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Priority Setting and Policy Making

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Retirement Stress in Nigeria: A Psycho-political Analysis

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Introduction

Retirement means different things to different people. Typically and like most English words, the meaning it takes depends on the context in which it is used. The context in which retirement is described here concerns 'giving up a regular job or regular activity with consequent cessation of the enjoyment of fringe benefits or other benefits associated with it'. Retirement could also be viewed as being outside the workforce, receiving some income from a previous job and having time to do the things the individual desires. Technically, retirement can begin anytime an individual has amassed enough capital to provide a living without holding a job. Retirement is not necessarily a dichotomy: retired versus not retired. It is a process that begins when the individual realises that some day he or she will leave a job, and ends when the individual becomes so feeble and impoverished that they can no longer play the retirement role (Atchley 1976). This then indicates that retirement is a process through which the retirement role is approached, taken up, learned, mastered and relinquished. When retirement is viewed as a social role, it undergoes the following phases: pre-retirement phase, honeymoon phase, disenchantment phase, re-orientation phase, stability and termination phase. The pre-retirement phase is divided into the two phases of remote and near, with the remote phase beginning when the individual takes a job and finishing when the individual ends his career. The near phase begins when the individual becomes aware that he or she will take up the retirement role very soon, with the attitude towards retirement becoming negative, probably because the realities of retirement become clear. The honeymoon phase is rather a euphoric stage in which individuals wallow in their newly found freedom of time and space, with many trying their hand at things they never had time for before. After the honeymoon is over and life begins to slow down, some people experience a period of disenchantment.

This depends on a lot of factors: few alternatives, little money, poor health etc. The re-orientation phase is then necessary for those whose honeymoon either did not get off the ground or landed with a crash. Here, the retiree tends to explore new avenues for involvement and to develop more realistic views about alternatives. The stability phase ushers in a relatively well-developed set of criteria for making choices while in the termination phase, people tend to lose their retirement role through illness and disability, which sometimes accompany old age. At this point, the individual ceases to retire and becomes dependent.

Retirement, seen as one of the biggest changes in the life cycle, can be a stressful period; no matter how prepared you may think you are, as there can be something that has not been planned or foreseen to upset things. With increased rate of early retirement, the experience of retirement can be very difficult. It may be an opportunity for increased leisure time for those with adequate pensions, but for those retiring through ill health and with a low or no pension, retirement may bring despair and limited opportunities. Indeed, there is a sense in which psychology as a state of mind and political economy of care, as perceived and experienced by the retirees, underlie the whole process.

This paper intends to critically examine retirement stress from a multi-disciplinary perspective with the emphasis on the psychological and political contexts. It is clear today that no comprehensive study of social issues could be done without recourse to the interrelated factors causing or influencing events. In this case, the focus is in analysing the various dimensions of retirement stress in Nigeria as they relate to both the political and social dynamics.

However, this study is basically a review of the state of discourse of retirement stress and relevant literature in Nigeria. It does not lay claim to any systematic survey for information gathering. However, extensive person-to-person interviews and primary documents were used as reliable sources of first-hand information on the plight of retirees and the state of retirement policy in Nigeria.

For a better understanding of the discourse, the paper raises the following questions:

a) To what extent can retirement stress be said to be a problem in Nigeria?
b) What are the political structures for managing retirement in Nigeria?
c) Is the financial architecture for managing pensions in Nigeria adequate?
d) What are the possible psychological implications of unchecked retirement problems on the national psyche?

Theoretical Underpinnings

Two theories, which dominated social gerontology in the 1950s, were Disengagement and Activity theories. Both postulate not only behaviour changes with age and retirement but also imply how that behaviour would change (Powell 2001). Disengagement theory, associated with Cumming and Henry (1961),

proposed that a gradual withdrawal of older people from work roles and social relationships is both an inevitable and rational process. For this variant of functionalism, this process benefits society, since it means that the death of an individual member of society does not prevent the ongoing functioning of the social system. This theory argues that it was beneficial for both the retired individual and society that such disengagement takes place in order to minimise the social disruption caused by an ageing person's eventual death (Neurgarten 1998). A number of critiques exist: first, this theory condones indifference towards retirement, old age and social problems. Secondly, it represents a threat to the promotion of a positive and involved lifestyle for ageing persons across the lifespan (Powell 1999).

Activity theory, a counterpoint of Disengagement theory, claims a successful retirement can be achieved by maintaining roles and relationships. Any loss of roles, activities or relationships within old age, should be replaced by new roles and activities to ensure happiness, value consensus and well being. Thus, 'activity' was seen as an ethical and academic response to the disengagement thesis which recast retirement as joyous and mobile (Powell 2001). Nevertheless, Activity theory tends to neglect issues of power plays, inequality and conflict between age groups. An actual 'value consensus' may reflect the interests of powerful and dominant groups within the society who find it advantageous to have age-power relations organised in such a way (Phillipson 1998).

As an intellectual background against such functionalist theoretical dominance, the political economy of old age emerged from Marxist insights in analysing the capitalist complexity of modern society and how old age and retirement were socially constructed to foster the needs of the economy. The political economy approach desired to understand the character and significance of variations in the treatment of the aged and to relate these to polity, economy and society. For Ester (1979), political economy challenges the ideology of older people as belonging to a homogeneous group unaffected by the dominant structures in society. Political economy therefore focuses upon an analysis of the state in contemporary societal formations. Here, we can see how Marxism is inter-connected to this theory. Ester (1979) also looks at how the state decides and dictates who is allocated resources and who is not. This impinges upon retirement and subsequent pension schemes. As Phillipson (1982) pointed out, the retirement experience is linked to the timing of the reduction of wages and enforced withdrawal from work, and has made many older people financially insecure. Hence the state could make and break the fortunes of its populace.

From this perspective, the nature of the Nigerian state as presently constituted, the state of its democracy, and the character of the political class, all serve as important constituents in examining social security and retirement. The suspicion is that the not too efficient Nigerian state characterised by official corruption and poverty has been instrumental in generating retirement stress for a significant percentage of its citizenry.

Retirement as Stressors

The question that most people often ask the newly retired person is: 'What do you do now?' I have watched most retirees literally torn between eagerness and reluctance to answer when asked this familiar question, probably followed by another: 'How do you pass your time?' Surprisingly, many fumble for an answer, with their thoughts turning from family responsibilities to pensions and concern about how to make ends meet. Faced with their problems, accentuated by a nagging wife or uncaring children, they are unlikely to seek comfort in retirement.

Stress is as much part of retirement as of any other period in life, however the impact of some sources of stress seems to intensify during retirement. Retirement, whether voluntary or involuntary, is a transition that requires tremendous adjustment. Most people take it for granted that they will retire someday, while some express dread of retirement. Attitudes towards retirement could be seen as a function of health, ageing, income, roles and expectations, relocation, changes in identity, and position held at retirement. Others could include educational background, versatility of the retiree, government's economic and political policies on retirement, gender, death of spouse, attitude to life, and emotional predisposition.

The concept, stress, was originally used in physics, primarily to describe tension or force placed on an object to bend or break it. When applied to the human condition, it was described as the non-specific response of body to demands placed on it (Selye 1956). Stress can also be understood as a life event that causes physical and psychological reactions in the individual. Today, the word stress is frequently used to describe the level of tension people feel because of the demands of their jobs, relationships and responsibilities in their personal lives (Seaward 1994). In eastern philosophy, stress is considered to be an absence of inner peace. In western culture, stress is viewed as a loss of control, while psychologically speaking it is described as a state of anxiety produced when events and responsibilities exceed one's coping abilities. To the disbelief of some, not all stress is bad. In fact, there are many who believe that humans need some degree of stress to stay alert. When stress serves as a positive motivator, it is considered beneficial, but beyond this optimal point, stress does more harm than good. Notable side effects of stress include high blood pressure, heart attacks, irritable bowel movement, aches and pains, ulcer, dizziness, sleeping difficulty, poor vision, headache, tiredness and in the extreme, death. Psychological effects include depression, anxiety, lack of concentration, tiredness and misery, irritability, negative mood, restlessness and suspicion. Others could lead to reduction in coping capabilities, low self-esteem and self-image, absolutist and dichotomous thinking, fear, hopelessness and helplessness. Other negative impacts of stress could also present themselves in the form of family and marital difficulties, disruption in effective communication, interpersonal difficulties, child abuse, wife battering, political alienation, corruption and greed, etc.

