; IDRC, 1988; Maguire, 1987). Shared ownership of research among researchers and participants is therefore a defining principle in these approaches, in their efforts to avoid the historically extractive and exploitative underpinnings of positivist research (Park, 1992; Reinharz, 1992; Chambers, 1992; Feuerstein, 1988). The traditional researcher-researched relationship is transformed from one that is hierarchical and detached to one that is horizontal, reciprocal and hence non-exploitative (Maguire, 1987: 89).

Weaknesses in participatory research and feminist methods have been illuminated by Patricia Maguire (1987). She has criticized participatory research for its historical, androcentric bias which, despite its attention to the centrality of power in the social construction of knowledge, has failed to address the centrality of male power as a factor in this construction (1987: 81).⁸⁶ She has also recognized the poor record of feminist

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⁸⁶ In an analogous sense, David Mosse has illuminated this weakness in the context of participatory rural appraisal (PRA) in developing countries. He points out that despite their democratic intentions, PRAs are frequently conducted in public settings, which effectively construct knowledge "in ways that are strongly influenced by existing social relations" of power and gender (Mosse, 1994: 497). He suggests that certain kinds of knowledge tend to be excluded, as the voices of women and other groups marginalized by centres of power in communities remain peripheral to the participatory process.

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PRECISION^{SM} RESOLUTION TARGETS

researchers in translating theory into the use of genuinely participatory practices (1987: 90). She developed a feminist framework for conducting participatory research in an effort to bring together the strengths of these two approaches. Her framework integrates tenets of both feminist and participatory research, such that the discussion of gender is central on its agenda.⁸⁷

The significant body of literature related to feminist research methods and participatory research approaches guided the research process I was engaged in prior to and during my fieldwork experience in Sigoti. I attempted to integrate five key principles characteristic of these approaches into my research approach and analysis: 1) rejecting positivist research approach 2) embracing subjectivity; 3) emphasizing democratic, reciprocal relationships; 4) rooting my analysis in the experience of research subjects; and 5) basing methods used on the context of the research.⁸⁸ Perhaps the most effective way to illuminate the actual methods we used and why is through an examination of this process.⁸⁹

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⁸⁷ Patricia Maguire's framework includes the following key principles: 1) it is built on a critique of both the positivist and androcentric underpinnings of the dominant paradigm; 2) it places the discussion of gender as central on its issues agenda, with an inclusive focus considering gender, race, culture and class; 3) it recognizes and celebrates diversity, exposing and ending all forms of oppression; 4) it gives attention to gender at all phases of the research process; 5) it gives explicit attention to gender language use; 6) it gives attention to issues of composition of research team including gender, race, class and culture; and 7) it considers how power has, based on gender, been redistributed or maintained by the project (Patricia Maguire, 1987: 104).

⁸⁸ The sixth key principle that these approaches share is linking knowledge creation with social action. It was not my intention to link my research project with social action in Sigoti. My reasons for excluding this principle in the study's framework are illuminated in the following section.

⁸⁹ In reference to the research approach and methods used, I use the term "we", because at no time was I alone in developing the research approach (it was defined in collaboration with Dr. Oranga), or in conducting the research in Sigoti. The research was a shared experience between myself, my research assistants, and the participants.

4.4 Developing the Research Framework: Pre-Departure Planning

4.4.1 The AMREF Connection

In developing my research approach, I was faced with a number of constraints which would limit the extent to which my research framework could incorporate feminist, participatory principles. I would be working under the auspices of a Kenyan non-governmental organization (NGO) on a study with pre-defined objectives. AMREF was an external parameter which would influence and organize my work.⁹⁰ Not only had the research question been defined by AMREF, but I had also been advised by Dr. Oranga of an approach that he felt would be viable given the time constraints of my component of the study (three and a half months) and the nature of the research question. The goal of my component of the study was to assess the effectiveness of the Bamako Initiative in ensuring gender-equity in decision-making aspects of health service delivery. The initial objective was to determine the level and nature of participation of women and "vulnerable groups" in the implementation of the Sigoti Location Bamako Initiative site in Kenya.⁹¹ He suggested the use of a variety of methods which would consider several levels of BI implementation. Specifically, I was to examine:

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⁹⁰ I would be working with a Kenyan supervisor and an NGO that had been involved in both researching and implementing community-based health care for several years. Dr. Oranga was a senior Kenyan researcher at AMREF who had done extensive work in Kenya in the area of community health. This was my first fieldwork experience overseas, and I recognized that I had much to learn from others. Having the support of a Kenyan-based NGO tempered my concern over being an uninvited outsider of Sigoti.

⁹¹ It became clear in the early stages of the study that there were insufficient time and resources first, to determine who in the community was deemed "vulnerable," and second, to integrate them effectively into the study. As a result, the study addressed only the nature and content of women's participation in the initiative. In retrospect, I was relieved with this outcome, as I had been uneasy about producing an analysis that lumped the category "woman" together with "vulnerable groups." This is precisely the type of approach that has been criticized for its tendency to identify women as a homogeneous group of vulnerable and powerless members of the community.

- 1) the nature of women's participation in the initiative by analysing their roles at all levels of the management and implementation process. Women's participation at the district and local village health committee level were to be assessed;
- 2) the role of community health workers (CHWs) and traditional birth attendants (TBAs); those working closest to, and most familiar with, the health concerns of the community) in decision-making;
- 3) the role of women ("and the poorest") at the community-level in decisions around BI implementation; and
- 4) women's perceptions of, and involvement in, the BI at the household level, including the poorest and most vulnerable.

The methods Dr. Oranga proposed were both qualitative (key informant interviews, focus group discussions) and quantitative (a household survey).

I was pleased that Dr. Oranga had incorporated qualitative techniques into the research framework. Key informant interviews and focus group discussions have been identified as appropriate techniques to use when conducting participatory rural appraisal, particularly if they make use of open-ended questions and are flexible, such that participants may actively shape the knowledge created in the sessions. Surveys are used less frequently, but if kept short and simple, and developed with participants, have also been considered to be participatory (Chambers, 1992: 16-17). Despite this, I questioned whether having a set research framework prior to meeting with the research participants was contradicting the spirit of a participatory process, which stresses the importance of joint problem identification and analysis among researchers and participants (Park, 1992; Ramphela, 1990; Chambers, 1992; Feuerstein, 1988). The actual methods used are less important than the active participation of subjects in shaping the type of knowledge created (Chambers, 1992: 16-18). It is generally agreed that drawing on the active participation and collective knowledge of community members produces more valid descriptions and explanations (e.g. Chambers, 1992; Ramphela, 1990). I was concerned

that the research would be less useful to participants if they did not both shape the question by reflecting on their own priorities, and provide input into what form data collection and analysis would take.

Further, in addition to having a pre-defined question with set data collection methods, the research framework did not leave room for an action component. As noted in the previous section, one of the defining characteristics of both feminist research and participatory research approaches is the assumption that knowledge must be linked with action that will lead to social transformation (Hall, 1992). Producing knowledge for knowledge's sake or for some indefinite future application in the face of poverty has been referred to as exploitative and extravagant (Mies in Maguire, 1987: 100). However, linking my research with social action in Sigoti was beyond the scope of this study, and certainly was not my intention. I recognized that a truly participatory research approach which links knowledge creation to social change calls for institutional, financial, human and material resources, and above all, time. Patricia Maguire required a full year to establish relationships which eventually led to a participatory project (Maguire, 1987: 195). I simply did not have the resources, authority, experience, or time to engage in such a project. My role in this study was not to transform the structure or process of participation in the BI in Sigoti, nor was this an objective of the larger, three-country study. Rather, my effort was geared towards understanding the social dynamics guiding the operation of the Sigoti BI, and particularly, how gender relations impacted on the nature and extent of women's participation, through the eyes of the participants.

My real concern was ensuring that the research was not exploitative, such that

participants would have an equitable voice and power throughout the research process. Producing an analysis based on issues deemed relevant to the Sigoti community was my first priority. I accepted that my time constraint would inevitably result in a less radical or less critical analysis and vision for action.⁹² I was optimistic that at a minimum, the participants would gain greater awareness of their situation. Mamphela Ramphele suggests that participatory techniques such as organizing group discussions of women's experiences can generate knowledge among group members as they attempt to understand their situation (Ramphele, 1990). I was hopeful that the women I would work with might benefit in this way from the project.

One further limitation of the research framework is worth noting from the outset. I had been informed by Dr. Oranga that for health reasons it would not be advisable for me to live with a family in Sigoti during my field placement. Malaria is endemic in the area and Dr. Oranga felt that a family would not have the resources to provide me with safe living conditions. Dr. Oranga suggested that I stay in Kisumu for the duration of the study, a town approximately 80 kilometres from Sigoti. I was quite concerned that by living outside of the context of the research I would be unable to establish a relationship of trust with research participants, and my analysis would suffer considerably. I would certainly be less attuned to cultural nuances of the Sigoti community as a result. Johan Pottier, a social anthropologist, doubts the possibility that researchers can generate a complex understanding of the social and cultural dynamic relations characteristic of rural settings in the South in a brief period of time, and stresses

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⁹² Patricia Maguire (1987: 47) has noted that time constraints in conducting research invariably have this effect on analysis.

the importance of living in a community and learning which interconnections are important. He maintains that to produce a valid analysis

...[a] researcher must understand the participants' shared and private modes of thought, their socially constructed values, their attitudes towards the interview as a social occasion (which implies notions of propriety and insider-outsider interaction), their ways of manipulating interviews and the importance of gender specific responses to certain questions" (Pottier, 1991: 4).

I expected that this restriction would limit the complexity of my analysis.

Despite my reservations, I accepted that because I had no experience conducting fieldwork, it would be wise to work within the framework advised by Dr. Oranga. I recognized that a truly participatory project was more of an ideal goal than a reality. Even if I had no set framework prior to initiating the project and called upon participants to shape the analysis, there was no guarantee that they would be interested in engaging in participatory research. Numerous accounts of participatory researchers' experience point to the passivity of participants in providing input and suggestions, leaving the researchers responsible for defining questions and modes of analysis (e.g. Maguire, 1987: 42; Ramphela, 1990; Small, 1988). I also did not see the necessity of placing a label on the approach I took, particularly prior to its completion. I felt that at this stage it was more important to be flexible and let the project evolve over time, according to the circumstances. I was resolved to make the project as participatory as possible given the constraints I faced.

4.4.2 Multi-level Analysis and Multiple Methods

The BI is a grassroots community health strategy which pervades every level of social organization. It is intended to benefit individuals in rural communities; it is organized

and implemented by a community which is comprised of a diverse group of women and men with different interests and involvement in community activities; it is coordinated by the ministry of health at the district level; it affects and is affected by national health policy; and it was conceived of and is sponsored by an international organization with its own interests and goals. None of these levels operates in isolation of another. Therefore, an analysis of even one element of the BI (in this case, social dynamics of participation) must examine critically the connections between these levels which impact on that element.

Dr. Oranga proposed a multi-level and multiple methods approach which would consider various levels of BI implementation. One of the principles of knowledge creation in participatory research and feminist methods is triangulation, which is based on data collection through use of a range of methods, types of information collected, investigators and/or disciplines (Chambers, 1992; Reinharz, 1992). Triangulation is used in concordance with the alternative paradigm to the extent that it is a means by which the researcher seeks and understands diversity; and deliberately looks for, notices and investigates contradictions, anomalies and difference.⁹¹

I anticipated that a multi-level analysis would allow me to make important connections between different actors while grounding my analysis of the BI in the realities of women's lives in Sigoti. My objective was to develop an understanding of the social relations which impact on the BI's implementation and effectiveness, particularly how

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⁹¹ Triangulation can also been used in a positivistic approach, whereby the search for "the facts," or sameness entails use of a range of methods or subjects, such that data collected is cross-checked, or validated.

women involved in its implementation are situated at the center of a hierarchical health system based on the biomedical model.⁹⁴ I sought to understand how women's experiences with the BI both shaped and were shaped by the new structures and relationships created through the establishment of the BI. This approach would enable me to incorporate ideas and suggestions from participants with diverse interests in and knowledge of the BI throughout the research process. Alison Goebel suggests that using informants' words and phrases to design questions is a potential way to gain a "more fluid understanding of the interaction of people with their social and historical context" (Goebel, 1994: 22). She states that

without explicit attention to the construction of subjectivity in a particular social and historical context, researchers run the risk of producing subjects that mirror their own interests and beliefs (Goebel, 1994: 23).

I hoped that information gained from the focus group discussions would assist in the development of questions for the household survey which mirrored (or at least considered) the women's interests and beliefs as much as my own.

4.4.3 Defining Issues

Critical reflection of my own biases and assumptions was my first step in defining issues. I had done substantial secondary research related to gender and health care issues, including an analysis of the international discourse related to women's health, gender dynamics of local participation in community-based health care in Kenya, and the relationship between the structure of Kenya's health care system and the effectiveness of

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⁹⁴ A proponent of this approach is Dorothy Smith (1987), who suggests that by grounding the understanding of social relations in everyday experience, analyses will go beyond the reporting of experience to the development of a knowledge of the social relations within which we work and struggle as subjects

primary health care programs in meeting women's health care needs. I was also familiar with gender issues in Kenya related to land tenure, food security, and local women's organizations.

Based on this knowledge, I had formed certain preconceptions regarding gender dynamics in the BI in Sigoti. The first was my implicit assumption that women were most likely faced with certain constraints limiting their full participation. The literature on community-based health care in Kenya invariably points to women's primary roles as implementors of projects through their role as volunteer health workers, and to their minimal or insignificant role in making key decisions regarding these projects' management.⁹⁵ I expected the Sigoti BI to be characterized by a situation in which women held primary responsibility for volunteer outreach activities with the community, but were marginalized in key decision-making positions. Recognizing this bias, I made a conscious effort to avoid the use of leading questions which would implicitly seek the confirmation of my preconceived notions about women's involvement in health care. I understood that the use of open-ended, neutral questions would be an important way to filter out some of my biases.

The case studies of CBHC projects I had read rarely addressed how women responded to their marginalization, or whether they were interested in taking a more active role in decision-making. Speculating about these issues led me to the realization that housed within my research question was the implicit assumption that maximum participation of women in the BI implied a positive situation. Yet the BI has a number of pre-defined

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⁹⁵ Examples include Hezekiah & Wafula (1989); Jacobson et al. (1989); Johnson et al. (1989); Kaseje & Sempehwa (1989), Mhuru (1994).

objectives, along with selected interventions to meet these objectives. I questioned whether the BI conformed to women's self-defined priorities. There was a possibility that the BI might be low on the list of priorities for women in Sigoti, in which case their maximum participation would be less significant, or at worst a negative situation, particularly if their participation was limiting them from engaging in other, more pressing activities. I recognized that local women's organizations have been instrumental in enabling women to gain control over resources and direct development efforts for their own purposes (e.g. Stamp, 1986; Mackenzie, 1987). I wondered how women's involvement in the BI impacted on their daily lives and relations with men at the household level. I felt I must address these issues with women in Sigoti. Understanding why or why not women were participating was as important as understanding how, and to what extent they were participating.

Also contributing to my "conceptual baggage" were two BI background documents given to me to assist in the development of questions for the study. The first was a document on BI implementation produced by the UNICEF country office in Kenya. The document outlines the rationale for the BI in Kenya, its goals, organizational structure, and guidelines for implementation. I became familiar with the desired linkages between and responsibilities of the various actors, in addition to the document's treatment of gender issues. While the document prescribes that women should be "involved" on the village health committee, it does not make explicit what form this involvement should take. Instead it is implicitly assumed that women's interests will be adequately represented through their membership in the committee. There is no explicit mention of

potential barriers to women's full participation (i.e. lack of influence over decisions made at committee meetings), or to mechanisms to eliminate barriers. I anticipated that because these issues were not addressed explicitly in the document, many of the historical barriers to women's full participation, discussed in Chapter Three, may have surfaced in the implementation of the Sigoti BI. The second document was the project proposal for AMREF's two year comprehensive study of the BI in Kenya. Through analysis of the proposal, I was able to situate my component of the study within the broad study's framework. I realized that my component of the study was just a small component, and rather peripheral to, the larger study.⁵⁰ While these documents provided insight into general BI organizational and implementation issues, I had little specific knowledge about the Sigoti BI site's history, structure and organization, or the nature of its relationship

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⁵⁰ My study was a very minor component of, and peripheral to, the two-year, three county study. The goal of the study is to help improve the health of the people in African countries through community cost-sharing and participatory activities in their self-identified health needs and priorities. The purpose is to develop and improve the functioning of the local Bamako Initiative schemes with regard to equity. Its specific objectives are (1) to describe the nature of, and variation in, the equity-affecting features of BI schemes; (2) to analyze the equity impact of BI schemes through evaluation of: (i) their perceived impact on effective prices within communities; (ii) the effectiveness of different mechanisms for protecting the poor/vulnerable from payment; (iii) their potential and perceived impact on quality of care; (iv) the effectiveness of the clinical and managerial support provided by the wider health system; (v) community and health worker perceptions of success in protecting the poorest; (3) to assess the pattern of community decision-making within BI schemes and its importance to the equity impact, through evaluation of: (i) the structure and process of community decision-making within schemes; (ii) the role of the community in decisions concerning the equity-affecting features of schemes; (iii) the role of marginal groups, such as women and the poorest in decision-making; (iv) the structure supporting local level decision-making and the process of national decision-making with respect to the BI; (4) to evaluate the success of existing BI schemes in the delivery of equitable and effective malaria-control activities, through, for example, (i) determination of the equity of the bed-net provision within the community; (ii) assessment of the effectiveness of malaria case-management activities (especially diagnosis and prescribing practices) relative to pre-determined standards; (iii) assessment of the utilisation of services by vulnerable groups relative to other groups within the community; (5) to draw general conclusions concerning ways of enhancing the equity impact of BI schemes through a comparison of international experience in their implementation; (6) to feed the findings of the research into national and international health policy and financing debates, through their wide dissemination within and across countries; (7) to establish links between national and international research teams to enable them to learn from each other, facilitate discussion and dissemination of research findings and develop expertise in operational research (AMREF, 1994a). My component of the study was to look specifically at point (3, iii) in one community

to the Ministry of Health.

Further, I realized that women and men in Sigoti were not a homogeneous group; not only would gender relations produce different relationships to the BI between men and women, but women in the community would be involved differently according to their type of involvement in the project, their age, socio-economic status, distance to the pharmacy, and other factors. Membership in women's groups, and participation as community health workers or traditional birth attendants, were just a few factors that would produce unique relationships to the BI among women in Sigoti. Being attuned to the heterogeneity of women made it particularly difficult to define issues prior to conducting the study, because I realized that what may be an important issue for one group of women (e.g. community health workers), might be rather insignificant to another (e.g. women's group leaders).

I recognized that it would be difficult, not to mention undesirable, to develop specific questions prior to my familiarization with the study area upon my arrival in Kenya. Further, it was my explicit intention to involve participants in defining questions, in keeping with my goal of making the study as participatory as possible. For this reason, I considered a broad set of issues to discuss with the various groups I would be meeting with, and expected that they would participate in modifying these according to their circumstances and wishes. Patricia Maguire's framework for conducting feminist, participatory research was especially useful in the development of issues to address with the Sigoti community, as the BI is a participatory strategy with gender issues central to

its agenda (Maguire, 1987).⁹⁷ I expected that a refinement of questions would be required at every stage of the research process, and that questions would emerge as participants became engaged in the investigation (see Section 4.6 for the general issues addressed with each group of participants).

4.4.4 Arriving in Kenya

Upon my arrival in Kenya, two orientation activities I participated in were very useful to me in refining issues to address in the study. First, I had the opportunity to give a seminar presentation at AMREF outlining my research objectives and strategy. AMREF staff and students of community health at the University of Nairobi attended the presentation. The seminar participants had many useful questions and suggestions, which allowed me to refine my strategy, and also to get acquainted with my host institution. I had been concerned that as a Canadian woman I might be met with some hostility from a group of Kenyans working in and/or studying the field of community health in their own country. This concern was relatively unfounded, as people were very receptive to me and supportive of the project.

The second orientation activity I participated in was observing Dr. Oranga lead a rapid assessment of six BI sites in Homa Bay District. The objective of the assessment was to gain background information about the BI sites, and based on this information,

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⁹⁷ She suggests that a feminist PR study should consider 1) how central problems are similar and different for local men and women; 2) how area men's and women's perceptions of central problems overlap and differ; 3) the voice, role and power that local women have in community organizations and institutions; 4) how women and women's interests are represented by community leadership, the role or voice of women in problem-posing forums; 5) the linkages between patriarchy, one oppressive structure, and the named problems; how access to project participation is similar and different for women and men, 6) how women's double day minimizes or affects their participation; 7) what mechanisms are instituted to offset participation obstacles; 8) how women and men's unique strengths are built upon within the project, and 9) the treatment of gender with respect to benefits of the project (Maguire, 1987: 105).

to select two sites for the comprehensive study.⁹⁸ Participating as an observer benefitted me in a number of ways. First, it sensitized me to the male dominance which characterized the health sector. My first day in Homa Bay was spent meeting with Ministry of Health (MOH) officials, who all happened to be men. I assumed that this composition of MOH staff reflected that in other parts of Kenya, based on the secondary sources that I had read about women's involvement in Kenya's health system (e.g. World Bank, 1989). The project team for the rapid assessment, which included Dr. Oranga and several Ministry of Health officials, was comprised solely of males -- despite the BI's objective of specifically targeting women as beneficiaries. I assumed that the male composition of the team would affect the type of knowledge generated in the assessment.

I also learned of the general attitudes toward women of these officials:

The past two days have opened my eyes about gender relations once again, mainly through informal conversations with MOH staff. We got onto the topic of wife beating, and they looked at me with shock and astonishment when I told them that it was both culturally unacceptable and illegal to use physical force on a woman in Canada, whether it is a stranger or a spouse. I learned today from these men that "it's necessary to discipline your wife with physical force" (i.e. beat her) -- "how else will she learn?" (Personal Journal, Jan. 27, 1995).

These conversations undoubtedly added layers to my "conceptual baggage" prior to conducting my research. I suspected that the perpetuation of these attitudes among men account for much of the resistance of men in enabling women to gain "authentic"

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⁹⁸ The rapid assessment for Kisumu had been conducted in November of 1995. The type of information collected in the rapid assessments included demographic and socio-economic information about the community; community-identified health problems; the history of the BI (how it was initiated); the organization and structure of its village health committee, community health workers, and traditional birth attendants; and statistics related to funds generated and use of funds, as well as drug flow. The information was collected through focus group discussions with the VHC, CHWs, and TBAs and well as through the review of background documents.

decision-making power in community initiatives that involve both men and women, such as the BI.”⁹⁹ Second, observing the assessment enabled me to gain firsthand knowledge of how different BIs function. By making simple observations at the BI pharmacy, and talking informally with people involved in BI implementation (those who could speak English), I already had a much firmer grasp of the BI. This allowed me to reflect critically on the assumptions I had made about the BI, and also on the questions I had been considering for my interviews and focus groups. Although I only had the opportunity to observe assessments at three BI sites, I was surprised by the diversity of their functioning. While two of the sites were very cohesive, one was ridden with operational problems, that I learned later were attributed to power struggles among community members. Seeing this diversity firsthand brought home the important point that each research experience is unique, driven by its particular context. My findings in Sigoti would illuminate one community’s experience with the BI, and the findings would not be easily generalizable to others.

Third, I gained insight into the process involved in conducting focus group discussions, which was to be an important component of my research in Sigoti. Notably, all of the questions had been defined by researchers in advance. Despite this, I was impressed by the interactive nature of the assessment. The two main facilitators asked questions about the implementation process and management of the BI. Participants were able to reflect on their processes, and gain a collective awareness regarding possible ways to improve them.

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⁹⁹ This point is not meant to imply that all Kenyan men hold these attitudes; rather, it is intended to illustrate that my understanding of gender relations in Kenya was undoubtedly shaped by such comments.

Finally, and perhaps most important, I became sensitized to how I would be received by the community as a Western outsider studying gender dynamics in the BI:

Today we went to Karyenga community and it was my first contact with women. They were entirely open and friendly and did everything they could to make me feel at home - I have a feeling that they believe I have much more influence than I really do. Their introductions were incredible. They began with a song -- "The Bamako Initiative has called upon us, etc..." and then proceeded to introduce themselves individually. There's a real sense of pride, community and solidarity. I think this is a very cohesive site - although one of the TOTs did say that they were looking forward to speaking with me in the absence of men - that says something (Personal Journal, Tuesday, January 24, 1995).

Through my experience as an observer of the rapid assessment, I realized that my research would inevitably be characterized by unequal power relations, to the extent that participants believed that I had more to offer them than I actually did. Being connected to AMREF was positive, in the sense that I gained almost immediate credibility with the community. Yet community members tended to associate me wrongly with UNICEF, the donor. They had the perception that I could "help them," mainly by bringing them resources (despite that they had been informed that I was there solely as a Canadian observer, with no connection to UNICEF). I hoped that should the research participants in Sigoti also have this perception, I could mitigate or change it by explaining clearly to the participants the purpose of the research and my reason for being there.

4.5 The Research Process

The research process was comprised of three main phases - key informant interviews, focus groups discussions, and a household survey. The purpose of this section is to illuminate the process undertaken in each of these phases. Section 4.6.1 describes the process involved in conducting the key informant interviews; section 4.6.2 describes the

focus group discussion phase of the study; and section 4.6.3 discusses the process leading to and during the household interviews. Section 4.6.4 discusses the information gained through informal channels. A list of participants is included in Appendix 1. It is important to note from the outset that my research assistants, participants of the key informant interviews, and those with whom I held informal conversations, did not object to being cited in this thesis. While focus group participants did not object to having their names included in this thesis, they were assured that their particular comments would remain anonymous if cited. Similarly, participants of the household survey were assured that their responses would be strictly confidential.

4.5.1 Key Informant Interviews

Following my return to Kisumu, Dr. Oranga and I drew up a general research plan together, including a plan of activities and budget. Dr. Oranga moved very quickly, and expected me to work quite independently. We decided that a necessary first step would be to meet with various members of the Kisumu District Health Management Team (DHMT), both to inform them of my role in the study, and to gain information regarding the district's role in the BI, both generally and with specific attention to gender. We arranged to meet with the Bamako Initiative Coordinator, the Primary Health Care Coordinator, Hospital Secretary, the Medical Officer of Health, the District Public Health Officer, and a District Public Health Nurse.¹⁰⁰ I developed nine key issues to address with each person I would be meeting with, based on the objectives of the study, and with specific attention to gender issues. These were as follows:

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¹⁰⁰ There are two District Public Health nurses in Kisumu who hold positions on the DHMT.

- 1) how the DHMT first became aware of and involved in the BI;
- 2) the nature and effectiveness of linkages between the DHMT, the MOH at the national level, and UNICEF;
- 3) the nature of women's involvement in decision-making at the district level (i.e. gender composition of the DHMT);
- 4) the DHMT's general perception of its responsibilities in the BI, and specifically, the nature of its linkages to the various BI sites in Kisumu;
- 5) background information about the Sigoti community and BI site;
- 6) the DHMT's perceptions of the BI's effectiveness, in terms of increasing accessibility of health care to rural areas, and in terms of the strength of participatory processes;
- 7) the nature and effectiveness of the linkages between the district and the various groups involved in BI implementation; namely, the pharmacy committee, trainers of trainers (TOTs), community health workers, and traditional birth attendants;¹⁰¹
- 8) the DHMT's perceptions of the effectiveness of the BI in promoting gender equity, in terms of accessibility to BI services, and also in terms of women's involvement in participatory processes; and
- 9) suggestions regarding issues to incorporate into the study.

While this set of issues was used as a guideline, my intention was to hold rather informal, semi-structured interviews, which would evolve as the participants raised issues that I may not have considered.

Because I would not have the opportunity to meet with members of the DHMT more than once (with the exception of the Bamako Initiative coordinator), I assumed that it would be difficult to establish rapport, or anything close to a reciprocal relationship with the DHMT. I anticipated (based on my knowledge of how I was received during the rapid assessment in Homa Bay) that my association with AMREF would lend me some credibility and respect. I hoped that by being open and transparent about my own intentions, the DHMT would reciprocate by consulting with me openly and honestly. In

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¹⁰¹ This issue was addressed to get a general idea of whether groups other than the pharmacy committee had any formal linkages to the DHMT, or any informal means of addressing concerns with the DHMT should problems arise.

order to make the study as participatory as possible, and as a demonstration of respect for the DHMT, I actively sought suggestions from them regarding issues they wished to be addressed in the focus groups and household interviews. I expected that since they had been involved with the BI since 1989, they would have important insight into the participation dynamics of various sites.¹⁰²

A few observations related to the interview process are worth noting. First, the interviews were a positive experience, both in terms of the process involved and the information gained. I learned a great deal about the general functions of the DHMT regarding PHC organization and implementation. This enhanced my understanding of the magnitude of the constraints (both monetary and operational) the DHMT faces in effectively coordinating PHC initiatives in remote areas. The interviews were generally very informal. I asked open ended questions, and took notes during the session.¹⁰³ The interviewees were free to intervene with their own questions or points to add at any time during the interview. The DHMT was friendly and cooperative, and I gained a significant amount of background information related to program logistics. None were opposed to being cited directly in my analysis. My fear of being met with hostility by the people I would be working with had not yet materialized. But while I was well

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¹⁰² It is important to note that I was somewhat conflicted over whether to incorporate the concerns raised by the DHMT into my discussions with participants in Sigoti. I recognized that the various groups that I would be dealing with would have different concerns and priorities from the DHMT. I questioned whether I would be responding to the DHMT's agenda, rather than that of the Sigoti community. Despite this concern, the insight gained from the DHMT was useful to me in defining issues prior to the focus group discussions. While I planned on using this information as a guideline, I also intended to probe for issues that each group felt would be important to incorporate into the study.

