The Dissonance Between the Rhetoric and Reality of

Health Policy and Service Delivery:

A case study of gender and primary health care in Gwassi, Kenya

Sally Eleanor Crook

Gender Institute

London School of Economics and Political Science

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Abstract

This thesis exposes the gendered assumptions underlying primary health care policies and practices in developing countries and the power relations underpinning them. These are offered as reasons for the dissonance between the rhetoric of health policy and the reality of health service practice, drawing on a case study of primary health care in Gwassi in rural south-west Kenya, served by government, diocesan and international NGO health services. Theoretically the research is animated by organisational theory to develop an approach that goes beyond a traditional evaluative stance of the planning and delivery of health services, instead making visible and giving voice to the users.

The thesis argues that gender frequently remains hidden, unexplored or untheorised, but is nevertheless embedded in the sociological, organisational, economic and medical models regularly used to both plan and research health care. The present globally prescribed model of primary health care rests on just such gendered premises, which have been incorporated and insinuated into national health policies and professions. Historical roots for today's rituals and practices in primary health care in Gwassi are examined using a gendered perspective. Due to the preponderance of maternal and child health activities in such rural locations, along with the use of community health workers in health care delivery, these aspects are focused upon in the literature review of primary health care that frames the research.

The thesis concludes that the lack of attention paid to the gendered nature of primary health care by health policy analysts and planners has resulted in and perpetuated a health service, which is designed and delivered in response to a skewed view of the community and its health needs. This in turn limits effective and feasible solutions to health problems. Through a gendered analysis of the findings it is concluded that in practice, primary health care only recognises women's roles and consequently mandates health responsibilities and activities to women. Men's roles are ignored and their participation remains optional, with gendered consequences for all health care users as well as for the efficacy of the service.

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Tables

Acronyms

AIDS	Auto Immune Disease Syndrome
AN	Antenatal
ANC	Antenatal Care
BMJ	British Medical Journal
CHC	Child Health Clinic
CHW	Community Health Worker
CMO	Clinical Medical Officer
CRS	Catholic Relief Society
DANIDA	Danish International Development Assistance
DFID	Department for International Development
DHS	Demographic Health Survey
DMO	District Medical Officer
DO	District Officer
DVS	Danish Voluntary Service
EOC	Emergency Obstetric Care
EPI	Expanded Programme for Immunisation
FACS	Food and Child Survival (project)
FP	Family Planning
GAD	Gender And Development
GOBI-FFF	Growth monitoring, Oral rehydration, Breast feeding, Immunisations – Family Planning, Female Education, Food supplements
GOK	Government of Kenya
HC	Health Centre
HFA	Height For Age
HIV	Human Immunodeficiency Virus
HSP	Health Sector Reforms
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
INGO	International Non Government Organisation
IT	Information Technology
KCPE	Kenya Certificate of Primary Education
KEN	Kenyan Enrolled Nurse
KRM	Kenyan Registered Midwife
KRN	Kenyan Registered Nurse
KSh	Kenya Shilling
MCH	Maternal and Child Health
MMR	Maternal Mortality Rate
MoH	Ministry of Health
MOH	Medical Officer for Health
NCPD	National Council for Population and Development
NHS	National Health Service (British)
NGO	Non Government Organization
OPD	Outpatient Department
PH	Public Health
PHC	Primary Health Care
PHCW	Primary Health Care Worker
PR	Participatory Research
PRA	Participatory Research Assessment
RCT	Randomised Controlled Trial

RH	Reproductive Health
SDA	Seventh Day Adventist church
SPHC	Selective Primary Health Care
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SWAPs	Sector Wide Approaches
TAC	Teachers Advisory Centres
TB	Tuberculosis
TINA	There Is No Alternative
TFR	Total Fertility Rate
U5M	Under Five (years old) Mortality
UN	United Nations
UNAIDS	United Nations Fund for AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States department for Aid
VRP	Village Responsible Person
WB	World Bank
WFA	Weight For Age
WFH	Weight For Height
WHO	World Health Organization

Chapter 1   An overview of gender, organisations and health

Introduction

This thesis exposes some of the gender assumptions that underpin the present day models of primary health care, through a case study of primary health care delivery in Gwassi in rural Kenya. It is argued that uncovering gendered assumptions and the power relations that underpin them helps elucidate reasons for the dissonance between the rhetoric and the reality of health policy and health service delivery. The analysis is founded upon the observation that the health care offered in rural areas of sub-Saharan Africa follows a highly prescribed form. This is due to the interplay of historical factors that have their roots in colonial and postcolonial models of health and development (Vaughan, 1991; Tranberg Hansen, 1992), as well as the institutionalisation of contemporary medical and economic paradigms (Lupton, 1995). It is argued that these factors continue to be influential, including within generic global models advocated by the World Health Organisation, UNICEF, the World Bank and other major agencies working in the field of health. It is demonstrated through the present research that they also underpin the less-than-ideal delivery of primary health care as practiced in rural south-west Kenya by both governmental and non-governmental providers.

The research investigates the reasons for the persistent inability to overcome barriers to change in the delivery of primary health care, such that it responds more effectively to gendered health needs and the reality of women's and men's lives. The research involved participant observation and investigation of the perceptions and attitudes of both providers and users in clinic and community situations. Here the discourse and relations between practitioners and community members was explored, rather than the organisation of the health service itself.

This first chapter provides the context out of which the investigation grew, with a brief overview of academic and practical approaches to the gendered assumptions and gendered blindness evident in development in general, health organisations more particularly, as well as in the analysis and understanding of daily lives. Many of these gendered assumptions are being challenged by feminist research, at both

epistemological and methodological levels. The present research is animated by this challenge and an important critique underpinning it is that the gendered assumptions that underlie primary health care policy and planning are usually ignored or taken as unproblematic.

Gendered assumptions in development

Fundamental to the analysis advanced in this thesis is a recognition that the prescribed model of health services described above, rests on highly gendered assumptions that have been incorporated into the medical profession and health services through the course of their development over the past century. However, because health systems, like all modernist enterprises, usually make claims of being scientific, they are often regarded as objective and hence un-gendered or gender neutral (Hearn and Parker, 1993; Pfeffer, 1997; Hearn, 1998). Much feminist research over the past few decades has revealed the many gender biases (Elson, 1995) do in fact exist. They are present and deeply entrenched at epistemological and methodological levels within the academy, and follow through into policy applications and models that arise from theory and analysis (Jackson and Pearson, 1998).

Gender awareness is an important basis for categorisation in society and in social policy and planning, as it is one of the ways in which individuals and organisations make sense of society (Geis, 1993). However, although gender categorisation is common it is not always correct and policy makers and planners like people generally, are not always infallible in this regard (Banaji, 1993; Folbre, 1988). There is a tendency, therefore, to use ideas about gender roles and responsibilities in a biased way, and this gives rise to stereotypes and assumptions that produce circular arguments in both our understanding of social life and the policy, planning and management of development initiatives that flow from it. As Elson and Pearson pointed out in the mid-1980s: the problem is not that women are "left out" of analysis and the development process, but that gender relations are factored "in it" in particular ways and are often transformed by it (Elson and Pearson, 1984, Ch.2). This insight is the starting point of the present research. Similarly the research takes off from the claim by MacIntosh (1984, Ch.1) that:

The object of analysis should not be women and their role in social production but the relations between men and women within the social process as a whole and the way in which those relations work to the detriment of women.

These two observations, drawn from the 1980s remain a critical starting point for looking at health policy and practice through a gendered lens today. A concern with much gender-sensitive research is that often the research fails to theorise adequately the multiple dimensions and levels at which gender and power relations operate (Halford and Leonard 2001, Chs 1 and 7). Elson (1994) refers to macro-, meso- and micro-levels in her analysis of the economic sphere and Levy has demonstrated the links between our understanding of the lived experiences of women and men and how this may or may not translate into gender sensitive policy (Levy 1996). For Elson, problems occur due to what she calls 'male bias' at all three levels of analysis in present development theory. Elson also identifies the problem of *either* looking at the family level, *or* looking at the state level, but rarely considering how these overlap and inter-relate in reality. More recently, the links between institutions operating at the different levels of state, society and the economy (including academia) and gender relations within the family or household have been accorded greater emphasis (Beall and Kanji, 1999; Goetz, 1998; Moore, 1988, 1994). The interplay between gender relations operative at different levels of analysis or engagement can be seen to affect the policy, planning and practice of health services.[1]

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[1] See Claeson et al 2001 on the need to consider these three levels in a World Bank (WB) strategy paper on Poverty Reduction and the Health Sector (para 5). However, the WB does not consider the patients or community as part of the organisational system at the micro-level, reserving this level for service provision.

Gender blindness in health organisations

In order to understand how historical factors and contemporary medical and economic paradigms influencing gendered practices become embedded in the actual local delivery of a health service, the present research draws on organisational literature. In doing so, it includes in the conceptual framework issues of power, as well as a consideration of the analytical boundaries raised around what constitutes 'the health sector'. The starting point here is the assumption that gender bias occurs at all levels of health service planning and delivery and is reinforced by the paradigms advanced, the methodologies used, the medical practices followed, data collected and the way it is then interpreted in research and the findings used in planning and management. The thesis reviews some of the gender biases which have been found to operate within health service organisations generally. It then seeks to understand how such biases are being perpetuated through the empirical study of the organisation of a particular health service in rural Kenya. The investigation examines how this occurs not only on the part of those engaged in the delivery of the service, but also by those who interact with the service.

The past two decades have seen a sustained proliferation of information relating to gender imbalances in development in general and in the health sector in particular. A number of United Nations (UN), World Bank and academic publications state the need to take gender issues into account and to invest in women (e.g. Buvinic et al 1996). However, as pointed out by Geissler (1993), O'Connell (1996), Razavi (1997), frequently this rhetoric does not become translated into either policy or practice. The situation on the ground, at the point of delivery, often remains unchanged in fundamental and important areas (Walker, 1995; Smyth, 1999). Moreover, the ability of individuals to interact with programmes as presently planned and delivered can be limited, due to underlying assumptions that do not accurately reflect the reality of their lives (Bryceson, 1995; Elson, 1995; Leslie, 1989; Ostergaard, 1992; Standing, 1997). As mentioned, this thesis investigates the reasons for the persistent inability to overcome barriers for change in the delivery of primary health care, such that it responds more effectively to the reality of women's lives.

A review of the literature suggests that many of the blockages to change in health service delivery are rooted in intransigent theoretical perspectives and conceptual

frameworks as well as inappropriate models used in health planning and policy. However, for the health practitioners involved at the 'coal-face', the barriers often seem more prosaic and appear to be insurmountable due to pressures of work, lack of resources and limited time for reflection or room for innovation. For the users who are interacting with the service, the limits to change can be due to lack of influence or simply to a lack of knowledge or imagination of possible alternatives (Oakley, 1993). The recognition that these two important stakeholder groups - providers and users of health care - appear to hold very conservative views is an important starting point for the present research, as it seeks to understand the seeming lack of current alternatives in health service delivery in both planning and practice. Within health service research it is also clear that these two groups are frequently addressed in isolation from each other, with a focus either on the health service providers, or those to whom the service is delivered. The present research departs from this dichotomised thinking and, drawing on participant observation of their interaction at clinic and community level, explores the perceptions of providers and users, as well as non-users. This endeavour is assisted by using Foucault's approach to an analysis of power and how all stakeholders are perceived as complicit in the perpetuation of the power / knowledge axis. One way that this is achieved is through identifying the use of norms to which individuals can measure themselves (Rabinow 1991).

In seeking to understand the embeddedness of ideas and practices within organisations, use has been made of the literature on development where there is a clearly articulated debate raising issues on how researchers and theoreticians on the one hand, and policy makers and practitioners on the other, must re-assess their work to move beyond the present impasse between analysis and action.[2] Leach and Mearns (1996), from an environmental / development perspective, point out how claims to 'truth' rest upon particular theories, methodologies and methods and that such claims to 'truth' serve particular institutions and interest groups. However, they assert that one 'truth' obscures or displaces other possible 'truths' (p.6) and that 'received wisdom' is simply a set of beliefs held by the establishment. Reality then becomes 'boxed-in' in institutional establishments with pre-conceived agendas and 'labelling conventions' (p.6). Crewe and Harrison (1998) in their overview of aid, also focus on such 'received wisdom' and how ideas and assumptions are perpetuated in

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[2] The issue of translating research into policy and action is not confined to the consideration of gender (Surr et al 2002).

bureaucratic organisations. Such considerations infuse the organisational perspective employed in this research of health services, to explain how even when gender has appeared as a crosscutting theme, it becomes 'boxed-in' at many different levels.

In the health sector there has been less analysis of this sort and access to 'truth' is strongly defended by the medical establishment, with dominant paradigms remaining strongly in the medical model. Wider health issues are sidelined as the medical model continues to be justified through present data collection systems which focus on communicable diseases (Collins et al, 1999). Although health is acknowledged to have a high social content, much research is conducted by way of a strictly medical model, with emphasis placed on empirical data and results. In public health, epidemiology and statistics remain in ascendance (Petersen and Lupton, 2000, Ch.2; Gabe, 1995). Fee and Porter (1992) point out that the statistician has been identified as the most important person in the public health team. Without adequate attention being paid to the social content of health, it is difficult to insert a concern with gender issues. A social perspective should be included in all public health research (Baum, 1995; Weaver et al, 1996) but often gets squeezed out due to medical reliance on quantitative data (Popay and Williams, 1996; Kernick, 2000). This failure to engage with alternative perspectives is seen by Nyamwaro et al (1998) and Williams et al (2002), as due in part to the lack of structures to aid the incorporation of socio-cultural information into health planning.[3] Moreover, much current health care planning is superficial and biased towards service inputs and outputs and its own costs, rather than towards accommodating social complexity (Simon et al, 2001). Such managerial or insider bias is discussed in Chapter Two, with reference to theoretical perspectives on organisations.

Paolisso and Leslie (1995) suggest that innovative research is required to move beyond medical models, and to attempt to understand women's perceptions of their own health needs through focusing on users and non-users of formal health care and constraints faced in accessing health care. This approach concurs with that of Inhorn and Whittle (2001) who see the need for the active engagement of women in health research, with the starting point being health needs as women themselves define them, not as identified by outsiders. These are important observations for the concern in the

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[3] Recent work in onchoceriasis prevention has successfully incorporated social research into the programme in order to respond to issues as they arose (quoted in Surr et al 2002).

present research with the perceptions of users and non-users. It is more difficult to find literature concerned with engendering the organisation of health care itself. Tolhurst (1998) attempts to move beyond identifying problems and towards providing solutions for improving gender awareness in the health sector. Although agreeing that information, training and the supervision needs of staff must be addressed, her examples remain squarely in the traditional models of health policy and health economics. The examples are also focused on *either* the macro- *or* the meso-levels. The argument advanced in this thesis is that such a separation is false and allows important gender issues to be ignored or downplayed in both research and policy. First, it allows medical models to proliferate in the absence of a social medium that by definition is more open to gender analysis. Second, over-emphasis on policy obscures from view meso- and micro-level analysis of problems, required for a more bottom-up analysis concerned with implementation and delivery.

Gender and daily lives

Critical to engendering health policy, planning and implementation is a recognition that gendered assumptions about roles and responsibilities within families, and particularly the issue of who constitutes the carers, infuses the design and delivery of health care. Moreover, it is often western ethnocentric assumptions about the sexual division of labour, family sharing of income, resources, task distribution and the primacy of women's domestic responsibilities (Tranberg Hansen, 1992) that inform understanding of and solutions to development. Middle-class family patterns are assumed to pertain by health policy makers and health workers (Ostergaard, 1992) around the world. These assumptions then feed into health policy and practice models, which are exported as the "natural" way to run services and clinics around the world, which is depressing and powerful. The linkages between private and public institutions are most acutely seen in social and health policy areas. As Hearn (1998, p.11) has argued, "...for [the welfare state and social policy] the primary focus appears to be the agendered citizen, even though it is implicitly gendered, being based on the assumptions of the nuclear family and the unpaid work of women".

Assumptions about gender incorporate sweeping generalisations and stereotypes about both men and women (Chant and Gutmann, 2000). The assumption that all

women conform to a western ideal of womanhood, including motherhood and nuclear families with pooled income and expenditure patterns (Ostergaard, 1992; Safa, 1995), allows additional pressures to build up for women when interacting with presently conceived and activated health programmes (Leslie, 1992). This bias of a nuclear family ideal has also allowed men to be ignored, as primary health care has been planned to interact mainly with women and children. Despite recent moves towards reproductive health rather than maternal and child health (Mayhew, 1997; Lush et al, 1999), men remain marginal in health service research and delivery (Greene, 2000).

Recent research into child health clinics in Britain demonstrates that gender roles are reinforced by health staff. The staff actively respond with different reactions and have different interactions with fathers compared to mothers, making starkly visible some of the culturally-constructed assumptions that we have about nurturing roles (Edwards, 1998). This example drawn from Britain, of health visitors' assumptions of mothers' and fathers' innate abilities as child carers, was explored in the present research and is reflected in the child health policy and practices around the world.

Oakley and Rigby (1998) point out that the way early gender-blind sociologists have defined the family is now repeated in the way epidemiologists study social patterns of health and illness. These same theoretical styles are likely to reproduce the same gender biases, gender blindness and theoretical impasses that the earlier sociological work produced. This in turn filters down to health policy makers, who are static in terms of their understanding of gender relations, which then reinforces and reproduces the gender stereotypes that were created by researchers and planners in the first place. This vicious circle is expanded upon and explained in Chapter Two.

Sub-Saharan African Health Programmes

The present research is specifically concerned with health care provision in a rural area in sub-Saharan Africa. In such regions it is women (not men) who are invariably the ones who are asked to interact with health services, both as users of health services for themselves and their families (especially children) and as providers of both paid and unpaid health care services. With this in mind, the present research has focused on whether and why:

a) Women use or do not make regular use of clinic services (specifically antenatal, family planning, child health and immunisation clinic services);

b) Women obtain benefits from such attendance, particularly in the light of the costs and opportunity costs expended in use of such clinics;

c) Community health workers being used as unpaid junior staff in the delivery of primary health care (PHC) services is of benefit and to whom;

d) Men react to their exclusion from this model – both from clinic services and the role of community health workers.

The literature suggests that there is a high opportunity cost for the women in participating and this cost is often transferred to girls and younger women in a household (e.g. through removal from school to complete the household chores, care for siblings and so on) (Turshen, 1991; Reynolds, 1991; Mosse, 1993; Fuller and Liang, 1999). Yet this cost is generally ignored by the health service planners and providers for, despite the present day emphasis on economic issues in health care planning, many community and social costs remain invisible and absent from consideration. For many years we have known that women are overextended in their daily activities in rural sub-Saharan Africa and the time constraints they face are not considered in the planning of health services (Leslie, 1992). The role of men, though, remains under-researched and their input into general family health unknown.[4] For this reason the research seeks to understand the constraints of conventional models of health care provision in rural sub-Saharan Africa on intra-household responsibilities and gender relations. In doing so this research is interested in the wider community (older people, younger people, women and men) and how they view and interact with the services presently provided, given the constraints they face as a result of their designation in households and communities.

In looking at health services I am interested in elucidating (paraphrasing Ann Oakley's words) "Why women use clinics – not why they do not" (1992) and what happens when they do so. In other words, how do women view their interaction with the services from a more holistic viewpoint, and how do staff view their interaction with women? In addition, the aim is to reverse the usual staff / service response and instead of asking what is wrong with the women when they do not attend, ask instead

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[4] Their input into even their own health remains under-researched, unless it is employment related. Recent interest in men in Africa has focused on sexual heallth, including STIs and HIV.

what is wrong with the service? (Schiell, 1997). Dudley (1993), for example, clearly sees the power differential between the expert outsider and the rural community as important. In health service provision the community's perception of the health service package and their ability to influence what is offered is often highly constrained at several different levels.

To analyse interactions between users and staff, recourse is made to organisational theory which is discussed in Chapter Two. This includes an analysis of power and gender issues and how they are included in organisational research in general. In addition, the notion of the boundary is explored and how the definition of the boundary of an organisation can satisfy some stakeholders in the organisation above others. For example, the managers or providers may be better accommodated by these boundaries, above the needs of the consumer or patient (Hatch, 1997; Hearn and Parkin, 1993; Pfeffer, 1997; Smith and Cantley, 1985). The boundary can also exclude entire groups or sub-groups, and be highly gendered.

There is an abundance of health information from sub-Saharan Africa on health programmes and policy. Many focus on the macro-, the meso- or the micro-level. However, rarely do articles question the interface, linkages or disjuncture between these different levels. A key objective of the present research is to contribute to recent gender research concerned with analysis of macro-, and micro-linkages with regard to policy, planning and management impacts (Beall and Kanji, 1999; Goetz, 1997; Kanji, 2003; Fraser, 1989). As such, it seeks to go beyond the conclusions of many articles originating from evaluations of health care delivery, which reflect the view of service providers (or managers) (Kardam, 1997; Walt, 1994). These tend to place at the centre of the analysis the problem definitions and priorities of service providers, drawn from their own image of the service (Hatch, 1997). The evaluations made available to me on health research conducted in south Nyanza Province in Kenya where my fieldwork was undertaken, include evaluations of primary health care provision (Bennett, 1987), as well as the extent and kind of use made of hospitals and other health facilities (Hodgkin, 1996). Such studies are clearly most interested in why women do not use a service – often implying that there is something wrong with the women who make this choice, rather than with the service itself (Schiell, 1997). Typically evaluations from the region present the medical model unquestioningly, and represent women as 'the problem' for not participating in programmes as originally

designed and planned. This tendency was reflected in Buvinic's (1984) early and prescient study of the *misbehaviour* of projects and how this comes to be blamed on women, rather than on the design of the project itself. The present research is inspired by early critiques such as that of Buvinic's (1984) analysis of development interventions in general and more recent critiques in respect of health care delivery.

The bureaucratic aspects of international health agencies identified by Foster (1987) remain under researched and this is addressed here. Public health (PH) and primary health care (PHC) are both discussed in depth in Chapter Three. Clearly this thesis cannot cover all aspects of public health. The areas that are covered in the research are the main services and modes of delivery affecting women and men in their interaction with formal health services in a rural area in Kenya. These services, run mainly by qualified staff, comprise antenatal care and child health services, including immunisations (EPI), in conjunction with community health workers and hygiene messages. The research analyses their different views and those of other stakeholders, about the service as presently planned, delivered and used.

Summary

This thesis aims to uncover some of the gendered assumptions which are embedded in the sociological, organisational, economic and medical models used to both research and plan health policy in rural sub-Saharan Africa. Many of these assumptions are being challenged by feminist research, at both epistemological and methodological levels (Harding, 1997; Longino, 1993). An important premise underpinning the present research is that these gendered assumptions, which underlie primary health care policy and planning, are usually ignored or taken as unproblematic. However, they are frequently incorrect.

Feminist research has challenged and added value to more conventional sociological and anthropological analyses of health service development and delivery (Gardner and Lewis, 1996) through insisting on including a gendered perspective and gender disaggregated analyses, alongside the more traditional categories of class, race and culture. It has also become highly influential in relation to changing developmental discourse, although unfortunately in practice it has often been less successful (Moser,

1993; Kabeer, 1994; Maguire, 1996). In health research, where there is a clear understanding of the biological categories of men and women, the issue of gender has often been considered as meaning the prioritising, or targeting, of women's health care needs (Elson and Evers, 1998). This has allowed the old (rural medical) models to continue unchallenged (Heggenhougen et al, 1987) into the 21st Century. The present research is a feminist contribution towards challenging this discourse and practice.

Outline of thesis

Chapter Two introduces the theoretical perspectives used in this thesis. Organisational theories are introduced, including feminist perspectives on organisations and power and their relevance to research on health organisations. As well as the modern / postmodern divisions in epistemology, tensions between quantitative and qualitative research are highlighted. For a sociological approach to the analysis of health care, such issues are highly pertinent. A discussion on the use of sociological and anthropological perspectives in medicine, as applicable to primary health care, is introduced here. The issues of power and empowerment are then introduced, as they are frequently alluded to in both development and health discourses and are a central part of the conceptual framing of the present research. This includes a consideration of the ideas of Foucault and his contribution to the understanding of power relations in organisations in general and in health institutions in particular. In addition, his 'methodological precautions' (Foucault 1986 p232) for uncovering power relations and their perpetuation and legitimisation at the local level are taken into consideration. Empowerment terminology was in frequent use in the day-to-day delivery of health care in Gwassi, Kenya. Unfortunately this was employed in circumstances which often seemed highly disempowering, as discussed in Chapter Seven.

A history of primary health care is given in Chapter Three in order to clarify and contextualise the practices observed during the fieldwork in Gwassi, Kenya. This history builds heavily on British precedent, as this model was fully exported to Africa during the colonial era, and remains the basis for much of the thinking behind today's primary health care services. The three areas within primary health care which are

highlighted by the present investigation are antenatal care, child health clinics and community health workers, as these are the three services that are still most clearly prioritised in health service provision in Gwassi today.

This historical background will then lead into the methodological presentation in Chapter Four. This research followed a case study approach in order to focus on both the health services under scrutiny and the community served. As such the case was defined geographically, while recognising that health services in one particular rural district of Kenya, Gwassi, are part of a national health sector from whence some of the decisions emanated. The deductive approach adopted in the research prevented the total delineation of the research questions in advance, and allowed modifications of methods once in the field. One theme running through Chapters Two and Four is the issue of boundaries and who is included and who is excluded from the 'organisation', and therefore who is included in and excluded from the research. During the fieldwork, the issue of men and how they interacted (or not) with the health services presented a major methodological problem. They are included here not as stakeholders within the services as originally planned - they were clearly 'outsiders' in terms of planned local systems - but rather as community members who understood some health and hygiene issues and were able to act on their knowledge (to prevent cholera and scabies for example), but only outside the operation of the health service (see Chapter Seven). Also underpinning the methodological approach was Foucault's (1986) notion of power, and the aim to study it at the extremities, where it is embodied in and actioned by communities.

Chapter Five provides a description of Gwassi, a fairly remote area of south-west Kenya where the fieldwork was conducted. It is a rural sub-district beside Lake Victoria where fishing and agriculture are the main livelihoods people pursue and where infrastructure is lacking. A detailed description of the health facilities in Gwassi, and a comparison of how these relate to the situation in other districts within Kenya follows in Chapter Six. This also includes an analysis of the views of the qualified nurses interviewed on the situation in which they found themselves working. Their isolation and lack of professional support is highlighted, together with their perspectives on the personal characteristics required to remain unbeaten by the remoteness and their unsupported situation.

Chapter Seven discusses the substantive results of the research. The tension running through this chapter is the competition between the various health facilities to recruit women to their particular services, and how this influenced the nature of the services and the style of delivery. This tension was identified through analysis of perspectives held jointly by the trained staff, the community health workers and members of the community. The old image of the rural clinic services providing only for women (the traditional maternal and Child health (MCH) activities) remains intact. An important part of the analysis in Chapter Seven concerns the rituals of the antenatal or child health clinics. These meet an almost compulsive need on the part of staff and community health workers to continue educating the rural women in the practices and procedures they have learned and internalised themselves: whether appropriate to their needs or not. Despite such practices being overlaid by the new languages of gender and development, sexual and reproductive health, and above all, empowerment, they remain central to health practice.

The men continue to be peripheral and shielded from these rituals. Moreover, the men cannot understand how the services could be of relevance to them in any event. Chapter Seven shows how men are unable even to visualise their place in health service activities in Gwassi, to the extent that they frequently could not understand the questions posed in the research and would reply that 'this is only for women' or only directed 'to their wife'. Triangulation of evidence and views showed that their perceptions are an accurate reflection of the lack of concern for men, emanating from the trained staff or the community health workers within the health system and of the health system's neglect of men's health or men's role in health creation within the family. Unsurprisingly perhaps, the conclusion drawn is that the health system remains firmly focused on women and in very particular and stereotypical ways – and this has been reinforced rather than challenged by the addition of 'gender' (understood as 'women') to the discourse of health policy. The evidence provided in the chapters that follow show that the policies and practices remain the same; only the language has changed. This is not seen as remarkable by members of the local communities who are engaged in health-promoting activities. Men deny that they are involved in "health", as men do not "do health" and thus activities involving men cannot be classified as health. This analysis leads towards the conclusions drawn in Chapter Eight: that the circular creation of a gendered image of health care has closed into a vicious circle that leaves men outside the organisation of health service

provision. It appears that men have no return route for integration in the present rhetoric of primary health care services and are excluded in reality. While women are embraced by current health policy and practice, they remain trapped inside often empty rituals of service delivery and a genuinely gendered approach to primary health care remains at the level of rhetoric.

Chapter 2   Gender, Power and Organisations.

Introduction

This chapter comprises a literature review that explores current organisational theories, both structural and post-structural; plus ideas around culture, ritual and myths in organisations. It also reflects on why early approaches to organisational behaviour are insufficient for framing this research. The chapter then moves onto the issue of power within organisations and especially in relation to health and health care organisations. A short summary of sociological and feminist approaches to medicine and development is given, followed by reference to other approaches to power. Finally the concept of empowerment is addressed. Empowerment is included here because the rhetoric of empowerment was frequently found in health sector discourse during the research in Gwassi. This overview of the literature then leads into an analytical review of a Foucauldian approach to power in health, and, using examples from developing countries suggests why such considerations can assist in the present research.

Epistemology

> ...Discourses, practices and institutions that can no longer claim ungendered
> innocence. We may name modern science, bureaucracies, models of moral and
> cognitive development, conceptions of reason with western philosophical
> tradition and models of citizenship bequeathed by western political theory.
> (Di Steffano, 1991, p.2/3)

The topic and subsequent research questions identified in Chapter One have been informed by a feminist position. Feminists have long argued that gender is an important dimension through which a society is viewed and views itself – as important as other more established sociological categories of class, ethnicity, race. These gender views are carried over into academia and research, frequently in an unproblematised and untheorised way. Gender informed theories attempt to capture these gendered viewpoints, and to address them in the theory and methods of research. Feminist epistemologies attempt to expose the assumptions underlying much previous research and theory, and to re-problematise the issues with all underlying assumptions clearly expressed and enunciated (Ramazanoglu, 1990). This research is

not espousing a "feminist standpoint" position – as such a route can lead to problems of validation (Longino, 1993), but to acknowledge that all knowledge is socially situated, not value-neutral (Harding, 1993). It aims to engage with policy makers and practitioners in health who relate to more established epistemological paradigms, and so to add to the theories and debate through feminist dimensions on exactly which questions to ask (Harding, 1997; Schmidt, 1993), as well as results garnered. Feminist research makes clear that all theory is dependent upon "assumptions" or "conditions" (Gilbert, 1993; Longino, 1993) and that the previous uncritical acceptance of androcentric assumptions is not acceptable if policy is to follow-on from theories and research in a way that is relevant and significant for the whole of society.

For feminist researchers, a major problem has been the exclusion of women from research at both methodological and epistemological levels. This has resulted in the implicit research of male worlds, male bias in the questions posed and the theoretical constructs used to define the problem, and the methods used to collect the data (Harding, 1987). In health research, this has led to morbidity and mortality affecting men being researched more vigorously than female specific illness, except for women as child bearers and nurturers (Davis, Lewis and Kieffer, 1994; Inhorn and Whittle, 2001). In the introductory chapter, the issue is discussed of why the "add women and stir approach" is unlikely to rectify the present position and why a more wholesale re-appraisal of research is required (DiSteffano, 1991, Geisler, 1993), especially in the health field where gendered assumptions are not acknowledged.[5] The issue is not only which questions are being investigated, but also which questions are not even being asked, let alone researched (Harding, 1997). As Acker et al (1991) elucidate, in the final analysis, the researcher has the power to define the research question and the power over what to include and exclude from the final report and conclusions. Seen in this light, the feminist researcher has to dislodge the "ungendered innocence" (Di Steffano, 1991, p.2) of the issue under the spotlight. These issues will be elaborated on when power and empowerment in health and development are examined.

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[5] This is expanded in the Chapter Three for PHC interventions.

The organisation of health care

Health services are the mass production of a service for the majority of a population. The location of Primary Health Care (PHC) in the mass delivery of health services will be discussed in more detail in Chapter Three. Suffice to state here: it is a strategy for delivering health care nationally in a way that incorporates notions of equity and accessibility (WHO 1978). To deliver health care equitably there must be goals and standard services laid down at the national level (Abel-Smith, 1994). So for health service provision, vast bureaucratic structures have developed to deliver a common and comprehensive health service. Around the world, countries have health services planned and delivered at national and regional levels, augmented by local and *ad hoc* services – embracing both private practitioners and international non-governmental organisations (INGOs) and mission-based services. The growth and prominence of large bureaucratic edifices for health service delivery is described in organisational theory by Scott who states: "In the twentieth century organisations are prolific and have a direct bearing on our daily lives. They are particularly structured around the provision of services, including health care" (Scott, 1992, p.8). Despite such recognition of the huge relevance and importance of organisations in both theory and practice of health service delivery, the interrogation of organisational theory is rarely a starting point for informing health service research, let alone from a gender perspective.

Feminist Concerns with Organisational Theory

As many feminist researchers have pointed out, there is a general lack of gender considerations in respect of organisational research (Heckman 1994; Logino 1993). Much of the organisational literature is informed by the management's perspective, and what is considered appropriate for management is highly gendered. Hearn and Parkin (1993) see mainstream organisational theory as being unable to cope with issues of gender – as the theory is supposedly non-gendered or gender-blind. They advocate post-structuralism as providing a way of recognising and hence theorising the diversity and gendering which occurs within organisations. They see the construction of public / private dichotomies as fundamental for ordering gender and

other oppressions within organisations as this allows socially-sanctioned exclusion from power and power-structures within the organisation (Hearn and Parkin, 1993, p.157; Pfeffer, 1997, p.186). As is discussed below, rational analysis tends to align itself with the management view of the organisation (Hatch 1997 p.291). Coleman has pointed out that:

> Organisations contain within them sets of normative assumptions, values and overt roles which delineate the area for action within that organisation, and which themselves are assumed and taken for granted rather than subjected to scrutiny.   (Coleman, 1991, p.1)

The health sector contains organisations that have sets of assumptions, values and roles deeply embedded within them. These are both explicit and implicit for both the staff within the service and for patients interacting with the staff. As will be expanded on in Chapter Three many of these assumptions are highly gendered in health care. But even within organisations in general there are many gendered ideologies lurking.

Halford and Leonard (2001) reviewed gender and organisations at the beginning of the 21st Century and found, as their first heading states: "a complex and contradictory picture" (p.1) although "…gender still appears to be a major issue within organisational life" (p.4). Despite this realisation, in their attempt to understand the "complex and contradictory evidence" (p.9) they find that present accounts of gender and organisations are incomplete. Different theoretical perspectives offer different, but only partial, understandings of what is occurring within organisations from a gender perspective. They suggest that the key to deeper understanding is the inclusion of power within the analysis.

Classical / Modernist organisational theories

Weber is acknowledged as one of the first sociologists (Ferlie, 2001) to pay particular attention to organisations, and to conceive of them as social structures. For Weber, the rise of rational, bureaucratic forms of organisational control marked the break with pre-modern society, which had been based on feudal and non-rational forms of organisation, including nepotism and abuses of power (Hatch, 1997, p.164). Weber is seen as having either an unduly optimistic or pessimistic view of organisations, in

particular the rise of bureaucracy. On an optimistic theme: Weber saw the spread of
bureaucracy due to "its purely technical superiority over any other form of
organisation" (Weber, 1948, p.214, cited in Clegg, 1990, p.29). Here he was
comparing it with feudalism or nepotism as forms of organisation. On the pessimistic
side: Weber saw the "iron cage of bureaucracy" as having a hold akin to bondage over
individuals within them (Clegg, 1990, Ch.1), or being inflexible (Hatch, 1997, p.172).
But Weber was also explicit in that bureaucratic / administrative structure creates
formal role hierarchies that legitimate the exercise of power. A more thorough
discussion of power will be undertaken in a later section, but note here that
bureaucratic control is but one incarnation of power. Power, both overt and covert, is
of course of interest in feminist research, including within gendered analyses of
organisations, such as that undertaken in the present research.

Frederick Taylor in the early 1900s initiated and popularised the ideas of scientific
management based on engineering principles for defining the most efficient ways of
doing a job. Management therefore came to be built "around engineering ideals rather
than around religious, philanthropic, paternalistic or social Darwinist ones" (Pfeffer,
1997, p.10). This Fordist approach to management, which grew out of an era of
factory level mass production of goods and delivery of services, is not seen as all
negative by members of society. Even beyond factory manufactured products, for a
wide range of goods purchased and services received, individuals prefer to receive the
same standard of goods and services wherever they are actually delivered. For
example, in health care itself, there has been much emphasis on equity and efficiency
in service delivery, exemplified by the United Kingdom's (UK) National Health
Service (NHS) foundations, or the World Health Organisation's (WHO) Alma Alta
declaration, both premised on notions of equity and efficiency. Both equity and
efficiency can be delivered within the standardised ideals of engineering-style
management – which since Victorian times has pioneered the idea of common sizes
and standards for equipment and procedures.

This engineering approach to organisational delivery came to be reflected in
modernist / rational interpretations and theories of organisations. For example,
Hassard and Parker (1993) refer to Bell (1974) who saw post-industrial society
relying on rational / theoretical knowledge at both the systematic and technocratic
levels, which was to facilitate social control and to direct innovation and change.

Rational methodology, therefore, was often used to study large organisations that were seen as implementing such rational and technocratic solutions to problems. But rational research techniques can only examine pre-defined and determined structures and services. This approach presupposes that the research questions are already evident and that only the rational elements of the organisation are under scrutiny (Clegg, 1990, Ch.1).

In addition, the problem exists that "most people are attempting to maintain existing organisations than with maximising organisational performance" (Meyer & Zucker, 1989 quoted in Scott, 1992, p.348). This means that only the official views of organisational objectives are assessed. The modernist approach to the organisation is to take the official view as the rational view. Researchers can also reflect this by re-emphasising certain measurable criteria in their research, which are the criteria used by managers within the organisation[6]. Using six key points raised by Scott (1992), several of these modernist perspectives are shown to correspond to explicitly feminist concerns about the nature of health research. These are referred to here using health service examples and again, briefly, at the end of this chapter when they are related to Foucault's "methodological precautions" (Foucault 1986, p232) for examining power.

1. *The setting of standards:* Who has defined the standards? If the researcher accepts standards used within the organisation one has to ask where these have come from? This is particularly problematic in the case of health care, where many procedures have not been subjected to controlled trials.

2. *Selecting indicators*: Relative indicators are often used in health. Do health institutions have to produce improved health outcomes or only improved delivery of services? This is particularly relevant in the present research on the area of antenatal care, where the relevance of service delivery in the antenatal clinic is not clearly related to positive health outcomes for pregnant women, as a result of the actual antenatal (AN) activities undertaken (Maine, 1992; Rooney, 1992; Vanneste et al, 2000).

3. *Identifying processes*: Those selected only relate to effort, not achievements (Walt, 1994). Such goal displacement is common in organisations, including professional bodies, and is evident in health economic analysis where adherence to a focus on health management ritual displaces outcome measures. This is

especially the case in situations where information systems are poor (Maynard, 1994; Phillips, 1997).

4. *Highlighting structures*: In looking at structures, emphasis is on physical structures or, for example, the amount of staff training. Again, this focus is the result very much of an insiders' perspective. So, for example, service delivery styles are often designed for staff ease, rather than that of the patients. Looking at structure without concern for the agency of both staff and patients who use the structures is only considering an incomplete picture.

5. *Selecting samples*: Micro- or macro-level approaches and the relationship between the two, have to be decided on in designing health research, leading to issues around quality and quantity of data, such as the relative weight given to each and the purposes for which information is collected. These issues relate clearly to feminist concerns about quantitative versus qualitative data collection when trying to probe relational issues (Oakley, 2000).

6. *Prioritising participants*: Who participates influences what is prioritised. Managers emphasise structural measures and workers emphasise process measures, as these are the areas over which they have most control and in which they are most interested. Professionals also emphasise processes (standard practice is preferred as it minimises reference to knowledge gaps), while clients generally emphasise outcomes, although it is well known that health outcomes and attribution are often difficult to measure. The health researcher tends towards the organisations' own definitions of success criteria rather than those of the client. This is because there is both more readily available information in-house, and organisations are clearer in depicting what the goals of health care might be (Scott, 1992, Ch.13).

A rational / functionalist approach to organisational research came to be criticised in the following manner:

> The language of efficiency and effectiveness, the presumption of voluntary
> exchanges and transactions (as with economic models) and the invocation of
> environmental - competitive or regulatory - constraints and pressures are
> frequent in the organisational literature. Each of these linguistic and

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[6] See St Leger *et al*, 1992, Ch.12, for health sector examples.

theoretical conventions has the effect of rendering many outcomes as

inevitable and produced without much human agency.

(Pfeffer, 1997, p.177)

Pfeffer goes on to say that such studies only serve the interests of management and
address managerial problems alone or, to put it more strongly, it has been argued that
the researchers become "servants of power" (Baritz, 1960 quoted in Pfeffer, 1997,
p.177).

So, modernist organisational researchers are accused of having a view of
organisations which aligns them too closely with a management or control
perspective. Other stakeholders in the organisation are neglected through this focus on
organisational survival, legitimacy, growth, and profits in the rational model. Scott
(1992), whose work is drawn upon in the present research, points out that when trying
to assess an organisation's effectiveness, the researcher needs to acknowledge that
there are many different stakeholders, not only the managers, and that it is difficult for
an organisation to satisfy all of them and certainly not all can be addressed at the same
time.

Postmodern perspectives on organisations

Hassard (1993) sees traditional modernist research "proceeding under discourses
previously defined and shared" by the managers and the professional, academic
community. So research is simply "reflecting pre-existing intellectual categories"
(p.12). Postmodernism provides one way of accessing previously ignored or silenced
voices (Hearn and Parkin, 1993). Clegg sees the continued comparison with the pre-
modern age as insufficient to examine organisations in the 21st Century, and that
postmodern theories must augment modernist interpretations and theories of
organisation. Other and especially external stakeholders often have alternative
perspectives and definitions of the issues (Coleman, 1991). Recognising this, Parker
(1993) sees the need for challenges to be made to the management's perspective, and
for research to leave room for competing voices to be heard. Hatch also echoes this
idea of issues being silenced in organisations, especially in those with a strict
hierarchy. Alternative views can often be dismissed by a charge of being irrelevant to

the firm (Hatch, 1997, p.291). When this happens though, issues of power are at stake, as expressed by Lukes (1974), who has argued that the determination of which issues even reach the agenda is a very strong yet unseen use of power. The issue of power is discussed at length later in this chapter.

Scott (1992) questions the positing of modernism and postmodernism in opposition to each other. Rather these are seen as offering different explanations of a phenomenon due to different starting assumptions. As such they only displace and do not disprove one another. This mirrors Clegg's assertion that postmodernist approaches are "not to shock sensibilities reared in the good taste of modernist conventions as to augment them" (1990, p.21), since postmodernism and modernism are on a continuum, not oppositional. There is debate, however, as to whether postmodernism is on a continuum with modernism (Clegg, 1990) or an antithesis to modernism (Carter & Jackson, 1993). However, as Best and Kellner (1997) suggest, there is not a rupture between modernism and postmodernism, although as postmodernism evolves and develops, it may challenge modernism further. This was also alluded to by Halford and Leonard (2001 Ch.1), in that previous research in liberal, structural and post structural perspectives all only catch partial perspectives on gender within organisations. The present research takes a continuum position – that postmodernism can expand and augment the theoretical position of modernism, but that it has not yet managed to break with its modernist roots. The opening provided through including a postmodern approach here is to give sufficient space and attention to alternative views on health service delivery in a rural, marginal community and so enhance understanding and theoretical perspective on health service organisation.

Boundary Setting in Organisational Theory

Another major problem with early theories on organisations was that of setting boundaries. If they are set too rigidly then all external factors are discounted. If they are too porous then nothing and no one can be excluded. Boundaries are best seen as 'sieves, not shells' (Scott, 1992, Ch.8). If managers are left to define organisational boundaries they tend to place their organisation in the centre of networks, which tends to determine who else is included and excluded, and slants all reporting back towards themselves at the 'centre'. Today the environment is usually assumed to be influential, but boundary definition still needs attention in organisation research

(Hatch, 1997, Ch.3). Moreover, the organisation is not simply a contributing member to the environment, but embedded in all of it. This is especially important in health service research, as often sector evaluations are seen as representing the dominant medical view only, and as ignoring some alternative groups or views (St Leger et al, 1992, Ch.12). This was alluded to earlier, around the question of selecting indicators – in health services relative indicators are often used which relate to the effort of the service, not the health outcome results received by the individual or population (Scott, 1992).

Fluid use of terms and conceptions of roles makes boundary definition even more difficult, including the issue of who gets included and excluded from boundary setting itself and associated problem definition. Also self-definitions of jobs or roles can vary from official labels (O'Reilly et al, 1980 quoted in Bryman, 1989, Ch.1). As will be discussed in below, Stakeholder Analysis is frequently suggested as a route to cope with whom to include in research. This is significant because in Gwassi the boundary of what was defined as "health" was very important and problematic in the research – especially across genders. Boundaries, including professional boundaries will therefore be discussed again in Chapter Four on methodology.

Stakeholders' Analysis

> Stakeholder analysis is an approach, a tool or a set of tools for generating knowledge about actors – individuals or organisations – so as to understand their behaviour, intentions, interrelations and interests; and for assessing the influences and resources they bring to bear on decision-making or implementation processes.
> (Varvasovszky and Brugha, 2000, p.338)

Stakeholder analysis is explained in the quote above as a process and a tool to introduce new knowledge about the institutional background relevant to policy-making processes for the managers and the policy makers. Stakeholder analysis has recently gained in popularity due to increased awareness among managers, policy makers (Varvasovszky and Brugha, 2000) and also researchers, such that it is important to understand the central role and influence that all the various stakeholders

(Clarkson 1995; Freeman 1984) have on the organisation. Stakeholding first came to be recognised in the 1930s in business management theory (Preston, 1990). But for many years it retained a managerial / control focus. The managers are seen to remain firmly at the stated centre of the organisation, its analysis and planning. Other stakeholders circle around this core, but are never invited in to permanently join the centre. Different stakeholders are seen as operating at different levels of interest and power. This reflects the view of Parker (1993) that perspectives competing with the managers' views need to be given voice.

Despite these managerial origins and leaning, stakeholder analysis has entered the language and practice of developmental organisations and agencies, starting in developmental circles as a tool to enable INGOs and other actors to make sense of the "complex web of interactions in a particular context" in which they find themselves (Tandon, 1996, p.41). The notion of multiple stakeholders is used to assist in understanding an organisation's multiple accountability (Shah and Shah, 1995). It is still seen largely as a planning or management tool, but one that helps cope with issues of accountability through consultation. Accountability is defined as "an obligation or requirement to give an explanation for all actions taken, including, but not restricted to, the use of resources" (Green and Matthias, 1997, p.151). In particular, there is a need in development contexts, for the managers of development organisations to be accountable both upwards and also downwards (to staff, volunteers, communities and ultimately beneficiaries). Stakeholder analysis is therefore seen as a mechanism to assist managers to recognise all their various stakeholders and the accountability they have towards all of them. Thus stakeholder analysis is often conducted in response to the need of the developmental organisations to assess their performance - including perspectives from all their various stakeholders and not only the more powerful ones (Fowler, 1995). Multiple stakeholder engagement is thus seen as a way of accessing and including social judgments of local actors into the appraisal of an organisation's actions. Fowler (1995) recognises in the case of INGOs that they have multiple demands placed on them by the various stakeholders, who individually have different expectations, power over and understanding of an INGO and its role. But this role is usually still self-defined by the INGO itself. Government and private sector organisations are less likely to invite such wide stakeholder involvement, their impact assessment being through the ballot box and consumer choice respectively.

In development contexts, therefore, the rhetoric of organisations acknowledging, listening to and acting upon the demands of *all* stakeholders is shown to be very challenging. As a result, stakeholding has come to be seen in the more pragmatic sense of acknowledging all stakeholders, but in the final analysis still allowing the managers and policy makers to limit the attention they pay to individual stakeholders, thus retaining organisational control and power (Edwards and Hulme, 1995). Or, in the more critical words of Sternberg (1997) "the only way that the stakeholder doctrine can be made workable is to employ the very substantive objectives that it explicitly rejects" (p.74).

Nevertheless, for Hutton (1997) this is missing the point. Various stakeholders now have voices, and insist on being heard. Political choices have to be made over which voices should be included as well as the owners. Walt (1994) is clear that in health policy the level of support and the legitimacy of various stakeholders is important in determining what issues get turned into action. This will be discussed further in this chapter in the focus on power, and "what gets onto the agenda" (Lukes, 1974); and will be demonstrated empirically in the chapters on health care delivery in rural Kenya that follow.

In summary, stakeholding analysis is not a single tool, but rather a range of methodologies. It can be operationalised at various levels. It is a process and one that informs strategic planning. But it cannot answer the political influences on organisations, nor define who is and who is not allowed to have a voice in the aims and objectives of an organisation. Often these rely on historical practice and policy, and the way things have always been done. From a feminist perspective, relying on historical practice and policy is unacceptable because such path dependency does not allow for the optimistic agenda of challenging gender relations and policy and practice that operates against the interests of women.

These issues echo some of the dilemmas encountered in inclusive or participatory research. Just as INGOs and other grassroots' organisations who are working for and with local society claim that the voice and opinion of the beneficiaries are important to the organisation, so too do participatory researchers. Stakeholder analysis and participatory rapid appraisal (PRA) are both nevertheless still infused with issues of

power (Guijt and Shah, 1998). In research the power of the researcher to define and limit the research gives weight to claims that stakeholder analysis reinforces locations of power situated outside of the community and away from beneficiaries, and closer to the realm of academia and the managers. The research process always has its own criteria for identifying and defining stakeholders. This, after all informs why and how the analysis is conducted (Burgoyne, 1994). These issues will be followed up in the next chapter on reflexivity in research, an important dimension in feminist academic investigation. The idea of stakeholding can be very persuasive but in the end political decisions have to be made on the basis of who is defining the mission of the organisation, or the purpose of the research and as such, who will be included in the analysis. These issues clearly mirror feminist concerns (Maguire, 1996) about who is being included in the research and for whom the research is ultimately being carried out. These dilemmas infuse the present analysis as well. This issue will be reconsidered later in this chapter in relation to Foucauldian methodologies for uncovering power in society.

Defining Organisational Goals

The previous sections have looked at modern and postmodern theories relating to organisations. Also, as touched on above, was the notion that organisations must have a mission or goal. Important and taken up here, is how the organisation itself, as well as researchers of an organisation, define and view these goals.

All organisations must be managed. Without some control organisations and the society in which they are located would be characterised by chaos (Czarniawska-Joerges, 1988, Ch.1). In the 1960s organisations were seen as social units pursuing specific goals. As discussed above they were seen primarily as functional, and so they could be studied using deductive methods. Now the idea of unified goals across the whole of a large organisation is viewed with less certainty, and so the study of organisations has in turn also become less sure. Herbert Simon (Hatch, 1997, p.273) questioned the assumption that organisations are able to follow a rational model of behaviour as long ago as 1959. He stated that the rational model assumes decision-makers have full knowledge of all the information and the alternatives and the consequences of implementing any of the alternatives. The rational system also

ignores any attempt to understand the politics within the organisation by assuming that the whole organisation has consistent preferences. In reality there is incomplete and imperfect information. The problem is highly complex so that few people have all the information available, as humans have only limited information-processing capacity and time is short. There are also conflicting preferences amongst decision-makers about what information is important and relevant for organisational goals. As one commentator has put it:

> As long as we assume that organisations have goals and that those goals have some classical properties of stability, precision and consistency, we can treat an organisation as some kind of rational actor. But organisations do not have simple, consistent preference functions. They exhibit internal conflict over preferences. Once such conflict is noted it is natural to shift from a metaphor of problem solving to a more political vision.
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> (March, 1981 quoted in Scott, 1992, p.110)

This image of imperfect information can be gleaned from a much broader range of development literature as well. For example, Chambers (1983) suggests six "biases" (or information-gaps) to explain why projects and their stated goals did not fully address the real needs of rural populations. Or as stated by Stamp (1990, p.180), "many aid projects are built on erroneously incomplete knowledge". Ferguson (1997) also gives an example at the country level (Lesotho) of incomplete knowledge being recycled in development documents and discourse. More recently, the use of logical framework (logframe) analysis and other management devices can be seen as an attempt to clarify goals and objectives, along with associated assumptions and potential problems, to a whole range of actors within organisations and stakeholders associated with them. However the top-down use of such devices frequently skews the whole process of goal setting back towards the managers and their viewpoint, and away from input and engagement by the beneficiaries of the organisation or service at stake.

In practice, both participants within an organisation and the external public do relate to organisational goals (Scott, 1992, Ch.11). Acknowledging that organisations relate to a wide range of stakeholders and pursue a range of diverse goals, organisations come to have both official and unofficial or operative goals. Official goals are those stated in corporate charters, annual reports and plans; and operative goals are those

which are more specific and include actual operating policies and procedures and informal 'rules of the game'. In organisations with many different stakeholders there will be multiple goals and choices that have to be made. Goals may even be different in different parts of the organisation when it is large and complex (Hatch, 1997, Ch.4). Moreover, specific actors within an organisation may choose not to support the official or operative goals.

Another important dimension of organisational goal setting is that goals are not fixed. In particular, once one set of goals are attained, the organisation may define new goals to continue its existence (Pfeffer, 1997, Ch.1; Harrison, 2001). In many organisations, and health services are one important example, the goals may be assumed to exist and to be known by all, but are chimeras when studied (Smith & Cantley, 1985). This is expanded on below. Qualitative research approaches are more flexible and sharper analytical instruments to capture and deal with such multiple and fluid viewpoints (Murphy, 2001).

Organisational Ideology, Myths and Rituals

If organisations do not have clearly defined and enunciated goals for the researcher to capture and understand, their organisational culture and ideology are even more illusive. Yet such a focus is critical for a feminist study of organisations. The existence and operation of culture and ideology becomes apparent in attempts to describe exactly how the participants are behaving within organisations. As Czarniawska-Joerges (1992) points out, many researchers use several such terms interchangeably - such as culture, ideology, myths, rituals – terms which are taken up here.

Ideology is said to be found within organisations. Pfeffer (1997) and Scott (1992) both see the profusion of theoretical perspectives on organisational culture and ideology as confusing and disabling in organisational research. Moreover, organisational ideology in the past has been viewed quite negatively. However, Czarniawska–Joerges prefers a more positive definition that "...ideology is a world view enriched by a vision and a prescription for action". Nevertheless, she cautions that it is not reality, but a 'desired state' for the organisation (Czarniawska-Joerges,

1988, p.8). Czarniawska–Joerges also clearly separates the idea of an overarching ideology from the perpetuation of myths within organisations. For her, the myth is a narrative of events. It is possibly erroneous but it is adhered to by people within the organisation, despite possible contrary evidence. The myth is a dramatic form of socially shared explanations of important phenomena in the organisation. She sees the myth as being important, resistant to change (but not immortal) and helping to maintain or express social solidarity between members of the organisation (Czarniawska-Joerges, 1988, Ch.3). Ideology, on the other hand, is a set of ideas that inform how things are planned, or should be, and ways to achieve a desired state (Ch 5). Ideology is also a means of control within the organisation and so it is important to establish who is exercising the control and who is subject to control. The basic function of ideology is to facilitate collective action on the part of organisation's members, which is to create organisational action through a framework of shared meaning (Ch 6). Even though the ideology may not match up to reality, it can persist due to long time delays between organisational action and observable effects.

Ideology can also be defined as "the process by which actions are repeated and given similar meaning by self and others which leads to institutionalisation" (Meyer and Rowan, 1977 quoted in Scott, 1980, p.111). This equates with Giddens' (1984 p.25) understanding of institutions which he explains in terms of social systems understood as the "reproduced relations between actors or collectivities, organised as regular social practices". Actions can be repeated due to explicit organisational rules and laws, or through the norms, values and expectations of the workplace, or simply due to a desire to act according to conventions, to 'fit in'. So, here it is defined less as an idea than as a process. However, not even rules are always as clear as the name implies. There may be additional, informal rules, which are 'below the waterline' (Salaman, 1980), not always visible or even acknowledged to exist. And even explicit rules are sometimes enforced and sometimes forgotten (Salaman, 1980). Rules actually only exist when applied, or are acknowledged to be broken (Czarniawska-Joerges, 1992, p.129). Different groups can use, bend or ignore rules to gain power and / or prestige within the organisation.

Czarniawska-Joerges (1992) in discussing organisational culture, sees the culture of an organisation as 'a way of life' (p.170) and one that may not always reflect the 'management' view of the organisation. It may also reflect the informal structure – the

actual way things are done (not the formal rules, regulations and decisions). It has been explained that "...organisational culture can be thought of as the glue that holds an organisation together through a sharing of patterns of meaning. The culture focuses on the values, beliefs and expectations that members come to share" (Siehl and Martin, 1983, p.227). This appears to be a fusion of the ideology and myth mentioned before – the informal and formal view members have of the organisation.

For Hatch (1997) too, beliefs and assumptions are seen as central to an organisation's culture. Assumptions for her are what members believe to be reality within the organisation and so influence what they perceive and do. The assumptions are 'taken for granted' and 'generally are not up for discussion' (Hatch, 1997, p.210). But this definition of assumptions appears to overlap with the following definition of myths used by Clegg (1990).

> Rational myths are simultaneously not only affirmations of value, in as much as they tell us about culturally prescribed forms, but also denials of alternatives – in as much as the rational element is stressed.
> (Clegg, 1990, p.84)

But he is looking at myths at the organisational level, at how management views the situation. This use of 'myth' is not the beliefs held by members of the organisation in the sense used by Czarniawska-Joerges, but the use of a particular ideology to create organisational myths. In rational or technically sophisticated organisations rationality is not only a stated criterion for actually making a decision, it is also a highly valued form of decision making. The style or the appearance of 'being rational' is more important than actual rationality (Hatch, 1997, p.85). So things may not be actually rational, but merely made to appear or be reported as such. As Meyer and Rowan (1977) point out, rational myths are frequently not objectively tested and instead are allowed to stand as rational on the basis that 'everyone agrees they are true'. This is certainly an issue in relation to health care where "accepted practice" has not always been tested[7] in ways which are transparent and open to others outside the profession (Longino, 1993). In health care this is especially relevant when what is seen as rational needs to be transparent and comprehensible to patients and their relatives (Chalmers, 1998). Antenatal care, a key focus in the present research, is one such

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[7] See Maynard (1994) for a discussion on the need for evidence-based medicine. This is a frequent issue in medical journals (see Chalmers 1998 editorial in the BMJ) and for WHO (see WHOSIS site).

'rational myth', and one where the testing of the efficacy of the service has never been undertaken (McDonagh, 1993). It is allowed to stand simply because it has become a TINA – There is No Alternative - or a case of 'everyone does it' (Oakley, 1992). Clegg (1990) refers to TINAs as critical in shaping organisational methods and goals. TINAs he sees as an outcome of the adherence to rational decision-making processes within organisations. But as discussed above, what is seen as 'rational' may be more of a fiction than a fact, once the process has been unwound. Clegg sees some conventions as promoting the image of rationality in the process of creating TINAs. When specific antenatal clinic activities are assessed, however, they rarely meet either sensitivity or specificity tests usually demanded for screening in other areas of health service provision (Tew, 1990; Rooney, 1992). Such persistence of myths in areas of health related to ANC and other aspects of PHC will be expanded in Chapter Three.