The question that arises when these definitions and side effects are examined closely is: Is stress the event itself or must it be defined in terms of certain reactions to an event? It does seem that stress must be defined in terms of the individual's reaction to the event, which in this case is retirement. Thus, experiences of retirement could also aid in the disruption of the ego and a sense of self worth, when people who have been seeking you dwindle; subordinates, followers, admirers become conspicuous by their absence. It is difficult to accept the fact that you have to wait now instead of people waiting on you. (Dhar 2004). Dhar also reported the case of a retiree whose nagging wife was almost invariably found deriving some sort of vicarious pleasure, bordering on perversion, in shouting at and humiliating her husband, even in the public gaze. Following his retirement, the situation had gone from bad to worse, leaving him with a bout of self-doubt, and loss of confidence. He of course became worried and apprehensive of the uncertainties of the future and lost his sleep and his health. The big fear is usually, who will take care of him now? Will he be a burden to their children? Other difficulties could come in the form of a loss of control over key positions of responsibility with a resultant feeling of frustration and anxiety. A very serious problem is having too much time to spend. Suffice to note that a good number of retirees, immediately after retirement, usually wallow in their newfound freedom of time and space. Here, most try to do all the things they never had time for before. When the 'honeymoon' is over and life begins to slow down, most experience bouts of disenchantment and isolation. Disruption in the usual waking-up routine of the retiree is also a huge challenge, because when not adequately overcome, it could trigger boredom and isolation. Retirement can also trigger marital stress and adjustment in couples. Mein (1998) for example, in his study found that men felt adjusting to a new role and relationship with their wives was the most difficult and unexpected part of retirement. Although retirement might be a way to get rid of the stressors and strains of work, surprisingly, it seems that spending the golden years with a wife is not the recipe for joy either. In another report by Jungmeen et al. (1999), men sometimes complained that retirement tended to reduce their wives respect for them, especially when the wives were not retired. Jungmeen et al. in another study stated that men who retired while their wives were still working showed a higher level of marital stress and distrust. The happiest men were the ones who found another job and whose wives were not working, and they reported the highest morale and the lowest depression and suspiciousness.

This brings us to this important question, 'Why do people work?' Some work for the money and they are most likely to continue even when the income is no longer needed. Some for the social interaction it provides, while others work for the sense of accomplishment it gives. However, when work defines a person: what you are, what you do and where you work, the retiree is very likely to feel disenchanted and restless when this identity tied to his working life seems to have fallen apart.

Perhaps a peep into life events associated with old age could also explain some sources of retirement stress. Such old age events could come in the form of physiological (medical) complications like the loss of energy, vulnerability to diseases due to wear and tear of the body over the years, and the fact that most non-communicable diseases like cancer, diabetes, high-blood pressure etc., manifest themselves at this critical period. Of course, none of these changes begins suddenly at old age; gradual decline in some kind of functioning starts earlier. However, it is during old age that these changes become more apparent. Also, along with the multiplicity of health problems of old age, physiological disturbances are usually chronic and are more difficult to detect. This is due to the fact that symptoms may not have the same characteristics as that of the same disease in a younger person.

Politically and economically, in other words, in terms of its political economy, retirement stress could be caused by inability of workers to obtain their gratuity on time and the hiccups experienced in the payment of pension benefits, as complained by many retirees from both public and private sectors of the economy. The experience is almost universal, the only exemption being perhaps the oil industry and some major organisations in the manufacturing sector. Other sources of stress include waiting endlessly for hours or days to be paid, while in some cases most go home dejected without receiving their pension, others end up carving an almost permanent niche at the payment centres. Also the erroneous assumption that the traditional, extended family, informal welfare institution is a substitute for a well-articulated social security for the aged and retired needs to be re-thought.

Prolonged stress is believed to weaken the immune system, leading to susceptibility to diseases. Inadequate social support and retirement policies could hasten the triggering of stress reactions in the elderly and retired, and invariably complicate most of their physiological changes. It is therefore obvious that the aged and retired would experience much more difficulty in coping with stress and diseases, coming from a more disadvantaged position.

Problems of Retirees in Nigeria

It suffices to note again that retirement in Nigeria is no longer a stage to which people look forward. Gone are the days when retirees, especially those from the public services were assured of regular pensions. Today, they live from hand to mouth and more especially, their days on earth appear numbered. Pension scheme meant to provide succour to retirees do not seem to be working, and retirees from the public sector know better the negative effect of labouring for the fatherland. From different sectors, they have gory tales to tell. A case in point is the tragic state of retirees of the Nigerian Railway Cooperation who were owed their pensions for twenty-four months (*The Guardian* Nigeria, 2004). Several of the military retirees were reported to have turned the streets of Abuja and Lagos into homes begging for survival following the failure of relevant authorities to pay their pensions. The worst scenario is that of the retired primary school teachers.

This class of pensioners according to reports have not been paid for decades and their case is worsened by the fact that they do not know which tier of government to turn to for their stipends. The literature is rife with the woes that retirees go through in Nigeria, both in the public and private sectors (*The Guardian* Nigeria, 2000, 2003, 2004). For most civil servants and top directors, retirement may mean relocating from government quarters to a private residence, which is usually made worse if the retiree is unable to afford an alternative residence or to access funds from financial institutions. Coupled with the poor financial status of the retiree and the fact that there is no organised package on health care, retirement is far from satisfying for many. Retirement is satisfying for most people if they have a decent income, enjoy good health and were not forced to retire (Foner and Schward 1981). Mein (1998) also observed that health and income were frequently mentioned as sources of stress and depression among retirees, especially among those from lower civil service grades, while Benjamin, Idler, Leventhal & Leventhal (2000) in another study assert that health and income put together lead to a more successful retirement. The following lamentation of Godson, a retired captain would probably speak the mind of millions of retirees:

> Not many people know what retirees go through in this country. On a personal experience, I retired as a Captain due to ill health. For my poor condition, I had hoped to collect my benefit soonest so that I can give myself a good treatment. At the pension directorate in Lagos, I met a brick wall, no one was ready to assist. Besides being tossed about for days and weeks, my file was declared missing. I was told to start afresh.

In an attempt at interrogating the architecture for the management of retirement factors and pensions in Nigeria, perhaps another example could drive this point home more strongly:

'50 Retired Teachers die while waiting for pension':

> They are honourable senior citizens, notwithstanding how badly emaciated some of them appeared, who had put in their entire productive years in the service of their fatherland. But what a price to pay, now at the twilight of their own lives, when they need all the help they can get, the country which they had served so conscientiously had turned its back on them. They are subjected to deprivation, hardship and death. The chairman of Retired Teachers' Association for example, claimed that in the last 6 months, 50 of their members had died, due to inability to get their entitlement. He also reported that one of them, a treasurer of the association, died recently, because he could not get 50,000 Naira, needed for medical treatment whereas the government owed him over 150,000 Naira unpaid pension arrears. They therefore demanded, among other things, for upward review and prompt payment of their pension arrears and most importantly, for a welfare package like free medical care in government hospitals.

They also claimed that a governor in one of the Eastern states in Nigeria was unfair in a statement credited to him that 'our children should take care of us'.

They went further to state that while it is the duty of their children to take care of them, the government should not claim ignorance of the fact that most of their children cannot find jobs and are still liabilities for parents (*The Guardian* Nigeria, 2004).

Many African governments, including Nigeria's, certainly find it convenient to assume that the extended family in Africa continues to adequately meet all the needs of its members even in retirement. This assumption may be convenient for government to make since it appears to provide a basis for a minimal role for the state in ensuring old age and retirement care. The extended family that is presumed to be taking adequate care of the elderly is not living up to its expectations. The contributory factors include: the serious problem of economic survival faced by the young, the presumed caregivers in the context of prolonged economic crisis and depression; the span and speed of social change associated mainly with urbanisation, industrialisation and exposure to foreign ideas, and the value crisis now prevalent in most African countries (Akeredolu-Ale 2001).