¹⁰³ Because of the informal nature of the interviews, and the fact that the DHMT was not informed of the meetings in advance, it was inappropriate to tape the interviews.

received in all of the interviews, it became quite clear to me who was truly interested in participating in the interview, and who felt that it was low on their list of priorities.¹⁰⁴

I questioned whether the warm welcomes were genuine, or whether interviewees were hiding a deep-seated resentment or distrust of my intentions. Specifically, I was concerned that the gender focus of my research topic would be met with some latent distrust by the DHMT, who, with one exception, were all men. Yet the DHMT was accustomed to discussing gender issues, especially because a general condition for receiving funds related to primary health care from donors, UNICEF in particular, is that programs reflect health issues related to women and children. The BI coordinator was attuned to the conflict that has been created in Sigoti, whereby women are "marginalized by men, who feel that women are not literate enough and don't have legitimate input or concerns" (BI coordinator, Feb. 1, 1995). He was also attuned to the concomitant resistance of women, who "stand strong on the use of funds" (BI Coordinator, Feb. 1, 1995). Both the BI coordinator and the PHC coordinator had useful suggestions regarding gender issues to incorporate into the study. During my meetings with them, they confirmed much of what I had read about through secondary sources regarding the constraints facing women in participating in PHC programs, and the community leadership conflicts which tend to hinder the effective functioning of PHC. I was comforted in the knowledge that my research was addressing issues of concern to the DHMT - that my research might be useful to someone other than myself. Comments and

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¹⁰⁴ The level of enthusiasm with which the interviewees discussed the BI with me, coupled with their respective roles in the BI (some were much more intimately involved with the BI than others, depending on their positions) generally determined their level of interest in the study.

suggestions made by many of the interviewees regarding issues to incorporate into the study led me to believe that the DHMT (generally speaking) was informed about and interested in gender dynamics that were affecting BI implementation in local communities, and that the information that they were providing reflected their honest perspective, based on their experience with the BI.

Third, interviewing several members of the DHMT enhanced my understanding of the DHMT's role in the BI and its relationship to Sigoti. It enabled me to add layers of information, and compare information provided by different members of the DHMT. While common threads of knowledge and experience ran through each meeting, each member of the DHMT offered a unique perspective, based on his relationship to and experience with the BI, his personality, and his response to me as an interviewer.

4.5.2 Focus Group Discussions

Based on the objectives of the study, there were four key groups that Dr. Oranga and I felt should be involved in discussions: members of the pharmacy committee, community health workers, traditional birth attendants, and leaders of women's groups. Each of these groups had a different relationship to, or stake in, the BI. By holding separate group discussions with each of these groups, I hoped to gain insight into the differences in their perceptions of the BI, their perceived linkages to other groups, and their various concerns and priorities. The objectives of the focus groups and notable observations on the process through which they were conducted are discussed in the following sections.

Objectives of the Focus Groups

My interviews with members of the DHMT enabled me to review and refine the issues I had developed for the focus group discussions. Also assisting me in this process was a review of background information obtained in the Sigoti rapid assessment, which was conducted in late November of 1995. Included in the report was a community profile of Sigoti, a history of BI initiation and development in Sigoti, and an overview of current BI-related activities. Through reading this report, I learned that the Sigoti BI had effectively ceased to function. The report read as follows:

The only activity which has remained prominent is curative. Prescriptions and offers for sale of simple drugs and treated bed nets is by trained CHWs. Although preventive activities like home sanitation, family planning, promotion of latrine use, safe water supply and food supply, were stated to be going on, there was no evidence. Records are not maintained, and display of this vital information on the chalk and board has been abandoned. No transparency on revenue accruing from the sale of drugs and bed nets. The pharmacy committee is blaming the CHWs for failing to submit information regularly and absconding with money, while the CHWs on the hand are blaming the VHC, which they claim is not functioning (AMREF, 1994).

Based on this information, I decided that the best approach to take to understand social dynamics of participation would be to attempt to uncover the story, or rather, stories, regarding the breakdown of the BI. The various actors clearly had different interpretations of the origins of the breakdown. The Sigoti BI was ridden with conflict; community health workers and the village health committee (VHC) were each placing blame on the other for the project's failure. I realized that by holding discussions with these groups separately, I would likely receive contradictory interpretations of the "facts." My intention was to study these contradictions, keeping in mind the vested interests of each group. I anticipated that a key variable leading to the conflict was

gender relations. The report indicated that with the formation of the BI CHWs became marginalized by the pharmacy committee, whose executive was comprised of men. The committee was to manage the BI, make key decisions regarding the use of funds generated, and oversee the work of CHWs. Prior to the establishment of the BI in Sigoti, the CHWs (all women) had ownership over primary health care through their organization "The Sigoti Community Health Workers Project," registered with the Ministry of Social Services. While this issue was only touched upon in the report, it generated a number of questions to raise in the focus group discussions, discussed below.

The main objectives of the focus group with members of the pharmacy committee were to determine its perceptions of the functions of the committee; to determine the process involved in decision-making; to determine the committee's perceived and actual linkages to the district, divisions, CHWs, TBAs and the community; to determine the level of involvement of women on the committee; and to gain insight into reasons why the Sigoti BI effectively stopped functioning.

CHWs form the backbone of the BI, as they serve as a link between the community and higher levels of BI management. This is the function through which women are most involved in BI implementation, as they comprise 99% of all CHWs in Sigoti. The purpose of the discussion with CHWs was to determine their links to other levels, including the committee, the division, the district and the community; to assess their perception of and their satisfaction with, their level of involvement in making key decisions with respect to BI organization and management; to determine the effectiveness of the BI in incorporating women's voice into BI-related decisions (women in the

community, those not involved directly in BI implementation); and to determine their perceptions of the effectiveness of the BI in meeting women's priority health care needs.

TBAs are central actors in meeting women's reproductive health needs in Sigoti; but they are peripheral to the organization and management of the BI, as they are not involved in essential drug management or preventive health activities. The main purpose of the discussion with TBAs was to determine how TBAs were linked to the BI; to determine how the BI has impacted on their roles as TBAs; and to determine their perceptions of how the BI has impacted on the reproductive health of women in Sigoti.

The main objectives of conducting a focus group with leaders of the women's groups in the area was to understand how women in the community are linked to the BI; to determine their general knowledge of the goals and structure of the BI; to determine their relationship to the CHWs; to determine their level of participation in the selection of committee members; and to determine whether channels of communication exist which enable women in the community to have a voice in decisions made concerning BI management.¹⁰⁵

Focus Groups -- Notes on Process

The focus group discussions were conducted during the month of February and the first week of March. Because the CHWS are so central to BI implementation, and because they represent the key group of women involved in the BI, there was a significant amount of material to be covered in the focus group discussion with them. For that reason, we required two focus groups with the CHWs. In retrospect, having

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¹⁰⁵ The complete list of questions that were included in each of the focus group discussions is included in Appendix 2.

two discussions with the CHWs enhanced my understanding and analysis a great deal, because I was able to expand upon certain key points made in the first discussion.

The process leading up to the first discussion was extremely quick and efficient. AMREF as an organization, and Dr. Oranga as one of its senior researchers, had an enormous influence on the DHMT. The BI coordinator was able to arrange a meeting with members of the pharmacy committee with one day's notice, such that we could discuss the research that we would be conducting regarding the BI. The following day, Dr. Oranga, Mr. Owiyo and I met with the chairman of the Sigoti health centre, the chairman and treasurer of the pharmacy committee, and the treasurer of the pharmacy.¹⁰⁶ The committee welcomed us, and looked forward to participating in the study, the purpose of which was explained to them by Dr. Oranga.

Being connected to a senior researcher at AMREF established my credibility with the community immediately. People did not appear to be outwardly threatened by me, or by the purpose of the study. Prior to leaving for Sigoti, I had been concerned that people in Sigoti might not be willing to participate in the study, or feel it was an important issue to discuss. He reassured me that people in Sigoti would be eager to participate in the study; first, because communities generally perceive the BI to be a positive intervention; and second, because those responsible for the management of the BI were a group of retired civil servants (elites) with extensive experience in public and research settings. While this knowledge alleviated my concerns about the community's willingness to participate, it confirmed that I would be working primarily with a group

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¹⁰⁶ The distinction between the executive of the pharmacy, and the executive of the pharmacy committee is noted in Appendix 1.

of elites who did not represent the broad spectrum of people living in Sigoti. This factor would influence the type of information I would gain from the study.¹⁰⁷

We arranged to hold the first group discussion the following day. At this point my desire to undertake a participatory research process was met with the realization that the study's framework was more closely resembling a rapid rural appraisal (RRA), which effectively elicits and extracts information without facilitating participants' empowerment (Chambers, 1992: 11). RRA is a form of data collection whereby researchers take data away, analyze it, and learn from it (Chambers, 1992: 12-13). I expected that because I had no time to discuss the study with the actual participants prior to conducting the group discussions, there would be little opportunity for participants to direct the course of the study and raise issues of concern to them. I attempted to mitigate this constraint by ensuring that the participants understood that they could raise their own questions during the discussion, or at a minimum, intervene if they did not understand the purpose of a question, or considered a particular question to be inappropriate.

Asymmetrical Power Relations

To assist in conducting the focus groups, I hired a research assistant, Ms. Anne Mumma.¹⁰⁸ I wanted to hire a woman who lived in the community, who could not only serve as a translator for the discussions and the household survey, but who could also serve as a cultural link to the community. I placed importance on having no men

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¹⁰⁷ These elites were the people who were clearly benefitting the most from the BI through their active involvement in its functioning and their ability to pay for services provided. I suspected that those with less involvement, or less stake in the BI may have a very different perception of its ability to improve their lives.

¹⁰⁸ Ms. Mumma did not object to being cited in this thesis.

present during the women-only discussions, such that the discussion could create a private space or forum in which women could participate.¹⁰⁹ I expected that the women would be less inclined to discuss conflict or concerns in the presence of a male research assistant (e.g. Price, 1992; Welbourn, 1992). Further, I expected that a woman from the community would be able to translate my questions in terms that the women would be able to understand and relate to. Ms. Mumma was a young woman from Sigoti who had recently completed secondary school. She was fluent in Luo and English (and Swahili). I expected that by working closely with her over the course of two months, I would gain some insight into the social dynamics and cultural nuances of the community. Ms. Mumma was the daughter of elites in Sigoti. Her father was a retired senior civil servant and her mother was a retired teacher. Both were extremely active in community life. I hoped that despite Ms. Mumma's status as an elite, her young age and closeness to the community would mitigate the power imbalance among participants created by class differences.

In retrospect, the power imbalance between Ms. Mumma and the participants was less significant than that created by the misperception of participants of my role in the research. Upon our arrival in Sigoti, the CHWs and TBAs who would participate in group discussions in the weeks to come were waiting eagerly to introduce themselves to us:

The CHWs introduced themselves in a song - as they greeted me one of them lifted me up and exclaimed "You're very welcome!" and laughed. I was stunned - what a warm welcome. I had been worried about the Sigoti group because of what I

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¹⁰⁹ All of the focus group discussions, with the exception of the discussion with the pharmacy committee members, were women-only discussions.

had learned from the rapid assessment - but they seemed to warm up to me quite quickly and I got the impression that they did not feel threatened by me (Personal Journal, February 9, 1995).

It became clear to me over the course of the six weeks that we conducted the focus groups that a key reason for our warm welcome was the participants' misperception that I was there to assist them in solving their operational problems, such that the BI could begin to function effectively again. Despite my efforts to be clear about my role in the study and my reason for being there, comments made during the discussions revealed to me that this misperception persisted. In informal conversations following the discussions, the women in particular would frequently thank me for doing this research, and indicate that they thought that this was a great opportunity to bring about progress for the BI. This became a source of conflict for me, because I was aware that I could be of little assistance in this regard. At best, the study would enable participants to become aware of the source of the problems. But unless this awareness led to action on their part to solve their problems, the study in and of itself would be of little benefit to them over the long-term.

I planned to assist the community as much as I could given these circumstances by incorporating a feedback focus group into the design following the preliminary analysis of the findings, and by offering suggestions about channels of communication through which participants could go to voice their concerns. Unfortunately, time did not permit a feedback session, and as a result the study was predominantly extractive. While the women gained a collective awareness of their situation, this did not lead them to confront others and argue their case, as would be a desired outcome in a truly

participatory process (e.g. Ramphele, 1990). Rather, because the women sought to avoid conflict in their community, they advocated that I, as an outsider, represent their case to people who would be in a position to make change. For example, when the women's group leaders learned that they were entitled to participate in decisions that get made regarding use of funds at the pharmacy, one woman expected me to inform the pharmacy committee of their "proper" role:

...if we as leaders of women's groups, we would have known that, we would have said something so that Bamako could help us. But because we don't know how it works, we have nothing to say about it. And so, since you've made us aware of what is to happen, then you should inform those people on how to involve the community so that women's groups should know about the activities they do. That is also a cry that you should help us in.

Despite their new awareness gained from the discussion, they located the responsibility to deal with their situation with an external actor, with no real ties to the community. This was a source of conflict for me. I recognized that I was accountable to this group, as I was to every other group I worked with. Based on this knowledge, I felt that my role as an outsider should be limited to illuminating the various groups' concerns to the BI coordinator. As the DHMT is responsible for technical and material support of the BI, as well as resolving leadership conflicts, I felt that the BI coordinator should be fully aware of the findings of the study.

Transcription

All of the discussions were taped with no objections from participants.¹¹⁰ I assured

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¹¹⁰ In fact, during the women-only discussion, the women were very careful with the recorder, to ensure that everything they said was recorded properly. One exception to this was when the women's group leaders asked me to stop recording while we clarified a particular issue regarding community ownership of the BI.

the participants that while I would include passages from the transcripts in my analysis, the name of participants cited would be confidential. Ms. Mumma and I transcribed the tapes together following each discussion. While this process was quite time-consuming (it took between two and four days to transcribe each discussion), it proved to be invaluable in terms of the information obtained. As Marjorie Devault notes, the standard practice of editing that smooths out respondents' talk "is one way of distorting women's words; it is often a way of discounting and ignoring those parts of women's experience that are not easily expressed" (Devault, 1990: 99). She suggests that features of speech like pauses and emphasis provide clues to emotion and meaning, and these in turn are building blocks for the analysis (Devault, 1990: 99). Although I was unable to go back to the tapes and search for these clues following the transcription, I noted any pauses, laughter or other significant breaks in the discussion while we were transcribing. I asked that Ms. Mumma translate the exact words of the women (as much as possible). In many cases, we listened to passages several times in order to get a clear understanding of the context in which something was said, and the meaning behind what was said. The transcription process was extremely useful to me, because the information gained from completed discussions informed the development of questions for the next.

Questions and Translation

Our first discussion, with members of the Sigoti pharmacy committee, was facilitated by Dr. Oranga, myself, and Ms. Mumma. Dr. Oranga wished to be present during the first discussion for three main reasons. First, he wanted to assure participants that this research was a component of AMREF's study, and that I was working directly under his

supervision. My sole reason for gaining access to the community was through my association with AMREF. Second, he felt that it was appropriate that he be involved in the group discussion which would involve both men and women - he expected that the men would be more inclined to discuss issues openly if he was present during the discussion. Third, Dr. Oranga was a Luo from Kisumu, and he wanted to ensure that Ms. Mumma's translations adequately represented the meaning of the questions asked. Through this process, I learned that the questions I had phrased were too complex for adequate translation. For the remaining discussions, I simplified my questions considerably.

Ms. Mumma and I facilitated the remaining discussions alone. Following each question, Ms. Mumma allowed participants the opportunity to give responses, and then gave me a brief summary of what had been said. Based on the summaries I was given, I frequently probed further on certain issues. This often resulted in the formulation of leading questions, particularly in the discussions with the CHWs (see Appendix Two for the translation of the questions asked during the discussions). Generally these questions were used to clarify the meaning of the women's responses, or expand on what they were saying. In an attempt to avoid leading questions, I was essentially "beating around the bush," and the meaning or purpose of the question was not clear. The use of leading questions was often necessary to get to the point I was trying to make. For example, following a discussion that demonstrated women's lack of voice on the pharmacy committee, Ms. Mumma asked the women "because the present committee has more men than women, do you feel that the next one should have more women or just the CHWs

as the pharmacy committee?" The use of this question opened the discussion considerably, and frequently fuelled debates among participants, illuminating both commonalities and differences among the participants. In this sense, leading questions generated a more complex understanding of certain issues that neutral questions, such as "how do you think your relationship with the pharmacy committee can be strengthened?"

Participants

As has been noted by Yach (1992), a potential issue for focus group interviewing in African communities is that most people volunteering to be in focus groups know each other. Further, local status hierarchies may cause a certain degree of self-selection into groups favouring higher status as opposed to lower status participants. The focus groups conducted in Sigoti were certainly characterized by the predominance of elites, or community members who were fairly well-off socio-economically. The list of participants in the focus group discussions is included in Appendix 1.

The focus group discussion with the pharmacy committee comprised its executive, who are retired senior public servants (with the exception of one, who is a teacher), but also included two CHWs and a TBA responsible for the daily operations of the pharmacy. These women had no formal occupation (they were referred to as housewives, or mothers). I was concerned that the women would be marginal to the discussion, (particularly because the BI coordinator had informed me that the men feel that the women's ideas are not legitimate). However, the women participated actively in the discussion, and frequently contradicted what was said by the committee's executive. The conflict between the CHWs and the committee's executive became

apparent during the discussion, as both parties attempted to protect their interests.

While the focus group discussions with the CHWs had a more varied composition in terms of socio-economic status, most of the CHWs were literate or held in high esteem in the community. All of the participants knew each other well, and belonged to the original group of 24 CHWs who comprised the Sigoti Community Health Workers Project. There were 71 CHWs who were trained following the establishment of the BI, but many of these CHWs dropped out of the program or began to work independently of the BI. None of the less experienced CHWs participated in the study. Although the information gained reflected only the perspectives of the 24 original CHWs, the fact that they were able to provide the historical context leading to the breakdown in BI operations strengthened my analysis considerably. Further, the fact that these CHWs were very comfortable with each other was not a drawback during the discussion; rather, it created a relaxed atmosphere which fostered spontaneous discussion and debate. The discussions were lively and filled with laughter, and all participants voiced their opinions and perspectives.

Like the CHWs, the TBAs who participated in the focus group knew each other well, and all were keenly interested in having a voice in the discussion. They had all been practising TBAs prior to the inception of the BI, and as such, were able to discuss any changes in their roles that have resulted from the establishment of the BI in their community. TBAs, being the eldest and least educated of participants, tended to digress from the questions asked and focus on their problems. They perceived me as someone who could teach them, and bring progress in health to their communities. As one of

them said:

At first, I'm grateful because God has brought you so that we can learn together, so that we may tell you our problems, because we, the TBAs, we get to know many things from women.

Despite the tendency to focus on their problems, the TBAs provided much valuable insight into their linkages to the BI, and the extent to which women's reproductive health is addressed through the BI.

The focus groups with leaders of the most active women's groups in the area was the last discussion conducted, and was organized by the chairman of the Sigoti health centre. He assured me that I would get "good information," because the women he recruited were well-educated elites. Although the discussion failed to incorporate the voice of women in the community who were less-well off, I was able to draw certain conclusions about the nature of women's participation in the BI. I learned that the channel of communication to women in the community regarding BI-related information was weak at best. The women's groups had no knowledge of their potential involvement in BI-related decisions. I assumed that if these elite women, who were actively involved in community life, were not receiving adequate information or support through the BI, that less well-off women would be worse off in this regard. As a result, the fact that non-elite women did not participate in the discussion was less of a drawback than may have been the case otherwise. Further, I assumed that a broader perspective on women's knowledge of and involvement in the BI would be gained through the household survey, which would include a more representative sample of women in the Sigoti community.

4.5.3 Household Survey

The household survey was the final phase of the research process. The process involved in its design and implementation did not conform to feminist, participatory principles identified in Section 4.4 of this chapter. Due to time constraints and logistical problems, participants in the survey were not involved in identifying questions, or in the subsequent analysis. While participants in the focus group discussions were asked to provide input into the type of issues to address in the survey, they had no comments or suggestions. The survey was primarily quantitative, and purely extractive. While survey questions were developed based on information gained from the focus groups, women's participation in the survey offered them no direct benefits, but did make use of their valuable time. The objectives of the study and process by which the survey was conducted is described below.

Survey Objectives

The survey questions were developed based on the knowledge gained in the focus group discussions. The focus group discussion with women's group leaders had indicated clearly that among women not involved directly in BI implementation, there was a low level of awareness of the objectives of the BI, apart from the delivery of curative care and preventive health education to the community. Therefore, the general objectives of the survey were to gain information related to women's defined priority health needs (in relation to services offered through the BI); to determine women's knowledge about the goals of the BI; to determine their access to, use of, and satisfaction with, BI services; to determine their involvement in the BI (beyond receiving benefits); and to determine

the effectiveness of channels of communication to them about BI-related matters. Household dynamics around participation in the BI and decision-making regarding the use of BI services were also included in the study.¹¹¹

Notes on Process

Selection of Households

Dr. Oranga obtained a list of households in the sub-location of Ramogi, one of the five sub-locations covered by the Sigoti BI, and used a random sampling method to select the households that would be incorporated into the study. Ramogi is the sub-location in which the BI pharmacy is located, and presumably the sub-location whose community members benefit the most from the BI. While it was our original intention to sample households from all sub-locations, time constraints did not permit us to get a complete list of households of all sub-locations from the pharmacy committee. The exclusive use of households from Ramogi was a limitation of the study.

Interview Process

Ms. Mumma and another young woman from Sigoti were hired to conduct the household interviews. They were trained in interviewing techniques along with a large group of interviewers who were involved in AMREF's baseline study of the BI in Kisumu and Homa Bay districts.¹¹² The village chiefs were informed of the purpose

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¹¹¹ Survey questions were drawn heavily from the baseline questionnaire developed by AMREF to assess the equity impact of the BI, but was tailored to specifically focus on women's relationship to the BI, and to incorporate further questions related to women's participation in the BI.

¹¹² Issues discussed in the training session included the process of recording responses, and how to approach the household; interviewers were told to speak to the male head of the household first, if applicable, and inform him of the purpose of the study, then request to speak to the female head alone. Interviewers were also told what to do in cases whereby the female head of the household was not available to respond to the questionnaire.

of the survey, and of the weeks during which the survey was being conducted. As such, members of the Sigoti community were well aware of the study, and of the possibility that they might be interviewed. Participants were informed by the interviewers that their responses were confidential. The survey was quite lengthy, comprised of 96 questions. It would have been extremely time-consuming for the interviewers to translate responses to me during the interview, so they conducted the survey alone. I expected that I would gain less insight into the women's responses as a result.

Demographic Characteristics of Women Surveyed

The participants, along with their basic demographic characteristics, are listed in Appendix 1. The women who participated in the survey represented a broad range of ages -- 10 women were in their 20s, 10 were in their 30s, 12 were in their 40s, eight were in their 50s, 6 were in their 60s, and one was in her 70s.¹¹³ Women were fairly uniform across occupation. Of the 41 women who claimed to have an occupation, 78% were involved in farming, and 12% were involved in business.¹¹⁴ Eighty-eight per cent of respondents were married, eight per cent were widowed, and four per cent were single.¹¹⁵ Only eight percent of respondents had completed secondary school. Fifty-two per cent of women had no formal education, and thirty-eight per cent had primary

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¹¹³ Two women did not respond to this question.

¹¹⁴ The type of farming activities (i.e. cash crop or food production, or some combination of both), and amount of land used for farming was not specified. Nor was the type of business engaged in or the extent to which involvement in business provided for the women's needs.

¹¹⁵ While the study requested information related to the relationship of the respondent to the household head, it did not specify whether women were de facto heads of households, by virtue of the frequent absence of their husbands, or their primary responsibility for making key household decisions. All but two respondents claimed to be the wife of the household head. The failure to specify household decision-making patterns more clearly was a weakness of the study.

education. The socio-economic status of the women interviewed was more difficult to determine. Several questions were geared towards measuring women's socio-economic status, including the women's landholdings, income, ownership of livestock, and income in relation to the household head. However, several inconsistencies in the responses, particularly in relation to income, rendered the data unreliable. As such, an accurate picture of women's socio-economic status is not available through the survey, and it was not possible to draw comparisons among responses based on socio-economic status.

General Comments on the Survey Process

The information gained through the survey was useful to me, to the extent that it provided me with a general picture of women's relationship to the BI that I would not have seen had the survey not been conducted. Yet due to the primarily quantitative nature of the survey, and the process through which it was conducted, the information gained is limited in scope. Only six questions were qualitative, providing women with the opportunity to expand on a particular response (most questions had a range of possible responses that could be quantified). While it is possible to make some generalizations about women's relationship to the BI (e.g., all respondents were aware that there were CHWs in their community to assist them with their health problems), most of the substantive issues in my analysis are drawn from the focus group discussions.

4.5.4 Informal Conversations and Participant Observation

I had several opportunities to discuss BI issues informally with various people involved at some level in the BI. These conversations enhanced my analysis considerably, providing me with "inside information" that I could not have gained from

the formal components of the study. What was most enlightening through this process was the extent to which interpretations of the problems varied according to the various actors with whom I spoke. I had several informal conversations with the BI coordinator through the course of my research, particularly as I gained information from the focus group discussions. We discussed the constraints that the Sigoti BI was facing, from the perspective of the various groups involved. Based on the information I had gained he explained the source of the breakdown in operations from the perspective of the DHMT - which was quite different from the perspective of the members of the Sigoti community. The extent to which power struggles among the various actors were hindering effective BI implementation became clear.¹¹⁶

The most fortunate outcome of the study for me was my opportunity to stay in the home of Ms. Mumma's family. Over the course of about eight weeks, I stayed overnight with the Mummas on days that we held focus group discussions, and on days that I travelled to Sigoti to prepare for and monitor the interviewing process. Staying with the Mummas provided me with an inside look at life in Sigoti (albeit from the perspective of an elite family). I became more attuned to the extent of women's responsibilities in the home, and the dynamics between husband and wife in one family. Mr. and Mrs. Mumma appeared to have a very reciprocal relationship, yet it was clear that Mr. Mumma had ultimate authority in the household. In his presence, the women were silent and Mr. Mumma monopolized the conversations; but in his absence, the women were animated and very talkative.

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¹¹⁶ This issue is discussed in detail in my analysis.

Mr. Mumma took great pleasure in discussing the BI with me; first, because he was keenly interested in "bringing development" to Sigoti; and second, because he was interested in health issues, as the chairman of the Sigoti health centre, and as the former chairman of the of the pharmacy committee for the BI.¹¹⁷ We would frequently spend hours discussing BI issues over dinner. This was particularly useful to me, because it brought a male perspective to my analysis that was less predominant in the focus group discussions. We often discussed the relationship between men and women in the BI, and he frequently commented on possible ways to strengthen the BI implementation process. Mr. Mumma was extremely supportive of my research, and would frequently provide me with documents that he felt would be of use to me (e.g. BI-related correspondence that he had on file, demographic characteristics of Ramogi sub-location, a list of women's groups in the area, etc.). Mr. Mumma was very liberal minded -- he had ten children (five daughters and five sons), all of whom he supported through college or university. Despite my status as a young woman, he respected my opinions and our conversations were extremely engaging. His informal participation in the study enhanced my analysis considerably.

One constraint related to informal aspects of the study is worth noting. While my informal conversations were extremely useful to me, adding layers to my analysis, most of these conversations were with men. It was difficult to communicate with many of the women I worked with because of my inability to speak with them in the Luo language. While some of the women could communicate in English, our conversations were not as

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¹¹⁷ Mr. Mumma was not opposed to being cited in this thesis.

spontaneous or informative. I would frequently have to talk through Ms. Mumma, and it was impossible to determine the meaning of women's expressions or pauses.

4.6 General Conclusions on the Research Process

In retrospect, the study cannot be considered to be participatory in approach. The questions and issues addressed in the study were ultimately defined by myself.¹¹⁸ But while participants provided little direct input in this regard, the questions asked and knowledge gained was certainly guided by the participants' observations and opinions throughout the research process. I attempted to foster democratic, reciprocal relationships, and ground my inquiry in the experience of the research subjects, while staying attuned to my own biases and assumptions. My analysis makes substantial use of the words of the participants in the focus groups, as I attempt to situate my analysis in the context of the experience of the research subjects. My one consolation regarding this drawback is that participants frequently expressed their gratitude to me for conducting the research, and saw value in its objectives.¹¹⁹ A copy of this thesis will go to AMREF, and hopefully will be of some value in the context of its three country study of the Bamako Initiative.

The remainder of this thesis explores my research question -- is the Bamako Initiative an appropriate intervention for women?

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¹¹⁸ Apart from defining the central research question, Dr. Oranga was generally not involved in defining specific issues or questions to be addressed in the study.

¹¹⁹ A key weakness of this study was the lack of incorporation of a feedback session, which would have enabled the participants to learn from the knowledge gained, and which would have given them the opportunity to add to this knowledge by providing me with additional feedback. I will, however, attempt to impart this knowledge to the participants by sending them a brief summary of my analysis.

Chapter 5: Contextualizing the Sigoti Location Bamako Initiative Site: International and National Policy Implications

5.1 Introduction

The remainder of this thesis explores, through a case study analysis of the Sigoti Location Bamako Initiative site, the extent to which Kenya's BI represents an appropriate health intervention for women. Chapter One delineated the assumptions which have guided my analysis; namely, that an appropriate intervention has two key interrelated characteristics: effective integration of women's voice into its design, through women-centred definitions of priorities; and incorporation of mechanisms for women's empowerment, such that women hold true decision-making power, thereby influencing the structure and direction of the intervention. Chapters Two and Three described the conceptual issues which have informed my analysis, illuminating the historical constraints to the PHC approach in becoming a truly empowering force for communities in general, and women in particular. Through my analysis I attempt to produce a holistic understanding of the BI which locates women's health issues in a small community within the wider international political economy.

The purpose of this chapter is to situate the Sigoti Location BI within its international and national institutional contexts. As noted in Chapter Four, the BI is a community-based strategy encompassing every level of social organization, including the household, the community and larger administrative districts of nations, national governments, and international donors. None of these levels operates in isolation. I have attempted to ground my analysis in the experience of the research participants, while simultaneously

linking their diverse experiences¹¹⁹ to the various structures and processes (social, political, economic, cultural, demographic, etc..) which have influenced their relationship to the BI.