Again this links with the silencing of alternative views which never get onto the agenda in the first place and so have become lost in the delivery of the service. Leach and Mearns (1996) describe this as a case of ideas getting "boxed in" in institutional establishments with pre-conceived agendas and "labeling conventions". However, as discussed later in this chapter, what gets onto the agenda (Oakley, 1993) is important, including in relation to power (Lukes, 1974) and gender (Hartstock, 1985; Kabeer, 1994).

Czarniawska-Joerges (1998) when conducting research in organisations in Sweden found that top managers used the Swedish and English languages interchangeably. But she noted that the "purpose of English was very important for ideological talk". This was to make the talk appear as 'fact' or 'rational' when perhaps it was not – a rational myth being reinforced through the exercise of language. The use of English also made the ideas expressed more difficult to challenge by other staff, as not all staff spoke English to the same level and so they were not sure if they fully understood the use of language or the terms employed (1988, Ch.4). However, as Czarniawska-Joerges points out, comprehension and objectivity themselves are not important in defining ideas – what is important is that everyone agrees that the ideas expressed are important (Ch 5). This point will be discussed again in the next chapter, specifically from a health sector perspective, where statements about health and health care are presented as "facts", as "true" or "uncontestable", when in reality theory and knowledge are still developing (Lupton, 1997). In public health much advice given to

women is "in reality a mixture of facts, values and opinions" (Carter, 1995, p.171). This aspect of language I believe to be very important in the creation and perpetuation of ideology and myth in health services in the context of development interventions.

Myths and ideologies have been discussed at length here due to the extensive use of non-rational discourses to explain both organisational behaviour and beliefs by both health staff and the community. It was therefore felt that regular approaches to organisational theory, without the inclusion of power and gender are therefore incomplete (Halford & Leonard 2001).

Medicalisation critiques

> Medicine is becoming a major institution of social control, nudging
> alongside, if not incorporating, the more traditional institutions of
> religion and law. It is becoming the new repository of truth, the
> place where absolute and often final judgements are made by
> supposedly morally neutral and objective experts. And these
> judgements are made, not in the name of virtue or legitimacy, but in
> the name of health..... Today the prestige of any proposal is
> immensely enhanced, if not justified, when it is expressed in the
> idiom of medical science.
> (Zola, 1972, p.487)

Sociology of Medicine originated as a discipline which supported rather than challenged medicine – it was there to help the doctors understand their patients and their social situations and to suggest ways that outcomes could be improved, such as by removing patient non-compliance. It did not challenge the power of the medical profession, although at times some contributors alluded to it. As the discipline developed, it was renamed Sociology of Health and Illness to redress this bias, to allow more "nuanced delivery of services to patients, still not to challenge the overall paradigms". As such it remained very dependent on a medical model of health (Thorogood, 1992; Petersen & Lupton, 2000). Previously, Sociology of Medicine looked at the power and influence of the medical profession and used ideas of social roles (Talcott Parsons), and structural functionalism to explain how medicine had amassed this power. Social life and many problems were seen as having become

medicalised as the medical profession expanded its sphere of influence (Szasz, 1961; Illich, 1975). Zola (1972) and Friedson (1970) saw medicine as becoming the new agent of social regulation. Medicalisation was defined as dependency on the medical profession and the notion was used pejoratively in sociology. However, two issues sociology never really explained were: firstly, how medicine had amassed its power in the first place, even when many of its activities and claims for success are unproven and often highly dubious; and secondly, why society wishes to defer to this particular profession (Lupton, 1997). It has more recently again developed into "a critical epistemology of disease categories as elements of the moral control on individuals and populations" (Turner, 1997, p.ix), using a more Foucauldian perspective. The one area that has remained contentious throughout has been the power of the medical profession.

Feminists also engaged with the health sector and found many areas of concern. In their case too, they became deadlocked around issues of power and control, although with a different emphasis from that of the mainstream sociologists. For feminists, criticism centred on the patriarchal nature of medicine, for example, the hijacking of pregnancy and childbirth by obstetricians (Oakley, 1992; Sen, 1994, Ch.1; Wajcman, 1994; Lane, 1995), the male : female division of labour within the health services themselves (Donnison, 1988; Walby & Greenwell, 1994; Witz, 1988), or simply that the health care industry proves to be of more benefit to the industry itself than to women (Foster, 1995). Here again the issue of power – in this case seen as mainly male professional power and prestige over female patients and subordinates – remained at a theoretical impasse. Lupton (1997) sees feminist critiques in the 1990s remaining stuck in either Marxist, or consumerist approaches. Nevertheless, the feminist view remains that the presently prescribed model of health care rests on highly gendered assumptions that have been incorporated into the medical profession and health system throughout the past century. Health systems, like all modernist enterprises, usually make claims of being objective, scientific and hence implicitly gender neutral, but much feminist research over the past decades has revealed gender biases which are deeply entrenched at the epistemological and methodological levels (Harding, 1997; Longino, 1993).

In ways very similar to the sociology of medicine, anthropological perspectives on health also came to be seen as the use of anthropology to improve acceptance and

uptake of modern medicine in traditional cultures. Although as Donohue (1990) states, this use of anthropology is "now out of date" (p.85), it remains that anthropological researchers are caught in an impasse as to whether they are being used to provide "quick fixes" for health planners (Coreil, 1990) and whether they can ever effectively challenge the present development debates – accepting that, as Gardner and Lewis (1996, Ch.5) point out, these debates are neither homogenous nor monolithic. The recent influence of anthropology over PHC debates has been limited, just as its influence in development debates has also waned (Gardner and Lewis, 1996). Nevertheless, medical anthropology remains an important discipline concerned with the relationship between culture and health (Heggenhougen, 2000) but one that does not necessarily hold issues of power at the centre of its analysis and one that is not guilty of medicalisation (see Heggenhougen and Draper, 1990).

Critiques of previous approaches

Lupton (1997) sees problems with all the medicalisation critiques – both mainstream and feminist approaches. These she sees as always portraying medicine as having nothing to do with improving health status, when obviously for people with specific problems improved health status is highly valued. A positive value is placed on health outcomes – pain relief, recovery – by patients and their relatives. Furthermore, all the problems identified by the medicalisation critics were couched in terms of the power of the medical professions, but *how* they had accumulated all this power remained unanswered. Patients were always seen as helpless, passive and disempowered – as victims of the system rather than as being assisted in any way. It was seldom recognised that patients actively seek out doctors and medical care – without patients, doctors would have no power. There is a mutual dependency. Doctors were painted as a repressive force in society, but if this were unequivocally the case, how could the complicity and collusion of patients be accounted for? As discussed below, Foucault's approach to power helps uncover these issues in relation to health service delivery, and provides a route out of this impasse in relation to theorising power in health care.

While the previous sociological and anthropological attempts to explain the power and influence of the medical profession and its distance from the wants and needs of individuals can be seen as deficient, and even as these issues have remained unresolved, the health sector has embraced ideas around the empowerment of women

and added them to its portfolio. This shift in discourse was given added impetus after the United Nations Population Conference held in Cairo in 1994 and the Fourth United Nations Conference on Women held in Beijing in 1995. In order to understand the processes and relationships as well as the associated discourse involved, a more critical approach is necessary, especially if it is to include the gendered assumptions behind both the rhetoric and practice of present day primary health care.

Women in Development; Gender and Development

As has been pointed out by Diane Elson, "until the 1970s women had been invisible to policy makers" (Elson, 1995, p.9). It was Ester Boserup (1970) who re-focused[8] attention on the differential situation for women in Africa and who challenged the assumptions of planners who imputed a western model of farming and gender systems in African (colonial) countries. Boserup's work was a catalyst and assisted women working in other sectors in highlighting other incorrect and naive assumptions being made about women and development issues (Elson, 1995). Nevertheless, these assumed roles have continued to inform thinking in the planning of health services across the decades (Vaughan, 1991). Women are consistently assumed to have free time to attend preventative clinics, to care for the sick, and to work as CHWs (Timyan et al, 1993; MacDonald, 1993; Ostergaard, 1992; Leslie, 1992). Moreover, there is ample evidence to suggest that awareness of women in development (WID) or gender and development (GAD) has led to women being used instrumentally for development purposes rather than the other way around. As Razavi and Miller (1995) conclude ..."policy making institutions ....have reinterpreted the concept of gender to suit their institutional needs."

The original WID approach was concerned with welfare but this was supplanted with a concern over issues of equity. However, women's equality was seen as resulting from involving women in development (remembering that development was synonymous with economic growth (Harcourt, 1994)) through productive work. This was seen as an advance on and in opposition to the previous focus of development

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[8] Moore and Vaughan (1987) reveal how Richards in 1936 was pointing out that colonial assumptions about the roles of men and women in African farming systems were incorrect and led to female farmers being neglected. This in turn resulted in women who were too exhausted to fetch water and firewood to care for their families.

planners on women as reproductive vessels, addressing women's needs through welfare projects. Many health programmes fell into the WID category of welfare. The rejection of welfare has continued in most WID / GAD arguments as the fashion has moved first towards equity in health and then towards anti-poverty approaches, exemplified under PHC and then efficiency approaches which saw the introduction of user charges for example, following closely the schema of Moser (1993) (Beall, 1993). The full circle in the health sector has been completed now as the World Bank (1993) has justified renewed spending on health as essential to economic growth. Moser's final schema – empowerment – is seen (from a GAD perspective) as having more relevance to the health sector, as women and men are to be empowered to participate in maintenance of their own lives, including health.

As Elson (1995) points out, simply adding women into the development equation is not sufficient, if the underlying paradigms are left intact. Increasing women's involvement in development can simply add to women's burdens, not alleviate them; or can leave women as a residual, inferior category or group. This is often the situation in the health sphere where the underlying theory, practice, and rituals remain largely untouched by the application of the new knowledge and literature. Again, the addition of "empowerment" to the health sector is not sufficient when the underlying paradigms continue to be reproduced. This is discussed after the concept of empowerment itself has been interrogated more thoroughly.

Development debates and practices, particularly as they pertain to gender and development, have generally ignored or sidestepped power relations. Townsend (1999) even sees GAD as only having paid "lip service" (p 22) to issues of power. Power remains under-researched, under-theorised and often ignored in programme policy and practice. It also tends to focus on "power over" rather than "power to" or "power with" (Kabeer, 1994). This is due to the acceptance of the traditional view of power as coercive and also the view of power as a zero-sum game (Townsend, 1999).

Despite this under-theorisation of power, in development policy and practice, ideas around empowerment have clearly come to the fore, not least as a result of WID and GAD challenges to mainstream development approaches. But the theory and practice have not been developed in tandem, allowing unsubstantiated claims to be made for both power and empowerment. This idea of empowerment, when applied in the

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health sector appears to throw up more problems than solutions. I begin to suggest that this is due to adding new ideas to old models, without addressing the underlying gender bias and assumptions of the old medical models. One reason is due to the neglect of issues of power within the health sector.

Power

The traditional interest of the social sciences in power is in the application of power as a coercive force, "a force exercised by individuals or groups" (Townsend, 1999, p.23). In her work, Townsend found that local women also defined and used power primarily in this traditional sense, as a force, as power over others. As Hartsock (1985) points out, feminists are concerned with positive connotations of power; power as energy, ability or competence, not simply as dominance.

Naila Kabeer (1994) in her gender analysis of power and empowerment relies on Lukes (1974) who, looking at power from a philosophical stance, suggests that the traditional view of power is only "one-dimensional". The stress is on observable, concrete behaviour but for Lukes, who has a conflictual model of power, observation of only visible behaviour is not enough – as power is then understood only as the preferences of the elites which prevail; that which can be observed. Following Bachrach and Baratz (1962) a "two-dimensional" approach to power is suggested. They see power as having two faces, involving both overt and covert operation of power, but Bachraach and Baratz still stress actual observable conflict. This means that they remain for Lukes within a behavourist model; for Hartsock (1985) they remain within a market model. For Lukes this is a problem, as power operates not just at the individual level but also within groups and institutions; and socialisation can indoctrinate groups into acceptance of the *status quo*, and prevent conflicts from even arising or being aired. Non-decision making or inertia is not simply keeping grievances off the political agenda, it is also preventing grievances arising in the first place, through shaping expectations and thus constitutes a more insidious form of power because the absence of grievances does not necessarily mean a consensus. This would be the case when individuals or groups cannot see or imagine an alternative; things are seen as natural or unchangeable, even divinely ordained or immutable. So Lukes proposes a "three dimensional" view to move beyond this individualistic, behaviourist approach. The problem for the researcher though remains: how to

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capture this non-decision-making dimension of power at the institutional level? This is a key challenge in the present research. For Lukes, such a research endeavour is only possible by maintaining a sociological perspective and acknowledging that there are "points outside the range of observable political behaviour". But he acknowledges that this is very difficult to demonstrate methodologically. An example of how this is a critical issue in the research presented here is the question of how could you "..... choose something if you do not know it exists and cannot imagine it existing" (Oakley, 1993, p.45)? This applies to questions of how users of services might or might not be able to imagine alternative ways of addressing health needs. This links back to issues discussed earlier in this chapter on organisational ideologies and myths. And, as to be discussed in Chapter Four, it was also a methodological problem in this research.

Foucault (1986) looked at power in a distinctive manner and, like feminists, declined to view it wholly as a negative force, only acting through prohibition and coercion (Gledhill, 1995.) He also overcame the impasse in Lukes' work which remained focused on power, as in domination and subjugation within society, by suggesting the following "methodological precautions" (Foucault, 1986, p.232) to uncover power relations.

1.   The focus should not be on the regulated and legitimate forms of power but on power at its extremities. This he defines as: power in "its more regional and local forms and institutions" "where it invests itself in institutions, becomes embodied in techniques, equips itself with instruments and eventually becomes even a violent means of material intervention" (p.233).

2.   Not to look for power at the level of conscious intention or decision, but instead at its real and effective practices. This is the point of an immediate and direct relationship of power with its object: the " processes which subject our bodies, govern our gestures, dictate our behaviours" (p.233).

3.   Power is not one individual's domination over another – but it "circulates, as a chain, as a net-like organisation". Individuals are simultaneously both undergoing and exercising power. They are vehicles of power, not simply its point of application.

4.   Conduct an ascending order of power. Mechanisms of power have become economically advantageous and politically useful, so it is imbued right up into state and global systems. "Techniques of power" - exclusion, control and

surveillance maintain these economic and political advantages up through all levels. But power at the micro-level cannot be reduced to an extension of state level power.

5.   Power is the "production of effective instruments for the formation and accumulation of knowledge" – methods of observation, registration, investigation, research, control. So power "cannot but evolve, organise, put into circulation a knowledge or 'apparatus of knowledge'" (p.237).

So Foucault suggests looking to the material operators of power, forms of subjection, strategic apparatuses. Foucault (1986) sees this "disciplinary power" as different from previous forms of power – such as sovereign power – and relies on individual bodies being disciplined. The power is disguised in "grids of disciplinary coercions" (p.236). All disciplines have their own discourse, or apparatus of knowledge, and it is through these discourses that normalisation occurs and disciplines bodies. This is discussed further in relation to health later in this chapter. Power has tied itself to the ascent of scientific knowledge and techniques, and this is clearly seen in the medicalisation of the body. Foucault does not see power as mainly coercive or violent, but accepted as legitimate and normative at an everyday level (Turner, 1997) – such as at the clinic.

Foucault (1986) remains generally interpreted as focusing not on "power to" but on "power over", but his approach to power is clearly very different from the traditional behaviourists' definitions of power. He is looking at the ways individuals are being persuaded into certain behaviour and lifestyles through a comparison with pre-defined norms, or in the words of Moss (1996): to "validate a social preference" (p.2). Individuals police themselves and power is therefore not seen, not acknowledged. His approach can therefore be seen as one attempt to answer Lukes' (1974) concerns of how to include the institutionalised power of which individuals are not even aware. Foucault (1974) called these "rules", which operate independently of subjectivity, and are below the surface and not directly accessible or knowable. And his focus away from negative power also allows space for more positive conceptions of power.

Feminists have found Foucault's approach to deconstructing power relations very useful in looking at society (Ramazanoglu, 1993). Foucault (1974 & 1976) arrived at the position that it is the exercise of power that creates knowledge and that knowledge itself produces the effect of power. So the discourses of knowledge function as a set

of rules which become powerful in defining what is and what is not normal, or acceptable according to the rules. Or in Foucault-speak: "forms of knowledge" underpin "technologies of domination" (Gledhill, 1995). For Foucault, the point is not where discourses come from, or what interests they represent, but "what effect of power and knowledge they ensue" (Ramazanoglu, 1993, p.19). Bordo (1993) sees the consequence of a Foucauldian approach to power as being one where:

1. We cease to imagine power as a possession of individuals or groups or something people 'have' – and instead it is a dynamic network of non-centralised forces.

2. These forces are not random or haphazard but configure to assume particular historical forms.

3. Prevailing forms of self-hood and subjectivity are maintained not through physical restraint and coercion, but through individual self-surveillance and self-correction to norms.

(Bordo 1993 p.191)

In this dynamic field, no one person holds the rule to the game - but not all players are equal either.   And Bordo (1993) points out the problem that the rules have to come from somewhere – for Foucault they come from discourses, especially scientific and medical discourses. And again for Lukes, this links to the idea that the indoctrination of rules into our lives means that we are not aware of the rules and their application. For feminists this is not enough. As Hekman (1990) states, this is only looking at the symptoms, not the causes. The rules do come from somewhere and they are applied to the benefit of certain members of society above others (Ramazanoglu, 1993, p.256). The more powerful, or elite, are able to set the rules to their own advantage, but in a form which "construct(s) the illusion of consensus and complimentarity" (Kabeer, 1994, p.229).

Foucault does offer another positive aspect through his perception of power. Since power does not reside in any one individual or group, resistance is possible at the individual, local level. Also, since power is dynamic it is also changing and changeable, since power and knowledge are linked.

What makes power hold good, what makes it acceptable, is simply the fact that it doesn't only weigh on us as a force that says no, but that it traverses and

produces things, it induces pleasure, forms knowledge, produces discourses. It needs to be considered as a productive network which runs though the whole social body, much more than as a negative instance whose function is repressive.

(Foucault, 1984, p.61)

Such a view of power is useful when considering the actual behaviour and agency of both the clients / patients and the health staff, and how they interact with each other: to view the results of the interaction from both the givers and the receivers of the service.

Empowerment

Building on the above discussions of power relations and the problems of how to uncover coercive or institutionalised power within both society and organisations, the idea of empowerment is now discussed. Empowerment embodies many of the concerns expressed in relation to power, especially its under-theorised use in the development and health sectors.

Empowerment has emerged into both development and gender debates in the past decade (Rowlands, 1997), and Thomas (1992) sees "empowering the poor" as having become an almost universal slogan in the late 20th Century. This notion gained credence and popularity in the 1980s and 1990s, through INGOs adding "empowering" and "participatory" dimensions to their service delivery activities (Razavi and Miller, 1995). For Porter and Verghese (1999) after the women's conference in Beijing, ideas and words such as empowerment, like gender, moved into mainstream vocabulary. Empowerment itself, however, often remains non-specified or undefined. Its definition has, if anything, become more vague as more development institutions and planners use the term in their own undefined and ambiguous ways (Townsend, 1999). Even more confusing, it is often assumed to be understood and universal. In practice this allows it to be anything it is defined to be (Rowlands, 1997 & 1998). Townsend (1999) in particular points out that empowerment means very different things depending on the political position of the person defining its use. This can range from privatising health care to give individuals

more choice, to assisting poor people to help themselves through training or credit and therefore she sees the word as having been "emptied of content" (p.21). Empowerment becomes another jargon word, made technical and impotent (Porter and Verghese, 1999). Kate Young is particularly sceptical of its more widespread use by development agencies and their use of it to refer to entrepreneurial self-reliance, "unleashing the capacity of individuals to be more self-reliant. It is closely allied to the current emphasis on individualistic values; people 'empowering themselves' by pulling themselves up by their bootstraps" (Young, 1993, p.157).

As Edwards and Hulme, (1995) point out "…by its very nature the process of empowerment is uncertain although it is possible to initiate the journey in a structured way (using particular techniques and methods for example) the ultimate destiny is always unknown." Also, empowerment is really a contraction of self-empowerment, as no-one can empower another person, it has to be self generated. One can enable but not empower another. For Stein (1997), to 'give' empowerment is a contradiction in terms. If it were possible to 'give' empowerment then it would also be possible to 'take' it back, which would negate the term or experience. But the ability to empower women has proved to be difficult to execute if it is to be done with the emancipatory goals originally intended. As Kabeer states:

> Because there are risks and costs incurred in any process of change, such change must be believed in, initiated, and directed by those whose interest it is meant to serve. Empowerment cannot be given, it must be self-generated. All that a gender transformative policy can hope to do is to provide women with the enabling resources which will allow them to take greater control of their own lives, to determine what kinds of gender relations they would want to live within, and to devise the strategies and alliances to help them get there. (Kabeer, 1994, p.97)

The ability of INGOs, let alone of governments, to deliver this emancipatory process has proved to be very elusive, but empowerment remains a very strongly stated *raison d'être* among many players in the development sector, including the World Bank, United Nations agencies (here especially UNICEF, UNFPA and WHO), bilateral donors and INGOs. As health care remains a major field for all these donors and INGOs to be working in all have now also adopted rhetoric about empowerment in

the health sector. But generally, the delivery of such emancipatory ideals has been hard to locate.

Even in research that has set out to investigate empowerment at the individual, personal level researchers have found it difficult to locate clear examples of empowerment. An interesting example of a successful attempt is from *The Male in the Head* (Holland *et al,* 1998) where empowerment and what this might mean for individuals is explored in sexual relations. In looking at empowerment for young women, they found that there were two distinct levels of empowerment – intellectual and experiential. Intellectual empowerment is about identifying the changes required and intending to make them. Experiential empowerment is the ability to act on these intentions. The young women in their study are inhibited in their agency by conventions imposed and policed not only by peers, family and school, but also by themselves. The men's control over women is not overt but involves collusion between young men and women. Holland *et al* are clear that conventional femininity can be disempowering but empowerment is not a simple case of resisting these conventions. Empowerment here is clearly seen as a process. Young women in their study are offering resistance to conventional norms. They are resisting on an on-going basis but empowerment is never fully achieved. Important here is to recognise that empowerment is never simply a question of choice or individual agency. Kabeer (2000) acknowledges that individual agency is socially constrained but that people need to really live and experience the world. And in this living they can influence their immediate environment, which in turn can alter the structures in which they make choices. Kabeer (1999) also describes "choice" as incorporating three inter-related dimensions: resources, agency and achievements. There is an active feedback loop between these three dimensions.

Holland *et al* (1998) could never chart a simple progression from less to more empowered states in their study and some strategies the young women were adopting (for safe sex) were actually disempowering, and some strategies for empowerment resulted in very risky behaviour (unsafe sex). Individual empowerment does not and cannot alter the wider social and political environment. As such, the empowerment model of development is, at best, only able to deal with local problems by supplying local, immediate solutions (Thomas, 1992).

Kabeer (1994, Ch.9) points out how grassroots INGOs "by asking the relevant questions and being sensitive to the answers of the poor and of women can develop programmes that address the powerlessness and exclusion of these groups from mainstream societal institutions". This she sees as potentially empowering for women, and the poor for whom the programme is acting. But it remains a problem of how to ensure that the women are self-empowered so that they are truly non-dependant. For external actors such as INGOs, trade unions and so on, to assist in the empowerment process is difficult as is being certain that empowerment is actually occurring. This has meant that the focus has remained on more measurable interventions[9] which are *themselves defined* as "empowering" the poor / women / excluded to enter mainstream economic activity (Townsend, 1999). This has meant that for some women it has simply led to the acceptance of more responsibility without any increase in power (Batliwala, 1997; Rowlands, 1997) as the reality of their daily lives remains unchanged in other spheres. So claims to empower women remain elusive.

Such a focus on what is measurable in relation to empowerment clearly overlaps with issues of proxy indicators in health service delivery. How you measure "empowerment" is as problematic as how you measure "health" (Seedhouse, 1997). This in turn relates to the problem discussed earlier in this chapter regarding how you move beyond or get beneath managers' definitions of what should constitute performance indicators (Walt, 1994). The creation of a definition of empowerment which can be measured also overlaps with the discussion on ANC activities to address the definition (not the pathology) of pre-eclampsia[10] (Dekker and Sibai, 2001). And moreover, there are links to the problems discussed in relation to how one can be sure that the activities advised are actually empowering and not simply adding responsibility - for example for community health workers. Empowerment can be illusory if the real power still resides at a higher / different level – such as with the health sector managers and professionals (Kabeer, 1994; Fowler, 1995). Partnership is always assumed to be benign whereas in health care as in other aspects of development, partnership is rarely equal, and can possibly generate new forms of inequality (Townsend, 1999, p.176).

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[9] For Kabeer's work this centres around micro-credit.
[10] See next chapter for more detail on this issue of definition.

Feminist concerns with power have usually extended the focus from "power over" and "power to" to include also "power within" and "power with", in order to include the specific needs of women and their reclamation of power in their lives and the power derived from collective action. Townsend (1999) sees these more positive definitions of power as necessary to expand notions of power from the limited sphere of economics, to include more personal and political spheres of life. "If women's empowerment is to transform society, it must become a political force, an organised mass movement capable of challenging and transforming existing structures of power" (Batliwala, 1997). For this, women must exchange ideas and experiences and be able to take action without fear. As is discussed in Chapter Seven, in Gwassi, women (as CHWs) clearly were trying to challenge existing structures in promoting and in gaining access to family planning, often at significant cost to themselves.

Questions have been raised in the literature around whether women are empowered by having access to more money (Harriss-White, 1998, p.202) or schooling (Jeffery and Jeffery, 1998, p.251) for example, but in the health sector there has been little interrogation of what empowerment might mean in either policy or in practice. The exception is in the sphere of rhetoric such as a re-emphasis on health knowledge (renamed health promotion instead of health education). It is questioned here whether in fact women can be empowered by training in medical models of health and health information. If we take the example of IMCI[11] (WHO/UNICEF 1997) and its "12 key family practices", there appears, if anything, to be a return to models of the 1970s and 1980s that conveniently ignore the social and economic situations in which women and their families live, with a focus on biomedical solutions and reliance on assumptions about women's domestic role.

> It is believed that.... women, with more knowledge (but little more time or money) can heal, reconstitute, and fortify their children, although the underlying cause of much of the illness – inadequate nutrition owing to low incomes – cannot be dealt with at the level of health interventions.
> (Dwyer and Bruce, 1988, p18)

This is expanded on in Chapter Three with regard to several PHC activities found in Gwassi.

Empowerment and "New" Public Health[12]

In the health sector, the notion of power is not regularly evoked and if it is, it is usually ignored. The traditional maxim of "doctor knows best" continues in public health planning. Criticisms of this pre-eminence of the professional have come both from feminists and also workers in "new" public health (Lupton, 1997; Peersman, 1999). As Peersman (1999) suggests: "the language has changed but the power relations remained unchanged" (p.124). Empowerment in the health field is defined as "the process of enabling people to take control over and to enhance their own health" (Peersman, 1999, p.124). There is confusion as to whether the focus is at the individual or community level in many texts. But it is the application of empowerment models without a recognition of power that is the most serious criticism of health planners using such models. Mayall et al (1999) suggest that the "popular notion of 'empowerment' is a facile way of avoiding the social economic determinants of health" (p.6).

Petersen and Lupton (2000) and many other authors see a neat distinction between new and old public health. For them, old public health is seen to have encompassed quarantine, isolation, sanitary inspection and so on. This ignores the original emphasis on engineering and social solutions to health problems discussed in the next chapter. It also omits that the old public health from the early part of the 20th Century had particular forms of gender bias. It focused on women in highly moralistic tones (Wright, 1988); as the pregnant or lactating mothers of children, or the adult who was to present the child for weighing, immunisations and school inspections (Lewis, 1990); and as the adult who was to correctly feed and clothe entire families as directed by the newly emerging quasi-professions of nursing and sanitary inspectors. The old public health had highly specific views about family life and roles for men and women, and hence how medical interventions could be implemented. There still remains in public health today an underlying assumption that women care for others – both for their family and also in the wider community. Caring is seen as natural and as something women do (O'Connell, 1994), not men (Edwards, 1998). Old public health can therefore be seen to be highly gendered and moralistic in its assumptions.

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[11] Integrated Management of Childhood Illnesses
[12] In developed countries the usual terminology is public health; in developing countries PHC is mainly used to explain public health activities, especially those which involve women.

The new public health in contrast is seen to use concepts and strategies such as health promotion and health education, community participation and social marketing (Petersen and Lupton, 2000). It is also seen to rely on epidemiology, screening, immunisations which, as discussed in the next chapter, also clearly have their rituals and practice developed in the early part of the century, along with their western gendered image of women and men and their respective assumed roles in child care and family health and hygiene matters (Ramirez-Vallez, 1999; Ostergaard, 1992). In addition, both old and new public health rely on legislation and the threat of exclusion if individuals do not comply (Petersen & Lupton, 2000). For example: in Kenya women cannot access emergency obstetric care unless they have attended antenatal clinics; in the USA children cannot enter primary school until their immunisations have been completed (which leads to a sudden, late surge of immunisations in older children); in France families do not receive their child benefits unless the child has had the appropriate immunisations for the child's age.

An important way in which new public health has added new dimensions to its repertoire is through the idea of systematic "community participation" and "empowerment" in the pursuit of health (parallel to ideas and practices in the development sector - see Razavi and Miller, 1995). "Empowerment" (as discussed above) is now a central discourse in public health debates in both developed and developing countries (Petersen and Lupton, 2000, p.9). Other terms which are regularly used or evoked are "self-help, equity, access, collaboration, empowerment, participation, community control and so on" (p.11). Such language may promote a wide-based appeal but, as Seedhouse (1997) points out, much of it is ill-defined in practice and constitutes more rhetoric than practice. All these terms have a strong place in development discourses and as such help to improve the positive image of a programme or project (Guijt and Shah, 1998, Ch.1). As Bunton (1992) suggests, calls for participation are frequently added-on as catch-phrases, and do not involve any redrafting of the original model. Petersen and Lupton (2000, Ch.6) also see the use of such terms to specifically appeal to a broad-base coalition, and to mask the power relations that underpin the community and inequalities causing the ill-health. There is an assumption of the community as being benevolent for all members, without internal politics and frictions; one where all can participate equally (Mosse, 2001). In public health, the definition of a community tends to focus on the geographical area

over any other definition of community (Petersen and Lupton, 2000, p.146). This is because for health care, the delivery of a service to a defined population remains its *modus operandi*. The gendering of its patients is not considered beyond biological differences.

In 1987 Foster saw community participation in health as a "doctrine" which has "ritual obeisance" only. Today, as participation has been re-entering health discourse with the new language of empowerment, it is still "found to be tokenist only" (Welbourne, 1998). This reflects the lip-service use of participation noted by anthropologists in development circles (Nyamwaya et al, 1998; Gardner and Lewis, 1996; Lewis, 1998). The community may be consulted, but often participation is not carried over into major decision making – which remains firmly in the hands of the medical experts and the administrators (Kothari, 2001). "Citizens have often been encouraged to partake in decision making processes only insofar as this has been in line with pre-defined and pre-determined governmental objectives" (Petersen and Lupton, 2000, p.148). Although participation became a central tenant of public health for the 1980s and 1990s, it never removed or tried to deal with the power differential between expert and non-expert, let alone the gender dynamics associated with these differentials (Cleaver, 2001). In public health, the "unstated assumption" (Petersen & Lupton, 2000, p.153) was that the medical model was superior and was to be accepted by lay people in their response to admonishments to improve their health situation and status. Petersen and Lupton (2000) also see how:

> [T]he emphasis on individual and collective entrepreneurialism in health and welfare, and the devolution of responsibility for heath care and other social services to "communities", have received widespread endorsement across the political spectrum during a period when the limits of welfare as an economic, political and social strategy have become apparent.
> (p.10)

Within this context it is no surprise that "[H]ealth promotion is expanding" (Bunton and MacDonald, 1992), although Seedhouse (1997) sees much of the input into health promotion being to "keep people out of hospital", and as such, much of health promotion has not encompassed wider social and economic determinants of health. Sears (1992) also sees public health to be essentially a technocratic and government-led endeavour. Most activities are sponsored by the state on behalf of its citizens (or

by the UN or World Bank through the intermediary of the state) and are administered through state or other (for example service delivery INGO) bureaucracies.

All 'new' public health is still reliant on top-down planning despite the rhetoric of community involvement and participation. Power continues to be exerted this way, while incorporating empowerment models as demanded by the 'new' public health models. This is acknowledged as a major tension in trying to meld the two very different approaches. Although there has been a shift in the language of planners and policy makers towards empowerment, it "has not been accompanied by a corresponding clarification on how to make this concept operational" (Laverack and Labonte, 2000, p.259). Laverack and Labonte still assume, however, that these two approaches – top-down planning and empowerment - are ultimately compatible and indeed, the purpose of their article is to "present a framework intended to assist planners, implementers and evaluators to systematically consider community empowerment goals within top-down planning" (p.255).

Given these constraints alongside the immobility of gender stereotypes in public health, it is difficult not to remain pessimistic about a medical model of health services being able to address issues of gender inequality and to instigate empowering strategies (Kothari, 2001). Nevertheless, such rhetoric of empowerment has been accepted into health care delivery in Kenya and its impact is discussed in Chapter Seven. How useful a concept or strategy is empowerment in such a highly gendered sector as health in general and PHC in particular? Stein (1997) remains pessimistic that in the health sector women can gain empowerment – mainly on the grounds that powerful health professionals are unlikely to give away their power. Peersman (1999), who sees the concept of empowerment as being used in a covert way to mask an on-going top-down approach, also holds a sceptical view. The power of professionals to define which problems are to be addressed is not questioned. Nor are the power differentials of men and women in local communities which impinge on their "choices" (Kabeer, 1999) questioned; "choices" men and women have for their own and their families' health status. As outlined in Chapter Five, the highly traditionally structured society in Gwassi with specific gender norms, socially and economically, constrain the choices of both men and women.

Empowerment and its use in development / health discourse in Africa

Kaler (2001) is helpful in suggesting that the word "empowerment" is being used in three different ways by individuals in Kenya and South Africa, and uses discussions around the promotion of the female condom to illustrate these different usages.

She suggests that a first meaning is "empowerment-as-meeting-strategic-gender-interests" and this is mainly used by government officials, senior INGOs and educated women and men, many of whom are familiar with the Cairo Convention and associated language of UN meetings. They agree with ideas of changing relations between women and men, and believe that giving women more choice and control over their own bodies and reproductive potential is empowering. This is mainly an elite view. As she travelled out from the centre, comments challenging this elite view were made, including:

> "They (the elite) aren't aware of the social and gender-related issues that make it difficult for a women to actually use (a female condom)"; and
>
> "The female condom is being driven by the whole Cairo reproductive rights discourse. It's very high-minded, but it doesn't take into account the reality of women's lives in Africa. Within this discourse it's assumed that of course it will empower women – that anything women can use without going through men will be a good thing. That assumption is wrong" (p.785).

Although local changes are occurring through education and development of local women, there is still a long way to go before women are able to be in control, as the following quote she provides illustrates:

> ...in a rural setting you can't talk about changing any aspect of gender roles, above and beyond sex. A rural woman can't even ask her husband to get her a glass of water or to help her feed the children because to do so would challenge his role as a man. (p.786)

As Kaler summarises, "the winds of change are blowing – but most women are not yet ready" (p.786). And when all the women she interviewed were pushed, it turned out that none would use the female condom themselves. The female condom is seen as only suitable for single, unmarried women with multiple partners – i.e. commercial

sex workers (CSWs), who are different from how the women defined themselves - since CSWs are seen as promiscuous and immoral.

The second definition of "empowerment" she found being used was "empowerment-as-meeting-practical-gender-interests" (p.788). This is a use of the word often found in discussions about the problems women faced in their daily lives, including heterosexual relationships, and strategies to minimise these risks. These relationships are seen as being characterised by mistrust, suspicion and violence. It is also seen as not possible to change these relations, but the condoms can empower the woman to minimise the risks, "blunting the sharp edges of heterosexuality" (p.788) but not transforming gender or sexual relations. The female condom is seen as particularly useful for a range of women who have to engage in sex for either direct financial remuneration, or situations where women must provide sexual services to the boss to keep their job etc. In situations usually referred to as "coerced sex", as well as actual situations of rape, women are seen to be able to use the female condom to protect themselves from STDs and HIV, as well as pregnancy. A practical response is envisaged through the use of the female condom - which does not alter the power relations between the sexes.

The final definition of "empowerment", Kaler elaborates, was "empowerment-as-zero-sum-game". In this scenario, staff saw the female condom as potentially giving women more power, and so men will therefore have to have less. Therefore the female condom is a threat to men. This comes from rumours about the bad effects the female condom can have on men – everything from transmitting HIV to allowing women to collect a man's semen and through witchcraft affect the man and his future fertility. People who hold this view of power would focus on the potential for the female condom to be used secretly by women – if men are not aware, then they will not feel dis-empowered. This also leads on from many instances of men viewing women's control of their fertility with suspicion and distrust.

Kaler's definitions have been reported at some length here, as they demonstrate the wide variety of understanding of the notion of empowerment, although users would initially assume that there was only one definition which everyone understood. In particular, however, the idea of the word's definition changing and being challenged

as "one moved out from the centre" also resonates with my organisational perspective and field research experience.

Foucault and Medicine

It is useful at this point to return to Foucault and his view of power, in order to suggest how his approach may be useful in health research, in order to cope with issues of both power and empowerment. Foucault suggested that his work should not be taken as a set of "dogmatic assertions" but instead as "openings". His aim was to challenge taken-for-granted assumptions and challenge ideas taken as self-evident. (Foucault, 1981, p.4 quoted in Tyler, 1997, p.77) Here, Foucault's approach will be built on with direct reference to public health.

According to Turner (1997) the single most important thread in Foucault's work is his study of power - but for Foucault, modern power had a very specific orientation. Foucault saw the gradual change from the power of the sovereign and authoritarian, a coercive power (the power of death); to the power of governmentality that relies more on constructive and discursive elements (the power over life) (Gastaldo, 1997). The power of managing populations and disciplining individuals Foucault termed "*bio-power*" and the medical profession holds one key (others are held by other professions) to bio-power through their day-to-day practices and actions (Rabinow, 1991, p.258).

Society has become regulated through discourses which are diffused through society, not just among the powerful elites – here understood as the medical profession. The general population supports these dominant discourses; they are complicit in their reproduction and sway over society (Turner, 1997). This is seen to have been achieved through surveillance (the "clinical gaze") and data collection which has then been used to create "norms" and definitions of what is normal, acceptable. In Foucauldian terms, the clinical gaze has informed the discourse. As this thesis uncovers, in Gwassi, Kenya, the discourse can develop a life of its own and does not depend on being true or false: it becomes an accepted myth. Individuals are educated about these norms and are to discipline themselves to adhere to these prescribed norms (Lupton, 1997).

Epidemiology, and in particular statistics, has informed the clinical gaze. The use of statistics allows individuals to be studied and a "norm" to be calculated. This norm is to inform government about the population, to improve "governmentality". But this norm also informs the population. Individuals also come to relate to this norm and to compare themselves with it. This, according to Foucault, assists in control of the population, as individuals are personally controlling their behaviour according to use of comparisons to such norms (Rabinow, 1991, p.195). By reference to the norm, certain behaviours and ways of thinking are deemed appropriate, and through such devices, individuals "govern themselves" (Rose, 1993, p.290).

The main departure of Foucault from previous critiques of the power of professions (as such the analysis can also be applied to other professions such as law and religion) is that the general population is seen to be complicit in the creation of the power of certain discourses (Rabinow, 1991). Power is not coercive or violent, but the activity is accepted as legitimate and normative by (almost) everyone (Turner, 1997). This is a radical departure from the medicalisation critiques of earlier sociology (Lupton, 1997; Turner, 1997). It also moves beyond the previous impasse discussed above of the previous medicalisation critiques that could never clarify how doctors and other professionals had amassed their power in the first place. Foucault's analysis includes both the positive and negative aspects of power; power can be productive as well as limiting. He also does not see power as a zero-sum – you cannot say the patient has no power and therefore the doctor has all. Power / knowledge is a productive network (Rabinow, 1991, p.61) that runs through society; it is collusive. Doctors are not "figures of domination" but "links in a set of power relations" and so it is impossible to remove the power from the doctors and hand it to the patients (Lupton, 1997, Ch.5).

The main difference with traditional medicalisation critiques of medical power is that for Foucault the call to re-distribute knowledge to the general population can paradoxically lead to an *increase* in medicalisation as lay people then take on more self-regulation (Lupton, 1997). Preventative care may lead to a decrease in clinical care and so less direct interaction with doctors, but this is achieved through the population accepting the medical knowledge and regulating their lifestyle according to the medical model. The medical gaze has increased at the individual level. From

this perspective, even an increase of alternative medical practices is overall an increase in the medicalisation of our lives. And so, I would add, as individuals accept the medical model, they also bring its gendered assumptions and practices along with the medicalisation of the problem.

Most research using a Foucauldian perspective has been undertaken in the developed world. One exception is Gestaldo (1997) who applied this framework to health education in a Brazilian context. It is often assumed, because health education is seen as an asset, as part of health care through the provision of information and possible alternatives to improve health status for individuals and families, that it must be a "good thing" (also see Seedhouse, 1997). But using a Foucauldian perspective and seeing bio-power as the power over life, power over individuals and populations, she points out that there can be seen a more subtle use of health education techniques. Individuals came to be seen as "resources and manageable objects" linked to the state's concern with growth of the population and maximising the health and hence productivity of its population. So according to this view, the techniques of power allow control in a subtle, non-coercive way.

In theory policies in Brazil moved from a traditional approach of disease prevention and personal responsibility, through to health education and health information (where the healthy choice becomes the only rational choice an informed individual can make (see Thorogood, 1992, also)) and finally to what was termed a radical approach where empowerment to control one's own health and address issues of social inequality through community participation was introduced. However, even this radical approach continued in the form of informational campaigns that were pre-defined and delivered by the experts at the Ministry of Health. Consequently, the experts remained in control of the process. Also, these policies in Brazil were clearly written with the poor and destitute seen as the recipients, who were those lacking facilities. So although participation was seen as the way forward in all policy documents from 1982 to 1992, it was within a very pre-defined agenda.

Moreover, in her study when actual implementation was evaluated there was little concrete achievement and so the impact of policies appear simply to have been confined to telling the staff at the clinics what to do. Participation by the local community appears to have meant nothing more than helping immunisation

campaigns, writing complaints for the suggestions' box and so on. Real and equal participation did not occur - even at focus group meetings the doctor remained in control by supplying the correct message and ensuring that all the issues were medicalised (Gastaldo, 1997). Moreover, all participants deferred to the nurse or doctor to supply the "correct answer".

Gastaldo (1997) sees participation and empowerment as a dominant discourse today, reinforced by international influence and favour for such strategies (by WHO, UNICEF, WB as well as INGOs). However, in her research, she did not find this dominant discourse and policy successful in practice. Power remained in the hands of the professionals and bureaucrats in all health education strategies over an extended period of time in Brazil. In Foucault's terms, this can be seen in terms of *anatamo-politics* - of learning to be a healthy citizen. It becomes a part of daily life, an invisible power to discipline bodies. There will be a mixture of knowledge and self-surveillance. For Gastaldo (1997), this extension of the clinical gaze and self-surveillance through information is described in negative terms, despite the so-called empowerment derived from the increase in knowledge. In Foucauldian terms, all health education should be both to liberate and discipline bodies; however, it also contributes to the management of individuals and populations. Lupton (1997) sees Foucault's analysis only applying to western societies, however as Gastaldo illustrates, the global nature of modern medicine and health policies allows such techniques to be applied around the world. The focus is not on individuals (lay or professional), but on the discourse. And the dominant discourse has taken on a truly global outlook. The applications of such discourses in practice are of interest to researchers of health care delivery. Bio-power can be seen as the link between micro- and macro-levels (Gastaldo, 1997). The present research is part of that endeavour and for this reason the debates on power, empowerment and most particularly the Foucauldian perspective have been explored at some length in relation to development and more specifically to the delivery of health care.

Conclusion

This chapter has explored organisational theories, particularly in relation to organizational culture, ritual and myths. It has reflected on the issue of power within

organisations and especially health care organizations, relating this to feminist approaches to medicine and development. The concept of empowerment was elaborated on because of its frequent rhetorical use in health sector discourse, even in the far reaches of rural Kenya, where as the research in Gwassi shows, it is particularly difficult to translate into any kind of reality. The Foucauldian approach to power was reviewed here because it provides a helpful framework for explaining why this is so and for understanding seeming anomalies in perceptions and relationships uncovered by the present research.

The issues summarised by Scott (1992) - the setting of standards; selecting indicators; identifying processes; highlighting structures; selecting samples; and prioritising participants in attempting to study health organisations - are addressed in this research by following Foucault's *Methodological Precautions* (1986 p.232). This, helps address and uncover some important issues related to gender and power relations within the specific organization of the health sector in Gwassi.

This critical review of the relevant theoretical literature helps frame the research, which was undertaken at the extremities, among remote rural health care providers and the local community members with whom they engaged and who interacted, or not, with the services provided. The resultant approach served to uncover how the knowledge and power that follows from this became institutionalised into their daily behaviours.

Chapter 3
The History and Pre-history of Primary Health Care

Introduction

Primary health care (PHC) is an important concept and one that is central to my
research. It is a frequent and familiar term used in policy and practice, at global,
national, provincial and district levels. However, it is not always commonly
understood. Therefore, a brief description and history of primary health care ensues,
locating it in the history of public health in general and expounding on three specific
interventions in particular - antenatal care (ANC), child health clinics (CHC) and
community health workers (CHWs). These three interventions are discussed in more
detail, as they were the most obvious and accepted PHC activities in rural health care
delivery in Kenya.

The argument I make in this thesis is that at the point at which the progressive ideas
of primary health care are transformed from policy intentions to actual practice, those
involved in delivery often revert to older ideas and rituals which have their roots in
earlier public health policy. Public health policy has a long and highly gendered
history which informs these ideas and rituals. In tracing the history of primary health
care, this chapter illuminates the assumptions, including gender assumptions, behind
practices that are commonly and routinely performed in PHC programmes around the
globe.

Background to Primary Health Care

The WHO definition of health is "A state of complete physical, mental and social
well-being and not merely the absence of disease" (WHO, 1948). Kelly and Charlton
(1995) point out that this is a very postmodern definition of health. It has managed to
dissolve the distinction between science, art and morality.

PHC was born in 1978 with the publication of the WHO document *Health For All*,
which followed on from a UN meeting in Alma Alta. It is based on five founding
principles: equity; prevention; community involvement; multisectoral co-operation
and appropriate technology (Walt and Vaughan, 1981). The idea was to move health

care delivery away from high-tech tertiary health provision, which had often been based in large urban centres, to a more appropriate health care system for the common diseases and problems experienced by the majority of the people living in the rural and minor urban areas in the Third World. PHC was defined as:

> Essential health care based on practical, scientifically sound and
> socially acceptable methods and technology made universally
> accessible to individuals and families in the community through their
> full participation and at a cost that the community and country can
> afford to maintain at every stage of their development in the spirit of
> self-reliance and self-determination.
> (WHO, 1978)

PHC as advocated by WHO was seen to have eight essential elements:
- Health education
- Nutritional supplementation
- Immunisation
- Maternal and child health and family planning
- Water and sanitation
- Control of local endemic disease
- Treatment of common diseases and minor ailments
- Provision of essential drugs

The reason for suggesting the eight elements was to give guidance to Ministry of Health staff in countries everywhere to start planning specific interventions, which moved away from urban, hospital-based health care. They were not meant to be seen as definitive or as constituting an exhaustive coverage of PHC.

This definition of PHC was at the time seen as very political. Health is a political, social and medical construct (Seedhouse 1986). The Ottawa Charter (WHO, 1986) is also explicit in detailing issues of power and control in health promotion. As such, these UN health documents can be seen to be trying to merge science, politics and bureaucracy (Kelly and Charlton, 1995).

PHC remains the official policy for the majority of countries around the world. It has been both heavily supported and severely criticised in both policy and practice (Streffland and Chabot, 1990; Phillips and Verhasselt, 1994). Early divisive

arguments for health practitioners and policy makers have been around the promotion of comprehensive or selective versions of PHC (Rifkin and Walt, 1986; Asthana, 1994). Selective PHC (SPHC) is, as its name suggests, totally selective as to which aspects of PHC it promotes. It also operates largely within medical models, according to economic and medical principles of effectiveness and efficiency (Walsh and Warren, 1980). This approach was to only provide interventions that fell strictly within the health and economists professionals' domains and that could be assessed as having a high (immediate) impact on mortality rates (it ignored morbidity). A key element of the original article by Walsh and Warren was the linkage to orthodox economics which links the "final" cause of death to a moneterised input. They therefore only recommend the few interventions such as immunisations and oral rehydration therapies as being (economically) appropriate to primary health care. In view of the fact that the interventions proposed under the original SPHC do not deal with the distal causes of death and disease, only proximate ones, this is known as the "fire-engine approach" (Mosley and Chen, 1984). They do not address underlying causes, for example, death due to malnutrition or dirty water (Rifkin and Walt, 1986).

Unfortunately PHC was entering the health policy agenda just as the global economy was undergoing the 'oil crisis' and a global recession in the early 1980s, and hence funds for its initial implementation were incredibly tight. Some donors and governments were already interpreting it as a cheap health system, to be delivered at low cost to marginal and difficult-to-reach groups. For others, it was seen as a stopgap measure until 'real' health care could be delivered to the population as a whole. Very quickly the problems around initial implementation were being addressed by the design and advocacy of a slim-line PHC approach. The "Selective Primary Health Care" as advocated by Walsh and Warren in 1979 / 1980 was therefore rapidly taken-up.

Such specific SPHC interventions cut across the original philosophy, politics and practical ideas of primary health care. In particular, ideas of *community involvement* are removed due to imposition of medical models with which the community can only be involved at the 'acceptance level'. Walsh and Warren specifically reject intersectoral collaboration as they reject the notion of including water and sanitation as a worthwhile - in economic terms - intervention for health care programmes to pursue. And the idea of whether SPHC is promoting *appropriate technology* is also

questionable from such a technocratic model. Banerji (1999) would see SPHC as the "antithesis" of the original Alma Alta declaration of primary health care, in a similar way to how Rifkin and Walt (1986) saw SPHC as "contrary" to the original definition of PHC.

This reorientation of PHC goals into discrete selective medical programmes suggests that the *Health For All* ideas have been re-instituted as medical, technocratic vertical programmes relying on medical and economic paradigms. However, all staff - from the Ministry of Health to the nurse in a remote rural dispensary, to a community health worker - are also functioning under a rubric of PHC and notions of equity, multisectoral cooperation and community involvement. But the reality is of a technical, medical model. Actual change in medical services has been small, and many rural services remain clearly in the original (and often colonial) "rural health model" of the 1950s and 1960s (Woelk, 1994), and there is limited re-allocation of resources away from the urban high-tech hospitals (Heggenhougen et al, 1987; Mburu, 1992). In many countries, the majority of trained staff remain in the large urban centres, leaving the majority of the population far from quality services (Ministry of Health, Kenya, 1994).

SPHC programmes are vertical, top-down and preferred by most donors for the ability to control discrete activities and interventions (J Macdonald, 1993). Such programmes as UNICEF's GOBI/FFF[13]; WHO's *Safe Motherhood*; UNICEF's and Rotary Clubs' *Kick Polio Out of Africa*; WHO and DFID's *Roll back Malaria* and many other programmes found in African countries all fall into SPHC models (Banerji, 1999). WHO, UNICEF, and major donors added other vertical programmes to SPHC programmes, such as programmes called *Child Survival* and *Water Decade* to attempt to rectify the social and environmental issues lacking in the original SPHC programmes. Integrated management of childhood illnesses (IMCI) has recently been promoted by WHO and UNICEF (WHO, 1987 and 2001) to try and re-integrate vertical medical approaches (along with supply and logistical issues) in caring for children[14] to promote efficacy of care (Claeson and Waldman, 2000).

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[13] GOBI/FFF stands for: Growth Monitoring: Oral rehydration; Breast-feeding; Immunisation; Family Planning, Female Literacy and Food Supplements. Its origins are from UNICEF, 1988.
[14] In particular diarrhoea and acute respiratory diseases (ARI).

These vertical, selective programmes remain strongly supported by all the major donors and are centralised and delivered from a national or sub-national level – although the recent interest in Sector Wide Approaches (SWAPS) is also bringing into the picture some recurring costs and social issues. Also, large INGOs often prefer to be offering vertical and selective programmes at the local level, due to their mandates being formed around single policy issues (Green and Matthias, 1997). Family Planning and some Child Survival INGOs fall into this SPHC category. Donors, INGOs and Ministry of Health (MoH) departments still undertake selective interventions, as they are discrete, can be more easily measured, more easily controlled and have little reliance on national government plans and policies.

> Target driven, high profile inter-national initiatives often benefit the easiest-to-reach children instead of making structural changes needed to secure the rights of the most marginalised.
> (Save the Children, 2002)

A stark example of vertical programmes in many countries is where the MoH and the Ministry of Population and Welfare remain completely discrete, and run separate health and family planning (FP) clinics and outreach workers. They have only recently been merged in many countries (Mayhew, 1996; Lush et al, 1999). The Hutubessy et al (2001) paper is rare in challenging both medical, economic and policy views to define what is an appropriate response in situations of scarce resources and with our present levels of understanding.

The call for a "return" to comprehensive PHC remains and is voiced in academic (Claeson and Waldman, 2000; Kalipeni, 2000) and policy documents (DFID, 2000; Ministry of Health, Health Sector Reform Secretariat, 1999). It is frequently linked to a call for correction from the budget and service reductions caused by the application of Structural Adjustment Policy (SAP) reforms on social services including health in many countries (Turshen 1994). WHO held a meeting in 1998 to mark the 20th anniversary of the *Health for All* (HFA) approach of PHC, again in Almaty[15]. This meeting again promoted PHC, including the production of checklists and directions for achieving HFA (Hussain, 1999).

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[15] As it is now spelt.

But as stated by David Morley back in 1983 "yet primary health care programmes are not moving into a total void. On the contrary: they have to find their way through a maze of political, socio-economic, organisational, and technical problems" (Morley, 1983, Forward). The 'maze' included gender stereotypes and other social norms, which influenced public health policy development, application and public health norms. But Morley's (1983) warning seems to remain ignored. In particular, gender and power issues remain largely unacknowledged or researched in present day health policy and practice (Turshen, 1984; Foster, 1995).

The Link back to Public Health

This reiteration of the origins of PHC has been given at length, as it remains a central part of public health policy and approach in many countries[16]. It is often the starting place in many texts (e.g. Green and Matthias, 1997) for positioning / explaining the present situation in health services in developing countries. But the statement by Morley (1983) above shows how PHC moved into an area already colonised by public health discourses, which were highly gendered, individualistic and technocratic in their approaches in the 1970s, and continue to be so today.

Public health is seen to have arisen in the mid 19th Century due to the rising population densities in rapidly expanding towns and cities. This concentration of people led to epidemics of infectious and contagious diseases, causing high mortality and morbidity. In Britain, social reformers, not the medical profession, initially led the response to these human tragedies (Fee and Porter, 1992). In Britain, this led to the sanitary reforms proposed by Edwin Chadwick in the Poor Law Report of 1834 which relied on his famous assertion of "greatest happiness to the greatest number" through "engineering principles" and models (Fee and Porter, 1992; MacDonald and Bunton, 1992). In the USA, the response remained more within an individual moral arena, with a focus on personal failings and poverty, until later in the 19th Century, when again a more sanitary response in all major cities was implemented. Both Europe and America used a broad non-medical framework for preventing disease and poverty until more individualistic and medical models gradually replaced this early approach to public health. This was linked to the newly emergent germ theory, which had

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[16] In Kenya there is a "Division of PHC" within the MoH.

replaced miasmic theory by the early 20th Century. The other strand to public health came to rest around control of communicable diseases. As germ theory progressed, development of vaccination and immunisation became a focus of public health research. This gave doctors more influence over policies to control diseases, as the aetiology of diseases became understood. And so social, economic, and political causes of ill health came to be marginalised as biomedicine rose in prominence (Turshen, 1984; Vaughan, 1991).

Public health interventions and women

In early 20th Century Britain, in the period after the Boer War (when recruits had been found to be unfit for military service), the focus for improving adult fitness came to rest on the health of children and their subsequent physical development into healthy adults. In reviewing the writers from the late 19th and early 20th Centuries, Wright (1988) sees how initially the response to this unfit stock of young British men was not to suggest technical (medical) interventions but instead focused on moral reasons. Writers of reports on the health and ill health of children deplored the "fecklessness of mothers", or even their "selfishness in working after marriage" (Wright, 1988, p.302). He continues that "such moralisation never completely disappeared", but "changed in emphasis" as the medical model gradually came to the fore. The change was from "lamentations about immorality, drunkenness or cruelty of the poor" to a new discourse about "good intentions and loving care nullified by ignorance of hygiene or the ill effects of deleterious customs" (Wright, 1988, p.307). Barriers to lowering the Infant Mortality Rate (IMR) and improving the health of surviving infants and children were perceived to be mothers' ignorance and neglect of their children. In the words of the day: "Expressed bluntly, it is the ignorance and carelessness of mothers which causes a large proportion of the infant mortality" (Newman, 1906 – quoted in Carter, 1995, p.41).

But despite this view of the problem and its gendered assumptions and stereotypes, the main solution was not sought in either education nor in assistance to help prevent the neglect (i.e. mothers having to work long hours to feed and clothe their children). Instead the focus remained squarely on the medical profession who were able to redefine mothercraft. Moreover, the barriers to the achievement of this ideal to a

satisfactory standard were defined according to men's own view of the problem. Diet and hygiene (at the family level) were also always mentioned in the policy documents but since men had very limited knowledge of these subjects, the doctors relied on women to fill a role in the education at this individual level (Abbott and Sapsford, 1990). Doctors, as men, only knew about illness, not about nutrition, feeding or general care (especially of infants); nurses, as mothers and women, knew better (Wright 1988 p.311). Nurses, midwives and social workers therefore were required to be the link between the medical model and the female world of food, budgets and survival (Williams, 1989, Ch.6).

The medical model for decreasing both Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR) was also heavily influenced by the Medical Officers of Health's refusal to accept a linkage between the maternal mortality rate and nutrition data. The Fabians' call for a "Family Allowance" to be paid to wives of workers in 1910 was dismissed by the medical lobby. In the 1930s, the nutrition debate and a new call for the "Family Allowance" re-surfaced, but obstetricians stuck to calling for more beds as the way to reduce the maternal mortality rate (Lewis, 1990).

This medical, technical approach brings with it very explicit definitions of what is a good and a bad mother. These are essentially middle-class and patriarchal values (Abbott and Sapsford, 1990) about what an ideal family should be like, and especially how mothers (not fathers) should behave (Edwards, 1998). An (unstated) assumption is that all women should prioritise the needs of husbands and children over their own needs (Abbott and Wallace, 1990, Ch.1). The nurses and health visitors personalise the problems experienced by the mothers, although many problems have their roots in social, economic or political causes. The children are prioritised over the mothers. A particular family ideology is assumed and subsumed into health visiting (Edwards, 1998). Also, the advice given to women is treated and seen as factual – when it is in reality 'a mixture of facts, values and opinions' (Carter, 1995, p.171).