This then paints a clear picture of what retirees in most of the developing world go through every day due to inadequate or poorly managed retirement benefits and policies. When compared with their counterparts in the developed world, they are certainly having a rough deal. This is a bad signal for the retirees as well as millions of younger Nigerians who see in what is happening a frightening reflection of their own future.

Retirement Policy and Retirement Management

Until the mid 1980s, there were no widespread instances of retirement of old people from work in Nigeria; rather, they continued to work until they were compelled to leave due to ill health. However, it was during the Buhari regime of the mid 1980s that the retirement rule became very effective in the Nigerian public and private sectors. During this period, many workers who were above the official retirement age of sixty were compelled to retire and since then, retirement has become a planned phase and programmed aspect of employment in Nigeria. Today, the retirement age in Nigeria is sixty years or thirty-five years in service, while for university lecturers and judges it is sixty-five years and fifty-five to sixty years for the private sector. A person is qualified for a gratuity when he or she has put in five years of service while eligibility for a pension is ten years of service. The public sector, prior to the recent pension reform in 2004 in Nigeria, operated a non-contributory pension scheme, (pay-as-you-go scheme), while that of the private sector is contributory. Pension benefits in Nigeria are reviewed from time to time in order to meet with the social and economic changes in the country.

On the situation in the Africa region, the ILO assessed as 'weak' the coverage and effectiveness of existing social protection schemes relating to the contingencies of retirement, invalidity and death. It concluded that 'many African schemes have failed to provide effective social protection, even for the small minority of the population that they cover' (ILO 2000). North Africa has the oldest and most

comprehensive schemes, with pension schemes based on social insurance principles operating in Algeria, Egypt, Libya, Morocco and Tunisia since the 1950s. In Francophone sub-Saharan African countries, priority has been given to employment injury schemes while many of the countries have similar schemes with pension provisions based on social insurance principles which guarantee a defined benefit determined by reference to length of service and average earnings. In Anglophone Africa, the emphasis has been placed on employment injury schemes, while the development of social insurance schemes has been much slower than in Francophone countries. Pension schemes have been restricted in most cases to permanent public servants, though national provident funds have been provided in some cases to cover non-pensionable public servants and employees of big firms in the organised private sector (ILO 2000).

The fact that the Nigerian government is not living up to expectations as regards pension and retirement is very obvious. Nothing could be more horrifying for the retired than to be owed money when other sources of income are closed. Solanke (2004) observed that government has a problem of funds. They do not fund as and when due, and when it is time to pay, they find it difficult to pay. For some, very few parastatals are trying to put money aside for pensions, it is either the trustee who does not manage the funds properly or the funds are lost in the process of management, or worst still, such funds are stolen out-right. And when this happens, the pensioners are subjected to untold hardship. Solanke concluded that the major problem bedevilling pension funds in Nigeria is outright corruption. Other problems associated with government pensions include arbitrary and sporadic retirement and retrenchment of 'under-aged' officers, thus expanding the population of young pensioners, the over-centralization of pension administration, inefficient record keeping, and the lethargic attitude of government employees which causes delays in effecting payments. Most importantly, there is the dishonesty and the phenomenon of ghost pensioners. Pension problems in Nigeria are also bedevilled by the lack of seriousness in addressing the problem by successive governments, money trapped in distressed banks and bureaucratic bottlenecks experienced by pensioners in a bid to access their pension. *The Guardian*, Nigeria (2004) observed that the pension crisis arose largely because the public service ballooned without control, under the belief that government money was inexhaustible. The situation of unpaid and irregular pensions clearly encouraged indolence, corruption, divided loyalty and inefficiency in the system. Such irregularities and deformities also have a tendency to discourage originality, creative hard work and patriotism. All these necessitated the cry for pension reform in Nigeria.

In the past, Nigeria initiated reforms with the setting up of committees. First was the Ajibola-led committee in 2002 which was mandated to harmonise the public-private sectors' pensions, while the privatisation agency in the country also set up a steering committee on the pension reforms with certain objectives. There was also an insurance industry committee on pensions set up to provide technical advice to the government on pension reform. The other was the Fola Adeola-led

committee charged with the responsibility of pension reform in the country. The common denominator in all the committees' recommendations and resolutions was a call for reform based on the unanimous conclusion that the public sector, unfounded, pay-as-you-go defined benefit pension system has failed woefully. This led to President Obasanjo's call in his May Day speech for a contributory public sector pension scheme. The latest effort by the Federal government to address the issue is now generating a lot of controversy. The controversial pension reform bill sought to merge the separate private and public sector pension schemes into one, scrapping every other system in the country including the Nigerian Social Insurance Trust Fund (NSITF), among other things. One criticism is that the bill will not solve the existing problem in the public sector, but will rather infect the private sector with the same virus that rendered the public sector scheme unmanageable. However, the report of the Senate ad-hoc committee, after several deliberations, suggested the separation of the public sector contributory pension scheme from the private sector. In addition, the Nigerian Social Insurance Trust Fund (NSITF) was also retained despite the government's proposal that it should be scrapped. To ensure that operators and administrators do not abuse the scheme, the committee endorsed the idea of a regulatory body to be called the National Pension Commission (*The Guardian,* 16 February 2004).

The Pension Reform Bill was finally passed on the first of July 2004, two hundred and seventy- four days after it was sent to the National Assembly. President Obasanjo reiterated the fact that the bill was set to eliminate the embarrassing situation where workers give their best in productivity, and receive no pension. The Act, which harmonises public and private sector pensions, has the following as its highpoints:

- Any organisation that has more than five staff is duty bound to run a pension scheme;
- The Act preserves the existing private sector scheme, but lays down a framework within which they must operate to protect the welfare and rights of the beneficiaries;
- Although the bill repealed the Nigerian Social Insurance Trust Fund (NSITF) Act, the committee, after considering stakeholders' views, came to the conclusion that the NSITF be retained as a platform for delivering social security services to Nigerians. This is in consonance with the ILO convention.
- That the concept of Pension Fund Administrator (PFA) and Pension Fund Custodian (PFC), as introduced by the bill, was found desirable since it contains the most refined techniques for effective checks and balances. The qualifications of custodians were modified to ensure that only the most credible finance institutions could provide the services;
- The Act makes it mandatory for pension fund administrators to open savings accounts for pension beneficiaries;

- Pension fund administrators may also invest in real estate to protect funds against inflation and other economic hazards;
- The Act provides opportunities for Nigerians covered to make additional contributions and receive additional benefits, and for those not covered to willingly join the scheme.

On the speculation of what will become of the viable contributory pension scheme on the ground, the Senate stated that government parastatals like the Nigerian National Petroleum Corporation (NNPC), the Central Bank of Nigeria (CBN), and the Bureau of Public enterprises (BPE), which had pension funds of one billion and above will be allowed to set up their own funds management system. Other government organisations with pension schemes not as successful as CBN, NNPC, and BPE, will not be allowed (*The Guardian,* 30 June 2004). Some amendments made by the Senate include: the adoption of the House of Representative version to replace section 9 (1) (a) (i) & (ii), which provided for a minimum of 7.5 percent employee contribution and 7.5 percent employer contributions. Another amendment was in section 4(2) where the withdrawal of a lump sum by the retirees was reduced from 50 percent to 25 percent.

With the signing of the Bill into law, the Pension Act of 1990 expired.

After the review of the nation's new pension law, the Nigerian Labour Union observed that the new Act excluded certain pensioners like the Nigerian Railway Cooperation, Primary Schools and the Military. An enraged labour leader, Adams Oshiomhole, remarked that there was nothing to celebrate about the Act, as far as those pensioners who die daily in the queues waiting to collect pensions are not provided for. He lamented the fact that it was in response to their plight that the pension reform came up, and pitiably, there was no mention of their plight. Labour also lamented that the new Act put the pensioners at a disadvantage and many of them at risk of losing their savings to failed fund administrators. It also queried the measures put in place to guarantee savings of the pensioners in case of default by the pension administrator (*The Guardian,* 16 July 2004).