This chapter is divided into three main sections. Section 5.2 introduces the Bamako Initiative, an Africa-wide health strategy conceived of at the international level, and considers its policy implications for empowerment of the populations it intends to serve. The extent to which the strategy provides an institutional context at the international level which can foster an empowering, community-based health strategy will be discussed. Section 5.3 situates the Sigoti BI in its national context by briefly describing Kenya's BI strategy. Section 5.4 considers this strategy in terms of its relationship to the structure and processes which characterize Kenya's health system, and explores how these characteristics impact on BI policy objectives. Section 5.5 examines the discourse around gender in the strategy. This sets the context for the case study analysis of the Sigoti BI site in chapter six, which examines local level responses, particularly of women, to the BI in Sigoti.

5.2 The Bamako Initiative: An Empowering Strategy?

The purpose of this section is to situate Kenya's Bamako Initiative in its international policy context. An essential point of departure from which to begin this discussion is a brief description of the origins of the Bamako Initiative, its goals and guiding principles.

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¹¹⁹ As noted in Chapter Four, women in Sigoti have had diverse experiences with the BI, depending on their particular relationship to its operations. Some women have been actively involved as community health workers, while others have participated solely as beneficiaries.

5.2.1 What is the Bamako Initiative?

In September of 1987, a resolution of the World Health Organization (WHO)'s African Regional Committee meeting of Health Ministers (including the Kenyan Ministry) called on UNICEF and WHO to help accelerate the implementation of primary health care (WHO, 1988). At that time, many African countries were faced with real declines in their health budgets in response to severe economic constraints and with the introduction of structural adjustment programmes (McPake et al., 1992: 1). Governments were finding it increasingly difficult to sufficiently fund recurrent expenditures in health; health workers' salaries were being left unpaid, drug supplies were failing for substantial periods of time, and resources were unavailable for maintenance of equipment and vehicles (McPake et al., 1992: 1). The Bamako Initiative was developed in response to this problem. Its goal is universal access to PHC, as described in the first WHO-produced document related to the BI:

The goal of the Bamako Initiative is universal accessibility to PHC. The attainment of this goal would be enhanced through a substantial decentralization of health decision-making to the district level, community level management of PHC, user-financing under community control and a realistic national drug policy and provision of basic essential drugs, leading to a self-sustaining PHC with emphasis on promoting the health of women and children (WHO, 1988; cited in MCPake et al., 1992: 2).

The 38th Session of the WHO Regional Committee for Africa adopted three guidelines for the implementation of the Bamako Initiative: 1) national commitment to the acceleration of universally accessible health care services; 2) substantial government financial support for primary health care; and 3) substantial decentralization to the district level for decision-making in the management of primary health care (WHO, 1988).

UNICEF/WHO support for implementing the BI depended on a government's adherence to the following basic principles:

- acceleration of the development of universally accessible PHC services;
- essential drugs policies compatible with and complementary to the rational development of PHC;
- development of community financing for health care services, usually in the form of payment for consultation, treatment, and/or drugs, which remains consistent throughout the different levels of the health system;
- substantial decentralization of decision-making to the district level by the ministry of health for the management of PHC;
- decentralized management of community resources (i.e. funds collected at the community-level remain under community control and are used for the replenishment of drugs and supplies and other operational expenses of the programme); and
- clear definition of intermediate objectives and development of indicators for monitoring and evaluation (UNICEF, 1991: 5-6).

Thus, a prerequisite of the BI is increased commitment by national governments to redistribute resources to peripheral levels of the health care system, and to decentralize management to district and community levels. UNICEF's role in the BI was to provide initial support, through participating ministries of health, for the supply of drugs which form the basis of a revolving fund to purchase more drugs. It was originally anticipated that the donor contribution would be required for the first year of operations, such that the community could accumulate enough initial revenue to ensure the maintenance of the revolving fund for drug purchases (WHO, 1988).¹²⁰

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¹²⁰ It is important to note that not all countries who adopted the BI strategy developed financing schemes involving revolving drug funds. There was considerable flexibility accorded to individual countries to define payment mechanisms suitable to their particular health systems. Insurance schemes and pre-payment mechanisms are two examples of alternative financing strategies which have been used in BI schemes

The Bamako Initiative represents the African health policy response to considerable world-wide changes in health care policy through the 1980s, whereby global economic recession and resource crises have been met with the influence of the "New Right, leading to calls for the introduction of alternative financing mechanisms for public health services" (Gilson, 1995: 695). Since its initial formulation, there has been considerable discussion and debate around both the potential of the Bamako Initiative to meet its goal of universal access to PHC, and the extent to which the BI embodies a strategy that can lead to the empowerment of the populations it intends to serve. The next section illuminates the key elements of this debate.

5.2.2 The BI: Community-Defined or Supply-Driven?

Chapter Two illuminated an inherent contradiction in WHO's and UNICEF's formulation of global health strategies which attempt to address the health care requirements of diverse local contexts in the South. These strategies have been criticized, both for their insufficient attention to the various epidemiological, social and economic realities of particular settings, and for their tendency to be technocratic and dependence-producing. I argued that the distinct parameters around which the local context is enabled to respond contradicted the true spirit of a broad, democratic and empowering health strategy. Further, I asserted that policies of WHO and UNICEF are driven by dominant political-economic ideology. In the 1980s and 1990s, this has meant a shift in policy emphasis from demand-oriented questions of health care needs to supply-oriented questions centring on cost-effectiveness and affordability (Zaidi, 1994). I

(McPake et al., 1992).

illuminated the incongruity between WHO's and UNICEF's setting of global policies in the spirit of social justice and empowerment, which place the burden of responsibility for health care on national governments, communities and individuals, while simultaneously masking the disempowering forces at play at the international level, which limit the capacity of PHC programs to foster self-reliance and sustainability. The key issue to be addressed in this section is whether WHO and UNICEF discourse around the BI challenges these historical contradictions, or reinforces and perpetuates them.

Reginald Green suggests that the conceptual framework of the BI essentially embodies the synthesis of three very different and ultimately contradictory approaches to health policy based on community-financing. The first is driven by neo-liberal ideology (and very real resource constraints), which absolves the responsibility of the state in the provision of health care services, and places an inherent value on fees for services. It is assumed that "normal state revenues" cannot be made to cover basic primary, secondary and tertiary health services, and efforts must be directed towards either raising more funds from patients or communities to expand services or to substitute them for allocations from general tax revenue (Green, 1991: 752). A second approach is driven by a commitment to health for all and to varying degrees community participation beyond financing. Community financing is perceived as a means to raise total resources, increase community influence over programmes and support broader community involvement in improving health. As Reginald Green notes, UNICEF's commitment to benefitting the poorest and to community participation in policy decisions is very real

(Green, 1991: 752).¹²¹ This approach entails collaboration between communities and a decentralized formal health system. The third approach, derived from some non-governmental and church medical services (but relatively weak in Africa according to Green), is also committed to health for all. It sees community payments as a necessary means to replace an incompetent and intrusive state presence,¹²² and to empower the community through community-determination of health services and programs (Green, 191: 752).

Thus, at one level, the BI can be seen as a burden-imposing strategy which places the responsibility of health care on poor and impoverished populations, but does little to transform the structures of poverty which perpetuate ill health. But at another level, the BI represents a strategy which creates the possibility of empowering communities with real decision-making power and increased access to health resources. The debate around the BI has typically centred around which of these scenarios rings true in practice.

Two interconnected critical issues have fuelled the debate over the appropriateness of the BI strategy in meeting its goal of universal access to PHC -- its identification of curative care as a catalyst for strengthening rural PHC services, and its focus on

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¹²¹ Mary Hollsteiner has summarized the experience of UNICEF in trying to be more oriented towards participatory, or community-driven development. She states that in the 1980s, UNICEF has attempted to transform its structure and operations in an effort to promote and facilitate genuine participation, such that people at the grassroots level initiate and develop their own priorities. Some of the actions UNICEF has taken in this regard include local procurement of supplies; decentralization of personnel and decision-making, the recruitment of more social scientists, women professionals, and professionals from the South; performance evaluation criteria recognizing staff capacity to interact at local levels; determination of disbursements of budget funds by beneficiaries of projects; and strengthening the relations between donor governments and national committees (Hollsteiner, 1984: 71).

¹²² Sjaak Van der Geest has also pointed to the limited scope for effective decision-making by communities that is the result of centralized government-provided health care (Van der Geest, 1994: 1033).

community financing of health care. The sale of essential drugs was seen as the point of departure from which PHC services would evolve and become strengthened in local communities. This point was made clear in a speech made by James Grant¹²³ at the 38th session:

We are discovering that there is a key to making PHC centres work effectively, that *there is one element* which, when available on a dependably and affordable basis, draws families to the centres and for which the great majority of families are actually willing and able to pay. *The component of PHC which may prove most capable of filling this catalytic role is the provision of essential drugs for all* (cited in McPake et al., 1992: 3, my emphasis).

Implicit in the BI strategy is the assumption that ensuring a steady supply of drugs for sale at reasonable prices represents a magic bullet through which more effective PHC services will be developed and sustained. Community participation remains integral to the PHC process, and the broad range of PHC components, which focus heavily on preventive and promotive health measures (outlined in Chapter Two), are assumed to be incorporated.

The identification of the sale of essential drugs as a lead intervention, the spearhead to PHC development, has been met with substantial criticism. First, because like other "silver bullet" approaches (e.g. community participation, as discussed in Chapter Two), the BI strategy was developed in response to the experiences of a very limited number of "successful" projects that made use of community-financing schemes. The formulation of the BI was based on two small pilot projects in Benin and Ghana, covering 12,000 and 30,000 people, respectively. The efficacy with which the impact of two small projects

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¹²³ James Grant was the Executive Director of UNICEF at that time.

could substantiate the development of a multimillion dollar enterprise was questioned, particularly because it was suggested that the two pilot studies were exceptional, and economical only because they were not fully costed (Lancet Editorial, 1988: 1177). The BI was therefore criticized for falling into the same trappings of other global health policies, which wrongly presupposed that the incorporation of one key element of PHC would have a common catalytic effect on community health care programs in diverse local settings.

It would be expected that a region-wide strategy would be flexible in its conceptual framework, leaving room for considerable leverage on the part of local communities to adapt its constituent elements to local circumstances. The initial BI resolution signed by the African health ministers was left purposely general, such that individual countries could define program parameters in the context of the needs of their own health care system, and such that changes could be made in the orientation of the programme over time (McPake et al., 1992: 3). Despite this, the BI was formulated under the implicit assumption that community-financing of health services, and in particular, payment for drugs and supplies, *forms the basis through which PHC is strengthened*. Thus, regardless of the particular setting in which it is being implemented, the BI represents a supply-driven program which attempts to increase the demand for and use of health services.

Eva Orosz suggests that health policies are often formulated without clear problem identification or based on wrong assumptions (Orosz, 1994: 1290). The BI has by no means been immune from this criticism. Cloaked within the statement made by James

Grant is the implicit assumption that the BI strategy will create a steady supply of affordable drugs for which "the great majority of families are actually willing and able to pay (cited on the previous page)." This assumption is problematic. Studies have shown that community-financed health systems based on cost recovery tend to disqualify a considerable proportion of poor inhabitants of rural areas.¹²⁵ For example, two studies in Kenya have pointed to the negative impact of the introduction of user fees on accessibility to health services. One was a World Bank study, which showed that any fee instituted would exclude 40% of the population, who are most in need of access to these services (Lancet editorial, 1988: 1177). The other was a study of the impact of user fees in the Kibwezi district of Kenya, where it was found that household income strongly influenced the choice of provider, and that user charges impeded access by the poor to what was probably better quality care (Mbugua et al., 1995: 833).

Further, the assumption of willingness and ability to pay has derived mainly from a narrow conception of affordability based on demand for services, ignoring key information pertaining to how individuals are funding their health expenditures. Few studies in sub-Saharan Africa have addressed affordability in terms of looking at opportunity costs of paying for health care, namely, how fees have undermined the capacity of households (or household members) to meet minimum food expenditures or have been used to substitute for agricultural development and education (McPake et al., 1992: 23).¹²⁶ While the BI emphasizes that mechanisms will be required to ensure that

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¹²⁵ Studies which have pointed to this problem include Asenso-Okyere, 1995; Mbugua et al., 1995; Thomason et al., 1994; Habiyaambere & Wertheimer, 1993; Van der Geest, 1992; Unger et al., 1990; and Lancet Editorial, 1988.

¹²⁶ Since its initial formulation in 1987, UNICEF has recognized that community-financing through

households unable to pay for services are exempt from payment, no effective exemption mechanisms have been reported to date, in Kenya or elsewhere (McPake et al., 1992: 32; AMREF, 1994a).¹²⁶ Where community-financing of health care systematically excludes poor and marginalized groups from participating, it cannot be said to promote either universal access to PHC or broad-based community empowerment.

The lack of attention the BI gives to intra-household expenditure patterns also obscures the negative impact that "community-financing" may have on the health of women and children. The BI strategy was formulated under the assumption that the key barrier to women's and children's utilization of health care is lack of drugs at health facilities. Implicit in the BI strategy is the assumption that with a steady supply of drugs and supplies, families will be "drawn to" the centres -- implying that women and children will participate as key beneficiaries of the strategy, not only through receipt of drugs required for immediate treatment, but will receive additional benefits associated with utilizing services, such as maternal and child health care. This assumption obscures the impact that user fees may have on utilization of services. While it may be true that "availability" of drugs at centres increases the likelihood that community members will

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user fees may not be feasible politically or administratively in some countries, and has accepted alternative methods of financing, such as insurance, registration fees, or local taxes. But it has emphasized that the principles of financial flow initially put forward in the resolution still stand, with supplies of essential drugs guaranteed and additional resources being made available for certain operation costs of the PHC system at the local level, as well as for system expansion (McPake et al., 1992: 5).

¹²⁶ As Sjaak van der Geest notes, the dark side of free health care is also well known. "Government run health care systems found themselves in a deplorable state due to inefficiency, mismanagement and lack of funds. There was often a shortage of medicines and medical personnel in the rural health centres. The paradoxical result was the free services proved to be more expensive for the population. People were frequently forced to buy medicines in the commercial circuit and to travel long distances to find a nurse or a physician" (van der Geest, 1992: 187).

use health facilities, this term masks the potential negative relationship between user fees and access to these services. As Rae Blumberg notes, husbands and wives frequently maintain separate expenditure patterns in African countries (Blumberg, 1989: 15). Income under women's control has been shown to be most often spent for children's nutrition and the family's basic needs, especially among women with provider responsibilities (Blumberg, 1989: xvi).¹²⁷ It is noteworthy that a study of the impact of user fees in the Kibwezi district in Kenya showed that attendance at the fee-charging facilities was 29% lower during months during which the full fees were in force, consistent with findings of studies carried out in four other districts in Kenya. Further, the only two facilities which provided inpatient and maternity services in Kibwezi recorded 12% fewer general admissions, 24% fewer general inpatient days, and 12% fewer maternity admissions during the full-fees period (Mbugua et al., 1995: 831).¹²⁸ In this case the deterrent to use of facilities created by user fees seems to have outweighed the attraction to centres created by drug "availability." Rather than enabling more women to utilize health services related to their reproductive health needs, access to maternal and child health care appears to have suffered in response to the implementation of user fees, despite the increased "availability" of drugs at the centres.

Thus, the assumption that "the great majority of families" are willing and able to pay

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¹²⁷ For example, in Kenya, where rural women's roles in both reproduction and social reproduction form the basis of their identity (see for example, Okeyo, 1980: 191), women's earnings have frequently been used to finance iron sheets for roofing, water storage tanks, school fees, cows, goats and household utensils or furnishings, all of which have direct or indirect effects on the well-being of women and their families (Thomas, 1989).

¹²⁸ Studies on the impact of user fees on utilization of health services in Ghana have shown similar results (Asenso-Okyere, 1995: 87).

for health services is problematic, given the evidence from various local settings which contradicts it. Further, it cannot be assumed that a readily available supply of drugs will act as a catalyst towards improving access to other PHC services. As a health strategy whose basis is community-financing, the BI may not reflect local level capacity to generate the substantial resources required to sustain it. But upon signing the BI resolution, a government's funding is contingent upon its adherence to certain basic principles encompassing the strategy.

There is also an inherent contradiction between health policy-makers' encouragement of PHC programs that are rooted in and express self-reliance, when PHC programs often develop only with a commitment of funds from abroad (Van der Geest, 1992: 185). It has been suggested that rather than promoting sustainability and self-sufficiency, the BI is dependence-producing, both at community and national levels (McPake et al., 1992: 4). Almost all African countries face a severe shortage of foreign currency for the purchase of drugs, and it has been argued that while the BI may generate local funds, these funds cannot be converted into foreign currency required to maintain a steady flow of drugs to the community level. In the early stages of BI implementation it was suggested that even if donors supply the essential drugs for three to five years, this policy will maintain a state of dependence (Lancet, 1988: 1177). Early evaluations of the BI showed that cost recovery at the community level is difficult to attain, and led UNICEF itself to question whether full cost recovery can be achieved given the economic circumstances of participating countries:

It is clear that full cost recovery may be reached only over a number of years. Some countries are already taking this into account at the outset of programme

planning, but this is a divergence from the principles laid down in the BI, and more careful analysis will be necessary to determine to what extent exceptions of this nature might be appropriate (UNICEF, 1989; cited in McPake et al., 1992: 5).

The recognition of the difficulties in achieving cost recovery through community-financing led to the acknowledgment by UNICEF that greater resource provision by external donors would be required to sustain BI programs. In an effort to marry the concept of self-reliance and sustainability with economic realities, which require substantial resource commitments on the part of the donor, UNICEF assumed the role of partner with governments and communities:

The composition of this partnership will vary according to national circumstances; for example, in better-off countries, it is expected that governments with communities will take the major share in financing, with donors concentrating on the poorest segments of society, particularly the unreached. For countries hard-hit by economic recession and the AIDS epidemic, however, a major financial burden will have to be assumed by donors to respond to needs beyond the normal levels of support, both in type (including recurrent costs) and quantity, given the low financial capacity of governments and the large proportion of low-income and even destitute families (UNICEF, 1990; cited in McPake et al., 1992: 6).

The acknowledgement by UNICEF of its responsibility in relation to sustaining the BI is somewhat paradoxical. By sharing in the responsibility to deal with the severe economic constraints faced by African countries, UNICEF has challenged the criticism (outlined in Chapter Two) that international agencies tend to focus the burden of dealing with health issues solely on national governments, thus concealing the crucial role played by the agencies themselves in determining the health policies of the South (Morgan, 1990: 233). Despite this, UNICEF support takes very specific forms (i.e. technical support, drugs and supplies), and is therefore contingent upon the government's (and communities') agreement to adhere to certain BI principles. Participating countries

maintain a state of dependency on foreign imports of pharmaceuticals.¹²⁹ Thus, while governments and communities gain access to resources, the type of resources at the disposal of communities is largely defined by UNICEF itself. The catalytic role that essential drugs will have on strengthening other aspects of primary health care also becomes questionable, as substantial resource commitments by donors are required just to sustain the drug component of the program.

As was discussed in Chapter Two, an empowering health strategy provides the context through which a health program develops, but it does not necessarily begin with pre-conceived objectives and targets. The BI strategy has three pre-defined objectives: 1) increased provision of essential drugs, 2) community-financing and 3) cost recovery. The identification of curative care as a catalyst for the strengthening of the PHC system necessarily privileges curative care as a component of PHC of high value to community members. This essentially places parameters around both the way in which PHC programs are organized and implemented at the community level, and the content of the programs. These parameters may limit the extent to which the strategy can account for community-defined priorities, organizational structure, and the management process related to its PHC program.¹³⁰ Where international policy objectives do not mirror those of the communities involved in BI implementation, or where the process involved

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¹²⁹ While not all drugs and supplies derive from foreign pharmaceuticals, in many cases African states are heavily dependent on foreign imports. In Kenya, for example, over 73% of supplies were imported as of 1993, placing a heavy burden on foreign exchange reserves (Kenya Ministry of Health, 1994).

¹³⁰ UNICEF challenged this criticism on the grounds that an overly narrow view was being taken of the BI concept, obscuring the real objective of the BI - to strengthen PHC services at the district level through community participation (McPake et al., 1992: 4).

in meeting objectives conflicts with the health care process envisioned by communities, the BI cannot claim to represent the voice of those it intends to serve.¹³¹

Chapter One pointed out that an empowering health strategy for women calls for a reconciliation of the agenda of international health experts with that of the local women international health programs propose to serve. Reconciliation is based on the assumption that the benefits of biomedicine, with its effective drugs and treatment, must be tempered with an interest in and respect for local knowledge of needs, appropriate types of programs and resources (Brems & Griffiths, 1993: 261). Insofar as the BI policy guidelines define the key means by which PHC will evolve and become strengthened at the local level, there is a real possibility that local knowledge, and particularly women's knowledge, will at best become incorporated into the existing strategy, or added on, rather than form the basis through which the health program is developed. While the BI strategy purports to specifically target women and children, there is no explicit attention to how women will be incorporated more effectively into the health care process.

WHO and UNICEF BI policy documents give no explicit attention to incorporating women's articulated needs and concerns into the health care process. This is partially a function of the ill-defined conception of community participation in policy documents related to the BI.¹³² But it also represents the absence of a gender-sensitive

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¹³¹ This point is not intended to discount the importance many communities place on both curative care and preventive health activities; rather, it is my intention to illuminate the contradictions inherent in a community-based strategy that has pre-defined objectives and pre-defined means of obtaining them.

¹³² Barbara McPake et al. note that the guidelines for implementation of the Bamako Initiative emphasize the need to define the functions to be fulfilled by the community. The guidelines make reference to three

conceptualization of the BI. This is evident in the policy's failure to consider that access to project participation will be different for women and men; or draw attention to how women and women's interests will be represented by the district or through community leadership channels. Early studies of local participation in the BI have documented the male dominance of local committees, whereby women have played a passive role relative to men (MckPake et al., 1993). Failure to address potential obstacles to women's full participation in policy documents reflects a weakness in the conceptual framework of the BI, and is incongruent with WHO's increasing attention to empowering women through the health and development process:

... women's concerns will need to shift from the sidelines of development to a concerted initiative to bring women into the mainstream; to promote the role of women as agents of change; to make their health and social needs a top priority; and to equip them with equal access to information, technical and economic resources, skills, education and opportunities (WHO, 1992a: 2).

Thus, while the BI strategy recognizes the crucial link between strengthening community level health care provision and reaching the majority of women and children, it falls into the trappings of past PHC efforts, which have been devised under the implicit assumption that the community represents a monolithic whole. This obscures the very real differences in access to both services and decision-making forums that various members of the community have by virtue of their sex, age, and socio-economic status. The absence of explicit attention to gender in BI policy documents reflects a lack of political

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levels of community participation -- community health workers, community mobilization and community financing -- and refer to numerous functions, namely, participation in joint committees with health workers, to fulfil such functions as management and accounting for finances and other resources; management of physical facilities, organization of clinics and integration of services; record keeping; referral systems; support services; transport, communications and logistics; health education; defining training needs and designating community health agents for training; and monitoring (1992: 46-47).

commitment on the part of WHO and UNICEF to ensure that women's interests are accounted for through the BI. WHO and UNICEF remain immune to the highly political ramifications associated with redressing systemic gender inequalities that have pervade all levels of the health system, and perpetuate women's peripheral role in setting policy, defining health priorities and managing community health care.

5.2.3 Concluding Remarks on the International Context

The Bamako Initiative has faced challenges related to transportation, skill and drug shortages by calling for greater resource provision by all parties involved in the development and implementation of health systems, including external donors, central governments, communities and individuals (Green, 1991: 752). In the above section I illuminated the various tensions and contradictions associated with implementing an internationally conceived strategy that creates specific parameters around health development, which simultaneously attempts to be community-based. How these parameters have been manifested in local communities implementing the BI clearly varies according to individual countries' BI strategies, and specific national and community institutional contexts. Notwithstanding the parameters around PHC that are created through a country's adoption of the BI strategy, discussed in the previous section, the conceptual framework of the BI does leave room for the possibility that communities (or perhaps some community members) will be empowered through health. This is indicated by three basic elements of the strategy; namely, that: 1) power is accorded to the community by enabling it to retain control over funds generated through community-financing of the BI; 2) considerable flexibility has been accorded to governments in

determining payment mechanisms and program structures suitable to their particular context and circumstances; and 3) communities are accorded considerable flexibility in other aspects of their health program, provided that they are committed to ensuring the steady supply of drugs and supplies with funds raised.

In the remainder of this thesis, I explore whether Kenya's BI strategy has actualized this possibility, by enabling a community-supportive environment, and more specifically, by creating an environment which enables the incorporation of women's voice into the health development process. In the remainder of this chapter, I situate the Sigoti BI site within its national context. The next section briefly describes the structure and organization of the Kenyan BI, as conceived of by UNICEF in collaboration with Kenya's ministry of health.

5.3 The Bamako Initiative in Kenya

Primary health care initiatives emerged in East Africa in the late 1970s in response to the recognition that widespread poverty-related health problems of the rural poor were not being adequately addressed by the formal "modern" health care system. At that time, there was an immense disparity in health service provision from one region to another, and an especially disproportionate distribution of services between urban and rural areas (Mburu, 1979). The Kenyan government openly endorsed the primary health care (PHC) approach in the late 1970s as a potential solution to the inaccessibility of basic health care to the majority of its population.¹³³ Prior to Kenya's adoption of the BI strategy, PHC initiatives were in operation in Kenya for over a decade and a half, mainly under the

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¹³³ In the 1970s, 87% of registered nurses, 53% of enrolled nurses, 70% of enrolled midwives, and 45% of health inspectors served only 10 to 25% of the population (Mburu, 1979).

jurisdiction of non-governmental organizations, with limited financial assistance from Kenya's Ministry of Health (Johnson et al., 1989; Kaseje & Sempebwa, 1989).¹³⁴

Kenya signed the resolution establishing the BI in 1987 for two main reasons. First, the government recognized that while access to health services was reportedly higher in Kenya than in many other African countries, long distances to services and poor transportation meant that only those patients with acute problems reached health services, a situation exacerbated in the rainy season (the season during which susceptibility to disease, such as malaria, acute respiratory infections and diarrhoea peaks) (UNICEF, 1991: 10). Second, the absolute shortage of drug supplies at rural health facilities (often covering only half a month's requirements) led to growing recognition of the potential role that communities themselves could play in improving the health of populations in rural areas (UNICEF, 1991: 10).¹³⁵ The BI represented a strategy which could achieve more widespread availability of and access to drugs for the treatment of the most common diseases in Kenya. It was anticipated that this action would significantly reduce mortality and morbidity in young children and pregnant women in the immediate future, while gradually strengthening preventive measures (UNICEF, 1991: 12).

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¹³⁴ The Bamako Initiative is a UNICEF sponsored project, but falls under the jurisdiction of the Ministry of Health. Therefore, with the establishment of the BI, the Kenyan government has taken a stronger role in the development and implementation of primary health care.

¹³⁵ The three major causes of childhood death and morbidity in Kenya, apart from immunizable diseases controlled through immunization, are acute respiratory infections, diarrhoea and malaria. Malaria is the most frequent cause of morbidity among adults, particularly pregnant women (UNICEF, 1991: 11).

5.3.1 General Structure and Organization of the BI¹³⁷

Kenya's BI centres on community action to accelerate access to basic primary health care. The BI was superimposed onto the Ministry's existing PHC program, which involved networks of community health workers, engaged in health prevention and promotion activities (first trained in 1982), and village health committees, responsible for the coordination of PHC activities. New BI activities related to community financing were essentially added on to the existing program (McPake et al., 1992: 77). The BI planning document acknowledges that government supported primary health care activities prior to the implementation of the BI were weak at best. Village health committees established to support local health action reportedly had few resources with which to implement specific activities. Their lack of resources, and lack of remuneration for CHWs limited the effectiveness of these workers and committees and led to a high drop-out rate. It was expected that the linkage between the village health committee and the CHWs would be strengthened by opening community pharmacies, with the CHWs trained to handle a small number of drugs for the most pressing health problems in the community (UNICEF, 1991: 10).

The BI strategy involves the collaboration of several sectors and levels of administration, but has a district and community-level focus that attempts to broaden the scope of PHC to include activities related to water and sanitation, immunization, nutrition, control of diarrhoeal diseases, malaria control and income-generating activities. The following is a description of the various actors' roles, as defined and understood by

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¹³⁷ This information is based on the UNICEF document entitled Community Financing of Primary Health Care: "The Bamako Initiative in Kenya" (UNICEF, 1991).

UNICEF and the Ministry of Health.

Community Level Involvement

The focal point of Kenya's BI is the community pharmacy. The pharmacy is the supplier of basic essential drugs for the most common health problems in the community. The community is responsible for setting aside appropriate space for a small store with appropriate conditions of cleanliness, storage and security. The pharmacy is community-owned and managed by an elected village health committee. The committee is generally comprised of six to twelve community members (elected according to the community's own customs), and usually includes representatives of groups with particular influence in the area of health, those who are known to be good organizers or whose educational level or other skills are compatible with committee activities. It was suggested that the committee should involve women, "because they and their young children have the most frequent contact with the health system," and that "the committee as a whole should be sensitive to the needs of women and children, particularly those from usually underserved or deprived sections of the community" (UNICEF, 1991: 9). The main functions of the committee are to:

- a) help identify and prioritize the health problems in the community;
- b) help identify community resources and coordinate them in planned activities aimed at overcoming health problems;
- c) help select community health workers and provide administrative support for their work;
- d) provide a channel of communication between the community and the health and development committees at the divisional level;
- e) help monitor the health status of the community as the basis for continued health activities;
- f) initiate and help manage communal income-generating activities for health; and
- g) identify those in the community unable to pay for health care and provide alternative payment for their health care costs (UNICEF, 1991: 18).