Foster (1995) sees public health as presently practiced by health service providers as having a poor record in promoting good health for women. This is because women's unique positions in society and the daily stress in and on their lives are not addressed. Domestic work is not valued, not understood, not counted and not assessed for the effort involved (Waring, 1989). Therefore women's participation in health care

programmes is equally not considered in any of these terms. It is simply assumed that the implications of the health care and health messages can be subsumed into the woman's day, at no cost to the woman herself. Health though is often affected by factors completely beyond the control of individual women (Carter, 1995). There is little appreciation of the socio-economic barriers to taking up medical advice given in outpatient, antenatal and child health clinics[17].

This reflects Foucault's ideas of "governmentality", and of the population disciplining itself according to these ideas promoted by the medical and nursing (and other) professions, through their day-to-day practices and actions (Rabinow 1991, p.258). Foucault termed this *bio-power*. The general population supports the dominant discourses and they are complicit in their reproduction and continuation (Turner 1997). This occurs at the micro-level. But the meso- and macro-level are also influenced by Foucault's ideas of "govermentality", its achievement through surveillance and the *clinical gaze*.

Lupton sees the emergence of the hygiene discourse and discovery of the microbe, allowing emphasis to lead away from social to individual and pathological reasons for illness (Lupton, 1995). But as discussed above, the pre-microbe era emphasis on moral and individual reasons for maternal and infant ill-health, and the general individual moral approach to public / social issues, assisted the primacy of individual medical interventions of the medical model over other public health, engineering or social models for improving health (Wright, 1988). Medical discourse was already heavily influenced by laissez-faire liberal ideals, where the focus was on the individual and not the social conditions of the working class and politics of the day. There was no desire to improve living conditions through raising taxes unless the upper classes, and later the enfranchised classes (Szreter, 1997[18]), were the ultimate beneficiaries of such schemes (such as sewerage and piped water schemes in Victorian cities), and so the emphasis, for example, lowering IMR and MMR, remained around individualised mother and infant medical care and advice.

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[17] See message eleven (Follow the health workers' advice about treatment, follow-up and referral) in the *Twelve messages for families* in the IMCI approach for the primacy of the medical message (WHO/UNICEF 2001).
[18] Szreter's work (1997) highlights the political constraints and developments on public health initiatives in fast growing Victorian cities.

Public health is seen as serving the needs of the community "dispassionately" and "politically neutrally" (Lupton, 1995, p.59). But the discourses and practices of public health are often heavily imbued with "moralistic and discriminatory meanings", but in a "utilitarian logic" (Lupton, 1995, p.46). These are the moralistic and laissez-faire vestiges of the medical profession's view of the appropriate medical response to maternity and infant deaths of early 20th Century Britain, that continue to permeate approaches to public health, and indeed PHC into the 21st Century and beyond the borders of Britain. Public health uses norms and definitions that in and of themselves define what is normal / acceptable[19]. Foucault maintained that these dominant ideologies are maintained and circulated by the general population (Rabinow 1991 p.195), through their adherence to the prescribed norms (Lupton 1997; Turner 1997).

Nursing and medicine – creating professions

Nursing and social work both have their origins in 19th Century philanthropy. They were able to expand rapidly from their middle class philanthropic routes (Lewis, 1992) with the coming of the welfare state. In the early part of nurse and midwifery development, women relied on men to help define these new professions. This was partly due to the desire of the new regulatory bodies to have regulations and standards laid down through statutory laws. But at this time women did not have suffrage and so could not directly petition parliamentary members for such definition of their profession. Influential men were therefore called upon to define the roles, boundaries and eligibility for these emerging professions. In Britain, this meant that these roles had been highly shaped and influenced by men. These men were mainly lawyers, doctors and the clergy – i.e. middle class educated men who had a certain outlook on life - both public and private (Hugman, 1991, Ch.1). Present day descriptions of professionals and occupational groupings cannot just be understood in terms of present social relations but are also rooted in past relations. These relations are both public and private. It relates to men wishing to limit the contact their wives and female family members had with the world of work, and hence independent financial control is related to private views of women's boundaries, *vis a vis* men[20]. Also, in

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[19] See details later section in this chapter on epidemiology and statistics - creating a norm.
[20] E.g. In 1909 (around the time of nurse and midwifery laws) the Trade Union Congress forwarded motions banning wives from working (to reserve jobs for men) (Pateman 1988).

the public arena men were able to limit and control conflict over boundaries of overlapping professional areas of expertise[21] (Walby and Greenwell, 1994, Ch.3).

Only more recently has there been any interest in this gender division in the development and subsequent practice of the caring professions. In nursing, early descriptions clearly demonstrate the conflation of good nurse and good woman. There was an emphasis on domestic skills and obedience (MacKay, 1990: Hugman, 1991, Ch.7). Also early in the century the position of nurses to doctors appeared naturally to be hierarchical, when it was assumed that men were doctors and women were nurses, because it was the simple reproduction of the social relationships within wider society. Nursing assumed the traditional feminine role, and women were 'controlled' by the male medical profession (Abbott and Wallace, 1990, Ch.1; Hugman, 1991, Ch.3). Organisational studies in general tend to ignore gender relations within organisations (Halford and Leonard 2001; Hearn and Parkin, 1987). And early attempts to theorise the professions also ignored gender relations, for example in the trait theories and Friedson (1970) and Etzioni more recently (Lupton, 1997). Within both medicine and nursing, there are the gender relations within and between the different caring professions, and also the gender relations between the professionals in general and the patients or clients (Hugman, 1991, Ch.7). Chapter Two provides more detail on organisational issues in relation to gender and health.

Nursing and health visiting were and remain heavily influenced by both hygiene and gender discourses raging throughout the last two centuries. These discourses are still found in the day-to-day functioning of PHC around the world. In particular, the moral and gendered assumptions are reproduced in both the staff training (nurses and midwives) and also views of the community and appropriate roles for community health workers. This isexplored at more length below, with examples from specific public health interventions used in the delivery of PHC. First, however, there follows an account of how 'uncontestable facts' or 'strong statements' (Petersen and Lupton, 2000, p.43) reinforce this gendered ritual of delivery.

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[21] See Chapter Two on organisational issues for additional detail of this male control.

Epidemiology and Statistics – creating a norm

Epidemiology, which relies heavily on statistical analysis, has grown with the advances in statistical practices and has now eclipsed engineering as the dominant paradigm in public health (Inhorn and Whittle, 2001). "Epidemiology is concerned with the pattern of disease occurrence in human populations and the factors which influence these patterns" (Lilienfeld and Lilienfeld, 1980, p.3) and uses biological and statistical elements. So, "by 1916 statisticians were identified as the most important and influential profession in public health" (Fee and Porter, 1992, p.266).

Epidemiology is the usual preferred research methodology in public health. It has adopted a 'biomedical, clinical model for the study of disease via "risk factors"' (Inhorn and Whittle, 2001, p.553), moving away from its more social roots (Pearce, 1996). In doing so, it has excluded women from research, including problem definition and knowledge production (Inhorn and Whittle, 2001; Turshen, 1989; Stein, 1997). Epidemiology has only focused on women as reproducers and carers and has ignored the social dimensions of health and illness; thus it reinforces rather than challenges issues of gender (Foster, 1995). As such, it can be seen as having been "grossly misused" (Banerji, 1999) by public health experts.

Experts can be seen to play a crucial role in political rule in modern societies. Foucault (1980, Ch.6) charted how human sciences (which included medicine) developed since the 19th Century, and which he saw as part of a system of moral regulation. For Foucault, the new prisons, clinics and schools were all part of this scheme of control and discipline. Such institutions encouraged individuals to conform to the morals of society. The collection of data in the form of tables and charts also allowed the defining and circumscription of the social world through these new emerging professions. The terrain was divided between various experts who then proposed definitions of the problems and suitable solutions to the problems as defined. Epidemiology is a practice that neatly conforms to Foucault's image of the collection of facts and compilation of statistics which are then used to define the problem and also the answer to the problem (Petersen and Lupton, 2000). But "facts are not autonomous entities 'out there'; on the contrary, it is through scientists' knowledge and belief systems – themselves developed and expressed in the context of professional interests, resource allocation, available technology and power relations -

that scientific (and other) facts, models and theories are brought into being" (Fleck, 1979 / 1936, quoted in Petersen and Lupton, 2000, p.29).

Despite epidemiology's prominence in public health, many common PH / PHC interventions remain unverified in their effectiveness. Issues around evidence-based health care have been slow to be adopted, and tend to focus on high cost tertiary care (Maynard, 1994; Sacket and Rosenberg, 1995; Fulop et al, 2001, Ch.1). In the late 1990s, WHO and the World Bank commenced a review of the "burden of disease" and other necessary information systems to attempt to base policy decisions on need and effectiveness rather than tradition and ritual (WHOSIS, 2003). In PHC, organisational inertia and lack of professional support or re-training has allowed ritual rather than proven effective intervention to dominate in much service delivery. For example, for pregnant women in developing countries, training of traditional birth attendants (TBAs) has continued, despite the lack of evidence that such initiatives have reduced maternal mortality (WHO Safe Motherhood Initiative, 2001); and antenatal care (ANC) has taken on a ritualised form in many countries, and the benefits of many of these rituals are only assumed and remain unproven (McDonagh, 1996; Oakley, 1993)[22].

Researchers, practitioners, academics – the experts – all know that knowledge is contested; that theory is developing all the time. However, the discourse which travels out and reaches the public is often much less ambiguous. The statements are presented as "facts" or "true". Strong statements are used in policy documents, training manuals, health education literature etc. Statistics, graphs and tables are used to again give an image of 'fact' and 'incontestable' information. Petersen and Lupton (2000) refer to this use of strong statements as quantification rhetoric (p.43). These 'facts' come to inform and influence the ways individuals view themselves and their bodies, and how they respond to the health service and its staff when sick. By saying something in scientific terms gives it a credence and authority, which is difficult for individuals or communities to contest (Petersen and Lupton, 2000).

The use of particular models in public health, or research techniques, all rely on theory and practices being presented as 'strong' or 'true'. How this feeds into both

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[22] See section below for elucidation on ANC.

health policy and, perhaps more importantly, practice, is elucidated through discussions of the fieldwork in Chapters Six and Seven. But first, specific practical activities undertaken under the public health / primary health care rubric are explained in detail. These activities (Antenatal Clinics, Child Health Clinics and the work of Community Health Workers) are focused on, as they were the activities referred to by both the staff and the community when people talked about health care provided in the local community.

Antenatal care[23]

Obstetricians' perspectives

Antenatal care provides an excellent example of how an idea (in this case antenatal care) is presented as a 'fact' although as the following textbook description demonstrates, a vague routine is all that underlies what has become a ritual.

> In order to ensure that the outcome of the pregnancy is optimal for both
> mother and baby, a routine is undertaken which is embraced by the term
> antenatal care. In essence, we seek to detect any abnormalities that already
> exist and to prevent or minimise any additional complications during or after
> the pregnancy.
>
> (Beischer and MacKay, 1986)

Such a non-specific definition of antenatal care is repeated in: "The overall aim of antenatal care is to produce a healthy mother and baby at the end of pregnancy" (Lindmark and Cnattinguis, 1991). The 1986 textbook goes on to state that this 'routine' can only be realised through the following:

i)   The patient is seen early in the pregnancy, preferably before the 10th week, and at regular intervals thereafter.

ii)   A full history is taken and examinations made at the first visit, and routine investigations are performed.

iii)   "Risk factors" are carefully assessed and necessary action taken, such as referral for special opinion or to an appropriately staffed and equipped hospital.

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[23] Antenatal care will be the term used here – it is referred to as prenatal care in American texts.

iv)   The patient and her family receive adequate psychological, social, and
        educational support from medical and paramedical attendants.
        (Beischer and MacKay, 1986)

Dekker and Sibai (2001), using the example of pre-eclampsia, however, caution how
such 'routines' have taken on a myth of their own making; that is they have created a
'definition':

> A major flaw in almost all studies on prevention of pre-eclampsia published so
> far is the focus on prevention of the definition of pre-eclampsia. Pre-eclampsia
> is defined as de novo hypertension plus proteinuria in the second half of
> pregnancy. But having pre-eclampsia is only a risk marker - most patients with
> pre-eclampsia feel fine and pregnancy outcome will be good. The study that
> showed that vitamin C and E supplementation could prevent pre-eclampsia
> was a good example of prevention of a definition rather than the actual
> pathology.
> (Dekker and Sibai, 2001)

The important point to note is that the attention is directed towards the definition,
which may remain partial, and /or unhelpful. But as is demonstrated, such definitions
take on a life of their own, reinforcing the routine from which they were born. This is
despite there being "no widely accepted test for the prediction of pre-eclampsia"
(Chappell et al, 1999). Similar criticisms can be directed at other antenatal "risk
factors" presently investigated in ANC.

Definitions in resource-poor environments

As stated in the introduction to PHC earlier in this chapter, maternal and child health
(MCH) is seen as one of the essential elements of PHC. WHO held a conference on
Safe Motherhood in 1987 in Nairobi to address the issue raised in Rosenfield and
Maine's famous 1985 article entitled *Maternal mortality – a neglected tragedy:
Where is the M in MCH?* The conference identified four main objectives to achieve
safe motherhood:

i)Adequate primary health care and an adequate share of the available
    food for girls from infancy to adolescence; and family planning
    universally available to avoid unwanted and high risk pregnancies.

ii)   After pregnancy begins, good prenatal care including nutrition, with
      efficient and early detection and referral for those at high risk.

iii) The assistance of a trained person for all persons in childbirth, at
      home and in hospital.

iv)   Women at higher risk, and, above all, women in the emergencies of
      pregnancy, childbirth, puerperium must have access to the essential
      elements of obstetric care.

(Mahler, 1987, p.669)

Here both the ideas of PHC and antenatal care (here called prenatal care) are
presented as ways to improve maternal mortality (and by default maternal morbidity).

Although antenatal care is frequently referred to in global documents, there is no
standard agreement as to what the actual practice should comprise. Many authors
point to the wide variation in antenatal care around the world (Rooney, 1992).
McDonagh (1993) suggested the following five procedures[24] should constitute
antenatal care at the primary level in developing countries:

- Screening (for 'at risk' factors)
- Routine measurement of weight
- Nutritional interventions
- Routine examination of blood pressure
- Abdominal examination.

The emphasis is clearly on medical interventions here as well. These five
interventions were observed to form the core of antenatal care in Kenya. The ability
of such activities to improve outcome is discussed later in this section, but first, a
history of the development of ANC is provided.

History of Antenatal Care

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[24] Tetanus immunisation was excluded as it was seen to relate more closely to Expanded Programmes
of Immunisation (EPI) rather than antenatal care programmes.

In Britain in the 20th century, maternal mortality declined, especially during and after the war. Alongside this decline, antenatal clinics grew from their origins in Edinburgh in 1915 (Oakley 1982), and London a few years later. Lewis (1984), Oakley (1992) and Carter (1995) chart the construction of "antenatal clinic activities" which later grew into "antenatal clinic services" in Britain in the 20th Century. From the non-medical perspective, these accounts show social control of the mothers to be more important than medical effectiveness of the ANC activities. Tew (1990) also questions the role of antenatal care in improving the maternal and infant outcomes of pregnancy. This is not to say that all members of the medical professions agreed that antenatal care achieved what it was claiming to achieve (Browne and Aberd, 1932). Across the century there was considerable public interest in reasons for improved maternal outcome. In 1932 the *Final Report of the Departmental Committee on Maternal Mortality and Morbidity* sent a special delegation to Denmark, Sweden and the Netherlands to investigate the causes for the lower maternal mortality reported there. They had to conclude that "wide difference in social conditions and habits of life in these countries and in many parts of England and Wales' made comparisons difficult, but overall they felt the superior social conditions and general health of the population were to be considered the single most important factors in the lower mortality and morbidity" (quoted in Fee and Porter, 1992, p.266). By the middle of the century the medical interventions in childbirth which most helped to lower the maternal mortality were antibiotics[25] and blood transfusions[26] – interventions which play no role antenatally (Belsey, 1990; Tew, 1990). Many other important changes occurred in the first half of the 20th Century, which also affected the outcome of pregnancy and childbirth. Since so many changes - socioeconomic, nutritional, hygienic, scientific advances, medical and midwifery training, and war - occurred at the same time (1930s to 1950s), it is problematic to accurately establish the effect of antenatal care on improving the outcome of pregnancy (Tew, 1990; Hall, 1992).

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[25] Antibiotics, along with hygiene in delivery, were important since puerperal sepsis had been the leading cause (over 40% in 1930) of maternal mortality. The rate fell sharply (from 1.35 to 0. 37 / 1000 births) between 1935 and 1945, and then over half again (to 0.13) by 1950.

Present day practices in Antenatal Care

Oakley (1992), in her work regarding motherhood and the medical practices around pregnancy and childbirth, again focused on issues concerning the appropriateness of various practices that had developed within the medical model. Her work into perinatal mortality demonstrated the immense difficulties the medical profession has in imagining or accepting that there is any other solution to problems other than a medical interventionist approach. The widening of the "problem" into non-medical fields is resisted fiercely (Tew, 1990, Ch.9). The key theme of Foster's (1995) book is that "women's consumption of health care is generally less beneficial to them than is generally believed". She asserts that doctors are empire building rather than providing care in the most beneficial way, and uses obstetric care as an example[27].

One consistent attempt to improve outcomes from the AN clinic and the prescribed activities was and is to discourage "late attenders" and to get all women to attend early in their pregnancy (Foster, 1995, Ch.2). This is purportedly to enable early intervention and to increase the total amount of intervention offered to each woman. However the rituals of the antenatal clinic are generally unproven – even the weighing of the mother is now acknowledged to have no predictive value and hence no health benefit (Steer, 1993 quoted in Foster, 1995; Dekker and Sibai, 2001). Routine antenatal care has never been subjected to rigorous scientific research and it is unlikely to pass medicine's thresholds as an effective intervention or strategy if it was now tested (McDonagh, 1993). McDonagh scrutinised the five procedures she defined as part of antenatal care in developing countries and found "all the collated evidence suggests there are substantial grounds to doubt the effectiveness of the procedures ritually performed during an antenatal visit and that are collectively called antenatal care" (1993, p.32). This reflects the conclusion of The House of Commons Health Committee 1991 which stated "the present imposition of a rigid pattern of frequent antenatal visits is not grounded in any good scientific base and... there is no evidence that such a pattern is medically necessary..... are not the appropriate place to

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[26] Haemorrhage accounted for maternal mortality of 0.5 / 1000 in early 1930s; falling to 0.3 in 1945 and 0.1 in 1950. Improved nutrition also prevented anaemia through the war years.

[27] Inductions of labour are one area where the care provided was not the most beneficial for either the women or the babies. The rate rose from 10% in the 1960s to 40% in the 1970s and then fell again to 12% in the 1980s as it was realised that inducing labour did not lead to improved outcomes – in fact the reverse was true and inductions led to more assisted and caesarean deliveries. And the use of scalp monitors during induction led to 20% scalp abscesses in newborn babies, necessitating antibiotics.

care for healthy women" (House of Commons Health Committee, 1991, p.vliii, quoted in Foster, 1995, Ch.2). The Expert Maternity Group pointed out "the issue of safety ….used as an overriding principle, may become an excuse for unnecessary intervention and technological surveillance…" (1993, p.9 quoted in Foster 1995). However, for the medical profession, the dominant ideology is that "health is first and foremost, a medical product", and therefore medical antenatal care is the best and only means to promote maternal and child health (Oakley, 1992).

Present routine practices in many aspects of medicine are not objectively verified – they have never been subjected to a randomised controlled trial, or even a case-control study. However, they have come to be regarded as good or accepted practice. The lack of controlled experiments is not due only to the problems of teasing-out the cause and effect in a large study – it is also due to the unwillingness of senior staff to have their behaviour subjected to systematic evaluation, and comparison with others (Oakley, 1993, p.257). Unfortunately, this allows doctors to continue to experiment with new fashions in practice and use of technology on unsuspecting patients (p.263). Scientists claim the right to set agendas for research - the questions posed and the direction in which the work is to proceed, but they are not the only people who can claim that right (Dickersin and Schnaper, 1996). Moreover, the profession has codified and recorded these practices and they are now part of the accepted wisdom of the profession and its practice. There remains little conclusive evidence that modern obstetric care caused the observed fall in maternal mortality rates in Europe (Oakley, 1993, p.12; Tew, 1993). It has just been advantageous to obstetricians to claim any benefits as having been due to medical interventions – when few practices have been scrutinised sufficiently to see whether any practice is more advantageous than another, or even to the alternative of no practice at all. All improvements are often assumed to be the result of medical intervention (Oakley, 1993, p.20). But the 1980 BMJ editorial concluded that reasons for the falling perinatal mortality were "not clear". It *could be* services, improved monitoring, or it *could be* because mothers were younger, having fewer children or using contraception to space pregnancies. Following the launch of the safe motherhood initiative in 1987, the review of safe motherhood programmes led to the rituals of ANC being questioned (Maine, 1992) from both epidemiological and economic perspectives. This is repeated now by UNFPA (2000), WHO (2001) and World Bank (2000) in recognising that efforts must

address emergency obstetric care, family planning and general socio-economic conditions in which women fall pregnant, to reduce maternal mortality rates.

When reviewing each separate antenatal procedure, all are found individually to have poor predictability. Antenatal care has particularly low sensitivity and specificity abilities, that is the ability both to detect true positives and screen out false negatives. This means that antenatal care cannot detect or prevent many problems for the foetus, new-born or mother, without so widening the net as to include over half of the women under scrutiny; i.e. to include more false positives, or label more women as having 'high risk' pregnancies. But recent studies have questioned whether antenatal screening by trained midwives can distinguish those who are at "high risk" from those who are not (Vanneste et al, 2000). Prual et al (2000) found in Niger that even "the midwives behaved as though they had little faith in the service itself". The quality of the service delivered was poor, and this was not due to lack of equipment, time or sufficient staffing levels. Perhaps the staff was aware that the risk approach to ANC cannot prevent all emergencies, and so have little faith in the antenatal rituals they have to complete. Both McDonagh (1993 and 1996) and Maine (1992) recommend the improvement of local efficient obstetric care, including family planning and legalised abortion, to improve the outcome for mothers - not to increase antenatal care. This has recently been echoed by WHO and UNFPA who, in reviewing interventions to improve maternal outcome for effectiveness, have questioned some routine screening during antenatal care. The required frequency for such antenatal clinic visits has also been questioned (Villar, 2001). The emphasis on such antenatal routines has allowed more effective obstetric interventions - those addressing Post Partum Haemorrhage (PPH), Post Partum Infection (PPI) and abortion complications (complications which together make up over 50% of maternal deaths) - to be neglected (WHO, 1998).

Recent research from industrialised countries has confirmed previous work (Lederman, 1985; Ahmed et al, 1990) that the *self-selection bias* of which women attend antenatal clinics is acknowledged to negate any claims for beneficial effects of such routine antenatal clinic activities (Joyce, 1999). This 1999 work from New York found it impossible to correlate any improvement in the outcome of the pregnancy as due to attendance at antenatal clinic, unless the women were also eligible to receive food supplements (Food Stamps), which was equated with improved outcome.

Vanneste et al's (2000) claim that antenatal care can "facilitate better use of obstetric care services" may also be falling into a similar self-selection bias – women who are able to utilise antenatal services will already be more able to access emergency obstetric services due to social, spatial, economic and/or cultural factors.

The export of ANC rituals

The fact that this organisation of the 'unproven ritual' of antenatal clinics led to a huge network of antenatal (and child health) clinics across the world is testament to the rise in the power of the medical professions and their social control over pregnant women (Ramirez-Vallez, 1999). Antenatal clinics were originally often separate from both child health clinics and curative services, leading to excessive journeys and time away from home and agricultural work and responsibilities (Mayhew, 1996). CHCs also took precedence (Rosenfield and Maine, 1985) as children continued to be prioritised in both policy and practice. The export of western health care (Ostergaard 1992) has followed a technical approach (Leslie and Gupta, 1989; Ramirez-Vallez, 1999). This led to both inappropriate and inaccessible care for the majority of populations. It has also been called the "totalitarian" approach (Banerji, 1990), as it has left no room for alternative models. Raikes (1989), Vaughan (1991) and Tranberg Hansen (1992) also see the missionaries as having had a high influence on both health care in general and MCH services in particular. The missionaries initially, and international donors and UN bodies more recently, promoted specific gendered and class views of family life (Ramirez-Vallez, 1999).

For rural PHC (including ANC) in low-income countries, the distances involved (Leslie, 1989) and the medical facilities available may make it impossible to deliver more than a cursory shadow of the service 'as planned'. This turns the clinic activities into almost meaningless ritual, and the woman is neglected in the quest for the 'medical solution'. This is where the rationale of antenatal clinics - to identify "high risk women" (Oakley, 1992) - is meaningless if there is either nowhere to refer them, or the distance makes tertiary care almost inaccessible (McDonagh, 1993; Maine, 1992). So again, why do women attend – what is their expected benefit?[28] In the

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[28] One possible benefit is that in Kenya a woman cannot enter hospital for delivery unless she has an antenatal clinic card – so she must attend at least once in pregnancy should she have any reason to believe that she might deliver in a hospital setting.

Kenyan context all the advice given at antenatal clinics concerns diet, rest, malaria prevention, and place of delivery. For most women the ability to alter any of these factors away from what they are practising already is almost nil. How do the women respond to all this 'good advice'? Do they hope to alter things in a forthcoming pregnancy? These are key questions pursued in the present research. However, as discussed in the following chapter, it is difficult to get behind such ideas and suggestions, and to engage with alternative views if alternatives are not present in key discourses (Oakley, 1993; Lukes, 1974).

But by taking a bio-medical approach, the woman is not considered to need any more resources (other than more education and advice), as she is only doing something considered 'natural' (Dwyer and Bruce, 1988). This then feeds into the medical paradigm, that the antenatal clinic and its rituals will somehow equip the woman for a safer delivery and a healthy child. But for many women access to food or some rest might be more beneficial than advice meted out in the clinic, which they have no hope of putting into practice (Guldan, 1996).

Another aspect to this antenatal clinic activity (and in the event, of particular significance for my research) is "The stereotyping of patients and mothers by health service staff as irresponsible, childish, unable to make 'sensible' decisions" (Oakley, 1992, p.63). This stereotyping occurs across health services in hospitals, clinics and in community settings (Edwards, 1998). It can occur through the use of medical terms, often in English, which are not translated for the mothers into local languages, and are assumed to be understood by both staff *and mothers*[29]. Dingwall (1977) demonstrated how health visitors in Britain used middle class language to exercise ideological power over their clients. The use of language can both exclude outsiders, and produce particular images of status and roles of both the client and professional. As well as use of middle class language with clients, the use of verbal shorthand among staff, e.g. 'antenatal', 'malnourished child', 'inadequate family' are routinised, rarely scrutinised, and taken for granted as being both fair and accurate, and understood by other professionals (Hugman, 1991). The medical model's pre-definition of possible problems to be encountered can also exclude 'outsiders' knowledge and perception of the problem. This is what Foucault termed *bio-power* (Rabinow, 1991), and the use of

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[29] See Chapter Six and Seven for examples witnessed in Kenyan AN clinics.

power held by the professions. From an organisational perspective, Czarniawska-Joerges (1988) examines the use of language for the perpetuation of "rational myths" in the organisation. Why does it occur, and why does the staff feel free to express themselves in this way? Is it a direct mirroring of dominant early 20th Century views of women as fickle and downright irresponsible? It is shown below that in Kenya such assumptions are made by staff (see Chapter Six), even though the actions on which such judgements are based are very tenuous, not least of all because the antenatal clinics themselves often lack real efficacy.

Child Health Clinics

As mentioned above, child health care (CHC) and antenatal care (ANC) clinics were exported to developing countries, along with changing approaches to medical care and technical solutions to ill health throughout the 20th Century (Vaughan, 1991; Ostergaard, 1992; Ramirez-Vallez, 1999). Gendered and other social assumptions were exported along with the technical issues (Tranberg Hansen, 1992). As with antenatal clinics, the exact activities undertaken under the term CHC are non-specific and varied. In Africa today, they usually cover the activities recommended by UNICEF under GOBI – growth monitoring, oral rehydration, breast-feeding and immunisations.

Oakley (1992) discusses how regular weighing (growth monitoring) of children became a by-product of the scientific need to understand and hence control the growth of the child. "Regular weighing instituted as part of a system of educating and regulating mothers in continental Europe, Britain and the USA in the early 1900s" was a product of the desire to understand, normalise and then control child feeding both through amount and timing. In Britain, the accounts of medical staff, politicians and policy makers and their interest in infant and child nutrition usually start from the period following the Boer War and the rejection of many recruits on medical grounds (Abbott and Wallace, 1990, Ch.2). This linked in to eugenic and nationalist pressures to "improve the nation's stock". This also led to an emphasis in social policy to attempt to increase the birth rate and to lower the infant mortality rate (IMR) (Williams, 1989). The focus settled on the infants and was expressed as reducing the

IMR (i.e. the death rate of children under one year). Mothers were made responsible for the nation's health via their children's health. This was through individual nutritional and hygiene advice and instruction. It also imposed norms of motherhood and the sexual division of labour (Wright, 1988; Abbott and Wallace, 1990).

Here again there is the struggle between the medical paradigm to understand the normal growth patterns of children in order to promote "scientific methods" for infant and child feeding, and the real world of the families who had to feed and care for their children (Lupton, 1995). The caring professions claim the right to instruct mothers in this area and, in so doing, exercise control over them. Tactics of coercion involve teaching people how to achieve goals defined by 'experts' as 'desirable'. They can also be seen as providing a surveillance system (Abbots and Sapsford, 1990). The new 'professions' maintained an individual focus, using the laissez-faire model, even when this model was challenged by socio-economic explanations for poor health outcomes (Black Report, 1979; Duncan, 1996). This medical model is the basis for child growth monitoring, as exported and practised around the world (Leslie and Gupta, 1989; Banerji, 1990). But health is affected by many factors completely beyond the control of individuals (Carter, 1995; Lupton, 1995). The growth and development of children is not only determined by the child's own mother, as the medical approach suggests.

However, the scientific accuracy of health education messages is not absolute. There have been many fashions within many disciplines, including infant feeding, within the past twenty years (Carter, 1995). The messages still exert oppressive social control over women's lives if taken at face value. And health education is often unable to tackle the primary causes of unhealthy behaviours and health problems (Foster, 1995, Ch.7). As discussed above, the use of "strong statements" in health promotion presents issues as 'facts' or 'true' and prevents discussion or challenge (Petersen and Lupton, 2000).

Carter (1995) sees the "tidal wave of good advice" offered out to mothers as having its origins in the view by policy makers that the poor are both poor and ignorant[30]. However, the aims of many health education and health promotion campaigns are

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[30] See the quotes in section on "public health and women" for expressions used in the early part of the century to describe the ignorance or fecklessness of mothers.

built on only one assumption – that the mother is wrong and in need of correction and control (Marshall, 1991). Assistance with poverty is seen as outside of the medical, technical intervention area. The fashions for the advice meted out to her change, except for the underlying idea that the woman is ignorant. In the medico-economic health care paradigm, this continues to underlie many of the approaches taken in community health and clinic advice (McKinlay, 1996; Guldan, 1996). The Integrated Management of Childhood Illnesses (IMCI) 'Twelve key messages' preserves this idea with its key message number eleven *"follow the health workers advice about treatment, follow-up and referral"* (WHO/UNICEF, 1997). What is implied is that the experts have the power to define what is normal for a baby, child, mother (Marshall, 1991). The construction of a particular image of 'motherhood' is central to the advice given. This was explicit in the social engineering seen as necessary by the missionaries in Africa (Vaughan, 1991). Mothers do not have any choice but to follow the advice and rejection of the advice is not an option (Marshall, 1991; WHO/UNICEF, 1997). This is achieved by moral and economic sanctions although, in the context of the present research, the ability to impose overt sanctions was found to be low in rural Kenya, except when linked to a mission hospital or health services.

Nutrition messages can be valueless if the primary cause of malnutrition is poverty and lack of access to food (Guldan, 1996). The style of delivery and the content of nutrition messages effectively screens out any underlying socio-economic and cultural factors. For example, at a nutrition conference on child nutrition and feeding in Africa, (presented in Alnwick et al, 1988), presentations from East and Southern Africa all give a realistic account of poor weaning and the underlying reasons in rural Africa. However, the recommendations made at the end of the conference screened out the common information presented across all the countries (lack of women's time to prepare germinated / fermented foods) and opted instead for the western health education approach (educate the mothers). This mismatch between theory and reality, and of health service professionals' perception and rural women's perception of the problem, means that all the nutrition advice in the world is never going to address the problem. Growth monitoring had claimed in the 1990s to empower women through their knowledge of nutrition and child growth and involvement in the monitoring itself. But with so many issues outside women's control, it actually becomes dis-empowering (Smith, 2001). As with ANC, the ritual itself (here weighing children) has claimed to be a valid activity to promote, even when its ability to address the

pathology is absent. Such pre-defined medical definition of issues has also skewed programmes around breast feeding[31].

Fathers did not even feature in psychologists' concerns around early childhood until about ten years ago. Previously, fathers were considered by such experts to have little significance for the child (Tizzard, 1991), which led to Bowlby's famous assertion that mothers who went out to work were depriving their children. All the dominant ideologies of motherhood were premised on a particular gendered division of labour. Still today, paid work is not to take precedence over mothering. In the health sector this means that mothers must attend antenatal or child health clinics above any other life- and health-enhancing responsibilities – or face the wrath of a health worker[32]. "The idealisation of motherhood as all-powerful, strong and caring brings with it implication that mothers alone have full responsibility for childbearing and all the related household caring and domestic work" (O'Connell, 1994, Ch.3). This dominant ideology is reproduced by the media, family, doctors, health visitors and social workers (Lewis, 1991). The mother-child dyad displaces all other considerations in PHC. For example, a study in Senegal shows the importance of grandmothers in child nutrition (Aubel et al, 2001) which has been recently re-discovered by health workers, and which has required a change of emphasis in their target groups.

Costs for participating in AN and CH activities

Originally, in 1980, WHO advocated the inclusion of 'social costs' in calculations of the cost of health service, alongside financial recompense for work done for the health service itself (Creese and Henderson, 1980). However, these are now dropped from calculations of project costs, even for SPHC. Such social costs (Gray, 1986) have even had to be dropped from EPI programmes (for which there is no argument in the effectiveness of the intervention) as to include social costs, it is argued, would negate any claims for cost-effectiveness comparisons. Even when done as an academic exercise, as by Vos et al (1990) in Zimbabwe for comparing and contrasting fixed and mobile clinics' costs, they only included the *monetary* costs incurred by the community and not time costs or opportunity costs in relation to activities foregone to

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[31] See Chapter Seven.

attend. Not paying attention to social costs constitutes a neglect of women and a disregard for the impact of gender relations. Elson (1995) also condemns the reliance on women's work and care roles, which disregard the inelasticity of women's time and energy.

Health Sector Reform Programmes in Africa have further moved away from considering social to only including monetary costs, as cost recovery schemes are advocated. This is perhaps in contrast to moves within western health care where, for example, the re-consideration of social costs as relevant and important is leading to inclusion of travel costs in the evaluation of women's use of mammogram screening (Clarke, 1998). Walker and Fox Rushby (2000) found an increase in the use of cost benefit analysis for health programmes in developing countries, but found it frequently had a narrow perspective (dominance of the provider's viewpoint); bias (exclusion of some costs); lack of transparency; and absence of critical examination of findings. Exclusions of costs included donated goods and supplies (which made interventions appear more cost effective) and patients' costs. Affordability was also rarely included in economists' discussions (Hutubessy et al, 2001). Walker and Fox Rushby (2000) agree with feminists' concerns over the negation of women's costs to participate in PHC programmes. The present research confirmed that for CHC in Kenya, social costs are seen as secondary to health sector costs. These social costs clearly fall on the shoulders of women as is demonstrated in Chapter Five.

These two illustrations of ANC and CHC illustrate how the application of PHC has been heavily influenced by the early public health debates. This included highly moralistic and gendered views of women by the male medical profession, which were readily exported in the context of colonialism and development. Today, the continuation of PHC as applied in developing countries remains within the medico-economic framework and so all problems are pre-defined within a highly specified and gender stereotypical framework. This limits possible interventions and endorses the suggestion by Leach and Mearns (1996) that ideas get "boxed-in" in institutional establishments, with pre-conceived agendas and "labelling conventions". The example of pre-eclampsia presented above, being a self-perpetuating definition rather than pathology, is such a labelling convention. Women are seen as having to respond to the medical model, with the associated socio-economic inputs expected to be

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[32] See Chapter Seven for details.

provided by them[33]. Using an organisational perspective as discussed in Chapter Two, Clegg (1990) refers to TINAs (There Is No Alternative) which also points to the use of particular conventions and "rational myths" that are created at the managerial level. This links in turn, to the silencing of alternative voices, both through who is allowed to contribute, or whose voice carries weight and gets included in planning activities.

Foucault encourages us not to just see such power as "top down", but that the general population is colluding in its perpetuation and circulation (Lupton 1997, Ch.5). This was discussed in the previous chapter in some detail and here, has been shown to apply to ANC and CHC. The focus of the medical model leaves many distal causes of ill health unaddressed. Buvinic's (1984) famous analysis of the *misbehaviour of projects* – when the women do not respond as planned - can clearly be seen in relation to health projects. In this case, it is specifically due to the narrowness of the medical model and the lack of consideration for the reality of the lives of women.

Community Health Workers

Before concluding the discussion of PHC, it is important to pay some attention to an important group of health care providers inextricably involved in its delivery in developing countries. For several decades now, government, mission and INGO health care providers around the world have trained Community Health Workers[34] (CHWs) to work in various roles within communities (Ramirez-Vallez, 1999). The original logic behind the training and utilisation of CHWs is found in the early PHC work, which itself was modelled on China's bare-foot doctors and Cuban paramedic training (Sidel,1972; Morley et al, 1983). Many causes for ill-health were seen to be amenable to low-tech, preventative care that did not require persons to be trained as doctors or even nurses. Due to the lack of resources and person power to meet health care needs, an alternative approach was finally decided by WHO in 1975[35]. This new approach was set out in *Alternative Approaches to meeting Basic Health Needs in*

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[33] An example from health research undertaken in a geographical area near to the present research which clearly could not conceive that women had other needs other than that pre-defined by the health providers, can be seen in Hodgkin 1996.

[34] Community health worker, family health educator, family planning promoter, community health educator, village health worker, primary health care worker, health post aide, outreach worker.....

[35] Note that this pre-dates the Alma Alta declaration by three years.

developing Countries: A Joint UNICEF / WHO Study (WHO, 1975). This marked a shift away from the paradigm of the urban medical model of health care (Lee, 1997). But possibilities for the implementation of the CHW system were split between the 'Chinese barefoot doctor' and the 'Western Lady Health Visitor' models. The western model was more commonly followed (Ramirez-Vallez, 1999), with its particular concept of motherhood. And so, like other aspects of PHC, the implementation of the CHW approach is importing specific gendered assumptions into their roles.

The widespread approach of CHWs was found not to work after several decades of various programmes due to several reasons: and despite what Zakus (1998) terms "the great hope accorded to community participation in health". In East Africa, over many years, the CHW programmes have failed to deliver the goods (Heggenhougen, 1987; Walt, 1990; Woelks, 1994). The reasons are varied and diverse across each programme, but these can be grouped into two main themes documented in medically orientated texts: Pay and Activities.

1. Pay. CHWs generally are not recompensed by either the state, another sponsor, or by the local community (Streefland and Chabot, 1990). Other studies have also looked at the mismatch between the workload and remuneration – in particular, Zakus (1998) in Mexico comments upon the low pay[36] of CHWs in the government system. Zakus talks in terms of the appropriation by the state of community resources and in particular, women's time. He sees this approach and the use of CHWs as "entirely for its utility in supplying resources and not for any democratic or intrinsic values" (such as participation). In other words the Ministry of Health has co-opted resources of the community to meet its policy objectives (expanded health coverage). Leslie (1992) has also commented upon the assumption of rural women having spare time to donate to health programmes as being incorrect, leading to the failure of many programmes. This is reflected in Tendler's more positive findings in Brazil, where the decision of a state-level government to fully fund the staff and the nurse supervisors allowed community health services to be made available in rural areas (Tendler, 1997) without recourse to the use of unpaid or very low paid community labour. The persistent under payment of CHWs is a reiteration of Gray (1986) who pinpointed disparities between the planners' and local populations' perceptions of costs and benefits in

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[36] US$ 4 per month.

health projects as being due to the planners' ability to negate or ignore social reality and gender burdens. This is also the "bias" of which costs are included and excluded from cost benefit analysis of health programmes in developing countries, reviewed by Walker and Fox-Rushby (2000) and discussed above under the CHC section. The inclusion of private costs can seriously change results and hence decisions on fixed and mobile clinics (Vos et al, 1990). But planners frequently assume women have totally elastic and low value time (Elson, 1995).

2. Activities. The CHWs are also not allowed to participate in ways that are meaningful to locally perceived needs – usually curative care involving drugs and treatment (Gilson et al, 1994). Many programmes did not allow CHWs to handle drug supplies, which undermined their status in the community (Walt 1990). Zakus and Lysack (1998) suggest that the refusal of doctors and nurses to relinquish power and status is a frequent impediment to the full utilisation and working of CHWs and as long as the power remains in the hands of the professional and administrative structures, true community participation remains only cursory (Brownlea, 1987), despite claims that this is a reason for training CHWs. Shear Wood's (1990) study in New Zealand shows that CHWs found an important way of gaining community status and recognition for their skills through the use of auroscopes to diagnose ear infections among school children. Despite support for this community-defined role for the CHWs by organisers of the programme, the doctors refused to allow the instrument to be given to the CHWs, and so the programme folded. This is a stark example of how professionals hold on to power in all societies. Or, to paraphrase the words of David Werner (1995), the village health worker remains a lackey (to the medical system and doctors) not a liberator, as PHC originally envisaged them to be. Experts outside of the community plan the programme and the delivery of training. Walt's (1990) study also uncovered the lack of support / supervision of the CHWs. In Africa, the local staff (often nurses) who have to train, monitor, support and supervise the CHWs are not involved in the original planning of the programme.

These two core themes (pay and activities) will sooner or later impact in any context, on the sustainability of CHWs and their ability (or not) to continue to deliver what the programme intended. But the more serious charge against the use of CHWs is that CHW programmes are simply a sub-optimal rural or remote delivery system for the medical system (Walt and Rifkin, 1990; Woelk, 1994), or the government simply

abrogating its responsibility to provide services to its rural population (Heggenhougen, 1987). Community health workers are frequently expected to achieve much with minimal training, very few resources, minimal supervision and cursory support and, as mentioned above, little or no remuneration (Walt, 1990).

But CHW programmes are firmly embedded in the western gendered model of motherhood. What these texts (Walt, 1990; Heggenhougen, 1987; Gilson et al, 1994) tend to omit are the gendered aspects of the programme, or as Ramirez-Vallez (1999) points out, the model of CHWs (Lady Health Visitors) is one which also promotes a particular concept of motherhood and its role in reproduction, whilst ignoring fatherhood.

Globally, however, CHWs were conceived more as change-agents rather than "just another pair of hands" in the delivery of PHC (Walt, 1990). PHC is meant to go beyond medical delivery of western health care and address the underlying reasons for morbidity and mortality. But the present reliance on SPHC interventions by donors and national governments alike means that CHWs are simply assisting in the delivery of a specific health care intervention (Ramirez-Valles, 1999). Child and female immunisation programmes are the most visible (and successful) example of this (Banerji, 1990). But CHWs were originally conceived as important health / development workers who would mobilise and empower the community to improve their health status via various social, environmental and agricultural activities, conduct health education activities and undertake basic health care as required (Gastaldo, 1997). This is rarely how they perform in reality, due to the narrow practices of SPHC. This was how all primary health programmes were utilising CHWs in Kenya, where they were confined to strictly SPHC interventions. Chapter Seven discusses how water engineers (not allied to the Ministry of Health) in Kenya used CHWs in alternative ways. Whatever their tasks, the CHWs are expected to complete them in difficult circumstances - often without roads and transport, electricity and phones, water and sanitation, which is often why the government is unable to provide a health service similar to that found in urban areas.

CHWs are trained to fulfil a wide variety of roles and perform a huge range of tasks. The actual delivery of training and the planned support and supervision of CHWs are important to the range of tasks the CHWs find themselves doing. It has been noted

that although doctors generally plan national PHC and CHW involvement in the programmes, their training and supervision has generally been left to other staff, usually nurses or midwives (Walt, 1990). These staff may feel very differently about the CHW working with or beneath them. And they may be either reluctant to train junior staff to undertake roles they feel should be reserved for themselves, or they can off-load the more repetitive or arduous tasks to these junior members of the organisation. This isdiscussed in Chapter Seven in relation to the actual activities performed, supervision, support and remuneration of the local CHWs in the separate programmes in the location studied in rural Kenya.

As stated above, the concept of CHWs imported specific gendered views of motherhood into PHC (Ramirez-Valles, 1999). This has been frequently expressed as CHWs being a role for only women. The CHW has been found to be predominantly one sex in different programmes due to loosely thought out ideas around entry criteria for training; and reinforcement of gender stereotypes by managers and 'outsiders'. For example, literacy requirements or ability to attend training in a regional centre might skew the intake to men, or an emphasis on care of pregnant women will result in women being put forward for training. New managers coming into a programme have sometimes dictated a complete change of the sex of the staff[37]. This is often due to changes in western bias and prejudice on appropriate family roles and responsibilities. The ability of such gendered assumptions to be used by outside managers of programmes is seen as a legitimate exercise of gendered prejudices. However, comprehensive planning of a gender perspective into health programmes for the elimination of gendered bias is not considered early in health policy planning.

Worldwide, the development of informal community care rests on an assumption that women are available to care (Williams, 1989). This negation of the cost of the CHW role to the individual woman is possible due to the present system of economic accounting, which allows women's home-based work to be ignored by economists and statisticians (O'Connell, 1994). Domestic work is undervalued by men, women and economists (Elson, 1995). This blindness to the work women do has fed into the health care field by the planning of such community health worker projects (Mosse, 1993). Health planners' belief that rural women have totally elastic free time is a

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[37] See UNICEF Sri Lanka programme where staff changed from male to female overnight (Walt 1990 p.156).

complete fallacy (Elson, 1995). Apart from some interest in women's free time from their attendance at clinics, there is usually no mention of the time constraints women face in their daily lives. The additional request to be a CHW or to undertake any other time consuming task is usually posited and researched from a very unrealistic perspective (Daykin and Naidoo, 1995).

Again, my interest is to understand why the women do undertake this role, to the extent of withdrawing their daughters from school to cover home and agricultural responsibilities whilst training or working as a CHW, and what benefits they see for themselves and their community. The health and education messages are both being prioritised in developmental discourses. At the local level, it appears that health is winning when daughters have to forgo their education to enable health workers to complete their activities in the community. Again, the cost is borne at the individual level, and so the health sector does not have to account for the loss of education for the daughter.

This sectoral approach is ignoring the present practical roles and responsibilities of men and women in their family responsibilities. Although as Whitehead (2000) suggests, African men have earned a title of "lazy" more for colonial political reasons than true hours worked, involvement of men in family health has always been overlooked in the health sector. The double burden on women has been well documented over many studies (Ostergaard, 1992), but policy makers remain committed to the old paradigms, and uncommitted to developing new ones. The present model of primary health care is adding to the workload and not positively assisting the women in their daily lives. There have been calls for gender sensitive research (Elson, 1995, overview). But gender sensitive research in health is still confused by the conflation of sex and gender. Women do have additional health needs due to their biology and associated with their reproductive roles. However, this should not extend to a naïve acceptance of a gender blind approach to health care delivery, and this requires dislodging. This is a central endeavour in the present research, which places both men and women, in communities and the professions, including the CHWs, at the centre of the investigation.

Evaluations of Primary Health Care: a self-reflexive exercise?

Medical evaluations of primary health care focus on medical interventions or health problems defined in medical (epidemiological or case) terms and rely heavily on quantitative research (Oakley, 2000). This limits research to a focus on the service itself – through investigation of pre-defined objectives and the quantification of previous defined goals (Nyamwaya et al, 1998). Due to the difficulty of measurement of much that constitutes "health"[38], alternative or proxy indicators are used - such as the number of patients seen or treated, staff trained, immunisations given and so on - which again emphasises the service itself (Walt, 1994).

Due to high levels of donor involvement in health care in developing countries, most research is undertaken in the form of evaluations (Walt, 1994, Ch.9). This also skews the emphasis towards economic and medical indicators, which in turn focus on such issues as efficiency and effectiveness. As stated earlier, the use of SPHC vertical programmes allows interventions to be viewed as single entities and allows possible linkages to be ignored (Chen, 1986), although through Health Sector Reforms (HSR), there is an emphasis on promoting service delivery to link relevant programmes. For example: Family Planning and STD / HIV programmes might be combined, having often been initiated as separate donor funded projects, frequently found outside of regular health service provision in many countries until the late 1990s (Mayhew, 1996). The introduction of Reproductive Health programmes has the potential for intersectoral approaches but is often no more than the re-packaging of previous MCH and FP programmes (Standing, 1997). Only if such service delivery issues are defined as a problem, does the service evaluate them critically. Paolisso and Leslie (1995) have also stated that more "innovative research is required", that is research outside of the present evaluative model, to meet women's health needs.

Qualitative research is also undertaken. However, it often remains slightly removed from the main health programme, and again appears to be applied in terms of a 'fire-engine approach' once problems have been encountered. Today, few anthropological and sociological pre-planning assessments are undertaken and those that are commissioned have to use rapid assessment techniques (Chambers, 1994) which are themselves, often undertaken as a ritual (Cooke and Kothari, 2001) rather than as a

source of necessary information to be fed into the planning and implementation stages (Nyamwaya et al, 1998; Gardner and Lewis, 1996). Some see participatory research assessments (PRA) as potentially able to re-align local voices in the bio-medical model of health (de Koning and Martin, 1996; M'MacDonald, 1994). But for many, participation is seen simply as a new "ritual" in development and health that has been hijacked by the dominant paradigm (Brett, 1992; Gardner and Lewis, 1996, Ch.5). As Gardner and Lewis phrase it: "Like 'participation', PRA is easily abused in practice" (p.115). This is echoed for health care research (Guijt and Shah, 1998; Tandon, 1996) and as Maguire (1996) points out, PR was originally androcentric and male centred, so PRA is not without its own historical biases and politics.

More extensive qualitative evaluations of PHC programmes are sometimes undertaken. However, they often remain focused on the medical or health intervention and do not challenge the basic models and assumptions of health service delivery (Coreil and Mull, 1990). Researchers also acknowledge that they frequently cannot address all issues – for example, often issues of quality are difficult to assess without visiting all health care providers and observing them at work (Walt, 1990). Moreover, frequently all costs, such as social costs, are not included in analysis, due to the fact that much work in developing countries is non-monetised, which often results in women's costs being excluded from economic research (Elson, 1995). So health service research and evaluations remain partial in their findings and results, and remain skewed towards the service as defined by health planners and providers (Walker and Fox-Rushby, 2000). See the previous chapter for criticisms of modernist approaches to research simply "reflecting pre-existing intellectual categories" (Hassard, 1993).

There is also a contention between disciplines as to the emphasis in research on PHC of being on the service itself, or on the providers or the receivers of health care. The profession of medicine remains accused of putting itself at the centre of all research – so that evaluation and research remains essentially a self-reflexive exercise[39]. Cohen et al (1997) see interventions as being directed at the patients without "scrutinising the systems – the institutions and professionals – that provide the health services" (p.81) and hence allow the system to blame the patients for non-compliance, without

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[38] See also Seedhouse (1986) for problems over the definition of the term 'health' and the use of different theories of health by different professions (p.xi).

uncovering the day-to-day needs of patients or ineffective service delivery systems. Sociologists tend to focus on either the providers or the receivers of health services, but still often on services as pre-defined by the service itself. And for specific sectors there remains a certain bias - Nettleton and Burrows (1995) feel that the research focus remains on the "receivers not the peddlers of health promotion". But as many feminist researchers point out, much health care remains at the level of ritual rather than a service evaluated to the objective standards claimed by the medical profession (Lane 1995). Although there are moves towards "evidence based health care" this is slow to evolve due to professional structures and training (WHO, 2001b). The WHO / WB *Burden of Disease'* and *Evidence and Information on Health Policy* discussion papers point out that there are often significant gaps in data and understanding (WHO, 2001a and 2001b; Hutubessy et al, 2001). As Maynard (1994) phrases it: "…[medical] practice is not knowledge based". Oakley points out how so many activities have passed into "accepted practice" without any objective scrutiny, since doctors (obstetricians) are unwilling to conduct RCTs – as they would also show high inter-doctor variation not only in practice but also results (Oakley, 1993, p.257). But also, the gendered assumptions behind much PHC intervention mean that the rituals are often not only unproven but also potentially gender role reinforcing by the specific family models they promote (Edwards, 1998).

The research presented here is attempting to get behind the 'ritual' of PHC in policy terms and to move beyond an evaluation of its practice. It seeks to uncover and challenge the rituals, and to expose their underlying assumptions in the context of rural Kenya. This is done by placing users at the centre of the research, while also including the community health workers and the local staff and services. The linkages between them all and how they relate to the design and delivery of health services are central to the present analysis. This is done while attempting to address some of the issues raised by Halford and Leonard (2001) of including power and gender in the consideration of the organisation; in addition to using Foucault's suggested "openings" to study power at the extremities, at the point where it is circulated and actioned.

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[39] As discussed in Chapter Two.

Chapter 4

Methodology and methods

Methodology

> In general case studies are the preferred strategy when "how" or "why"
> questions are being posed, when the investigator has little control over events,
> and when the focus is on a contemporary phenomenon within some real-life
> context.   (Yin, 1994, p.1)

This thesis is interested in the how and why questions in health service delivery; in
why services have taken the form they have, how services have been allowed or
encouraged to develop, why staff have the expectations they do, how the community
interacts with the service, how the service is viewed as a success or failure, why
certain gender ideologies persist. Significant attention is paid to methodology in this
chapter and the thesis more generally because the research endeavour is profoundly
reflective, the research goal is explanatory and the research field is interdisciplinary.
Within the latter context scientific methods predominate and so alternative
approaches, particularly when based on qualitative methods, require the presentation
of a strong rationale.

This chapter expands on the use of the case study approach and why it is useful to
answer these agendas and why, following from Chapter Two, other research strategies
can be seen to be deficient for present purposes, as they are too prescriptive and
assume a prior understanding of the situation under study. As introduced in Chapter
Two, the inclusion of gender in the various theoretical (and hence methodological)
perspectives of organisations is frequently incomplete (Halford and Leonard 2001).
An issue of particular concern is how to include power in the analysis.

The rational model of organisations in particular, depends on previously defined
issues taking on an often managerial or donor, perspective. Research strategies used in
health service research are often too aligned with the organisation and services they
are meant to be researching (Hassard, 1993). Studies at the national or global level
tend to have the manager's viewpoint as the starting point (Kabeer, 2000). They often
assume the model or theory underlying the service is correct, or can be taken as

correct. The presumptions and assumptions around the organisation can make some outcomes appear either inevitable, or desirable by foreclosing other alternative voices (Pfeffer, 1997). However postmodern approaches in and of themselves do not redress the power issue and so Foucault's "methodological precautions" were introduced in Chapter Two as a potential route to uncover power relations. Where the research should concentrate is on the peripheries, where power is actioned by individuals, the stakeholders in the organisation. The other important issue introduced in Chapter Two is around the dynamic and changing nature of power. And as the researcher moves into an organisation s/he will also interact with other stakeholders and can influence the dispersion and circulation of power within the organisation: the discourse itself.

Research does not simply passively reflect reality. It also actively constructs a perspective on reality. Pat Usher (1997) points out that we are "socialised into a methodology, which is a theoretical framework deriving from a research position". We need to be aware how our choice of methodology guides and forms the context and rationale which we use in our research. This then shapes the questions we ask. A mixture of historical and cultural influences shapes all our knowledge. Values, knowledge and politics are all interconnected, even for the researcher. This is a reason for reflexivity in our research. Reflexivity seeks to understand that power is not external to knowledge or to social relations, but is embedded in conditions of our existence. Traditionally in research, reflexivity is seen as a 'problem' – to be dealt with through strict adherence to a 'scientific method' - but reflexivity is not necessarily a problem. It can also be a resource by virtue of recognising the researcher in the process (Usher, 1997, Ch.3). Scott (1997) believes that "decontaminating" the research by removing the researcher is impossible. The researcher has always tacitly or overtly mapped the area under research, and so s/he is enmeshed in the research concepts, design and execution. For feminist research this is particularly important, as connections between knowledge and power are very pertinent to the position of women in society and their explanations for it. But women are not a homogeneous category and the researcher also has the power to define the people (women) under study and their "problems" (Acker et al, 1991). This is particularly problematic in health and social work as what is defined as a problem and the possible and appropriate solutions to the problem are very particularly structured

through medical, nursing and social work hierarchies and discourses. The issue of reflexivity in actual data collection is expanded on in this chapter below.

As stated in the previous chapters, underlying my research is an interest in elaborating a theorised understanding from a gender perspective of the present policies and practices within health and development debates. This has a direct bearing on the methodology followed in research, as theoretical and methodological issues are interconnected at several levels, including at the design stage of research. As outlined in Yin (1994), the research design is "the logical sequence that connects the empirical data to a study's initial research question and ultimately to its conclusions" (p.19). It is an "action plan for getting from here to there" (p.19). A comprehensive and self-conscious research strategy is required, in order to follow through the interconnections between theory and design. This is laid out in what follows.

Validity

Case studies are important as they are not attempting to develop generalisable findings in the statistical sense - this is in contrast to epidemiological research[40], for example, which is attempting to produce results which have a high degree of external validity, or what is known as replication logic. For case studies, theoretical attention must be paid to what Yin refers to as the generalisability of the theoretical logic and propositions. The goal is to 'expand and generalise theories' (analytic generalisability) and not to 'enumerate frequencies' (statistical generalisability) (Yin, 1994, Ch 1). Rose (1991) also sees generalisation as important but depending on the adequacy of the underlying theory, as well as on the use of multiple sources of evidence. For Hakim (1987), the 'Case study is the social research equivalent of the spotlight or the microscope; its value depends crucially on how well the study is focused', and hence for her, the case study also requires a large amount of prior knowledge. Indeed, the value of a case study can very much lie in the way it illuminates the broader literature and debates within which it is grounded. With this in mind a case study also allows for a flexible methodological approach (Hakim, 1987, Ch 6). And a variety of data collection techniques are therefore used to gain a more thorough understanding. When the focus is on complexity, then a case study is most suitable (Daly and Lewis, 1998). This is undoubtedly the case in the present research.

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[40] See chapter three for a discussion on epidemiology and "creating a norm".

For Yin (1994), a case study has to fulfil the following characteristics:

1.   Construct validity, which is achieved through a clear chain of evidence.

2.   Internal validity, which means that rival explanations or hypotheses can be discounted and that a convergent argument is produced.

3.   External validity is achieved, which for Yin means analytic generalisation (not statistical), and is also open to verification through replication.

4.   Reliability is demonstrated through both replication by others and also the re-analysis of the data collected.

How these issues impinge on the present research is discussed below.

Defining "the case" – boundary definition

One central issue to be addressed is: What is my case? This is a problem for all case studies, and also for all studies of organisations. Where are the boundaries for the 'case', or for that matter the 'organisation'? What is included and excluded is an explicitly weighted decision. However, in much health and social science research, this issue is frequently ignored, taken as unproblematic, or stated as a given fact – when it is not. As outlined in Chapter Two, organisational theory can give some indications of how inattention to boundaries can exclude individuals and their perceptions from research. In particular, the assumed division between public and private areas which often follows a male-centred view of the world, with the prioritisation of cash economy, can be detrimental to women and their overlapping roles and responsibilities (Hearn, 1998; Bradley, 1994).