Organised labour also disagreed with the provision regarding the contribution ratio between the employer and employee in both the private and public sectors, observing that the harmonised position of labour submitted to the National Assembly was for 12.5 percent contribution for the employer and 5.5 percent for the workers. Similarly, the Senior Staff Association of Nigerian Universities (SSANU) also frowned at the contributory ratio of 1:1 saying that it negates the 3:1 internationally accepted norms of contributory pension schemes. (*The Guardian*, 3 February 2005). However, the Senate, in a bid to amend the new Pension Bill, is currently asking that government contribute an extra 2 percent of the monthly wage bill to its workers to the Redemption Fund. This is to ensure that the 'living standards of the employee are reasonably brought in conformity with that of their counterparts who occupy the same position in future and also

by harmonizing the earnings of a previously retired person to rank pari-passu with that of his counterparts who have just retired and is payable under the law' (*The Guardian*, 30 January 2005).

On the lingering issue of pension arrears, President Obasanjo noted that the issue will require the government to come up with viable strategy and policy that will assure those who are owed arrears of pension that they will be paid. He therefore apologised for the pain and deprivations caused because of irregular and unpaid payments.

Conclusion

In concluding this article, one thing is obvious – that we all must retire one day and that each of us will react differently to our retirement situation. Some will find it easy to accept, while others will find it really traumatic. Though our ability to choose a rosy retirement may be a mirage, it is still very important to plan for retirement to avoid the pain and depression that normally accompany unplanned retirement. In the face of rapidly disintegrating joint family structure and inefficient government policies, people walking into retirement are likely to turn greyer and lonelier by the day, the more so if they do not have financial security. Perhaps this paper may sound stern if it suggests that individuals should try to take personal responsibility for the retirement problem that afflicts them, and perceive pensions and gratuities as an additional resource. If the government is finding it difficult to pay the working employees, it is certain that they may find it almost impossible to make the case of the pensioners a priority, unless there is sincerity and empathy. Even the corporate giants may not be prepared to discuss the need of retired persons due to dwindling income and profit coupled with suffocating demands for higher pay as a result of crippling inflation. Of course, the plight of retired teachers, railway workers, military personnel and a host of other pathetic stories about pensioners should serve as red signals for the working class and a constant reminder that 'the only person who should be concerned about your retirement is you'.

On the new pension contribution scheme in Nigeria, I feel that there is a point to be made for the Nigerian Government to have a more human face by lightening the burden on the various institutions, both public and private, in terms of the percentage contribution to the scheme. The war against corruption by President Obasanjo's administration and the effort at sanitising the public service are a welcome development which hopefully will impact positively on the management of pensions, and hence the plight of retirees in Nigeria. Also for a happier retirement and old age status, government should think of providing free medical services for its retired citizens, as a thank you gift for serving the state diligently. This is also necessary because of the health complications of old age and thus, coming from a more disadvantaged position, retirees may experience more difficulty in coping with stress and disease.

On a lighter note, after retirement, since one is no more a slave to a fixed schedule, one can devote some time to introspection, to try and rediscover one's self and acquire new ideas or pursue unconventional hobbies and interests. Think of retirement as a new lifestyle not as the end of the road. Develop your sense of humour and laugh at difficult situations. Take your health as an item of the highest priority, take pride in who and what you are now, be enthusiastic about the present and optimistic about the future and take personal responsibility for your financial future. Since enthusiasm is caught and not taught, the secret of growing old gracefully is never to lose your enthusiasm in remaining active in life.

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Prefinancement communautaire des soins de santé pour un meilleur accès des populations rurales aux services de santé de base:
une estimation du consentement à pré-payer des ménages au centre du Cameroun

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Dans une procédure d'analyse à deux étapes, les tests statistiques nous permettront d'apprécier le degré de corrélation entre les différentes valeurs du CAP et certaines variables socioéconomiques et culturelles prises individuellement.

Les résultats de cette étude enfin nous donneront des indications sur le taux de cotisation individuelle des membres dans une perspective de la mise sur pied d'un système de préfinancement des soins de santé de type mutualiste en milieu rural. Par ailleurs, l'identification des facteurs affectant la valeur du CAP les soins permettra de définir le profil des futurs mutualistes en vue d'aider les acteurs du développement local à mieux asseoir leurs stratégies de mise sur pied du système de préfinancement des soins de santé de base dans la localité d'étude. En estimant les capacités réelles des ménages ruraux au financement des soins, cette étude nous situera enfin sur les objectifs d'équité de la politique de contribution des ménages au financement des soins de santé.

Introduction

Le Cameroun a enregistré d'excellentes performances économiques qui se sont traduites par un taux de croissance annuel moyen de 7% au cours des deux premières décennies qui ont suivi son indépendance politique. Ces performances lui ont permis de se doter d'infrastructures sanitaires appréciables. A titre d'illustration, le Cameroun disposait de 1 031 établissements sanitaires dont 1 Centre hospitalier universitaire (CHU), 2 hôpitaux généraux de référence (Hôpital général), 3 hôpitaux centraux, 8 hôpitaux provinciaux, 38 hôpitaux départementaux, 132 hôpitaux de

district et 842 centres de santé (Republic of Cameroon 2000), avec un personnel médical d'environ 14 292 employés (Ministry of Health 1997). Toutefois, les difficultés économiques devenues insoutenables depuis le début des années 80, ont nécessité des réformes de politiques sous l'impulsion de la Banque mondiale et du Fonds monétaire international. Ces mesures ont imposé, entre autres, le désengagement de l'État et la réduction des dépenses publiques, notamment dans le secteur sanitaire, faisant passer les dépenses du secteur sanitaire de 35 817 millions F CFA en 1986/87 à 18 167 millions F CFA en 1995/96, soit une baisse globale de 49% en huit ans.

Contrairement aux prédictions théoriques, la dévaluation du Franc CFA intervenue en 1994 n'a pas provoqué un recul de la pauvreté au Cameroun en général et dans les zones rurales en particulier (Republic of Cameroon 2000). On estime que l'incidence, l'intensité et la gravité de la pauvreté ont augmenté au Cameroun au cours de la dernière décennie; ce qui signifie que non seulement la pauvreté s'est généralisée, mais elle est également plus profonde et plus grave. La pauvreté est considérable dans toutes les régions rurales. En 2001, 50,5% des Camerounais sont affectés par la pauvreté, soit environ 6 217 058 millions d'individus.

En milieu rural, la pauvreté est devenue plus intense avec un taux de paupérisation de 56,7% en 2001. Les nombreuses mesures d'ajustement entreprises par le gouvernement, même-si elles n'étaient toujours pas directement ciblées sur les populations rurales, ont toutefois eu des effets délétères sur leur bien-être. À titre d'exemple, la diminution du niveau de rémunération des employés du secteur public et privé formel a eu pour conséquence la baisse du niveau de demande des produits alimentaires offerts par les populations rurales d'une part, et, d'autre part, la baisse du niveau de transferts familiaux vers les populations rurales.

L'état de santé occupe une place de choix parmi les indicateurs de bien-être, dans le processus de développement économique de tout pays. La santé peut être appréciée non seulement en tant qu'indicateur de développement économique mais aussi comme forme de capital humain. Comme indicateur de développement économique, la santé permet d'apprécier le succès ou l'échec d'un pays dans sa tentative de procurer à sa population des moyens vitaux. En tant que forme de capital humain, c'est un élément important du développement futur d'un pays. La santé est aussi un indicateur de pauvreté humaine.

Au Cameroun le bien être des ménages pauvres et vulnérables repose essentiellement sur un bon état de santé. La faible capacité des ménages à payer les soins de santé les amène à recourir à des solutions diverses. Il est courant de s'abstenir de tout traitement ou de pratiquer l'automédication avec des remèdes traditionnels ou de recourir aux guérisseurs traditionnels.

Suite à l'initiative de Bamako en 1987 et devant les difficultés budgétaires, l'État a mis en place un nouveau système de santé basé sur le cofinancement et la cogestion des services de santé par les bénéficiaires de la communauté. En principe, cette politique dite de recouvrement des coûts ne pose pas de problème si

elle est accompagnée d'une amélioration de la qualité de ces services (Shepard 1992, Diop 1994, Schneider *et al.*, 2000, Griffin 1998). Toutefois, cette politique de recouvrement de coût n'est pas toujours de nature à faciliter l'accessibilité aux services de santé de base des populations rurales généralement vulnérables au Cameroun.