Community health workers (CHWs) have the key role in implementing health activities in the community, and usually comprise women from the community.¹³⁷

CHWs are trained in the following areas:

- a) curative care for priority health problems of the community, including malaria, diarrhoea, worms, conjunctivitis, anaemia, scabies and fever;
- b) home visits to mobilize families towards better health habits, including immunization;
- d) counselling on home improvements, including proper storage in the home, use of latrines and the safe disposal of household waste;
- e) counselling on family planning practices and community distribution of contraceptives;
- f) promotion of kitchen gardens to provide additional food varieties to the diet, particularly for children;
- g) registering of births and deaths in the community, as well as keeping a record of all curative and preventive activities engaged in; and
- h) keeping a record of money obtained from the sale of drugs (UNICEF, 1991: 19).

Activities of CHWs and the committee are supported by the Ministry of Health at divisional and district levels. CHWs receive stocks from the community pharmacy and return revenues upon re-stocking. The CHW makes no direct profit out of drug sales, but benefits from a fixed incentive from the community fund, if determined by the VHC (UNICEF, 1991: 22). It was anticipated that following one year of operations, the community would be in a position to utilize revenue from the fund in a number of ways:

- a) to replenish essential drugs and supplies;
- b) to remunerate CHWs;
- c) to provide fuel for transport, required for supervision by the district;
- d) to participate in workshops/seminars; and
- e) to initiate and sustain income generating activities related to health (UNICEF, 1991: 30).¹³⁸

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¹³⁷ CHWs work in collaboration with a local team of trained traditional birth attendants, who are more peripheral to the BI structure in terms of level of involvement and participation in decision-making.

¹³⁸ It was expected that approximately 50% of funds generated through the sale of drugs would be required to replenish drugs and supplies, and the remainder would be used for both providing an incentive

District Level

District Development Committees (DDCs) are responsible for planning and coordinating all development work in a district. Health is seen as an intersectoral objective of development, and through the district development process, sectors coordinate activities which have a bearing on health. The District Health Committee is a sub-committee of the DDC which provides a forum for joint training, discussions and planning for primary health care activities.¹³⁹ A District Health Management Team (DHMT) is responsible for planning and implementing government health services in the district and for giving technical advice on all health matters. Functions of the DHMT include:

- a) to know and understand the substance and location of the major health problems in the district;
- b) to determine the action that should be taken to reduce these problems;
- c) to determine the availability of resources from the community, the different government sectors and NGOs;
- d) to prepare plans for the use of available resources in a coordinated fashion;
- e) to conduct training of trainers (health workers in health centres and dispensaries);
- f) to provide technical support and supervision to primary health care activities in the community; and
- g) to monitor implementation of the district health plan -- both the activities carried out and their effect on health status (UNICEF, 1991: 16).

The district therefore coordinates management of PHC activities and undertakes periodic supervision and training of VHCs and CHWs. The district is also responsible for the selection of BI sites in consultation with local community leaders. There are five main

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for CHWs and creating a local health development fund (UNICEF, 1991: 20).

¹³⁹ The District Health Committee is chaired by the District Commissioner and typically includes the District Medical Officer of Health, Agricultural Officer, Water Engineer, Education Officer, Information Officer, Social Services Officer, Transport Communications and Works Engineers and NGO representatives (UNICEF, 1991: 15).

criteria used for selecting sites: 1) the project satisfies a felt need of the community; 2) that there are ongoing PHC activities, preferably with an existing committee and CHWs; 3) the community is willing to pay for drugs and mosquito bed nets;¹⁴⁰ 4) the community is willing to set up and maintain a revolving fund and bank account; and 5) the DHMT has the capacity to supervise and monitor community initiatives (AMREF, 1994a).

Divisional Level

The Divisional Development Committee's jurisdiction covers a sub-division of the district, and is more closely linked to the community through its membership, which includes government workers from different sectors, party and religious leaders and leaders of women's groups. The committee often delegates responsibility for coordinating primary health care to a PHC Coordinating Team. This team has an operational role in planning development activities, such as the training and support of CHWs and maintaining contact with VHCs. It is also responsible for monitoring activities and reporting to the Divisional Development Committee.

National Level

According to Kenya's BI planning document, Kenya's Ministry of Health has met the guiding principles for the BI as recommended by the 38th Session of the WHO Regional Committee for Africa (UNICEF, 1991). A national commitment to the acceleration of universally accessible primary health care services was included in Kenya's National Development Plan for 1989-1993. The Plan strongly emphasized the government's

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¹⁴⁰ The sale of insecticide-impregnated mosquito nets is a unique feature of Kenya's BI, in an effort to enhance malaria control measures in areas characterized by endemic malaria.

commitment to PHC, for which community-based action was seen as central. The Kenyan government increased its share of financial support for PHC,¹⁴¹ and has shown dedication to strengthening its capacity to deal with PHC activities by forming a Primary Health Care Unit of the Ministry of Health. The unit is responsible for coordinating primary health care activities in the country, of which BI activities now form a central part.¹⁴² Finally, the government's adoption of the "District Focus for Rural Development Strategy" in 1983 was seen as an indication of its commitment to allocating resources to various health programs based on district priorities (AMREF, 1994a).

5.4 Policy Implications of the National Strategy

As shown above, the Kenyan BI represents a community-based health care model, because it rests ownership and control of the health intervention with the community itself (UNICEF, 1991). While Kenya's BI strategy is based principally on the supply and sale of essential drugs, its structure and organization embodies a process through which community-defined health activities can be organized and implemented. The conceptual framework of the Kenyan model allows for the incorporation of broad health priorities of communities in its promotion of community-defined communal income-generating

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¹⁴¹ Despite this stated emphasis, it is important to keep in mind that preventive and promotive services only receive approximately 20% of the recurrent health budget (Kenya ministry of health, 1994: 22). Internal allocations of the ministry of health's recurrent budgets continue to favour curative care in hospitals. Since 1979/80, hospitals have received approximately 70% of total recurrent expenditures (Kenya ministry of health, 1994: 10).

¹⁴² The specific responsibilities of this team include: a) reviewing and evaluating PHC activities with a view to identifying areas in need of strengthening; b) providing technical assistance and financial resources for PHC activities; c) promoting inter-sectoral collaboration in PHC at all levels; d) establishing and maintaining relevant guidelines for the implementation of PHC; e) liaising with WHO, UNICEF, other international agencies, such as USAID and the World Bank, bi-lateral agencies and NGOs on matters relating to PHC development; and f) maintaining a data base on PHC development and providing quarterly and annual reports on progress (UNICEF, 1991: 15).

activities for health. These may include such activities as the purchase of dairy cattle for milk production, development of fish ponds, poultry farming, the purchase of land for a collective farm, among others, and are geared as much towards food and income related priorities as they are to health in the narrow sense. Thus, while the BI's focal point is the community pharmacy, it is expected that the development of a self-sustaining revolving drug fund will act as a catalyst to build local capacity in shaping the direction of PHC.

As was discussed in Chapter Two, to be effective, community-based health care strategies require a concerted effort by planners, health professionals and health agencies to share information and collaborate with community members in clearly defining tasks involved, and to ensure that communities possess or obtain the resources required to fulfil their tasks (Rifkin, 1990: 26). Yet historically, the potential of PHC programs to meet community empowerment goals has not been realized due to inadequate reallocation of national health resources to rural areas, and a concomitant lack of training and supervision of local populations to effectively organize and manage PHC programs. Implicit in Kenya's BI strategy is the assumption that Kenya's health care system provides an enabling, or "community-supportive" environment in which the BI can flourish. The purpose of this section is to explore the conceptual framework of the BI in relation to the structures and processes which characterize Kenya's formal health system.

5.4.1 Kenya's Health System: Community-Supportive?

While self-reliance of communities is a key objective of Kenya's BI, district level

support, particularly in the area of monitoring and supervision, is seen as essential to ensure the sustainability of the BI. Effective implementation of the BI therefore requires that district level health personnel have sufficient skills, and are accorded resources and decision-making power such that they can fulfil their tasks. This section will show that despite the Kenyan government's stated commitment to the acceleration of universally accessible primary health care services, particularly through the reallocation of resources to various health programs based on district priorities, an inadequate proportion of government resources have been channelled to the district level for primary health care. A profile of the structure of the health care system serves to illustrate this point.

In Kenya, there are three tiers in the "modern" health system: private services, non-governmental services, and government, or public health services administered by the Ministry of Health. The public health sector forms the bulk of "modern" health services, accounting for two-thirds of Kenya's hospital beds and four-fifths of its rural health facilities. In 1985, the Ministry of Health operated 80 hospitals, 245 rural health centres, and 1,032 rural dispensaries (Bloom and Segall, 1993).¹⁴³ Despite the large number of rural health centres and dispensaries, the distribution of resources remains heavily skewed in favour of urban, curative care. For example, in 1989, only 20% of the population was effectively covered by the government health services, and

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¹⁴³ Private services are offered on a fee-for-services basis, and cater mainly to the more affluent social groups in urban areas who are already enjoying better health. These services do not touch the majority of the population, for which low cost preventive and curative interventions can result in the greatest health benefits (Bloom & Segall, 1993: 65). Non-governmental organizations provide approximately 1/3 of hospital beds in Kenya. Although they cater to a great extent to the rural population, they also require fees for service, and as such they exclude a large portion of the most marginalized groups, particularly female heads of households (e.g., McPake et. al., 1993).

approximately half the population had no access to public health services (Dahlgren, 1990). One way of determining accessibility to "modern" health care is to examine the ratio of doctors to population: in 1984 the ratio in urban areas was 1 doctor per 1,600 people, but in rural areas it was only 1 in 17,000. Even these figures do not clearly express the disparity between different regions. For example, in Nairobi, the capital city of Kenya, the ratio increases to *1 in 500*, while in the Turkana district, where the population is primarily nomadic, the ratio decreases to *1 in 160,000* (Dahlgren, 1990: 69).

While doctors in and of themselves may not be a priority for rural areas,¹⁴⁴ the large number of doctors in urban and provincial hospitals has had negative implications for the distribution of resources that the Kenyan government provides at the local level in rural areas.(WHO, 1979). Salaries of doctors and trained personnel who work primarily in urban centres or district hospitals have absorbed the lion's share of the Ministry of Health's (MOH) recurrent expenditure. This focus has resulted in fewer funds being available than necessary for primary health care services. Only 15% of total government expenditure on health was allocated to rural and preventive/promotive health services in 1983/84 (Bloom and Segall, 1993: 27). While the government has increased its financial commitment to these services since then, they still only receive approximately 20% of the MOH's budget allocations (Kenya Ministry of Health, 1994: 22). Thus, at the district level, health services have been known to be seriously short of supplies, equipment and

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¹⁴⁴ PHC is based on the premise that the services available should prevent context-specific health problems at a reasonable cost to the community. Personnel that can deal adequately with rural health problems might range from trained community health workers or traditional birth attendants that are members of the rural population, to registered midwives or nurses.

transportation for outreach activities (Bloom & Segall, 1993: 23). A large proportion of professional staff in the field of health promotion and disease prevention lack the means to do their job because of these shortages (Dahlgren, 1990).

The Kenyan government has recognized that there continues to be a gap between the formal health system and the health initiatives that have been developed at the community level, such as the BI (Kenyan Ministry of Health, 1994: 21). In Kisumu District (the District in which the Sigoti BI site is located), lack of funds to the District health level causes serious operational constraints, limiting the effectiveness with which the DHMT can fulfil its roles in coordinating, supervising and monitoring PHC activities, including BIs (Personal Interview, Hospital Secretary, 1995). The District requires transport to the community primarily for deliveries of drugs and supplies, and for its supervision and monitoring activities. The community is usually not required to pay for fuel or the vehicle, with the exception of unusual events (e.g. if the community wants to observe the operations of another BI site in Kisumu, it must find the funds for transport). The main problem with this system arises from the chronic shortage of funds the District has to work with to fulfil this, and its other roles. The District generally uses its entire six month budget allocation for recurrent expenditures from the Ministry of Health within a period of two months. The effect is that the DHMT has to rely on cost-sharing money (facility improvement funds) generated at health centres to meet costs for eight months of the year. As a result, there are insufficient resources to meet the demand for drug supplies and dressings, and its outreach activities to community-based health care (CBHC) programs like the BI are severely hindered (Personal Interview, Hospital

Secretary, 1995).

The implications of this for communities initiating BI programs are manifold. Implicitly recognized in the BI strategy is the inability of the District to fulfil its support roles in the BI. As noted in section 5.3, it was expected that within one year of operations, revenue generated from the community pharmacy would go towards providing fuel for supervision by the district, and to participate in workshops/seminars. Burden is placed on the community to fund recurrent health expenditures that are the responsibility of the district. However, elsewhere in Kenya these activities have been shown to be too costly for communities to sustain through use of their own resources. For example, a case study of a community-based health care project in Chogoria, Kenya, showed that major financial assistance was required by international donor agencies from the time community health activities began to expand. Staff salaries, cost of transport for delivery of supplies and supervision, and other overhead costs were major items of expenditure in programme budgets that could not be financed by local sources. A central point brought forward in the study was that frequently the full cost of running programmes is never calculated, because the expatriate workers, equipment, commodities and transport donations are not included in programme costs. As a result, many programmes have collapsed because insufficient attention has been paid to long-term viability after external donor contributions have ceased (Deboer and McNeil, 1989).

A key point to illuminate in the context of the BI is that district support of communities is dependent upon the community pharmacy's ability to achieve cost recovery, and is therefore quite volatile. As shown in section 5.2 of this chapter, local

capacity to finance health care through the BI is questionable. To expect the community pharmacy to generate enough revenue to ensure the steady flow of drugs and supplies, remunerate CHWs, sustain income generating activities, in addition to financing its own supervision and monitoring is therefore a substantial leap of faith. In fact, an early evaluation of the BI in Sigoti showed serious potential problems with regard to cost recovery due to low sales levels (McPake et al., 1992: 81). This does not preclude the possibility that other pharmacies may achieve cost recovery. But it does point to an inherent problem associated with allocating unearned revenue to mandatory program expenses. Kenya's BI strategy does not incorporate mechanisms to deal with problems associated with cost recovery, should they arise. As district level responsibilities are so essential to sustain the BI, the fact that these costs are not explicitly accounted for in either the *MOH's or UNICEF's budget* represents a lack of realistic resource planning for communities implementing the BI.

Chapter Six explores how weak linkages to the district have impacted on the local level functioning of the BI in Sigoti. The next section explores the discourse around gender in the Kenyan BI strategy.

5.4.2 BI Discourse and Gender in Kenya: A Panacea for Women?

The Kenyan BI strategy targets women in two main ways. First, by bringing treatment closer to the homes of women in the community, it is assumed that health care will be more accessible to women (and children), through lower cost for treatment and less time required to obtain treatment (prior to the establishment of the BI one of the key barriers to women's access to care noted by the Ministry of Health was the high cost and

time required in travelling long distances to obtain treatment for themselves and their family members).¹⁴⁵ Second, many of the health activities promoted through the BI are geared specifically towards enabling women to carry out their domestic tasks more effectively. Health and nutrition education tends to be geared to women and children, and income generating activities promoted generally involve food and income-related priorities of women. Where these activities mirror the interests of local women, and enable them to reap the benefits of participation (such as increased income, time saved, improved nutrition for themselves and their families, among others), the intervention could constitute a process through which women can take greater control over their own development.

Chapter Two noted that one of the key reasons for the failure of PHC programs to develop and sustain broad-based participation has been the failure by planners to look for and define community diversities, power groups and basic social, political and economic inequalities which perpetuate local power struggles and domination by elites, and limit the extent to which marginal groups, such as women, participate. Experience from community-based health care in Kenya demonstrates that male community members have tended to predominate in forums that influence the nature of PHC activities, such as the village health committee.¹⁴⁶ This has been attributed to the process through which the community has been mobilized for health activities. Planners have generally approached

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¹⁴⁵ As noted in Chapter Five, in 1989, only 20% of the population was effectively covered by government health services, and approximately half the population had no access to public health services (Dahlgren, 1990).

¹⁴⁶ See for example Johnson et al., 1989; Jacobson et al., 1989; Kaseje & Sempebwe, 1989; and DeBoer & McNeil, 1989.

village leaders or chiefs to orient them to the idea of PHC, and have invited them to assist in the process of defining their problems and finding ways to solve them as a community (e.g. Kaseje and Sempebwe, 1989). The subsequent formation of village health committees has typically excluded women from participating, because they have been identified as public forums through which key development decisions are made. This finding is not surprising, given that in Kenya, with the exception of some women's local organizations in Kenya, which have been instrumental in enabling women to gain control over resources and direct development efforts for their own purposes (e.g. Stamp, 1986; Mackenzie, 1987), men have traditionally dominated in public, political spheres of village life (Thomas, 1989).

Women's historically peripheral status in key decision-making health forums is somewhat incongruous with their predominance in the implementation of health-related activities. Women in Kenya have traditionally been keenly interested in health issues, and have been actively involved in health promotion activities through their involvement in women's associations (e.g. Jacobson et al., 1989). Earnings or capital from women's groups have frequently been used to finance iron sheets for roofing, water storage tanks, school fees, cows, goats and household utensils or furnishings, all of which have direct or indirect effects on the well-being of women and their families (Thomas, 1989). Further, women have tended to predominate in roles as community health workers, who perform a variety of health promotive and limited curative functions on a voluntary basis (Deboer and McNeil, 1989; Jacobson et al., 1989; Johnson et al. 1989).

The BI, in theory, attempts to redress these past imbalances. Participation of women

in the BI is seen as necessary to ensure that their interests are accounted for, and incorporated into the health development process. As noted in Section 5.3, planners emphasize that the committee should be sensitive to the needs of women, and should include women as members. The Kenyan BI model could conceivably empower women through the health development process, through their active involvement in defining health priorities, and in managing and implementing PHC activities that reflect these priorities. Further, despite the voluntary nature of the work of CHWs, their work is valued in the strategy. This is indicated by the recommendation by planners that CHWs should be rewarded in some way for their efforts. It is recognized that compensating CHWs for their work enables them to carry out their responsibilities more effectively (and is necessary to combat the high drop-out rate of volunteer CHWs).

But despite the lipservice given to women's contribution in the successful implementation of the BI in Kenya's BI policy, no real mechanisms are in place in the strategy to ensure that women's interests will be accounted for. Kenya's BI planning document states that the pharmacy committee should be elected "*according to the community's own customs*" (UNICEF, 1991: 9, my emphasis), and that CHWs will benefit from the community fund, "*if determined by the VHC*" (UNICEF, 1991: 22, my emphasis). By placing ultimate responsibility on the communities involved to ensure that women's voice will be represented and needs accounted for through the BI process, planners essentially fall into the same trap of past PHC efforts, which have implicitly assumed that PHC is apolitical, minimizing or ignoring the effects that local power hierarchies may have on women's equitable participation. As discussed in Chapter

Three, the value both planners and communities place on women's involvement in the PHC process -- that is, whether women are empowered in their roles as health care providers and beneficiaries of PHC programs, through increased knowledge, resources, compensation and influence over the direction of health activities -- is an indication of whether authentic participation of women is sought (Muhondwa, 1986; Matomora, 1989; Mburu, 1994). Kenya's BI strategy does not effectively address issues of gender equity in its conceptual framework. As will be shown in the next chapter, the failure of the BI strategy to institutionalize incentives for CHWs, and its failure to ensure that women's interests are effectively accounted for through their full participation in BI-related decisions, have been key sources of the lack of efficacy with which the Sigoti BI site has met its objectives.

Chapter 6: The Bamako Initiative in Kenya: Appropriate for Women? Building on Experiences in Sigoti

6.1 Introduction

In this chapter, I explore the local level response to the Bamako Initiative in the Sigoti community in Kenya. Chapter Five described the international and national institutional contexts which have shaped the development of the BI in Sigoti. Of course, how the BI functions at the district level and in various communities is a function of the relationships between the particular actors involved. Each district and community is characterized by particular economic circumstances, distinguishing geographic, demographic and cultural characteristics, as well as unique social and political dynamics. By building on the experiences of the research participants, my analysis of the Sigoti BI explores how the relationships between the international and national contexts and the local level response to them in Sigoti have shaped its health development, with specific attention to women's relationship to this process. Whether the Sigoti Location BI site has enabled women to take greater control over their health development, through increased access to knowledge, resources and decision-making power, is central to my analysis.

This chapter is divided into four main sections. Section 6.2 situates the BI in its local context in Sigoti, by providing a brief profile of the Sigoti community, and tracing the historical context which led to the establishment of the BI there. Sections 6.3 and 6.4 specifically explore women's relationship to the BI. My analysis considers the experiences of community health workers (CHWs), traditional birth attendants (TBAs) and that of women in the community-at-large separately, because CHWs and TBAs have

unique relationships to the BI, through their special roles in BI management and implementation.¹⁴⁷ In section 6.3, I consider how women have been incorporated into the BI management and implementation process through their roles as CHWs. Of all women in the community, CHWs are those most likely to be "empowered" through the BI, through their increased knowledge of health issues gained through training, their participation in its management and implementation, and their corresponding accessibility to the services it provides. Section 6.4 addresses whether the BI has enabled TBAs to meet women's reproductive health needs more effectively, and whether their voice has been incorporated into BI-related decisions. In Section 6.5, I consider how the BI process has impacted on women in the community, generally speaking. I separate their experiences in this way for conceptual clarity, recognizing that the small fraction of women in the community who take on roles as TBAs, CHWs, or pharmacy committee members, also share many common life experiences and face the same common health problems as other women in the community. Their unique interests which derive from their special roles in the BI are interwoven with the health-related interests they share with other women.

6.2 Situating the BI in its Local Context

The purpose of this section is to provide a brief profile of the Sigoti community, and to describe the historical context which led to the establishment of the Sigoti BI site in September of 1989.

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¹⁴⁷ Factors such as geographic distance to the Sigoti BI site, socio-economic status, age, etc., also influence women's relationship to the BI.

6.2.1 Profile of the Sigoti Community

Sigoti is a large community with a population of approximately 70,000 people, located in Kisumu District, Nyanza Province in western Kenya. It is comprised of five sub-locations, including Ramogi, Koguta, Kadianga East, Kadianga West and Kajimbo (these represent the smallest administrative units next to the village). The community is predominantly Luo, the second largest ethnic group in Kenya. A few defining characteristics of the Luo ethnic group include the following: (1) the Luo have to a great extent maintained their traditional land tenure practices,¹⁴⁸ and, generally speaking, they oppose the idea of a land market in which lineage land can be permanently alienated through sale to outsiders (Shipton, 1992: 365); (2) land is considered a permanent family asset essential to lineage survival, as it consolidates one's place in the social order and maintains a link with ancestors; and (3) patrilineal and ethnic group ties and customs characterize Luo culture, dictating a lineage system through which men inherit land from their fathers, and women get use rights as wives and daughters (Shipton, 1992: 375; Okeyo, 1980: 188). Women's role as producers and mothers of sons is crucial to the maintenance of the Luo patrilineal system and the familial mode of production; as such, the Luo have historically tended to be polygynous and have several children (Parkin, 1978; cited in Gordon, 1995: 896; Okeyo, 1980: 191).¹⁴⁹

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¹⁴⁸ According to Achola Pala Okeyo, traditional Luo customary land tenure can be described as corporate, whereby proprietary rights in land reside with a group, as opposed to with individuals. Individual men and women have a multiplicity of use rights to land which are wide-ranging and well defined (Okeyo, 1980: 188).

¹⁴⁹ Polygyny is less prevalent among the Luo today, but is still practiced (Personal Interview, PHC Coordinator, 1995). As Margaret Jean Hay notes, labour, not land, was the limiting factor of production for well into the early colonial period, and this contributed to the high social value of polygyny and the desire for numerous offspring. Women's labor was the critical element in determining the standard of living of

The main sources of income for members of the Sigoti community are farming, handcraft production and small scale industries, such as bakeries and brick manufacturing. The majority of the population have low income and inadequate food supplies¹⁵⁰ (malnutrition significantly contributes to pre-school deaths), supply of water is poor, and latrine coverage is low (AMREF, 1994b).¹⁵¹ Literacy rates for Kisumu district are estimated to be between 40-70% for males and 30-50% for females (AMREF, 1994a).¹⁵² Infant and maternal mortality rates in this district are of the highest in Kenya (AMREF, 1994a).¹⁵³ Common diseases in Kisumu district include malaria, acute respiratory infections, diarrhoeal diseases, intestinal worms and skin disorders. Malaria is the leading cause of morbidity and mortality (particularly among children and

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the household, and as such, marriage represented the most significant form of investment for a man (Hay, 1976: 93). Today, increasing pressure on the land means that land has become a significant limiting factor of production, thus reducing the prevalence of polygyny and the desire for several children.

¹⁵⁰ Women are primarily responsible for cultivating food crops in Sigoti. What seems to be a general trend in Sigoti has been reported elsewhere among the Luo in Kenya. Women's use land primarily for subsistence-crop production, but sell some produce in order to raise cash for the purchase of household goods. Some land is also used for grazing livestock (Okeyo, 1980: 207). Women also grow some cash crops, including sugar cane, cotton, sweet bananas and pineapples, mainly for sale in local markets.

¹⁵¹ Information gained from the household survey in Sigoti supports this claim. Eighty per cent of respondents stated that the round trip to the nearest water source takes over two hours during the dry season (but this figure drops to less than 30 minutes during the wet season); a latrine was not available in 21/48, or 44% of respondents' households. Sixty-six per cent of respondents ranked clean water, food or proper sanitation as their number one priority health need.

¹⁵² The household survey supports this claim. Fifty-two per cent of women had no formal education, and thirty-eight per cent had primary education only.

¹⁵³ According to Kenya's 1989 demographic and health survey, the infant mortality rate (IMR) for the period 1984 to 1989 was 60 deaths per 1,000 live births. However, these rates fluctuate greatly depending on both region and area (i.e., urban vs. rural). The survey suggests that the IMR is highest in Coast Province, at 107 deaths per 1,000 live births (National Council for Population and Development, 1989: 14-15). Kisumu District's IMR is located at the high end of this continuum. With respect to maternal mortality, in Kenya, women are faced with one of the highest maternal mortality rates in the world, at over 500 per 100,000 births. Further, the probability that a woman will die in her lifetime due to pregnancy and childbearing is greater than one in twenty-five (Uyanga, 1990). Pregnancy and childbirth thus pose great risks to women in their reproductive years.

pregnant women); other causes of chronic morbidity include anaemia and malnutrition (AMREF, 1994a).¹⁵⁴ The problems which lie at the root of the poor health status of women in Sigoti parallel those of women in other rural areas of Kenya, generally speaking. Poor nutrition and lack of food lead to anaemia, exhaustion and a general wearing-down, particularly as women continue to perform heavy manual agricultural work in addition to all other household tasks throughout pregnancy and lactation (Raikes, 1989: 448).¹⁵⁵ The next section traces the historical development of community-based health initiatives in the Sigoti community

6.2.2 Historical Development of Community Health Initiatives in Sigoti¹⁵⁶

Community-based health care has been in operation in Sigoti since 1984, when approximately 100 women from its five sub-locations were trained by the district as volunteer community health workers, to teach community members about basic health preventive and promotive measures.¹⁵⁷ In addition to making home visits, CHWs

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¹⁵⁴ Through the focus group discussions with CHWs and TBAs, it became clear that the impact of the AIDS epidemic in Kenya has been felt by the Sigoti community. Comments by CHWs regarding the prevalence of orphans in the community, as well as the reference by TBAs of their risk of contracting dangerous diseases while assisting women in childbirth, were indications of the prevalence of AIDS in the community.

¹⁵⁵ Responses of women to one of the qualitative questions included in the household survey are consistent with Alanagh Raikes' assertion. In response to the question "what are the most common health problems that confront women in your community?", the most frequently noted problems were body aches (backache, legs paining/swelling, or body ache), malaria, and problems related to women's reproductive health (gynaecology, obstetrics, abdominal pains, haemorrhage, or stomach ache).

¹⁵⁶ I refer here to primary health care as conceived of internationally. A weakness of this study was its failure to consider how use of indigenous healing methods have historically interacted with "formal" primary health care services accessible to the Sigoti community, or how the introduction of the BI transformed this relationship.

¹⁵⁷ Women's group leaders who participated in the focus group discussion stated that each village selected two women for training. At this time, a number of traditional birth attendants (TBAs) were also trained in safe methods of delivering babies, in identifying women at risk of complications, and in basic antenatal care. Training was conducted locally, at the Sigoti Health Centre.

taught prevention in schools and women's groups. Due to the time-consuming and arduous nature of the work,¹⁵⁸ which offered no tangible benefits to women for their participation, approximately 75% of the CHWs dropped out of the program prior to the completion of the entire training process, which occurred over the course of three years. However, a core group of 24 CHWs committed to primary health care goals remained active in their health activities, and sought ways to sustain and enhance their roles as health care providers. In 1986 they registered their group with the Ministry of Social Services under the name *Sigoti Community Health Workers Project*. Members contributed Ksh20 per month towards the purchase of "simple drugs" for the main health facility serving the Sigoti community, the Sigoti Health Centre, in order to reduce the common shortage of drugs and supplies at the facility. Sigoti Location was selected by the DHMT as the first Bamako Initiative site in Kenya, because of the history of active community health work in Sigoti, and because there was a felt need among community members to improve the supply of drugs and supplies to Sigoti. In 1988, both the active 24 CHWs and a community-elected pharmacy committee representing all sub-locations were trained by UNICEF and the Ministry of Health in managing a BI site.¹⁵⁹

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¹⁵⁸ CHWs were expected to spend approximately two days per week engaged in these activities, in addition to all of their other domestic responsibilities. Further, Sigoti is characterized by rough terrain (hilly, swampy areas). Travelling from household to household is therefore quite arduous.

¹⁵⁹ The Sigoti BI site operates somewhat differently than other BI sites in Kenya. While most BI sites in Kenya are operated at the sub-location level, the Sigoti site is operated at the locational level. The pharmacy committee includes representatives from each sub-location. The pharmacy committee is responsible for essential drugs management and making decisions regarding the use of funds generated at the pharmacy. Each sub-location also has a village health committee (VHC), which is responsible for defining its sub-location's health priorities and facilitating the development of preventive health activities. Members of the VHC are not necessarily represented on the pharmacy committee. Ideally, the VHCs and pharmacy committee would collaborate, such that BI-related decisions reflect the priorities of all sub-locations.