A case study approach is appropriate to study the delivery of health services as it insists that the boundaries set by the researcher for the definition of 'the case' are clearly defined and enunciated. Hatch (1997, p.94) sees boundary definition as being squarely in the hands of the researcher and that the boundaries will be determined by the reasons for undertaking the study. The construction of public / private relations is fundamental in organisations, including health services, and this has a bearing on both where organisational boundaries are drawn and where researchers focus their attention in organisational research (Hearn and Parkin, 1993, p.157). Whether the organisation and then the researcher chose to include, for example, consumers, clients, patients or volunteers in the definition of the organisation and the activities under study, are

based on wider societal definitions of what activities are placed in the public or private domains. This approach has had the effect of making women invisible, as "policy takers, not policy makers" (Lister, 1990, p.459 quoted in George and Wilding, 1994, p.148). However, since theory and also policy is often made for those placed outside the boundaries, Hearn and Parkin (1993, Ch.9) see that theory should attempt to include women and their perspectives.

Gender based roles are taken for granted by managers, policy makers (Daly and Lewis, 1998) and researchers and so they are not included in the focus of research due to women's often-perceived situation in the private sphere (Elson, 1995). Therefore, if the public sphere is the area under scrutiny, then it is often assumed not to be relevant to include gender issues in the research. But such issues can have major influences on how women interact in the public sphere, due to constraints placed on them in their private lives, and so to ignore such factors is to ignore the true influence of gender dynamics for the issues under study (Hirdman, 1991). Kabeer (2000) suggests that there is also a disjuncture between the presentation of "Third World Women" in the academic and development literature, and the local situations in which women live and work. The formal academic portrayal of women as victims - weak, passive and lacking in agency (Pearson, 1998) - is reproduced when the focus is on structural issues at either global or national levels (Kabeer, 2000). So women are characterised, for example, as "young / unmarried / migrants / uneducated" (Kabeer, 2000) or whatever the focus for the researcher might be. Any implications of this kind of labelling for the women themselves are ignored.

For health research, the boundary is frequently drawn between the patient and the provider of the health service. One is often looked at in isolation from the other. This split is obviously artificial and has the effect of divorcing analysis of service delivery and health outcomes in much health related research. Also, in research of organisations, it is important to identify whether problems which have occurred are due to underlying organisational problems, or to the individuals' themselves (Bryman, 1989, p.178). In health service delivery, this can easily translate into 'blaming the victim' and is often due to this movement in analysis of the shifting between the providers and receivers of the service.

In this research, 'the case' is all western-based health care delivered in formal settings in Gwassi, a rural location in south western Kenya. The location (a Kenyan administrative unit) provides a locally understood, yet porous boundary, and all preventative and curative services provided within this location are included. Members of the local population - men and women - and the local staff are all potentially included in the research. The managers and donors, situated outside of the location, are also included on the basis that they operate on if not within the area. The location and the health services provided are described in some detail in Chapters Five and Six.

Level of research

As stated in Chapter One, my interest lies in the interaction between policies, health staff at the district / sub-district level and the local community: that is as policies turn into practice and in identifying the resulting rhetoric and reality across the macro-, meso- and micro-levels (Elson, 1995). Micro-level research is the empirical focus but it also reflects meso- and macro-level forces (Elson,1995; Schwartzmann, 1993). By starting at the micro-level through a study of the daily reality of individuals using, interacting and working (i.e. exercising agency (Kabeer, (2000)) with or for the health service, contradictions can be observed between stated and delivered policies and practices, and through these, the uncovering of some of the silencing of voices in health service provision can take place. This is to follow Foucault's (1986) focus on "power at the extremities", at "its more regional and local forms and institutions" (p.232) to uncover both active and non-active decision making. Part of this process involves exposing the true cost of using the health services on the part of women, and why men are unable to participate or assist in promoting family health as defined by the health service. The services studied include the provision of antenatal, family planning, child health clinics and services; and experiences around 'community participation' of primary health care (PHC) services and preventative activities, especially the provision and use of clean water and latrines. In addition, the research includes the contact and communication between staff within the location. The different levels must be considered for a full picture of health service policy and provision (Daly and Lewis, 1998). The 'organisation' needs to be considered at

macro-, meso- and micro-levels, but also from formal and informal viewpoints – the organisational ideology, myths and rituals of the health service.

This study used the following criteria. At the macro-level, there are both the "hegemonic systems" of the World Bank, International Monetary Fund, World Health Organisation, bilateral aid programmes and non-governmental organisations, and also the national systems which encompass history, culture, finance and debt, welfare and political systems (Twaddle, 1996). At the meso-level, there are health systems which may be public, private, generalist or specialist, preventative or curative orientated. The meso-level also embraces cost and financing issues, and equity, effectiveness and efficiency issues (Cassells, 1995; Gilson and Mills, 1995). At the micro-level, there are the interactions between all the health care providers and the local community. At all levels, the opportunities and constraints in which the actors operate are important to their experiences and expectations.

Within academia, there are journals and libraries devoted to all these issues and across all levels but the direct challenge to the dominant medical paradigm remains very weak (Guldan, 1996). In international agencies, the overt admittance that there are challenges to the medical model is also rare and even if alternative paradigms do get mentioned, they rarely get followed through into discussion of policy. For example, in the report of a Population Council symposium (1993) looking at "critical issues in reproductive health and population" there is an admittance of the two conflicting paradigms informing maternity care in the west. The dominant paradigm is that of the high technology interventionist approach.[41] The alternative is one of appropriate support for the woman when required. The symposium report suggests that the agency should not "blindly export the dominant paradigm, but apply the model most appropriate in different settings". But the remainder of the report then conveniently forgets the conflict involved and proceeds only with the one dominant model, and references to any alternative model are thereafter absent. The power to define health services remains within the medical domain – and hence possible solutions and approaches.

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[41] Oakley (1992, p.11) expresses the dominant ideology thus: "Health is first and foremost a medical product".

The distance between the rhetoric and the reality of health care delivery is often a huge chasm and the interest and the ability to bridge it is often only cursory, if at all. Factors at the different levels may or may not influence the front line staff and their interaction with the patients or community. The pressures on staff to perform to targets – the present emphasis on efficiency and effectiveness issues – means that their perceptions on and of the patients may be divorced from the local understandings and situations (Twaddle, 1996). That the level of analysis can also constitute a boundary is frequently inadequately considered in research design (Bryman, 1989, Ch.9). This research hopes to capture the several levels (from micro- to macro-) and the ways in which they are intertwined and reinforce one another, by the use of a case-study approach.

Stakeholders within a case study approach

Recent developments in the use of stakeholder analysis were discussed in Chapter Two. The relevance of a stakeholder approach in relation to my chosen methodology is followed up here. Pertinent for recognising multiple stakeholders and their variable perceptions is the following observation. "Adding theory to the client's view not only tells us how practice is experienced" (Powell, 1997, Ch.11), but it also informs the practitioners how their actions are perceived, interpreted, used or dismissed by others, and adds legitimacy to all these perceptions. However, as Smith and Cantley (1985, Ch.1) point out, empirical research results, whether or not they have included the perceptions of the receivers of the service, have had little impact on professional practice and health and social policy.

One helpful way of organising the analysis of stakeholders is by looking at users and providers. However, health service is not neatly split into users and providers of services. Providers comprise different groups, with their own views of their work and the organisation. And providers can also be users, and users can be both actual and potential users.

> Organisations, including those which provide social and health care services,
> are not homogenous entities with clear and unitary goals; rather they are made
> up of a variety of sub-groups with different interests and concerns. In addition,
> social and health care services typically have a variety of users with differing

needs: not only direct users and their families and other carers, but in a different sense professionals providing services complementary to that forming the focus of the evaluation concerned.

(Powell and Lovelock, 1992, p.8-9 quoted in Powell, 1997, Ch.11)

Within health service provision, the donors, providers, managers, clients, and families can all be seen not to have fully congruent views.

Most individuals promote and treat their own health on a daily basis – through nutrition, shelter, personal attention to cuts and scratches, herbal and local treatments of other diseases and symptoms. The division into providers and users has been created in response to the study of the provision of western medicine: it is not a given criterion carved in stone. In many countries across different health care systems, women in their own families provide most informal care (Pizurki et al, 1987; Leslie, 1992; Claeson, 2001) or in some locations assisted by grandmothers (Aubel et al, 2001). One group of stakeholders who are also often forgotten are the potential users, those who are not availing themselves of services at the present time but may do so in the future. The users are easily identified, but the rest of the population is also interested in the service, both as direct potential users and for their family members. The omission of men as users or potential users of many services is now starting to be recognised, but without a clear strategy as to how to address this absence (Nzioka, 1999; Greene, 2000), nor how to develop a full gender analysis and response for health services (Elson and Evers, 1998).

A stakeholder analysis is meant to attempt to capture the views of all stakeholders, although definitions of who to include or not is still defined by the researcher (Burgoyne, 1994). This research captures a variety of views from different stakeholders by placing the community (i.e. all members of the location, whether users or potential users) at the centre of the research and then placing all health services around the community – not the other way around. This has resonance with Kabeer's (2000) middle way theoretical approach, which includes putting at centre stage local voices and choices, to attempt more nuanced and policy applicable research. This allows the community to define who the health actors and what the health services are, as well as to include other sectors or services not usually included

in conventional perceptions or analyses. This also reflects Foucault's approach to concentrate on the peripheries to uncover power dynamics.

Therefore, this research identified and consulted the following stakeholders within the location:

- Older women who had been consulted on various community health activities – several had previous community health involvement over previous decades;
- Young women trained as community health workers. Most were married and all had had a live birth. All were running their own home and farm (*shamba*), plus other income-generating activities;
- Young men who participated in community health activities. All had been married and all were under-employed;
- Community elders (men), including councillors who were interested in health provision in their area;
- Members of local community groups, in particular women's groups;
- Users of preventative services – in particular newly delivered mothers. Plus the fathers – although fathers could not be defined as direct users;
- Trained health staff (nurses) working in the location, in government, diocesan and private facilities;
- Members of Suba District offices – Agriculture and Health Officers;
- Diocesan health office staff – Health Coordinator and staff;
- Local priests and other religious officers (Catholic, SDA and Maranatha churches);
- Leader and staff of the Scout Development Centre;
- Primary school teachers in various centres;
- INGO staff with a project in the location;
- Local women, men and children from fishing centres and agricultural villages;
- District, Provincial and national health staff (including the District Medical Officer (DMO)) involved in PHC.

Interviews, one-to-one discussions, non-closed questionnaires and taped interviews as appropriate, were held with the various stakeholders listed above. See Appendix 1 for further details on the research tools employed and the number of persons interviewed. In addition, participant observation was undertaken in the clinics, dispensary and with CHWs in their community work. This included emergency assistance to the nurses at

the dispensary and health centres. Local men and women discussed with me family and community health matters and these interactions were treated as research opportunities in the context of participant observation.

Multiple views and goals

In case studies, the situation under investigation may not have one clear single set of outcomes predicted. For example, for Smith and Cantley (1985), discussing their research design and data collection in the study of a health service (a new geriatric day hospital), they were faced with three problems:

1. Experiment was not possible. The service was up and running;

2. There was a range of views about what was a success – usually aligned around loose consensus according to which group's views were under scrutiny;

3. The exact nature of the service to be evaluated remained unestablished. (Smith and Cantley, 1985, Ch.3).

These problems also reflect some of the challenges of action research conducted *in situ* and in the context of existing, on-going service delivery. These three problems were present in this study of health service provision in Kenya. An important fact confronting me, as the researcher was that I had no control over events. This was another reason for choosing a case study approach, as it accepts that experimentation is not possible.

Secondly, Smith and Cantley saw the need for a pluralistic research approach "to tap as many perspectives as possible" - which is also what was attempted in this case study in Gwassi. This can be achieved through a case study which attempts to put some limit to the research in terms of a final boundary, but which leaves the object under scrutiny exposed to a wide variety of research methods. The realisation for the researcher that there is a range and variety of possible criteria of success is important. Who can define the success of the service: the managers, the staff, the patients, the families or the researcher? This also points the way to using a postmodern approach, which values diversity, addresses not only the multiplicity of views, but also includes the researcher in the problem – through reflexivity (Hatch, 1997, Ch.2; R Usher, 1997).

Thirdly, Smith and Cantley also faced the problem that the stated goals and policies of the health service they were studying were only vaguely and ambiguously defined. So a question for them was how to evaluate the service when there was no clear agreement of what exactly the programme should deliver. Different people defined the service in a variety of ways and they found there was no simple division of views between the professionals and the consumers. All groups and also sub-groups had their own interpretations. They saw any data as potentially 'biased' due to its source and the perspective of the providers of the data. For their evaluation, they choose to evaluate the service "in its own terms". This is a conservative approach. It allows success to be defined as "quality of service" as planned and as delivered (from the managers' perspective). It does not question whether this is an appropriate success criterion from other political, moral and other principals involved. It also entails reverting to "common-sense" notions of what is an appropriate service (Smith and Cantley, Ch. 11 and 12).

This discussion illuminates the problems pointed to above in relation to organisational theory, where the ideology, rituals and myths of the organisation may not be consistent across the organisation. To reflect this, the researcher must not only consider the managers' viewpoint, but also include the local actors who are exercising their own agency within certain societal or structural constraints (Kabeer, 2000). But when there is no agreement as to exactly what the service is meant to be delivering, it becomes more difficult for the researcher to know how to break away from the managers' perspective or to present a coherent picture.

This research moves beyond an evaluation of services simply 'as planned and delivered' (the managers' perspective) and questions whether new ways of addressing the issues and of delivering the service are necessary to achieve agreed outcomes or outputs. This means giving some room, at least equal room, to the views of stakeholders who are not involved in the present definition and planning of the services. External stakeholders have alternative perspectives and definitions of the problems and issues which are easily ignored by simply accepting the organisation's view of itself (Coleman, 1991). The insider perspective may only be the perspective of some of the insiders, which can be an issue if participant observation is undertaken, or if researchers accept uncritically the similarities between researchers / academics and professionals / practitioners (Hakim, 1987, Ch.6). Nevertheless, anticipating

differences among insiders assumes that alternative visions have not been completely obliterated by the dominant paradigm, and that there is room for competing ideas and views (Oakley, 1992). Again this reflects the pertinence of Foucault's perspective on power and its (dynamic) application (Rabinow 1991) through its discourse.

The inclusion of other and competing perspectives is consistent with a feminist approach that aims to refocus attention on women who previously were ignored or assumed in a gender neutral way, to be included in an otherwise androcentric approach to organisational analysis (Coleman, 1991). Kabeer (2000) sees the need to include women (and men) not as "passive dupes" (p.39) but as competent, reflective and purposeful individuals. By seeing women as full cultural actors, but operating within "constraining structures within which they exercise their agency" (p.47), means that a theoretical 'middle ground' is covered which includes the organisation, the wider environment and the individual women. The aim of the present research design and case study approach was to capture such multiple views.

Organisations are artefacts of the dominant culture. As discussed in Chapter Three, and reflecting this fact, the gendering of the health and welfare services has a long and involved history (Foster, 1995; Gordon, 1990; Williams, 1989; Elson and Evers, 1998). However, in much primary health care, the excluded are the men (Greene, 2000). They have been encouraged by the health service to abrogate responsibility for the health and nutrition of their family and often themselves as well. This is through the focus of health services on women as reproducers and as carers of the family. This emphasis on women having all the responsibility without any corresponding rights or means, while men have retained all the rights without any of the responsibilities, has been explored in the economics sphere (Safa, 1995; Folbre, 1994). What is often missed is that health services also reinforce this male removal of themselves from responsibilities (Edwards, 1998). That women (not men) will care for love (not money) is also assumed (Elson, 1995; James, 1998) and implicit in much health service design. As Folbre (1994) points out, most ILO policy documents have a clear gender bias and are gender role reinforcing; they are not fresh analyses in new cultural settings and situations. I believe this conclusion can be drawn and extended to many other UN and donor agencies' policy documents working in health fields.

In their final analysis, Smith and Cantley (1985) saw the hospital they were studying was not a success on various counts; however none of the constituent groups themselves mentioned failure. The problem of organisational myths and culture, which their conclusions reflect, is addressed in Chapter Two. Sufficient to state here is the fact that this issue of reluctance by providers, users and other interested parties to define a health service as deficient is something I expected and encountered in this research too. All groups have an interest in continuing to define the service in non-failure terms for a variety of reasons. This aspect of organisations investing in their own future is expressed by Meyer and Zucker (1989) who say that "most people are concerned with maintaining existing organisation than with maximising organisational performance" (quoted in Scott 1992, p.348). Pfeffer (1997, p.7) more pessimistically suggests that "the perpetuation of the organisation becomes their main goal". Pierson (2001) refers to this as "institutional stickiness" but his analysis refers more to the higher political and policy (macro) levels. Smith and Cantley (1985) are working at the meso-level, where staff, patients and families interact and reflect on their actual interrelations within the service. This is reflected by Goetz (1997, Ch 1) who sees the need to look at the interface between the organisation and the clients. Bringing all the agents and actors back into the analysis (Daly and Lewis, 1998; Kabeer, 2000) is seen as necessary to inform the organisation.

Nevertheless, as can be seen from Smith and Cantley's (1985) example, it was not only the staff who were investing in the continued structure of the health service by their refusal to define the service as a failure. The patients and their relatives also avoided saying that the service was failing to meet their needs, beyond vague generalisations. Scott sees such views as the acceptance of a "rational system view of performance which privileges the official view of objectives" (Scott, 1992, p.348). As can be seen from Smith and Cantley's study, no one defined the service as a failure; so did everyone accept the official view? To answer this question in the context of Gwassi is an important quest in my research. Is it possible to get behind this official view (held by both staff and clients) of a health service as a researcher (Oakley, 1992)? I hope to demonstrate that it is, by using a methodology informed by a Foucauldian analysis of power.

Triangulation

From a methodological perspective, in their research Smith and Cantley (1985) were interested in all groups and they did employ methodological triangulation, so different methods were used to reflect a wide range of interests, ideologies and interpretations of the service as delivered. As mentioned above, a benefit of the case study approach is that it allows for, if not demands, a multi-pronged approach. This is mainly due to the need for 'triangulation' in order to improve the validity of the argument. Using multiple sources of evidence and multiple research methods and techniques enhances the argument and creates a more convincing and accurate argument (Yin, 1994, Ch.4). See *Action plan for Kenya* at the end of this chapter to clarify what this means in the context of this research.

Bryman (1989, Ch.6) points out that the case study lost favour due to problems of generalising up from the data / case under consideration and due to the primacy given to statistical validity (i.e. external validity) in research design. But if Yin's approach is followed then this is not a stumbling block as the case study is not attempting to provide statistical generalisability (Yin, 1994; Fulop et al, 2001). It is an attempt to answer qualitatively different questions and to be suggestive and indicative rather than categorical in the conclusions that can be drawn.

As Patton (1987) points out, triangulation can be achieved through a number of distinct approaches, most of which were adopted in the present research. Another perspective is that of Clark and Causer (1991), who see choice of various research methods as important in allowing for corroboration and cross-checking of data, although Allan (1991) sees a problem with assimilating the findings from too many or too diverse a collection of research methods. Oakley (2000), who found multiple sources may actually conflict rather than confirm, also sees this as a potential problem. So a balance must be struck and was aimed for in the present research, between multiple methods to aid triangulation and accumulating just too much data to be usefully assimilated and analysed.

Live (and moving!) research

All these methodological ploys are meaningless if the basic theoretical stance is flawed. The underlying theory, elaborated in Chapter Two, is carried over in the present research into different attempts at triangulation in an effort to improve the validity of the findings and conclusions. I agree with Yin that initial attention to the theoretical concepts informing the research questions is important in case studies (Yin, 1994, p.24). Nevertheless, the theory should be continually re-examined throughout the research process, as this allows the questions posed to be refined or new questions to be included. The answers received must inform the process, not just the conclusions and this is particularly important in a research endeavour such as the one undertaken towards this thesis. Such an approach puts emphasis on the adaptive nature of qualitative research – the research is not 'closed' in advance of the data collection as in quantitative research. It allows new directions to be taken, as long as they are pertinent to the original research questions, to follow up contradictions and to refute accusations of pre-conceived bias.

Acker et al (1991) found, for example, that returning to the same women again in their research had allowed some reflection to have occurred not only for themselves as researchers but for individual women as well, so that they wished to "correct" what they had said at previous interviews. Their own view of the situation had changed as they had re-examined it after the initial interview and what the interviewer had prompted them to think and talk about. The women often would bring this up by mentioning that earlier accounts had been "chaotic", or "disorganised" and they wished to clarify or even correct what had been said previously. Dialogic approaches to research have gained increasing currency but which account is the correct one? Data "shifts" as it is elaborated upon and as omissions are filled. Acker et al found this important because "Obscured experiences are central to the systematic devaluation of women in a male dominated world" (1991, p.149). And as Oakley points out as well, "Interviewing is rather like marriage: everybody knows what it is, an awful lot of people do it, yet behind each closed door there is a world of secrets" (Oakley, 1986 quoted by Jones, 1991, Ch.17). How much the interviewer and interviewee influence each other is unexplored in much social research, but as mentioned above, in trying to probe behind the official view of the health service, I

wish to fill in the gaps and produce a more complete picture. As a result, I welcomed additional reflections and thoughts from all respondents.

Schrijvres (1997) advocates a dialogic approach to try to bridge the gap between theory and practice in feminist research. This is to acknowledge that feminist research is not value-free, that it starts with what Mies (1983) refers to as *conscious partiality* (p.122), which will include a critical consciousness and exchange. But Schrijvers (1997) is calling for a more transformative or action-research strategy to allow the dialogic approach to be exercised. As stated above, this was not possible in the fieldwork for the present research as the PHC interventions were already up and running, and the aim was to research the policy and practice as practiced. However, there are alternative ways to acknowledge Mies' *conscious partiality*, including through acknowledgement of reflexivity.

Reflexivity

The reflexivity of the researcher I see as central to the research process. How does the researcher affect the research? What is the interviewee 'allowed' to say or express to a researcher? How does the researcher 'give permission' to 'think / dream the impossible', or just think tangentially about a problem as discussed formally at meetings or with outsiders? Or as expressed by Bulmer and Warwick (1993, Ch.11): "What is a problem and what is an opportunity?" and who is defining the issue in a particular direction? This again links back to issues raised in Dudley's *The Critical Villager* (1993) about *who* is defining the problem / success / failure in all development practice, an issue that translates well to reflexive research practice. Wright and Nelson (1997) define reflexivity thus:

> ...reflexivity is a process of continuously moving from the intensely personal experience of one's own social interactions in the field, to the more distanced analysis of that experience for an understanding of how identities are negotiated, and how social categories, boundaries, hierarchies and processes of domination are experienced and maintained. Reflexivity is the means through which the fieldworkers double perspective of outsider / insider, stranger / friend, and participant / observer is kept in tension.

Oakley (1992) also questions the assumed neutrality of the positivist researcher, and emphasises how human interactions influence all research. In most research however, the researcher is still positioned as 'an expert' and outside the area under examination. The "conventions of doing research still tend to assume that our subjects somehow communicate 'raw material' to us ... moreover in conducting qualitative research we are still positioned as expert knowers, drawing together the narratives that our informant provide and reshaping them back into another, academic, narrative" (Jackson 1998 p.48).A reflexive approach aims to bring the teller (the researcher) back into the narrative. The idea is to "...show that the author / researcher does not exist in a transcendental realm but is embodied, desiring, and herself invested in contradictory privileges and struggles" (R Usher, 1997, p.39).

In this research all the contradictions highlighted above were in evidence, and were agonised over either at the time, or in moments of reflection. For example, in the 'participant / observer' tensions: "Should I have gone to assist at the dispensary at night (when requested)?" – and allied myself with the actual service. Certainly the assistance I could offer to the nursing staff helped them to see me less as an (interfering) researcher and more as someone who appreciated the pressures under which they worked. Even more difficult were occasions when I went outside of the location and met / interviewed the managers and suppliers of the various health facilities. Meeting these senior staff often had an immediate and dramatic effect on the service – in one case a WHO vehicle arrived with drugs within a fortnight; and in another the nurse was invited to a training session (she had not been invited to anything during the previous three years). My actions as researcher were clearly affecting the interactions between various stakeholders. Even my frequent access to towns (and senior managers) meant that members of the community and health staff used me as an access / courier system – from delivering letters to their manager and collecting drug supplies through to checking whether gas cylinders for fridges were available. Within Gwassi, CHWs clearly redoubled their efforts when they learnt that I wished to visit their villages. All villages had undertaken some specific activities prior to the visit or the interview[42].

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[42] Specific examples of CHWs and women following my movements to utilise my skills are given in Chapter Seven.

At the level of 'stranger / friend', "How did my staying with two particular households affect others' perceptions of me?" This was potentially an issue due to the clan-based nature of the area, and rivalries for health facilities to be located in certain geographical areas. Most senior community members assumed I must be about to start a 'project', rather than being there to reflect on services they already had in the location, and so much time had to be spent disabusing people of this assumption.

But as a participant in the location, I was always to be an outsider, and I recognised this from the beginning. I already knew that I did not have the required skills or physical strength to live as a Luo woman in this remote location. I depended on others, and bought services I was either too weak, too ignorant or too isolated to provide for myself. One woman I lived with saw the issue thus: she said I did not know how to "live" there, so I paid her family to help me. The family clearly saw themselves as my guardians (for a fee). But I would not become an "insider", only perhaps a "friend". In the clinic situations I could be a participant or insider, but I did not want to be solely aligned within this health service's prescribed roles, as these roles would distort the way community members then interacted with me. For my social interactions I wanted to be more "observer" than "participant" (Wright and Nelson, 1997), but I also needed the participation to sanction my credentials. It was always to be a tension.

Action plan for Kenya

The research methods adopted had to ensure that I could do the following:
- Access actual behaviour and agency of individuals both in the community as well as in the health service context
(see Appendix 1 for the list of stakeholders engaged with);
- Follow what is considered best practice for a case study approach
- Take into account both gender and also power issues within a community; and
- Maximise various methods of data collection.
In order to achieve these objectives the following methods were considered and utilised:

1. *Triangulation*. This was achieved through the collection and analysis of data from various complementary sources along lines recommended by Patton (1987).

2. *Documentation*. Documents and textual analysis allowed initial understanding of the health services in Kenya as presently planned and delivered from the Ministry perspective. Documents also assisted planning for interviews and later for the corroboration of data from interviews and observation. They included job descriptions, funding proposals, reports at local and national levels and so on. Documentation also gave insights into who has access to which data. Documents generally reflect official goals and policies of the organisations offering health services. In Kenya, as in many other resource-poor environments, textual analysis can be challenging as only limited copies are available, usually located only at central offices: local staff do not have access.

3. *Archival records*. This included clinic returns (disease incidence and patient and staff attendance sheets) maps, charts, budgets, reports, flow diagrams, and organograms of the health service over the years of different donor involvement, staffing levels etc. Although this was often an 'official version' of what the service has been undertaken or planned, it provided some historical or temporal context for the research. These records often reflect intention, process and effort rather than outcome. It was also planned to include collection of incidence and prevalence data from the location, as requested by epidemiologists and managers, but the reliability of clinic based data was too poor to provide more than very general trends.

4. *Interviews*. Using qualitative research methods, interviews were open-ended and included opinions of the respondents. Respondents included many stakeholders not always included in health service research – both local users and non-users of services; key informants who have direct access to important local and central information; and staff both paid and unpaid. Community Health Workers (CHWs) were the focus of the interviews, as they existed on the edge of the health service, at the interface of the private and public spheres. In Foucauldian terms they were "at the extremities", and so demonstrated the traversing of knowledge / power within the community as a productive network (Foucault 1984, p.61). All CHWs and nurses in the location were interviewed, plus new mothers and fathers. Men were targeted equally alongside women to prevent gender stereotyping, although since they were more mobile their participation was more difficult to ensure. This resulted in many new 'couples' having to be recruited as the man of a previously recruited 'couple' could not subsequently be located for interview and follow-up. Interviews were

conducted individually, plus a few in small groups. They were taped in *dhoLuo* and later transcribed, translated and then checked again for translation and my general understanding.

5. *Direct Observation*. This included both formal and casual observation in both clinic and home settings. The purpose of this was both to verify stated ideas and aims in practice, and also to build on the adage "actions speak louder than words". Bryman (1989, p.25) reflects on the gap between what people say they do and really do. This issue has been known in health research since Stimson and Webb's work in 1975 and remains an issue in micro-level research (Murphy, 2001). Direct observation of physical aspects is important in demonstrating and making visible unspoken issues in the organisation of the workplace (and living conditions). This included geographic access (to clinics, water pumps), dress codes, equipment, clinic layout (privacy), transport, food availability and so on.

6. *Participant Observation*. This is a well-used ethnographic method in case studies. In my case, by participating in clinic activities it provided me with 'insider knowledge', although this was mainly from the perspective of one group of stakeholders – the staff. There were many issues around access, although as a white woman, participation was very overt in Gwassi. Despite concerns about being too closely associated with the delivery of the service as it now functions, participation in the delivery of health care allowed access to staff, their managers and community leaders, as well as the users of the services including patients in a wide variety of situations.

(Based on Yin, 1994, Ch.4.)

A total of over six and a half months were spent in Kenya, with over six months spent in Gwassi in two blocks. In between, local assistants spent another two months in completing taped interviews in dhoLuo and transcribing and translating all the interviews. The full list of tools, lists of stakeholders and the time frame are attached in Appendix 1.

Chapter 5

Locating the marginalisation of women in Gwassi, Kenya

Introduction

The research was conducted in southwest Kenya, in a single rural location[43] – Gwassi. The location was chosen due to the researcher's previous knowledge of the area. Also there are no accessible large hospitals or alternative facilities within or nearby the location and so the local population has to rely on health services provided under the PHC umbrella for non-indigenous health care.

The location is described at length below, including its particular geography, poor infrastructure and limited economic opportunities, the cultural stability of the area, and the gender division of labour. The centrality of women to the agricultural sector, the self provisioning of most families through the labour intensive agricultural practices completed by women is balanced against the marginality of women in all economic and development spheres. In addition, Gwassi location itself is marginal within Kenya, which limits possible returns on agricultural as well as other activities. This marginality is demonstrated in this chapter through distance and the poor and deteriorating infrastructure. Such marginality in south west Kenya has its roots both within the colonial administration, which did not develop all geographical areas of the country equally, and in ethnic and political divisions within Kenya both pre- and post-independence. An example of colonial inequality is still reflected in the allocation of health resources around the country. Mburu (1992) points out medical care in Kenya has retained "…Colonial institutional structures, including health care services, almost intact" (p 102) with urban hospitals still functioning at the expense of rural facilities. Without any drastic structural changes the bias in favour of urban areas continues into the 21st Century. This is reflected in physical facilities, personnel allocation, and drug supply. South Nyanza and Western provinces in the west of Kenya suffer 43% and 37% deficit in staff allocation respectively in 2000 (Nation, May 20 2000). Alternatively, as expressed in Kenya's Health Policy Framework: there is a 400% difference between allocation of staff between urban and rural areas

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[43] The location is the smallest administrative unit in Kenya, with its own Chief. Locations are further divided into sublocation with sub-Chiefs. Locations are grouped into Districts and up through Provinces to the central government structure.

(Ministry of Health, 1994, p 23). Hence, Gwassi suffers both for its particular geographic and natural features, and for being in the wrong province and being totally rural.

Immediately following Independence, Kenya's economy grew rapidly and supported an equally rapid expansion of the public social sectors, especially health and education. Following poor economic performance in the 1980s, it became difficult to sustain the public sector, and cost sharing was introduced in 1989. In the health sector this resulted in a decline in use of some facilities by 45%, due to inadequate provision and preparation, especially around issues of quality, availability and affordability. In 1993 health expenditure had fallen to its lowest - $3.6 per capita (from $9.5 in 1981/2). The general economic crises and Structural Adjustment Policies have impacted on Gwassi harshly due to the previous low levels of human and capital investment and have reinforced the marginality of the area. This impinges on women in Gwassi heavily due to both the general situation of the marginalised rural areas as well as their own personal situations.

Within Kenya women have remained outside of the main apparatus of development and planning. This has its roots in colonial administration and the gendered norms and values which were promoted and expected (Boserup, 1970; Tranberg Hansen, 1992). In rural areas in particular, the position of Kenyan women in the economy was never valued. This was due to the British translation (colonial and missionary) of the gender division of labour as equating men with the public sphere - economic activities including agricultural production - and women with the unpaid domestic spheres of the home. Also agriculture was divided into commercial crops and subsistence crops. Subsistence agriculture was to be completed by women remaining in the rural areas, while men migrated to towns or to work in the commercial agricultural sector (Hay, 1976; Mutoro, 1997). This was to be completed without any investment directly to women through credit, training or research. Investment remained aimed at men (Moore and Vaughan, 1987) and their activities. Women's subsistence crops remain neglected in research (Gatter, 1993). At the end of the 20th century, although women's central role in farming has again been recognised, it has still not been translated into support for women who nationally provide 80% of household food crop production, as well as 50% of export crops (Central Bureau of Statistics, 1998).

"Whereas the Kenya Development Plan acknowledges the central role of women in economic / agricultural development, little or no consideration is given to them when measures to improve agriculture are taken. All changes that pertain to land entitlement, agricultural technology, extension services, the co-operative movement, credit and capital acquisition, and conservational technology appear to favour men alone"

(Mutoro, 1997, p 5).

Central policy makers continue to ignore the roles and perceptions of women. Mutoro (1997) in her rural study concluded that sector policies remain gender blind. Women, despite their centrality in agriculture remain invisible to agricultural policy makers (p 239). Inputs and extension services are still directed at men (Kalipeni, 2000). Local income generating activities remain limited for rural women. The continued assumption within policy is of nuclear families with aggregated production and consumption, rather than the Kenyan specific gender division of labour, and associated control and responsibilities. The effect of this assumption is to devise and promote policies that do not support women with their specific and high levels of responsibilities within the home. This further marginalises women economically and socially as they struggle to cope with their responsibilities.

Background to the study area – Gwassi, Suba District.

In this chapter, the emphasis is to give the reader a picture of the day-to-day situation across the agricultural seasons for the population, and especially for women living in Gwassi. The impact of the economic and structural constraints experienced by women for the delivery of health services is discussed at length in the next chapter.

Geography

Gwassi location is situated along the lake shore of Lake Victoria mid-way between Homa Bay and the Kenyan-Tanzanian border. Lake Victoria is the largest surface of water in Africa (69,000 sq km), and is shared by Kenya, Tanzania and Uganda. It is now important for fishing in all three countries. Its use as a transport route has diminished since the demise of the East Africa Railways Union in 1976, which

previously had run ferries between ports around the lake. Previously these ferries had called regularly at both Homa Bay and Karungu (to the north and south of Gwassi), but none ply these routes today. The demise of transport infrastructure is dealt with in more length later in the following section.

The area contains Gwassi Hills, old volcanic eruptions (igneous rock) which rise to 7450 feet from the lakeshore, with many smaller eruptions rising to 5000 feet in the vicinity. The wide flat valleys leading from the hills down to the lake are fertile with deep black cotton soils and usually adequate long rains[44]. The long rains in the equatorial lake basin zone are expected between March and June and shorter rains between November and December (Waters and Odero, 1986). Annual rainfall on average is over 1000 mm, which is adequate for maize production. The lake side of Gwassi Hills experiences a heavier rainfall than the Lambwe Valley side; and the hill tops experience regular precipitation throughout the year. The Lambwe Valley itself is a wide fertile valley, now a game reserve. Deforestation is causing some soil erosion down through the valleys, and the El Nino rains of 1998 exacerbated this problem. However the very deep soils in the valleys have still not been depleted, and the lake shore fields and especially lower fields on the Lambwe Valley side receive new soils through this flooding, although most of the displaced soil ends up in the lake. Between the wide valleys, the volcanic rock is friable and liable to erosion and so some land on steep exposed sites is very poor and unsuitable for much farming. But these areas are also preferred for housing as water quickly drains off in the rainy seasons – the black cotton soils of the valleys can become very saturated and difficult to traverse even on foot in the rains. The black cotton soils also make maintenance of tracks difficult in the rainy seasons and often the few *matatus* (public transport vehicles) and fish lorries get stuck in the mud.

Gwassi Hills was an area covered by deciduous forest of hardwoods, however as more land is allocated to settlement, the trees are being logged (*mvuli* and other varieties prized for the boat building carried on at the lakeside) and the land used for small farms. On the lake side of the hills most new settlement is of families from lower slopes moving up the hillside to clear new land for expanding families, for young men

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[44] The long rains in the past two decades have failed twice, and the El Nino rains of 1998 resulted in crop damage and huge losses to the maize crop.

to establish their own *dala*[45]. On the Llambwe Valley side, some natural expansion up onto the hills has occurred, but there is also inward migration from much more densely populated areas of Kisii District. Previous problems for permanent settlement in south Nyanza in general and the Lambwe Valley in particular were the persistence of tsetse flies. Tsetse flies cause trypanosomiasis (sleeping sickness) in man and *nagana* in cattle with an over 50% mortality rate (Waters and Odero, 1986). Both *nagana* throughout the early part of the 20th century and the great rinderpest epidemic (*apamo*) of 1890 limited migration of Luo clans down into south Nyanza (Hay, 1976; Francis, 2000). Also, in the colonial period, the creation of a Game Park in the valley had limited migration into the valley since the middle of the century. More recently the creation of the SONY sugar estate to the south at Awendo, between Karungu and Migori, has displaced some sub-clans and prevented further natural expansion down into this area. Land is an asset and inherited by sons. Although today in Kenya daughters can also inherit (Oduor-Noah and Thomas-Slayter, 1995), in Gwassi land is not yet titled, with customary laws still being followed, giving wives usufructory rights.

In the past decade local efforts at tree planting have been encouraged, with spectacular results in many compounds. All primary schools are now surrounded by hundreds of trees of four to five metres, and this is now being repeated in many *dalas*. There is one very enthusiastic tree nursery man in Nyandiwa, who has led and utilised a women's group project for the past 15 years to grow different varieties of seedlings which are then sold and distributed through churches and schools throughout the district. Men are interested in growing appropriate varieties for house and also boat building, while women are more interested in trees for shade in the compound and potential firewood properties. Some trees are now also planted as fences around *dalas*, or to stop people from walking across fields. A few fruit trees - mainly lemons and guavas - are sometimes found in compounds. Papayas have also been encouraged, and women will sell any available fruit in the local markets.

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[45] Home. The social unit of the family, but also used to denote the physical structure, the whole homestead including persons, animals and huts or houses.
eg *Adhi dala* = I am going home .
Also see later sections on People and Agriculture to explain this further.

Infrastructure / communications

Facilities and infrastructure in south Nyanza as a whole remain poor, and for Suba district they have deteriorated since the 1980s. The track north from Nyandiwa has been impassable since 1997 and hence no vehicles can now reach Kitawa or Kisegi. There are no tarmac roads and few graded roads in adjoining locations either (see map). In 1997 the road from Rodi Kompany' to Karungu was tarmac-ed but ends there. There are very few *matatus* in and out of Gwassi location and most vehicles are not roadworthy and so unable to continue to nearby towns and markets, as they would be stopped and impounded by the traffic police. Passengers and traders therefore always have to change vehicles and are charged high fares for their journeys to any facilities or markets outside of Gwassi. During the period of my fieldwork the number of *matatus* making the 24 km journey from Nyandiwa to Karungu reduced from 3 to 2^{46}. The number of *matatus* travelling from Magunga to Karungu increased to 4 and they continue making journeys throughout the day; there is also one vehicle that travels from Magunga through the Lambwe Valley game reserve towards Mbita. From Mbita and Karungu there are *matatus* travelling to Homa Bay (with the nearest banks and wider range of shops and supplies) throughout the day – journey times 30 to 50 minutes – they stop on request *en route*. The *matatus* leaving Nyandiwa in the morning take a minimum of two hours to travel to Karungu where they stop until making the return journey in the evening. For the local councillors who have to attend meetings for Suba District in Sindo, the quickest way to reach Sindo from Nyandiwa, Kitawa, Kisegi is to walk – over 12 km, occasionally taking a boat from Kisegi if one is conveniently leaving. The councillor from Nyakasera was suggesting that these meetings should move to Mbita to improve access for all councillors due to the atrocious transport facilities.

Water transport along the Lake is also intermittent, unreliable and overloaded. Transport along the lake shore is heavily dependent on the fishermen and the fishing trade, although there is one boat with an engine travelling daily from Nyandiwa to Karungu via Kiwa Island. And from Kisegi a boat goes south to Karungu on Sundays and Wednesdays and north to Sindo on Tuesdays and Fridays (market days). As well as passengers, all boats are also carrying large amounts of goods for export and

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[46] The population of Gwassi is 48,000 (1999 Census) and each *matatu* carries max 25 people.

import to Gwassi. This is regularly *omena* (see paragraphs below for an explanation of *omena*), and after the harvest some maize goes out by boat. And rice, sugar, flour, oil comes back in throughout the year, but also doors, door frames and other large items will also be loaded onto boats and *matatus*. Many travelers refuse to travel by boat as there are "accidents" in rough weather and people drown (very few people including fishermen can swim). All shopkeepers and traders near the Lake are responsible for the transport of goods for sale into the Location, as no delivery lorries visit the area.

The situation for distribution of services and resources found here in Gwassi is similar to the situation in South Nyanza Province data:

Table 5.1. Distance to services in South Nyanza

% Distribution of households to basic services by 2km distance	local market	Bus/matatu route	Posho mill	Postal service	Cattle dip
	47.3	54.4	56.4	11.6	27.0

Socio-economic Profiles, 1990, Ch 7 South Nyanza
Ministry of Planning and National Development, 1990.

There is no electricity[47] in the location, except for a generator at the Mission and limited solar power in a few schools. The nearest phones are in Karungu – even the divisional offices in Magunga do not have phones. There is a limited potable water supply for some communities – but still women and children have to head load the water back to their own *dala* in buckets. The capped spring from Kisaku high in Gwassi Hills originally piped water to the Mission at Tonga – including to the Health Centre there – with the surplus available to the local women at a tank. This protected spring now[48] also channels water to several communities along a pipe route from Kisaku down past God Bura School to Nyandiwa *dukas* and Scout Centre on the peninsula. There are seven delivery points along this route. There are latrines in all primary schools and in the main fishing centre in Nyandiwa. Private homes do occasionally have latrines, but this remains the exception rather than the rule. Water and sanitation is discussed at length in relation to primary health care (PHC) in the next chapter.

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[47] The lack of electricity in rural Kenya is neatly acknowledged: "Nearly everyone in Kenya uses paraffin for lighting, except for the upper half of urban non-poor whose privilege is electricity" First Report on Poverty in Kenya Vol 2, National Council for Population and Development 1998.

The lack of infrastructure and communications is significant for many aspects of life in Gwassi, and local opportunity and workload – especially for women. Women's workload is returned to in several of the sections covering aspects of life in Gwassi. Lack of infrastructure also applies and can be found in the discussion of health and health care delivery in the following sections and the findings of health care delivery in the next chapter.

Population

In 1993 the former South Nyanza District was sub-divided into Homa Bay and Migori Districts. This has since been re-allocated to Homa Bay, Suba, Kuria and Migori Districts to reflect the ethnic population distribution across this area.

The total population of Kenya at the 1999 census was 28.68 million, and Nyanza is the 3rd most populous province at 4.40 million. The 1989 figures are: total population 21.45 million and Nyanza 3.50 million. The intercensal growth rate is therefore 2.9 for Kenya as a whole and 2.3 for Nyanza. The total population for Suba district is 156,000, of whom 81,000 are female. The population of Gwassi location is 48,000, with 25,000 women and girls.

Table 5.2. Nyanza Population, 1999 Census.

Nyanza Province	male	female	total (in thousands)
Province Total	**2096**	**2301**	**4397**
Districts			
Gucha	221	243	463
Homa Bay	137	154	291
Kisii central	235	258	493
Kisumu	243	257	500
Kuria	74	78	152
Migori	248	269	517
Kisii North	240	260	500

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[48] With support from the Italian-Kenyan Scout Project in Nyandiwa.

Rachuonyo	146	162	308
Siaya	220	260	480
Suba	**75**	**81**	**156**
Nyando	145	152	297
Bondo	112	127	239

Ministry of Finance and Planning, 2000, Nairobi

Provisional Results of 1999 Census, Feb 2000

As can be seen from the census data presented in the following table, the sex ratio for Gwassi stands at 92 which is close to the District and Province ratios both of 91[49]. This reflects the male out-migration from the whole province to the urban centres of Nairobi, Mombassa and Nakuru (which all have sex ratios of over 100 for men). Although Gwassi has its fishing, which is done entirely by men, the sex ratio is still low, reflecting the high male migration away from this location, as for all other Districts in Nyanza.

Table 5.3. Sex ratio at District and sub District level.

Suba District	male	female	total	sex ratio
District Totals	75,000	81,000	156,000	91
Locations				
Mbita	22,000	24,000	46,000	92
Lambwe	9,000	10,000	19,000	90
Central	13,000	14,000	27,000	93
Gwassi	**22,400**	**25,000**	**47,400**	**92**
Mfangano	8,000	8,000	16,000	100

Ministry of Finance and Planning, Nairobi   Provisional Results of 1999 Census, Feb 2000

Other figures provided in this section are also from this 1999 census.

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[49] Only Nyanza and Western Provinces have no districts which have a sex ratio which is equal or in favour of men (– not even Kisumu District) all other Provinces have some Districts which have sex ratios in favour of men.

The sex ratio is demonstrated in the following table, which indicates that men between 20 and 50 are absent from Suba District. Although historically due to male out migration, males are also absent due to their earlier infection with HIV and increased death rate.

Table 5.4. Age:Sex Graph for Suba District.
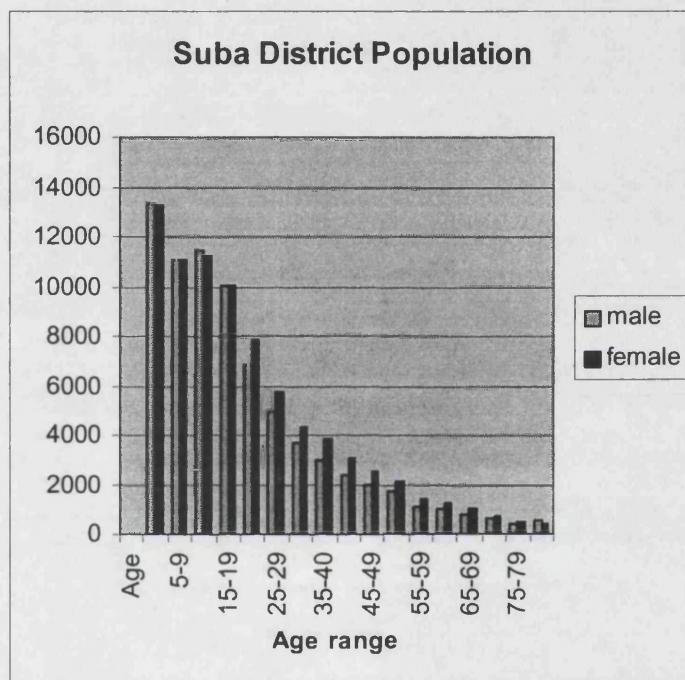
Ministry of Finance and Planning, Nairobi   Provisional Results of 1999 Census, Feb 2000

As well as District boundaries, Location boundaries have also been redefined and allocation of Chiefs and sub-Chiefs has been affected. In 2000 the number and role of the Chiefs has been under discussion, as elected councillors are now also introduced into new local government systems in Kenya. Gwassi Location is divided into 5 sub-locations – Gwassi North, Gwassi Central and Gwassi East, Gwassi West and Gwassi South. Some district offices remain in the divisional level offices at Magunga – a small market town. This includes the District Officer (DO) and the District Agricultural Officer. The District Health Officer is found in Mbita. The Suba District Offices are however now at Mbita, although the newly elected councillors have moved their meetings to Sindo to facilitate the attendance of representatives from Gwassi – the most southern location in the District. Gwassi Location had only a Chief

and one sub Chief for the period of this research, as the sub Chief representing Nyandiwa and Kiwa had died just prior to my arrival in the location and new elections had not been finalised over the year.

The population density is low in Gwassi at 142 persons / square kilometer, ranging from 109 persons / square kilometer in Gwassi East (Kibwer and Seka) to 235 persons / square kilometer in Gwassi West (Tonga and Nyandiwa). But Suba District as a whole is also only 147 persons / square kilometer[50]. Gwassi as a whole has 9,983 households for its 47,000 people, indicating an average household size of almost 4.7 persons.

From the recent census, population growth rates appear to have dropped for all of Kenya. An intercensal growth rate (an average over 10 years) of 3.4 for the period 1979-1989 has dropped to 2.9 for 1989-1999. The figures for Nyanza as a whole were 2.8 and 2.3. This rate provides a figure that covers both death and birth rates. The district and location specific birth and death rates have not yet been published. The DHS for 1998 shows that the Total Fertility Rate (TFR) in Kenya has dropped from 6.7 in 1989 to 4.7 in 1998. For Nyanza, the change has been of a similar magnitude, dropping from 7.1 to 5.0 over the same period. The decline is much greater in urban areas. The rates in 1998 are 5.2 in rural areas compared to only 3.1 in urban areas. This is reflected in access to and use of Family Planning. This is highest in Nairobi and Central Provinces where 61% and 56% of women practice family planning, whereas in Nyanza and Coast Provinces only 28% and 22% of women practice family planning.

Child mortality has *increased* over the period covered by the last two DHS surveys – the Under Fives Mortality[51] (U5M) has increased by 24% over the decade and now stands at 112 / 1000 live births. In Nyanza Province this now stands at 199 / 1000 live births which is almost twice the national average. In the DHS it was found to be highest if the preceding birth interval is less than two years. This suggests that the ability of the mother to cope is important in the mortality rates for young children (National Council for Population and Development, 1998). More specific data on the

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[50] Mbita has 219 persons / sq km and Mufangano Island 250 persons / sq km.
[51] U5M incorporates neonatal, perinatal, infant and child deaths into a single figure

health of the population is provided in the next chapter on health and services in Gwassi.

The low population densities, and historically poor and deteriorating infrastructure, negatively impact on both users and providers of health services. Young adult male out-migration also leaves mothers to cope with demands, including health demands, of the rest of the family. The increase in child mortality in this part of Kenya in the previous decade illustrates the problems mothers face in their daily lives.

People

The people of Suba District are of both Suba and Luo origins. Many families have over the years intermarried and today many children speak dhoLuo (language of the Luo people) as their first language. The Suba are a Bantu speaking people – most closely related to their neighbours the Gusii and Kuria in south west Kenya and the Luyia in west Kenya. The Luo by contrast are Nilotic speakers. The Luo share their ancestry with other large ethnic groups now found in the large ranges of central Kenya, the Maasai, Samburu, Pokot and Nandi. The Suba people are found in a small geographical location around the islands of Rusinga and Mufangano, as well as on the adjacent mainland between Homa Bay and the Tanzanian border. The Luo are among the largest ethnic group in Kenya and occupy lands across central and southern Nyanza and Siaya, centred around Kisumu which is the main urban centre in western Kenya.

Gwassi Location reflects this intermarriage of Luo and Suba people. Some communities living in Gwassi Hills were reported to be "pure Suba" but whenever visited, people would claim to be both Luo and Suba and a common response would be "my mother was Suba but now I speak dhoLuo". This equates with the anthropological accounts of the Luo southern expansion over the past centuries as being of "expansion, conquest and assimilation" (Ogot, 1967). The children attending primary school are taught in dhoLuo as their mother tongue for the first four or five years[52]. Although there are recent attempts to re-introduce Suba as the mother tongue

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[52] English becomes the medium of instruction by grades 7 and 8 (if not earlier), and is the language in which the KCPE is conducted at the end of grade 8. There is no mother tongue examination in the higher grades, there is a KiSwahili compulsory paper.

in some areas, this did not occur regularly in Gwassi schools. Within Gwassi all language heard in the local markets and at the fishing centres is dhoLuo.

The family system in Gwassi, as in other Luo communities, is patrilineal and virilocal. The settlement unit is the *dala*[53], which consists of a senior man, his wives, and children plus married sons with their own *udi*[54] and perhaps widowed mothers (Hay, 1976). Within the *dala* the senior man has final authority. As reported in Oduor-Noah and Thomas-Slayter (1995 p175) "The Luo give a high public profile to males. Patriliny, bridewealth, and polygyny all reinforce each other". Women move to their husband's *dala* on marriage, although until the full bridewealth has been paid she can return to her parents reasonably easily. Polygamy is also very common. The 1989 census (breakdown of the more recent census is not yet available) showed that in South Nyanza 40% of currently married women had a co-wife, and that among young (15 –24 years) married men, 25% were in polygamous unions. This agrees with the 1998 DHS that found polygamy in decline across Kenya at only 16% but still at 24% in Nyanza. In 2000, twenty couples with a child aged less than one year interviewed in Gwassi for health data, 33% were in polygamous marriages. In Gwassi, in polygamous marriages the first wife was regarded as the senior wife and unless there was a grandmother in the compound, the first wife would make household decisions in her husband's absence. Each woman remains responsible for provisioning her own children through the fields allocated to her, and her own granary and trading (Hay, 1976; Oduor-Noah and Thomas-Slayter, 1995; Mutoro, 1997). Francis (2000) sees tendencies for separate production within the *dala* to be a recent phenomenon – whereas in Gwassi it appeared that women being personally responsible for their own production and provisioning their children was the traditional, expected norm. It also means that mothers are able to direct their own children's labour, in conjunction with fathers' demands on children's time – such as herding animals or assisting with intermittent building and other repairs and tasks. Women who have several children are able to "lend" children to any other woman of her choice, in Gwassi a child could be "helping" at *dalas* related through either the mother or father – it was not automatically to co-wives and their labour needs.[55]

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[53] Home. The social unit of the family, but also used to denote the physical structure, the whole homestead.

[54] Physical house which may be traditional local construction of wood and mud thatched with grass, or of local Nyandiwa stone or rarely of bricks.

[55] See also Geisler et al (2000) discussing children "visiting" other *dalas* to "help" in a Luo community nearer to Kisumu.

The ability of a *dala* to function cooperatively, with *winjruok* (understanding in the home) often depended on the relationships within the household (Francis, 2000). As many wives were not consulted about the imminent arrival of a co-wife, the sudden disjuncture of the equilibrium often took some time to re-adjust. But the presence of sisters-in-law and mothers-in-law is also important to individual women and other friendships and co-operation is often in a wider circle than the immediate *dala*. Certainly in Gwassi, women interviewed at length about community health worker demands on their time talked mainly about the help they had received from mothers-in-law as central to their coping strategies. And today these same women talked about sending younger daughters to help newly married daughters in their new homes. So women's allocation of labour depended on many personal, family and friendship perceptions and reciprocities. This view concurs with that of Francis (2000, p 153) who found sharing of resources between women of different *dalas* was as common as within the *dala*. In Gwassi, since much of the women's activity is around subsistence activities, the sharing of labour is an important strategy for the women. Friendships can be based on church activities, previous educational and work experiences, and hence inside or outside any family relationships.

This access to child labour power is discussed in the Chapter Seven around issues of health services being dependent on women's allocation of child labour to enable women to complete unpaid community health activities for the health sector. But perhaps this is to the detriment of the child's own educational or personal development. The subsistence and economic activities undertaken in Gwassi by these rural inhabitants is discussed at length before returning to health services available in Gwassi.

Fishing

The main commercial fishing is now Nile Perch *(Mbuta)* which was introduced to Lake Victoria in the 1960s and has now eaten most local Tailapia.[56] The annual catch from the Lake is 500,000 tonnes annually or 1,500 tonnes daily (for all three countries around the Lake). Fishermen have been encouraged to form cooperatives for fish

trade since the 1980s. These cooperatives are based around fishing centres and hence subclans living there. In 1990 there were 16 fishing cooperatives, all active, in South Nyanza, with 2899 members (Ministry of Planning and National Development, 1990). Fish lorries (which purchase and transport Nile Perch and are owned by traders from Kisumu, Nakuru and even Mombassa) used to come to fishing centres at Nyandiwa, Kitawa and Kisegi. Fishermen from intervening centres would land their catches at these main centres where the fish lorries bought the fish and placed it on ice as soon as it was landed. Now only two lorries come irregularly to Nyandiwa on the rough track, and do not travel further north along the lakeshore to Kitawa as the road north was cut by erosion in 1998. Fishermen from Kiwa Island now transport their fish direct to Karungu, rather than land it at Nyandiwa and receive lower prices here. The fishing centre at Kitawa has disappeared and fishermen at Kisegi have to transport their fish to Sindo direct. Since the 1990s, most of the more successful fishermen have motors on their boats to travel far out into the lake, however a few fishermen do manage with only sails and paddles still. Fishing along this section of Lake Victoria was affected by the EC ban on Lake Victoria fish from 1998 onwards. This was after it was discovered that fishermen were using arsenic to kill the fish. The ban was under discussion but still in place in 2000, although sales to other countries had resumed – notably Japan and the Middle East (Nation, March 14th 2000).

Fishing is potentially a high value occupation, however the fishermen are certainly today losing out on the profits made by the large traders who own the lorries. The traders from outside the area are dominating the trade in Nile Perch. It remains almost a totally male activity, with just a few women weighing and recording the individual boats' catches to be seen at the fishing centres.

Also affecting the fishing industry during the period of the research was the proliferation of the Water Hyacinth weed. This had not been the major catastrophe along this stretch of the lakeshore as it has been nearer to the Ugandan border and round into Kisumu and Kendu Bay (USGS, 2001). However men had migrated from areas around Kisumu and Kendu Bay as the weed had formed mats and prevented boats putting out, or fish being able to breed and breathe. Some fishermen (mainly from around Kendu Bay) therefore came to Gwassi to continue fishing – bringing boats, nets, outboard motors etc with them. This had depended initially on clan

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[56] Freshwater species native to the lakes of the rift valley lakes as far south as Lake Malawi.

contacts to be able to land catches at a particular beach. The influx of these fishermen had also caused some frictions and problems around availability of fish, as the migrants sometimes had larger boats, nets and / or motors than the local fishermen. Also, the new arrivals were blamed for the reported previous poor fishing practices (arsenic use), which had caused prices to collapse as export markets were closed. But the clans were also used to migration of men up and down the coast, e.g. in previous decades male family members from Tanzania had moved up to Kenya to earn higher wages from their labour or even their own catches. The large influx of men due to the Water Hyacinth weed infestation in other areas (USGS, 2001) resulted in good business for *hoteli* keepers and people with rooms to rent in fishing centres. It also resulted in an expansion of prostitution, especially on Kiwa Island[57]. In mid-2000 initial successes with control of the water hyacinth had allowed some fishermen to return to their original fishing villages (USGS, 2001).

As well as the Nile Perch which are primarily sold direct to fish lorries, the other main catch is of a small fish *omena* which is caught in small nets at night using pressure lamps to attract fish into the nets. The fish are landed and then the women take over – drying the fish at the lakeshore and then transporting and trading the dried *omena*. *Omena* is transported throughout Kenya and even reaches Mombasa. In Gwassi, *omena* is a staple source of protein and eaten possibly three or four times a week in households along the lake. Just a few kilometers inland this is reversed, with vegetables being more commonly eaten. Therefore the main trade of women between the lakeshore and its immediate hinterland is *omena* going up the mountains and vegetables coming down. This production side of the *omena* trade around the lakeshore can be compared with the account in Thomas-Slayter and Rochelau (1995, Ch 7) of the profits to be made from *omena* sold in inland markets such as Rongo. Some men have also joined the *omena* trade, mainly buying dried omena directly at the fishing centres and transporting it out by boat or *matatu*, however women do still generally dominate the trade, both in Gwassi and markets inland. Younger women are often involved in the more arduous tasks – drying and then packing the *omena*, and physically headloading the (40 kg +) sacks up to the local markets in Kijabe or Magunga.