D'après le rapport 2002 sur les conditions de vie et profil de pauvreté au Cameroun, le nombre de visites dans les centres de santé a considérablement diminué. Dans l'ensemble, parmi le nombre de personnes ayant déclaré avoir été malades en 2001, moins de 48,7% ont été capables de s'offrir des soins médicaux dans un centre de santé, pendant que parmi les populations les plus vulnérables, seules 36,1% ont pu se rendre à un centre moderne de santé. En ce qui concerne les dépenses en soins de santé proprement dits, la somme dépensée par an par personne s'élève à 13 000 F CFA, soit 5 600 F CFA par personne chez les ménages pauvres contre 37 000 F CFA chez les autres (DSCN 2002).

Il apparaît dès lors clair que le paiement individuel direct, comme forme d'expression de « recouvrement des coûts », présente plusieurs inconvénients:

- il ne permet pas le partage des risques entre malades et bien-portants;
- il bute très rapidement sur la capacité des individus à payer et, face à des événements de santé très coûteux, ne permet de récupérer qu'une partie des coûts;
- il maintient souvent des individus dans une gestion au coup par coup des événements de santé et n'incite pas à l'anticipation des dépenses;
- les différentes solidarités, horizontales entre malades et bien-portants et verticales entre groupes sociaux, sont difficiles à prendre en compte.

Le caractère aléatoire de la maladie, la lourde charge que représentent pour les individus les frais inhérents à une hospitalisation ou à une maladie grave et, plus largement, l'origine sociale et économique des grands problèmes de santé militent en faveur d'une couverture collective des principales dépenses de santé surtout dans nos sociétés traditionnelles.

Il est grandement reconnu que les systèmes communautaires de partage de risque tel que le pré-financement pour utilisation future des services de santé sont en mesure non seulement, d'améliorer l'équité dans l'accès des populations rurales aux soins de santé de qualité, mais, en mesure également d'inciter les pourvoyeurs de ces soins, d'améliorer la qualité et l'efficacité des services offerts ainsi que l'implication des populations locales dans leur mise en œuvre et leur gestion (Atim 1999, Schneider *et al.* 2000). À cet effet, les systèmes de préfinancement de type mutualistes, avec une gestion décentralisée, peuvent constituer une voie originale, alternative et à la portée de nos communautés rurales.

En théorie lorsque l'on est en face de plusieurs catégories de demandeurs d'un bien ou service, la question d'équité nécessite de procéder à une segmentation du marché; de sorte que ceux qui ne sont pas capables de payer puissent payer le

montant maximum qu'ils consentent payer. Il est donc important de connaître les montants que les populations rurales, généralement moins nanties, sont capables de payer et de comprendre les facteurs qui expliquent ces velléités à payer.

Comment peut-on résoudre le sempiternelle problème de disparité dans l'accessibilité aux soins de santé de base des populations rurales au Cameroun ? Quelle stratégie mettre sur pied afin de leur permettre de recourir facilement aux services de santé modernes en cas de maladie ? Quelles peuvent être leurs contributions pour la réussite d'une telle stratégie ? C'est à ces différentes préoccupations que ce projet de recherche tente à apporter quelques éléments de réponses.

Cette étude a donc pour objectif d'apprécier les possibilités réelles de participation des ménages ruraux au préfinancement collectif des soins de santé. De façon spécifique, il s'agit d'estimer, d'une part, la disposition à pré-payer des ménages et, d'autre part, à identifier les facteurs qui l'influencent.

Revue de la littérature

Elle porte essentiellement sur les systèmes de préfinancement de santé volontaires, les typologies généralement rencontrées en Afrique, le consentement à payer et les déterminants du consentement à payer.

Les systèmes de préfinancement de santé volontaires et à but non lucratifs

La dernière décennie a fait l'objet d'un intérêt croissant dans l'introduction et l'expansion des systèmes de solidarité basés sur le financement des soins de santé en Afrique (Abel-Smith 1986, World Bank 1987, 1993, Vogel 1990a, b, Shepard *et al.* 1992, WHO 1993, Ahrin 1995, Schneider *et al.* 2000). Les raisons souvent invoquées dans la promotion de ces systèmes est leur potentiel comme source de revenus stables et additionnels au financement des structures de santé, leur capacité à réduire les barrières financières à l'utilisation des services de santé ainsi que leur effet redistributif (Schneider *et al.* 2000).

Il est apparu évident que l'engouement d'un regain d'intérêt national dans la promotion des systèmes traditionnels de financement des soins de santé en Afrique au sud du Sahara n'est ni une forme équitable, ni efficace comme option de politique de financement en ce sens que dans la majorité des cas, seuls les employés du secteur formel sont pris en compte dans ce genre de système. Vogel (1990b) a parcouru les systèmes de financement des soins de santé dans 23 pays en Afrique au sud du Sahara et a abouti à la conclusion que ces systèmes ne promouvaient pas une grande équité dans l'accès aux soins de santé par les pauvres. Gruat a confirmé ce résultat en analysant l'allure et les problèmes de système de sécurité sociale en Afrique (Gruat 1990).

Il existe une littérature abondante sur les systèmes volontaires et à but non lucratifs de financement des soins de santé ces dernières années, attestant par là même, l'intérêt des chercheurs et du politique dans ce domaine. Cet intérêt a été

conforté en reconnaissant en partie que les frais de santé affectent négativement le but important de la politique de santé d'équité et de plus grande accessibilité des pauvres aux services de santé (Gilson 1988, De Bethume *et al.*1989; Waddington and Enyimayew 1989, Abel-Smith 1993, Shaw and Griffin1995, Criel 1998, Schneider *et al.* 2000).

De Ferranti (1985) a examiné la faisabilité du recouvrement des coûts des soins de services de santé par les usagers en Afrique. Son étude a fait ressortir de nouvelles possibilités de politiques de financement des soins de santé qui sont devenues assez courantes aujourd'hui dans l'environnement sanitaire africain, spécialement, en ce qui concerne les frais de santé. De Ferranti (1985) a réalisé que la contribution des usagers aux coûts de santé pourrait prendre non seulement la forme de recouvrement direct au point de la réception des soins amis, également, la forme d'un préfinancement pour une utilisation future des services de santé. La dernière option selon lui a un potentiel assez élevé de recouvrement en ce sens que les charges de couvertures sont relativement moindres. Une croissance rapide et une participation entière de la communauté pourraient donc être source de revenus substantiels.

Dans ce même ordre d'idée, Carrin (1987) a examiné l'opportunité de préfinancement des systèmes communautaires de financement des soins de santé pour l'Afrique subsaharienne, au travers desquels les communautés en milieu rural et urbain contribuent au financement de leurs soins de santé soit directement dans les centres de santé, soit indirectement. Néanmoins, il insiste sur le fait que le financement communautaire entraîne une certaine implication de la population dans l'organisation du système. Il a mis en exergue deux avantages tant pour les systèmes de financement décentralisés que communautaires dans ce sens que le contrôle local des revenus aurait un impact positif sur l'incitation du personnel de santé dans la collecte des revenus tandis que, la conservation interne de ces revenus aurait pour conséquence de stimuler le personnel de santé à l'implication dans le système de financement. Le second avantage était que le système répondrait bien aux préférences et demandes des populations locales de sorte qu'ils acceptent en retour les mesures de recouvrement de coûts.

Kutzin et Barnum quant à eux, ont examiné les effets des programmes de financement des soins de santé sur les services de santé des pays en développement à travers une revue des principales caractéristiques institutionnelles de quatre systèmes y compris le système de financement des services de santé communautaire de l'Hôpital de Bwamanda en RDC (ex-Zaïre) et l'évaluation de leur impact tant sur l'équité que sur l'efficacité du secteur de santé (Kutzin and Barnum 1992). Les résultats de cette analyse ont montré que le système de financement de Bwamanda a atteint ses objectifs dans l'augmentation de la mobilisation des ressources des services de santé dans cette région mais, par contre, la principale faiblesse de cette approche était qu'elle a entraîné un accès inéquitable aux soins de santé entre les membres et les non-membres du système. Bien plus, il est apparu des possibilités de hasard moral en ce sens que les membres du système avaient tendance à une

surconsommation des services offerts dans la mesure où le coût inhérent à un tel comportement était assez moindre pour eux comparativement à celui que pourrait supporter les non-membres. Il est également apparu la possibilité que le risque de sélection adverse existe: c'est à dire, la tendance pour les personnes malades de s'intéresser beaucoup plus au système comparativement aux personnes bien portantes.