Two of the CHWs who participated in the CHW focus groups¹⁶⁰ describe the evolution of community health work in Sigoti, up to the establishment of the BI, in this way:

Why we became njamrerwas (CHWs) is that we were chosen by the villagers where we live. Why they chose us is because they had problems. There were deaths of children at all times. When a woman wanted to deliver, she could not get a good delivery, so all the villages sat down and had an agreement about what they could do. Then, after they'd agreed, they decided to choose the CHWs and take them to a course which is called the primary health care, so that the villages could get help, and that's why we became CHWs.

...When we started the project, we were many...we were about 100 people. So, only 24 people volunteered through thick and thin and they took over three years to be trained. After we finished the course we were doing at Sigoti health centre, we sat down as the 24 people and we talked on what we can do after the course was over...the community felt that people have problems in getting drugs since they go to the hospital, they're prescribed for drugs to buy, and they walk miles away to get the required drugs...We never knew that UNICEF would help us so we started by ourselves and bought drugs like Benzyl for scabies, and others, like for malaria, according to the diseases that we were trained for... After doing that we sat down and thought of what we could do because we saw that our money was little, that we could not buy many drugs to help all the villages... we wrote to UNICEF and when we wrote to them, they didn't even finish two weeks, but they came. Then they asked us questions and made a seminar for us and they found out that we already knew how to treat the diseases, and how to prevent them. This is when UNICEF brought for us help, by bringing for us drugs. Then we started the pharmacy as 24 CHWs.¹⁶¹

UNICEF provided the Sigoti BI site with a free supply of drug kits and bed nets.

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¹⁶⁰ As mentioned in Chapter Four, the CHWs who participated in the focus group discussions all belong to the core group of 24 CHWs originally trained by UNICEF and the MOH.

¹⁶¹ During the second focus group discussion with the CHWs, I asked the CHWs for permission to look at the minutes of the CHW and committee meetings on record at the pharmacy, to gain a greater understanding of the historical development of the BI. No one present objected to my request. The statement made by this CHW parallels the minutes of the CHWs - which documented the CHWs' desire to procure drugs.

Following the initial training of the committee and these CHWs, an additional 71 CHWs were trained to cover Sigoti Location.¹⁶²

The remainder of this chapter explores whether the Sigoti BI has acted as a mechanism for women's empowerment, enabling them to exert control over their lives and health in a more effective manner.¹⁶³ Whether BI discourse, and its practice in Sigoti, have incorporated or alleviated the historical constraints facing women in planning, implementing and managing PHC is central to my analysis.

It is important to note from the outset that despite the continuing enthusiasm and commitment of the original CHWs who established the BI, by 1993 the Sigoti BI had begun to experience a number of leadership and operational problems. Drugs were in short supply; meetings of the pharmacy committee, as well as those with CHWs were not being held regularly; reporting by CHWs had deteriorated, such that the chalk and board information system had been discontinued;¹⁶⁴ CHWs had begun to work independently of the BI structure, purchasing drugs at private pharmacies in towns and re-selling them to community members (factors underlying this outcome will be discussed in a later section); and there was some conflict over how the BI should progress (whether it should

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¹⁶² While less than 100 CHWs were trained, an estimated 300 CHWs are required to cover the entire catchment area in Sigoti (AMREF, 1994a).

¹⁶³ It was beyond the scope of this study to determine whether or to what extent the health of women has improved as a result of the establishment of the BI in Sigoti. While the study did address women's perceptions of the impact of the BI on their lives, the study's main focus is the BI process. It was my intention to gain an understanding of whether through the planning, implementation, and management process of the BI, women have been enabled to participate in and shape their own health development.

¹⁶⁴ The chalk and board display is a health information system used in the BI which compiles the bi-weekly reports that CHWs submit to the pharmacy committee. Among the information listed on a monthly basis is births and deaths, infant mortality, latrines built, latrines collapsed, water sources protected, number of immunizations, number of children weighed, new family planning acceptors, incidence of illnesses (measles, diarrhoea, acute respiratory infections, malaria, and worms), and funds banked.

be divided such that each sub-location managed its own BI pharmacy). No income generating activities had been initiated, and the BI (as envisioned by the Ministry of Health and UNICEF) had effectively ceased to function. As will be shown below, this outcome reflects the interplay of local level power struggles and resistances, some of which derived from gender relations, severe resource constraints, leading to problems associated with cost recovery, and weak and sometimes conflicting relationships between local and higher levels of the health system.

What is important to illuminate here is that women's relationship to the BI at the local level is both a product and a source of the breakdown in operations of the Sigoti BI. My analysis draws substantially on the group discussions held with the pharmacy committee, CHWs, TBAs, and women's group leaders. These discussions were characterized by contradictory statements made between groups participating, and in some cases among participants in the same group, deriving from both conflicts of interest between and among key actors involved in the BI management and implementation process, and from the uncertainty with which participants spoke about the underlying causes of the breakdown in the BI. In my analysis I attempt to bring meaning to these contradictions, and in doing so, produce an understanding of how the establishment of the BI has transformed women's relationship to the health development process in Sigoti.

6.3 Transforming Health through the BI: New Resource, Better Process?

The purpose of this section is to illuminate how the establishment of the Bamako Initiative in Sigoti transformed the relationship of CHWs to the health development process. Prior to the establishment of the BI there, membership of the Sigoti Health

Workers Project was comprised of an exclusively female group of committed community health workers. CHWs have a heavy stake in the discourse around health -- the health care activities they promote and engage in (nutrition and hygiene education, maternal and child health care) epitomize women's traditional roles in social reproduction, and seek to enable women to carry out these roles more effectively. As noted above, women's roles as producers and mothers of sons is crucial to the maintenance of the Luo patrilineal system. Further, motherhood provides the basic self-identity of Kenyan women (McAdoo and Were, 1987: 136). Community health work reinforced and legitimized women's autonomy in providing for their families. As two CHWs commented:

In this work, it makes people to see us as lamps put on the table due to the work we are doing, and that makes us happy wherever we are working. ...and the training we got makes us to be happy with our work. It also makes the people in the area like us because long time, if somebody was sick at midnight, it can be difficult to reach hospitals since some people live miles away, and if the CHWs come from the area, it makes people to get easy help.

Our husbands like this work because a woman who has been trained on CHWs has a sharper brain to maintain her staying with the husband and children. You can't get the children with runny noses, you can't get that there is no hygiene, and so, our husbands like this work very much...

Thus, prior to the establishment of the BI, CHWs had a strong sense of pride and ownership over primary health care, making community health work a key source of CHWs' authority and autonomy, both in the community and within their households.

CHWs remain central to primary health care provision in the BI; their contributions of labour represent the key means through which women are enabled to

participate actively in the BI.¹⁶⁵ Yet new relationships of power created through the establishment of the BI in Sigoti have effectively transformed CHWs' relationship to the health development process. The creation of a pharmacy committee to supervise CHWs and manage PHC, the addition of a "revenue component" to PHC, with specific emphasis on cost recovery, and the new relationships established between the BI in Sigoti to the district level of the health system, and the donor, have been integral to this transformation. As will be seen, while CHWs retained ownership over PHC through the BI, layers of structural dependency on key actors in the BI were created which essentially undermined their autonomy in the provision of health care.

6.3.1 Relationship between CHWs and the Pharmacy Committee

As mentioned above, prior to the establishment of the BI, community health was under the exclusive ownership of CHWs under the *Sigoti Community Health Workers Project*. While increased access to curative care had been identified by the community as a health priority, resources generated by the *Sigoti Health Workers Project* were insufficient to meet the supply of drugs required by the community. Activities of CHWs therefore focused primarily on health prevention and promotion, and while they received no tangible benefits from their work,¹⁶⁶ they did receive increased knowledge gained through training, and the esteem accorded to them by the community and their families for their strong commitment to primary health care.

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¹⁶⁵ Ninety-nine per cent of CHWs, and one hundred per cent of TBAs in Sigoti are women. The one male CHW in Sigoti is not one of the original group of 24 CHWs who formed the Sigoti Health Workers Project. Unfortunately, I was unable to meet with this CHW, and his voice has not been incorporated into the study.

¹⁶⁶ This was a key reason for the high drop-out rate of 75% of CHWs originally trained in the program.

With the commencement of the BI, curative care became a central component of the work of CHWs, and the focus of primary health care in Sigoti was transformed. The development of a revolving drug fund effectively elevated PHC's status from a community self-help endeavour aimed primarily at women in their domestic roles, to a viable economic development activity. PHC became associated with and legally bound to a tangible resource, the community pharmacy. Further, CHWs' labour became associated not only with altruistic efforts geared towards health promotion, but could now be appropriated for the purposes of material accumulation at the pharmacy. The community pharmacy created through the BI represented a means through which the community could "develop". If effective, the BI could generate enough resources to ensure the supply of essential drugs to the community, to reward CHWs for their labour contributions, and also to allow communities to organize income generating activities around pressing food and income-related priorities.

The pharmacy committee became the central organizational structure created to manage and ensure the sustainability of the BI, and to ensure that CHWs fulfilled their roles in both curative and preventive aspects of PHC effectively. As noted in Chapter Five, the BI pharmacy is community-owned and managed by the committee, which is responsible for assisting in the identification and prioritization of health problems in the community, identifying community resources and coordinating them in planned health-related activities, linking the community to divisional and district level health and development committees, and initiating and helping to manage communal income-

generating activities for health (UNICEF, 1991: 18).¹⁶⁷

While the pharmacy committee became ultimately responsible for the management of health resources, including drugs and supplies procured through the BI and the labour of CHWs, the processes embodied in the work of CHWs and the committee were interdependent. The success of the pharmacy depended upon the effectiveness with which CHWs fulfilled their responsibilities, particularly those related to their accountability to the pharmacy. Accurate reporting of drugs sales and cases treated by CHWs, and their commitment to returning revenue from the sale of drugs to the pharmacy, were essential to the sustainability of the BI. CHWs were also dependent on the pharmacy, because it represented an organizational body through which CHWs had to pass in order to act upon their concerns and interests.

It is important to note that despite these relations of interdependence, the commitment of labour required by CHWs far surpassed that of the committee. CHWs committed two full days per week to their health activities on a voluntary basis, and met as a group on those days to discuss any problems they were having in fulfilling their responsibilities.¹⁶⁸ Their meetings represented a private forum through which they could compare their reports and discuss potential solutions to problems, such as outbreaks of certain diseases, and also discuss potential use of funds, particularly related

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¹⁶⁷ Prior to the establishment of the BI in Sigoti, VHCs at the sub-locational level were responsible for coordinating PHC activities. With the establishment of the BI pharmacy, the pharmacy committee took on the key role in monitoring the work of CHWs, and managing curative aspects of the BI. VHCs at the sub-locational level became more peripheral to the PHC process, and were generally involved in bringing forth the interests of the various sub-locations related to health prevention and promotion.

¹⁶⁸ CHWs generally engaged in community health work on Tuesdays and Thursdays, which are non-market days in Sigoti.

to the initiation of income generating activities. As three CHWs explained:

When we meet in our CHWs meetings, the CHWs bring their reports from places where they walk in [do home visits], that, in the places they work in, how many [dish] racks have been built, how many children have been delivered in the homes, and the reports of sales of drugs. So those are the things we try to solve when we meet.

If we meet twice a week it makes us know the types of diseases that are reduced within the villages and also we get to know the diseases which have broken out, that can make us go and work hard in those areas...

When we could meet twice in a week...we could also bring the problems that the villages have, as women who came to help themselves, as we are also those who have children. We sit down and discuss how we can teach our children, or how they can get some knowledge. Those are some of the things we could learn the days we could meet. So that this project of ours could develop. We should get even some skills to build this project of ours...

In addition to meeting regularly, two of the CHWs (and one TBA) were responsible for the daily management of the community pharmacy, and were legally bound to it, through their roles as signatories to the pharmacy bank account. As will be shown below, this was a contentious issue, and met with much resistance by male committee members.¹⁶⁹ Therefore, with the establishment of the BI, CHWs retained a sense of collective ownership (in addition to legal rights) over primary health care. They perceived the pharmacy committee to be an advisory and supervisory body to their work. Two CHWs described their relationship to the committee in this way:

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¹⁶⁹ A point of clarification is required here regarding financial accountability in the BI. The CHWs who were responsible for managing the pharmacy on a daily basis, and who were signatories of the pharmacy's bank account, were also represented on the pharmacy committee. However, the pharmacy committee's executive was comprised of male elites. The CHWs represented on the committee were financially accountable to both the community-at-large, and the committee executive. Technically, although they were signatories of the bank account, they were not permitted to make use of funds generated through the sale of drugs without first consulting the entire committee. Similarly, the committee could not make use of funds without agreement by the community. Decision-making processes related to use of funds are detailed below

The pharmacy committee are people that we come together with *to help us make decisions* in what we can do (my emphasis).

The pharmacy committee are people who help us to make decisions that we can do, or *after we've passed a decision we have to inform them* and so they're the ones who pass it to the health centres and to the MOH office if there is something we can get (my emphasis).

The pharmacy committee met as required but quite sporadically, ranging from every two weeks to every two months.

While CHWs retained a sense of ownership over the BI, the "official" forum in which BI-related decisions were made was committee meetings. The channel through which CHWs participated in decision-making was therefore indirect, through their forwarding of their collective interests and concerns to the committee. Decisions were made on the committee through voting. While committee members were entitled to a vote, CHWs, as a group, were not. They expected that their interests would be accounted for, since the CHWs and TBA who were signatories of the pharmacy's bank account were represented on the committee. These CHWs have been represented on the committee since its formation in 1989, and women in general are equally represented (numerically) on the committee. At the time this study was conducted, seven of the twelve committee members, including three CHWs and a TBA, were women (see Appendix 3).¹⁷⁰

For a number of reasons, to be discussed below, despite the committee's proportional representation of men and women, the pharmacy committee failed to act as a support structure through which CHWs autonomy was reinforced or enhanced, or

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¹⁷⁰ The other women on the committee include two divisional TOTs and a teacher.

through which they were empowered with increased control over health-related decisions or resources. The next section discusses how the addition of a revenue component to PHC essentially undermined CHWs' autonomy in the health development process.

6.3.2 CHWs and the BI Management Process: On Ownership and Control

Barbara Thomas (1989) notes that in Kenya, women's associations in pursuit of the alleviation of poverty have historically been wholeheartedly endorsed by the government. They have been seen to constitute a "safe" commitment, as long as they stay within the boundaries defined by an extension of traditional female roles. While some women's associations in Kenya have been instrumental in enabling women to gain control over resources and direct development efforts for their own purposes (e.g. Stamp, 1986; Mackenzie, 1987), these have generally occurred in areas with a substantial resource base to allow women investment and ownership possibilities (Thomas, 1989).

The *Sigoti Community Health Workers Project* represented a "safe" association of women -- CHWs represented members of the community who were willing to sacrifice their time for the benefit of the community, and their work centred on women's assumed altruistic tendencies. As two of the CHWs explained:

...why we were chosen as CHWs was because at first we were selected from each village. They were looking into our characters and behaviours and the kindness that they [CHWs] could have. Then the villages took the people they chose to be trained as CHWs so that you can come back and help the community...

...when the CHWs were going to be chosen, there were rules that were set to be followed. At first, for you to be CHW, you had to be somebody who stays at home without moving to town. Secondly, you had to be somebody who never had problems with the villagers. Thirdly, you had to be somebody who could accept to encounter any difficulties. Fourthly, you had to be someone that volunteered, because according to this work,

it was to be done without any pay....Lastly, it was to be somebody who could go anywhere without discrimination.

Further, the capacity with which the group could generate funds was low, leaving it with no investment possibilities, and providing CHWs with no opportunity to expand their resource bases. In fact, the contributions made by CHWs each month towards the drug fund put pressure on their resource bases. Their work was "apolitical" -- it did not attempt to transform relations of power in the community -- as such, CHWs were allowed considerable autonomy in their roles.¹⁷¹

With the establishment of the BI, however, the new resource (essential drugs) available to the PHC program was perceived by community members to be a means through which the community could invest in its "development." Further, this resource was not directly linked to the means of production in Sigoti (primarily land and livestock), or to women's domestic activities, per se; it represented health technology accessible only through the community's linkages to macro arenas, such as the district and UNICEF. For women alone to reap the benefits from a much valued resource tied to macro structures would have been a digression from cultural norms in Sigoti.

It is not surprising, then, that the newly elected pharmacy committee's executive was comprised of men. When CHWs were asked why "many people in the pharmacy committee are men," two CHWs explained:

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¹⁷¹ There were village health committees in each area to supervise CHWs and coordinate PHC activities specifically related to health prevention and promotion, however, CHWs did not feel constrained by the existence of these committees. As one of the CHWs noted about their relationship with the VHC, "we are happy with the VHC, because they have to pass through us is when we agree on something....When we are visiting the homes, the VHC strengthens us and they also stress on what we are teaching. That they are good things. And they also try to find out if what we are saying is not true. So they try to follow-up what we are doing, if we are doing home visiting, and they connect us to the community."

Why many of the pharmacy committee members are men is because we thought they can have more information than us (women), so that they could help us to make decisions.

Why we chose men is because we thought that men are people who can get information from many places, so they can give us advice, and as men they can do difficult work very fast.

Men's greater access to and experience in dealing with public forums and "external agents to development" was seen by CHWs as integral to the successful management of the BI, particularly because for the most part, men on the executive were retired senior public servants with connections to government officials. As such, the men were also better educated than the CHWs, who had little formal education and no formal occupations. CHWs were not necessarily community elites, as one of the CHWs noted: "they [CHWs] don't have any means of earning income that can make them get some help for their homes..."¹⁷² Thus, while CHWs were represented on the pharmacy committee, they perceived their voice on the committee to be somewhat subordinate to the executive of the committee, who were well-educated elites. As one of the CHWs on the committee commented during the focus group discussion with the pharmacy committee, "...with the CHWs, we *are under the committee*"¹⁷³...(my emphasis)".

CHWs' willingness to have their interests represented by a male executive was not, however, met with a corresponding willingness on their part to forego their ownership over PHC. Gender-based conflict over use of funds between CHWs and the executives of the two pharmacy committees that held office since the commencement of

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¹⁷² The question asked which evoked this response was "Are there any CHWs amongst you who comes from homesteads where they're unable (to pay for treatment) or cannot get any help?"

¹⁷³ This CHW was referring to her position on the committee relative to the committee's executive.

the BI¹⁷⁴ was a key factor leading to the eventual breakdown in its functioning.

Conflict between the CHWs and the first committee executive derived from the resistance of the executive to CHWs' positions as signatories of the pharmacy's bank account. One of the CHWs describes the process leading to their establishment as signatories as follows:

When the bank account was being opened, there was a bit of problems between the committee [executive] and the CHWs, but we sat down and solved the problem, and people agreed that the CHWs became the signatories. So the problem was solved when Mrs. X [a district public health nurse] came and she said that this was a project started by women, and so the women should be signatories at the bank. So we sat down with the pharmacy committee and agreed....

Control over funds continued to be a source of conflict between the CHWs and the executive, and was manifested in men's resistance to participate in committee activities. One of the CHWs on the committee during the focus group discussion with the pharmacy committee explained:

At first, when we had the first pharmacy committee, there were so many problems and no agreements, because the pharmacy committee [executive] wanted to be the signatories for the money got from the pharmacy, and also, when meetings were called, they never attended.

By 1991, tensions between the executive and CHWs had grown to such proportions that CHWs requested an election to replace the existing executive. Disenchantment with the committee was outlined by the CHWs in a document produced at one of their meetings. The document (which was not dated) was entitled "The Problems Between Nyamrerwas [CHWs] and the Pharmacy Committee Official.," and read as follows:

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¹⁷⁴ The first pharmacy committee was elected in 1989, and the second in 1992. Both executives were comprised of men.

- 1) Since we held a meeting on the 19/3/91 and we asked for new election, they went for good. No meeting has ever been held since that time but the current office are only complaining to be back in the office.
- 2) There is no negotiation between the committee members. Some do make secret meetings and forward false minutes to the offices while others are not aware.
- 3) They are against our TOTs, they keep on writing letters to the offices about them.
- 4) They go out in search of other women's groups to come and join our project.
- 5) They don't know their role, they said that we Nyamrerwa have taken their role which they should play. So they should state their role.
- 6) We started the project as a women's group. We invited them as our advisory committee of the project of which they had done nothing to advise us to make the project move fast. Instead, some of them want to defunk our project into other projects.
- 7) They are only after money. We want election (Minutes from CHV Meeting, 1991).

CHWs therefore felt threatened by the committee executive: first, because of its desire to take control over funds generated at the pharmacy, and second, because of the perception by CHWs that the executive was purposely undermining their autonomy in the project. Conflict between the CHWs and the committee executive was clearly the product of a gender power struggle.

CHWs were effective in their lobbying, and by 1992, a new executive (again comprised of men) was elected. Three key factors accorded CHWs considerable support from and negotiating power with various actors in the BI (UNICEF, the district, divisional TOTs, community members). These factors were (1) CHWs' original autonomy in the PHC process and dedication to community health work, (2) their

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positions as signatories at the bank, and (3) their collective control over the labour process entailed in the BI. CHWs were indispensable to the effective functioning of the BI, and at that time, had been fulfilling their roles meticulously, reporting bi-weekly and returning revenue from the sale of drugs. By the end of 1991, Ksh 288, 269 (approximately CDN\$ 10,000) had accrued in the pharmacy's bank account.

It is important to note that while the conflict grew out of a gender-based power struggle over control of funds between the executive and the CHWs, CHWs located the source of this struggle with the particular men who held positions on the executive. CHWs did not question or challenge the asymmetrical gender relations which legitimized men's efforts to consolidate their knowledge and power to take control over the BI. As such, the second executive was also comprised exclusively of male elites. All other members retained the same positions they held on the first committee. (See Appendix Three for a list of committee members who held positions on the second committee.)

Gender-based conflict also characterized the CHWs' relations with the second committee executive, but with very different results. The conflict, from the perspective of the CHWs, was centred less on the executive's desire to take control over funds than it was on the committee's inaction over ideas and concerns put forward by CHWs. This conflict came out during the focus group with the pharmacy committee, in which both CHWs and members of the executive participated. It began with a claim by a CHW that the committee (executive) was not fulfilling its obligations to the project:

The new committee [executive] are the ones to give us [CHWs] guidance and advice so that we may develop but they don't do that. We've not seen any improvement. With the CHWs, we are under the committee and

because they can't give us help we don't see any development.¹⁷⁵

One member of the executive openly contradicted this claim:

What the CHW has said is not true because if a meeting is called the people (CHWs) don't turn up. You know that if letters are passed for the people to come for the meeting and they don't turn up, you feel bad. Somebody like me can always come at nine a.m. and leave at this time (3:00 p.m.). Same too, somebody like Mr. X, so we've always been coming and there is a let down...and somebody like me now gives up... So what has been disturbing us is that if we call the meetings the CHWs, the TOTs and the TBAs don't turn up. We would have liked that because [if] they're doing this work voluntarily and honourably they would have tried to come for the meeting because myself, Mr. X, and Mama Y comes here in the morning, and we too have our duties to do. And so, if you come maybe two or three times without meeting people, you give up, and so that is what has really been the main problem to us.

There is no doubt that there are "truths" in both the CHWs' and the committee executive's knowledge claims. The committee failed to act upon CHWs' ideas and demands (the nature of which is the subject of the next section), and the CHWs responded by failing to report, failing to return revenue earned from the sale of drugs, and refusing to meet both amongst themselves and with the committee. Further, they began to work independently of the BI, purchasing drugs in towns and re-selling them to community members (at a higher cost than those sold through the pharmacy). Reasons for these outcomes will be discussed below.

During the focus group with CHWs, CHWs presented the source of conflict to be their lack of voice on the committee. In response to the question "do you think that because some of the CHWs are members of the pharmacy committee, your problems are

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¹⁷⁵ The CHW then said something to the effect of the committee interfering with the CHWs at the pharmacy, however, this statement was unclear as her voice was blocked out by external noise (a goat outside the pharmacy).

solved?". the following discussion transpired between a number of CHWs:

That is what has been disturbing us, because even after we've decided something, they don't react to it, and that is what should be solved.

In the committee here, we still don't have power. I am one of the CHWs that is in the committee, but because men are there we give them their chance so that they're the ones who have to call the meetings. They're the ones to think of something, and so we can't do anything that they don't set to be done. I am a member there, but I can't.

What I can say as the chairlady of the CHWs, but even if we make a good decision that can be done for the CHWs, and if I go to the committee [executive], they don't do for us what the CHWs want, so that we can be strengthened in this work that we are doing. That makes us not happy with the committee [executive], who are men that we chose, that can give us a chance so that us too, we can have our rights as the CHWs. It [the project] was ours, but they are people who get for us information from different places and also pass the information to other people. The way we chose them as men, that is how we see it.

...why the work can't go on well depends on the men that we chose, because after the women have decided to do something, then they refuse or reject, so that makes the CHWs be not free and not happy with the work we are doing.

Despite CHWs' legal control over funds banked, they perceived themselves to be powerless to assert their rights over the use of funds:

...the CHWs, they cannot do anything using the money, even if they're the signatories, without the [pharmacy committee executive], so they have to inform the [executive]. They have to hold a meeting and know the amount of money to be withdrawn....it's a community thing, and so the CHWs don't have any power to withdraw money without contacting the [executive]...

Thus, CHWs located the source of conflict with the failure of "the men they chose" to advise them and to act upon their concerns. However, the executive saw the source of conflict in a different vein, placing the locus of responsibility on CHWs, for their lacklustre performance in fulfilling their obligations to the BI.

An important point to illuminate here is that the conflict between the CHWs and the second committee executive resulted in a very different outcome than that with the first. The second executive's inaction over CHWs' concerns (reasons underlying its inaction will be discussed in the next section) did not lead to a collective resistance, through which CHWs confronted the executive and effectively argued their case, as was the outcome of the conflict between CHWs and the first committee executive. When asked "what do you do if you had decided to do something but the committee does nothing towards it?", three of the CHWs explained:

What we do when the committee does nothing about what we decide is nothing, and this is why now our work can't move ahead...

Because they are people that we chose to help us in decision-making, if they don't respond to it, we just keep quiet.

Because it was a rule from UNICEF that we had to pass through them, and what they decide is what is to take place, so we too, there is nothing we can do, because the rule was from UNICEF that we must have a committee.

In the second case, CHWs perceived themselves to be powerless to take action. As a result, solidarity among CHWs deteriorated. The CHWs' perceived marginalization by the committee resulted in an outcome common to development initiatives which have served to undermine women's autonomy.¹⁷⁶ CHWs resisted marginalization by the committee by boycotting the project, and using the knowledge gained through their knowledge and the resources available to them (i.e. drugs) for their own ends

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¹⁷⁶ The means by which women have historically resisted development initiatives are included in Connelly et al. (1995). These include sabotage and general non-compliance, lacklustre participation in participatory schemes imposed from above, non-acceptance of technical advice and inputs; maintenance of shamanism and other spiritual practices which question the hegemony of scientific logic (Connelly et al., 1995: 27).

(Matomora, 1989; Carney and Watts, 1990).

While the breakdown in functioning of the BI was manifested in a local power struggle along gender lines between the CHWs and the second committee executive, the breakdown also reflected the many levels of dependency that were created through the BI management and implementation process. As will be discussed below, one of the key factors underlying CHWs' resistance to the project was the failure of their prospects for compensation to materialize. Despite their active efforts to obtain incentives for fulfilling their responsibilities effectively, the committee executive failed to consider this issue seriously. The independent selling of drugs by CHWs was a means of resistance with some immediate economic benefit to them. The next two sections will show that while failure to compensate CHWs was in part a product of the de-valuing of CHWs' labour contributions by the committee executive, the prioritization of cost recovery by various actors in the BI was also a significant factor contributing to this outcome, effectively overriding CHWs' articulated gender interests for compensation. The comments of the CHWs cited above reveal a critical external parameter which influenced CHWs' perceived (and real) ability to act upon their concern -- their dependency on the donor, UNICEF.

6.3.3 The Politics of the Labour Process in the BI: Whose Time, Whose Money?

Prior to the establishment of the BI in Sigoti, CHWs' labour (and material) contributions to PHC were centred on altruistic goals of improving the lives of women and their families, and no tangible benefits accrued to CHWs themselves for their participation. This resulted in a high drop-out rate of CHWs; only 25% of CHWs had

remained loyal to their responsibilities. With the commencement of the BI, CHWs' labour could be appropriated for the purposes of material accumulation at the pharmacy, but CHWs were also informed by UNICEF of the possibility that they would receive tangible benefits from their participation, primarily in the form of an incentive for their efforts. As one of the CHWs commented:

The way you see the CHWs sitting down here, there's no income that they get from anywhere. In any case they get any income, it's just from their husbands....when we started this work, it was said [by UNICEF representatives] that we could be given 10% of the work we do (sales).¹⁷⁷

While compensation had been an issue for CHWs since the establishment of the BI, the conflict between CHWs and the executive had precluded them from obtaining any form of incentive for their efforts. Further, the CHWs responsible for the BI were the same ones who had been loyal to the PHC project without compensation since their initial training in 1984. So despite the continued voluntary nature of their work, CHWs had remained accountable to the pharmacy committee, reporting and returning revenue generated from drug sales regularly.

In 1992 the second pharmacy committee was formed. CHWs expected that the new committee executive would be more sensitive to their interests than the first had been. By 1992, the Sigoti pharmacy had generated a significant amount of revenue from the sale of drugs, with 1992 being the year in which the most funds were banked.¹⁷⁸

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¹⁷⁷ According to the BI planning document (UNICEF, 1991), CHWs were to receive a fixed incentive for their efforts. However, it appears that CHWs in Sigoti understood that they could be compensated in terms of a percentage of their sales.