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[57] See section below on women's income opportunities in Gwassi.

Tailapia was the main fish in Lake Victoria and found in a large variety of sub-species until Nile Perch was introduced. Small amounts of Tailapia are still caught – some by rods and others by inshore nets. This is often an activity of young boys who sell directly to richer households, and also poor households fishing for their own food.

Women in the fishing centres smoke Nile Perch and also some Tailapia. The women must buy the fish from the fishermen, and so are in competition with the fish lorries. Often women are using either family contacts - husbands, brothers, or personal contacts (including sexual favours[58]) to ensure a regular supply. The smoked fish are then transported to local and sometimes urban markets. Remembering the lack of public transport into the location, women are constrained both in collection and transport of wood for smoking down to the lakeshore as well as transport of the finished product out to markets. Women will walk up steep inclines to Kijabe and Magunga to sell fresh, smoked and dried fish – about 10 km one direction, headloading up to 40 kgs. However to reach any more lucrative markets outside the immediate vicinity requires either access to donkeys or vehicles. So most women are constrained in their ability to expand these lucrative activities by lack of capital and also lack of reliable and affordable transport.

The fishing industry has high potential, including for individuals from Gwassi. The income accrues predominantly to the men, leaving women as mere petty traders to local markets. In addition, the decline in roads and lack of buyers into the district mean fishermen either travel out for longer periods, or migrate along the lake, removing them from assisting their families. Assumptions of nuclear or pooling households cannot be made in this polygamous and traditional community, and women remain solely responsible for much day-to-day provisioning and even cash needs of their family.

Agriculture – animals and arable

The other main activities in Gwassi centre on agriculture, and for villages away from the lakeshore all local opportunities are from farming as there are no industries. Cattle are the preserve of men. Men own the cattle and young boys largely care for

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[58] This was confirmed by NGO staff working in FP and HIV prevention programmes near Kisumu and surrounding areas in 2001.

them. "Pastoralism" is highly regarded and men measure their wealth in the number of cattle they possess (Hay, 1976; Francis, 2000), although to describe today's practice in Gwassi of keeping cattle as pastoralism is to diminish the term. There is little land left to graze widely, and cattle are often kept tethered or in small corrals for many weeks when the maize is ripening, and only after harvest has been completed are animals able to wander freely and eat their fill of the maize stalks. Cattle are an integral part of Luo customs, especially around marriage and funerals. Cattle are still paid as bridewealth to the girl's family, and so exchanges of cattle are ways wealth is redistributed around the community. Four animals are the usual payment, however in poorer families it may take many years for the final payment to be made. The Catholic Church in Gwassi does not solemnize marriages until cattle have been exchanged, as unions without at least half the payment made are liable to dissolve (personal communication Tonga mission). Bulls must be slaughtered for a funeral for a senior man, and the funeral party lasts for at least four days. In addition, herding of cattle owned by the deceased and clan members over the new grave reinforces the image of clan wealth resting on cattle ownership.

One exception to men keeping cattle may be older widows who may retain her husband's cattle, as they will be her sons' bridewealth. Women milk any cows and care for the young calves in their *dala,* usually strictly along lines of wives caring for animals owned by her husband, although mothers may also care for her sons cattle should both husband and wife be residing outside the area. Milk is highly prized but almost always in short supply. A small amount is sold / exchanged between or within *dalas* on a private arrangement between women; little is made into butter or transported to markets. Cattle are mixed local, zebu, and European breeds, but are neither bred nor fed for milking. Bulls are used for ploughing. No zero grazing was observed in Gwassi, neither are there any dipping facilities. An area of conflict was frequently between the women and their maize and vegetable fields and the men and their cattle – often the cattle ate or damaged the maize standing in the fields. The men would blame the young age of the boys sent out with the cattle, but basically the men felt that the cattle came first and no additional action was ever made to protect the women's crops. The main maize fields are unfenced. Fencing around *dalas* is to keep cattle (and goats) safe at night. Small "kitchen gardens" next to the *dala* for women to grow tomatoes, beans etc will be fenced. The cattle were not allowed to roam freely while the maize was growing but all cattle had to be taken to water daily and it was

often on these supervised trips to the nearest water source that the damage would occur. This reflects the maxim reported by Hay that summed up the Luo perspective on farming and on the division of labour: "pastoralism is superior to agriculture as men are superior to women" (Hay, 1976, p 90).

In Gwassi agriculture is the main responsibility of women. Women are allocated fields by the head of the *dala* – either her own husband or another senior man in the clan (Mutoro, 1997, Ch 2). From her fields a woman is expected to provision herself and her children. In Gwassi, in contrast to changing practices reported by Hay (1976) and Francis (2000) (in locations near to main roads), a woman still kept her maize and millet in her granaries in her compound (not hiding it away in sacks inside her *ot*). Many new granaries were being made (by men) after a particularly good harvest in 2000. And women remained free to save or sell the grain if they had been the main producer. Market day at the local markets would be of women arriving with a tin[59] or two of hulled maize or millet which they sell in order to immediately purchase other foodstuff – tomatoes, *sukumaweki*, fish, eggs etc. Men are still expected to clear new fields and assist with any ploughing done with cattle in women's fields. Any greater involvement by men was resisted - as more involvement would mean that the man also had more say in the disposal of the grains (Francis, 2000, p 175).

In Gwassi there was still a small surplus of land – and new migrants, many of them from the Kisii Highlands, where land is very short and population pressure is forcing people to migrate, were still arriving in 2000 to be allocated land on the Llambwe Valley side of Gwassi Hills. A 1990 survey indicated that the average holding in South Nyanza is 7.6 acres and 60% of households have more than four acres (Ministry of Planning and National Development, 1990) but they also noted that only an average of 2.4 acres were actually under cultivation. And more land was being brought into production throughout the 80s and 90s as more forest was cut up at Kisaku at the southern end of Gwassi Hills – this land usually being taken as sons split from their father's *dala* and established their own *dala* in a new location. But often the clans had already "claimed" parts of the mountain through earlier attempts at clearing some land and so it was not considered unclaimed land / virgin forest that they were entering.

In the wide valleys maize is the main crop, although millet[60] is still grown. As mentioned before, men will assist their wives with ploughing by cattle; also women can hire someone to plough their fields. Three persons are however required to manage the cattle and the plough, and usually the woman whose field is being ploughed also assists in this process. Poor families with land in the wide valleys still have to dig their whole holding by hand using simple *jembes* (short-handled hoes), if they do not own bulls, or are too poor to hire someone to plough with bulls. Women do the majority of the hand digging, although men do assist, especially away from the lakeshore. Fields on the steeper slopes are dug entirely by *jembes*. On the hillside fields women plant some maize and millet, often with beans interplanted, but also finger millet, cassava and groundnuts are grown here. It is generally agreed that weeding is as arduous and onerous a task as ploughing. This tends to involve even younger children, and also young men as well as the women. Weeding can take many weeks, often in the mud and rain. It is through help at weeding that friendships and loyalties are most clearly demonstrated – whether it is a woman herself going to help, or sending children, and in which order friends are assisted. Harvesting is seen as an easier and happier task. The women choose which seeds to retain for planting next season. All the harvest must be transported back to the *dala*. This is also mainly done by women headloading, although donkeys could often be used for larger or more distant fields.

The clan allocates and also re-allocates the land. Husbands allocate land among their wives, and women can re-allocate their portion among their children (Hay, 1976). Women usually have at any point in time land in several very different locations. This allows each woman to have a variety of advantages and disadvantages in her farming. Not only does she have a variety of soils and climatic conditions, but also issues of access and ease of working the land. Several women would talk of how when first married they had land that was much further away (over two hours to reach, so four hours walking before any work is done in the fields). However older women had usually more fixed fields in a location near to her *dala*, and more fixed planting patterns, as they had learnt what grew well where and the labour requirements. A new wife arriving in a *dala* would require land to be re-allocated; only a few clans living

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[59] The unitary measure remains a volume, not weight in Gwassi market places.

[60] Millet is grown for beer brewing, making *nyuka* (soft or liquid) porridge especially for young children, and also *ugali* the thick porridge which is the staple – although today maize is preferred for *ugali*. See also Moore and Vaughan 1994 for the continued cultivation of millet for beer in Zambia.

up in Gwassi Hills now would have much untilled or unallocated land remaining to be newly allocated. So land has to be found from either the husband or older women who are now unable to cultivate their land, and have no more sons to inherit land, or from co-wives, or from reclaiming land higher in Gwassi Hills. The younger wife is often allocated the more distant and unappealing sites. Families were also eager to maintain land that had been cleared in previous generations, and so wives would often go and plant cassava in more distant and steep locations – as the crop could be left in the ground for several years and not require her continuous attention. As described by Oduor-Noah and Thomas-Slayter, lack of (women's) labour is the limiting factor for agricultural production rather than lack of land (1995, p 168). This is in contrast to Francis (2000) who saw lack of male labour as limiting farm output (p 106). Oduor-Noah and Thomas-Slayter felt that one woman could only manage one hectare of maize using the technology and inputs traditionally available to her. As a woman's children grow and can assist her, this can obviously increase - but there is then a clash between schooling and agricultural work as described below. In Gwassi, the lack of transport further limited any marketing of surplus staple crops, but many women did cultivate more than a hectare, and did have enough to sell and still have enough staples left at the year-end. However other families had to resort to begging and borrowing and intensive petty trading to get through the hungry months – similar to activities described in Francis (2000, Ch 7 and 8). Other opportunities for income generation are discussed below.

The "ideal" division of labour between the genders as described by Hay (1976) was still the ideal for families in Gwassi[61]. This is still possible due to the present adult generation in Gwassi not being land-poor - as has already occurred in many other areas of Kenya – and any imminent shortage of land holding has probably been reversed due to the present high death rate due to AIDS. In several families I observed vacant semi-permanent homes and untilled fields where adults had died; the land would be re-allocated whilst children were still too young to inherit their father's land. In addition, the fertility of most land is not exhausted due to the continuous deposits of soil *into* the wide valley floors. This ideal division of labour is that men have a duty to clear the land and break the soil for the first cultivation only. The men then also contribute their labour in building granaries, houses and fencing. Their remaining

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[61] See also Whisson 1964 for traditional Luo agricultural roles, discussed in Francis, 2000, p 108.

duty is the defence of the family, cattle and land (Hay, 1976, p 91). Men today also plough with cattle, although women are now also undertaking this role as men are sometimes absent at crucial ploughing times. This leaves women with all other agricultural work – ploughing with *jembes,* planting, weeding, harvesting and transporting the harvest back to the *dala.* Women are also responsible for storage of the food supply, all housework, cooking, childcare and water hauling. Women also maintain the walls of houses and granaries by annual re-mudding (Hay, 1976), which they can do alone, although often with another woman. Women also fill all walls after men have erected the timber shell for a new house, although for this they usually have a large group of women (friends from inside and outside of her *dala*) to assist.

This is the "ideal" division of labour. In Gwassi most older households conformed to this ideal. They often are men with more than one wife, older children who can assist their mothers' in their farmwork, and other high-energy tasks such as water, firewood, crop haulage, and so men are able to remove themselves from the workload. Men remain keen to maintain the division of labour activities in agriculture and their main activity remains the ploughing with bulls, although the necessity for weeding means they can also be found in the fields at this time. Younger men who are part or full-time economic migrants are able to also be absent for much of the agricultural cycle, although some men will try to return home either to assist their mothers or their young wives with either ploughing or weeding (but not both). Fishermen earning cash can pay for additional labour in their fields. Migrants could also (in theory) send back cash to allow the woman to buy-in labour to assist on her fields (Mutoro, 1997; Francis, 2000). But finding labour often meant that she would have to wait until families had finished on their own fields first before selling out their labour to work on other women's fields, so even here, personal relationships were important in finding additional labour.

In all these homes the ideal division of labour also gives the woman control over the harvest, as she is expected to feed her children. After harvest, a woman could make calculations (within her immediate economic situation) as to how much she could sell, and whether to sell immediately or wait and hope the price would rise. A popular choice after a good harvest in Gwassi was to sell maize or millet and buy goats or chickens with the proceeds (see also Hay, 1976). Women were loathe to reveal too great a surplus, as the main bargaining in the home would take place over the larger

items – school fees and *mbate* (corrugated iron) roofs, furniture and even items such as blankets and clothes for the children. The "European ideal" for the division of labour which had been preached from the pulpits (Vaughan, 1991), imposed and taxed by the colonial authorities, and assisted by ignoring women in education and agriculture, that the man should be the breadwinner, had been acceptable and possible whilst the urban economy had been able to absorb and provide jobs for male migrants. However since the 60s, education and school leaving certificates have become less and less a route to lucrative paid employment (Francis, 2000). As men have started to renege on their responsibilities, especially over school fees, but also over household items, women have found themselves in Gwassi being expected to perform yet another miracle and find cash in a rural area which has never been planned or designed to provide women with cash.

Young men who were living in Gwassi and stated that they were full-time farmers were rare around the lakeshore - where most young men were more attracted to the high earning potential of fishing. But either due to saturation of fishermen in the industry, or to a dislike of fishing, or even a fear of the lake, more young men are now seeking a livelihood in farming. This is in contrast to Hay (1976) who saw farming as "beneath most men". But male work in agriculture appeared to be on their own fields, and on their own terms. Also young men would hire themselves out as labourers, usually to women who had an outside source of cash – often remittances from husbands or children in town. But these young men saw agricultural work as a temporary occupation while waiting for better opportunities (Narman, 1995). This agrees with Hay (1976) who found wealthy men "scorned work in the fields" although "poor men might help their wives". Women also employed women in their fields, possibly on a more "sharecropping" type arrangement, if they had no cash to spare. These arrangements were linked to friendships and reciprocal arrangements beneficial to women across the seasons and years[62]. Food crops are still primarily grown, tended, harvested and hauled by women in Gwassi. Lack of cash crops, and efficient transport for any marketable surpluses has limited men's involvement in agriculture (Mutoro, 1997). Lack of mechanical agricultural labour-saving devices has

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[62] See Obbo (1980) comments on pooled labour for rural Luo women in Uganda too.

also prevented male involvement in agriculture. Motors in Gwassi are only regularly found as outboard motors on boats and in *Posho mills*[63].

Due to the very poor transport links to markets, there are no cash crops grown except for the local markets in tomatoes, *sukumaweki*[64], and bananas – foods still dominated by women. Surplus maize, and to a lesser extent millet, is transported out from the area, but limited, difficult and high transport charges limit the profit actually gained. As more young men are unable to find work in urban areas, male involvement in maize trading in good harvest years has increased. Women and men use donkeys for transport of such goods, purchasing maize in the small markets or even direct from women in their *dala*. Young men and older women often form alliances for such trade. The donkeys transport the maize out to Karungu or Mbita where larger traders (male and female) are purchasing maize for urban areas of Migori, Homa Bay and Kisumu.

Goats in most homes were seen as an investment for men, women and even children. Surplus grain would be sold and young goats bought (Hay, 1976). These would be fattened. There is a high sale of goats in January when school fees are due – so a canny family tries to sell later in the year when prices have risen again. There are butchers in Nyandiwa and Magunga who slaughter both cattle and goats for sale locally and to local *hotelis*. The potential for goats to reproduce twins makes them a popular investment for women. But the propensity of goats to escape into gardens and fields also makes them a nuisance for the women. Young men also raise goats in order to gradually trade up to cattle to raise the bridewealth necessary to marry. Women keep chickens for both eggs and meat. However, Newcastle's Disease is very common and lack of vaccines means that potentially all chickens throughout scores of *dalas* can die in a week. While I was in Nyandiwa one woman started a small poultry keeping project with 100 hens and was assisted by the local Ministry of Agriculture officers from Magunga to get vaccines. This was the only poultry project in the area, although the demand for eggs was high from local *hotelis* and *dukas,* including out on Kiwa island.

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[63] Posho mills are for grinding maize – which are now common in Gwassi such that few households grind their own maize. Payment for grinding can be in cash or kind at all mills. Most are owned by men, but a few women also own mills.
[64] Green vegetable grown for its leaves, of the brasica family.

Also changing was the ability of women to own land (Oduor-Noah and Thomas-Slayter, 1995, p 165). Although several educated women were aware of this change, none yet owned land nor were preparing to fight for title deeds. Usufructory rights appeared to satisfy most women, although some women looking ahead were concerned for their own children within a large *dala*.

The maintenance of traditional agricultural practices and division of labour means that women continue to work in extremely arduous conditions to self provision for their families. Women rely on child and reciprocal labour to complete their agricultural tasks, especially at key times in the agricultural cycle. As discussed above, women are overworked and rely on assistance to complete all their agricultural tasks. The expectation by the health sector that women can work as unpaid community health workers is disregarding the heavy workload women already carry. Women's ability to provision their family has an impact on nutrition levels for the whole family. In the next chapter, data demonstrate that Gwassi women are able to maintain good nutritional levels for young infants (less than six months) through breast feeding, but once older, infants left at home while mothers travel to distant fields do not receive adequate nutrition. Mothers away for whole days are unable to prepare more than one meal per day. This ability to care for children due to commitments outside the home also had implications for women trained as community health workers and was revealed in the interviews.

Houses, water and fuel

Most people in Gwassi still live in local designed and built houses, or *ot (*plural *udi)*. It is the responsibility of men to build the structure and to thatch it – however women must infill with mud and smear the walls and also often carry the thatching material down from the mountain. Today, semi-permanent homes are preferred, with *mbate*[65] roofs and cemented finished walls and floors – which reduce the upkeep for the women. *Mbate* roofs allow rainwater catchment which can greatly assist women. Few homes have large catchment tanks, but simple run-off of the rain into buckets can improve water availability in a home, and reduce a woman's trips to collect water from the lake or small streams. The 1990 socio-economic profile of South Nyanza (as then was) found the housing situation to be "extremely poor" and 83% of homes were

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[65] Corrugated iron

entirely of local, temporary construction and only 2.2 % in the entire District – which then included urban areas of Homa Bay and Migori – to have permanent homes (Ministry of Planning and National Development, 1990).

There are almost no wells in Gwassi, although in the last two years the Lake Basin Development Authority has installed some India Mark II Handpumps in the villages further from the lake – four in Gwassi and four near Magunga. The success of these initiatives are discussed in Chapter Seven. Women are the sole carriers of water – usually in 25 litre buckets. Children help their mothers, especially girls (Geisler et al, 2000). Women can be travelling up to five kilometers to collect water – the journey back up the mountain side can be very steep. Another initiative in the area has been to cap a spring in Gwassi Hills and bring the potable water down to communities. This was organised through the Catholic Church and the Italian Scouts. There are now seven points where water can be collected between Kisaku and Nyandiwa. This is in addition to the previously capped and piped supply to Tonga Mission, Health Centre and village. Some wealthier *dalas* living far from water (such as from God Bura and Nyenga) had started to use donkeys in the 1980s to assist with water collection. But water collection still remained the responsibility of the women in the *dala*, although as her children and especially daughters were old enough, they would also be expected to assist her in this relentless task. Pupils at primary schools are also used to collect water for the teachers.

Most women in Gwassi continue to use solid fuel for cooking over three stones in their *ot*. The preferred fuel is wood for most cooking, especially *ugali* . The few women also working as teachers, traders etc will use kerosene in small "Chinese kerosene stoves". Women cut their own wood fuel and haul it back from Gwassi Hills whenever possible and some women also cut and sell wood in the market, but few women can afford to pay for wood. Women who smoke fish are often buying wood from their relatives "to order". Women can also supply wood fuel to *hoteli* owners both in Nyandiwa and out to Kiwa Island – again often on a regular basis. As more trees have been planted around *dalas* in Gwassi location, more women have access to some small branches. In the past ten years myself and several other visitors returning to Gwassi after an absence feel that some areas of Gwassi are "bushy" again, as recent good rains have regenerated small bushes and trees – which provide local fuel for women. Women also travel up into the forested areas to make charcoal.

This is preferred, as the charcoal is lighter to carry down, and also commands a higher price in the markets. However this practice is also illegal.

An indication of the poverty of households in South Nyanza is shown by the following survey data of the few household items in homes:

Clocks	23%
Chairs	63%
Tables	47%
Lamps	39%
Beds	82%
Radios	16%

Ministry of Planning and National Development, 1990, Table 7.12

This is similar to the situation found in Kisumu – a District which includes a large urban area. But such data indicate how the low ownership of kerosene lamps and radios - items traditionally bought and used by men - can disadvantage women in their access to information. Also almost 20% of households have no beds – indicating whole families (i.e. women and children) sleeping on the floor and its associated health hazards for children – snakes and scorpions.

This section has demonstrated the self provisioning nature for much of the lives of families, from shelter to daily fuel and water. This is due in part to the very limited disposable income families and especially women possess. Women daily self provide for fuel and water as it is free, but costs in time and energy to herself. They own very few household items beyond traditional items for cooking and collecting water. Although improvements are slowly arriving for water availability for communities living away from the lake, the cash payments required mean that some families are still unable to benefit from this cleaner water. The issue of clean water and hygiene generally was important in the research, due to recent outbreaks of cholera in the location.

Income generating activities

The ways women have been able to earn income within Gwassi have remained very limited. As discussed above, men have dominated the fishing industry, leaving only the *omena* production and generally small scale trading to women. In the 1980s,

women were also encouraged to smoke fish to preserve it and allow safe transport to some more inland markets (i.e. Magunga, even Migori and Kisii). Access to sufficient quantities of wood and poor transport has limited this activity. Individual women do smoke smaller quantities (20-40 kgs) to head-load up to markets in Magunga (four hours away) and Kijabe (two hours uphill).

There are few agricultural options open to women apart from sale of their surplus grains and to a lesser extent pulses (pinto beans) and ground nuts. Market gardening is reasonably lucrative if the rains are prolonged, or there is access to safe land near to water (hippos invade the best land and can destroy a tomato crop in one night!), and good fencing or hedging is in place. Families near suitable sites will often jointly tend and water tomatoes, *sukumaweki,* onions plus beans, papayas, guavas or lemons. But continued attention is required to keep out goats and cattle, as well as daily watering. Young men as well as married women will often dominate a plot for a few years, before graduating to other activities. As well as providing the family with food, the sale of produce in local markets provides welcome cash for the family. Women dominate the sale of such foodstuffs in the local markets. All are sold by number (tomatoes, *sukumaweki,* onions) or volume (beans, grains, *omena,* even cassava flour). Pitches in the formal markets are both licensed and attract a small fee. More established traders may have a crude bench, or even a cover. Most women sell direct from baskets on the ground.

Trading opportunities outside of Gwassi require capital, but a few women have graduated to long distance trade of grains (especially maize if the rains have been favourable), *omena,* and to a lesser extent dried fish. The transport costs (*matatus* or motor boats) are however high so knowledge of relative prices, as well as enough capital to purchase stock, is important. An alternative would be to hire or own donkeys. These were not commonly introduced into Gwassi until the 1980s. These are owned by both men and women, and can be used for water haulage, as well as transport to markets for large quantities. They are also hired for collection of harvests from more distant fields – again payments may be in cash or kind. In addition, daily work could be found head-loading large (40 kgs) sacks of *omena,* maize or other agricultural products, or cutting and transporting firewood. These were arduous but common ways for women to earn extra cash, and suggested and practiced by many

women interviewed in Gwassi. One days work head-loading items around Gwassi would earn enough money for a family's evening meal.

Women also own, run or let small businesses in the small fishing / trading centres in Nyandiwa, Kisegi, Osiri, Kiwa etc. These enterprises are variously small shops (*dukas*) selling daily essentials such as soap, sugar, cooking oils, rice etc, small restaurants (*hotelis*) serving hot food[66] or simply tea and *mandazis*[67] or chapattis. Sodas are also sold to the fishermen and the few teachers and other salaried people in the area. There is today only one bar left in Nyandiwa selling bottled beer and it is run by a women. In the villages are homes selling the local brew made from millet (*busaa*). Women who brew the beer usually sell it themselves. Also fermented in Gwassi is *changaa*, which is made from molasses and highly intoxicating. It is illegal but is available; women who make this often do not sell from their own homes but supply others. There is also a strong temperance movement in some evangelical churches. Women are also successful tailors, usually making women's and children's clothing, while men make suits and school uniforms.

In the 1990s the previous ban on second-hand clothing (*matumba*) was lifted In Kenya. This ban had previously resulted in the smuggling of clothing items up from Tanzania (*magendo*) into the remote areas such as Gwassi. Women traded this small quantity of clothing in villages. Today the *matumba* trade is thriving and growing across Kenya and is the cause of many recriminations (closure of Kenyan textile and clothing industries, and shops in towns) and numerous newspaper articles. The main sellers of *matumba* in Gwassi markets are women. Larger traders are men, and men are also found in urban markets selling *matumba,* especially men's clothes. Early after the ban was lifted, an individual woman buying a sack of clothes and selling it locally could make good profits. Today, with many more people attracted into the trade, only by travelling to Kisumu or Nakuru could higher quality clothes be found which would fetch a good price – prices have fallen and people's expectations have risen considerably. Women even in Gwassi specialise, some selling sheets and tablecloths and others children's clothes or handbags.

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[66] Maize and beans, rice and beans, ugali and meat or *sukumaweki*.
[67] Doughnut without the sugar coating.

Other petty trade involves household items – locally made brushes, kerosene lamp glasses, buckets, bowls and other plastic items, *sufrias,* teapots and other metal goods, cloth and wool. These are sold in the local open markets as well as in small *dukas.* Women as well as men are involved in such activities.

All the above activities suffer from saturation of the market, squeezing profits and make returns to an individual very small. Many women dip in and out of a variety of activities across the agricultural seasons and her need for cash: Petty trading, casual labour, agricultural surplus sale, and animal husbandry. In addition, loaning animals, children and her own labour to others to repay old debts or to build up her own social capital are non-remunerated activities also in her repertoire of coping mechanisms. Women may be in business on their own, or with their husbands, co-wives, friends, or relatives. This depends on trust, access to capital, or even inheritance. Many women also rely heavily on their children to assist in the business, or children have to complete the home chores whilst their mother is working.

There are trained and untrained female teachers in Gwassi primary schools. The trained teachers are usually from outside of Gwassi, although some are also married now within the area. Untrained teachers are secondary school leavers (or dropouts) who are either waiting for teacher training places or will never be able to raise the necessary fees. Women are less than 20% of teachers in the division. This is discussed in the later section on education.

Prostitution is increasingly common. It is found mainly in the fishing centres. As well as the more common forms of prostitution such as "Bar girls", where men pay women for a single sexual encounter, there are also other arrangements where single women are concubines for fishermen. As well as providing sexual services, the woman will also prepare food and complete other domestic tasks while living in a single room with the man. Local people from Gwassi thought that the arrival of more fishermen from outside the area in the previous few years had also increased the number of prostitutes. It was also suggested that numbers of prostitutes had also risen through an increase in widows due to the rising death rate from AIDS. Women who were shunned by their families were left to desperate coping mechanisms to support themselves and their children. The women also tended to come from outside of the

area, some were from as far away as Rwanda. It was particularly common out on Kiwa island.

Women's Groups

A description of the location and women's lives would not be complete without a passage about Women's Groups.[68] These have existed in Kenya since the 19th century and the women's councils of the Kikuyu, and in the early 20th century mutual assistance groups were formed among women in many areas of Western Province. In the 1940s, women's clubs appeared which by the 1950s were organised under the National Women's Organization "Maendeleo ya Wanawake". Maendeleo itself had been formed under a philanthropic model – for white women to assist black women in traditional women's tasks. These tasks could be child care, sewing, embroidery, knitting, singing etc. Most rural women's groups today still confine their activities to the customary duties and responsibilities of women. This has therefore, in the Kenyan context, expanded from household tasks into agricultural and related food processing activities too (Mutoru, 1997, Ch 8). Urban based women's groups are also formed around occupational and other interest groups of women (e.g. nurses, lawyers, environment). Maendeleo continues to be the largest group. It is though frequently accused of promoting individual elite women who function as "tools of male politicians". This is because it retains a stress on female domesticity, and has done little to assist or empower ordinary women (Bujra, 1986; Kabira and Nzioki, 1993). It is now affiliated to the ruling party. Maendeleo has been allocated the role of coordinating women's groups around the country, implementing income generating and other welfare projects, channelling government and donor funds to women's groups.

Women's groups and organisations have, since 1975 (UN Conference for International Women's Year in Mexico) and again after 1985 (Third UN World Conference on Women in Nairobi), become part of the central government's planning apparatus, especially for rural development. This has mainly been actioned through Maendeleo, remembering it is also affiliated to the ruling party. Since the 1994-96 development plan, when self-help and income generating groups were seen as a way

of ameliorating the deteriorating economic situation in rural areas, women's groups in the rural areas have been re-targeted for such activities. In Kenya the ideology of *Harambee* (pulling together) was promoted since Independence and this links again to ideas of self-help. The huge local effort put into *harambee* is illustrated by the estimate that central government only contributed 6% of total costs (Copestake, 1993). Much of the local labour was women's labour, with men's participation often limited to paid or managerial roles (Safilios-Rothschild, 1990; Thomas-Slaytor, 1992). *Harambee* declined after government could not meet recurrent costs, plus increased bureaucratic controls and planning mechanisms (Copestake, 1993).

The churches throughout Kenya have encouraged women's groups to promote ideas of Christian womanly and wifely virtues (Tranberg Hansen, 1992) through morally laden messages (Berger, 1995). In the 1980s and early 1990s central government policy has promoted women's groups through the Ministry of Culture and Social Services, where groups are registered. The criteria for forming a group are that there must be at least ten members, have a formal structure[69], open a bank account, and then the group can register. The aim of registering is to access government and donor funding. Many groups were expressly formed due to this "promise" of funding (Mutoro, 1997, p 285), and when it was not forthcoming the groups collapsed.

Women's groups have targeted women in rural areas primarily in their traditional roles as homemakers, food processors, child rearers, wives (Tranberg Hansen, 1992; Berger, 1995) and more recently as agriculturalists. The more recent emphasis on income generating has coincided with the general economic downturn and the introduction of SAPs and cost sharing initiatives. Similar to that found by Mutoro (1997), membership of groups in Gwassi was often found to be categorised according to: Membership of the same church; from the same village; common interests or goals (especially educated women, traders etc); related by birth or marriage. Most members of women's groups were either married or widows. DANIDA in the 1980s had supported groups according to village mainly, so this image had tended to dominate previously, but now other characteristics were more common. In particular, all denominations of churches still promoted women's groups.

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[68] See Were 1985 & Moore 1988 for a history of women's organisations in Kenya generally.
[69] with chairperson, secretary, treasurer, plus assistants to all post holders.

In Gwassi, women's groups had been heavily promoted in the late 80s and early 90s through DANIDA and DVS. In South Nyanza there were 1269 Women's Groups registered with over 40,000 members (which is only 8% of all adult women), but not all were active (Ministry of Planning and National Development 1990). Since Gwassi was a location receiving particular assistance from DVS, it can be assumed it had a higher coverage of groups and members than some other parts of South Nyanza. Funds and technical and administrative support were available to support the groups. Projects centred around agriculture and horticulture (tomatoes, *sukumaweki*, onions and papayas), and fish processing (drying and smoking), and women's artisan skills (basket weaving, sisal stripping, tailoring, knitting and crocheting). These had all been promoted as income generating activities. However many projects were heavily dependent on the outside assistance especially in accessing markets (lorries to transport produce out of the area, or access to craft markets in Nairobi for example), and maintaining the formal leadership structure and access to additional funds due to low profit margins on the original activities. The only project involving women's groups that was still active and highly visible during the research period was a group organised around a church (Maranatha) and ran a tree nursery in Nyandiwa. The same pastor ran this project for over 20 years. There were also other horticultural activities of this women's group. Income raised was used to erect small homes for elderly persons and pay school fees for orphans etc. But other smaller women's groups did still meet and continued on less high profile activities and projects. Other activities centred on small localised horticulture or very limited craft production – especially knitting and crocheting. Again, the small amounts of cash raised were often for charitable purposes within the community – such as school "fees" for impoverished families or orphans, rebuilding a house after a fire, to meet medical bills for a group member etc. This reinforces women as maintaining both their own, their families' and the society's welfare. Income generation was a necessary means to maintaining this welfare. So women's groups appear to be hijacked into reinforcing a welfare-promoting image of women. This is slightly different from the common image of women as welfare recipients of project activities. But this shares an image (welfare-promoting rather than welfare-receiving) with health sector delivery as discussed in the following chapters.

But many women's groups in Gwassi were in abeyance during this fieldwork. Activities may still be ongoing, and were conducted on a private basis among a small

number of individuals. Formal meetings were not convened and bank accounts were dormant. Committee members had often appropriated assets (sewing machines, *jembes* etc), as the formalised group had collapsed. Highly relevant to the non-continuation of the group was lack of ongoing capital to continue the activities. However the group could be reactivated should additional external funds become available to groups – all the structures were in place. The women though had not gained enough from the more formal group to justify its continuation. Church based women's groups may still meet in more formal ways, but their activities would mainly include bible reading and choir practice type activities. Small scale income generation of such groups would be to buy tea, sugar and possibly food for the priest or pastor when visiting the locality.

The women's groups in Gwassi confirm what Mutoro (1997, Ch 8) found: that women join women's groups hoping for financial benefit.[70] This hope was sown by central government's encouragement for women to form groups for income generation and access to external funds. But few groups ever reach a stage where they are generating enough income to repay their members for the labour they sink into the group's activity. The groups are handicapped by the limited opportunities presently available in rural areas. The groups also do not introduce labour-saving technology to women in the rural areas (Tranberg Hansen, 1992) such as piped water, electricity or other domestic labour-saving devices. The focus on traditional women's tasks also reinforces the standing gender inequalities which women face, rather than assisting women to break into new spheres, including income generation or to reduce their drudgery (Muturo, 1997). The emphasis on welfare objectives also allows men to negate their role in social welfare – why shouldn't men be involved in supporting poor orphans or widows?[71] Men's workloads and roles are never suggested to relieve women of their high and rising level of responsibility (Smyth, 1999). Women here are seen responsible for the welfare of others, without considering the possible returns for the hours of work they put into the activity. Independence – including to be free of such responsibility for the welfare of others - is seen as "a masculine prerogative" (Pateman, 1988). The propagation of such uses of women's groups by government

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[70] This does not concur with Rauchod Nilsson (1992) in Zimbabwe who found women used Women's Clubs to gain educational and managerial skills. But these clubs appear to originally have been targeted at urban elite families.

[71] Luo urban groups maintain social funds to provide for the sub-clan in times of need – often such resources are called upon for medical and funeral expenses. (Also see Obbo 1980 re the power of such groups in Uganda.)

and church holds women in their traditional spheres of responsibilities ever more tightly.

The last few sections have discussed the very limited opportunities women have for economic activity that would adequately recompense them for the effort expended, even when they had formed women's groups as encouraged by central policy. Women remain farmers producing the staple foods to feed their families throughout the year, and farming or trading to provide meat, fish or vegetables. They also participate in a myriad of other activities to either buy or trade for other essentials, for example school fees, uniforms and books for children to attend school, items for their homes, kitchens and farms and also for health care costs. The returns for all these activities however remain very low, and women struggle to build up working capital; instead they are trapped in subsistence agriculture using simple and often repaired tools. Also, the notion of nuclear, pooling households can be seen not to apply. Traditional polygamous unions and highly gendered male and female economic roles and spheres of responsibility continue to be reproduced locally.

Education

There are 24 primary schools throughout the location. Some are only grade 1 to 4 and function as feeder schools, whilst the remainder continue up to grade 8. The local communities build all primary schools – just a few were built with assistance from the Catholic and SDA churches in the 1970s. Today all schools are short (by one or two staff) of government allocated and paid teachers. Policy dictates that communities are asked to pay for additional teachers (resource-sharing). Parents therefore have to contribute "fees", in addition to uniforms, books and other costs necessary for children to attend school. All schools in Gwassi have good enrollment in grades 1 and 2. This confirms what Geisler et al (2000) found near Kisumu where almost all children were found to have a minimum of two years of schooling.

From the recent census of a total of 22,082 children aged 5-9 years in Suba District, only 1,150 reported no schooling at all – 583 boys and 567 girls. In the 10-15 age group, of 22,720 children it dropped to 326 children who had never attended school – 171 boys and 155 girls – indicating that some children may start school late but they

will try to enrole. Although the sex ratio now is even, in the past it favoured boys –
age groups 25-29 have a 1:3, 30-35 a 1:5, and 35-39 and above a 1:7 ratio of boys :
girls who never attended school. Today the dropout from school starts in the low
grades and by grade 7 and 8 often only those students who are hoping to take KCPE[72]
are still attending regularly – about 10-20 % of original enrolment. Nationally
enrolment rates have dropped from 95% in 1989 to 88.8% in 1999[73], and only 47%
complete primary schooling.

Children often repeat grades due to poor attendance or in order to improve their exam
grades. Children are frequently removed to assist their families – either regularly (the
day the mother goes to market) or in a crisis (when someone is sick) and many
children are removed for peak agricultural seasons such as ploughing and weeding.
Girls are more likely to be removed from school, both on an *ad hoc* and final basis
(Lloyd and Mensch, 1999, p 98). This affects both the results of girls and their ability
to enter secondary schools. At Nyandiwa Primary School, the final KCPE school
leaving results of pupils are listed by sex. For three years the top boys are 50+ points
ahead of the top girls (e.g. 412 v 346), or a 16% difference in exam performance. The
headmaster and other staff are aware this is not due to the girls' ability, but their
attendance rate at school due to the home commitments they have to assist with or
cover for their mothers' work (Fuller and Liang, 1999). Girls at school are often used
by teachers as maids, which again removes them from the classroom (Lloyd and
Mensch, 1999). Pupils are also used by the school for manual work – repairing
classrooms, fencing, hauling water etc. During the research pupils from several
schools were found working in fields weeding. These pupils were sometimes working
in fields allocated to teachers, and sometimes were hired out to local men able to pay
the teachers for the pupils' labour. One brother of a senior teacher (a TAC[74] tutor) had
paid the local headmaster 200 KSh[75] to have pupils weed his field. Pupils, especially
the senior pupils, resented doing this work, but refusal was not possible. A
justification given was that the money would be used for school supplies and so
would benefit the pupils indirectly – however the financial arrangements did not
appear to be transparent to the pupils!

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[72] Kenyan Certificate of Primary Education - the National Exam sat after Grade 8.
[73] Nation Thursday Sept 9 1999 report.
[74] Teachers Advisory Centres. Senior staff were to promote good practice through providing advice and
examples of good practice from a non managerial perspective.
[75] This was thought to be less than a third of what local adult labour charges for weeding the field
would be.

In the location, there is one boys' secondary school at Tonga, run by the Catholic Mission and has a good reputation and high enrollment; and a mixed secondary school at God Bura of low quality and enrolment. A girls' secondary school had also very recently been opened in the neighbouring location, again by the Catholic church. All charge fees – only a very few "government" schools in Kenya provide free secondary education. Fees are set by individual schools. Parents thought 8,000 KSh for a day pupil and 20,000 KSh for a boarder to be average fees in south Nyanza – few students would be able to afford to travel further for an education.

As in other parts of Luoland, education is highly prized. Senior educated men spoke of their own struggles to gain education – walking across Gwassi Hills on a daily basis to finish a secondary education etc. Teachers are a respected group within Gwassi – both the incoming teachers who work in the local schools and educated Gwassi men who teach outside the location. As in Britain, teachers themselves complained that they are not valued as before - especially in the remuneration they now receive. In the past ten years, the number of female teachers has increased and almost all primary schools now have one female teacher. There are even a few female head teachers.

Male migrants who had successful urban jobs were still looked to for assistance with school fees for the new rural generation. As Francis (2000, Ch 6 and 7) points out, the fall in most salary scales for government jobs means that urban dwellers are themselves struggling to keep up their lifestyles and support their own children through schooling. The First Report on Poverty in Kenya Volume 2 (Central Bureau of Statistics, 1998) also points out that a third of urban poor in 1998 are secondary school leavers, dramatically illustrating how education can no longer prevent poverty. But fathers, uncles, aunts, brothers, sisters and cousins did still contribute to fees for their rural relatives. But in many rural families it was only a firstborn or otherwise favoured child who would complete secondary schooling now, with a bias in favour of sons (Lloyd and Blanc, 1996). Even fees for one child are usually provided though various contributions from a selection of relatives (Montgomery and Lloyd, 1999).

Families attempt to continue education for their children, and children themselves will try to raise cash for school demands for money through small scale trading (selling lemons, tomatoes, tailapia, *sukumaweki*), or head-loading *omena*, firewood. But as mentioned earlier, girls are pulled out of school earlier than boys. Odour-Noah and Thomas-Slayter report one man (from a nearby Luo area) saying: "If I had money, I would rather educate one and leave five home to starve" (1995, p 179). This can be expected to have a distinct bias in favour of sons. This is also a male perspective on education – since men are not primarily responsible for feeding his children he can make this statement! Women however in Gwassi were reporting that husbands are more unable / unwilling to even support the low levels of fees required for primary schooling – and leave women to provide the 10 or 20 KSh asked by pupils of their family each week[76]. These payments can be for anything from sports day to kerosene for evening prep lamps. As reported above, drop-out rates by standard 7/ 8 are around 80%, which shows how the economic and labour necessity to remove children from school remains dominant, despite claims for valuing the education route. Among teachers working in fishing communities, complaints about the ambivalence of the fishermen to supporting education appeared to be gaining ground, with reports of many men not contributing to fees in any regular way, despite cash in their pockets.

Families in Gwassi were acutely aware how the standard of education required to guarantee access to lucrative urban jobs had been rising over the years. No longer could a secondary education alone lead to a well paid government or permanent job. They still supported the idea of education – but the returns were seen to be much more risky, and certainly not guaranteed as they had been in the 1960s and possibly the 1970s. This agrees with Francis (2000, Ch 6) and the responses given about expected returns on education in a Luo area near the main Kisii to Kisumu road. Despite the high risk, families and pupils in Gwassi still dreamt of salaried and pensioned government jobs, or in recently privatised banking, telecommunications or even as a teacher in a *harambee* secondary school – and some still do succeed. In a family I stayed with, a son had completed police training and was now posted to Mombassa after struggling through a mediocre secondary schooling.

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[76] This agrees with Lloyd and Blanc (1996) that if the household head is a woman (not just the mother) this is to the child's advantage in enrolling and completing.

School fees at government primary schools are a very political issue at present – with President Moi publicly abolishing them. But they are then reintroduced locally due to schools ceasing many central activities including supply of teachers or books, and local issues around kerosene for students to undertake prep communally in the evening around pressure lamps etc. The local imperative appeared to often overrule the central decree.

But many poor families had a large proportion of their cash income disappearing into school "fees", even for primary schooling which is officially provided by the State. This limited the cash available for other life necessities, including clothes, food and home and agricultural improvements. Decisions about expenditures, including school fees, often meant very basic choices for women, including health care expenses. Health issues are discussed in the following chapters, including the costs involved and which parent is expected to meet them.

Concluding remarks

This description of Gwassi has conveyed a sense of a rural location with very poor infrastructure, limiting trade and economic opportunities for the population. The lack of cash crops and the relatively sufficient land has allowed the traditional division of labour in agriculture to remain intact. Male opportunities in the fishing industry, coupled with Luo enthusiasm for male formal education and urban advancement, have possibly contributed to this maintenance. However this has left women in a "remainder" or residual category. Women remain central in subsistence farming, and receive no assistance in this sphere. As pointed out by Obbo in 1980 in Uganda, the introduction of *posho mills* and ploughing with oxen had reduced Luo women's drudgery – which had enabled women to trade, rest or allow daughters to attend school. Since this development over 40 years previously, no additional positive developments have occurred for rural women. Although with sufficient land they can with good rains maintain a basic survival level for their families, the encroaching needs for cash are now being displaced onto women without any preparation at either policy or practice level. The income earning opportunities for individuals however remains extremely limited, and attempts to promote Women's Groups have floundered again due to the poor infrastructure to transport goods to markets. This is

in contrast to the income opportunities available to men, in particular in the fishing industry. Development ignores women by refusing to look inside the family at the position of women. Men's privilege is never questioned, and policy makers are unwilling to confront gender imbalances (Smyth, 1999). Women are assumed to be able to rear and nurture their children plus tend the sick and elderly without much assistance. Men remain "independent" from the day-to-day welfare of others (Pateman, 1988). How this situation impinges on, and is reproduced through, health policy and practice is incorporated in the following chapters.

Chapter 6   Health facilities in Gwassi

Introduction

This chapter builds on the description of Gwassi location and the limitations it experiences in many aspects of development and infrastructure, including health structures. Comparative data is presented illustrating the poor indicators for the location, extending up into district and provincial levels. The chapter then illustrates the extent of the challenges facing health care providers in Gwassi. It focuses on the health services as planned and delivered, and relatedly on the staff functioning from the fixed facilities. Subsequent chapters reflect on the needs of the community and how individuals perceive and use the available services.

From an organisational perspective, this chapter is therefore designed to present the management perspective, the planned or official view, placing the health centre and related staff and their practices and needs at the centre of the analysis, with patients and others occupying only peripheral roles. Subsequent chapters reverse this, placing the community (i.e. both users and potential users) at the centre. See Chapter Two for elucidation of the organisational issues at stake.

Health services

Before discussing in detail the health services provided in Gwassi, a brief background is provided concerning the situation of the contemporary health sector in Kenya. As stated in the previous chapter, the economic crisis of the 1980s led to a huge downturn in funding for all public sector activities, coupled with cost sharing initiatives being introduced. In the health sector this meant the introduction of user fees, initially without a robust system of waivers for poor clients. This led to a crisis in the health sector across Kenya for both providers and users of services. Investment disappeared and user fees failed to generate sufficient income for running costs except in more affluent - usually urban - areas. In 1993 the World Bank published the World Development Report: Investing in Health. This reversed the previous neglect of the health sector in developing countries, highlighted the need to increase expenditure in

health, and prioritise health interventions to improve health and hence productive output.

Kenya's response to its ongoing crisis in health service provision, deteriorating health indicators, and to this influential World Bank report has been to move from "provision" of health care to "promotion" of health services. Shortly after the publication of the World Bank report, the Government of Kenya defined the goal of the health sector as:

> To promote and improve the health status of all Kenyans through the deliberate restructuring of the health sector to make all health services more effective, accessible and affordable.

Kenya Health Policy Framework Paper, 1994 - 2010, Ministry of Health, 1994.

The role of the Ministry of Health has moved from one of service provision to one of policy formulation, regulation and general support. Major reforms will be required within the Ministry at central, Provincial and District levels to fully achieve this, but change is only just starting to be implemented at District (provider) level.

To operationalise the Policy Framework, a National Health Sector Strategy Plan (NHSSP) for 1999-2004 was drawn up. This framework defined six priority interventions:

> HIV / AIDS / TB
> Malaria
> Reproductive Health
> Integrated Management of Childhood Illnesses (IMCI)
> Expanded Programme of Immunisation (EPI)
> Environment Related Communicable Diseases.

(Ministry of Health, 1994)

According to the framework, these interventions are to be given priority in resource allocation, and are to include preventative as well as curative services. But as noted in the framework document, previous policies advocating prevention and promotion "are yet to be translated into concrete action" (1994, p 22). Such measures continue to receive only 20% of the recurrent expenditure budget. It is recognised that Primary Health Care services from all providers still "will need to be integrated, intensified and expanded" (1994, p22) to meet the needs of all Kenyans and to deliver services of sufficient quantity and quality in the six priority intervention areas.

In addition to this major reorientation of the Ministry's planning functions, the NHSSP also adopted a decentralisation strategy for delivery of actual services in line with the ministry goal given above. In the implementation of decentralisation planning, process lessons were to be learnt from earlier District Focused Referral Development of the 1980s. To prevent the development of "wish lists", district planning is to take into account both health needs and available resources. The new District Planning Format has only recently been developed and is being implemented in an initial 17 districts in the 2001/2 financial year (Kamigwi, 2001). Suba District was not in this initial phase.

Further detail of Kenya's central health policy is not elaborated here, not least because at the local level in Gwassi, little of the detail has reached health staff or community members. This is due to the historical reliance on Mission health care in the location, as well as very limited supervisory visits from District to local level. The DMO had not visited the government clinic in Kisegi in over two years, and no one from the Diocese Health Offices had visited their facilities in Tonga or Nyandiwa in over three years.

Health Statistics

Some population statistics were introduced in the previous chapter which reflect general health and well-being in Kenya and Nyanza. They show that health statistics for South Nyanza remain among the lowest in Kenya. DHS data shows U5M[77] had increased over the past decade to 112 / 1000 live births in Kenya and 199 / 1000 in Nyanza (NCPD 1998). In Kamwango (a location near Gwassi), Oduor-Noah and Thomas-Slayter in 1995 reported mothers losing 25-33% of children (1995, p 185). Their table given though shows 52% of children had died of measles, 26% from malaria, 9% "birth related" – leaving only 10% from diarrhoea and 3% from "anaemia, kwashiokor, other". Their analysis states that this (U5M rate) was due to "lack of potable and safe water, inadequate environmental sanitation, insufficient protection through inoculations and malnutrition", but the statistics provided in their table do not justify the ordering of the reasons in this text. From the 20 couples

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[77] Under Five Year Mortality.

interviewed in Gwassi who had a living child under one year, the women reported a total of 90 live births but 24 of these children had died (over 26%). Neither Oduor-Noah and Thomas Slayter's nor the Gwassi statistics specifically control for perinatal and neonatal loss. They do however confirm the poor and deteriorating situation in more rural areas, even worse than the provincial level data.

DHS 1998 data also showed that children in Nyanza have similar or slightly raised incidence of reported ARI, diarrhoea and fever, plus similar health seeking behaviour of parents for their children compared to children across Kenya. But far fewer children in Nyanza receive immunisations. EPI rates have fallen across Kenya since 1993, down from 79% to 65% of children completing the full schedule, and in Nyanza this had fallen to 49%[78]. In Kenya as a whole, child malnutrition data indicates that many children are malnourished (stunted, wasted or low weight for age). Most children are well nourished in their first six months, and continue to be reasonably well nourished until the end of their first year of life. But then all indicators (HFA, WFH and WFA[79]) decline.

Table 6.1: Indicators for child malnutrition at specific ages under 5 years

National	HFA		WFH		WFA	
	-3SD[80]	-2SD	-3SD	-2SD	-3SD	-2SD
Under 6 months	0.8	7.1	1.3	5.2	0.4	2.3
12-23 months	17.5	41.8	1.6	9.1	7.2	26.9
36-47 months	15.3	35.6	1.8	4.9	3.3	23.8
48-59 months	14.7	38.0	0.8	4.0	4.0	22.7

Source: DHS Data, 1998

Boys and girls are found to have similar levels of all nutrition indicators. In the Fifth Nutritional Survey (1996), girls were found to be slightly better nourished than the boys across all three indicators. It is commonly worse for higher birth order children. Also, larger families are found not to influence malnutrition data except for a slight increase in malnutrition with larger households (over seven persons), however this only holds true for WFA and not HFA or WFH which show different trends (Fifth Nutritional Survey, 1996, Appendix B). DHS data suggests that Nyanza data is not

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[78] Although 93% had BCG, 1st DPT and 1st polio.
[79] HFA = Height for Age; WFH = Weight for Height; WFA = Weight for Age.
[80] -3SD (and -2SD) means minus three (or two) standard deviations from the mean. This is the standard way to define severely and moderately malnourished children following a nutrition survey.

widely different from national statistics for malnutrition. The Fifth Nutritional Survey has data analysed at Homa Bay and Migori District level – which show both Districts were poor according to Nyanza Provincial levels.

Table 6.2:

Provincial and district data locating Gwassi nationally for child malnutrition

0-5 years	HFA		WFH		WFA	
	-3SD	-2SD	-3SD	-2SD	-3SD	-2SD
Central Province	10.5	28.7	1.6	4.9	2.4	13.9
Western Province	17.0	37.0	1.5	8.0	7.3	26.3
Nyanza Province	15.5	36.4	1.6	5.5	6.3	20.0
Homa Bay District	20.2	41.6	4.8	6.0	6.0	19.1
Migori District	21.1	44.8	0.0	6.1	13.2	29.9

Source: UNICEF Fifth Nutritional Survey, 1996

In addition, the UNICEF survey (1996) finds that stunting (HFA) is linked to high levels of morbidity, especially fever / malaria. Malnourished children are more vulnerable: "a malnourished child is likely to fall ill and a sick child to become malnourished" (p 52). Other factors which they found to be positively associated with malnourished children are lack of clean water and sanitation. Also higher levels of education decrease malnutrition, especially stunting.

Table 6.3:   National data comparing mothers' educational levels with child malnutrition (5 yrs)

Mothers education	HFA	
	-3SD	-2SD
None	21.4	46.4
Primary education (some)	16.4	39.7
Primary completed	11.3	31.5
Secondary education (some)	5.0	19.2

Source: DHS. National Council for Population and Development, 1998

This data is at national level. It should be remembered that in Gwassi today girls as well as boys are receiving some primary education. But education itself can also be a proxy for other poverty indicators, and children who do not go to school are not the same as children who do attend school – who become the mothers in surveys such as this (Montgomery and Lloyd, 1999; Thomas, 1999).

Breast feeding in Nyanza is slightly above national trends; in Nyanza Province as a whole 98% of mothers commence breast feeding, and 92% are still feeding babies more than six times per day at six months, and continue for a mean of 20 months (DHS, 1998). A UNICEF nutrition survey (1996) found that Nyanza Province had the longest duration for exclusive breast feeding in Kenya at 3.1 months, with the Districts Homa Bay and Migori even higher at 4.0 and 3.6 months respectively. The prolonged length of breast feeding must be balanced against mothers' own health. Maternal characteristics in Nyanza Province as a whole are good compared to Kenya. But also in interpreting such figures, note that they include other Districts with different ethnic groups, i.e. Guissi women who are on average shorter and smaller than Luo women. No surveys are commonly conducted which show incidence of anaemia or other nutritional status of the mothers. Although hookworm and malaria are both common in Gwassi, and repeated pregnancy can all increase anaemia. No women are circumcised in Luo communities[81], and only a very few men.

Table 6.4: Maternal characteristics at national and Nyanza Provincial levels.

Maternal characteristics	Height		BMI	
	mean	%<145 cm	mean	%<18.5
Nyanza	161.4	1.1	21.5	11.3
Kenya	160.0	1.1	21.9	11.9

DHS data - National Council for Population and Development, 1998

HIV infections in South Nyanza are unfortunately amongst the highest in Kenya, which has an overall rate of 14% in 1998. The District Medical Officer in Mbita reported infection rates at the end of 1999 as 47% and the Medical Coordinator for Homa Bay Diocese in Homa Bay as 40%. Neither could clarify either the source or the denominator for these results. But the consensus among the local staff was that it was high and rising. The sex ratio was also reported as equal. Data from the World Bank suggests that Kisumu does indeed have the highest infection rates among pregnant women in urban areas: 34.9% compared to 16.3% in Kisii and 15.5% in Nairobi in 1997. For 1995 the figures were Kisumu – 25.3%, Kisii – 4.3%, Nairobi 24% (World Bank Epidemiological Fact Sheet, 1998), illustrating a rapid increase in

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[81] This compares with over 90% of mothers and daughters in nearby Guissi communities (DHS 1998).

HIV infections in the provincial towns near Gwassi. In addition, it is now clear that women are infected at much younger ages than men. Data from Nyanza shows 23% of young women aged 15-24 are infected compared to 3.5% of young men in this age group, and in 20-24 year old age group, 38% for women and 13% for men (US Census Bureau, 2000, p 3). This results in an overall higher infection rate among women – 30% for women against 20% for men (UNAIDS, 1999).

But in Homa Bay and Suba Districts, the level of knowledge about the disease, its transmission, symptomatic treatments etc among both the general population and also the health staff, was found to be very low. Surveys from Kenya and Tanzania now show that there are serious gaps in coverage of knowledge across the population and also misconceptions about HIV and AIDS among the youth (UNAIDS/WHO, 2001, p 15). Projects to improve information and knowledge about the disease appeared to have by-passed Gwassi and other inaccessible and remote rural locations. There was only limited assistance, including updating knowledge and appropriate responses, reaching health staff in the remote health facilities by early 2000. This is discussed at more length in Chapter Seven.

The poor infrastructure, including transport and communications, ensures any professional staff are relatively isolated - few supervision visits occur within the location, and invitations to attend meetings seriously disrupt work schedules due to the prolonged journey times to reach any site allocated. Even regular scheduled meetings for government staff or councillors can require personal effort and cost to access such meetings. So access to information within Gwassi is limited and individuals often gather information at their own expense. The situation in Gwassi reflects the overall situation in South Nyanza District – which had covered Suba District prior to 1994 and is shown in the following table.

Table 6.5:

Access to health facilities by distance – Old District boundary level data

% distribution of households by 2 km distance to health facility	GOK Hospital	GOK H/ centre	Private Hospital	Private Dispensary
	0.1	5.0	3.7	9.1

Ministry of Planning and National Development, 1990. Table 7.5

These issues, and others relevant to health raised in the previous chapter will be drawn on in the discussion of the research findings in the following chapters.

This chapter continues with a description of the fixed facilities and then explore other delivery issues found in the location through the research. As explained in Appendix 1, the research methods included interviews with the local women and men, staff and CHWs; visits to see staff at work in health centres and dispensaries; visits to various preventative clinics and other preventative health activities in the community. As discussed earlier, the community - the receivers of the health service - remain at the focus of the research. However, to assist the reader, a description of the facilities is given first to assist with the reader's image of the area and services available to the community and especially to women. And local women exercising their agency are also highly influenced by resources (health facilities and staff) available to them (Kabeer 1999). But as described below, the staff characteristics are more important than the physical facilities in influencing where individuals seek health care.

Health Services in Gwassi - Fixed facilities

Health services are a mixture of government and mission provision.

Government:

At Kisegi in the north of the location there is a health centre, a large structure completed in the early 90s. It remains a shell, with only one room used and having only two permanent, well qualified KEN[82] male staff (who rotate their time in the health centre – each effectively working two weeks on, two weeks off). Since the road no longer reaches Kisegi this area is now considered a real backwater. It takes one whole day to travel to and from Sindo by boat to collect vaccines and supplies. To collect their drug kits they have another day of travel on up to Mbita to the District centre. Nurses have to collect these themselves, and complain they do not receive a travel allowance. Attendance at this centre is low (less than five patients per day in the months prior to the research). In the 1990s government facilities introduced "cost-sharing" for drugs and consumables. Nurses remain paid by the Ministry of Health. They receive some retraining and updating opportunities, commensurate with their responsibilities, and centrally agreed courses. They are subject to supervision and

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[82] Kenyan Enrolled Nurse.

support from the District health offices in Mbita. However no senior staff from Mbita had visited in the previous two years, according to one staff member in Kisegi.

In Magunga there is a government Health Centre with four experienced KEN nurses and four nurse assistants and a laboratory technician. The Health Centre has in-patient facilities that are used, but without either a resident or visiting doctor for any additional treatment, the patient must be transported out to Homa Bay hospital. From the lake shore few patients visited Magunga HC due to the lack of direct *matatus* and it is too far to walk when sick, or to carry someone. Magunga runs three mobile clinics (antenatal and child health and EPI) per month including the CRS one in Gwassi. Magunga Health Centre is reported to be utilised at the rate of 15 patients per day, plus some in-patients.