Une étude récente de Creese et Bennett va plus loin sur la question de savoir dans quelles mesures les systèmes de préfinancement en milieu rural tels que discuté par Atim (1999) sont réellement en mesure de contribuer à l'accroissement des revenus des structures de santé ou à l'augmentation de l'équité dans l'accessibilité aux soins de santé; deux des principales raisons qui militent en faveur de la promotion des systèmes de pré financement des soins de santé (Creese and Bennett 1997). Sur la base d'une enquête mondiale sur les systèmes de pré financement, ces auteurs aboutissent à la conclusion que les systèmes mis en place dans les pays à faible revenu ont généralement une couverture très limitée, un taux de recouvrement des coûts très faible et une assez faible habilité à protéger les pauvres. Cependant, les auteurs ont atténué ce pessimisme en mentionnant que plusieurs des systèmes étudiés ont été très mal conçus. Par conséquent, il était possible qu'avec une bonne organisation et une bonne prise en compte des expériences d'ailleurs, la plupart des problèmes identifiés pourraient être résolus.

Par ailleurs, des études menées par Shepard *et al.* (1992) puis, Shneider *et al.* (2000) sur le développement et l'implantation des systèmes de pré financement au Rwanda ont montré que les systèmes de pré financement des soins de santé apparaissent comme des outils viables dans l'augmentation de l'autonomie financière des structures de santé et dans l'amélioration de l'accessibilité aux services de santé de ces communautés.

Par contre les réseaux de solidarité traditionnels tel que celui étudié au Cameroun par Atim (1999) n'a pas eu un intérêt similaire dans le contexte du débat sur le financement des soins de santé.

Typologies de systèmes de financement de santé volontaires et à but non lucratif

Il existe en Afrique, au moins cinq types de systèmes de financement des services de santé volontaires à but non lucratif tels qu'ils apparaissent dans la littérature et les observations. Le premier groupe est constitué des réseaux traditionnels sociaux de solidarité basés sur les liens tribaux (clan ou ethnie) du groupe cible, mais ces réseaux sont généralement basés en milieu urbain. Tel est le cas au Cameroun comme le mentionne Atim (1999). Le deuxième groupe se compose de mouvements ou association mutualistes de santé très inclusifs qui sont basés dans les communautés rurales ou urbaines, les entreprises, les syndicats, les associations professionnelles, etc., et qui ne sont pas restreintes aux critères ethniques ou autres facteurs similaires. Le troisième groupe forme un modèle de financement

communautaire simplifié ou à faible participation, généralement organisé par les pourvoyeurs de soins de santé eux-mêmes dans un contexte de recouvrement de coûts et dans lequel, l'implication des membres dans la gestion du système est faible voire inexistante. Le quatrième groupe est un modèle de financement communautaire complexe ou à grande participation dans lequel la communauté participe à la gestion, tout au moins, au premier niveau des soins (centre de santé), habituellement, en partenariat avec le pourvoyeur des soins de santé. Le cinquième groupe est constitué de « sociétés d'aide médicale ». Ce sont en pratique les formes les plus avancées et développées des mouvements mutualistes, organisés à grande échelle en terme de membres et qui nécessitent un staff professionnel et certaines techniques de gestion empruntées aux compagnies commerciales d'assurance. Ces systèmes sont généralement rencontrés au Zimbabwe et en Afrique du Sud (Atim 1998).

Consentement à payer (CAP)

Il s'agit ici des montants que les personnes interrogées consentiraient à pré-payer dans le cas de la création probable d'une mutuelle de santé.

Dans la littérature, cette technique d'évaluation du consentement à payer tire son fondement dans la méthode d'évaluation contingente (CVM). Le principe fondamental de cette méthode est que les préférences des individus doivent servir de base à l'évaluation des gains et des pertes des biens et services qui n'ont pas de marché. Il revient alors aux individus d'exprimer leurs préférences à travers le concept de consentement à payer. Du fait qu'elle repose sur l'auto rapport, les économistes en particulier restent sceptiques à propos de la valeur de cette méthode, dans la mesure où les intentions déclarées ne correspondent pas souvent au comportement des individus. De plus, du fait de sa nature hypothétique, plusieurs biais peuvent survenir au cours de l'enquête (Mitchell and Carson 1989, Neill *et al.* 1994, Whittington 1998, Frykblom 1998, Bateman and Willis 1999, Smith 2001) entre autre:

> le biais stratégique qui survient lorsque le répondant pense aux conséquences ultérieures de l'enquête. Alors, il adopte un comportement stratégique et ne révèle pas sa vraie préférence: on dit qu'il joue au « passager clandestin ». Certains biais sont liés au manque d'information au niveau du répondant, ces biais potentiels sont appelés biais de l'information, dans cette catégorie on distingue en général, le biais du point de départ, la valeur proposée par l'enquêteur peut servir de point de repère au répondant.

Dans la littérature, l'on a assisté à un foisonnement de la recherche sur la méthode d'analyse contingente, et notamment plusieurs de ces études ont été faites dans le secteur de l'environnement. Les études dans le domaine de la santé sont à notre connaissance, très rares. Munasinghe (1996) et Smith (2001) fournissent plusieurs exemples de la méthode d'évaluation contingente pour évaluer la qualité des ressources environnementales dans les pays en voie de développement. Whittington *et al.* (1990) ont utilisé cette méthode pour évaluer la contribution financière des

populations dans la fourniture de l'eau potable dans les pays en voie de développement et plus spécifiquement au Sud de Haïti.

En Afrique subsaharienne, Wasikama (1998) a utilisé cette méthode pour évaluer la contribution financière de la communauté internationale pour la préservation de la forêt de Taï en Côte d'Ivoire. Houdégbé (1999) a utilisé cette méthode pour évaluer le coût économique de la dégradation des ressources naturelles au Bénin et la valeur monétaire des aires protégées dans la zone cynégétique de la Djona au Bénin respectivement. De plus, Treiman (1993) cité par Pokou (1998) a utilisé cette méthode pour estimer également les aires protégées de la Pendjari. Par ailleurs, cet instrument a également été utilisé dans divers domaines socio-économiques outre qu'environnementaux: c'est le cas des travaux de N'guessan (1997) et Pokou (1998) où il a servi à estimer respectivement la valeur du moustiquaire imprégné dans les régions de Memni et Montézo en Côte d'Ivoire; et la contribution financière des populations pastorales dans la lutte contre la trypanosomiase animale dans le Nord de la Côte d'Ivoire.

Les déterminants du consentement à payer

Dans cette littérature, certains auteurs ont conclu que le consentement à payer était influencé par des caractéristiques économiques, socio-démographiques et les caractéristiques du bien en question (Whittington *et al.* 1990, Coffie 1997, Flores and Richard 1997, Pokou 1998, Houdégbé 1998, Bloom and Shenglan 1999, Atim 1999, Criel *et al.* 1999).

Tshinko *et al.* (1995) dans une évaluation ex-post, regroupent ces facteurs en trois catégories distinctes à savoir: les facteurs de prédisposition, les facteurs facilitateurs et les facteurs de renforcement.

Outre les variables socio-démographiques telles que l'âge, le niveau d'éducation, le genre, la religion, la taille du ménage, les facteurs de prédisposition découlent généralement de l'environnement socioculturel des répondants. Il s'agit généralement de la tradition d'utilisation des services de santé par les répondants, de la tradition locale d'entraide (expérience associative) et l'ouverture d'esprit des répondants.

Les facteurs facilitateurs sont essentiellement issus des conditions économiques des répondants: dans ce cas, le niveau de revenu des ménages est souvent considéré comme un indicateur pertinent de ce facteur. Et, enfin, les facteurs de renforcement synthétisent les caractéristiques propres au bien proposé: il s'agit souvent dans ce cas de l'expérience sanitaire vécu par le répondant (accueil, disponibilité des médicaments, qualité du praticien, etc.).