¹⁷⁸ By 1991, an additional 71 CHWs had been trained for the project, which is one of the reasons why funds banked in these years were the highest. When it became apparent that CHWs would not be receiving

The breakdown in funds banked as at November 1994 is listed in Table One on the next page. The increase in revenue generated starting in 1991 was a result of drug sales by an additional seventy-one CHWs who had been trained for the Sigoti BI in 1991. These CHWs participated under the assumption that they would be given some form of incentive for their work. As such, CHWs' demands for compensation increased with the formation of the new committee in 1992 (as noted in Chapter Five, it is a provision in the BI that CHWs receive some form of compensation *if determined by the committee*).

Problems regarding reporting and returning revenue to the pharmacy arose following the realization by these CHWs that they would not get compensation for their work.¹⁷⁹ As one of CHWs on the committee noted during the discussion with the committee:

Why the meetings are being called and people don't come...the first one is they just work without pay and they get nothing. That's why they don't turn up for the meeting. So, they wanted some allowance so that they're encouraged and when, considering the money we have in the savings, we thought if we give them allowance regularly as they wanted, that money

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compensation for their efforts, CHWs began to resist marginalization by failing to report or return revenue generated from sales, and began to work independently of the BI structure.

¹⁷⁹ According to the CHWs who participated in the discussion, it was primarily the 71 additional CHWs who were responsible for the problems associated with accountability for revenue from drugs and reporting. One of the CHWs stated that "when we started it [the BI], it was very good because we liked it and we made sure that we brought the reports in every single week. And the money was brought to the pharmacy on Tuesdays and Thursdays... They [the additional CHWs] were trained just a bit and then they joined us so that the drugs could not expire because there were too many for us to sell. So after the 71 had joined the 24 CHWs is when the problems like having business with drugs came about. Now the reports also were not being brought like how the 24 could do it. So I'm sure that the reports of the 24 CHWs are the ones which can be found in the pharmacy, and very few new CHWs who are hard-working also brought the reports. But some people have never attempted to bring back the reports...". Thus, the new resource accorded to CHWs in the BI led to a different form of resistance by CHWs to the appropriation of their labour. Before the BI, no personal or material gain could accrue from participation, and CHWs simply dropped out of the program; after the BI, CHWs' new skills in treatment could be used for personal material gain, so CHWs continued to participate, albeit outside of the BI structure.

would be finished up, and so when they heard that they weren't going to get an allowance at any time, then they sit back, we don't get (a high turn out), at least when we call a meeting, that was a sweeping statement. At least we are to get a quarter of them (a quarter of them to show up), but we don't get the entire or a half.

TABLE ONE: FUNDS BANKED AS AT NOVEMBER, 1994	
YEAR: 1989	AMOUNT: Ksh 18,193
1990	Ksh 67,516
1991	Ksh 232,560
1992	Ksh 295,135
1993	Ksh 129,690
1994	Ksh 3,000
TOTAL	Ksh 736,094

Source: 1994 Rapid Appraisal (AMREF, 1994)

Thus, despite the substantial revenue generated at the pharmacy by 1992, the committee was unwilling to allocate any amount of the funds to CHWs, the outcome of which was illustrated in the previous section.

What I wish to illustrate in the remainder of this section is that this outcome is in part a product of the executive's insensitivity to the realities with which CHWs were expected to fulfil their obligations to the BI. The next section will deal with another important issue that influenced this outcome -- cost recovery. The executive failed to give attention to the implications of three important factors related to CHWs' participation in the BI in its decision not to compensate CHWs: namely, the opportunity costs to CHWs of their participation in the BI, the influence of intrahousehold relations on CHWs' accountability to the community pharmacy, and the pressure placed upon

CHWs to deal with members of the community unable to pay for treatment.

As noted in section 6.3.2, CHWs in Sigoti generally do not fall into the category of "elites." They face the same challenges as many other women in the community, struggling to meet daily requirements for survival for themselves and their families. Their obligations within the household are manifold. As one of the CHWs noted:

Women are people who have a lot of work to do in the house because she is the one who knows everything within the house from the youngest child, how to get paraffin, what the children can use for school fees, soaps and so in many cases, the money that the women get is just used within the house without doing other things. If any other thing is done, it's just paying school fees. So it's their responsibility.

Income under female control is therefore essential for meeting basic household requirements. When asked how the women could "get income to see that the activities required are catered for," two CHWs explained:

There are some signs that you can see, like the one I came with here [making baskets].... some [women] make pots, do farming and so, from all those activities, we can get some money that we cater for our families, even with the school fees. But it is very difficult, because women have a difficult task, and so, we feel that men cannot do for us all those, because at times, they're lost out in town. Sometimes they get drunk, falling down. There's no way how we can help it and we don't have work to get all this money, like making baskets, making pots, farming.

Like now we are digging our farms because there are rains coming, so we can plant vegetables, beans, groundnuts, so that we can get help in our families because men can't do such things. So as women, we work hard in order to get things like seeds to plant in our farms so that you earn some money that can even help you in paying school fees.

Women's agreement to take on roles as CHWs in Sigoti translated into two days per week during which CHWs could not engage in income generating activities outlined above. Lack of compensation for their work therefore resulted in a loss of potential

income. Thus, without compensation, CHWs' participation in community health work was met with a substantial opportunity cost -- it hindered CHWs' ability to meet urgent household requirements (hence the substantial drop-out rate prior to the establishment of the BI). Revenue generated through the sale of drugs from the BI pharmacy was for some CHWs an essential means by which they could reduce the costs associated with their participation. Two of the CHWs explained:

[Among CHWs] here, there are some people who have children and their husbands are not working, and they too don't have any work. And sometimes, she has 10 or eight children, so if she comes to do this work it makes her have some business so that she has no time to come here [to the pharmacy]. Now, if something can be found to earn them income, they can just do their work well.

...so this one [the pharmacy] could not give them any help and it made them using the money they'd got from the sales of drugs, without bringing it here or back, because they don't have any means of earning income that can make them get some help for their homes and they bring back the money from the sales of drugs. At times, they walk from door to door giving treatment and when she comes back she finds that there's nothing she can do except that it will force her to take the money that she had sold, even if she doesn't want to take it, and put it in the expenses that she has....Secondly, in the community health work here, there are people whose husbands don't have any work and she's the one who has to take care of the house and also herself, and according to the lives of today, it is difficult since you also have to pay the school fees, prices for food also are high and everything is done using money...

The second point made by the last CHW reveals a second key factor underlying CHWs' lack of accountability to the pharmacy. Their ability to fulfil their roles effectively was tied intimately to the intrahousehold relations between themselves and their husbands. Henrietta Moore suggests that "regardless of the success or failure of group income-generating activities, the benefits which individual women gain from the income they produce depends largely on their ability to negotiate intrahousehold

relations" (Moore, 1990: 162). Through informal conversations (mainly with the DHMT and the rapid assessment team) I was made aware of the pressure that many of the CHWs' husbands placed upon them to retain revenue earned from the sale of drugs for household uses.¹⁸⁰ In such cases, CHWs had little choice but to abide by their husbands' demands.

The failure of the executive to address seriously CHWs' requests for compensation represented a basic insensitivity to both the costs associated with their labour contributions and the demands placed upon CHWs within their households. While this in part reflects the executive's concern with cost recovery, it also reflects a basic devaluing of CHWs' efforts. As one of the CHWs noted, no effort by the executive was made to assist them in finding alternative means of compensation for CHWs:

...They are women who have children and the husbands are not working. They took some minutes to the committee to see how they could get some allowance, even they could hold a harambee [fundraiser] with the community so that they could get some allowance to make them not give up in doing this work, but the committee didn't take any action, how the CHWs can get some allowance to help them, even buying soaps, even salt. So the committee was to see whether to hold a harambee to help them. They are the ones who are to make the decision, but making this decision to help these people wasn't done....

The expectation by the committee executive that CHWs could fulfil their roles voluntarily "indefinitely" effectively legitimized the exploitation of CHWs' labour.

Further, the executive failed to address the challenges to CHWs associated with dealing with members of the community unable to pay for treatment, by placing the onus on CHWs to deal with these members' debts. CHWs frequently encountered situations

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¹⁸⁰ I did not address this issue directly with the CHWs in the focus group discussions.

in which community members were unable to pay for treatment. Two CHWs explained:

According to that question that has been asked, we get many patients who cannot afford to buy drugs, and in a day, you can even get two of them and in week there can even be four such people.

At this moment, we meet such people frequently because some of them have no parents. They've died and so they cannot help themselves and this makes us meet many of them.

As two CHWs noted, CHWs were frequently obligated to provide such community members with drugs free of charge:

According to that problem, that is the main problem that we have in the villages, because each CHW helps her community. She's the one who knows the villagers who are unable to afford the drugs and she also knows the ones who can pay, but sometimes has been attacked by the disease and doesn't have the drugs. So it is a duty for the CHW that she caters for the village. She has to know her people. She has to know those who can pay and those who cannot pay. If it is someone who cannot pay at all costs, then she can give the person the drugs and she knows how she'll pay for it. But if it is somebody who is able to pay and at that moment he is sick and doesn't have the money, then the CHW has the right to give the person medicine and then he will pay later.

According to that, since there's lots of debts, there is a case where the mother is dead, the father is dead, and the children are very many in the home. Now it forces us as the CHWs. We have to help them. That is why it can be said that the CHWs have some debts...

CHWs' closeness to the community made it morally unjustifiable for them to refuse treatment to those unable to pay. What is important to illuminate here is that when this situation arose, the committee's concern with cost recovery predominated over CHWs' resulting indebtedness. The number of patients requiring exemptions surpassed what could be covered effectively by the pharmacy for it to be sustainable. As such, CHWs frequently indebted themselves, and were unable to return revenue generated through drug sales. When asked whether the committee was aware of the debts incurred

by the CHWs, three CHWs explained:

There are some people that we find that cannot pay for the drugs, and we've reported this to the pharmacy committee, that we have debts, but they tell us just to tell the people to try paying the money so that they do it. But there are some of them that don't pay it at all. There are some people who are unable to pay the money and so even if you tell them, there's nothing they do about it.

They've [committee executive] not seen anything they can do for us, they've just left it that we have the debts, and so, they're just written that way.

Since we are the one who take the drugs from the pharmacy, our names are written as responsible for them and so, it's not considered whether or not you've given the drugs to someone who is incapable of paying for them. And so, they've [committee executive] not done anything about the debts but it forces the [CHWs] to pay for them.

In effect, the committee failed to act as a support structure for CHWs through its failure to face up to the challenges faced by CHWs in fulfilling their responsibilities. The committee executive absolved itself of all responsibility to deal with very real resource constraints of many community members, and essentially failed to address the possibility that community-financing of the BI in and of itself was problematic.¹⁸¹ Exploitation of CHWs was seen as justifiable by the committee on the grounds that the pharmacy should be self-sufficient, at all costs.

Yet it would be a dramatic oversimplification to attribute the marginalization of CHWs in the BI solely to their location "on the receiving end, dependent on the goodwill of men" (Mburu, 1986: 786). Their legal control over funds meant that the committee

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¹⁸¹ An early evaluation (summer of 1991) of community-financing aspects of the Sigoti BI site indicated that "serious potential problems were identified with regard to cost recovery due to low sales levels" (McPake et al., 1992: 81). This was part of a four country study on community-financing aspects of the BI conducted in Burundi, Guinea, Kenya and Nigeria by Barbara McPake et al. (1993).

executive could not make use of funds without agreement from CHWs. As one CHW noted:

Why the pharmacy committee doesn't listen to what we say, we don't know. They have not told us, but what they can do without our knowledge is nothing. Because everything which is to be done, money has to be used, and so even if they come to us to do it, we don't do it, and that's why there's separation.

As such, conflict between CHWs and the committee executive did not result in one group dominating another, in so much as it produced a virtual paralysis of the BI management process.¹⁸² CHWs' response to this was to resist marginalization by using the skills and the resources available to them to their own ends.¹⁸³

The breakdown in the Sigoti BI site was not only a function of a local power struggle along gender lines, but was also a function of the many levels of structural dependency created through the BI, rendering the committee's ability to make use of funds generated for any purposes -- not just those related to the needs of CHWs -- weak at best. Failure of the committee executive to be responsive to CHWs' needs must be

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¹⁸² A point of clarification is necessary here to illuminate this point. CHWs understood that it was "a rule set by UNICEF" that they must consult with the whole committee prior to using funds; therefore, they did not make use of funds without the agreement of the committee. But their legal control over funds also meant that the committee executive could not make use of funds without the support of the CHWs who were signatories at the bank. The BI Coordinator stated that CHWs in Sigoti stood strong on use of funds, and did not blindly accept the executive's demands (Personal Interview, BI Coordinator, 1995). As such, conflict produced a paralysis in BI operations.

¹⁸³ James Scott refers to the term hidden transcript to characterize discourse that takes place beyond direct observation by powerholders. The hidden transcript consists of "offstage speeches, gestures, and practices that confirm, contradict, or inflect what appears in the open interaction between subordinates and those who dominate" (1994: 4). He asserts that the hidden transcript "is not just behind-the-scenes griping and grumbling; it is enacted in a host of down-to-earth, low-profile strategems designed to minimize appropriation" (Scott, 1994: 188). In the case of the CHWs, it was not enough that they had a private space to articulate their concerns and interests. To the extent that they were powerless to act on these concerns, they sought means to minimize the appropriation of their labour. Retaining income earned from the sale of drugs was the most effective way to do so.

considered in relation to the magnitude of responsibilities conferred upon the pharmacy committee in its agreement to establish and manage a BI site.

6.3.4 The BI Pharmacy: Community-Owned, Externally Operated?

Chapter Two pointed out that a health development process that seeks to empower communities necessitates that participants have sufficient resources and an appropriate information base with which to participate (Brownlea, 1987: 607). The absence of these conditions in Sigoti limited the capacity with which the committee could effectively manage its BI site. The Sigoti BI site was faced with three key structural constraints which have historically limited the effectiveness of primary health care initiatives to meet empowerment goals -- (1) failure to encourage the local population to think or act for themselves, resulting in the maintenance of dependency on external resources, (2) inadequate training and supervision of the local population to effectively organize and manage PHC activities, and (3) insufficient resources of the right kind at the disposal of the community.

Although the Sigoti BI site was community-based, with ownership over the BI conferred upon the community through its legal entitlement to funds generated through sales of drugs and bed nets, the community was never accorded ultimate control over the management of its BI site. The DHMT made it clear to the pharmacy committee that it was not to use funds for purchase of drugs without consulting the District first. Two committee members explained:

We have stayed for a long time without receiving drugs. We were told that we had at least three supplies and the three supplies have not reached us up to this moment, so we are running this on our own. But when we asked them can we use our money to go and buy drugs so that we can

keep it active -- [the DHMT said] no, we are going to supply you. When we sent this lady, and this one here, to go and get drugs, the drugs were not given to us. So that is the most important conflict that we have raised to the DHMT...

...And the pharmacy has not been given the authority to buy drugs when they feel they have not been given an O.K. by the DHMT to buy drugs they feel they need when there is a shortage.

While the community retained ownership over the BI, ultimate control over the resource was not accorded to them by the District, which maintained a strong advisory role in decisions regarding use of funds for the purchase of drugs and supplies, and regarding the initiation of income generating activities.

Committee members spoke with uncertainty about management issues, particularly those related to the management of drug supplies and use of funds. As one committee member commented, "...the [pharmacy committee] should also be trained because they were not initially trained on management." The committee did not have a precise understanding of the amount of revenue that would be required to achieve self-sufficiency, and as illustrated above, was essentially dependent upon the DHMT to approve its decisions regarding BI-related issues. As such, the committee was hesitant to use funds for any purposes, for fear of threatening the sustainability of the project.¹⁸⁴ In effect, the committee lacked essential information with which to base any kind of funding decisions.

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¹⁸⁴ As McPake et al., noted in an early evaluation of the BI in Kisumu, "communities were found to be very unsure about the arrangements for the phasing out of UNICEF subsidies. Although they were aware that they would start paying for the drugs at some time, they did not know what prices they would be charged or when they would start. It seems unrealistic to expect them to manage resources and set appropriate prices in the absence of clear information about what will be required of them" (McPake et al., 1992: 80).

This in part can be attributed to the District's own dependency on UNICEF, and lack of management training for the BI. With respect to supply issues, the layers of dependency trickle upward to the donor level. The UNICEF/MOH planning document is quite vague in its treatment of drug supply issues, as it does not allocate responsibility for ensuring the steady supply of drugs with any actor (see Chapter Five for a brief description of each actor's responsibilities). As such, the District may have been lacking the information *it* required to accord the Sigoti community control over management of the pharmacy. Barbara McPake et al.'s early evaluation of the BI in Kisumu District pointed to these problems. They point out that:

Members of the district health management team themselves require training in their supervision and monitoring of the activities. Monitoring was found to be rather weak in all districts. There are currently no clear guidelines as to what should be monitored and resources at the district and facility level are inadequate to do this job properly. Often monitoring PHC has been added to the existing duties of a district or facility officer. Since the Initiative often expands services to increasingly remote areas, the time requirements of the job are likely to increase faster than the overall expansion rate of the project. In this context, it is difficult to see how the quality of monitoring and supervision can improve without new resources (McPake et al., 1992: 79).

Thus, dependency on the donor for resources, information and training began with the district, and subsequently flowed down to the committee, and finally, to CHWs. Each actor was constrained by lack of power to act by virtue of its dependency on UNICEF for drugs and information.

In addition, while heavy supervision by the District had been a key factor underlying the success with which CHWs had fulfilled their responsibilities in Sigoti before 1992 (UNICEF, 1991: 19), supervision by the District had deteriorated at the time

when the BI in Sigoti began to expand (with the training of an additional 71 CHWs to serve the area), and subsequently experience operational problems. As one committee member commented:

... first, they [the DHMT] started very well and they trained people very well, and as it's been going on when we wanted them to retrain the CHWs, they then relaxed, so we don't know why they relaxed and we could no longer see them.....they told us they would [re-]train the CHWs, they have not done that, so they have relaxed of late.

Responsibility to deal with conflict situations as they arose was located with the community, despite the committee's reliance on the District for guidance and supervision, not to mention resources and information-sharing. For example, when CHWs' began to resist marginalization, the DHMT absolved itself of the responsibility to deal with the problem. A TOT who participated in the discussion with the pharmacy committee explained:

Well, as far as we're concerned I don't know the reason why they do that [ignore Sigoti], but as I remember, when I went to the District the other time, one of the officers mentioned to me that because some CHWs have violated the rule or principle of PHC by going to sell the drugs at the market, they would not supply us with drugs until they stop completely, so I think that might have been the reason, I just think, because that was mentioned to me in the office when I went there.

What is paradoxical about the DHMT's response (or lack thereof) to problems in Sigoti was that it was relatively out of tune with (or chose to ignore, or was unable to act upon) the structural constraints faced by Sigoti. In effect, the District failed to acknowledge the relationship between the very real resource constraints of the Sigoti pharmacy and the CHWs' subsequent actions. While at one level, the DHMT did not enable the committee to make decisions without first consulting the District, it expected

the committee alone to solve problems that were ultimately related to cost recovery issues, which required significant collaboration with and support from the District.

The same can be said for UNICEF, which failed to act when serious problems associated with compensation for CHWs arose in Sigoti. According to two CHWs who participated in the focus group discussions, UNICEF was aware of the debts CHWs were incurring in carrying out their roles, and was aware of their requirements for some form of compensation. However, UNICEF placed the burden of dealing with these situations with the pharmacy committee, without providing the committee with the requisite knowledge or resources that would enable them to do so. One CHW explained:

UNICEF had known all about it [CHWs' debts], and we had sat down with the pharmacy committee and it was said that such a thing is difficult, and so, the CHWs and the pharmacy committee should sit down and see how the CHWs can help themselves, and...the UNICEF leader said "you cannot do the work from 1 - 31st of the month without paying, and you have children, and your husband." Then it was left to the hands of the pharmacy committee to see what can be done so that the CHWs can have something to help them in their lives back at home.

Thus, no actor took responsibility for conflict situations and operational problems as they arose, creating a spiral effect which inevitably destroyed the proper functioning of Sigoti's BI site. It is somewhat ironic that the failure to allocate resources to CHWs for their efforts posed a greater threat to Sigoti's primary health care program than did problems associated with cost recovery. Perhaps the most unfortunate result of the CHWs' resistance was the negative implications it had for both CHWs and other women in the community.

The collective solidarity which had developed through the CHWs' meetings was a motivating factor for their continued commitment to health promotion and prevention

activities. The CHWs' failure to carry out their responsibilities effectively undermined this important aspect of their health program, as well as disrupting proper functioning of the BI pharmacy. This was a source of the CHWs' own discontent, as it caused tension between CHWs and community members. As two of the CHWs commented:

Our meeting was always good because it could make many things to happen, but because nowadays we don't meet, there's nothing which can happen. When we started one project, which is essential drug management, it is the only one that is still standing. We should be building, we should be having different activities, such as agricultural places, keeping chickens, making different things, dental places, because there are many skills people can do but now we can't meet and these things can't work out.

Today I'm saying that when we could meet on Tuesdays and Thursdays we were very happy. When we met here we could learn. When we come from home [when CHWs used to meet regularly], we hear different things from people. When we go back home, the villages say that "but they're working, don't you see them going to work on Tuesdays and Thursdays." Nowadays when we don't come to the meetings to report, the villagers dislike us. They just say that "what work are they doing? They just rest, nowadays they just sell drugs." And so this step back that we've had, that nowadays we don't come to the meetings, that we sit back at home without reporting, it has let us down with the people we teach and the people we give drugs to. They've disliked us.

What is important to illuminate here is that while the establishment of the BI in Sigoti enabled CHWs to gain greater access to and control over health knowledge and resources, and while it enabled CHWs to articulate their gender interests for survival and priority health needs, the BI did not act as a catalyst through which CHWs could take action to address these interests and needs. CHWs perceived the source of this problem to be their peripheral status on the committee, and suggested that they should take on executive roles in the committee to redress this imbalance. As two CHWs commented:

...according to what we've talked about, we feel that, we the CHWs are

the ones to form the pharmacy committee because those who come from the outside will still give us problems since this thing is ours. So it means that we have to be more than them [the men] so that we strengthen them. They have to be there, but the majority should be us.

At this moment, we are allowed [we will accept] to be with men only if they accept to put on the skirts; then we'll work with them, except that women are the owners of the project...but them, the men, are just put there to help us in decision-making. Nowadays women have higher posts in the groups [i.e. women's groups] than men.¹⁸⁵

Yet it is important to recognize that the BI, as a national health strategy being implemented throughout Kenya, represents an attempt by the state to tap women's labour for the purposes of "western" developmentalist goals, making modern, curative care more accessible to rural populations. In an analogous sense, Patricia Stamp states that for the Kikuyu of Mitero, the discourse of traditional cooperation referred to as "matega"¹⁸⁶ has

on the one hand articulated and legitimized women's efforts to retain and increase their autonomy, while on the other hand forces seeking to control and channel women's endeavours stretched the meaning of matega to incorporate male-directed and developmentalist goals, so that the practice of matega might be redirected towards these ends (Stamp, 1987: 6).

While the primary health care discourse which reinforced and legitimized women's authority in health care provision was used by CHWs to challenge the undermining of their autonomy as "owners" of health care by men in executive positions at the local level, the fact remains that CHWs were dependent on both the state and the

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¹⁸⁵ It is true that in Kenya, some women's groups are beginning to pursue real empowerment for women; seeking to own and control land, resources, and their own labour and are resisting both class and gender exploitation - starting business, factories, and training programs, larger organizations are buying land (Kabira & Nzioki, 1993: 57-60).

¹⁸⁶ "Matega" represents the ideology and practice of sharing among Kikuyu women in Kenya. Historically, matega referred to women's aid of other women in childbirth, and in present day has become an animating principle of women's self-help groups (Stamp, 1987).

donor, and their labour was appropriated by these actors in the name of "health for all." CHWs' gender interests were subjugated by the state's and UNICEF's interests in increasing the population's accessibility to modern health care at little or no cost (however unrealistic), and in the interests of maintaining the illusion that health is apolitical, requiring no transformation of the structures which perpetuate ill health.

The next two sections will show that following the establishment of the BI in Sigoti, prioritization of curative care rendered women's gender-specific health needs peripheral to the health development process.

6.4 Women's Reproductive Health and the BI

As stated in the introduction to this chapter, one of the key health needs expressed by women in the community was to ensure that women receive proper assistance in childbirth. Approximately 75% of pregnant women in Kenya deliver at home, with no assistance or with the assistance of TBAs (Raikes, 1989). The purpose of this section is to illustrate that the establishment of the BI in Sigoti did little to enable TBAs to carry out their roles more effectively, and as such, failed to strengthen maternal and child health services.

With the establishment of Sigoti's primary health care program in 1984, TBAs were trained in safe delivery methods, in identifying women at risk of complications for referral, and in basic post-natal care. But they had few resources with which to carry out their roles effectively. When the BI was superimposed onto the existing program, the only added component to their work was the availability of delivery kits to the community pharmacy. At a cost of Ksh 20 (approximately \$CDN 0.65), the kits

included surgical gloves, a needle to cut the umbilical cord, an alcohol swab, and string to tie the cord. Women could purchase kits from TBAs prior to their delivery date, or following their child's birth.

However, TBAs encountered similar problems to CHWs: many women could not afford to purchase delivery kits, and the onus was placed on TBAs to deal personally with the debts of women they assisted in childbirth. One of the TBAs explained:

At first, we could sell the kits is when we bring back the money and even these ones [she points to a kit], we could take them and give help to the women who were delivering, is when we bring the money [to the pharmacy]. Now, when it turned to be that the money from the pharmacy is what could be used for buying drugs [when cost recovery became an issue at the pharmacy], if people took long without bringing back the money, it could delay the buying of drugs and that is why it was put that we have to buy the kits, is when we can be given them.

Again, the committee's pre-occupation with cost recovery overrode both the TBAs' needs, and women's needs for accessible services at little or no cost. Use of kits was particularly important for TBAs, as the surgical gloves reduced their susceptibility to contracting the AIDS virus during deliveries. Meeting women's reproductive health needs in a safe way for both TBAs and pregnant women was seen in terms of a luxury, as opposed to a basic right to a safe delivery, or an integral component of any primary health care program.

Thus, while the pharmacy committee was to act as a support structure for TBAs, the one TBA who was represented on the committee was not effective in lobbying around TBAs' needs, nor could she adequately represent the articulated needs of women related to reproductive aspects of their health. As two TBAs noted:

The problems we've always given to the committee, like all the TBAs, we

have not received any help...

We've not got any help from Bamako. We help ourselves, because we don't like when a pregnant woman suffers and we are around.

Both the committee's and the CHWs' pre-occupation with curative aspects of the BI overrode TBA's interests. Thus, the expectation that the BI would act as a catalyst to strengthen maternal and child health care -- as outlined in the resolution signed by African health ministers at the 38th session of the WHO Regional Committee for Africa -- failed to materialize in Sigoti. Conversely, little importance was placed on meeting women's reproductive health needs in a more effective manner with the establishment of the BI.

The remainder of this chapter shows that in addition to the failure of the Sigoti BI site to effectively incorporate CHWs or TBAs into its management and decision-making processes, it has not enabled a broad range of women in the community to participate "fully" in and benefit from the BI. By participating fully, I refer to women's key role in identifying health priorities, such that these priorities are incorporated into the framework of the BI, and to women's capacity to participate in and influence key BI-related decisions. In doing so, I address a key discrepancy between BI discourse and its actual practice in Sigoti -- its failure to elicit broad-based participation and community control of primary health care. The development and implementation of the BI in Sigoti was dominated by a select few community members.

6.5 Community Participation in the BI: Broad-Based?

Implicit in the conceptual framework of Kenya's BI is the assumption that participation will be broad-based, incorporating the needs and interests of community

members who tend to be peripheral to the health development process, such as those of low socio-economic status and women.¹⁸⁷ Theoretically, community members¹⁸⁸ are enabled to participate in the BI in three main ways - as beneficiaries and financiers of health care provided through the BI; through participation in the selection of CHWs and pharmacy committee members; and through participation in decisions related to the BI. BI-related decisions generally deal with setting the prices of drugs and bed nets, decisions regarding any changes to be made in the structure and organization of primary health care, and decisions regarding income-generating activities to engage in through use of funds generated at the community pharmacy (and also through use of community resources).¹⁸⁹ These roles are identified in the Kenyan BI planning document (see Chapter Five), and were also articulated as such by key local actors involved in the BI process. The pharmacy committee is accountable first to the community, and cannot take action regarding use of funds (with the exception of replenishing supplies) prior to consulting with the community. Some pharmacy committee members described the decision-making process as follows:

The decisions we make here, if it is worth it, we take it to the Assistant Chief, to the Chief, so that they may be told that this is the thing we would like to do, because it will help the people. That is one thing. Then the other thing is committee members that come from here, they inform

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¹⁸⁷ Of course these two categories of community members are not mutually exclusive. Many (but certainly not all) women in the community are also socio-economically worse off than men.

¹⁸⁸ I refer here to those members of the community not involved directly in BI implementation and management through their roles as community health workers, traditional birth attendants, or pharmacy committee members.

¹⁸⁹ These may include such activities as the purchase of dairy cattle, development of fish ponds, poultry farming, the purchase of land for a collective farm, etc. As noted in the previous section, no income generating activities had been initiated through the Sigoti BI at the time of the study.

people in their villages that we want this thing to be done here, that it will help you, and so you [community] should be involved in these activities.

And if it's something true, they also announce it in schools, in primary schools, even at the barazas.

I think you've also seen that the village health committees from each sub-location, sometimes they bring for us priorities from the community...

At first, when we make decisions, there must be those people who come from the villages who are not the committee...They are called for a general meeting, so they're asked about what they think and we discuss, and if their decision is not similar to ours, then we work with theirs. Because we who are here are not brighter than them. There are people who are brighter than us and so we give them a chance on what they think and we tell them what we think. And so, what they decide in the general meeting is what should be done.