Diocesan:

Homa Bay Diocese runs a health centre at Tonga built in the 1970's, staffed at present by one nun who is both KRN and KRM[83]. She is free to employ four nurse aides trained at Ombo Hospital, Migori (also run through the Diocese Health Board). Tonga Health Centre has always charged for consultations and drugs. The receipts must cover both salaries for the nurse aides, drugs and consumables. Attendances are approx 10/ day plus 6/ day for MCH clinic activities. The sister also has a vehicle that she controls for collecting drugs and vaccines and transporting sick patients to hospitals outside the location.

The Diocese has also in the past three years re-opened a dispensary at Nyandiwa. This is staffed by a KEN nurse and a nurse aide only, and has at least 10 patients/ day. They also have to raise the money through fees to cover their salaries as well as drugs and consumables. They must also pay to travel out to purchase drugs in Homa Bay or Migori. They irregularly ran MCH clinics, for which vaccines were collected on an *ad hoc* basis from Magunga Health Centre.

At the Scout Centre in Nyandiwa, which is supported by Italian Scouts, a room is made available to a CMO[84] to run a clinic. The CMO was not present during all my time in Nyandiwa, and left a Tanzanian nurse (TEN) to run the clinic. This nurse had

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[83] Kenyan Registered Nurse and Kenyan Registered Midwife.
[84] Clinical Medical Officer

few patients and was relying on fees charged to both pay his salary, his boss and replenish his limited drug stock. The Italian Scouts had also recently built a new structure up at Kisaku at the top of Gwassi Hills to serve the growing community living up there. This was where the CMO was reported now to be living, but he was never met, although another male KEN nurse was working here with the same arrangement as the KEN met in Nyandiwa Scout Centre. It was unclear whether these two clinics supported by the Italian Scouts were private enterprises or under the auspices of the Diocese. They were not gazetted and the Diocesan Coordinator did not accept any responsibility for them.

Present levels of utilisation

The fixed facilities - government, private and Diocesan - across the location are reasonably well distributed geographically for the 48,000 population (1999 census data). Nine qualified staff (CMOs, nurses and midwives) and nine support staff (nurse aides or equivalent) staff the facilities between them. They are also assisted to varying degrees by community health workers (CHWs) especially for clinic activities, such as clerking attendees and weighing babies.

All facilities at present were found to be underutilised. The patient numbers were very low both for preventative clinics and also curative treatment. At the government services at Kisegi HC the nurse-in-charge suggested that the average attendance was probably around 50 OPD / month, immunisations of 30 / month and in-patients of less than 5 / week. From the HC records appraised, this appeared to be a generous average – in April and now May the figures were much lower – only 30 OPD / month and no immunisations as there had been no gas. If the HC were open five days per week, the stated number would only result in around two out-patients per day. There are potentially two trained staff and one untrained nurse-aide plus a cleaner at Kisegi HC, although as stated above, usually only one nurse is present at a time. Since this HC is in a busy fishing centre, with the Chief of the location also living near, and no facilities within a two hour walk this is a surprisingly low utilisation. There are three wards, delivery suite, a laboratory and extensive consultation rooms and verandah space. The nurse stated that the women usually delivered at home, and he had not attended any difficult deliveries. There was also a fridge for vaccines, but no gas or vaccines for three months. The women living near to this health centre complained that the drugs regularly ran out before the end of the month, resulting in poor

attendance at the end of the month. In addition, there are two staff accommodation blocks on the site.

At the private clinic at the Scout Centre the attendances fluctuated over the year, but were rarely more than 35 consultations / week. The nurse here needed to keep attendance high, as his salary was directly related to fees received, and frequently complained to me that the numbers of patients were not enough. He had no assistance on a daily or weekly basis, although he thought he would get holiday cover from staff at another clinic also under the Scout Centre. But his attendance to this clinic was regular over the months. His wife ran a *duka*[85] in the nearby centre, which included some medicines. There were some drugs erratically available at the clinic, but most patients would also have to buy more. Occasionally there were in-patients, who stayed on the floor in another room in the same block at the Scout Centre. The woman who ran the Scout Centre could provide basic bedding in an emergency – when relatives could not bring some from home.

At Nyandiwa Dispensary, which was only half a kilometre from this private clinic, attendance was higher and seemed to rise over the year. At this dispensary there was a trained nurse / midwife and an experienced nurse-aide. They had recently attempted to hold monthly immunisation / AN clinics (50+ attendances) and this attracted both more custom and helped to publicise the clinic through the Catholic Church. The OPD attendance was around 20+ / day. In addition, there were frequently more than two in-patients overnight, which resulted in overspill into another house, as there are only two beds at the dispensary. The dispensary was affiliated to the Diocese, although no-one from the offices in Homa Bay has visited since it had re-opened three years previously. The local community loosely managed it through a committee, which meant supervising the income and expenditure on a monthly basis, and ensuring that the nurse and the nurse-aide were paid monthly from the fees, and that drugs and other consumables were purchased with the remainder. The use of the nearby house for additional in-patient beds was arranged through the committee. There was no fridge in 2000, and so vaccines for the *ad hoc* AN and CH clinics are hand carried down from Magunga HC by a local man paid to do this - a five hours round trip.

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[85] Small shop.

The Health Centre at Tonga has large consulting rooms, delivery suite and 20 in-patient beds. There was a fridge, and vaccines and gas were available throughout the year. The sister in charge was a trained nurse and midwife, and she also employed four nurse-aides, a cleaner and groundsman. Attendance was around 15 / day OPD, and there was an AN/ CH clinic daily. There were few in-patients, only one or two per night during the research. Often these were women who had delivered and were resting before walking home the next morning. Sister thought that there were about 20 clinic visits / week although from the records in 2000 there seemed to be fewer. There was no longer a specific day for AN / CH clinics, but since for years these were on Tuesdays and Fridays, most women arrive on these two days still. Sister was also a nun and so supported by her congregation. She lived with two other nuns who worked in the schools and in the parish. Sister was busy raising funds to modernise the HC – an even larger new building is half-complete, although funds have now run out. The project was much larger than originally planned, and the builder ran away with 1.1 million KSh. She was struggling to find more cash to complete the project, the previous money had come from Germany in 1995. The relatively low level of utilisation though impacts directly on the salary sister was able to pay the four nurse-aides; although their salaries should be 3,000/- per month, she was usually only able to pay 2,000/- (they also received free accommodation and water on the site).

These four facilities demonstrate that the physical structures were less important than the perceived service delivered in determining which facilities the community uses. The dispensary here has fewer staff and cramped facilities but more patients than some much more extensive and well-staffed Health Centres. The church-based services were better utilised than the government services. This was clear both from the attendance figures held at the health centres and also in response to questionnaires about where women preferred to attend. This corresponds to research in Tanzania in the 1990s (Gilson et al 1994). The Tanzanian research confirmed that satisfaction is an important element of health care – which also feeds into ideas of Luo interaction with health care. In Tanzania it was also felt that problems with services were structural but also due to "interpersonal skill failings". These interpersonal skill issues will be covered in more depth later in this chapter.

Charges

The different facilities had different rationales for charging for consultation and treatment. Clinic fees - for AN and CH clinics - were more uniform across the location, and even out beyond the location to district level.

Table 7.6: Fees charged in Gwassi Location across different providers.

\ service Clinic provider	AN – 1st visit	AN visit-subsequent	CHC / Imms 1st visit	CHC / Imms subsequent visit
Tonga HC	30/-	20/-	20/-	10/-
Nyandiwa Dispensary	30/-	20/-	30/- (includes 10/- for syringe)	20/- (includes 10/- for syringe)
Kisegi HC	10/-	10/-	10/-	10/-
Scout Centre clinic	-	-	-	-
CRS – FACS project[86]	20/-	10/-	20/-	20/-

Source: Present fieldwork

For curative services there was a variation in both consultation and drug fees, according to the drugs dispensed, and will often include an additional charge for a new needle and syringe. The usual charge for a consultation was 30/- and then the government dispensary stated that they charged a fixed fee of 20/- per drug dispensed. At the diocesan facilities the charges for drugs were more related to the actual cost of the drugs dispensed. The charge can escalate, especially for STIs. Charges for multiple STI drugs could be as high as 1000 KSh at both the dispensaries and the clinics.

The charge for in-patient costs were variable, and depended on issues such as ability to pay, ability to move (home or to advanced medical care), and whether charges were being incurred for drugs and other services. One sister said she would not charge additional fees for a child, and another nurse-aide said that if the patient was being charged for IV infusion, she would not add additional charges for in-patient care to the costs.

The sister at Tonga asked for a deposit of 200/- for deliveries, the woman will have to pay more if there are complications and drugs and equipment are used. The sister at

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[86] The CRS FACS project was a child survival project operating both a village based CHW project, and a mobile clinic that came to Gwassi supposedly once per month. The sub-office was in Mbita.

Nyandiwa was also vague about actual charges for a delivery, stating that it depended on complications and drugs and supplies used, such as IVI giving sets.

At all facilities there is a limited list of charges displayed for patients, but it usually only stated charges for consultation and clinic activities; drug costs were excluded from the lists. Often women would attend with cash for only part of the costs for curative care. The nurse would then write the amount outstanding on the treatment paper, and most patients would re-appear some days later with the remainder of the costs. Men who attended clinic usually had a sufficient amount of cash on them to pay immediately for treatment.

The government health centre at Kisegi purchased drugs from the district medical offices in Mbita. Women in Kisegi reported that the drugs often "ran out" and so attendance at the clinic was often higher at the beginning rather than the end of the month. This could explain the low monthly attendance at this clinic. The staff here reported that they were not given any transport money to go and collect the drugs – which required two boats up and down the shore over a minimum of two days.

Tonga Health Centre was in a slightly better situation as the sister had use of a vehicle to go and collect drugs – although she would have had to pay petrol costs. Also, as she is from a Diocesan facility, she is free to purchase her drugs either from private pharmacies or through MEDS[87]. The sister at Tonga however said that she rarely used MEDS as she would have to order in advance, but she was never sure of her income and hence her potential purchasing power each month. The vehicle also facilitated transport of vaccines in a secure cold chain – plus ease of transport for gas cylinders. The sister had decided that it was worth driving all the way to Kisumu – especially for the discounts she was able to get there, and the much cheaper price of gas there. She was also able to stay with her congregation there. It would take a minimum of five hours to reach Kisumu.

Nyandiwa Dispensary was in the most precarious situation for supply and purchase of drugs. There was no vehicle available, and relying on *matatus* meant that it would

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[87] A collective purchasing body for all mission facilities in Kenya which gives guarantees both for price and quality on the open market through bulk orders and also additional checks on the international suppliers.

take one whole day to reach Homa Bay – the nearest town for pharmacists able to handle bulk purchase with reliable quality and prices. Once in town she would again have to pay for accommodation unless she could find a relative with whom to stay. Sister complained that when she had asked the health committee to undertake the purchasing for her, they wasted money on accommodation or transport costs. Other problems would be that often essential drugs were not purchased, as the committee member would either be unable to make decisions on generic substitutions from the list given; or drugs would be removed from the list due to questions of meeting other travel costs, or due to arguments with the shopkeeper over drug prices compared to previous prices charged. This resulted in either the nurse or nurse-aide still travelling over two days to purchase drugs, or small orders placed with "friends" travelling out for a day. This lack of transport also contributed to the lack of vaccines and gas at this dispensary. There was no coordination between the different facilities for drug or gas purchase and vaccine transport.

There was also no coordination between services across the facilities and fees charged. The most glaring example was from Tonga Dispensary and the CHW programme at Kimange organised under the CRS FACS project. The CHWs at Kimange had been encouraged by CRS to "sell" the AN cards to women to encourage the women to attend AN clinics. The CHWs would try and charge 20/- for these. This is the same as the charge for the "1st visit" to AN clinic – and would include the cost of the card. The sister at Tonga found women attending her AN clinic but with a card purchased from the CHWs. She would then find the women refusing to pay the "1st visit" charge at Tonga, as they already had the physical card.

One male CHW described how he was paid thus:
We are issued with cards which we change into money.

And another Kimange CHW was also clear that items, including AN cards, were for sale to create a cash income:
Issued with items – nets, cards, drugs to sell. Money received from this - we share.

Sister from Tonga felt that the CHW programme was trying to "steal" clients from her, and was scathing about their efforts in the community, as they were working for their own commercial gain, not for the benefit of Tonga Health Centre. Charging for

the card (which comes at almost free cost to clinics) has become in Kenya a valid method for raising money to subsidise salaries and other services in government and mission facilities. Sister felt that the hospitality she had shown to senior CRS staff who had stayed in her accommodation when they had initially assessed the area had been betrayed. This "capture" of clients by facility is discussed again later in the chapter.

A WHO vehicle unexpectedly arrived at Nyandiwa Dispensary one day with STI drugs, registers, needles and syringes under a WHO STI / HIV programme[88]. The nurse-in-charge accepted the drugs and registers and incorporated them into her regular stock. She continued to charge clients as before. The market prices of the drugs, plus the need for large doses or longer courses of treatment justified this charging. It was certainly a fair strategy for the diocesan clinics, which usually had to raise costs to replace drugs for future use. Also most patients attending knew the cost of drugs – both wholesale and retail - and so were prepared to pay the cost.

Staff perceptions of working conditions

Although staff at all facilities had some serious gripes and moans about their working conditions, none suggested that they should abandon their position altogether. The main problems that they expressed were about their isolation – both personally and professionally. The lack of transport meant that they had to deal with serious emergencies on their own, and it was difficult to transport patients to advanced medical help when required - leaving them to cope for hours or days on their own. The physical isolation also meant that staff often went without supplies – drugs and vaccines were often found to be absent due to problems of transport of the volume of goods themselves or the gas for refrigeration, and the cost of transport. There were also problems of access to information – the few letters informing them of professional meetings arrived too late, and even information about their own families arrived after the event. One nurse relied on professional information from her husband (also a nurse) working in Migori town.

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[88] This occurred 2 weeks after my visit to the Diocesan offices in Homa Day and the DMO in Mbita and was clearly influenced by my visit to these managers and discussions about the services functioning in Gwassi.

Coping with the professional and personal isolation was particularly admirable in the two diocesan facilities. At Tonga Health Centre, the midwife tried very hard not to turn away any patients, and managed to conduct difficult deliveries on her own without any additional trained staff assisting her. She included breech deliveries as normal deliveries, and said that she only had to refer out of the location for *"transverse lie, hand presentations and placenta praevia"*.

And at Nyandiwa Dispensary the nurse-in-charge had not had any prolonged holidays for three years, since the local health committee had not paid for any trained staff to replace her. So she felt she could only take long weekends off, as:
My assistant is not trained, so when I am not here I worry what problems she may be seeing[89].

Both of these trained staff always turned out at night if patients came to seek assistance in the night. Although the need to work at night and the weekend was a major complaint with all staff, no reports were ever received of a staff member not coming to see the patient at night – even if treatment is left until the morning, when it is light. Sister at Nyandiwa did see the disadvantage of "always being on call".

The person remaining here is like in a jail. You cannot move, even on a Sunday. I tried to close (on Sundays) but I was told I was harsh. They can come and look for you.

At the government clinic in Kisegi, the low workload and the isolation had meant that the two trained members of staff had adopted a different approach. The men had divided the month between them, and so worked a fortnight on, fortnight off arrangement. Both nurses came from Mufangano Island and so it took two days travel in both directions to reach home.

The difference between the government and diocesan staff responses to the isolation and lack of professional support is perhaps due to their reliance on fees received to create an income. For the staff at the diocesan and private facilities this is more important, as income is required to pay their own and other staff salaries, as well as buy drugs and other consumables, and even pay *matatu* fares out to town and the

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[89] Within a week I was called at night to assist in the delivery of a hydatid mole.

pharmacy suppliers. At government facilities, at least the trained staff salaries are paid directly, however many patients are seen. Drug supply at government facilities now does depend on "cost sharing" and so cash has to be remitted for a full re-supply.

The need to create an income and drug re-supply system appears to have impacted on the facilities and their staff. The staff and their motivation were much more important than the physical facilities, or even ease of access (distance) in determining the number of patients using the facility. This then was translated into cash for drug re-supply, and for the diocesan and private facilities, salaries. Service delivery standards were important considerations for the community, but at the level of interpersonal skills than professional competence issues. Knowledge about the facility, the staff presence (or not) and the level of drugs were all common knowledge around the location, by men and women alike. But as discussed in the following section, it was difficult to get objective statements from members of the community about their preferences and the reasons for using certain facilities more than others, or even using them at all. The old adage "actions speak louder than words" certainly rang true here.

Requests for health services: more of the same

Both health staff and members of the community believed that more health services were required. This was discussed both in terms of access and need. It should be emphasised that I was not interested in discussing *more* health services (see following section on low levels of utilisation of present facilities). But this issue was spontaneously raised by health staff, senior members of the community to whom I had to introduce myself, as well as many of the interviewees in the discussions that followed the interviews. For example, a councillor from a *dala* in the hills expressed this in terms of access for his local community. This clinic he perceived as an autonomous structure staffed by a full-time nurse. This he felt would improve access to health care for the families who presently lived over one hour's walk from any other formal health care facilities.

An alternative voice is from a woman - again living at least one hour from any of the present facilities - and was involved in a project to provide CHWs in her area. She

wanted the work of the NGO[90] to extend and to erect a semi-permanent building so that the community can have a clinic there. She did not see it being staffed full-time by a nurse, but that it would be used when nurses visited from either the government or diocesan health centres nearby. She did not see her work as a CHW as a substitute for a trained nurse coming to see patients in the locality.

The woman in charge of the Scout Centre in Nyandiwa, where there is a room dedicated as a private clinic staffed by a trained nurse, thought that they needed to expand the service there. She was lobbying the Italian Scouts, with whom the Scout centre was twinned, to provide more drugs and perhaps laboratory facilities (and hence more trained staff). This woman's husband, on return from working out of the location, also thought that the centre required an expanded clinic. This was in a village with another facility, the Nyandiwa Dispensary, within ½ km of the Scout centre.

Staff working at the clinics also wished that their services were extended to include either extra staff or facilities (in two sites this meant extra in-patient facilities) so that they could deliver a wider range of services, and also to improve their own situation (such as to have time off and rotas for working at night.)

Requests for more or better health services all imagined[91] more of the same type of health service. This usually meant a small building, staffed by a trained nurse, and having a range of drugs available for purchase at low or subsidised cost. The emphasis is on a trained person and quality drugs.

No one suggested a radically different service; only sometimes an upgrade to a full hospital was expressed – perhaps to state that they would have preferred if the new diocesan hospital built down the lake at Karungu[92] had been built nearer to Gwassi. One elder from Kitawa even said to me that he would have given land to allow a hospital to be built in the vacinity if anyone had asked him for some!

This acceptance of the rural health centre model is unsurprising when for much of east Africa this has been the face of western health care to rural communities for many decades now. After reviewing PHC in Zimbabwe in the 1990s, Woelk found health

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[90] CRS – funded through USAID.
[91] This is the obverse of Oakley (1993 p 45): they *can* imagine (more) of what they already know.

care to be little more than expansion of the rural health services started in the 1950s (Woelk, 1994). In South Nyanza (as was then) there was a major drive by the diocese health services to provide PHC across South Nyanza in the 1980s and early 1990s. The bulk of resources went on preventative and curative medical services – such as clinics delivering EPI, AN and delivery care, and general treatment at fixed and mobile services. This actually met many perceived needs – as stated earlier over 50% of child mortality in South Nyanza is due to measles and over 25% to malaria (Oduor-Noah and Thomas-Slayter, 1995) – immunisation and treatment of malaria can address very real problems for mothers. And with an IMR of 130 -160/1000 live births, deaths of children less than one year old can indeed be high. These health services have since the mid-1990s broken down due to funding crises, mismanagement, corruption[93] and a change in the diocesan priorities. But in the local community, the fixed and mobile clinics that ranged throughout the location, and the PHCWs (who worked in both fixed and mobile clinics as well as community activities) were remembered as more accessible than the present services, except for in those villages where clinics are still located.

So in requesting more preventative and curative services, they are using a model of previous local services. They are referring to what they know. And as pointed out by Mosse (2001), villagers will also ask for what they think they will be able to receive. It is the real "deliverables" which people are interested in, and influence their reports and requests (Kothari 2001). And as discussed in Chapter Two, if patients are re-categorised as consumers with choice: "you cannot choose something if you do not know it exists and cannot imagine it existing" (Oakley, 1993, p 45). So the local community requests more of what it knows.

Also, several writers have commented on the Luo approach to all medicine: That they are both pragmatic and cumulative in their attitude to medical practices. They have assimilated many new ideas over the centuries, and the arrival of western medicine is simply another new system to be judged and learnt. Today, young Luo school children interviewed near to Kisumu have much informal knowledge, allowing

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[92] Over two hours away by boat or *matatu*, once a boat or *matatu* had been found.
[93] The dispensary in Nyandiwa had been closed between 1993 - 97 due to a staff member stealing drugs and selling them privately. The HC at Tonga has recently had over 1.1 million KSh stolen by the contractor building the new clinic – he has since died so it is unlikely any money will be recovered.

self-medication of both herbs and shop-bought drugs. The children were found to know both what treatment they want and what they can afford (Geisler, 2000).

Iliffe (1998) saw this Luo attitude to treatments and medicine as "free-for-all, pragmatic, eclectic and dominated by patient power". This is in sharp contrast to the European system, which is "the closed, regulated, authoritarian, medical profession". So Luo communities can be seen to wish to have medical facilities near to them, as they interact with them in an informal and collaborative way. This is more difficult if the service is far, as it does not allow return visits and discussion with the provider. Their interaction with new medicines and treatment is experimental, the system is not closed (Geisler, 2000). For Whyte (1991), this has resulted in natural "privatisation" of health care – patients will take their custom where they feel they receive the best treatment, and see shopping around for treatment as normal practice.

So the request for more health care can be seen as a request for more accessible health services, nearer to the patient and allowing maximum patient involvement. But as presented earlier in the chapter, many problems are preventable, and many health problems involve mothers and the nutrition and care of children. The requests for more clinics is reverting to the old model of rural health care discussed by Woelk (1994); it is not engaging with the national framework with its six priority intervention areas. It is also not challenging the local gender division of labour. This important, gendered aspect of health interventions will be expanded in the following chapter. Alternative health service provision (also available and tested and accepted in the community) of clean water and sanitation will also be discussed. However, expansion of such provision was never mentioned as a necessary action for health improvement. Male and female involvement in such interventions will be highlighted. This chapter continues looking at the actual service provision at the present clinic based facilities.

Interpersonal skills and service utilisation

The low level of utilisation presented earlier does not sit well with the requests for more similar facilities. As more members of the community and staff requested an increase in dispensaries or clinics in their locality, I reflected back to them about this problem: That the present health centres and dispensaries did not have enough patients to give the present staff an adequate income and even more facilities could dilute patients per facility even further. When the councillor was asked about this, he was adamant that the low patient numbers were due to corruption. And that patients would attend clinics where there was no corruption – he was specifically referring to the corruption at Nyandiwa Dispensary which has been mentioned above. He did not mention what Gilson *et al* (1994) called "interpersonal skill failings".

But several women did mention the "personality" of the caregiver. In Gwassi, there were preferred staff known to be at certain health centres who were *kind / sympathetic*, or alternatively comments on staff who were *unkind / harsh / hard*. It was reported both in the formal interviews as well as informally that women would walk an extra two hours to attend a different preferred facility. No women in the interviews said that any staff were rude or uncivil to them. Nevertheless, attendance figures suggested high preferences among users for certain staff over others. How can one reconcile the preference of different facilities / staff when no one openly criticizes staff for their performance? Although noone would criticize a present staff member for being rude, the praise for *kindness* often mirrored higher use of certain facilities. In particular, many in-patients, or mothers staying with very sick infants or children, would all express their appreciation of the *kindness* of the staff member who was treating them. This was despite the comments from the staff that this was undertaken at personal cost to themselves – working through the night, worried about the outcome, knowing they were working beyond their training or capacity, worried they would never recoup the cost of drugs and other items they were using, and so on.

The PHCWs would also refer to their own behaviour and staff with whom they had to work in such terms of kindness and harshness.
One PHCW explaining what she enjoyed about her work:

Know it (clinic work) but difficult. If kind and good, not harsh person, they like me. I am laughing. Asking (me) questions... See your behaviours; they can see you, see a good woman (in) my work in Nyandiwa. I welcome them.

Another PHCW from the same group explaining the problems she experienced with the work:

Working with (name of sister). (she is) very harsh with people. Quarrelling. So we are frightened when she is coming... Harsh even with Chief. Very difficult. She is not understanding.... People are afraid of her.

And another PHCW commenting on her experience of the supervision she received:

(name of sister) – harsh woman. (laughs) Tough woman. (Laughs and stops talking).

And from the same group, a PHCW reflects on why the community stopped attending the PHC training sessions:

Come one or two times and then they refuse to come due to (name of staff). Quarrel, went away angry. They asked questions, they should have received an answer, not quarrel but an answer.

This suggests that harsh behaviour is judged negatively within the community. But without members of the community feeling able to openly criticize such judgments are hard to elucidate. Women looking back on their experiences as PHCWs do realize that their own or their supervisor's manner and behaviour is important as to how the community received them and interacted with the work they were undertaking.

But none of the women interviewed who were attending clinics – due to pregnancy or young children – would criticize the present staff in the interviews. Clinics though had been visited, and the researcher had gained access to both AN and CH clinic by assisting and so being privy to daily practices and attitudes of staff which were not elucidated in interviews with either clients or patients.

At clinics visited, women were observed being belittled by trained and untrained staff. This was through negatively and loudly admonishing women, e.g. towards women who arrived for a "1st visit" at CH clinics with children aged over three months old; women who attended for a 1st AN clinic visit after six months duration of their pregnancy; women who returned with children still underweight; women who had not visited hospital when requested. The professional was very much "in control" of the exchange with often the woman being given no chance to give an explanation or even a reply.

In one clinic, the woman attending for the 1st time (a "1st visit") with a child aged over eight months old was actually the grandmother, her daughter having been ill and died in the previous months (when attendance had been expected by the nurse). The nurse had managed to not only verbally insult the grandmother for arriving so late for the immunisations, but had also made the woman return to the back of the queue to weigh the baby again.

At the same clinic but in the AN section, the midwife was clerking new AN attendees. One woman (G6P1) attending after 28 weeks (of this pregnancy) was being berated for arriving so late. On being questioned on leaving the clinic, it transpired that the woman had such a poor obstetric history that she had decided that paying for AN cards was a waste as she never had delivered a live birth. Her arrival was therefore a final act of faith that she would deliver a live child this pregnancy and that the clinic could assist in this positive outcome – instead her experience was again expressed in that the clinic nurse was 'cruel' and 'unhelpful'.

Certainly this confirms the findings of Gilson et al (1994) that staff attitude and interpersonal skills are very important in perceptions of patients of the costs and benefits in using certain facilities rather than others. This will then impact on use of services and hence revenues generated. The earlier quote from the sister at Nyandiwa having to open the dispensary on demand – even at night or on a Sunday to prevent the community thinking she was "*harsh*", exemplifies the pressure on staff to deliver the services as demanded by the local community. Staff who do not conform to what is expected from them can find that their patients go elsewhere. Members of the community clearly exercise their agency in deciding which facility to use and for what reasons.

Conclusion

Staff reflecting on their own behaviour were able to elucidate non-acceptable behaviour, but it was difficult as a researcher to get behind the "official view" of a nurse (or CHW - see next chapter). All knew how to perform to expected and accepted norms and initially confirmed a stereotype of the work and how they reacted to it. But if community members and staff could not vocalise what was good and bad service provision, patients clearly could and they did so by voting with their feet. This demonstrates how low immunisation rates might improve if members of local communities were able to influence their local service providers even further. But the issue was not as simple as this, as the health service had recruited an intermediate body of workers between the nursing staff and the recipients of the service: community health workers. These workers clearly mediate between the facilities and the community, but in a highly prescribed way, with the conventional organisation of the health service firmly in control. This is the subject of the following chapter.

There is a question that arises out of the evidence presented in this chapter as to whether community members are asking for more quantity or improved quality of health services; that is, services they would feel happier using, or even facilities which they felt they had more control over (for example, simply being able to find staff whenever they need them). Separating out such issues is problematic when users of the services do not criticize present poor service delivery or bad professional behaviour. Only through positive experiences (such as the seeking out *kind* staff) could issues be uncovered. This and other issues raised in this chapter provide a demonstration of what Lukes (1974) would refer to as the "two dimensional" level of power. Issues remain or are kept off the agenda. Under such circumstances community members cannot begin to voice their preferences for particular facilities and staff, and yet their behaviour clearly demonstrates that they hold preferences. A contribution of this research has been to start uncovering the power issues operative at the "three dimensional level", that is by moving beyond the individualistic approach to "points outside of the range of observable, political behaviour". The challenge has been how to capture such "non-decision" making on the part of the community in respect of health service provision.

This research has attempted to move beyond the official view through focusing on the activities which still allowed individuals to exercise and reflect upon their personal agency, thus following Foucault's attention to the peripheries, or identifying Kabeer's (2000) "middle way". This approach goes beyond what people say, to include the real lives as lived by local women, and hence to move beyond an official stance. This in turn means de-centring the health facilities and staff from the analysis and refocusing on community members and their interaction, or not with staff involved with health care delivery. In the next chapter, this is achieved through an examination of the rhetoric and reality of the CHWs' roles, and the roles of men and women in promoting health within their communities. In particular, the use of the rhetoric of empowerment is critiqued using the research findings to demonstrate the validity of this critique.

Chapter 7

Rhetoric and Ritual: Myth creation / perpetuation in Primary Health Care

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Ritual and Rhetoric: Community Health Workers

In this chapter, specific examples of health service practice are used to emphasise the dissonance between the rhetoric of Primary Health Care (PHC) and the reality of needs and of service delivery as it was observed in Gwassi location. Several components illustrating such dissonance within PHC practice are highlighted, drawing together the insights drawn from the literature reviews undertaken in earlier chapters and the situation found in Gwassi. The reality as expressed by community members, including health staff, is presented and contrasted with the rhetoric of the services provided through PHC. Finally the gaps, the myths between the rhetoric and reality are discussed at more length in the concluding chapter of the thesis.

As discussed in Chapter Two, organisational language is not consistent across authors. Here the notion of myth is understood in the sense of Meyer and Rowan (1977) that myths are non-rational logics framed as rational arguments which are allowed to stand as "everyone knows they are true" (quoted in Hatch, 1997, p 85). And they are often presented as "facts" or "true" and "uncontestable" (Petersen and Lupton, 2000 p 43), reinforced at the medical researcher / practitioner - public interface. Such myths are created and then reinforced through both rhetoric and ritual in health service policy and delivery. The myth is formed and maintained mainly through the way in which services in a rural area are provided. They are granted social legitimacy. The acceptance of the myth also forms the basis of the requests for "more of the same" which was articulated in the previous chapter.

This chapter builds on the physical description of health services in this remote rural location given in the previous chapter. PHC services delivered in Gwassi are presented through the particular use of Community Health Workers (CHWs). PHC is the main myth from which all other myths emanate – as PHC is seen as "fact" and "uncontestable". Importantly, it is accepted both by the health staff *and by members of the community*. The myth also reinforces the physical structures and paid staff, and

the rituals they perform, but in a specific gendered way, as introduced in the previous chapter and expanded on here.

The previous chapter focused on health as defined by the health service providers. The health sector was promoting certain services through the fixed facilities and trained staff. In this chapter the community activities of CHWs are discussed. This is done in an attempt to give space to the socio-economic determinants of health, which the PHC approach is meant to address. This approach also allows the situation at the peripheries to be explored, and for the possibility of uncovering issues of power and gender operating on the practice of health care delivery in a remote, rural setting. Despite CHWs having a high profile within the community, all staff and the CHWs are found to relate to a highly medicalised image of health and health care. Also, they related almost exclusively to the interventions aimed at women and children, especially those involving their presentation at clinics (antenatal and child health). Although accepting of this service, the communities also had a definition of health that went beyond these activities, and also included men. However the community was unable to influence service delivery, despite the rhetoric of PHC that sees the involvement of the local community as central. As discussed by Gestaldo (1997), the issues remain medicalised and the absent expert remains in control through defining the "limits of what is possible" (Petersen and Lupton, 2000, p 10).

From an organisational perspective this is due to the health service remaining at the centre and in control. By re-defining the organisation to place the needs of the community at the centre, the disparity between the services offered and the services sought is brought into focus. In this chapter the reality of the health needs articulated by the local community and identified in the research are discussed against what was provided and available. Another way of perceiving this is through organisational boundaries. If the organisation chooses to place certain services or interventions outside the boundaries, it can. In this research, three specific areas were identified which were placed outside the boundary by the health service, but were considered important by the community:

- Health benefits from activities locally defined as *non-health*
- FP/RH needs and actual provision
- Men's and women's involvement

The first point was defined outside the boundary of health services by both the service and the community. The second point was mainly placed outside by the health service and by some men. Finally, men's needs did not appear to be included in local service provision, nor in the way local men perceived the PHC services. Women were however fully expected to engage with the health services.

This chapter starts with a focus on the performance, the ritual of CHW services in Gwassi, and later reflects on the service as actually delivered from a gendered perspective. This gendered perspective is both from the CHWs themselves as well as the services they are delivering (or not) within the local community.

The health sector in Gwassi, spanning government, diocesan and INGO providers, has over previous years trained Community Health Workers (CHWs) to work in various roles in the community. As discussed in Chapter Three, CHWs are purported to be utilising community resources for the promotion of health within communities under the PHC rubric, but in reality the CHWs are relating to and expounding on, a very specific, technical view of health and health care. The paradigm of the western medical model of health care has remained intact, despite claims to the contrary (Lee, 1997). This research concurs with that of Walt and Rifkin (1990) and Woelk (1994) that CHW programmes are simply sub-optimal rural or remote delivery mechanisms for the medical system. Also discussed in Chapter Three was the issue of the lack of recompense for time spent as CHWs and the assumed 'elasticity' of women's time (Elson, 1995; Leslie, 1992) and how health planners ignore these issues when planning CHW programmes. As the evidence marshalled in the present chapter found, this was still the case in the new century in rural Kenya.

Community health workers in Gwassi: a gendered perspective

In Gwassi the continued training and use of CHWs during the time of the fieldwork in 1999 and 2000 was surprising considering the previous abandonment in 1996 by the diocese of previously well trained and well supported Primary Health Care Workers (PHCWs) for the delivery of PHC in Gwassi location. During the research there were three active groups of CHWs across the location in 2000. Two separate sub-groups of women, twenty in all, trained by and relating to the government Health Centre at Kisegi (here treated together as the Kisegi CHWs). One group of eight women and

four men trained by CRS (associated with the Diocese Health Board) in Kimange. And one group of five men and five women trained as Village Responsible Persons (VRPs) by the Lake Basin Development Authority in Nyakasera area. All are still active to varying degrees – two to five years after training had been completed.

The non-active group of six community health workers had previously been trained and supported by the Diocese Health Board and were called Primary Health Care Workers (PHCWs). All of this group were women. These will be referred to as the Gwassi PHCWs as they had been consciously chosen to cover across the whole location.

None of the active groups received any pay. They received some payments in kind or items which they could sell to raise some cash for themselves. The PHCWs had received an "allowance" which although small[94] had been seen as a small income which could be used to partly offset the costs incurred by working outside of the home.

Supervision and support for all the active groups was intermittent, brief and poor. The groups often were awaiting visits but did not know when or if they would occur. They were unable to initiate visits, and relied on the supervisor to plan the schedules. Knowledge of the area by senior managers was often sparse or inaccurate. Visits by senior managers had not occurred for years.

In Chapter Three the literature identified two main themes around which failure of CHW programmes has previously been grouped: i) Pay and ii) Activities. These will be discussed from a Gwassi perspective as they were clearly of importance to the CHWs in Gwassi. Here in Gwassi though, additional issues, both positive and negative, towards their work were also raised. On the positive side, knowledge was seen to be very important, which was used by the CHWs in their own lives, family and community. On the negative side, direct violence was experienced by the Kisegi CHWs, in particular due to their promotion of family planning. These issues are explored in this chapter from a gender perspective. The claims of the CHWs to address hygiene issues are also explored, due to a recent outbreak of cholera and

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[94] 400 KSh in 1992 rising to 750 KSh by 1997

hence the staff and the community's reaction to water-borne diseases. This will be contrasted with the hygiene activities of the VRPs. Additionally, the rhetoric and reality of the use of "empowerment" in the work of CHWs is interrogated from a gender perspective.

Pay / recompense for work done as CHW

In Kenya, the policy is that CHWs should be "supported" by their local community, and not by the health services themselves. Most are offered no salary after their initial training – which may include some allowances and food. In practice, many schemes are now offering "incentives" to CHWs to encourage retention. Here in Gwassi, this took the form of allowing items to be sold, i.e. ANC or CHC cards and mosquito nets. Also, in lieu of salary, many CHWs regard items which are issued to them for their work as their personal property – jerrycans, small saucepans, pickaxes etc. This was particularly true for the VRPs, who were not issued with disposable items to sell.

Since the policy is such that CHWs are not to be paid, it was difficult to ask about any payments CHWs may receive in relation to their work – an immediate response was always to state "we are not paid". But with careful probing, other sources of income from their work as CHWs can be uncovered. These were different between men and women, and so required different perceptions and probes.

The problem of uncovering loss of income, problems with home responsibilities, issues around subsistence agriculture and other issues around "pay", or the lack of it, was also difficult to uncover for women and men because women and men interpreted questions in such gender-specific ways.

Lack of salary / recompense

The following analysis of interviews reinforces this issue of lack of payments and the displacement of other subsistence or income-earning activities as significant, which was easily elucidated from the women, but not from the men. For example, one Kisegi CHW usually buys and sells fish, and it is clear how CHW work affects her family's well-being:

*When I attended CHW work, like today, my other work is stopped. So soap, paraffin,
even tea for my child is not there. I do it without pay.*

A woman's agricultural work may be difficult to complete when working as a CHW,
which again is related to food supply in the home. Again from a Kisegi CHW:

*(I am) a farmer using simple tools like jembes. So when I go for CHW work the farm
will go untended. So this is a problem as I get grains[95] from this garden. The grains
help me as I do CHW with no pay. So this is a problem.*

A hope that the community will recompense women by assisting them with their work
is also not a practical proposition as the following shows:

*During weeding I have to leave my own work (to work as CHW). I leave my shamba
with weeds and no one will weed them for me. Others who do go do nothing – so we
quarrel. If I went I would have done the weeding.*

The effects of lack of time as a CHW, resulting in non-completion of family and
domestic chores, is only discussed here as it relates to the completion of the CHW
activities. The personal sacrifices made by individual women, and how they pass on
their lack of time to their daughters and other junior female family members is a
serious issue but only noted here. However it reflects issues found in Zimbabwe by
Reynolds (1991), and Fuller and Liang (1999) in South Africa of child and especially
girl labour allowing women to "cope" with domestic and agricultural responsibilities.
Although in Gwassi some women also relied on their mothers-in-law to cope, they
mainly relied on daughters to cover for their domestic roles when working as CHWs.
Domestic responsibilities are discussed further below.

A man from Kimange working as a CHW is clearly dismissive of the "salary" he
receives from his work as a CHW, equating it with a "piece of soap". But the men did
not equate their CHW work as displacing food from the family.

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[95] In Gwassi, women grow maize, millet and finger millet. So this woman is referring to losses in any
or all of her crops here by referring to "grains".

Paid through the drugs and (mosquito) nets which we sell. Sell these and share the money. This is enough for a piece of soap.

Several other Kimange CHWs stated that they received about 800/- per month from the sale of mosquito nets and AN cards. But all suggested that this amount was too small or insufficient for their family needs.

Positive incentives

Although lack of time and lack of pay were serious disincentives, there were many spontaneous comments around positive incentives from their training and/or work. One immediate impression gained was how in over 90% of the interviews the CHWs stated how strongly they valued their training, and so continued the work. They spontaneously expressed enjoyment at receiving the training, especially the additional knowledge it had given them personally and within their family.

Now know a lot more in (the) life of human beings. I will continue for life.

(I will continue) as it is good for me.

From the Kisegi programme, no woman from this group said she would stop CHW work in the near future. Different programmes had included different areas of work, and hence training and knowledge. The Kisegi programme was the only programme to include family planning in the repertoire of knowledge and skills given to the CHWs, and these appear to have been very positively valued by the women for both personal and community reasons. Women emphasised different aspects of the work that they found most helpful in their own lives and community, as the following demonstrates. Such benefits, which for the women in Kisegi were also balanced against the lack of pay or other support mentioned above, were expressed clearly:

I will not leave this work, it is good for me. It has made me learn a lot, it has even made me widen my mind.

It is work that helps me at home. It has made me know a lot that I did not know before. I cannot leave it. It is my special, hopeful job.

It has given me a lot of knowledge for my life and in (the) life of others. I have a great difference, a deep knowledge that I can survive on my own. I know this family planning. I can do (use) this to plan my own (family). Even without pills my husband can use condoms to plan our family. Now even our relatives, my community members have deep knowledge and they can have a great difference. Therefore I will not stop this work.

Because I love it. It has made me know a lot. How to keep clean, help women give birth, vaccinate children, how to prevent babies' diseases. I cannot leave it except through death.

I love this work. It also helps me. I have a lot of friends now because of this work. I know a lot of women and we help each other. We share out minds on all sides. These ideas help me as I find ease in my house.

The Kimange programme in contrast only focused on AN and CH clinics and home preventative / hygiene activities and they all found it easier to relate their work in relation to the staff of the local health facility than any pure, stand-alone community work. The following comments on what they enjoyed about their work demonstrates:

I'm happy – (it has) made me know benefit of clinics, latrines and using drugs.

Now I know a lot more in (the) life of human beings for example clinic, latrines and keeping compound clean. I will continue for life.

In my own home a lot of improvement. Babies that used to die not now dying. All babies now immunised so now we are happy.

Unsurprisingly the group in Nyakasera involved in the water project only discussed their work in relation to water and sanitation issues. However for them and their wider community, the benefits were clearly important to them as a man and then a woman related benefits valued by their community:

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(the community are...) Happy with the work because before people went to hospital often (due to) cholera. Now cholera stopped so now good life. Water precious. Mothers looking fat and no diarrhoea at all. Children no scabies at all.

Diseases like cholera, scabies, dysentry but we are not seeing them now. Even if you bathe no scratching now and no stomach aches. This is because of the water we now have.

This woman had earlier mentioned the benefit she saw of latrines:
(I am) happy as people have built latrines after (my) teachings Now it is hard to meet faeces compared to the old days.

So despite the complaints about poor pay, supervision, and support, all CHWs and VRPs were very clear that there were specific benefits at personal, family and community levels that they gained from the knowledge they were taught as CHWs.

This contentment with increased personal knowledge is reflected in other qualitative research in Africa. Bujra (2000) reported similar motivations among Peer Education Groups in Tanzania: "I joined for self development for life" and "I thought I would get a good life", but also tempered with more material possibilities "I thought I would get something" (p 125). This desire for personal knowledge and information to improve their own lives is women desiring personal agency and empowerment, as well as a desire for real tangible improvement in their own lives, their families and the wider community - defined from a personal perspective. However, such personal use of taught knowledge is not seen as an aim of CHW programmes, even though knowledge is highly valued, and is balanced by the individual CHW against the lack of financial recompense to assist them in continuing in the role. This reflects Kabeer (1999) and the idea of "choice" incorporating resources, agency and achievements. Knowledge is clearly a resource for the CHWs.

And presently the use of CHWs is aimed more at women, specifically reinforcing gendered roles. This is discussed from the CHW viewpoint in the following section, and later in this chapter the gendered aspects of actual clinic attendance is also discussed. Other negative experiences of the CHWs are presented; in particular violence from men in the community.

Household responsibilities for CHW workers

The four groups were all predominately female – Kisegi 100%, Kimange 66%, Nyakasera 60%, Gwassi 100%. Also, a prerequisite was that CHWs were married, whether men or women – although a single man was found to be a VRP. The use of women as CHWs can be seen as using women to empathise with and talk to other women, and hence hoping that there will be empathy and understanding between the women. This parallels the early use of female sanitary inspectors, health visitors and nurses to provide the bridge between the public health physicians and the mothers in the early PH activities in 20th century Britain. The practice also assumes that women alone are responsible for childcare, home hygiene, water carriage and storage, and aspects of pregnancy and delivery (Ramirez-Valles, 1998). But this assumption allows men to both remove themselves from the responsibility of the activity itself, and from assisting in the planning and the execution of such tasks (Edwards, 1998). It can therefore be seen as reinforcing women's domestic roles, and leaving the women in a ghetto surrounded by all their domestic work (Ostergaard, 1992).

The perpetuation of gendered assumptions and practices comes about due to policy makers and practitioners unwillingness to confront cultural issues, including gender roles. By ignoring such issues in their work, it allows them to also prevent challenges to their own personal attitudes, beliefs and behaviour, power etc (Kindon, 1998). It can also be due to women defending their roles and preventing men from assisting in areas in which they have previously not assisted in the home. Sensitive research can uncover both women's as well as men's resistance to changing roles. For example, in Uganda women identified their workload – fetching firewood and water, processing millet and sorghum - as the basis of all their problems, and such problems did not feature at all in the men's groups (Debrabandere and Desmet, 1998). Although men may demonstrate ignorance of this workload borne by women in the home and farm, local attempts to assist in childcare and other activities can be spurned - Frischmuth (1998) found women laughing at a father who took his daughter to clinic.

In the interviews conducted in Gwassi, it was difficult to generate data on gender differences in the work output of CHWs, since almost all CHWs were female. This

issue is returned to in the second half of this chapter from the perspective of the community and their expectations of CHWs' interaction with men and women. Nevertheless, clear differences emerged about how the men and women trained as CHWs responded to the added workload of the CHW work through adapting their previous workload and lifestyle – see examples below. This was mainly due to the point that the men did not have the problem of meeting their home and farm responsibilities as the women did. Men took the question of "How do you manage your home when working as a CHW?" to mean either cash issues - and related it to their salary, or lack of one - or dismissed the question as meaningless[96], or included their wife in their coping mechanisms. Male CHW replies to this question included for example:

As a farmer I have grain, so (need) cash for vegetables. 800/-. This is no money. Need to add more.

(I) leave home without doing anything until I return from this work (as VRP). No food until I return.[97]

(I) budget carefully via (my) wife's management for paraffin.

One single man working in the water project at Nyakasera felt that he could improve his home situation by getting *"someone to help him"* which, as was pointed out to me, meant getting a wife. This suggests that for the men the home is to be managed by women – either a mother or a wife – the men have no immediate concerns in the way the women do about food supply or the daily feeding of children. Men never mentioned care and expenditure on their children in response to this question or to questions about "pay" and cash[98].

Women however in response to the question "How do you manage your home?" all primarily talked of the domestic arrangements they must make to feed children and husbands, or complete their agricultural activities whilst they are undertaking CHW work. Several added a comment to suggest they take extra care of their children's diet

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[96] This rendering of the question as meaningless was again reflected when asking fathers about the relevance of CHW advice to them. See later section on Hygiene and Gender.
[97] When his mother provides / prepares his meal.
[98] Questions of "pay" and cash issues were dealt with in separate questions.

on return from their CHW work. But due to the subsistence nature of much of their work, they talked less in terms of cash than the time element – doing CHW work meant less time for work in the fields, as well as trading or other income generating ventures. But their first response to the question was always the daily care and especially feeding of their family[99].

The way I leave my children – as I don't have someone (to help) and I have a small child. So I wake very early, I prepare food and leave it with the father. He gives them breakfast and lunch. Then they wait until I come back.

On waking I make a plan – on how to leave my children, especially food while I am away. There is no one to leave in charge (of the kitchen). So I prepare and then I go.

I have a young daughter who comes from school and prepares the meal after I have left everything ready.

(I) Have some daughters who are old enough. I prepare veggies and leave ready. When they come from school they look (for the food) and eat. I prepare evening meal when I come from work.

I have a young daughter. I arrange for her to feed the other children after school. She does breakfast and lunch; in the evening I make sure all eat well.

The sex of the children affects how women cope with their day away from home.

(I) Leave after preparing morning meal and come back for lunch as (I) have boys only (and) so this is difficult.

PHCWs discussed at length how they had relied on grandmothers (husbands' mothers) to assist them complete their work. However few young CHWs today discussed the involvement of grandmothers, talking instead of their reliance on daughters, as mentioned above.

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[99] The speed of the women's responses also illustrated how they did not have to think about this question – it was clearly an issue they engage with on a daily basis.

Gwassi PHCWs appreciated the support grandmothers provided them when they were working:

Grandmother did everything for me here (when I went to work). Very difficult without her. I was having my boy, she was helping – she had a small child too.

First time Grandee here. Very kind woman. Left babies with her. Now can just go. Babies now big and husband here now. Now I can go anywhere, even to the moon.

(Children) small then. I do prepare food. I wake very early and prepare breakfast. At lunchtime we do have Grandee who prepares lunch. Little children left with her.

Only one Kisegi CHW relied on a grandmother at the time of the field research:

I am still cooking in grandmother's house so when I am away she prepares food for my children. On my return I continue where she has stopped. So I don't see any problems. I am happy with it.

This "*careful planning*", including the use of other female family members, demonstrates the personal sacrifice the women (and their families) make in order to participate in the work as requested by the health service. The total elasticity of women's time (Elson, 1995) is still assumed for community initiatives, and in the health sector; questioning women's present workload is never considered. "Add women and stir" (Buvinic, 1988) remains the accepted face of addressing "gender" concerns in the health sector.

Own work / subsistence

Getting behind this official view of the complete elasticity of women's time was methodologically problematic, as the women had internalised the issue that they "did not work" to such a degree that it was very difficult to elicit their normal "work" and "workload" directly.

In response to being asked about their regular work / activities / occupation, the women found the questions difficult to understand – answering that either they "did not work" or were "housewives". This was despite early and ongoing problems in locating the entire group, as they were all working dawn to dusk in their fields or in petty trade throughout the location and were difficult to contact. The problem was that "work / activities / occupation" however translated into dhoLuo appeared to be interpreted as only paid work. In subsequent follow-up interviews with more probing into their time use patterns, their varied work and daily lives emerged: in their own and other people's fields (*shambas*), trading locally either their own vegetable produce, maize, millet and cassava or fish (especially *omena*), or a few women trading fish outside of Gwassi, brewing beer, cutting firewood and making charcoal, smoking and drying fish, headloading and even stone cutting, teaching nursery classes and raising chickens, goats and calves[100]. Several women once talking about "daily activities" finished by aggregating all their work in their home into *"everyday duties"* or *"cooking for the household"* and one included *"giving birth to babies"* as her "work".

The few men all quickly responded easily to questions about their work / activities / occupation - as bicycle repair men, preachers, farmers. They also added riders to their answers to indicate these were temporary and/or part-time roles that they were doing until "real" or paid work could be found. No men with paid work (teachers, fishermen etc) also worked as CHWs. The men had seen CHW "work" in a similar manner to other temporary work to be sampled for its income producing potential.

Heggenhougen (1987) found in the 1980s that men left CHW work when it was realised they would not be paid. However women continued, and so now women tend to be targets for schemes - as was the case in Gwassi. This assumption that the female CHWs can undertake the work at no cost to themselves or to their families is similarly reflected in the assumption that mothers can attend distant AN or CH clinics and meet all associated costs. How these costs are borne in the family is not discussed in the health model. They remain issues outside the concern of the organisation.

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[100] See discussion in Chapter Six of women's daily workloads.

Disincentives - Promoting family planning and violence to CHWs

Women in Gwassi were frequently asking for additional information and services to exercise their right to control their fertility, whilst knowing they were impinging on another group - men - and their views on fertility. The interest and priority given to family planning by the one group of CHWs who were trained and used to deliver pills and condoms to women and men in their villages, negates claims by the supervisors and managers of other groups of CHWs, that women in this community were not interested in family planning. The role of the Catholic Church (and hence prohibition on artificial FP) was very important in the diocesan facilities and was reflected in the actual delivery of health care, including RH care[101]. But issues around sub-optimal FP and RH services were also found in government health facilities.

The male nurse now in-charge of the Kisegi CHW programme saw their work as combining PHC and FP work.

...we decided to have CHWs for areas we cannot reach. There are people now as CDB[102]s that means contraceptive distributors. They are distributing as well as helping community understand primary health care where they can build preventative mottoes, reach every home to debate the culture of Africans which is now leading to so many deaths as a result of inheriting widows.

Although he has quickly moved onto HIV prevention, he saw CHWs (all women in this programme) as expected to discuss FP with the whole community – there are no men in this CHW group trained to discuss the issue with men. This is an example of women being given full responsibility for an issue that actually involves both sexes.

The CHWs themselves were clear why FP was desirable and could assist the woman herself:
Kisegi CHWs are discussing what they were trained to do:

Helping women give birth; how to take 'tabs' for family planning – some women give birth all the time, others give birth yearly, sometimes a mother may have one child at

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[101] Roughly half the population in Gwassi is not Catholic, being Seventh Day Adventist (SDA), African Inland Church, Maranatha or other sects.
[102] The correct acronym is CBD – community based distributor.

hand and another in the stomach and she has a lot of prob.lems. We are also issued with condoms to give to men.

I also issue young men with condoms to prevent gonorrhoœa, also (for them) to use to plan their families even those who do not like to use something. So this made me teach them to use knowledge of different drugs to plan their famiüly.

The Kisegi CHWs are clear how this message is not acceptted across the community. Here they are talking about what they find difficult in theirr work:

Some areas are a very long way and hilly and stony. Whem it rains it is difficult to return. There are homes where we are not welcome, claim we teach wrongly. This makes us unhappy. Others beat us, say we spoil their homœs. We are beaten and we run. We get many problems. We like this work, we want to .teach so they receive civilisation – but they don't accept us.

(problems when) Mothers do not accept FP. Even husbandls do not accept their wives to receive pills. Men don't understand to receive condoms. Those are difficulties I face.

Some husbands chase us away after claiming we have gonœ to give their wives pills so as not to give birth.

There are some homes in the village where men are angry with us as we teach their wives and give pills to stop them giving birth while still young. Some homes you are chased away. Some homes are very hilly, problem going downhill if raining.

(I am) Not pleased with some homes where we are chased lbecause we teach family planning. That's what men feel bad about and they chase uss with rungus[103].

But the health service did not acknowledge, nor assist the CHWs in facing or dealing with this violence and intimidation. The (male) nurses in charge of this CHW

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[103] *Rungu* = short thick wooden stick with knob at end.

programme[104] had not accompanied the CHWs in the community, and expected the CHWs to cope without any direct support and supervision. Again, the organisation was happy to remove itself from the reality of the socio-economic conditions facing the volunteer staff. Arguments and violence in the community were not seen as its sphere of influence. This silence is in contrast to the publicity for AN and CH clinics which were announced at Barazzas[105] and other public meetings (see next section). But the CHWs found the work accepted by members of the community and hence rewarding, together with the additional personal knowledge it gave them, and continued the work despite the severe and sometimes violent problems which they encountered.

Problems for CHWs were compounded by the limited quantity and quality of contraception offered in the location by the government services which did not answer the needs of most women. Many women appeared to access contraception privately, as the local health services did not meet their needs and choices. Injections were preferred as they were seen as more reliable than pills. Injections can also be used discretely, without a husband's knowledge. Within Kenya, Depo-Provera and more recently Norplant have soared in popularity in the past few years since it was introduced, and knowledge about it has spread even to areas which neither promote nor stock it (as in Gwassi). 1999 data shows 56 – 65% of women using modern methods are using either Depo or Norplant (Ministry of Health 1999). Women from Gwassi would either visit private or NGO clinics in Migori, Homa Bay or Kisii – with associated travel costs over 100/- in each direction – to obtain Depo-Provera. Another way of obtaining Depo was for one woman to go and buy several vials (and needles and syringes) for her friends also. The women would then ask anyone they knew with experience in injections to administer the drug once it arrived at their home[106].

The demand by women for all family planning services appeared to outstrip any supply in the district. And the idea of choice was not addressed at all by the services delivered within the location. Permanent methods of contraception could also follow in conversation about health of children, their own health or general discussions around HIV. Women would freely talk about having had an "operation" in Kisumu or

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[104] The other CHW programme did not include contraceptives, as it was organised through Catholic Church, as were the health centre at Tonga, and Nyandiwa Dispensary.
[105] Chiefs' meetings.

Nakuru. In particular, women who had been widowed and are now remarried appeared to access permanent methods very frequently.

Pills and condoms (and Natural Family Planning) did not address all the contraceptive preferences for all women in Gwassi, and yet the health service did not attempt to increase this limited provision. It continued to believe that this was adequate for the people of Gwassi. Again the health service was reproducing its own organisational model as the adequate service provision and not interacting with the reality of demand. If the supervisors of the CHWs providing pills and condoms had asked the CHWs of the demand, and problems they were directly experiencing with the promotion of contraception, they would have had immediate access to a wealth of information both about the unmet demand within the community and the constraints of the present delivery system.

Lack of Organisational support for CHWs

The issue of Family Planning which is squarely in the Ministry of Health remit within Kenya has been screened out either through health service delivery through the Catholic Church, or by negation of this issue receiving appropriate weighting by service providers at the local level. The demand for FP was strongly articulated in the individual interviews of Kisegi CHWs and with other community members. However the work of most CHWs did not include this, and the government services did not attempt to reach those villages usually covered by the Catholic providers. The model delivered had been designed and taught away from the local community (Peersman, 1999). The " assumption of needs ...(is) ...made at the centre" (Nelson and Wright, 1995). The local community was only able to interact with a programme designed off stage by a different set of stakeholders. The image of CHWs being a bridge between the health service and community is shown to be a bridge built and maintained by the local professionals, church and elite, not the local community. All information flows from the health service to the community; there is noone asking for any returning information. The agency of the local women was neglected. They were expected to interact with the health services in ways which had been prescribed for them, without

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[106] I was frequently asked to administer Depo in private homes whilst I was in Gwassi. I also believe that the high interest in my movements could be linked to women obtaining Depo!

their needs having been included in the planning. Additionally, this approach negates claims that the services were "empowering women" (see section below).

But the small amount of knowledge the women trained as CHWs in Kisegi had been given was enough to convince them to put themselves in danger within their community. The violence that they experienced from men was extreme and obvious. In the interviews, they were surprised that anyone was interested in this negative aspect of their work – since their regular supervisors were not. The women here are challenging the normal social order, although this is not accepted across the community. The health service is clearly not willing to become involved in this challenge to social and gender order. The women, the CHWs, are again left to deal with this problem on their own. Men were not involved.

Positive and Negative issues for CHWs

The negative experiences of "pay" in either cash or kind have to be balanced against a very positive experience of personal knowledge and the desire to improve the situation at family, village and community levels. But clear gender differences were found in how this lack of recompense for CHW work done had a negative experience for the women, requiring them to ask family and friends to undertake their regular work while they were doing CHW work. But this often led to quarrelling or other frictions. And as discussed in Chapter Five women relied on extended networks of friends and relatives to assist with their workloads, especially during peak agricultural seasons or when mothers had young children who require care while she is away. The men also valued the personal knowledge, but were more likely to drift away, often due to the low "pay" and had more opportunities to find alternative work. They were neither as enthusiastic about the actual work, nor valued the actual knowledge in the ways that the women did. Perhaps the men had other sources of health knowledge, but due to the highly gendered nature of the messages, the men also did not personally engage with the CHW health messages, for as discussed in the next section, the messages were highly reinforcing of a particular gendered view of roles in respect of health and health care behaviour.