De cette revue de littérature, il apparaît que non seulement très peu d'études sur l'analyse du Consentement à Payer ont été entreprises dans le secteur de la santé en général et au Cameroun en particulier, la plupart d'entre elles entreprises dans le domaine du pré financement des soins de santé sont des études ex-post. Aucune étude à notre connaissance n'a abordé le problème dans le sens de la disposition des ménages à payer pour participer à un système de préfinancement

des soins de santé et les facteurs qui la détermine. Une étude de cette nature, qui vise à évaluer le consentement à payer des populations surtout pauvres, en vue de favoriser l'émergence des systèmes de préfinancement communautaires des soins de santé est donc justifiée tant sur le plan scientifique que social.

Méthode d'analyse

Échantillonnage et données de l'étude

Les données relatives à cette étude proviendront principalement de l'enquête de base effectuée par le Mouvement d'Action d'Aide aux Initiatives locales de Développement (MAILD) dans le cadre du projet: « *Accessibilité des populations vulnérables aux soins de santé de qualité: quelles opportunités pour la création des systèmes de préfinancement des soins de santé de type mutualiste au centre Cameroun* ? **»**

Cette enquête a été conduite sur la base d'un échantillon aléatoire de 1500 ménages ruraux. La procédure d'échantillonnage suivante a été utilisée: il a été procédé dans un premier temps à l'identification des services de santé dans différentes localité rurales de la Province du Centre, après quoi, différents villages ont été choisi de façon raisonnée. À l'intérieur de chaque village, il a été procédé une identification des principaux groupements ruraux d'action communautaire ainsi que la liste des membres adhérents. Un tirage aléatoire a donc été opéré en vue de constituer un échantillon de 1500 ménages.

Le questionnaire et le guide d'entretien ont constitué les principaux outils de collecte des données sur:

- les caractéristiques socio-démographiques et culturelles telles que l'âge, le genre, le statut matrimonial, le niveau d'éducation, la taille du ménage, le nombre d'individus actifs dans le ménage, le nombre d'enfants de moins de 15 ans dans le ménage, la tradition d'utilisation des services de santé modernes;
- les caractéristiques socio-économiques telles que l'appartenance à un groupement d'intérêt économique comme proxy du capital social, le niveau de revenu des ménages;
- la valeur du consentement à payer, c'est-à-dire, les montants que les individus consentiraient à pré-payer en vue d'être membre d'un système de préfinancement pour une consommation future d'une certaine catégorie de soins de santé.

L'évaluation de la disposition à payer

La contribution des ménages au financement des soins de santé soulève le problème de la fourniture et de la tarification des biens et services publics tel que discuté par Kahneman and Knetsch (1992), Diamond (1994), Whittington (1998), Kristöm (1993), Li and Fredman (1994), Jordan (1994), Li and Fredman (1994), Frykblom (1997), Brox *et al.* (2003).

Deux approches théoriques principales sont disponibles pour l'estimation fiable des velléités à payer des ménages. La première, l'approche indirecte, se sert des informations sur l'utilisation des biens ou services pour évaluer les réponses des consommateurs. Parmi ces méthodes, on note les modèles de coût de transport (travel cost), la méthode du prix hédonique (hedonic property value). La seconde, l'approche directe, consiste simplement à demander aux individus combien ils sont prêts à payer pour l'utilisation d'un bien ou l'amélioration d'un service. Cette méthode est appelée la méthode de l'analyse contingente. L'analyse contingente cherche à construire des marchés hypothétiques pour les biens publics. C'est une méthode d'enquête originairement utilisée pour attribuer des valeurs monétaires aux biens et services pour lesquels les prix de marché n'existent pas ou ne reflètent pas leur valeur sociale réelle.

Cette approche cherche donc à construire des marchés hypothétiques pour les biens en vue de permettre l'estimation de la demande de ces biens. Cette méthode qui a été appliquée à divers domaines s'est révélée appropriée pour évaluer les ressources non marchandes et les biens publics. Elle sera utilisée pour élucider la velléité à payer pour l'accès aux soins de santé.

L'un des problèmes majeurs liés à la technique de l'évaluation contingente est que pour certaines raisons, les personnes enquêtées ne répondent pas correctement aux questions et donc ne fournissent pas leurs vraies velléités à payer. Les deux variantes les plus utilisées dans l'analyse contingente sont la méthode de questionnaire ouvert et la méthode de questionnaire fermé ou la technique à choix dichotomique (bidding-game). Dans le questionnaire ouvert, il est demandé au répondant d'exprimer sa volonté maximale à payer. Par exemple, « quel est le montant maximum que vous serez prêts à payer pour participer à un système de préfinancement des soins de santé ? ». Le deuxième type de questions consiste à partir d'un montant de départ et de demander au répondant s'il est prêt à payer ce montant ou non (« bidding game »). Par exemple, « seriez-vous disposé à payer x Franc CFA pour participer à un système de préfinancement des soins de santé? ».

Pour les besoins de notre étude, nous nous serviront de la technique à choix dichotomique dans la mesure où elle répond mieux aux stratégie de marchandage pratiquées dans nos marchés locaux.

Les déterminants de la disposition à payer

Plusieurs techniques peuvent être utilisées pour identifier les déterminants du consentement à préfinancer les soins des ménages à savoir:

- les techniques économétriques où la valeur du CAP à payer est exprimée comme fonction d'un certain nombre de variables socioéconomiques et culturelles;
- les techniques statistiques où l'on procède à des mesures de corrélation entre la valeur du CAP et un certain nombre de variables socioéconomiques et culturelles.

L'utilisation des techniques économétriques certes plus complexes, nous permet d'apprécier l'effet de ces différentes variables sur le CAP prises globalement alors que les techniques statistiques permettent d'apprécier cet effet des variables prises individuellement.

Pour des raisons de simplicité nous nous servirons uniquement des techniques statistiques où il sera procédé à l'aide des tableaux de contingence à des tests statistiques des différents effets des variables socioéconomiques et culturelles sur la valeur du CAP.

Résultats attendus

Cette étude qui a pour objectif d'évaluer et d'analyser le consentement à préfinancer les soins de santé par les populations rurales vise une triple ambition: d'abord, l'estimation des différentes valeurs du consentement à préfinancer les soins de santé servira comme base de cotisation individuelle dans une perspective de la mise sur pied d'un système de préfinancement des soins de santé de type mutualiste en milieu rural. Ensuite, les résultats de cette étude permettront aux décideurs d'apprécier le niveau de disparité dans l'accès aux soins de santé de base des populations rurales en mesurant l'écart entre les coûts pratiqués dans les services de santé et les aptitudes réelles des ménages à payer. Enfin, l'identification des facteurs affectant la valeur du consentement à préfinancer les soins permettra de définir le profil des futurs mutualistes en vue de permettre aux acteurs du développement local de mieux asseoir leurs stratégies de mise sur pied du système de préfinancement des soins de santé de base dans la localité d'étude.

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15

The Impact of Structural Adjustment Programmes (SAPs) on Women's Health in Kenya

Damaris S. Parsitau

Introduction

The late 1970s and early 1980s were a difficult period for many developing countries because of high inflation, slow rates of economic growth, and declining earnings from exports. These factors affected national incomes and resulted in large government deficits, which in turn caused deterioration in the standard of living of families in the developing world.

During the 1980s, stabilisation and adjustment packages were introduced in many developing countries in an attempt to stop further deterioration in standards of living (Dixon et al. 1995, Barhin 1998). The term 'adjustment' refers to a range of macro-economic and structural measures that were promoted in the first instance by the Bretton Woods institutions - the World Bank and the International Monetary Fund (IMF) - to restore internal balances and increase the role of market force in the economy. Adjustment policies therefore denote the various mechanisms designed to reduce imbalances in Third World economies, both on external accounts and in domestic resource use. Adjustment frequently involved cutbacks in government expenditure. Consequently, real government expenditure per capita fell in over half the countries of the developing world in the period 1980-1984 (Cornia et al. 1987).