Thus, from the committee's perspective, the process through which decisions are made in Sigoti is participatory, incorporating the needs and interests of community members. It is expected that material benefits of the BI will accrue to a broad range of community members.

The statements made above by pharmacy committee members reflect their public account of the process through which the BI brings the community into the health development process in Sigoti. However, these statements mask a number of important factors which have limited women's actual participation in this process. It is clear from the research findings that, with the exception of CHWs and TBAs, women in Sigoti have participated mainly as beneficiaries of the BI, through increased access to curative care and health education. Women generally have not participated in the other capacities described above. Most respondents of the household survey were aware that the Sigoti pharmacy is owned by the whole community (37/48, or 77% of respondents were aware

of this), and that the pharmacy is managed on behalf of the whole community by a community-elected committee (40/48; or 83% of respondents were aware of this). Despite this knowledge, only 12% of respondents participated in the selection of their pharmacy committee representative.¹⁹⁰ Of those who did not, 51% were not aware that there was an election and 49% were not able to attend. No respondents stated that they were not interested in participating.

Lack of effective channels of communication is a key constraint to this type of participation, and appears to cut across class. Even highly educated, elite women fail to receive information regarding public events pertaining to health, such as elections. As one women's group leader commented:

This happens because the women's groups are not informed. If there was a way in which the information can reach the women's groups, like the leaders of women's groups, I think the leaders can make sure all the women in their areas know about the elections and that will make them attend the elections. But since the women's groups don't know what is happening, you can find two or three women, and each should be for women [all women should participate]. You find that women are not happy about it.

Failure of women to participate in elections represents a small component of a broader problem related to women's lack of incorporation into the BI process. Women rarely attend public forums through which BI-related decisions are made. Issues related to local development initiatives, including health, tend to be discussed with the community at public forums such as the Chief's baraza. Women rarely attend barazas unless a special baraza is called by the Chief which includes subject matter relevant to

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¹⁹⁰ According to the women's group leaders, the selection of pharmacy committee members was done through a general election. Community members from the five sub-locations were called upon to vote for their representatives.

women. In most cases women are discouraged from attending what is regarded by the community as a male forum. Forty-nine per cent of respondents of the household survey had attended no barazas in 1994, and twenty-six per cent had attended only once or twice. One of the women's group leaders described women's relationship to the Baraza in this way:

Only if they're called [women] by the Chief or Assistant Chief is when they attend the meetings...And so, women attend barazas on special occasions, but there's no woman who can just go there to sit at the baraza. They're afraid of men because men look at them - that so and so's wife is always at the baraza, and women have other duties to do.

As another leader pointed out, issues which come up at barazas are frequently of no interest to women, and attendance merely detracts them from more pressing family responsibilities:

In addition to that, why women don't attend barazas is because women are always busy, and this is because they're the people who see into what happens at home...at the barazas if there's no special meeting to take place, maybe just to settle conflicts between a wife and a husband, then women don't like going to barazas, because while she's there she would have gone to plant some vegetables, plant some potatoes, and maybe she would have done different other activities, or do other money generating projects; so you find that if there is a special call is when they attend.

Thus, women are absent from a key public forum through which they can articulate their needs and interests in relation to the BI. This finding is certainly not surprising, nor is it unique to the Sigoti community. Women have historically been absent from public forums in Kenya, particularly Chiefs' barazas (e.g. Rogers, cited in McCall, 1988). Men have predominated in public, political spheres of life in Kenya, and have dominated the development of village activities (Thomas, 1989a).

The cultural and structural barrier to women's involvement in the BI through their

absence in public forums does not negate the possibility that other forums could enable women's voice to be heard and accounted for in the BI planning, management and implementation process. One such mechanism through which it has been assumed that women are linked to the BI is through their involvement in women's groups. Local women's organizations in Kenya have been instrumental in enabling women to gain control over resources and direct development efforts for their own purposes (e.g. Stamp, 1986; Mackenzie, 1987; Thomas, 1989b). The entry point through which the Ministry of Health originally mobilized the Sigoti community for involvement in health activities was through women's groups (Personal Interview, PHC Coordinator, 1995). Women were sensitized to primary health care issues, and a number of women from the various sub-locations were recruited to be trained as CHWs.

Women's main connection to the BI is through contact with CHWs in their homes or through CHWs' meetings with Sigoti's strong network of approximately 60 women's groups.¹⁹¹ CHWs therefore serve as the essential communication link between women in the community and the BI. Unfortunately, the link between women and the BI has not translated into effective incorporation of women's voice into the BI decision-making process. CHWs tend to perceive their responsibilities to women mainly in terms of providing health education and treatment. This in itself is a positive outcome of the BI. Women in Sigoti have a high stake in the BI; they feel that it has made health care (in

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¹⁹¹ As Henrietta Moore notes, the goals of the different women's self-help groups in Kenya clearly vary enormously but include generating income through farm labour or small-scale industries, running a rotating credit and savings scheme, and investing in property and land (Moore, 1990: 157). According to the leaders of women's groups that participated in the discussion, participation of women in women's groups is broad-based in Sigoti, and includes women of diverse socio-economic status.

the narrow sense) more accessible to women in their community,¹⁹² has enabled them to carry out their family responsibilities more effectively, and also brings the possibility of longer-term benefits to the community. As three of the women's group leaders pointed out:

You find that from what they've been trained, they teach people on balanced diet during the meetings of women's groups. Those who want to deliver are also taught when they come to the women's groups and so we find that the relationship is good.

....I feel that it is good that UNICEF trained for us the CHWs and the TBAs, because at times the hospitals are far and you have no means of reaching them. And so if the TBAs or CHWs are near your home area, then you can get help very fast. So I'm hoping that it continues that way.

There's no other group we've got help from more than Bamako. This is because if you get drugs from Bamako, and you get cured, then you continue with your duties, which result [in] income generating activities¹⁹³...secondly, as women leaders from different places, we felt that Bamako can give help to the women, because according to the project that they brought, if they give even Kajimbo chicken and Koguta they give vegetable gardens, if they give Ramogi machines for school uniforms, then the children will get help. Since the goal of Bamako was to help both the children and the adults without suffering.

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¹⁹² It cannot be assumed that all women in the community have benefitted from the BI in this way. While it was beyond the scope of this study to determine the extent to which all members of the community benefit from the BI, it is clear that there are no effective exemption mechanisms for poor community members. Five out of forty-eight, or 10.4% of respondents of the household survey stated that they had been refused treatment because of inability to pay for drugs. Through the focus group discussions, it was clear that efforts are made by CHWs and the community to cover the cost of drugs for those who are unable to pay, however, no effective system was in place to ensure that poor members would be covered. CHWs frequently indebt themselves to cover the cost of drugs for a community member, but in many cases they are unable to secure the required funds. Further, as was noted in the discussion with women's group leaders, not all sub-locations are served equally through the BI. Sub-locations that are more distant to the pharmacy in Ramogi tend to be worse off. An estimated 300 CHWs are required to serve Sigoti Location effectively (Personal Interview, BI Coordinator, 1995).

¹⁹³ The results of the household survey also indicate that women in the community perceive the BI to be an intervention which has benefitted them, particularly with respect to curative aspects of the BI. For example, forty-four out of forty-eight, or 91% of respondents, feel the BI has helped them to treat illness that themselves and their families have suffered from. In response to the qualitative question, How has the BI helped you?, all respondents noted that it increased their accessibility to treatment.

Thus, women are aware of the actual and potential benefits of the BI, particularly with respect to the benefits that could accrue to women through income generating activities. As discussed in Chapter Three, participation in health promotion and preventive activities occurs when there is a concomitant transformation in structures which perpetuate poverty. If strategies which target women because of their relationship to domestic activities derive from their own articulated interests, and are accompanied by measures which enable women to build a secure support base, women will benefit through time saved and increased health. For example, women's ownership of dairy cattle or land for collective farming both reduces poverty (through their ability to generate income from the sale of milk or produce) and improves nutritional status.

Despite their awareness of the potential long-term benefits to their well-being, and that of their families, that could derive from the BI, the women's group leaders involved in the focus group discussion saw themselves (and women in the community in general) as somewhat peripheral to the health development process in Sigoti. They certainly did not perceive themselves to be key actors in ensuring that their priorities are accounted for. While women assumed that they would benefit from these activities, they perceived these activities to be the domain of CHWs and the committee. They did not perceive themselves as being ultimately responsible for defining them or managing them. This became clear during the discussion, when they commented that they were unaware that decisions regarding use of funds generated at the pharmacy were to be made in consultation with them. As two of the leaders stated:

...We heard that Bamako brought for the community drugs and nets, that we could buy them from the pharmacy, but we don't know anything about

the funds....and there's no way we can ask them how the funds are used, since we just see the CHWs together with TBAs meeting with their chairlady. So we also know that if we had the rights on the funds, they would have already informed us about it...As the community, we know that if you have money, is when you can get the drugs. And if you don't have money, people can contribute some money to buy you drugs. Where the money goes to, we've never been made aware of. The committee had never ever informed us that the money can be used on certain projects. As women leaders, we would have told them about the activities we want to carry out. So us we don't know where that money is taken to.

While this outcome surely reflects the fact that no income generating activities had been planned or initiated at the time of the study, it also reflects women's perception of their role in the BI in terms of an us - them relationship, whereby women passively (albeit happily) receive benefits that others (CHWs, TBAs, the committee, UNICEF) "bring" or "give" to them. The relationship between CHWs and women in the community was somewhat hierarchical, rendering CHWs in a position of authority in relation to the women.¹⁹⁴ One of the women's group leaders described the process through which information is passed on to managerial levels of the BI in this way:

...they try to teach us after which they ask us questions so that we can tell them the problems or complaints that we have and the outbreaks of diseases that we encounter or an increase of diseases, so after they've listened to our problems, they inform the pharmacy committee. Then if there are drugs, they provide people with them. That's how they work.

The main mechanism through which women received information about the BI, through CHWs and TBAs, was used primarily as a channel for health service provision and education, and as a means for CHWs to obtain information regarding health problems, rather than as a mechanism which enables women's voice to be articulated and heard in

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¹⁹⁴ It is important to note that this was the case despite the fact that the women's group leaders were elites, and the CHWs were not. The CHWs' training and connection to the BI management process enabled them to gain greater access to decision-making forums around the BI than elite women in the community.

decision-making forums which ultimately shape the direction of the BI. Women were not receiving information from CHWs regarding the BI's progress, nor were they made aware of pharmacy committee elections or their potential role in defining health-related priorities. One women's group leader expressed this problem clearly:

In addition to that, if we as leaders of women's groups, we would have known that, we would have said something so that Bamako could help us. But because we don't know how it works, we have nothing to say about it.

Another leader expressed concern over the failure of the committee and CHWs to properly inform them of the workings of the BI. She stated that "...if they knew the footsteps they were to follow, then we are to blame them, because all the community should know about it, not just a group of people..."

Thus, while women in Sigoti were key informants for CHWs, particularly with respect to curative aspects of the BI, they remained uninformed about and hence voiceless in actual decision-making forums. Women in Sigoti (those who are not CHWs or TBAs) are not represented well on the pharmacy committee, and tend to be poorly represented on sub-locational village health committees.¹⁹⁵ This result was not a function of women's apathy or disinterest in the BI. In fact, one women's group leader advocated a stronger role for women in managing the BI. The woman suggested, or rather, requested that women's groups from each sub-location be represented on the

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¹⁹⁵ Only one woman from the community not involved directly in the PHC process in Sigoti was represented on the committee (see Appendix 3). This woman did not participate in the focus group discussion with the committee, therefore her voice is not represented in my analysis. Her absence from the discussion is noteworthy, as it may in itself reflect her lack of influence on the committee. The size of VHCs varies considerably across the five sub-locations. A list of VHC members was obtained from three of the sub-locations in Sigoti. In Ramogi, 3 out of 14 members were female; in Kadianga East, 2 out of 43 members were female, and in Koguta, 3 out of 11 members were female. The men tended to predominate in leadership positions on these committees (AMREF, 1994b).

committee, such that women could gain increased awareness of and involvement in activities and decisions:

Another problem we have is if Bamako can accept then the women's groups should be representatives in the pharmacy committee so that we may be made aware of what is happening. Since at the moment we look like people who are naked and there's money at the pharmacy that can be used to help other projects to develop. So we request that from each sub-location one person should come from the sub-location so that she can forward the problems they have within the community...

Despite women's group leaders' stated interest in the BI, the BI's structure and organization in Sigoti necessitated that CHWs and TBAs represent women's articulated needs and interests in the decision-making process. In effect, the responsibility to effect change in the BI that represents the interests of a wide range of women in the community rested with a small group of women involved in BI management and implementation. It was implicitly assumed (by planners, women in the community,¹⁹⁶ CHWs) that CHWs could adequately represent the interests of women in the community.

It is true that CHWs have an intimate knowledge of women's priorities, by virtue of their close contact with women, and because these priorities largely mirror their own. CHWs face many of the same challenges and daily life experiences as other women in the community. However, as section 6.3 illustrated, the voices of CHWs have not been adequately represented in BI decision-making forums. Further, the shift in focus to

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¹⁹⁶ One indication of this was the general satisfaction with the work of the CHWs and committee of respondents of the household survey. Forty-two out of forty-eight, or 87% of respondents were satisfied with the work of CHWs (4/48 were not satisfied and 2/48 did not know). Similarly, thirty-nine out of forty-eight, or 81% of respondents, were satisfied with the way the pharmacy was being managed (1/48 did not know, and 8/48 were not satisfied because some of them felt that some of the drugs required by the community were not available). Given the magnitude of the operational problems of the pharmacy and its committee at the time of the study, it is safe to infer that respondents did not have a comprehensive understanding of the responsibilities of the pharmacy, or of its effectiveness in meeting its objectives.

curative care meant that women's interests in health promotion and prevention were overridden by the CHWs' interests in maximizing their roles in treatment components of the BI. As such, CHWs' voices may not have been representative of women's priority health needs, even if they had an equal voice on the committee.

6.6 General Conclusions On Women's Relationship to the BI Process

In this chapter I have shown that despite the assumed community-supportive environment inherent in the conceptual framework of the Kenyan BI, many of the constraints which have historically limited women's participation in the health development process were faced by women in Sigoti. First, the failure by key actors in the BI process (i.e. UNICEF, the DHMT and the committee) to incorporate mechanisms into the BI process to ensure that the work of CHWs was valued reflected their implicit (but false) assumption that the voluntary nature of the work of CHWs was acceptable, in so far as it represented an extension of their traditional roles as unpaid (and undervalued) health care providers. This assumption effectively legitimized the exploitation of CHWs in the labour process. However, as was seen in this chapter, remuneration of CHWs was essential to compensate for the opportunity costs associated with the heavy labour demands of community health work. Failure to value the efforts of CHWs therefore led them to resist marginalization by utilizing their knowledge and resources for immediate economic gain. This in turn jeopardized all aspects of Sigoti's health program, including those related to health prevention and promotion.

Second, the majority of women in Sigoti were passive recipients of the services provided through the BI, and the BI in and of itself did not enable women to exert

greater control over their own health development. Women's articulated food- and income-related priorities, as well as their reproductive health needs, were not addressed through the BI; rather, these interests were subjugated by curative aspects of the BI, and the overarching concern with economic efficiency. As such, the BI did little to transform structures which perpetuate women's ill health.

While this outcome in part a product of the persistence of dominant gender ideology in social policy, and the concomitant asymmetrical gender relations that characterized the Sigoti BI process, the Sigoti BI site was also faced with many of the same broad constraints to an empowering health strategy that have characterized past PHC programs, as outlined in Chapter Two. Most importantly, while ownership of the health program was located with the Sigoti community, the community was not accorded ultimate control over its management process. In this chapter, I illuminated the many levels of structural dependency that were created through the BI. The District remained dependent on the donor, UNICEF, for information and resources. The District lacked proper training and information related to drug supply and budget issues, not to mention sufficient resources, to fulfill its responsibilities effectively to the Sigoti community. Further, at the community level, several layers of dependency, summarized below, were faced by various actors in Sigoti's BI process .

First, the key organizational body responsible for management of the Sigoti BI site, the pharmacy committee, remained dependent on the District for information, knowledge and resources, without which it could not effectively fulfil its responsibilities. The committee was unclear about the process by which UNICEF would phase out its

donations of drugs, and it was not aware of the resources that would be required to sustain the BI independently. After six years of operation, the committee remained dependent on UNICEF for supplies to sustain the program. This outcome reflects the weak and sometimes conflicting relationships between the committee, the District and the donor, as well as the inability of the Sigoti pharmacy to generate enough revenue through drug sales to achieve self-sufficiency.

Second, CHWs were dependent upon the male executive, whose knowledge and connections to macro arenas placed them in a privileged position of authority over CHWs in decision-making forums, who tended to have low levels of formal education and no formal occupations. CHWs were also dependent on the District for continual training and supervision to ensure that they could carry out their roles effectively, and on the donor for the resource it "brought" to the community --drugs -- which accorded CHWs considerable status and credibility in the community, and which offered them some prospects for increasing their resource bases. Third, TBAs' peripheral role in the BI process meant that they remained relatively voiceless in BI decision-making forums. Finally, women in the community were dependent on CHWs for information, without which they could not effectively participate in the BI decision-making process. In effect, the absence of a participatory process through which women could influence the direction of the BI meant that women were dependent on both the committee and CHWs to represent their needs.

Notwithstanding the problems associated with cost recovery which limited the capacity of the Sigoti BI site to meet its objectives, the effectiveness of the BI process

clearly necessitated strong channels of communication between the various actors involved in the BI planning, management and implementation process, such that all parties involved both understood their roles, and were enabled to act autonomously within their particular roles. Further, mechanisms were required to ensure that each actor's interests or concerns, once articulated, could be accounted for in final decisions and operations. None of the actors in the BI process had the requisite knowledge, information or resources to fulfil their roles effectively. Each actor's uncertainty was translated into their inaction to deal with operational and leadership problems as they arose in Sigoti. As such, no process evolved through which conflict situations could be dealt with effectively.

There is growing recognition in the context of agricultural development programs of the need for

methodologies, organizational structures and institutional arrangements to analyse difference, explore conflicts, recognize negotiation processes and seek common ground, if the high ideals of productive, sustainable and equitable agricultural development are to be realised (Scoones and Thompson, 1993: 25).¹⁹⁷

I would argue that this same need exists for the broad range of community development initiatives, including primary health care programs, that necessitate the collaboration between various community members and groups with different experiences, and that require information and support from external agents (be they donors, NGOs or higher levels of government). There were no appropriate structures and processes in place in the Sigoti BI which could enable the various actors (i.e. CHWs, TBAs, the pharmacy

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¹⁹⁷ See also Cornwall et al., 1993.

committee, and women in the community) to negotiate their articulated needs with the respective organizational body (or bodies) that could potentially work towards meeting these needs. More specifically, there was no negotiation process in place to deal with conflict situations as they arose in the Sigoti BI. In practice, this translated into the virtual cease of dialogue between all parties involved, and the concomitant breakdown of program operations.

In the next chapter I identify lessons learned from Sigoti, and discuss policy implications of the findings. I conclude with recommendations to UNICEF.

Chapter 7: Lessons Learned from Sigoti

7.1 Introduction

Through my case study analysis of the Sigoti Location Bamako Initiative site, I explored whether the BI embodied an empowering health development process for women; namely, one that enabled women to exert greater control over their lives and health through their role in identifying health priorities, and through their equitable participation in the BI management and implementation process. The purpose of this chapter is to reflect on the findings of my research, and to consider the implications of lessons learned from Sigoti for health policy.

This chapter is divided into two main sections. Section 7.2 illuminates what the BI did and did not accomplish in light of its original objectives. As Chapter Six illustrated, the Sigoti BI site was faced with many of the same constraints which have historically limited the capacity of PHC programs to empower the community members they intend to serve. I will review the constraints faced by research participants, with a view to identifying the incongruity between Kenya's BI policy and local realities in Sigoti. Section 7.3 concludes with points of consideration for WHO and UNICEF.

7.2 Reflections on the Limitations of Sigoti's BI Site

In considering whether Kenya's BI is an appropriate intervention for women, I asserted that unless the BI incorporated mechanisms for women's empowerment into its design, it would fail to effect long-term, sustainable improvements in women's lives. It is important to note that the BI was a highly valued intervention among women in Sigoti, mainly because it increased their accessibility to essential drugs, enabling them to carry

out their daily responsibilities more effectively. The Bamako Initiative assisted some women in Sigoti in one main way -- by providing them with the provision of a basic, local level service to which they formerly had little or no accessibility.¹⁹⁸ While this in itself is a positive outcome of the BI, this short-term benefit must be considered in light of a key objective of Kenya's BI, which is to strengthen Kenya's whole PHC system -- particularly those aspects of PHC which result in sustainable improvements in the lives of women and children -- health preventive and promotive measures, and income generating activities. In their early evaluation of Kenya's BI, Barbara McPake et al. suggested that "the overall success of the BI in significantly improving morbidity levels depends primarily on the success or failure of the preventive activities" (1992: 82).

The operational and leadership problems that characterized the Sigoti BI site resulted in its failure to strengthen its primary health care system for three main reasons. First, the addition of a curative component to Sigoti's community health program essentially undermined existing preventive and promotive aspects of PHC, also valued by women in the community.¹⁹⁹ Second, the BI did little to meet women's reproductive health needs more effectively, which had been identified by them as one of their key health priorities. The key means through which the majority of women receive

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¹⁹⁸ As was noted in Chapter Six, not all community members could afford to pay for treatment. It cannot be assumed that all women benefitted in this way from the BI. In some cases, CHWs have been forced to refuse treatment to community members unable to purchase drugs. While all respondents of the household survey stated that the BI has "brought" drugs closer to the community, the survey was conducted in the sub-location in which the pharmacy committee was located. Through the focus group discussions, it came out that community members from more distant sub-locations were not benefitting equitably from the BI.

¹⁹⁹ As was illustrated in Chapter Six, CHWs' activities in health prevention and promotion were relegated to peripheral status when CHWs began to resist marginalization, and focus on curative aspects of the BI.

reproductive health care in Kenya is through the services of local TBAs. But TBAs in Kenya have historically had few resources and little training to provide pregnant women with antenatal care and assist them in childbirth (Sundari, 1992; Raikes, 1992). Increasing TBAs' capacity to fulfil their responsibilities has been seen as integral to improving women's reproductive health status (e.g. Sundari, 1992). The failure of the BI strategy to address seriously the needs of both TBAs and pregnant women was a significant weakness in its conceptual framework. Third, the BI did not act as a catalyst through which women could gain greater access to and control over the means of production in Sigoti through their collective involvement in and control over health-related income generating activities deemed relevant by women in the community.²⁰⁰ Thus, the BI failed to embody a far-reaching process which works towards transforming structures of poverty and inequality that perpetuate women's ill health.

As discussed in Chapter Six, the breakdown in functioning of the Sigoti BI site was in part a product of the absence of a gender-sensitive strategy to incorporate women's articulated interests and concerns effectively into the BI process. Women's relationship to the BI management and implementation process was characterized by asymmetrical gender relations, whereby active involvement of women in the BI implementation process first, was characterized by an exploitative labour process, and second, was not met with their equitable voice in decision-making forums of the BI. The CHWs' (and the TBA's) subordinate position to men who held executive positions on the

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²⁰⁰ Other BI sites in Kenya, particularly in high potential areas (areas with potential for high agricultural output), have been more successful in initiating and sustaining income generating activities. The general resource base of the community appears to be an important factor determining the success of these activities (Personal Interview, 1995).

committee was one factor which undermined their autonomy in health care provision. Further, women in the community did not have an effective channel of communication or means of participation through which they could shape the health development process. Their participation was restricted to receiving benefits, and forwarding information related to the prevalent health problems in the community to CHWs. They did not, however, participate in defining potential solutions to deal with these problems. Exacerbating these constraints was women's poor representation at the District level in Kisumu.²⁰¹ Poor representation of women in macro forums has been identified as a key factor underlying the failure of health interventions to effectively incorporate women's needs into the health development process in Kenya (World Bank, 1989).²⁰²

But the lack of efficacy with which the Sigoti BI site met its objectives can also be attributed to the failure of Kenya's BI strategy to elicit a community-supportive environment in Sigoti. The organizational structures and processes created through the BI did not "genuinely encourage responsibility, initiative, decision-making and self-reliance at the community level" (Werner, 1980: 94). Conversely, several layers of structural dependency were created through the establishment of the BI, which inevitably undermined the capacity of various actors in Sigoti's BI to build autonomy in their roles.

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²⁰¹ As was noted in Chapter Four, only one of the seven members of the DHMT, a District Public Health Nurse, was a woman.

²⁰² As was seen in Sigoti, women participating in higher levels of the health system can play a role in redressing gender inequalities at the local level, where women in the community alone may have less success in this regard. CHWs obtained legal rights over funds generated through the BI pharmacy following advocacy on their behalf by the one female member of the DHMT, a district public health nurse (see page 184 of Chapter 6). CHWs were less successful in receiving support from the BI Coordinator, particularly with respect to compensation-related issues. Rather, blame was placed on CHWs for stepping outside the permissible boundaries of their roles in the BI.

This problem is in part a function of the incongruity between Kenya's BI policy and local realities in Sigoti. The conceptual framework of Kenya's BI strategy implicitly assumes that communities can generate enough revenue to cover all recurrent program costs, including the steady supply of drugs and mosquito bed nets. Experiences with community-based health care, both in Sigoti and elsewhere, have shown that heavy supervision and training of community-level organizational bodies responsible for the management of PHC, and adequate compensation, supervision and training of CHWs, are basic to any community-based PHC program (Mburu, 1994; UNICEF, 1991; WHO, 1989). There were no provisions in the strategy regarding how to deal with recurrent program expenses should the community encounter cost recovery problems. In Sigoti, low sales levels and problems associated with cost recovery were apparent in early stages of program implementation (Mcpake et al., 1992: 81). *Six years* after the inception of the program, the community was still unclear about budget management issues. As such, all other aspects of the program were subverted by the pre-occupation with cost recovery, including gender interests of CHWs, TBAs, and women in the community-at-large. The resulting impact on the functioning of the BI was devastating. The resistance of CHWs to their marginalization was an overt response to their unacceptable and exploitative working conditions.

It is important to note that despite the magnitude of operational and leadership problems at the Sigoti BI site, and despite the conflict among and between various actors, participants involved in the focus group discussions were keenly interested in reviving the project. Curative aspects of the BI were highly valued by the community. As such,

program breakdown was less the result of the community's resistance to the introduction of an unwanted intervention than it was a reflection of the Sigoti community's lack of means (that is, information, negotiating skills and resources) to manage its BI site effectively. In effect, the layers of structural dependency created through the BI were manifested in power struggles between and resistances of the various actors involved. It is interesting to note that UNICEF, as an external donor, was a seemingly benign influence over how the BI process developed at the District and local levels, despite UNICEF's position as ultimate powerholder in the BI process. Neither the pharmacy committee nor the District challenged the prescriptions of UNICEF regarding the management process, issues of compensation, and issues related to cost recovery -- however unrealistic and unattainable these prescriptions may have been for the Sigoti community.

By failing to guarantee funds for mandatory program costs such as compensation, supervision and training in the BI strategy, UNICEF essentially renders these activities fortunate outcomes of the strategy, as opposed to integral to its success. In particular, compensation for CHWs was seen in terms of an "added bonus" for CHWs, *if determined by the VHC*. Anything less than entrenching compensation for CHWs within the constitution of Kenya's BI represents the legitimization of the exploitation of CHWs by national and international policy actors, "in the spirit of health for all." While Kenya's BI strategy places importance on involving women in the committee and compensating CHWs, paying lipservice to these actions is not sufficient to deal with the women's inequitable relationship to the BI process, as was seen in Sigoti. Further,

expecting communities to drive the supervision and training process is problematic. As Andrea Cornwall et al. note, participatory projects which attempt to transform structures of poverty and inequality entail a long-term process "for which the personal and political commitment of external agents is vital" (Cornwall et al., 1993: 25).

The key factor underlying the strategy's failure to entrench mandatory recurrent program expenditures such as compensation for CHWs, and training and supervision for committees, CHWs and TBAs, is clear. The problem lies in the absolute shortage of resources available at the district level to fund these costs. Community-financing of these costs was assumed by UNICEF and the MOH to be the only potential alternative funding mechanism, given the resources allocated by the MOH to PHC at the district level. Yet, as experience from Sigoti suggests, if the community does not have the capacity to fund these expenditures, a likely outcome is program breakdown. The Sigoti BI required substantial and sustained resource commitments by the donor to maintain even its most basic service provided to the community -- essential drugs. This point is not meant to imply that all BI sites in Kenya have experienced the BI in the same way, but it does point to the problems associated with the BI strategy's failure to incorporate mechanisms to deal with both cost recovery problems and conflict situations should they arise.

The next section concludes with points of consideration for UNICEF and WHO.

7.3 Points of Consideration for WHO and UNICEF

Chapter Two stressed that an empowering health strategy entails a process whereby confidence and solidarity among rural people are built up (Oakley & Marsden, 1983). The BI in Sigoti did not foster confidence, it bred uncertainty; and it did not

build solidarity, but created divisiveness. The BI is a community-based strategy promoted and supported by UNICEF and Kenya's Ministry of Health. As such, both UNICEF and the MOH must take ultimate responsibility for ensuring that the community receives the requisite support to manage its program effectively. This is especially important in the context of the BI, because the curative care it provides is not a benign "market" item for sale which generates income for the community -- improper use of drugs by community members is potentially life threatening.

Experience from Sigoti suggests that where communities do not have the capacity to finance the BI, the BI is less than successful in meeting women's broad health care needs. Neither community participation nor the provision of essential drugs represented a "magic bullet" through which the PHC system was strengthened in Sigoti. In effect, the resource constraints of UNICEF, Kenya's Ministry of Health and the Sigoti community were not conducive to the successful implementation of the BI strategy in Sigoti.

A genuine commitment to effecting sustainable improvements in the lives of women and children necessitates international and national political will to empower women with knowledge, resources and decision-making power. In the face of structural poverty and inequality, a "laissez-faire" approach driven by the demand for drugs will not lead to sustainable improvements in women's lives. Rather, the allocation of sufficient resources for supervision, training, and the maintenance of dialogue between community members and external agents is the first step in a long-term process leading to more ambitious goals of women's empowerment.