Why the women continued can therefore be seen as related to both the personal knowledge and desire to improve their community situation. They were not supported in the roles they were undertaking at personal risk and sacrifice. Their supervisors were not supporting them in difficult and controversial roles they were attempting to promote within their communities. The health staff were able to leave the private sphere of family relations as outside their concern. The health sector is highly gendered in its approach. The following section will expand on the issue of the gendered roles prescribed by the health service, again using the CHW roles as an entry point into the health service / community interface.

Boosting (women's) attendance at a particular facility: The primacy of technical interventions

As discussed in the previous chapter, the fixed health facilities had very low levels of utilisation, despite the continued support by the community for the idea of health centres and dispensaries, trained staff and health care generally. This section will highlight this dissonance, linking low utilisation and hence critically low revenue levels with the promotion of clinics, in particular AN and CH clinics, through a renewed focus on the role of the CHWs.

These technical interventions were the basis for the requests made for "more of the same" from both staff and community members. As discussed in Chapter Six, the "Rural Dispensary" or medical model (Woelk, 1994) was the image of health care in the rural community, as well as among health staff. In this section, the persistence of the myth allowing primacy of the promotion of the technical medical interventions in PHC will be discussed from the view of a highly gendered perception of PHC. This continued image of the clinic being the route to better health though is not congruent with the policy of PHC as presented by the Ministry of Health. Nor is it compatible with the claims by the CHWs to be promoting hygiene, nor from the comments presented above by CHWs for the positive personal and family gains from their increased knowledge. In addition, the ability to prevent ill health, especially cholera, through hygiene improvements was a very appreciated aspect of the VRPs' work. The topic of community interventions around hygiene will be discussed further in a

subsequent section. First, the persistence of sub-optimal and selective clinic services will be presented.

Recruitment of women to clinics

As discussed at length in Chapter Three, CHWs have been conceived as a way of involving the community in preventative and low-tech interventions to improve health in equitable and efficient ways. In Gwassi though, the technical health model continued to dominate, with a few specific interventions promoted. For the Kisegi and Kimange CHWs and the Gwassi PHCWs, these revolved around AN and CH clinics, hygiene promotion (centred around racks[107], latrines, clean compounds and removing bushy areas, plus use of clean water) and for the Kisegi CHWs, these, plus family planning messages. But in practice the clinic activities dominated. The novel and important finding in Gwassi was how the staff at the dispensaries and health centres all saw the need for CHWs to "recruit" women to attend their clinics. The clinic staff (who may or may not be the actual supervisors of the CHWs) saw this role as being a central reason for the work of CHWs. The work undertaken by CHWs has been denuded of the need to address any socio-economic or environmental reasons for the poor health and instead, attendance at a health facility for clinic services offering medical treatments and protocols are emphasised.

The need to boost revenue for the health facility was a response not mentioned in any recent discussions of CHWs in the literature (e.g. Gilson et al, 1994; Heggenhougen et al, 1987; Walt, 1990). This need to raise revenue to pay the nurses' salaries, purchase drugs and other consumables has accelerated in the past decade due to Structural Adjustment Programmes (SAP) and Health Sector Reform (HSR) initiatives. So after disillusionment with and retrenchment of CHWs during the 1980s (Heggenhougen, 1987; Walt, 1990), they were re-invented for the 1990s but for a more institutional and utilitarian role (Zakus, 1998) rather than a health enhancing role. The rounding-up of women to attend clinic has become a *raison d'etre* for CHWs to maintain income streams for the clinics and health centres.

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[107] A rack to place plates, cups, pans, crockery on to drain and dry in the sun after washing in the lake or river. The rack should be high enough to keep animals away. It is usually made of tree and sisal poles. See picture in Appendix 3.

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Both the sister at Tonga and at Nyandiwa clearly expressed the idea that they wished that there were CHW staff attached to "their" clinics so that the CHWs could encourage women to attend. This would, in the words of one sister *"increase the number of women attending"*. Here it is also worth recalling the argument (discussed in the previous chapter on fixed facilities and their charges) between the sister at Tonga and the CRS project when sister saw the CRS CHWs as "poaching" her clients by selling the women AN cards. The women are required to attend "her" clinic, to purchase "her" AN cards, they are not free to attend a clinic of their choice, in order to capture the cash spent by the pregnant women and mothers.

There was no mention of improving the outcome of pregnancy or child survival; presently for the staff member, the important issue is the throughput at their clinic, to generate income required for salaries and other costs. Trained staff saw clinics as a more positive and less stressful part of their work. The sister at Tonga was very optimistic about this as she was highly confident in her role as a midwife, and was also happy to delegate some clinic work to the nurse-aides who worked under her supervision. As for the diocesan situation, where the staff had to also raise money for their salaries, total attendance at clinics was important to ensure the financial viability of the facility and the payment of salaries. The sister at Nyamdiwa was direct in the connection between patient numbers and her own and her staff salary levels.

Only happy with many patients, getting much money. Need to consider welfare of staffing. But expect to keep on working even if low numbers..
It (fees) is also the means of getting drugs, paying for transport.

This was expressed by both trained and untrained (nurse-aides) staff. For the nurse-aides at Tonga, their salaries in a month with poor attendance[108] at clinics was reduced by 50%. This worry is shared by the sister in charge who reported:

(I'm) worried. Praying for salary - for each month. But worry for workers. Can't force patients[109] to come.

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[108] See previous chapter for actual patient and clinic attendance figures.
[109] Although staff often refer to the overall number of clients as patients it is clear from the relative numbers of patients versus those attending for clinic that the majority of the income is from clinic attendees, not true patients (who are also much more expensive to treat).

This focus on the number of attendees, on the recruitment of women to "their" clinic, is understandable when staff have to pay salaries and restock their drug stores. However this focus on clinics and revenue generating activities pushes alternative roles of the CHWs in the community to one side. The trained staff, who are meant to train, supervise, motivate and guide the CHWs, are too preoccupied with the clinic to provide appropriate support and guidance for the community roles. So the health service reverts back to the rural dispensary model of pre-PHC days, complete with gendered assumptions of an earlier era. As the staff focused on the CHW in a clinical, technocratic role in the clinics, this will be expanded on first. Alternative community based roles for the CHWs will then be discussed.

The ritual and reality of Clinics

As outlined in Chapter Three, recent research on clinic rationale is however questioning the assumed benefit between AN clinic attendance and improved outcome of pregnancy (Vanneste et al, 2000) due to the poor sensitivity and specificity (McDonagh, 1996) of the screening tools used. Joyce (1999) found no association between AN clinic attendance and pregnancy outcomes, except for those who also accessed food supplements through the clinics. Self-selection bias was responsible for any improvements in outcome for those women who did attend clinics. AN clinics without appropriate and accessible Emergency Obstetric Care (EOC) also cannot fulfil their role of referral.

This is additionally qualified in Africa by researchers who feel that the problem is not with the actual AN services themselves, but in the quality of the service delivery (Allotey and Reidpath, 2000). In Gwassi the service delivery was often of poor quality – e.g. lack of vaccines, and other essential drugs[110] and functioning equipment[111] or even staff. The performance of the ritual of AN clinic itself was never in question. AN clinic activities have taken on a life of their own.

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[110] Even iron and folic acid were not routinely prescribed, or in small quantities (5 days supply) only; malaria prophylaxis or broad spectrum de-worming was not routinely undertaken. Women would have to ask and pay additionally for such prescriptions previously taken as normal practice in ANC.
[111] Sphygnomanometer, auroscope, weighing scales for adults etc.

Similar problems of quality were experienced by child health clinics (CHC) in Gwassi. The main rituals of CHCs – weighing and weight recording on child health charts (growth charts) and immunisations - were both disrupted due to lack of functioning equipment or vaccines. In both Kisegi HC (government) and Nyandiwa Dispensary (diocesan), immunisations (and hence other CH activities) had in practice ceased due to lack of gas and / or vaccines. This was exacerbated due to very poor and expensive transport links.

An example of a focus on CHCs was a statement by a senior manager for CRS who was based in their sub-office in Mbita for several CRS project sites. He was adamant that a major problem was the lack of breastfeeding in Gwassi location. This was his major reason for the existence and present direction of the Child Survival Programme (CSP) project and hence the need to promote the weighing of babies through CHWs in Gwassi. This was in direct contradiction to the reality for babies in the location – where all mothers breastfeed[112]. The nurse at the Nyandiwa dispensary confirmed that some babies may be underweight – but this is more likely to be due to absence of the mother due to work, illness or death, or illness in the child herself. Babies tended to be solely breastfed for at least six months, with *ujii* (millet or maize liquid porridge) and other local food gradually introduced. This emphasis on poor infant feeding (knowledge and / or practice) may be relevant in other areas of Kenya but it was not the situation in Gwassi.

This focus was reflected by the Kimange CHWs, who were more likely to give *"weighing babies"* and *"weighing children and pregnant mothers"* as things they do as a CHW or enjoy doing than the other groups. But the act of weighing alone has no benefit unless it is interpreted and acted upon. The reason for the poor weight gain (in Gwassi unlikely to be due to lack of breastfeeding *per se*) and actions to address it need to be included. Anyway, mothers in Gwassi could identify malnourished babies without recourse to weighing, and this was reflected in local words for marasmus and kwashiorkor – words which held both social and well as physical resonance[113].

Allowing global definitions of a problem (for example "lack of breastfeeding") to take centre stage in programme design and implementation leads to programmes devised

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[112] See also DHS data discussed in Chapter Six.
[113] See Gerein and Ross 1991 for similar findings in Zaire a decade earlier.

for children and their mothers based on erroneous assumptions and inaccurate information. Such programmes will have no positive impact and possibly lead to misinformation and misunderstanding being propagated.

Clinic Attendance and the Promotion of Ritual

Any discussion of the true usefulness of clinic attendance was not found with most CHWs, trained or untrained staffs at the clinics, programme organisers and managers at local and national levels. It was unquestionably "a good thing". The myth survives intact. "Clinic" was usually referred to only in general terms, without specifying specific activities or benefits, as the weighing of babies demonstrates. The one group who discussed the specific activities and benefits of CHCs were Kisegi CHWs who consistently mentioned the benefit of immunisations:

...teaching mothers to take child to clinic and how to prevent simple diseases such as measles, polio and others that attack children and babies.

(I) Teach mothers to take children to clinic to prevent TB, leprosy ..(pause).. measles.... by taking babies to clinic. Mothers are to attend clinic so that they prevent diseases that can affect babies later.

(I am trained) on how to teach mothers on importance of taking children to clinic and how to prevent diseases such as measles, polio, TB. I have taught very many mothers on taking children to clinic. I have also persuaded some mothers to go to hospital and receive injection for preventing tetanus.

The standard of clinic service delivery was never questioned – even when the availability of vaccines or other basic equipment was irregular or non-existent. So here the CHWs saw immunisations as important activities, but during the year in Gwassi the availability of vaccines was seriously limited and disrupted. Mothers attending clinics would not know whether or not vaccines would be available. This was particularly true for Nyandiwa and Kisegi – both of which appeared to rarely have any vaccines available.

All clinics visited were delivering very sub-optimal clinic services, but all were deemed adequate to continue (including asking the women to interact with and to pay in time and money for substandard levels of service) by the staff undertaking them, and managers to whom they reported. And all still thought it relevant for the CHWs to be referring women to attend, despite knowing about the lack of vaccines or other essential supplies.

Although medical advice could be offered even in the absence of supplies and equipment, the interactions with staff are often so brief and brusque as to negate this potential reason for women's attendance. In Gwassi at one AN / CH clinic, three women with serious problems only had them addressed after being referred back to the sister-in-charge[114]. These problems had not been identified in the regular ritual of the AN clinic.

The ritual of the clinic has become self-perpetuating, and continues despite problems in delivering the technology or the social benefits expected to flow from the specific clinic activities. This is how it has become a myth, claiming to be able to deliver benefits even when the actual performance suggests that health benefit is unlikely. It has achieved this in a highly gender specific style.

Nevertheless, the community interviews revealed no resistance; the local community agreed that women's attendance at the clinics was a valid activity for the women to undertake.

Community views on clinic attendance were gained from 20 couples with a young baby interviewed. Of the 21 women[115] who had a child under six months who were interviewed, most stated two or more reasons to attend AN clinic (mean 2.1) and one or more reasons to attend CH clinic (mean 1.3). But their husbands also stated one or more reasons why the woman should attend AN clinic (mean 1.6) and gave more reasons than their wives why children should attend CH clinics (mean 2.5). All respondents knew of immunisations from CHCs and several also mentioned tetanus

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[114] One woman had attended as she had felt no foetal movements for the previous 48 hours and now no foetal heartbeat was found. A second was a girl aged 12 who was very small and the concern was whether she could have a normal delivery with such an immature pelvis. A third was a woman who had vaginal discharge, possibly gonorrhoea which would require treatment before delivery to prevent *ophthalmia neonatorum.*
[115] In one polygamous union, both wives had a young baby and so both were included.

immunisation for pregnant women. All women had attended for at least one ANC and one CHC visit.

The huge fall in child immunisation levels in the district and nation as detailed in Chapter Six and explained above may be due to supply rather than demand factors. Here, knowledge of child health clinics, and immunisations in particular, is shown to be high, yet immunisation rates across the location are so poor. Women had to either travel long distances past a local clinic to attend one further away or attend on several separate occasions to ensure they or their child was immunised. This choice of clinic must however also be linked to the "personality" of the staff as discussed in the previous chapter. But any discussion with trained staff or managers placed reasons for low immunisation rates on women's non-compliance, not lack of vaccines or sites where vaccines are available. The CHWs and their attitude to their roles, and the success of their work reflected this. The users, not the service itself[116], were at fault.

The community has accepted the myth of the clinic, despite the clinic not delivering what it is expected to deliver (here immunisations). The service is not seen as being at fault, instead any problems are blamed on women for not attending clinic, for example, for not immunising their children[117]. But as considered below, men are exempted from any health promoting role and hence any blame.

How CHWs reacted to and interacted with clinic work in Gwassi

The CHWs all stated that promoting or actually undertaking clinic activities were an important part of their work – 100% for Kimange CHWs and Gwassi PHCWs, and 95% for Kisegi CHWs[118]. These CHWs all expressed complete congruence with the nursing staff in their belief that women should attend for AN and CH clinics. The unambiguous stance taken by all CHWs was that women *must* attend AN and CH clinics, as defined by external protocols. The reality of local service standards of delivery (or non-delivery) is not considered in their reflections on the problems that they face.

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[116] Compare to Buvinic's "misbehaviour of projects" (1984).
[117] See recent discussions around process versus output indicators for other community health activities. LSHTM 2003.
[118] Nyakasera VRPs were not expected to promote clinic activities..

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Kimange CHWs clearly express this focus on clinic activities in terms of both what they enjoy in their work, and also why they will continue the work.

(I enjoy) weighing children and pregnant mothers.

I am happy, (it has) made me know benefit of clinics, latrines and using drugs.

(I am happy) keeping the environment clean. Pregnant women know the importance of clinic. Community also are happy through these improvements.

(I will continue as this work has) taught me how to take care of children, prevent diseases (through immunisations). Women know importance of clinics and now attend in large numbers. (I) can weigh 20 children and 10 pregnant women per clinic.

A Kimange CHW (female) is also clear that clinics also cause them problems. Here she is talking about what she does not enjoy in her work:

Some mothers do not want to take their child to clinic although we advise them several times. These mothers give us difficulty but we still advise them to go.

The women at Kisegi were also encouraging women to attend clinic, but since they had also been trained in family planning and more practical issues around hygiene and treatments, they had a wider view of how they were assisting their local community.

Great difference - now mothers take babies to clinic. Now mothers teach each other and prepare small gardens so get some money. Also (we) form groups and get some money – called mary-go-round.

I enjoy walking around and find that people have done what I told them. Mothers go to clinic for immunisations. (They) also attend clinic early with sick children.

That of midwife pleases me. Teaching mothers family planning and knowing how to keep village clean. Now (there is a) big difference in village – we have latrines and racks so common outbreaks of disease is not so common. At clinic we examine

mothers and babies. We give injections against TB and tetanus and others. We
examine and inject.

But there is also disappointment in this group when mothers do not respond as asked. Most of their problems of violence were from men's resistance to family planning (see above for elucidation on this issue), however clinic attendance is another area that causes them problems. Here the women agree with the Kimange CHWs and are talking about what they do not enjoy about their work as CHWs in Kisegi:

At some homes mothers do not understand even if you teach them very good things. They deceive you that they will do it (attend clinic), and then you visit and (find it) not done. In some homes they are very cruel to us, they don't even welcome visitors.

In some homes people do not do what we want, even if you explain. They only deceive you. They don't do anything. They do not go to clinic. This means they get many diseases, including babies. This makes us unhappy as later they say we did not teach them well. As if we do nothing.

The CHWs are clearly unhappy with their role in persuading women to attend clinic, and feeling that they are then blamed for having not instructed the mothers. But the community (including the CHWs) near Kisegi Health Centre knew that there were no vaccines.

But when the model is so totally medical – no practical or socio-economic factors ever entered into the CHW discussions about their roles and how they were seeking to improve health in their community – the local women are judged as to whether they have "gone to clinic", or not. No other option is available. This will be expanded in the next section with the example of water and sanitation interventions and CHWs' "success", or not. But when the clinic service is of such poor quality, the continued promotion of such activities is remarkable. The interest of the CHWs to maintain their status with the clinics, to remain insiders – allows them to negate the true worth of the clinics – which could not provide the activities (immunisations) they were clear were of benefit to the mothers and children.

This acceptance of women's role as one of presenting themselves or their children for examination, and possible interventions, is only recent. But it has become widespread and accepted across the world. Certainly this acceptance of Foucauldian "bio-power" and surveillance is unexpected in locations where the ability of rural women to participate in formal care is difficult; and where clinics frequently lack equipment or other supplies to deliver an effective service. That the health services have managed to actively involve the wider community in promotion of such surveillance is important (Gestaldo, 1997; Lupton, 1997) but frequently overlooked. Again the organisational focus on the service (not on the users) and predefined indicators has allowed the clinic services to remain paramount. In Gwassi, this was demonstrated through the CHWs' continued acceptance and promotion of the clinic services. This was despite the community knowledge of the poor functioning of the clinics, and the problems that the CHWs encountered in their work from their community. There has been an inability of health programmes in general and CHW programmes in particular to deliver tangible health benefits, but more collusive surveillance of women and the reinforcement of a medicalised caring role have thrived. This will be expanded on in the concluding chapter.

Targeting women (or avoiding men?)

Although none of the CHWs (or PHCWs or VRPs) explicitly saw their work as only targeting women, when couples with young children were asked about CHWs in their communities, it was clear that both men and women saw the work of CHWs as only being of relevance to women. In the interviews with mothers and fathers of a young child, the fathers either denied all knowledge of the work of CHWs (16%) or said that the CHW had visited their *dala* but that she *"only talks to mothers"*. And so the fathers had not followed her advice (42%), or said that there was no need for a CHW to talk to the men as the advice was only for women (37%). Several men found the question of whether the advice from CHWs was helpful as meaningless as they had to qualify it and say the advice was only for mothers, or even restricted to only pregnant mothers (26%). However all (100%) mothers had met CHWs, knew what their work entailed, and thought it was useful information for them, although 20% admitted not following the advice they received.

This view of the CHWs by the community was also mirrored by the CHWs themselves. Even the male Kisegi CHWs focused on the role of getting women to attend clinic. The response from these male CHWs about what they were trained to do, what they did and what they both enjoyed and did not enjoy in their CHW roles was similar to that for the Kisegi CHW women. All focused on the women attending clinics, and allowed men optional roles in health actions for their families.

So although the local community and especially the women are accepting the role of the CHW, they are accepted in a specific gendered way. The model of work followed by the CHWs is clearly in the medical model. Gendered roles are reinforced and perpetuated through the formal health service via the CHWs. The health service has a clearly gendered view of men and women and their appropriate interaction with the service. The medical model appears to only enforce the female gender roles. Male roles in PHC programmes are optional.

Men's health needs

But with all the emphasis on women and children, where do men access health care? Some men reported to prefer to visit male staff. But men in Gwassi had two clinics solely staffed by men, yet they did not attend there. The male nurse at the Scout centre said that he saw many men for STIs, but on reviewing his register it appeared that only two or three men a week attended his small clinic – and not all for STIs. At the nearby Nyandiwa Dispensary, the female nurse saw more men than this male nurse, most with STIs. This had rapidly increased to over 15 per week after the high profile arrival of the WHO STI / HIV vehicle with logos all over it (including the roof as children pointed out to me!) to deliver a wide range of drugs for STI treatment.

Another reason given was that men preferred to attend better staffed, supplied and equipped facilities, outside of the location. This was impossible to verify in this research, however there is evidence to suggest men were more mobile and the claim was made frequently and could be true. Certainly, as discussed above in relation to contraception, where women went to great effort to access services not provided in the location, and suggests that it was normal practice for individuals to seek additional health care from outside.

The emphasis on activities around pregnancy and child health activities has meant that the local facilities are perceived as only catering to the health needs of women and children, just as it is perceived the CHWs only talk to women, or provide information for women. But the arrival of the WHO vehicle did provide some advertising that the dispensary in Nyandiwa is actually also capable of providing services for the whole community – even though it was only specific for one particular group of diseases.

Women's participation in contrast to men's participation

Both male and female CHWs mentioned clinic attendance as an act *required* of mothers. Women were not targeted specifically by the health services except as mothers (see MacDonald, 1993; Oxaal and Cook, 1998) or as 'passive recipients' (Ostergaard, 1992). Although nutrition and clean water were mentioned in all programmes as necessary to improve health, it was the attendance of women at clinics that was emphasised by the three CHW groups related to "health" in the work that they undertook. Few specific activities to improve nutrition or water were mentioned by the CHWs in response to questions about what they actually do, or what they both enjoy and find difficult in their work[119]. Clinic attendance or its encouragement if not enforcement was the most frequently mentioned as work undertaken / enjoyed / problematic by the other two groups of CHWs. The work in the clinics always took on a much more central role in its performance than the other home-based activities. This was most noted in how the non-attendance at clinic was seen as a problem, and few CHWs mentioned activities that required male involvement (such as digging latrines) as being a problem – even though very few homes had actually constructed latrines.

So the "problems" were always the activities required of women, but activities required of men were not seen as activities to be actively pursued even when men did not participate. The relative power of all the actors is important here. CHWs felt able to admonish and complain about the women's participation in the programme as planned, however male participation was seen as optional and not to be commented upon if men did not cooperate.

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[119] Except the Nyakasera VRPs.

As discussed above, the clear targeting of women (mothers) allows men to feel that the work of the CHWs does not apply to them. But the CHWs also do not target men as they see their work mainly revolving around the clinics, where it is accepted that only women and children attend. The community staff have accepted the health service image of the appropriate gender division at clinics. As Edwards (1998) also found, health professionals can effectively "screen out men" from child health activities if they wish to re-inforce a "women-only" approach to child care and health issues. The sexual division of labour, which leaves women with too much to do (O'Connell, 1994), is again left unchallenged by health professionals. The ideology of motherhood leaves women as self-sacrificing (Lupton, 1995, Ch 3) and can assume women will care for others (Daykin and Naidoo, 1995) through maternal altruism (Crewe and Harrison, 1998), which is convenient for policy to shift costs for health care onto women (Nelson and Wright, 1995, Ch 1).

This image of the mother's role can be reinforced by women themselves – as Frischmuth's (1998) example of women laughing at a man who attended clinic with his daughter illustrates. The society at large (here represented by the mothers attending the clinic) can reinforce the institutional emphasis of the health service on the mothers' attendance. As Kabeer (1999) points out, deeply entrenched views, practices and norms shape local social life; and that all members of society, men and women, want to conform to the expected norms.

Here in Gwassi, the norm was not to actively engage with fathers and their roles in promoting family health, and there was no suggestion that men should attend the child health clinic – with all emphasis going on mothers and their need to attend clinics. As discussed above, the fathers readily concurred with this approach. In addition, the CHWs never mentioned men as an object of their messages. All responsibility was placed at the door of mothers (see also Smyth, 1999). But no additional resources were offered to assist the mothers meet these responsibilities (Nelson and Wright, 1995, Ch 1). The men, as discussed above accepted this: They did not consider the work of CHWs as relevant to them and their parental role. But the focus on the mother-child dyad has also perpetuated interventions which perhaps are not the most relevant here in Gwassi – as the example around the focus on breastfeeding babies demonstrates. Such a focus immediately excludes fathers and their responsibilities.

Hygiene and gender

In addition to the continued promotion of clinics in rural locations, other dominant discourses persist in PHC programmes in Kenya. The hygiene discourse in particular, which was exported to Africa along with Christianity, colonialism, and European gendered assumptions (Vaughan, 1991), has retained a major position in PHC and in CHW practices (Tranberg Hansen, 1992). This was certainly true in Gwassi, with all groups of CHWs promoting hygiene, and racks and latrines in particular. As the health sector was the main promoter of hygiene discourses in Gwassi, they also remained within the medicalised and gendered models of the health sector. These hygiene discourses were found in this research to maintain the gendered divisions of the earlier (pre-PHC) era. The exception was the Nyakasera VRPs, who are discussed below, after an introduction to the hygiene work of the other CHWs. The gender perspective of these different approaches is raised.

The role of hygiene in CHW work revolves mainly around family and kitchen hygiene. One tangible example is the construction of racks[120]. 4/6 of PHCWs, 10/12 Kimange CHWs and 7/12 Kisegi CHWs[121] all mention rack construction as an important part of their role. In addition in Kimange, seven out of ten CHWs mentioned latrines specifically and two more mentioned 'cleanliness in the compound' as work they were doing (as opposed to generalising about what they were trained to do). When they talked generally about their day-to-day work, they included both clinic and home-hygiene activities, including promotion of racks and latrines. Here are CHWs reporting what they "do":

Teach importance of cleanliness, advise women re clinics, latrines, racks and kitchen gardens.

Teach community members importance of cleanliness – latrines, racks, kitchen gardens – very important. Advise breastfeeding mothers and pregnant mothers and those with babies under 2 years about clinic.

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[120] See footnote 6.

Pay visits to homes allocated (to me) to check on cleanliness, (and for) children aged 0-2 years and pregnant mothers, breastfeeding mothers to attend clinic. I check clinic cards. Advise to attend if not going. Attention to cleanliness – racks, latrines, compounds clean to keep mosquitoes away.

Do work advising people on importance of kitchen gardens, latrines and pits. Walk around teaching in community.

I do the work of checking the standards of cleanliness. I also check on whether people have racks and latrines.

(I do this in my community) Teach community members importance of cleanliness – latrines, racks, kitchen gardens – very important....

(We are supervised by) Leaders of programme check children are weighed, check number of racks, check number of latrines. Forms are filled and then the next stage.

(the community supports me through) Improved health care and home hygiene evidence – constructing racks and things.....

The Kimange or Kisegi CHWs however, rarely achieve the hygiene activities. In Kimange, only three homes could be pointed out that had latrines in the area, and near Kisegi a busy fishing centre had no latrines. But hygiene activities are not mentioned as a problem when not achieved according to CHWs or their supervisors. This is in contrast to CHWs talking at length of women not attending clinics as a problem for them. See section above on CHWs' reaction and interaction with clinic work and its promotion. The CHWs managed to ignore one area of work (hygiene promotion) they were not successful in completing, while focusing at length on another area (clinic attendance) they were also experiencing problems with.

None of the hygiene messages they were promoting were adopted in the community. Apart from several CHWs in Kimange stating that their supervisor would visit a

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[121] and ¾ Nyakasera VRPs but they are not included in this initial discussion which only focuses on CHWs' work.

village with them and "*count the number of racks*" "*count latrines*", in practice this rarely happens as supervisors made so few supervisory visiits to the rural villages. No supervision had occurred for over four months in Kimange: and for over a year in Kisegi and were unlikely to occur again soon according to tthe supervisors.

Most CHWs talk at length about enjoying the work of cliniics (see previous section) and although women not attending was seen as a major proiblem for them, they could openly admonish women who did not attend. This occurredl both in the clinics themselves, and also during their home visits in the community. And the nurses and supervisors often attended the Chief's *barazzas* and churchi services in person to inform women (mainly through men as more men attend *baarazzas* than women do) to attend clinics. Higher authority could be relied upon to sancction this clinic aspect of the CHW work. In contrast, no-one spoke at *Barazzas* abouit constructing racks or latrines or other home based activities. Several of these homme based activities have male (construction) roles incorporated in them. But these rooles are not discussed directly with men, nor raised at public meetings. See sectiom above about men not interacting with nor seeing the work of CHWs as relevant too them, as the CHWs "*only talk to mothers*".

VRPs and hygiene promotion

The VRPs explaining what they do in promoting hygiene ini the community initially sounds very similar to how the CHWs explained their roles around hygiene:

Teach community members on cleanliness, how to build latrrines, keep water safe, cutting grass in compound.

Teach people how we can keep our life safe by latrines. We walk in homes, churches on how to prevent diseases.

And the supervision includes support and follow-up of the wwork:

Water project leaders come and check our work. Ask how fair you go. Sometimes fail to come so we send a report.

But in contrast to the villages where the CHWs were working, the VRPs had actually managed to get most households to build latrines and racks, and to collect water from safe sources. They also had very positive direct comments from the community about perceived benefits - lack of faeces on paths and around the *dalas* - indicating how much latrines are appreciated once constructed. It also was run by engineering (not health) staff who talked to both the men and the women in the community. The VRPs knew that their local community as well as local officials and also their supervisors support them in this work.

(the community support us through) Chief, sub Chief, elders and area leaders see how much we have done. They were also asking people to build latrines but they were already built. Community are happy.

Three VRPs talking about what they enjoy in their work:

(It) helps prevent diseases – cholera, malaria, worms. Now (they) use latrines and community happy. Now do not meet faeces on paths. Now development close to the people.

Happy with work because before people went to hospital often with cholera. Now cholera stopped so now good life – water precious. Mothers looking fat and no diarrhoea. Children no scabies at all.

...diseases like scabies, cholera and others have now stopped. They are not as frequent as before. Others prevented at home, malaria, stomach-aches and scabies - prevent before reaching hospital. Advise not to drink dirty water.

This is how the male secretary of the VRP programme saw their work progressing:

We have learnt a lot concerning cleanliness. We have been seeing dirty things around the area. We are now improving. We have been drinking dirty water but now drinking "Kisima" (borehole) water so we have not been getting a lot of diseases around the area. Especially cholera and stomach-ache and amoebas. Improvements are from

Lake Basin Development Authority[122]. Brought us materials for 48 latrines. The people who used to squat in the bushes are now not seen around the area. The diseases have now been prevented. So we are very much thankful for the water basin development authority for this project. The VRP people are very hard working. They have been walking around in the area they were given and there is a lot of improvement.

The difference in approach is subtle, but the actual engagement by the VRPs with the community is more direct, and importantly includes men, and other community leaders – here the church, Chiefs, subChiefs, elders are all mentioned as important to the success of the project. Also, the project included evidence and discussion of problems and solutions (*"then there was cholera"*, *"faeces on the path"; "We have been seeing dirty things around the area"*) with both men and women in the community before suggesting solutions. The project also assisted in bringing necessary items into the community - some cement and some wood to make the latrines' slabs (plus pickaxes and shovels) - but only after the community had contributed cash and labour. And in some other communities who had not contributed cash (*"Obanga fell"*), they had not proceeded with training VRPs.

The CHW workers in Kimange and Kisegi all said that rack and latrine promotion and construction were an aspect of their work, although none had managed to convince their communities to construct them. The VRPs had in contrast been highly successful. The work with the "Lake Basin people" did not carry with it the gendered stereotypes which health programmes also using community labour were emphasising. And the inclusion of men and their roles in the "Lake Basin" work had enabled the borehole to get financed and dug, and individual *dalas* to construct latrines. Now the community was planning to add more latrines across the community - both to add more latrines in the larger *dalas*, and to expand the coverage to more *dalas* - to improve access further. The community (including men) were clearly supportive of this project, and now wanted to expand it.

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[122] The Lake Basin Development Authority is trying to assist development in the rural areas around Lake Victoria, including this programme for improving access to potable water and improved sanitation.

For the VRPs, they did see their work to be about specific health improvements in people's lives, and when talking about the expression of these improvements, they were talking about lack of disease and improved general well-being. This group not only had the increase in personal knowledge which all groups mentioned as a reason for continuing with their work, but this group also had tangible improvements in their family and community health which they easily identified with and felt reflected their work and efforts.

(I am) Happy as people have built latrines after (my) teaching. Now it is hard to meet human faeces compared to the old days.

They (the community) do support us, especially Chief and sub Chief and clan elders due to problems of diseases we had in the past. Also (we are) supported by local school community. (this) makes work to be easy.

Like the CHWs, the VRPs are looking to improve health in their local community. Some differences found which assisted the VRPs to achieve latrine and racks construction at household level, as well as water points at village level:

- the VRPs did not accept that they were health workers
- the VRPs worked with both men and women equally, without the gender expectations of the CHWs in the health sector

VRPs as health workers?

The VRP programme addressed primary causes of ill-health, yet none of the community volunteers would accept that they were *health* workers. This programme was organised through the Lake Basin Development Authority and they were concerned with water and sanitation in villages away from the lake shore. All experts they dealt with were water engineers and sanitation advisers. Access to this group had been difficult, as none of them would agree that they were *health workers.* Access had only been possible through one woman who had previously been a PHCW and was now the VRP trainer. Since I had already interviewed her as a PHCW, she did not feel that the group was undertaking work which was totally divorced from her previous *health* work. Here, she is talking in her interview as a PHCW. In response to

the question "*What are you doing since stopping your work as PHCW?*" she responded:

Previously brewed changaa[123]*: difficult work. Men come at all hours asking for a drink. Now Lake Basin Work. Men from Homa Bay came and met Chief. He sent them to me. (They) Asked about my previous work. Then asked to have more people – Five. Made me their leader. Training, come with their things. I can do the training. All five of us from Nyakasera also (other groups in) Nyambarambe (and) Obanga (which) fell. In training - how to improve homes. Health and cleanliness. Houses and water to be clean. Major thing – clean water for drinking. After outbreak of cholera. Previously collecting water from river, need to boil but also people drink on the way. Rain, spring or borehole (is) clean water. Promised they will do it - whichever feasible here. Trained community first how to use clean water.*

She saw the connection between health improvements and water quality. But the rest of the group of VRPs remained adamant that they did not *do health*. Although the perspicuous conversations above show that the VRPs could see health benefits to their work, they were adamant that they were not working in "health" – but with the Lake Basin people (who were "*not health*", "*not doctors*", "*not nurses*").

Gendered perspective in PHC

But what is novel in this research is how, through the inclusion of a gendered dimension to this issue, the official view is seen as not simply due to organisational / professional sector loyalties. Instead, due to the medical approach being one, which has a highly specific view of appropriate male and female roles and responses to health issues, limits to the health sector approach are quickly reached. And the community concurs with these gendered views. At the community level, the VRPs did not want to be associated with CHWs and the health approach – as CHWs do not involve men in their work, who the VRPs clearly do include and engage with on a daily basis.

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[123] An illegal brew of sugar cane, or molasses.

In the health sector, this gendered perspective reinforces the pre-eminence of the medical technocratic approach. In medical circles, primary health care is synonymous with primary medical care (MacDonald, 1993). And this medical care is practised in clinics. In addition, the hijacking of PHC to SPHC, with its technocratic bias, avoids equity issues and assumes medical technical fixes are the best solutions for the health problems in rural areas (Rifkin and Walt, 1986; Woelk, 1994). And top-down planning of SPHC removes any possibility for local participation in the planning of the programme (Asthana, 1994). But what many criticisms of present "top-down", "technocratic" programmes fail to offer is which parts are worth continuing and how to refocus the programme. The top-down approach is evident in how the CHWs saw their interaction with the community (= women) in relation to the building of latrines; they talk of "checking" and "advising" – but nothing is actually achieved. In contrast, the VRPs also interact with the community (= men + women) and they managed to get latrines built.

So although in Nyakasera the hygiene problem and its solution had again been pre-defined outside of the area, there has been a more realistic attempt to engage with the whole community of that area to address the problems ("*due to outbreak of cholera*" "*helps prevent diseases – cholera, malaria, worms*") and work towards a solution. In Nyakasera, the water and sanitation engineers have been successful in addressing recurring and important health problems – from cholera and diarrhoea through women's nutrition and energy levels to scabies and worms. But none of the VRPs wanted to be associated with a "health programme", such as those found in neighbouring areas who also had suffered from cholera and similar problems of scabies and worms. But the health staff working in the clinics and dispensaries had also been seriously affected by the recent outbreak of cholera. In particular, the nurse-in-charge at Nyandiwa had been heavily overworked[124] and in her isolated situation, this had resulted in serious professional and personal demands made on herself[125]. But this had not encouraged the Diocese to support or promote prevention of cholera in the community or through local CHWs. Immediate efforts were again focused on (income-producing) activities within the Dispensary and the clinic activities, including their promotion by CHWs.

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[124]The outbreak had occurred during a strike of government services.
[125] The first three meetings with the nurse from Nyandiwa focused almost exclusively on how she had coped during the cholera outbreak; discussing for example, numbers of patients, bags of dextrose-saline utilized.

The nurse at Kisegi clinic expressed this when he was talking about the role of the CHW's for his clinic:

We are working as a health institution so the community must understand our activities which are being carried out in this facility. So these people are promoting us by informing the public and (of) the services (that) are now available at this centre. So as a result of this we get a lot of help from the community. I'm thankful to these people who bring people to this centre. So we feel motivated as we feel the people feel we are at their end.

But this demonstrates how trained staff see the community as needing to interact with their pre-determined health service, not for the service to interact with the needs of the whole community. The problems of the CHWs, and what the supervisors might do to assist them are not seen as part of his role. The ritual of the medical clinic work maintains its pre-eminence. In addition, issues around how the service might be more responsive to the needs of the community if gendered stereotypes were addressed need not be considered whilst the service itself retains its central position. None of the CHWs mentioned prevention of cholera (which had swept through the area only one year before the fieldwork) as a part of their work. All their focus was on clinics, and getting women to attend.

The VRPs, in rejecting the CHW and clinic model to improve their local health situation, have also rejected a highly gendered image of health care provision – where all attention was directed towards women. But this also left the medical model intact, as it was not challenging the medical model, but creating a parallel system. The engineers in coming into the District did not relate to the health system and staff, but to the administrative system through the Chief and sub-Chiefs. These public health issues are not removed from the nurse / doctor roles, but merely being executed by other staff. The health staff still claim to be promoting cleanliness, latrines, racks etc., as demonstrated by the work the CHWs claimed to be doing and promoting. The ability of the health sector to prevent the re-occurrence of cholera, or reduce the incidence of hookworm and scabies, is negligible in the present gendered approach. But it still claims that this is a valid role for it. To allow this work to pass out of the

health domain altogether would allow roles to be seriously re-evaluated, and with it, funds and resources.

Rhetoric and reality of CHW roles

The Kimange and the Kisegi CHWs[126] all talked about the hygiene based activities – but these had been less than encouraging for them – the latrines and racks were still not built after two to five years. To maintain a role for themselves in their community, the CHWs moved further away from any true community based activities and focused more on the clinic based activities. Clinic attendance may also give them problems, as discussed in the previous section, but they had nurses, supervisors and other senior figures in the community who all concurred and agreed that attendance at clinics was an acceptable thing for women to do, even when the outcome of such attendance was questionable, due to the quality of clinic services offered.

For both the Kimange and Kisegi CHWs, the clinic work allowed them to be associated with the staff and structure of the local clinic. It allowed their defined role to be in a bureaucratic power structure. They became 'insiders', part of the health system, and accepted the organisational ideology (even though the health system was clear in maintaining them as "outsiders" by keeping them off the payroll). They were then able to adopt a powerful position within the location; they could tell other women what to do. But the ratification for the reasons did not come from the CHWs themselves, but from other people also working in the health sector - the managers of government, diocesan and INGO health programmes, doctors and nurses who ran the clinics, staff who had devised the CHW courses and trained them, and those who decided the policies. It is also agreed by the whole community that clinic attendance is a valid activity to ask women (but not men) to undertake. This is a further example of Foucauldian "bio-power" and the acceptance of the medical surveillance at community level, and it is a highly gendered activity.

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[126] The Nyakasera VRPs were solely focused on water and sanitation issues in their community.

Traditional (and gendered) views of PHC

> "Professionals are finding it very difficult, consciously or not, to let go of their
> own ideas and judgements, whether in determining which problems to address
> or what should be done. And this also extends to the domain of whether this is
> doing more harm than good"   (Peersman, 1999, p 134.)

As well as the financial need to co-opt the CHWs into their work, the model of rural PHC has become "boxed-in" (in the words of Leach and Mearns, 1996). Leach and Mearns see the "received wisdom" as simply reflecting the beliefs held by the establishment, the "traditional hierarchical structures of authority" (Walker, 1995, p 817) in the health service. In Kenya, the medical establishment is reinforcing the "received wisdom" of a clinic model and use of CHWs. This "received wisdom" is perpetuating a highly gendered view of health needs and caring responsibilities which may be both inaccurate and reinforcing negative roles for the women (Tolhurst, 1998; Ramirez-Vallez, 1999).

Here in Gwassi, this entrenched view of appropriate primary health care activities encompasses both government facilities, NGOs and the mission sector, but it remains in the rural medical model (Woelk, 1994). And all have a view of CHWs as a method of delivering "PHC" services in a style that results in increased women's attendance at their facility. So the system has become self-perpetuating in a highly gendered way. The potential achievements of the CHWs in other non-clinic areas of their work are allowed to be non-achieving, as they are not expected to interact with men. This was not found in the VRP programme, which claimed not to be working in health, despite having health goals. And the VRP programme could claim important achievements, both from the community's viewpoint, as well as a professional evaluation.

Rhetoric and reality in the language of empowerment

Along with the development endeavour more generally, the health sector has appropriated the term "empowerment", thus maintaining its relevance and position within the context of rural development. But they are rendering the term vacuous and void (Townsend, 1999) through inappropriate use. Peersman (1999) sees that "the language has changed but the power relations remain unchanged" (p 124). Or as

Mayall et al (1999) suggest, the "popular notion of 'empowerment' is a facile way of avoiding the social economic determinants of health" (p 6). While donors and policy makers believe that women's situation can be improved without addressing or affecting men (Crewe and Harrison, 1998), little will improve at the local level. Senior staff and managers are accepting the use of this term in order to remain in the game, and are using it in the area of funding to attract resources. As suggested in the previous two sections, men are presently ignored by the health sector. So it is unsurprising that the use of the idea and term "empowerment" is also problematic in PHC.

Reality in Gwassi

Several staff mentioned the idea of empowerment when discussing the programme in which they were working. This was most obvious in the Kimange scheme organised by an external / international NGO. The nurse in charge of the CHW scheme used the term empowerment when referring to clinic activities and the CHWs also used the term in informal discussions. No staff used the term in the formal interviews – possibly, as when interviewed there was no concept by the interviewer of this term having become common currency in this programme.

"I am empowering these women."

The nurse managing the CHWs and the clinic at Kimange (through CRS) after completion of a monthly clinic (CH and AN) session said this. She strongly believed that provision of the clinic was empowering[127]. However it was not clear how this empowerment would work in the situation in which she was making the claim.

The use of the term, "empowerment", was totally inappropriate; it had no relevance in the situation in which it was used. The term was used in relation to women attending clinics as described in this and the previous chapter for themselves or with their children. The term was used alongside personal denigration of the women by the trained staff. The nurses at all facilities saw the attendance of the women at the clinic as paramount. Non-attendance or late attendance is viewed as a serious offence that

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[127] She was also highly indignant when asked to explain to whom and how empowerment was occurring.

allows severe public admonishment. The denigrating manner[128] in which staff treated women who were attending later than the recommended schedule for either AN care or childhood immunisations is unlikely to promote power, or disrupt the lack of power, that these women experience in their daily lives.

The CRS clinic work only focused on women as mothers – on health problems they might encounter as either pregnant or around delivery; or health problems from which their children could be protected either through immunisations or from growth monitoring. However, the programme had failed to address any socio-economic reasons for poor health, or ways women *and men* could be assisted in improving family health. The clinics themselves were offering only AN and CH services, including immunisations. Nurses and CHWs offered these in a style identical to other government or diocesan clinic service, including a rude and dismissive attitude. The only advantage of this clinic was that it brought the clinic nearer[129] to the women. But the attendance was low[130], possibly due to the erratic nature of the clinic – it had not been held for three months before this session.

The assumed power of the trained health staff over the mothers is in stark contrast to the language of empowerment used by the nurse running the CRS clinic. But for participation and hence empowerment to be open and transparent, a significant shift in power (away from the professional) is required (Nelson and Wright, 1995, Ch 1). As clearly stated by Stein (1997), empowerment is not something that can be given.

Women attending clinic was seen as the main activity and reason for the CHWs to validate their work in the community; and by the trained staff at the clinics to raise more fees to pay their salaries and for drug supplies. The emphasis remained on the service itself and the providers, not on any positive outcome for the women and children.

The continual insistence on clinic attendance without maintenance of clinical standards which might have produced positive outcomes, negates any idea that the

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[128] As discussed in the previous chapter (see section "Interpersonal Skills").

[129] The clinic was held mid way between Tonga HC and Nyandiwa Dispensary - approximately one hour from each fixed site.

[130] The three trained nurses and four CHWs saw twelve children/babies for growth monitoring and immunisations and seven pregnant women for monitoring and tetanus immunisations between them.

service is *in and of itself* empowering. This appeared to be the attitude of the CRS staff, that a clinic of itself was empowering. The work of the CHWs could not be seen as empowering either, as the main emphasis of their work was totally fixed on the women (and their attendance at clinic) despite claims to undertake other community-based work. The admonishments they receive possibly discourages women who feel the cost is already too high. This links back to Gilson et al (1994) and the idea that the quality of service, including interpersonal relations, is important in health service delivery. These relations are often linked to power structures – both innate in the community and through the health service and its bureaucratic structure and statuses.

Empowerment through knowledge and community support?

As discussed in earlier sections, the female CHWs in Kisegi were positive about their work in promoting family planning, despite violence and intimidation from the community and lack of support from their supervisors. But the women continued to promote family planning both from their own personal acceptance of modern family planning methods, and also in response to local women's support for their endeavours. CHWs were asked about any community support that they got, as separate from what they personally enjoyed and had problems with in their work.

There is a big difference in the homes where I live[131]. Previously diseases were there (but) now women attend clinic – in days back women not going. People plan their families. There is space between children so money will be found for school fees. Previously children (were) born yearly. These days they appreciate the work I do as good and they find ease at home.

This woman later reinforced this idea of friendship and community solidarity with her work in her explanation of why she would continue:

It also helps me. I have a lot of friends now because of this work. I know a lot of women and we help each other. We share our minds on all sides. These ideas help me and I find ease in my house.

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[131] This woman lived in a fishing centre at the lakeshore.

Another woman is also clear that FP is important knowledge and work to her and her community.

For herself:

I love it and it gives me much knowledge among other small things..... My work is very special.

And for the community:

(they support me) following my good work.

As discussed in earlier sections and above, all the CHWs were very positive about the knowledge the training had given them, and how highly this was valued. They also clearly saw themselves as supported by members of the community. In Kisegi, this is mainly linked to FP issues; for the Kimange CHWs the PHC knowledge was seen to be very positive, but they also report high levels of support from the community. This knowledge, which is challenging these CHWs in both their personal lives and in their relationships in the community - both with women and men - is potentially *empowering*. But the programmes themselves are not organised to assist in building on the positive community relationships that CHWs were reporting in their programme. The Kisegi CHWs are assisting women and men to challenge particular disempowering situations. But programmes need to promote more than just information for women to confront gender issues (here mainly in reproductive health).

Empowerment and the health sector

In order to address empowerment, the service must also address gender issues, which the health sector at present is not undertaking.

As discussed in Chapter Two, Kaler (2001) suggested three ways in which the term "empowerment" is used in development discourse. Kaler saw most health workers (in Kenya and South Africa) as using the second definition of the term empowerment - "empowerment-as-meeting-practical-gender-interests". This would fit with the situation found in Gwassi. The nurse saw the intervention as empowering, but this was only due to assumed practical implications of the intervention she was promoting. No strategic empowerment was even on the horizon, and was not considered

necessary for the intervention. But the use of this word assumes that the situation *is* empowering, whereas the poor quality of the services suggests that for the user there is little empowerment. The service is being delivered in a style that reinforces power structures around and within the health service – and more power is accumulating for the staff and the service itself through the revenue and other benefits of having many women attending.

And the stance taken by the CHWs suggests that for their roles the definition would be Kaler's third level of definition - "empowerment-as-sum-zero-game" as no CHWs were asked to, or suggested they should, confront any local gender roles in health care in the family. All care was to be undertaken by women, mainly through attending clinics. Hygiene promotion reinforced traditional gender roles. Men could opt in or out of health related activities. There were no sanctions or admonishments for men to fear. The VRPs' experience though suggested that men could be accommodated in successful hygiene promotion if they were included in the programme at all levels. The community can be empowered to improve their health situation, but not if gender is ignored.

Empowerment of women is not going to occur through the enforcement of clinic attendance. Women must have a free choice; similar to the men who appeared to have choice about whether or not to participate in health activities. As Kabeer (1999) points out, if women's agency is not acknowledged then claims to empower women are rendered void. Unfortunately, the language in which empowerment is operationalised often conflates resources, agency and achievements into a single instrumentalist idea - called "empowerment". This compression of many factors into a single idea (and limited indicators) also manages to place all emphasis on the individual, and to remove the social, the local situations in which women live and operate (Kabeer 1999). This appears to be the case here where the nurse viewed the women's attendance at clinic as somehow being empowering. But specific activities are not necessarily empowering in and of themselves. And the activities seen in this research were certainly difficult to define as such.

Conclusion

This chapter has demonstrated how despite various activities, the PHC services in Gwassi are not addressing many aspects of health needs. The health services remain focused on (sub-standard) clinic activities, which perpetuated the rural medical model. This orientation though leaves many gaps in provision, for example in the promotion of RH or prevention of Environment Related Communicable Diseases (as stated in the National Health Sector Plan (Ministry of Health, 1994)). The inability of the health sector to offer comprehensive PHC services is not commented upon by any of the service providers. The myth of PHC is allowed to continue unchallenged. The rhetoric of PHC is unrealised, and the reality is a basic rural medical service.

This inability to widen the remit for the health sector was due to both historical factors and also organisational inertia. The whole community along with staff and managers were referring back to an image of health care that they had experienced before. This image was of a clinic staffed by a nurse. Any challenge to the model was deflected, and the new ideas (RH especially FP, communicable diseases and IMCI, gender, empowerment) were simply added to the previous functioning system, which as demonstrated above frequently gave no room for the additional ideas to be incorporated in a useful or meaningful manner. The use of an organisational perspective allowed the health service and the staff to be displaced from the centre and to give space and voice to the local community, the potential users of the service. The daily reality for the community was ignored by the service providers. In particular, the CHWs and the dangers they faced in their work demonstrated how the clinics were very instrumentalist in how they utilised the CHWs.

The community views of the CHWs demonstrated how CHWs (even if male themselves) still only promoted a highly gendered view of health and health promoting activities, to the extent that local men screened out the CHWs and their work. Therefore any health promoting activities requiring the participation of men were not completed. Another programme, also addressing local health problems, was able to involve the whole community. The effect of this was that all health promoters - VRPs - in this group denied that they were *'doing health'* as their view of health was to only target women, and their programme was successfully involving men.

The continued focus on AN / CH clinics and the use of CHWs to reinforce the messages of these clinics alone, effectively screens out other "health" issues – as well as eliminates the wider socio-economic and gender impacts on health (Oxaal and Cook 1998). The health sector, by ignoring its gendered delivery style, promotes highly gendered roles for men and women. The inability of health organisations to reflect on gendered aspects of their policy and practice makes claims for empowering and other emancipatory goals very unrealistic. Issues "inside the family" - which remain domestic and feminine (Smyth, 1999) - remain ignored in health policy. This also denies agency to individuals who may wish to challenge such prescriptive roles. The high value placed on the knowledge gained by CHWs illustrated some of the resources desired by local women.

The "limits of what is possible" (Petersen and Lupton, 2000, p 10) remains reduced by the health service itself, whilst the community's demands and ability to respond to other assistance was demonstrated to be much higher. The ability to positively respond to the Lake Basin Development Authority to build, maintain and appreciate boreholes, latrines and other measures to prevent cholera, worms (and hence anaemia) and to improve general well-being occurred outside of the gendered health service. In contrast, the present gendered approach of the health service has a diminishing effect on what it is able to actually achieve.

Chapter 8   Trapped Inside and Locked Out

Through a case study of primary health care delivery in rural Kenya, the present research has exposed some of the gender assumptions that underpin the present day models of primary health care, which are commonly implemented around the world. The argument made, on the basis of field research conducted in Gwassi, is that there is considerable dissonance between the rhetoric and the reality of health policy and health service delivery. On the basis of the evidence collected, it is suggested that the failure of health service policy and delivery to be able to respond to health needs in the rural areas of Africa is due in part, to the continued use of specific gender stereotypes in present day health policy and practices and perceptions. It is also recognised that it is not possible to generalise from a single case study based on qualitative methods. What this research has demonstrated, nevertheless, is how women and men in one local community in their perceptions of health services, upheld the gender stereotypes of those within the health service. It is argued that the persistence of these stereotypes has contributed to continued missed opportunities around health improvements in Gwassi.

The conscious and unconscious operation of gender stereotypes extends to the policy and planning levels to inform the development and delivery of PHC in rural Kenya. They are then perpetuated at the practical level in the delivery of services. The operation of gender stereotypes was reinforced as they interacted at the different levels of policy, planning and practice. This was found to equate with Foucauldian notions of discourse and power, and the circulation of power, as a "net-like organisation" (Foucault 1986 p 233) as it is both experienced and exercised by individuals. The present claim by the health sector in Kenya, to be engaging with gender and gender issues, was found to be highly rhetorical and at times instrumentalist. Moreover, it was often the health sector itself that was contributing to the perpetuation of specific gender images of roles and responsibilities in health care that operated against power and empowerment of women.

Epistemological and Methodological Issues

In this research organisational theory was adopted in order to clarify both theoretical as well as methodological issues in the health sector. Organisational theory was utilised to highlight problems around inclusion or exclusion of different stakeholders in the research and their participation (or not) in health services. The pre-definition of the PHC "package"(Mosse, 2001) and the pre-drawing of boundaries by the experts and policy makers (Hatch, 1997) were shown to have the effect of removing many gendered issues from the horizon and as areas of concern. This lack of visibility of gender issues is also due in part to claims by medicine of being scientific and hence gender neutral or ungendered. This tendency was outlined in earlier chapters and included under the discussion of methodological issues. The use of an organisational perspective served to get behind the official or self-reflexive view of PHC to expose something of the reality and was confirmed as an important conceptual tool in application to the case study district of rural Kenya. An organisational approach also helped answer the issues raised by Halford and Leonard (2001) on how to include gender within the study of organisations. Importantly, to do this the question of power needs to be included. Organisational structures both empower and disempower women and men, who are both agents and subjects of power relations (Halford and Leonard 2001 p.63).

This research has attempted to move beyond the self-reflexive exercises identified by Walker and Fox Rushby (2000) of much current health research and evaluation. However, as highlighted in earlier chapters, in health research it is difficult to elucidate the construction of, and collusion in, dominant health discourse when everyone accepts the health service presently delivered as "a success" (Smith and Cantley 1985). This common acceptance mirrors Foucault's assertion of dominant discourses having displaced any alternatives in modern society. Despite awareness of the problem of a collusion or convergence of discourse in this research, it remained a methodological issue as to how to step outside what were considered by respondents to be normal boundaries and stereotypes. Gender stereotypes limit the discourses and responses to health issues in PHC. The research also demonstrated that the organisational "stickiness" or theoretical inertia associated with gender roles and relations in health care remained difficult to negotiate at the practical level. It also highlighted the problem of how to include as problems or concerns, issues that are not

even allowed to "get onto the agenda" (Lukes, 1974). In the case of the present research, it was also problematic as to how to include issues which people wished to remove or keep separate from the health agenda. In Gwassi it proved difficult to "allow" the community "...to choose something if (they) do not know it exists and cannot imagine it existing" (Oakley 1993 p 45), that is, to suggests alternatives not presented by the medical experts (Gestaldo 1997). In other words, despite it being an important objective of the research, it was difficult to explore other 'truths' about health and health care that are presently being ignored by the medical model and PHC, and not presently incorporated into health policy and planning (Petersen and Lupton, 2000). This difficulty is offered as one of the major challenges and potential limitations of the research, although it is posited that the attempted exploration and inclusion of alternative discourses is an important endeavour in itself. This is in order to move beyond the managerial self-reflection of the organisational goals and objectives (Schiell, 1997; Walt, 1994). Moreover, the deliberation within the research process of what gets included constitutes an important contribution in its own right.

Implications for Health Policy

> "The big picture and big theories of policy and science too often loose sight of the daily reality of people's lives" (Harcourt, 1994).

Health service research frequently ignores the gendered foundations of health services and their delivery, and moves quickly onto the biomedical, technological or economic aspects of health service policy and practice. The earlier feminist ideas, as expressed by Tinker (1990, Ch 1), that once policy makers and staff recognised and corrected the gender biases in data collection and documentation, so inequalities could be eliminated in policy and planning, have been proved to be naïve (Mayoux, 1998). This research concurs with the conclusions of Elson (1995), Geisler (1993) and Harrison (1997), that the "adding" of women, or gender, as an afterthought is not possible if the original theoretical position underpinning policy is flawed. As Razavi (1997) suggests, the problem is for professionals to accept theoretical shifts, which would ultimately undermine the very paradigms upon which their whole world is built – these are the "intrinsic design faults" (p 1122), which she refers to in relation to development policy more generally.

PHC policy is not "male-biased by omission"(Elson, 1994, p 35). Instead it is highly "woman-biased" due to its historical roots as discussed in Chapter Three. The continued focus in PHC on curative and MCH services (despite recent claims to be delivering PHC and RH services) was borne out in Gwassi by the almost exclusive bias towards, and use of, local services by women and children. However, this is not to say that PHC is female-biased simply because medical services are focused on sex, not gender. It is also underscored by gender stereotypes. The focus on women is not promoting the optimal health of the community, including women within it, due to the unrealistic expectations of the PHC services to deliver health improvements in a highly gender-specific style that relies on women as health conduits and carers. The focus on women is deeply embedded in a particular view of health, which is based on specific responses to the role of motherhood and nurturing, and which excludes men and their roles within the family and community.

Findings on Gender and Primary Health Care

The following areas are highlighted from this research to explain the poor performance of the PHC services:

- Continued focus on medical technology;
- A focus on powerless women in PHC:
    At clinics
    And in the community;
- An instrumentalist use of CHWs;
- Empowerment added to health

These four areas are discussed below in turn.

Focus on Medical Technology

In Gwassi, there was found to be a reversion of health services to a rural medical model as outlined by Woelk (1994), and this was being continued in circumstances where actual delivery standards were low due to a myriad of factors. The general physical problems and limitations within Gwassi that contributed to this poor delivery

were outlined in Chapters Five and Six. In both the Diocesan and Government health services, the isolated staff were inclined to continue the delivery of selective PHC services - with the focus on MCH services - in the traditional rural dispensary style, despite whatever messages were coming from or understood by 'the centre'.