Appendix 1 List of Participants

Key Informant Interviews

Alfred Abande	Primary Health Care Coordinator
Gilbert Ouko	District Public Health Nurse
Joel Owiyo	BI Coordinator
George Owuondo	Hospital Secretary
Hezbon Oluoch	Medical Officer of Health
Eliud Imbayi	District Public Health Officer

Focus Group Discussion - Pharmacy Committee

<i>Name</i>	<i>Position*</i>	<i>Occupation</i>	<i>Sub-location</i>
Leonard Obiero	Chairperson	Retired Teacher	Ramogi
Norman Okello	Secretary	Retired Teacher	Kajimbo
Wilson Ochieng	Asst. Secretary	Teacher	Koguta E.
George Koga	Treasurer	Retired Civil Servant	Kadianga
Debora Oyoo	Pharmacy Chairlady	TBA	Kadianga
Agneta Diela	Pharmacy Treasurer	CHW	Koguta E.
Rose Adhanja	Pharmacy Secretary	CHW	Ramogi

* Please note that there is a distinction between the executive of the pharmacy, who are CHWS or TBAs responsible for the daily operations of the pharmacy and the banking of funds, and the executive of the pharmacy committee, which is responsible for overseeing the activities of CHWs and making key decisions about use of funds.

Focus Group Discussion - TBAs

<i>Name</i>	<i>Age</i>	<i>Sub-location</i>
Debora Oyoo	60	Kadianga
Sarah Akulla	62	Ramogi
Rael Ambogo	58	Koguta East
Easter Akello	52	Kajimbo
Philista Otieno	48	Ramogi
Serphina Ogira	45	Ramogi
Rebecca Ajnang	*	Ramogi
Isdora Omolo	*	Koguta East
Siprosa Ongele	50	Ramogi
Rosalina A. Otieno	40	Ramogi

* These women were unable to provide this information.

Focus Group Discussion - CHWs

<i>Name</i>	<i>Age</i>	<i>Sub-location</i>
Suzanne Odhongo	39	Ramogi
Sylvia Goga	35	Ramogi
Clarice Otula	42	Ramogi
Juliana Odhongo	35	Ramogi
Mary Sigu	40	Ramogi
Martha Oniango	38	Ramogi
Silpa Denis	39	Ramogi
Rose Adhanja	39	Ramogi
Eunice Bondo	30	Ramogi
Penina Akinya	35	Kadianga W.
Naome Oyoo	35	Kadianga E.
Agneta Diela	45	Koguta E.
Margaret Oriedo	30	Koguta E.
Sylvia Owidi	38	Koguta E.
Grace Adem	38	Koguta E.
Joan Opiyo	38	Koguta E.
Carolyn Onyango	35	Kajimbo
Florence Okumu	39	Kajimbo

Focus Group Discussion - Women's Group Leaders

<i>Name</i>	<i>Women's Group</i>	<i>Sub-location</i>
Winnie Okoth	Kogondi	Ramogi
Rebecca Opiyo	Nyangwe	Ramogi
Rispa Okal	Kisero	Kajimbo
Christabel Omolo	Kasango	Kajimbo
Mary Ondulo	Ndori	Koguta East
Phidilia Guya	Siany	Koguta East

Household Survey

<i>Name</i>	<i>Age</i>	<i>Marital Status</i>	<i>Education*</i>	<i>Occupation**</i>
Sarah A. Onyango	20	Married	None	Business
Monica A. Were	23	Married	None	None
Jane Aoko	25	Married	Primary	Business
Margaret Augira	25	Single	Primary	Farming

Household Survey (con't)

<i>Name</i>	<i>Age</i>	<i>Marital Status</i>	<i>Education*</i>	<i>Occupation**</i>
Linet Achieng	26	Married	Primary	Business
Florence Odhiambo	26	Married	Secondary	Business
Jemimah Oketch	27	Married	None	Business
Esta A. Ojwang	28	Married	Primary	Farming
Penina Opiyo	29	Married	Primary	Farming
Monica Akinyi	29	Married	Primary	-
Jane Adhiambo	30	Married	Primary	Business
Jane A. Omollo	31	Married	Primary	Farming
Grach A. Ogutu	32	Widowed	Primary	Business
Bethsebe Juma	36	Married	None	Business
Kesia Olango	37	Married	None	-
Monica Onuonga	37	Married	None	Farming
Perez A. Ogal	38	Married	Secondary	Farming
Debora Ndege	38	Married	Primary	Farming
Tabitha A. Otoy	38	Married	None	Business
Ulda A. Agutu	39	Widowed	None	Farming
Josephine Atieno	40	Married	Primary	Farming
Bilie Odera	40	Married	Primary	Farming
Claris A. Otula	40	Married	Primary	Farming
Aska Sigu	40	Married	Primary	Farming
Monica Omollo	43	Married	None	Farming
Juliana A. Were	43	Married	None	Farming
Janet Abonyo	44	Married	Primary	Farming
Satome A. Ochieng	45	Married	Primary	Business
Mary Odengo	45	Married	Primary	Teaching
Milke Ongadi	45	Married	None	Farming
Ludie Opiyo	48	Married	Primary	Farming
Jeniga Opiyo	48	Married	Primary	Farming
Caren Abonyo	50	Married	No response	Farming
Justine Adongo	50	Widowed	None	Farming
Feleria Angele	50	Married	None	Farming
Mary A Aduda	50	Married	None	Farming
Nereah Atara	57	Married	None	Other (sick)
Rebecca Gaya	57	Married	None	-
Emma Atieno	58	Married	Secondary	Farming
Anna O. Ogutu	59	Married	None	Farming
Selina O. Ogola	60	Married	None	-
Dinna O. Owenje	60	Married	None	Farming
Maglide Sati	60	Married	None	Other (old)
Herina Opiyo	62	Married	Secondary	Farming

Household Survey (con't)

<i>Name</i>	<i>Age</i>	<i>Marital Status</i>	<i>Education*</i>	<i>Occupation**</i>
Eunita Otieno	64	Married	None	Farming
Priska Adhiambo	68	Widowed	None	Farming
Esther Awuonda	70	Married	None	Other (jobless)
Priskila Otieno	-	Married	None	Farming
Salome Tawo	-	Single	None	Other (old)

* Highest grade completed

** Categories used by AMREF in its Baseline Survey

Appendix 2

Focus Group Questions

The following questions are those that were actually used in each of the focus group discussions, based on the transcriptions of discussions. Anne's words are those that are included in this appendix. The first focus group was facilitated by Dr. Oranga, therefore, many of the questions reflect his input and direction during the discussions. For the four other group discussions (two with CHWs, one with TBAs, and one with women's group leaders), the questions reflect Anne's translation of my questions. In some cases the questions may not appear to logically follow one another, because they reflect points raised in the discussions, and possible digressions from the questions asked.

A. Focus Group Discussion with Pharmacy Committee

1. How did you form this committee?
2. Was the DHMT involved in this process?
3. Dr. Oranga: Is this the first committee that started this pharmacy or is this the second one?
4. Dr. Oranga: When was this next one chosen?
5. Dr. Oranga (to Agnes): Are you one of the committee members?
6. Dr. Oranga (to Agnes): From what you've said, what do you think is the problem that can't bring development to this pharmacy?
7. Dr. Oranga: How were you (the committee) selected? Was it by the community?
8. When you were forming this committee, did the DHMT involve itself in this process?
9. Who, and from which villages or sub-locations, was involved in this process?
10. So are there five (sub-locations)?
11. In this tug of war of the clans, what do they want? Is it ownership or do they want positions or are they...(interrupted)?
12. Dr. Oranga: Koguta wants the pharmacy to be removed from here?
13. Dr. Oranga: With this problem, can we say that this committee of yours is managing it?
14. Dr. Oranga: Now as it is when you go back to the issue that we are touching on the ..evaluation for the committee. By this time, how is the representation? Maybe we should start with that... Leonard Obiro comes from the sub-location Ramogi, village Ramogi. When this committee was being elected, did all these sub-locations participate?
15. Dr. Oranga: You were all together. How was the election done? Was it done by village, or could anybody be nominated from any sub-location?
16. Dr. Oranga: So, were they first of all made the representatives from their villages, selected by the villages?
17. Now why do you have, I can see that you have the pharmacy committee whereby you have the office and then I'm seeing, uh, this separate pharmacy treasurer. What's the role, for example, pharmacy treasurer, and the treasurer for the pharmacy committee?
18. Dr. Oranga: that means that the committee treasurer does a kind of auditing, or he has an auditing role rather than handling the money. And the same thing for the secretary, how does the pharmacy secretary share.. what are the responsibilities given to the pharmacy secretary?
19. Dr. Oranga: She says she is the pharmacy treasurer, so she receives the money and banks the money. Now what happens when it comes to withdrawal? Now the committee treasurer, what role does he play in withdrawals and things like that? Is he answerable or responsible for anything that happens to the money?

20. What are the main functions of this committee? Re-asked by Dr. Oranga: Generally what are the functions of the committee, what are the roles that you see as your functions, in this program, that might be too hypothetical, you might be seeing the function that maybe you should be doing and yet you are not doing. What do you think is the role that can be performed? To understand whether you are doing it then we'll maybe look at which one you are doing and which ones you are not doing.
21. Dr. Oranga: So what you've decided or the amount you've decided, they go and withdraw as it is and you still supervise how that money is used.
22. How do you make decisions? Re-asked by Dr. Oranga: One of the things, o.k., you have mentioned one in terms of calling meetings and then you do the planning and things like that. What is the linkage between you, the committee, and the CHWs?...let's say supervisory...you have a supervisory role over CHWs?
23. Is there anyone with another suggestion that can be given to that?
24. Who has another suggestion?
25. What do you discuss in your meetings?
26. Are you talking about what the CHWs and the TBAs do, not as the committee does? Does the committee do such things?
27. These meetings that you hold, are they always regularly or far apart?
28. Dr. Oranga: In any case, you want to withdraw some money. In meetings, everyone does not agree with one another?
29. Dr. Oranga: Is it a majority or some percentage that must agree? So even 51%, somebody has just won? Or does it have to be over 75%?
30. What type of training have you received from UNICEF?
31. Does the DHMT carry out their functions effectively? Re-asked by Dr. Oranga: What we really need there is whether training from the DHMT, I think that honourable Yusuf had talked about it, he comes from the MOH and they are the ones who have acted as the TOTs teaching the CHWs.
32. What is the relationship between the committee and the CHWs? Dr. Oranga: What the linkage is... What we're saying we've already discussed some of it in the rapid assessment. We are still having things hanging there, because what we wanted to find out from that question is the relationship between you, the committee, with women who are in charge of the pharmacy. This question arose when we saw the list that was given to us. That's why this question was framed. To see what kind of cooperation there was between this committee and those on the list that was given to us.
33. Dr. Oranga: One thing we are saying is this, like in this place one of the major rules of this pharmacy is to generate funds and these funds are to be able to spread out to help the community through primary health care. You can find places where they now raise chickens. Some people rear cattle, some people have also started their farms that they work in. Why do you do these? You don't do them for yourselves. The whole idea is that these are supposed to benefit the community. So, as a committee, how do you link with the sub-locations. Or how do you think these things can be decided? Because if you leave it here and you go and start it by yourselves the people will be upset. And so, if you do that, you should know that the BI is for the people. It is not yours.
34. Dr. Oranga: What she's [Anne] asking is this. When you are making these decisions in this committee, when you want to make decisions that will affect somebody, somewhere, will you just let the chairman decide?
35. And so, from those committees [VHCs at the sub-locational level] that have been passed at the meeting, and if they have what they think for themselves, do they have any power to say that they've not accepted what the pharmacy committee has said? Do you give them that opportunity on what they think?
36. Which people does this, your committee help? Re-asked by Dr. Oranga: The question is, this is accountability and so it is your accountability...if you do something wrong, now who points at you, or warns you about it?
37. Dr. Oranga: That's an interesting point. How, this is you mean the Chief, the District Officer, how do they come in, how do they step in?

38. Dr. Oranga: Do they (administration) get this initial feedback from the community or do they start it themselves?
39. Dr. Oranga: Who do you send the reports to? Do you normally send reports to Kisumu?
40. Dr. Oranga: How do you see the role of the DHMT. That is, how do you perceive the DHMT's role in the BI?
41. Dr. Oranga: And do you also think they should have dynamic training and retraining?
42. Dr. Oranga: So, with this training and re-training, I mean how do you pursue the retraining, because that has to be accompanied with support.
43. Dr. Oranga: But what are these things? Are there any mention of specifics? (This question is regarding the perceived failure of the DHMT to provide fair treatment and resources to Sigoti, as compared to other sites.)
44. Dr. Oranga: How does the DHMT influence your decisions?
45. Dr. Oranga: The thing is, say they don't pay attention, it seems they don't have a lot of interest over Sigoti. Why do you think that is happening? Why do you think that they're paying less attention to the BI activities here?
46. Dr. Oranga: Anybody else with any other contribution?
47. The relationship between the VHC and the DHMT, how do you think it can be strengthened?
48. Dr. Oranga: so there should be more visits?
49. What is the relationship between the pharmacy committee and the TOTs?
50. Dr. Oranga: Who is selling the nets?
51. Dr. Oranga: Who made that decision?
52. Dr. Oranga: Now in that case do these nets, do they end up here before they (TOTs) take them away to go and sell?
53. Dr. Oranga: They overpowered the CHWs?
54. Dr. Oranga: What about the pharmacy committee? Did you act, did you support them (CHWs)?
55. How much influence do TOTs have on BI operations?
56. How could this relationship be strengthened?
57. The rapid assessment states that the pharmacy committee consists of the original 24 CHWs and that they conflict with the decision-making role of the pharmacy committee. Can you clarify this?
58. Dr. Oranga: What types of decisions do they make, yeah well, this other group that does not participate actively on a daily basis? How do they come to decision-making, or do you involve them in decision-making?
59. What types of decisions can the committee make without consulting CHWs?
60. What are the problems with this approach?
61. How could the relationship with the CHWs be strengthened?
62. Dr. Oranga: This is the same response as the one which came first, that the meetings are being called and people don't turn up. Now what are the reasons?
63. The pharmacy committee said [in the rapid assessment] that CHWS were failing to submit the information regularly and were keeping money from the sale of drugs. Why do you think this is the case?
64. Dr. Oranga: So these drugs you buy using your money, but the original money came from here?
65. And now, why can't you return the money that came from here?
66. Long time [ago], how were you helping yourself?
67. Why are drug flow cards out of stock?
68. Why has the chalk and board system been abandoned?
69. What concerns have community members expressed to you about the way the BI is functioning?
70. Dr. Oranga: Do they think drugs are too expensive here?
71. Dr. Oranga: That we should reduce the prices here?
72. Dr. Oranga: Bed nets? [re: price]
73. How was the location of this pharmacy chosen?
74. Dr. Oranga: So that decision of coming here was agreed upon by everybody?
75. Who, specifically, was involved in this decision? VHCs, CHWs, community members?

76. Did the community vote?
77. Who benefits from this location the most? the least?
78. What is the reason for shortages in drug supply?
79. Does the pharmacy committee make requests to the DHMT that they want to buy drugs and they're turned down?
80. The DHMT is under the impression that the pharmacy is self-sufficient. Dr. Oranga: Are you self-sufficient?
81. Dr. Oranga: What areas of improvement do you think need to be done in managing the BI?

B. First Focus Group Discussion with CHWs

1. Amongst you all, how many of you have been CHWs since 1989?
2. Before you became CHWs, who approached you to become one?
3. Who approached you and told you to become CHWs, and which people trained you in this work?
4. In December, when the rapid assessment was done, it was found that the 24 CHWs who started this project felt that they could give help to the whole catchment area, now it was found that there are 71 other CHWs that have also been trained. Why do you think that the 24 CHWS think that they can give help to the whole catchment area?
5. Now, I want to ask you another question before we move ahead. Now, do you feel that the CHWs who were added later work on their own without involving you?
6. Because of this reason, do you still report?
7. As the CHWs, who do you report to?
8. What is your relationship with the pharmacy committee?
9. Why is it that many people in the pharmacy committee are men?
10. Why is it that the original CHWs were left out of the pharmacy committee?
11. Do you think that because some of the CHWs are members of the pharmacy committee, your problems are solved?
12. Was the first pharmacy committee formed in 1992?
13. Was this committee (the first) formed with the CHWs or with the men?
14. When the first committee was formed, is [this] when you started having these problems?
15. So when you wanted to keep this money, is [this] when you started to have these problems, or when did these problems erupt?
16. Before you started the first pharmacy committee, was there any money that had been kept or had been given to you?
17. How regularly do you meet with the pharmacy committee?
18. Do you, as CHWs, meet?
19. What do you discuss in your meetings?
20. How do you think you can work with the pharmacy committee, and if you can't work with them, do you think you can form another committee that you can work with?
21. Since the CHWs are in the pharmacy committee, do you have any right to say what you think the funds would be used for, like we want drugs to be brought, or the nets, or the prices of drugs, things like that?
22. Can the CHWs do something without consulting the pharmacy committee?
23. What do you do if you had decided to do something but the committee does nothing towards it?
24. Why does the pharmacy committee reject what you pass in your meetings as CHWs, and what else do they do without consulting you?
25. From the money you've received from the sale of drugs or nets, have you ever made a decision about what you would like to do with the money?
26. According to what you've said, is it something that has been discussed by the pharmacy committee and the CHWs, or is it just something that you've decided as the CHWs?
27. Has the pharmacy committee accepted your decision?

28. Because the present committee has more men than women, do you feel that the next one should have more women or just the CHWs as the pharmacy committee?
29. It has been found that the CHWs sell other drugs apart from the ones they are provided with. Even they get some from Kentons in Kisumu. So, what is the reason that brings this issue? Is it because you don't get some allowance, or what is it?
30. Amongst you as the CHWs, are there people who are in the VHC at the sub-location level?
31. What is the relationship that the CHWs have with the VHC in your areas?
32. What do you discuss in those meetings?
33. Have you been doing the curative more than the prevention methods? Why is this happening?
34. So it is not true that you've left preventing diseases and just cure?
35. Can the VHC do something without consulting CHWs?
36. So, are you happy with the relationship you have with the VHC?
37. Do you vote when the VHC is being chosen (by a show of hands, secret ballot, or by some people going out)?
38. Must all the community be present when you are choosing the VHC?
39. Why is it that most of the VHC members are men? And if there are more men, are there problems that you have?
40. Do you make decisions with the VHC, and if you're doing so, do they give you any help after making those decisions?
41. What do the divisional TOTs do for you?
42. What influence do the TOTs have on your work?
43. What do you do if you feel that the TOTs have done a bad thing? Like the pharmacy committee says that the TOTs took the bed nets and they sold them, yet you were the ones to do that work. Now, in such cases, what do you do if such a thing happens?
44. So, are you happy with the way you work with the TOTs?
45. How regularly do you get patients that cannot afford to buy drugs?
46. Now, if the patients can't afford to buy the drugs, what do you do as CHWs, what help do you give them?
47. Which months, or days of the year are there many diseases, or are the patients many?
48. During which time of the year do you find that many people cannot afford to pay for the drugs?

C. Second Focus Group Discussion with CHWs

1. At first, you said that many people who are sick cannot pay for the drugs, so as CHWs, you find that you have debts that you're not capable of paying; so, have you ever taken the reports to the pharmacy committee that you have debts that you can't pay because some people cannot afford these drugs?
2. After it has taken long without these debts being paid, have the pharmacy committee seen how they can help you cover the debts?
3. Since you don't have the drug flow cards and you have the debts, how do you know the amount of debts you have?
4. Why did they start giving you drugs after paying for them is when you sell them [when did you have begin having to purchase drugs prior to selling them to community members]?
5. Do you feel that it's good to buy drugs on delivery or it's bad since you are the ones who now incur the debts?
6. It is good if UNICEF knows that you have these debts, because if everything seemed to be going on well in the pharmacy, then they wouldn't know the exact thing. If the debts are recorded in the pharmacy, then UNICEF will know about it, but if you are the ones who have the debts back at home then it's not good, since they wouldn't know about it. So would you like UNICEF to know about it, since they want everybody's needs to be catered to? What do you think about it?
7. Do you always give the list or write the names to the pharmacy committee to know the people who cannot afford to pay for the drugs?

8. Does it happen that at times you don't treat people who cannot afford to pay for the drugs, or does it happen that after treating these people, you are not able to pay for those debts?
9. How often do you get people who cannot pay for the drugs, maybe in a week?
10. What percentage of households are women-headed? (explained the difference between de jure and de facto)
11. In such a case, do you find that mostly women are the ones who use their income to cater for the family needs more than men?
12. How do the women get income to see that the activities required are catered to? What activities do they do to get this income?
13. How often do you do the home visits?
14. And are there some households that you can't go for home visits due to the distance?
15. Are you called for when somebody's sick, or how do you know when a person is sick? Then you go and visit the person?
16. Do you find that you are mostly called for, or do you just visit the homes and you get to know the people who are sick?
17. How do people know that you are the one who is responsible for the village as a CHW?
18. Do you always find that people know you without telling them, as CHWs?
19. What problems do the women in the community tell you about the BI?
20. What are the problems that people tell you that they encounter about Bamako?
21. After getting these problems, do you forward them to the pharmacy committee, or do you just discuss them amongst yourselves on what to do?
22. Does the pharmacy committee do anything to solve the problems?
23. During your meetings (with the community), do you consider or discuss about the problems that people tell you, like when they cry that there's no water and the rest?
24. You said that you know people who cannot afford to buy the drugs and so we'd like each of you to write a list of names of people who are not able to buy drugs in the areas you come from.
25. How do you know, or define that somebody is poor or unable (like this person is blind, doesn't have land, etc.)?
26. How has your work as CHWs changed your role in the community and what benefits do you get from it?
27. As CHWs, how do your husbands react to your work? Do they give you any support or do they get annoyed since you're not paid for it. Is it good for them, or is it bad for them?
28. Why were you chosen to be CHWs?
29. Are there any CHWs amongst you who come from homesteads where they're unable or cannot get any help?
30. Amongst you as CHWs, do you have some people whose names can appear on the lists you are to write of the people who are unable to pay?
31. According to the question we asked last time, it was found out that the 24 CHWs feel that they can give help to the catchment area because the other 71 CHWs might bring other problems. So give us some of the problems that they're likely to bring.
32. The CHWs felt that they should form a new pharmacy committee and the pharmacy is not theirs, so how will you know that the decisions you've made are accepted by the community?
33. Do you think that people will accept that you have another election?
34. Do you accept that apart from these 24 CHWs, some women from the community could be chosen to be part of the pharmacy committee?
35. Do you feel that the CHWs and other women from the community, or the 71 CHWs should be elected to form another pharmacy committee, or how would you like it to be done?
36. Would you allow Donna to see the minutes that had been made by the CHWs and given to the committee?
37. According to the problems that came up, they started when the bank account was opened. So when was the bank account opened?
38. From the answer we got from a CHW, at first there were no problems with the first pharmacy

committee, but when the second pharmacy committee was elected, the problems started. So these things are contrasting because you opened the bank account in 1989 with the first pharmacy committee, so please clarify what you mean.

39. Is it that when the second election was done for the pharmacy committee, it's not that men want to be the signatories?
40. According to an answer we got, we find that the CHWs have some power because they're signatories and so nothing can be done without consulting the CHWs. Do you think that if the men on the pharmacy committee were the signatories, they would not consult you before using the money?
41. Do you think that men in the pharmacy committee would have used the money without consulting you if they were the signatories?
42. Do you think that the way you feel is the same way the government feels?
43. How can the men react when you tell them that the project should be for only the women?
44. You said that you'd like to have a home where you could start some projects, like a dispensary, nursery school, kitchen garden. Had you discussed about these with the community?
45. What benefits do you think the community will get from the projects like kitchen gardens, nurseries, etc..?
46. Why do you feel that if another pharmacy committee is elected, it should involve the CHWs and women from the community? Do you think that they will cater for the community well, or do you feel that you should be together with them?
47. When did you start buying the drugs using your own cash as CHWs and that's when you were given the drugs to go and sell?
48. When did this start?
49. According to the question you were asked, you told us that if somebody is sick, the person is given a prescription from the doctor. Then the person brings you the card and you go and buy for her the drugs, maybe in Kisumu, from the chemists. How do you get money to Kisumu just to buy drugs for one person?
50. There was a question we asked, and one CHW said that only the essential drug management is standing. So does it mean that there are no other activities that you can get some income from?
51. Is it because you've relaxed that you've left doing the preventive measures or is it because of the problems that you encounter?
52. Do these people, who are poor or unable, come to vote during the elections?

D. Focus Group with TBAs

1. What is the role that you have in the BI?
2. According to these problems that you're encountering, who do you report to that you don't have gloves, forceps, etc..?
3. Has the pharmacy committee helped you in the problems you've taken to them?
4. What do you do for the women who cannot afford to buy the delivery kit?
5. What percentage of women do you find that don't have the delivery kit or that don't have those things you can help them with?
6. Are the kits available?
7. The women that are pregnant, and you know them, do you always tell them to buy the kits, maybe three months before delivery?
8. Have the women always been told that they should pay for the kits given to them?
9. How many people do you help deliver in your villages?
10. What percentage of women deliver by themselves, without any help from the TBAs or from the hospital?
11. Why is it that when the BI was started, you were not given delivery kits to go with, so that after getting the money, you bring it back to the pharmacy?
12. When it was introduced, that you had to buy the delivery kits, were you happy with it?
13. Have you told the pharmacy committee that you're not happy about buying the delivery kits?

14. How many of you were TBAs before the pharmacy was brought here?
15. How has Bamako helped you in your work as TBAs?
16. Do you help the pharmacy committee in decision-making, like how funds can be used?
17. Do you think that if some of you are in the pharmacy committee they can solve your problems?
18. Have you ever gone to the local chief for this place to give you some help?
19. After telling the pharmacy committee, do you think you can get some help from other people, like even the Chief?
20. Do you attend the barazas?
21. Do you have your own committee, and do you meet?
22. How do the women who are almost delivering, who can't afford delivery kits, how do they tell the BI to give them some help?
23. How do the pregnant women know about the TBAs?
24. Do you tell them about this in the barazas, or do they know from their homes?
25. How regularly do you check those who are almost delivering? So, when their time comes for delivery, you don't have to fear, since you knew about it before?
26. Do you attend to the women who are almost delivering before that time comes?
27. Do you help the committee in making decisions, like the materials you need, such as delivery kits so that you can get them?
28. Do you have any relationship with the VHC?

E. Focus Group with Women's Group Leaders

1. Do you know when Bamako was started and why, and its objectives?
2. When the nets and drugs were brought, did you participate, did the community participate in deciding on the prices of the nets and drugs or did the pharmacy do it on their own?
3. Do you find that if the community complains on the prices of drugs or nets, the committee listens to it and lowers it, or they do nothing to it?
4. When the community has a problem like, the poor who cannot buy drugs and they tell the committee about it, how or what do the committee do about it? How do they solve the problems that you have?
5. As women from the community, do you get some priorities from Bamako more than from other groups?
6. What concerns does the community have about Bamako (CHWs, committee problems, etc.)?
7. Do you find that Bamako concerns only things to do with racks, diet, putting up latrines, etc., or is it that the community also informs them on the outbreak of diseases, complaints, etc.?
8. You find that the community should be aware on how the funds are used. For example, you should be able to know the projects developed by the use of these funds; since the community is part and parcel of Bamako, because their aim is to benefit everybody in the community. So, do you always participate in how the funds are used in different activities. Have you always suggested on the activities to be carried out using the funds?
9. Have you always, or have you ever told the pharmacy committee about the activities you want to carry out, like if you'd like to start projects like kitchen gardening, and it happens, or you never dared inform them on the activities you want to develop?
10. We got from the CHWs, TBAs, committee that when they want to carry any activity using the funds, they discuss about it and inform the community before doing it, so from you, we found out that you don't know how or what the funds are used for. So, is it true that what they said happens? For example, when you say you want each sub-location to have its pharmacy, do you discuss it with them?
11. During elections of the CHWs, TBAs, do you vote at that time?
12. When elections are being done, do you find that the majority are men or women (who participate)?
13. Why does that happen and are you happy that the majority who participate in the election are men?
14. What are your complaints about Bamako?
15. Do you feel that in most cases the poor who cannot afford the drugs and are not treated?
16. Who do you inform about the problems you encounter or the activities you want to carry out, like

when somebody cannot be able to afford the required dose?

17. Do you find that many women participate in women's groups, or do you find that some don't because of lack of information, time, or because of the activities they attend to?
18. Are the poor people also involved in the women's groups?
19. How do women get information about health? Do they find information from the women's group leaders or the community, or do they get the information from the CHWs, TBAs?
20. Do women attend barazas, and if they do, do they get information about health?

Appendix 3

Pharmacy Committee Members as at April, 1995

<i>Name</i>	<i>Title</i>	<i>Sub-Location</i>	<i>Occupation</i>
Leonard Obiero	Chairperson	Ramogi	Retired Teacher
George Koga	Treasurer	Kadianga	Retired Civil Servant
Norman Akello	Secretary	Kajimbo	Retired Teacher
Wilson Ochieng	Assistant Secretary	Koguta E.	Teacher
Deborah Oyoo	Pharmacy Chairlady	Kadianga	TBA, no formal occupation
Joan Opiyo	Pharmacy Vice Chairlady	Koguta E.	CHW, no formal occupation
Jane Odhiambo	Pharmacy Asst. Chairlady	Koguta E.	Teacher
Rose Adanja	Pharmacy Secretary	Ramogi	CHW, no formal occupation
Agneta Diela	Pharmacy Treasurer	Koguta E.	CHW, no formal occupation
Chrispin Ouko	Bookkeeper	Kadianga	no formal occupation
Silpa Nakinya	Member	Koguta E.	Family Planning Officer, TOT
Judith Omonde	Member	Kadianga	Nurse, TOT

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