Many of the stated PHC activities beyond curative care were not provided, not regularly provided, or only provided in theory. In practice, the lack of essential equipment, vaccines or drugs made the claims to be providing several of the eight essential elements of PHC, false. In particular, claims to be working in prevention, for community involvement or multi-sectoral cooperation were all highly implausible due to limitations of staff, transport problems and the lack of movement of staff around the area. Yet, the rhetoric of PHC was frequently alluded to, and claims to be delivering health care within the PHC approach were made by all service providers and their managers.

The staff at all facilities continued to prioritise women, and at the diocesan health centre and dispensary they relied on women's attendance to deliver the cost-recovery required to enable the continued functioning of their facility. For all of them, treating and seeing more women than men daily negated any idea of the need for any detailed gender analysis of their services. Since PHC is already pre-defined as being *for* women (as reproducers and nurturers) they did not look more closely at the social and gendered dimensions of their programme as was also found to be the case in the research by Inhorn and Whittle (2001).

Men, including elders and councillors, were highly desirous to improve the health situation at personal, family and community level. This was frequently expressed as requiring yet more health facilities (the medical model) in the location. The health services were highly valued by community members for their curative services, and yet the use of health facilities was generally low. In trying to understand the low utilisation of the various facilities, it was found that while people voted with their feet, no one would report any problems experienced with their local or other service providers. In this remote area with very limited access and transport facilities, the professional skills and physical presence of the nurses was highly commended and appreciated. Men and women, community leaders, users and non-users of services alike, all expressed this view. This suggests genuine appreciation of these services but

also might suggest a powerlessness to make criticisms of health professionals by respondents.

Both the local staff *and* community were seemingly untroubled by the disjuncture between the rhetoric and the reality of PHC understood more broadly. More *medical* services were viewed by all as necessary to improve health care within the location, despite low utilisation of present facilities. The lack of effective and efficient use of present facilities was not addressed by anyone. For example, staff welcomed the idea of getting additional staff into the area to allow for time-off and professional support. However, different existing service providers or individual staff did not presently offer practical support and co-operation to each other.

The very low utilisation of services meant that in effect, it was not possible to maintain the viability of curative health centres or dispensaries. The clinic attendance of women was now required to subsidize the facility as a whole, and the competition between the nurses for women to attend their facility was a reflection of this expectation. Men's attendance at local facilities was negligible, but nurses felt that they could not attract more men and did not try (men though were highly over-represented as in-patients at the nearby diocesan hospital). This illustrates very starkly the instrumental use of women as targets of PHC in ways never intended by policy design.

The technocratic model of health, with its claims of being gender neutral has continued, while incorporating economic models with their own biased gendered perspectives, and prioritising efficiency arguments along the way, with their negative consequences for women. Unfortunately, while the professional paradigms used in health remain the medical and economic models, with a focus on rationality and science, social, micro-economic, political and moral questions have been relegated to the background, and along with them a concern for gender equity. Consequently public health has managed to side step appropriate and alternative responses, for a "more-of-the-same" medical approach, which in Africa means the rural health centre of the type found in Gwassi. This is a highly conservative approach, and allows many assumptions "below the waterline" to go unchallenged, including assumptions about women being solely responsible for the health of their children and family more generally. The PHC approach has been subsumed into this technocratic medical

model at the local level, and was found to be accepted by both staff and community. However the actions and justifications of both these groups allowed the rhetoric of PHC to remain intact, with all its gendered assumptions for local practice.

Focus on powerless women

At clinics:

All health staff focused their attention on women. All discussions about PHC focused on women, and what they were either doing or not doing. This led to prescriptive health activities in which women must be encouraged to participate – whether in their own homes or through clinic attendance. Even when the observation of women's behaviour was incorrect, staff and senior staff felt confident to express themselves around what they held women to be doing (or not doing) according to learned international stereotypes. PHC and specific MCH myths and assumptions served to sanction such stereotypical beliefs. An MCH example, given in Chapter Six, was of a senior manager in Mbita claiming that *"(lack of).....breastfeeding is one of the main problems we face."* This was despite both local observation and all official and unofficial statistics indicating almost universal breastfeeding in Gwassi, suggesting that this was not a problem (or not in the way in which the speaker meant[132]). This is an extreme example of both the pre-packaging of an issue, as well as prescriptive responses that do not include reference to the views, behaviour or actions of the local community. It demonstrates the power of the professional to pre-define a problem and then a "solution", even when the rhetoric bears no relation to the reality. Petersen and Lupton (2000) describe this as the "absent expert" remaining in control, to both define the problem, and also the solution.

Within Gwassi, all the trained nurses, nurse-aides and the CHWs claimed to be following the PHC approach. In practice, this meant that they expected women to attend AN and CH clinics, even when they were aware that the equipment and drugs and vaccines for the full delivery of these clinics were not available. Women were targeted in their biological role as mothers and consequently men were not targeted. Men were ignored by the local health services and consequently felt that all the

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[132] The energy requirements for a woman to continue to solely breast-feed her child until six months, and then to continue feeding until the child may be two years old could be an issue for some marginalized women who are food insecure. Also the recent debates around breast-feeding in areas of high HIV infections could have suggested an alternative concern.

messages, particularly those from the CHWs were not relevant for them. In contrast, the women were well aware of the messages and their expected response. They were publicly admonished for not complying with the messages. An extreme example during this research was the verbal abuse directed towards a grandmother (the mother having recently died) for attending "late" with her granddaughter at child health clinic. Low-level criticism without seeking explanation for the behaviour was commonplace. The women were given no option but to comply. The almost universal reports from the CHWs of women *"not attending"* or *"ignoring"* their advice to attend and hence *"giving me problems"* reflects how compliance with their advice was expected – despite the clinics either functioning erratically or offering a very reduced and sub-optimal service. The CHWs felt able to vocalise the dominant professional view – reproducing the voice of the "absent expert" – despite the poor quality services at the local level. The CHWs were central to the circulation of the dominant discourse and of their role in the distribution of power at the local level. However the chief and other figures of authority also publicly reinforced the expected compliance of women in specific activities and behaviours. This chimes with Foucault's view of the general public being complicit in the creation of certain power discourses and power of professionals (Rabinow 1991; Turner 1997).

In the community:

In addition, women, not men, were also expected to complete activities within their homes, especially around sanitation and improved quality of potable water and increased use of water for hygiene, and around nutrition. Despite the requirement of male involvement for the successful completion of the construction activities, men were not explicitly or implicitly included in either the message delivery or activities discussed. Nor were they included as a separate audience for the messages through other routes.

In contrast to the hard-line approach to women and their expected compliance, men were free to opt in or out, and most men appeared to opt out. Staff, CHWs or community members never commented upon the non-compliance of men in their health and hygiene promoting roles. No private or public censure was directed towards men. Men were aware of, and interested in, the idea of PHC. They were interested in, and attuned to, the need for several preventative activities, both within

their *dala,* and also at the clinics. But for men, engagement with these health messages was optional. Their role within the family and as fathers was ignored, in contrast to the focus on women and a claim for the mother to be wholly responsible for their own and their children's health, in specific areas defined and claimed by the health sector. Men saw themselves as outside the concern and plans of the health service. Methodologically it was difficult to interview the men about PHC activities, as they continually related the questions as referring to issues that only apply to women or, in particular, to their wives.

For the staff, the CHWs and the local community, the idea was very strong that the function of the health facilities and the MCH clinics, and the work of the CHWs in the community, was to be offering services that were solely for women. Everyone had the image of PHC being concerned with women alone; of only women being able to attend clinics with their children, of only women being concerned with water quality and quantity in their homes, only women responsible for the hygiene of the dala and the people living there, only women concerned with nutrition. This limited image of the areas of health service concern was accepted thoroughly by everyone. The idea is totally "boxed-in" (Leach and Mearns, 1996) by the conventions of the health services. It has become an organisational myth, or a TINA (Clegg 1990).

That some men in Gwassi managed to participate in health and hygiene promotion issues - through distancing themselves from the health sector altogether - is a significant finding. Men were not disinterested in health and hygiene messages. They just did not feel that the work of the local health services related these issues to them. The members of one community group (men and women) who were achieving the activities promoted and supported by all CHWs (including the VRPs) – namely the building of home latrines and a potable water source nearer to their village - were adamant that they were "*not working in health*". The language they used when they explained why they had undertaken the work, which was now successfully completed, clearly indicated that this had been to improve *the health* for themselves, their families and the whole community, and even especially for the women. They described their work as having been to prevent the return of cholera, to prevent outbreaks of diarrhoea and other waterborne diseases and to prevent scabies. They saw that the reduction in the distances women travelled to haul water mean that "*mothers are now fat*" and that children are also more healthy. But they would not

accept that they were "*working in health*" or "*doing health*". This disjuncture was maintained, even though the hygiene messages were acknowledged to be the same as those promoted by the CHWs at other sites in the location. Men and communities could be highly mobilized to specific health activities; but only outside of the local health services. The important point here is that the health services were seen as only working through women, so the local men could not and did not engage with these same issues when raised by the local health services.

An instrumentalist use of CHWs

The health service used CHWs to reinforce highly gender-stereotyped roles for women, or what Rogers (1980) called over twenty years ago, the domesticating of women towards a western vision of motherhood (cited in Goetz, 1997, p2). Zakus (1998) has highlighted how CHWs are used in a highly instrumentalist manner by health services, and how they are utilised to deliver services on behalf of the health service. Ramirez Vallez (1998) also points out how CHWs are mainly female. Both findings were validated by the situation found in Gwassi, where CHWs were utilised to promote and reinforce the highly stereotypical roles ascribed to women generally by the health service and then enforced through the CHW work style and messages. Linking findings to the conceptual framework employed in the present research, it was found, therefore, that CHWs helped deliver the rules and myths of the organisation, to achieve the rhetorical goals of PHC (Peterson & Lupton 2000). These are the Foucauldian webs of power relations that run through the society (Rabinow 1991 p.61), and how they inform the links between the macro (international) policy and the micro (family) practices.

For the CHWs, men are invisible or screened out as irrelevant for their health promotion work. The potential and useful role of men is ignored. Even the few male CHWs working in Gwassi worked to a medical model that had a highly gender-specific view of the health messages of CHWs and to whom these messages were to be aimed. Health promotion within the *dala* was frequently alluded to as part of their role, but this was allowed to pass unachieved. The CHWs all gradually removed themselves to the more clinic based, medical aspects of their work. This was most succinctly seen through the continued focus on women's attendance at clinic. The fact

that the clinics only demanded women's participation, while the home construction activities would also require men's participation went generally unobserved. No one was making overt comments about men's behaviour and attitude for health promoting behaviour, as they openly were allowed to do about the women for not following their advice. Foucault's "grids of disciplinary coercions" (1986, p. 236) can be seen to be highly gender specific in PHC.

The nurses at the health centres and clinics supervised the CHWs. The need for the Diocesan and NGO services to raise cash for the financial viability and continuation of the service as a whole, clearly influenced the nurses' view of their services and total attendance at their clinics. There was even competition between the nurses as to which clinic the women were attending. So women's clinic attendance was also highly important in framing the relationship between the CHWs and their supervisors, with the CHWs being caught in the middle, given the need by the nurses for women's clinic attendance.

The CHWs trained and supervised by the NGO all mentioned improved hygiene in the homes, and especially construction of latrines and access to clean water and building of "racks" as very important activities which they undertook. And many mentioned their supervisor as coming to visit them in their local community and "counting racks" or "checking the latrines are built". However, this support and supervision did not appear to occur in reality and neither did the completion of these activities. Instead the nurse supervisor when she came to Gwassi undertook a regular MCH clinic. The CHWs were primarily assessed on their ability to get women to attend clinic. The community-based activities, which the CHWs found very difficult to achieve, were allowed to pass incomplete and un-remarked. This is in contrast to nurses and CHWs feeling very free to make comments about women's interaction with clinic services. And this is in stark contrast to the claims for the service to be empowering women, as elucidated in the following section.

As highlighted in Chapter Seven, all the CHWs were incredibly enthusiastic about their roles as CHWs. Many CHWs claimed that they would "continue for life" and that it "gives me great pleasure". However, this satisfaction appeared to derive from the increase in knowledge of individual CHWs. The gap between the claims about their role and their actual achievements was very wide. All CHWs also freely talked

about their frustrations with their role. As discussed above, the CHWs generally blamed these frustrations on the (powerless) local women for not doing what they had asked them to do.

Empowerment added to PHC

Today, PHC is becoming dressed-up in "community empowerment clothes". This has been driven by empowerment discourses outside the health sector (Porter & Verghese 1999). As suggested in Chapter Two, the adding of power and empowerment discourses within the health sector have not been encouraging in terms of practice and the health sector as a whole tends to ignore power issues (Peterson and Lupton 2000 Ch 6). The possibility in Gwassi for true strategic empowerment to occur from the "adding" of empowerment discourses to PHC are not conceivable whilst PHC remains highly steeped in traditional gender stereotypes. Social inequalities at the community level, especially between men and women are not considered or addressed, and social order is seen as immutable, natural even. In the health milieu of Gwassi, where a highly gender specific view and reinforcement of men's and women's role prevailed, it was not expected that claims by health staff to be empowering women would be encountered. How empowerment processes might proceed in the extremely dis-empowering situations seen at the NGO clinic, for example, is strongly doubted. Staff were clearly in control of encounters with women at all clinics, and verbally demonstrated their power over the women. This was most acute at the NGO clinic observed, which was also where the claim for empowering women was made.

For the staff members who were using the term, the definition of empowerment appeared to follow Kaler's "empowerment-as-meeting-practical-gender-needs", discussed in Chapter Two. However this outcome was observed to be highly unlikely in the clinics observed[133]. It also assumed that the depleted services offered, were beneficial in and of themselves. Kabeer's (1999) discussion of empowerment is highly pertinent here. In particular, the use of the word in Gwassi saw empowerment as a product, not a process. The top-down approach of the nurses and the CHWs in their interaction with women suggests that the adding of empowerment to their

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[133] Except to bring vaccines nearer to some women on an almost *ad hoc* basis

present roles would occur simply as a further message or item, which was delivered to the women. True empowerment could not proceed without a re-evaluation of the roles and methods used within the health sector.

The diocesan staff acknowledged their own power-diminished situation at the end of weak support and supply chains. The desire of these nurses to maintain concord with the local community meant that they did consider the community's views of them and attempted not to be perceived as "*harsh*". However, this did not mean that they saw their role as to offer any practical or strategic empowerment routes or circumstances for the local women. Instead, they held firm to the traditional MCH model of ways to improve the health of mothers and babies through AN and CH clinics.

However, the CHWs did highly value the knowledge that they gained from the CHW training; in particular among the group that had received family planning in their training. These CHWs were attempting to share this knowledge in their locality. However, the negative response to family planning messages by many men – despite a very positive response by many women – meant that they were struggling to maintain the impetus in transferring this knowledge. Local women expressed their agreement with contraception, not only by accepting pills from the CHWs, but also through attempts to access long term (and more covert) methods from outside the location. The government health staff supervising these CHWs did not engage with the empowerment rhetoric of the NGO staff. However, the limited practical support offered to the CHWs and the violence and problems they faced suggested that they did not wish to engage with such potentially empowering processes for the women.

Access to knowledge and information is very important to women and men in this remote location. And it can be the first stages of empowerment. The continuation of women to work as CHWs is partly due to the value that they place on the knowledge they receive from the training; linked to a general desire to improve their local situation, including health. But although the knowledge could be said to be empowering some women, it is unlikely to reach out to the whole community, and unlikely to be transformative, even though it was found that communities do want to tamper with issues, including health issues; they do want to get things done, and to change things for the better.

The organisational myth

The health care offered in rural areas of sub-Saharan Africa such as Gwassi follows a highly prescribed form. This derives from an interplay of historical factors that have their roots in colonial and postcolonial models of health and development, as well as the institutionalisation of contemporary medical and economic paradigms. These models and paradigms have given rise to a number of organisational myths underpinning the delivery of primary health care as practised in rural Kenya by both governmental and non-governmental providers. Myths are difficult to expose and research, let alone to counter. However, to develop more positive policies and practices for the delivery of improved health services and outcomes, myths need to be dislodged and displaced, including those around gender.

The medical, technological model, with its highly gendered history of professionally determined appropriate services that involve particular targeting of and responses from women and men, has been perpetuated and promulgated across place and over many years such that it has become an organisational myth. The reversion of local PHC services to such a medical model, irrespective of alternative designs and interventions along the way, has allowed a re-emphasis of the gender assumptions underpinning PHC that operate to over burden and dis-empower women. The non-interrogation of the gender stereotypes and biological emphasis underpinning PHC allows all health staff to believe that they are working with gender, and so allows them to feel they are fulfilling international health messages and mandates and to ignore any further interrogation of their work and its impact on the local community. The organisation retains the power to define the issues, which in turn is reflected in the policies and practices of the health service and its delivery at the local level. But, with men locked outside and women trapped inside meaningless health rituals, the organisational myth, however tenacious, can no longer deliver transformative solutions as originally promised by PHC.

Appendix 1

Summary of Interviews

The following is a list of the people interviewed and with whom the health needs of the location and the health service provision was discussed.

CHWs   *Taped:*

10   Kimange CHWs + Chairman + Helen
12   Kisegi CHWs + supervisor from Kisegi HC + Mary
5   PHCWs
4   VRPs + Secretary + Esther

Other officials interviewed   *Not taped:*

Chief of Gwassi
Councilor for Nyakasera sublocation
District Officer (DO) - Magunga
Medical Officer of Health (MOH) - Mbita
Head Diocesan Development Office - Homa Bay
Head of CRS FACS sub-office - Mbita
Deputy Director CRS programmes - Nairobi
Sister in Charge at Nyandiwa Dispensary
Sister in Charge at Tonga Health Centre
Nurse running Scout centre clinic
Nurse-in-charge Kisegi Health Centre
Nurse at Kisaku (scout) clinic
Nurse in charge FACS project for Gwassi
Priest for Gwassi & Tonga (Catholic)
Preachers for Gwassi (SDA)
Coordinator for Scout Centre in Gwassi
Retired MP for area
Director at St Camillus Hospital, Karungu
Nurse auxillaries 2 at Nyandiwa Disp
Nurse aides 2 at Tonga HC
Doctor, nurse and administrator at St Camillus Hospital
Project officer CARE RH project - Kisumu
Head masters at 5 primary schools in Gwassi (+ 1 in Llambwe)
TAC tutor in Gwassi
Chairman of Nyandiwa Dispensary Committee
Leaders of 3 women's groups in Gwassi
Ministry of Agriculture coordinator & staff – Magunga

Local people.
Couples with a child less than 12 months.   *Taped:*

20 couples = 5 couples from Nyakasera, Osiri, Kitawa, Obanga

Other relevant people: *Not taped:*

Staff and visitors to Scout Centre in Nyandiwa
Owners of businesses in Nyandiwa, Kiwa, Kijabi
Extended Families in Nyandiwa; Kiwa; Nyakasera; Kitawa; Kimange; Llambwe
Women farmers in Gwassi
Fishermen in Nyandiwa and Kiwa
Trained and untrained primary school teachers in Gwassi
WHO Consultant for EPI in Kenya - Kisumu
Director TICH, Kisumu
Staff and consultants on Schistosomiasis project – Kisumu
ICIPE staff – Mbita.

The format of all interviews was kept deliberately "open", but for the taped interviews a formal set of questions was devised to assist the conduction of the interviews among a homogenous group of workers. All staff and officials were asked both about the services they presently provided or managed, as well as their thoughts on additional needs or different emphasis required. Managers in Kenya have witnessed and managed major changes within health service delivery and so were able to vocalize many issues clearly. But again despite the rhetoric, at the practical level they were less sure of the delivery systems. Local health staff were certainly more candid and sharing after the researcher had been in the area over some weeks and had assisted them in minor and informal ways. Many local trained staff appeared to welcome the opportunity to have someone to unburden years of personal and professional hardship onto. This allowed a more nuanced response that was able to get behind the "official view" of the services as presently delivered.

Getting behind the "official view" of the CHWs was more problematic. As Walt (1990) suggested, unless a full ethnographic approach is taken with the whole team it is difficult to assess their work and the standard to which they actually perform. It quickly became clear that their responses and their actual performance were not fully congruent (eg no racks or latrines in evidence). The myths and organisational ideology were very strong and adhered to by all the CHWs. In order to appear less supervisory the role of interviewing was then given to a local woman. This was to try and probe their daily reality of completing their CHW roles more sympathetically. Follow up discussion and visits to clarify the gaps between the rhetoric and the reality were still required though. This was both with individual CHWs and also with the PHCWs. The PHCWs were no longer employed but were now involved in the CHW and VRP programmes and were able to reflect on their own and others' varying experiences over the years. This additional reflection on the data was most useful to make sense of the responses.

The gaps and silences in the interviewing – most notably the early refusal of the VRPs to be interviewed as they "do not do health" was very revealing and the prolonged fieldwork was able to capture and accommodate these alternative · voices. The responses and insights gained were very useful in finding new routes to attempt to get behind the official view of health as held by local members of the community. In addition the inability of men to understand some of the questions in relation to the work of the CHW also led to new probes to understand their relationship to the CHWs and the PHC teams and health in general.

All the taped interviews were conducted in dhoLuo (the language of the Luo people), transcribed and then translated into English. The English translation was then revisited alongside the original dhoLuo tape, and additional notes made if necessary. Finally the English version was typed up as Word and Excel documents. Except several men wanted to be interviewed in english,a dn so this was donw. However , this did not make the interviewing any easier, as the use of jargon, especially health jargon still required further elucidation and clarification. When interviewing in DhoLuo the probing and further questioning could be assumed to be for clarification and instruction for the translation.

A major problem with all interviews was in the locating and then interviewing of the individuals concerned. This was always problematic for young men. It was also problematic for all women during the main agricultural seasons of ploughing, weeding and harvesting. This necessitated repeated visits to some areas – often over four hours walk away. It required tenacity and stamina to complete several of the interviews, especially in the rainy season. Waiting until after the end of the rainy seasons was not an option either as many women take the opportunity in the dry season to visit their relatives and to complete familial duties. Staff presence at health centres and dispensaries was also very unpredictable, as was manager and supervisor location. Interviews, especially

with officials and managers had to be very opportunistic, as making an appointment for a return date was not a successful strategy.

Question schedule for CHWs / VRPs/ PHCWs   (English version)

Name and village

What is your usual work[1]?

At what standard did you leave school?

When did you join the health programme as a CHW / VRP / PHCW?

How were you chosen? Did you volunteer?

What training did you receive? And for how long?
Where did you complete the training?

Describe the work you now do as a CHW / VRP.

What parts of the work do you enjoy?

What parts of the work do you not enjoy?

How are you supported and supervised?

How does the local community support your work?

Are you paid? In cash or other items? How much?
Is this adequate for the time you have to work as CHW / VRP?

How do you manage to look after your family / children when you are working
as a CHW / VRP?
(not cash issues).

How many hours do you work as a CHW / VRP each week?

How does this affect your regular job?

Will you continue this work as CHW / VRP?

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[1] This question had to be probed / clarified extensively. It was particularly problematic for women respondents – as women tended to automatically default to "I do not work" / "I do not have a job" / "I have no other work" – despite working in the fields and as petty traders for many hours a day. In some months it was very difficult to locate the women as they were away from their homes for over 12 hours a day. This was true especially during the ploughing, weeding and harvesting seasons. For men again the question could be automatically assumed to refer to only paid / salaried work, or even to only permanent salaried work. eg A primary school teacher replied "I do not work" as he only had a temporary, local (cost sharing) contract with the school, not a permanent pensionable government contract.

Why or why not?

Interviews with community regarding AN / CH clinics

Interviews were only completed when both the father and mother of a young child could easily be located to be able to compare men's and women's knowledge and potential use and experience of the services. This resulted in having to raise the maximum age of the child to 12 months to locate enough 'couples'[2] to interview. Many halves of a couple were interviewed, but we could not then locate the other half to complement the interview.

Women

Name and village

Age and educational level

Total number of pregnancies. Number of living children
Age of oldest and youngest

Did you attend AN clinic for the last pregnancy? Total number of visits

Which clinic did you attend? How far (minutes to travel) for you to reach this clinic?
How long did you have to wait when you arrived?

Why did you attend this particular clinic?

What is the benefit of AN clinic for you? Are there any other reasons to attend AN clinic?
Did you gain any benefit?

How much did it cost (money)? – for the 1st visit and subsequent visits?

Have you taken the baby / child to CH clinic? How many times?

Which clinic did you take him / her to? How long did it take to carry the child to the clinic?
Did you have to wait once you had reached the CHC?

What services do you take the child to CH clinic for? Are there any other reasons to go to CHC?
Did you see any benefit from attending the clinic?

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[2] Women traditionally would not complete marriage customs until after the birth of a live child, and so young 'couples' here would be in various stages of formalising their union, including where they are living.

How much did it cost (money)? – for the 1st and then the subsequent visits?

Were the staff at the AN clinic polite (not harsh)?
Were the staff at the CHC polite (not harsh)?

Do you have a CHW in your village?
What do they do?

Have s/he visited you?

Did s/he talk to you and other women? and also to men?

Was the advice relevant for you and your family?

Did you follow her advice?

Men

Name and village

Age and educational level

Number of wives?
Total live children? Number of children with woman interviewed?

Age of oldest and youngest child?

Did the mother attend AN clinic for this last pregnancy?

How much did clinic cost? – 1st and subsequent visits.

Where did she go and why?

Who decided where she go?

What are the reasons why a pregnant women attends clinic?

Did this last born child attend CH clinic?

Where did the child get taken?

How long does it take to reach the clinic (minutes)?

What are the charges for CH clinic – 1st and subsequent visits?

Why did your child go to CH clinic?
Are there other reasons why a child goes to CH clinic?

Did you attend CH clinic with your child?

Is there a CHW in your village?

What does the CHW do?

Did s/he visit your home? Did she talk to you? What about?

Did you follow her advice?

Was the advice relevant to you?

Fieldwork Schedule in Kenya.

This schedule indicates location and <u>main work</u>./ people met during the stay in that location. Other people met (and re-met) are not listed in this abbreviated list. Important to note that journeys from Kisumu to Nyandiwa took between 5 (rarely) and 12 hours (mud and broken vehicles) through Karungu and Homa Bay. Walking between Nyandiwa and Nyakasera (my two key points) took between 2 hours (dry and downhill) and 6 hours (mud or uphill). So much 'unaccounted' time is simply travel time. See chapter five for physical description of Gwassi.

In Gwassi half the population is Catholic and so has Sunday as the Sabbath, the other half are SDA and so keep Saturday as the Sabbath – again, making planning more complicated. Place listed is location where night spent.

1999
July

6	Nairobi	Make contact with NGOs (CRS / CARE and VSO) working in Nyanza
		Meet DFID health & population staff.
9	Kisii	Visit Kisii Diocese Development Offices.
		Gwassi now under Homa Bay Diocese offices (Diocese split)
12	Karungu	Visit new hospital, St Camillus run by Catholic Church.
		Meet director & staff. Discuss plans and present work.
13	Nyandiwa	Reach Nyandiwa by boat (with luggage)
		Organise place to stay in Gwassi for coming months.
		- With Margaret at Scout Centre in Nyandiwa (on Lakeshore)
		Make and re-make contacts including Chief etc.
		Introductions to nurses at Nyandiwa Dispensary and Scout centre clinic + previous PHCWs and auxillary health staff in location contacted.
17 and	Kisaku	Day visit to new Scout supported dispensary up at Kiasaku
		visit water source for piped Tonga / Gwassi water system
18 Magunga	Nyandiwa	Funeral of sub-Chief on Kiwa. Introduce to DO from
19 Lake	Nyakasera	Visit to meet Esther (previous PHCW) in hills away from
21	Kitawa	Visit to old Barazza site, now deserted, with Theresa.
		Meet local elders
22	Nyandiwa	Arrange interviews with PHCWs,
		Interview nurse at Nyandiwa Dispensary
		& nurse at scout centre clinic
26	Homa Bay	Travel from Nyandiwa by boat to Karungu

		Meet Mr Dola Homa Bay Diocese Development Offices
27	Kisumu	Visit CARE sub-offices (Reproductive Health project staff)
		CRS acting director visit cancelled, rescheduled our meeting for Sept.
		Personal administration

August

3	Mbita	Visit MOH responsible, government health services in Gwassi
4	Mbita	Visit CRS sub-offices in Mbita, who supervise Gwassi FACS project
	Karungu	Visit to St Camillus Hospital. Discuss HIV with director. Given HIV/AIDS essay competition entries (English, dhoLuo and Swaheli)
5	Nyandiwa	Travel to Nyandiwa by boat
		Nyandiwa Dispensary daily visits to sister over coming days
		Scout Centre Clinic visit to nurse x2
		Interview Elisa (PHCW) + visit Antonina & Margaret
		MoAgriculture staff supervisor (f) met - for chicken project appraisal
13	Kiwa island	Day visit to see situation – guest of Margaret & husband & co-wife
14	Nyandiwa	Visit /assist at Nyandiwa dispensary
		Discuss with Scouts their health projects and direction
16	Nyakasera	Interview Esther (PHCW) + visit Anna. Meet Josey
17	Obanga	Arrange interview. Josey as guide
18	Obanga	Interview Dorcas (PHCW) + meet family. Josey as guide
19	Kisegi	Visit Kisegi hospital -no patients. Holding Census training session
		Interview Mary (PHCW) + meet family
21	Olando	Visit Olando to visit Mr Otonde and ex-MP for area
		Overnight with Nancy
22	Nyakasera	AIDS discussion with Esther and family (had left AIDS essays)
23	Nyandiwa	Scout Centre Clinic & Nyandiwa Dispensary visited
		Assist in Nyandiwa Dispensary – very busy + in-patients
		Interview Issaac, chaiman Nyandiwa dispensary committee.
		Visit to tree nursery project & women's group associated with it.
30	Nyakasera	Funeral in family so work aborted

September

1	Tonga	Interview sister at Tonga Health Centre + 3 nurse aides
		Visit to priest at Tonga – covers all of Gwassi. Bobby as guide
2	Nyandiwa	Assist at AN and CHC at Nyandiwa Dispensary with sister + aux.
3	Kimange	Interview Helen (PHCW). Bobby guide again.
		Discussions re VRPs
4	Nyandiwa	Return from Nyakasera. Make arrangements & pack
5	Kisumu	Travel out to Karungu by boat
		Visit to PMO office (out) + deliver Nyandiwa sister letters
		Met Susan Rifkin and Judith Ennew.+ colleagues / students.
14	Nairobi	Interview CRS deputy director
16	London	

October

6	Nairobi	Make contact with other diocesan health staff (Flora Hostel)
7	Kisumu	Attempt to visit PMO
8	Nyandiwa	Met Margaret in Karungu, back in matatu (not boat!)
9		Several large funerals in area so no contacts made
10		Moi Day. Meet Elisa and Antonina – discuss local women's group.
12		Visit to dispensary in Nyandiwa, nurse absent, new cashier! Esther down to check my schedule
13	Kimange	Visit to preachers at Ogutu's home – all men
14	Nyandiwa	Visit to dispensary – sister returned Meet MoAg technician re chicken project. Attend women's group meeting with Margaret
18	Kisumu	Stop at St Camillus on way out of area re contacts.
20	Nyandiwa	had to walk down into Nyandiwa from Kiabuya in dark (finally got lift in funeral vehicle)
21	Nyakasera	visit to Esther to plan interviews with Kimange CHWs finalise questions, draw up interview schedule. teach Esther to use dictaphone.
22	Kimange	visit to Helen with Esther to plan CHW interviews Trial interviews agree 'incentives'
23	Nyandiwa	Kick Polio Out of Africa Day. Find Beatrice doing follow-up
24	Kisumu	PMO out.
26	London	
Dec – Jan		CHW interviews, transcribing and translations completed in Gwassi

2000
March

7	Nairobi	Make arrangements to travel west.
9	Kisumu	Attempt to see Phanice again Travel to Nyandiwa
11	Nyandiwa	Planning visit for piped water extension to GodBura Sec School Visit Scout Centre clinic and Nyandiwa dispensary
15	Nyakasera	Visit to Anna (part of women's group in Nyandiwa) and on to Esther's Derry Lumbwa (Councilor) visit Kimange CHW interviews discussed at length (success) Listen to interviews + transcriptions + translations Discuss results with Esther. Plan Kisegi CHW interviews Interview Bernard re VRPs (VRPs now agreeing)
20	Nyandiwa	Plan to visit Helen & Kimange CHWs (Ogutu contact to Kimange)
21	Kimange	Visit to Helen. Discuss CHW interviews (complete) + visit some CHWs
22	Nyandiwa	AIDS / STD vehicle and staff visit Nyandiwa dispensary Interview sister re workload and work Assist for over 4 hours eg counting tablets (drug triangle missing)

29	Kisumu	Long walk out of Nyandiwa due to heavy rain – no *matatus*
		PMO out!
April		
1	Nyandiwa	Visit to Nyandiwa Dispensary
		All women working in fields + children
5	Kimange	Discuss with Helen my queries from CHW interviews
		CRS / FACS clinic with CHWs and Magunga nurses
		(cannot stay at Helen's due to my security!)
5	Nyakasera	Up to Esther – heavy rain, hard slog to get up hills!
6	Kisegi	Chiefs son's coffin arrives at beach as we walk along
		Kisegi Clinic – no staff found at all
		CHW meeting at Mary's home. 8/12 make it (funeral)
5	Nyakasera	Start VRP interviews with Esther.
		Organise Kisegi /Osiri CHW interviews with Esther
		Same questions and format as before
		Transcribing and translating discussions
11	Nyandiwa	chickens started to lay! Marketing issues!
		Still heavy rain – most families out weeding
15	Kisumu	After yesterday's failed attempt to get out of Gwassi,
		walk to Kiabuya
(19	Osiri	Esther and Mary start Osiri CHW interviews)
		Easter in Kisumu
25	Nyandiwa	Still rain + mud so long journey back
(26	Kisegi	Esther and Mary complete CHW interviews)
		Visit to Beatrice and get chased!
30	Nyakasera	Reach Esther and discuss CHW interviews
		Listen / read tapes / transcription / translations
		Look for Dorcas (but daughter delivered) and Anna
		Plan 'couple interviews' & conduct 1st couples' interviews
		with Esther
		Finalise interview schedule
May		
3	Kisegi	Stop in Osiri to visit sick CHW
		Visit Mary with Esther to discuss CHW interviews
		Visit Kisegi HC and meet 1 male staff member (finally!)
4	Nyakasera	Continue 'couple interviews' with Esther
		2 couples interviewed in one day, finalise timetable.
5	Nyandiwa	Church crusade at Scout Centre. Meet senior pastors.
		Visit to Dispensary and scout centre clinic
8	Kisumu	Awful journey – stuck in mud
		Ill on arrival in town. ? Malaria? Take fansidar
5		Visit doctor / collapse in pharmacy / take Halfan
		Book flights back etc. Meet Susan Rifkin again.
13	Nyandiwa	Slow journey back – mud still between Karungu and
		Nyandiwa
17	Nyakasera	Discuss interviews, results and translations with Esther.
		Enjoyed doing them!
19	Nyandiwa	return to Nyandiwa to pack
20	Kisumu	Bernard arrives with one more tape as leaving Nyandiwa
		at 6am!
		More fever. Back to doctor. Artemsia to clear malaria

Appendix 2   Maps

Map 1   Kenya

Showing location of Gwassi in Nyanza, south west Kenya,
next to Lake Victoria

Map 2   Nyanza

Showing location of main towns in Nyanza: Kisumu, Kisii, Homa Bay and
Suna-Migori.

Also showing smaller towns of Mbita, Karungu, and Sindo along lakeshore,
and Nyandiwa and Kisegi within Gwassi itself.

Map 3   Gwassi

Showing locations of Health Centres at Tonga and Kisegi and dispensary at
Nyandiwa. The DMO was located at Mbita, and the Diocesan Health Officer at
Homa Bay. The new hospital had been built near to Karungu.

From OS Map, 1983, Government of Kenya and showing tight elevations
within Gwassi.
Scale 1:250,000. This equates 2cms to 5 kms.

Kenya
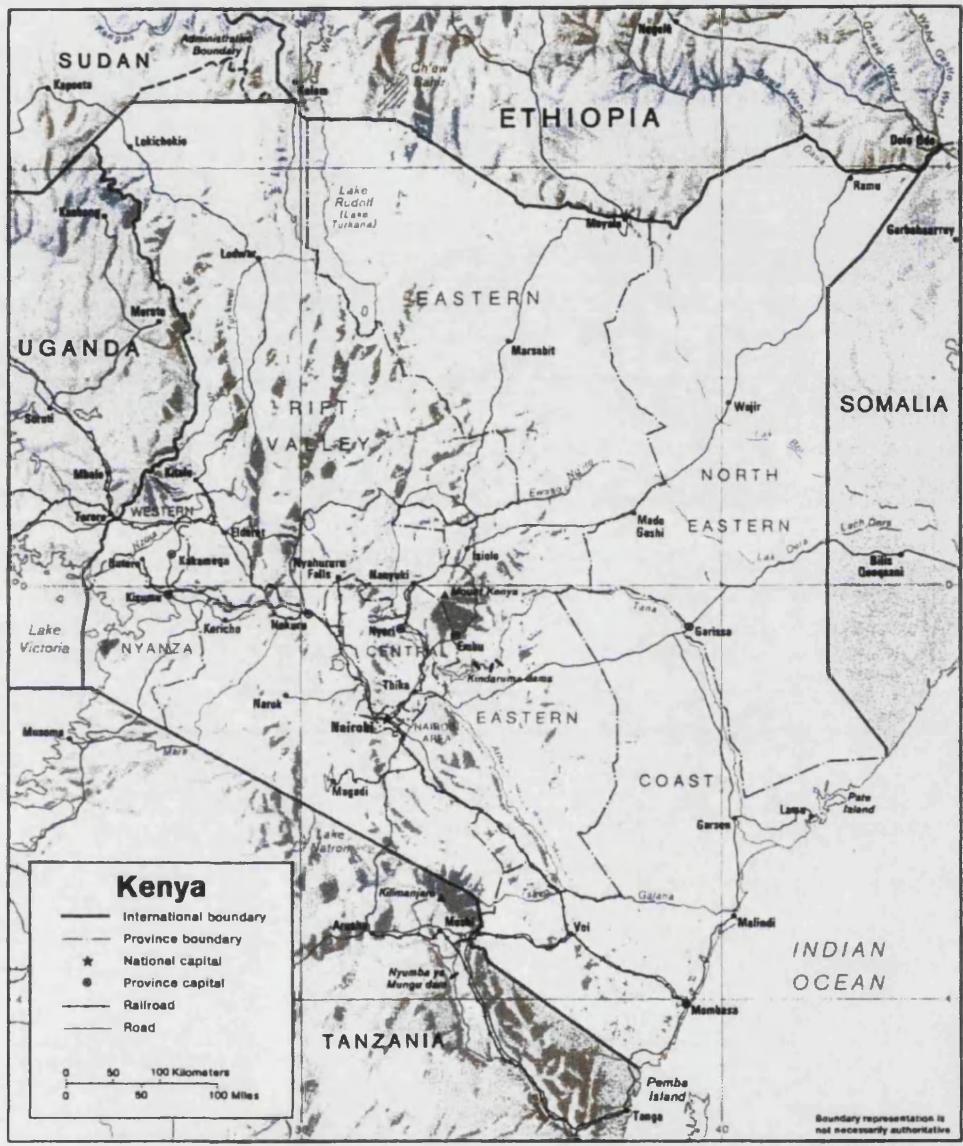
A map of the Nyanza region showing Lake Victoria, the Gwassi Hills (highlighted), and various locations including Siaya, Kisumu, Kericho, Sondu, Mbita, Homa Bay, Sindo, Kisegi, Nyandiwa, Karungu, Kisii, and Suna-Migori. Labels include WESTERN, RIFT VALLEY, NYANZA, and KENYA.
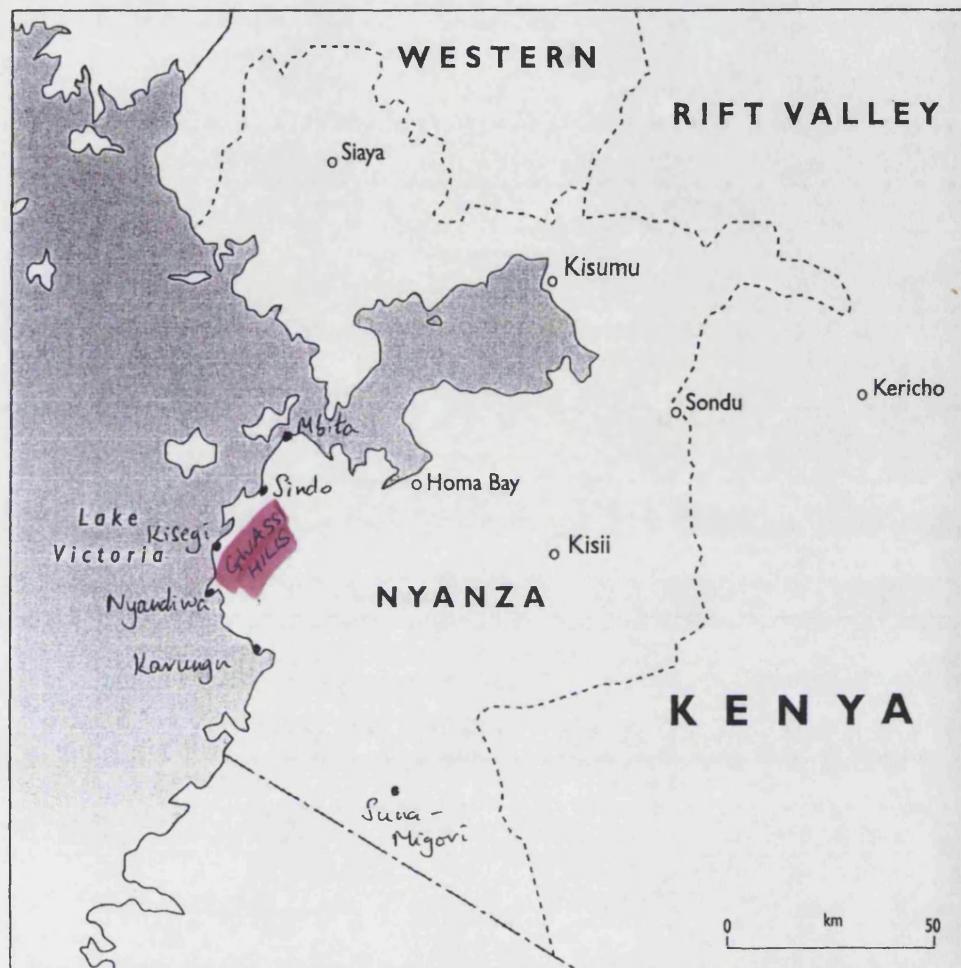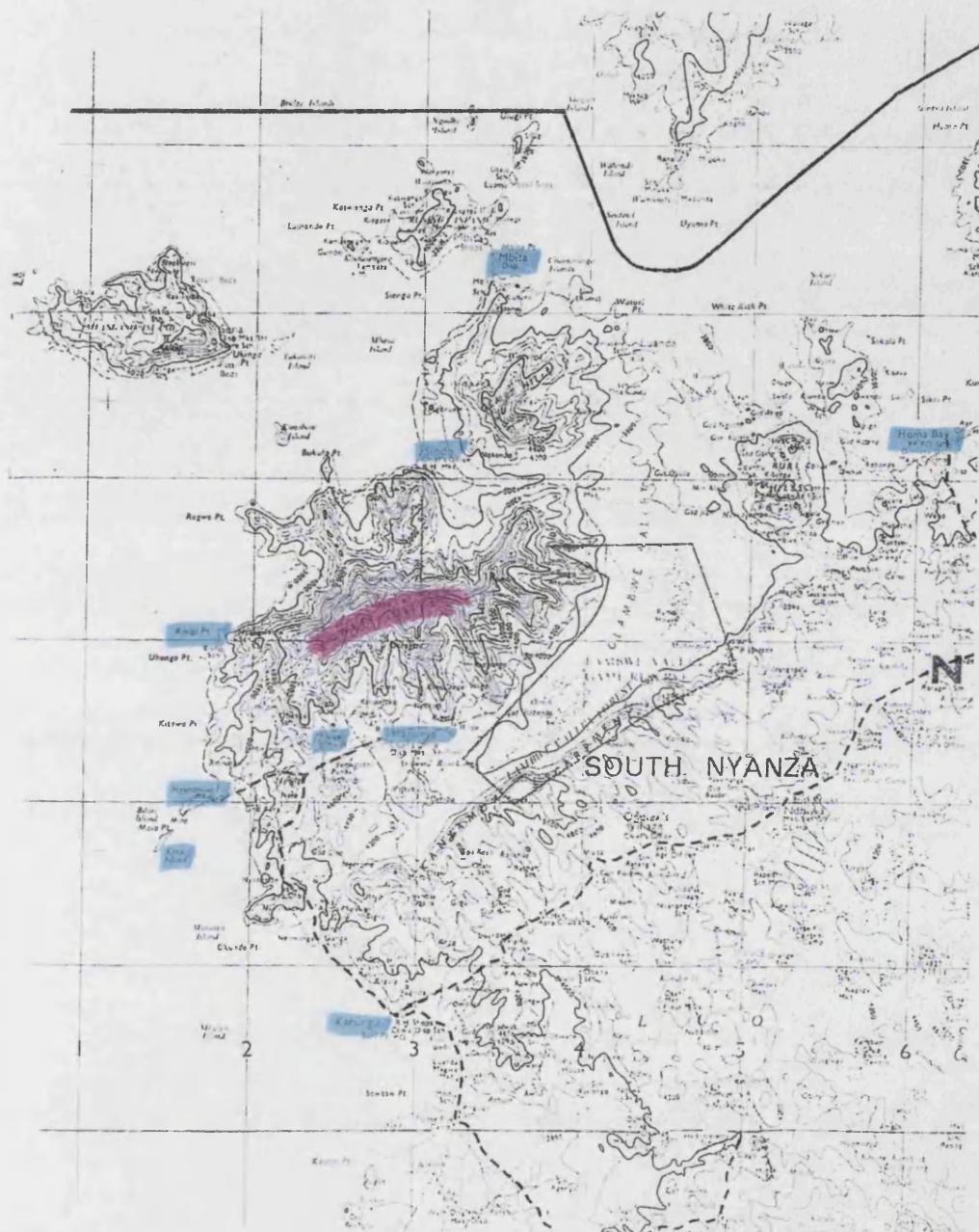
Gwassi

Appendix 3　　　Photographs of Gwassi

page i *top*　　View NE to Gwassi Hills from Nyandiwa Peninsular
From below dispensary.

　　　　bottom　View down to Nyandiwa Peninsular and Kiwa Island beyond from
below Nyakasera in dry season. Note: *mbate* and traditional roofs.

page ii *top*　　View north across Kitawa Valley in middle of rainy season

　　　　bottom left　　Rack outside kitchen showing draining utensils.
Goats playing on chick protector.

　　　　bottom right　　Goats tied around woman's granary to prevent straying.

page iii *top*　　View north towards Kisegi Point where primary school located.
Health Centre located at valley edge - large permanent buildings.

　　　　bottom　Nurse at Nyandiwa Dispensary preparing for duty.

page iv *top*　　"Road" along lakeshore ½ km north from Nyandiwa awaiting repairs.

　　　　bottom left　My host family in Nyandiwa (down near lakeshore)

　　　　bottom right　Scout Centre staff in Nyandiwa outside their main office

page v *top*　　Weighing Nile Perch at the end of mornings fishing on Kiwa Island.
Crews are paid according to their catch.

　　　　bottom　Fish merchant on Kiwa Island prior to boat transport to Karungu

page vi *top*　　Boats beached outside *hoteli* on Kiwa Island after fishing

　　　　centre　Local teenagers and children watching boat races from Nyandiwa

　　　　bottom　Crowds watching the boat races (paddling) looking south from
Nyandiwa Peninsular.

page vii *top*　　New granaries being made in Nyandiwa village after bumper harvest!

　　　　bottom　New houses and roofs in Nyandiwa. Millet is drying on mats.

page viii *top*　　"Track" to Tonga from Nyakasera. This is the route to the Health
Centre, the Catholic Church and the large boys secondary school.

　　　　bottom　Route from Nyaksera to Miramba. Erosion after El Nino rains.

page ix top　　Cattle resting in homestead after day ploughing fields.

　　　　bottom　Host family in Nyakasera (half way up Gwassi Hills).

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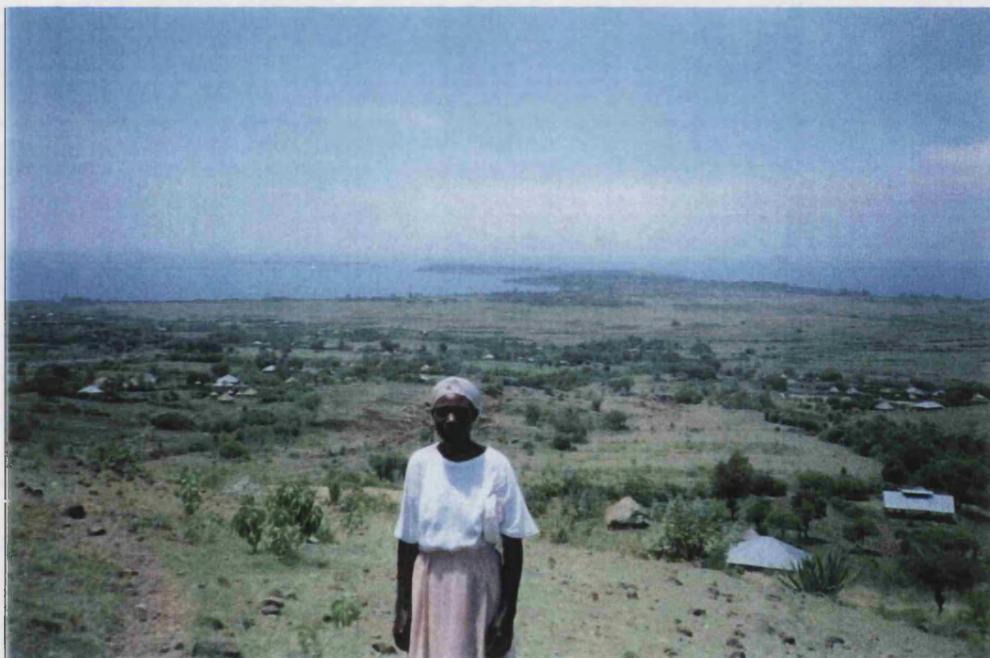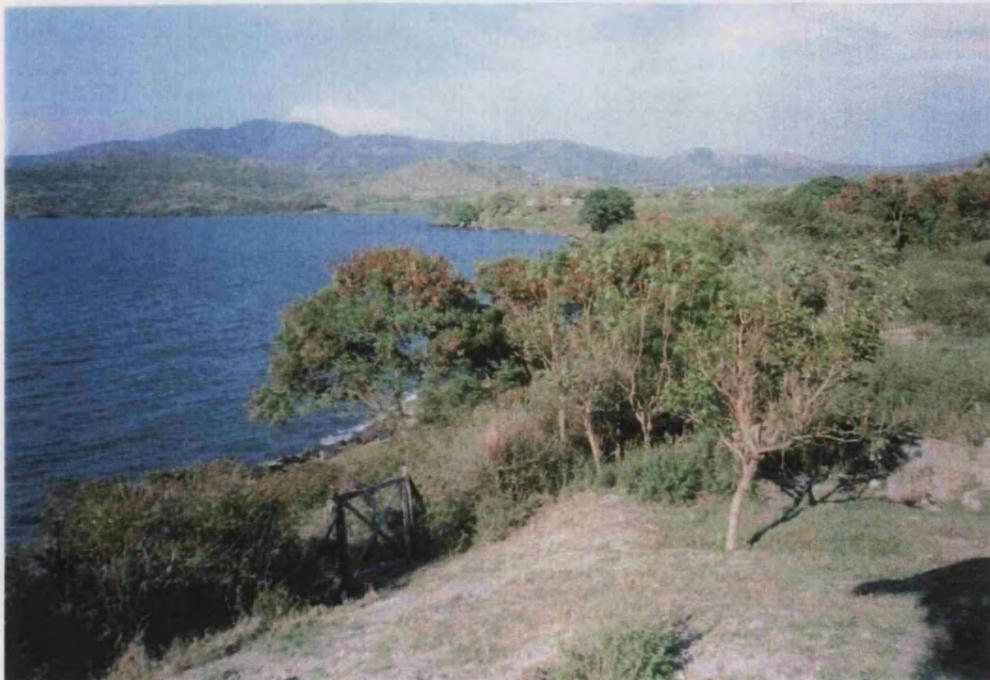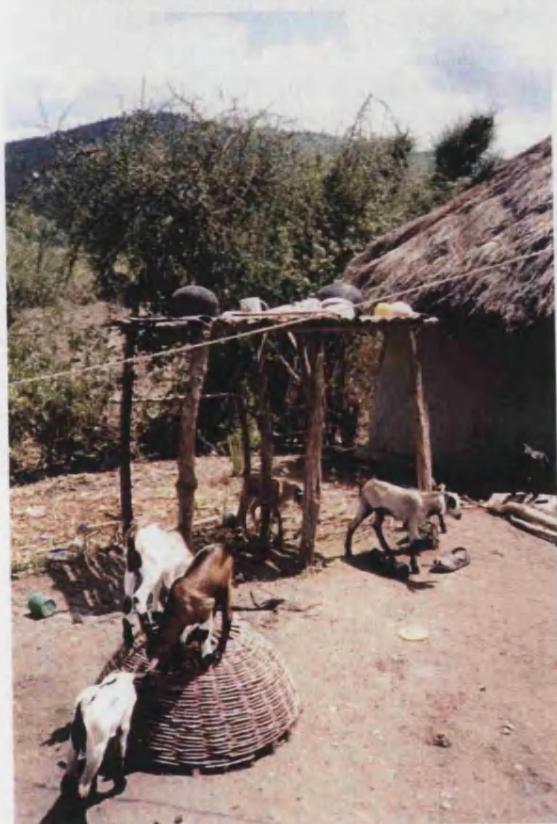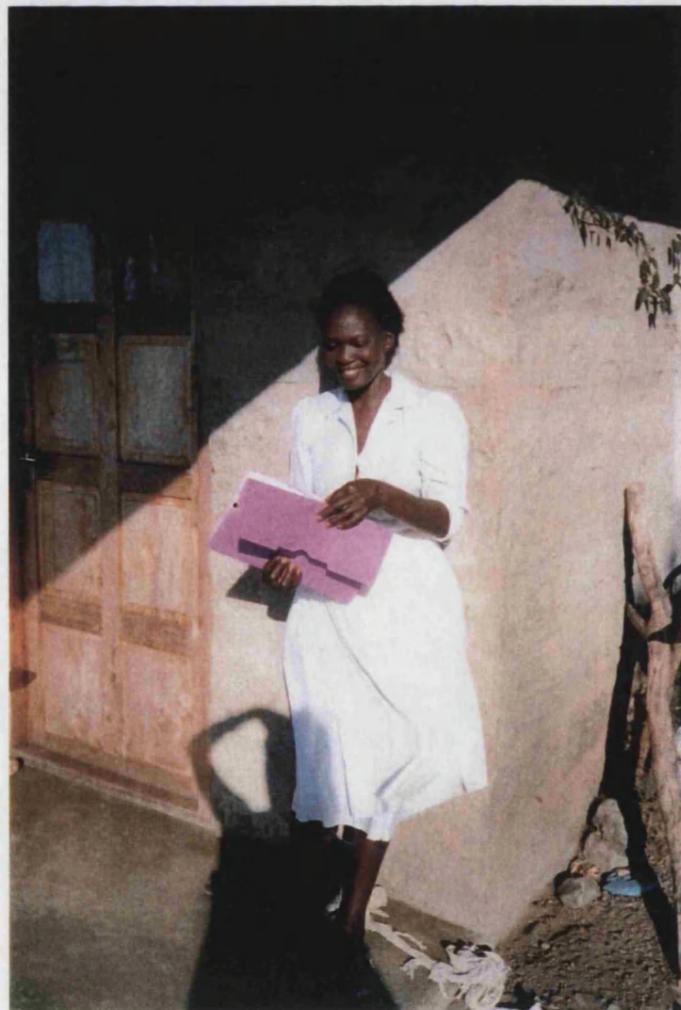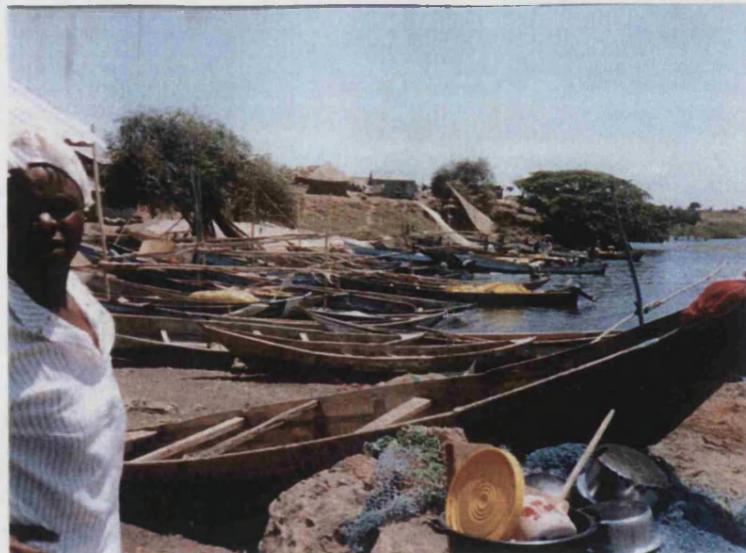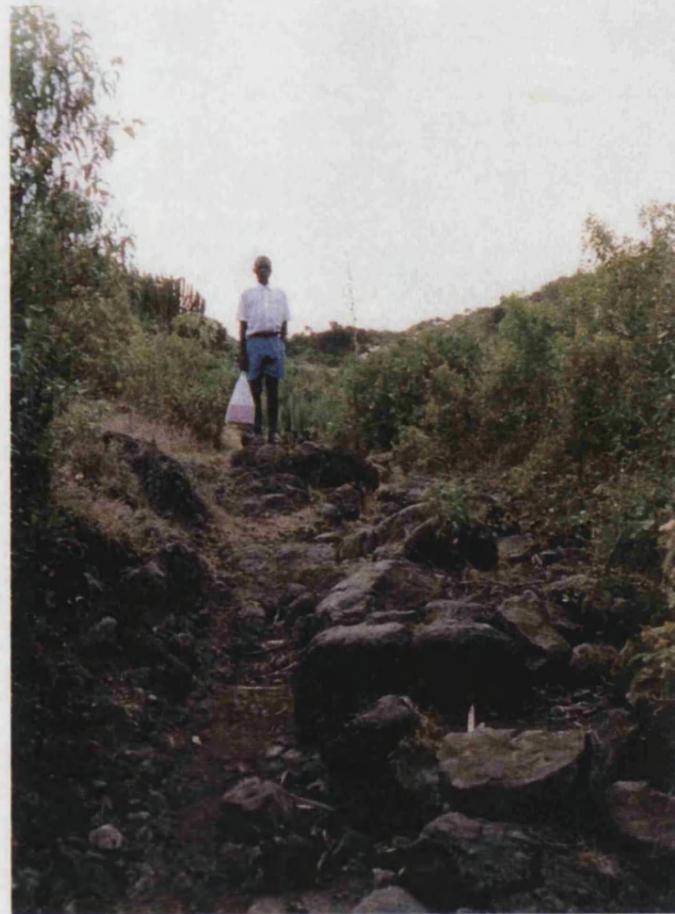
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