The impact of adjustment measures on local economic conditions varied widely as did the degree and consistency of their implementation. In sub-Saharan Africa, SAPs were implemented in only a handful of countries during the late 1970s, but by the end of the 1980s, most countries were formally involved (Streefland et al. 1998). In Africa, economic restructuring was a major component of the process of globalisation. Globalisation is a post-Second World War

phenomenon that has become manifest in the last three decades. This is a process involving the construction of a world system (Aina 1996). Globalisation entails the restructuring of the global, national, local and household economies, as well as social structures and livelihood strategies. It has transformed the international and local division of labour, changed relations of production, employment, the provision of social services, cultures and so on. These processes have affected communities in rural and urban Africa (Aina 1996). SAPs were an important aspect of globalisation.

In Africa, the restructuring process, coupled with the implementation of SAPs, has had a devastating effect on the provision of social services such as healthcare and education. Cutbacks in government expenditure have created constraints in the provision of these services, leading to a decline in social welfare. Since SAPs touched on every facet of life in the relevant countries, it affected governance in a way no other policy package had done before.

This paper examines the impact of SAPs on women's health in Kenya. It argues that the reforms brought upon by SAPs led to a decline in the health of most women in Kenya. It further argues that SAPs, an imposition on developing countries by the Bretton Woods institutions, violated the rights of Third World societies through the denial of access to healthcare, which is a basic human right. Since women were the most affected group in Kenya, the paper calls for the engendering of health services in the country in order to meet the health needs of women.

Health Services in Post-independence Kenya

From the 1950s through to the 1970s, Kenya, and indeed most African countries, made substantial progress in healthcare delivery. In the 1970s, relatively high prices for Kenya's exports, which are mainly agricultural produce like coffee and tea, coupled with low interest rates, made increased spending in healthcare provision possible. Healthcare related projects, as well as the number of state medical personnel, also increased during this period. Consequently, there was a dramatic decline in infant and maternal mortality rates as well as a rise in life expectancy. In Kenya, the overall mortality rate dropped from 20 per 1000 persons in 1963 to 13 in 1987. Similarly, life expectancy increased from 49 years in 1960 to 58 in 1987. Immunisation also rose to 70 percent by the 1980s and early 1990s (Republic of Kenya Development Plan 1997-2001).

From the 1980s, however, the situation began to deteriorate. The early 1980s saw large drops in national income as the prices of coffee and tea in the world market fell to record low levels. This situation was compounded by increased interest rates on government borrowing, making debt servicing a problem for many African countries. This was largely responsible for the introduction of SAPs, which exacerbated the situation.

The economic crisis in many African countries, coupled with SAPs, undermined the health of many people in a number of ways. First, the removal of farming

subsidies and the resultant rise in food prices threatened the ability of families to feed themselves and thus remain healthy. The increasingly harsh socio-economic conditions also affected many people's access to health services outside the public sector. Secondly, the reduction in government expenditure in the public health sector reduced both the quantity and quality of healthcare available to the general populace. Thirdly, SAPs brought about the introduction of user fees or cost-sharing in Kenya's social services sector in order to relieve the government of the financial burden of providing healthcare and education. The Bamako Initiative, which introduced user fees in the public health sector, meant that the beneficiaries of public health services, who hitherto received free medical care, would henceforth contribute to the financing of healthcare delivery. This meant transferring the cost of healthcare services to people who were already too poor to afford it.

At independence in 1963, the government of Kenya took the responsibility for financing public health services, thus relieving beneficiaries of the financial burden. But the cutbacks in government expenditure through SAPs hurt the poor and the vulnerable groups most because they were dependent on the previously subsidised social services. The negative effects of the SAPs were borne by the low-income population, the majority of who are women (Nzomo 1995). A World Bank study has shown that the poor suffered disproportionately from the effects of the economic decline of the 1980s and structural adjustment measures (World Bank 1991). Specific vulnerable groups, such as female-headed households, can be identified in both rural and urban environments.

Living conditions for urban and rural populations have clearly deteriorated since 1975. Public expenditure on health services has been low amidst increasing demand for these services. For instance, annual spending on health services per capita in Kenya declined from US $982 in 1980/81 to about US $6.2 in 1996 (Owino and Munga 1997). Today, the state can only cater for 50 percent of the total recurrent health expenditure. Meanwhile the majority of Kenyans are located more than eight kilometres from any form of health facility, and 40 percent of the rural population has no access to health services. There is also a general lack of quality healthcare due to under-staffing, under-stocking of medical supplies, corruption, and poor public health infrastructure.

Women and Health

The World Health Organisation (WHO) defines good health as a state of complete physical, mental and social well being of the whole person and not merely an absence of disease and infirmity. Good health is a human right that should be enjoyed by all. Moreover, a society's investment in the health of its citizens is essential for economic, social and political development.

Women play a crucial role in society. Besides their economic importance, they are educators as well as healthcare givers. It is therefore imperative that their health be taken seriously if the health of the rest of society is to be enhanced. It is

the mother who first notices a cold, cough, a rise in temperature, or a gastro-intestinal condition that may arise in any member of the family (Wallace 1990). Besides, women have multiple roles as wives, bearers and minders of children, food producers, fetchers of water and fuel, nursing the sick and elderly, part of the paid labour force, etc. This visibility of women in every facet of life makes it imperative to focus on their health (Kamara 2000).

Yet, available information indicates that women as a group are the least healthy population in Kenya. Compared to men, women in Kenya have less access to medical care, are more likely to be malnourished, poor, and illiterate, and even work longer and harder. The situation exacerbates women's reproductive role, which increases their vulnerability to morbidity and mortality. Furthermore, women's roles as mothers and wives make them the primary health seekers and caregivers, which exposes them to infections. Women's economic dependence, exposure to violence, limited power over their sexuality, poor nutrition, inadequate access to safe water, sanitation facilities and fuel supplies, particularly in rural areas, all have negative effects on their health (UN 1996). As a group, women therefore need healthcare more than men do.

Discrimination against girls, often resulting from favouritism to sons in access to nutrition and health services, endangers their health and well being. Girls need but often do not have access to necessary health and nutrition services as they mature (UN 1996). There are also conditions that force girls into harmful practices such as female genital mutation, early marriage and childbearing. This is perhaps what forced Kenyan female members of parliament to call for the distribution of free sanitary pads to all adolescent girls in Kenya's rural areas in 2004.

Furthermore, women are subjected to peculiar health risks through childbirth. The lack of services to meet health needs related to sexuality and reproduction during pregnancy and childbirth is among the leading causes of mortality and morbidity of women of reproductive age in Kenya and the developing world. Maternal problems are preventable through access to healthcare, including safe and effective family planning methods. In many countries, Kenya included, the neglect of women's reproductive rights severely limits their opportunities in public and private life, including opportunities for education (UN 1996).

It is clear that provision of adequate healthcare, particularly to women, is critical to a nation's development. But how is the provision of healthcare services in Kenya? What has been the impact of SAPs on women's health in Kenya? What effect has the introduction of user fees in Kenya had on women's health?

SAPs and Women's Health in Kenya

A 1992 World Bank Report shows that the implementation of SAPs had a negative impact on a variety of groups. These groups include women who form the majority of the poor in society, but who are paradoxically the critical providers of health at home. This is particularly the case among female-headed households

in both rural and urban areas. It is evident that the poor have suffered disproportionately from the effects of economic decline and the structural adjustment measures (Wallace 1991).

Economic decline and SAPs hit women harder than men. Being responsible for the well being of their families, women found it difficult to cope with increased burdens of disease and hunger. The retrenchment policies resulting from implementation of the SAPs also affected women more than men as women dominate the less skilled work force. As a group, women are less educated and their participation in formal employment is low. With SAPs came the rationalisation of formal sector employment, leading to the retrenchment of the less skilled cadres, mainly women. Cost-sharing policies in education and the healthcare sectors also affected women adversely. The removal of subsidies in the agricultural sector, and the resultant high cost of inputs as well as low returns on farm products, also adversely affected the living standards of women and children (Aina 1995).

A 1992 situational analysis by UNICEF shows that for every maternal death, about a hundred women suffer serious physical and mental complications (UNICEF 1989). Indeed, cases of such complications go unreported. During pregnancy, many women not only suffer infections, injuries and disabilities, but also receive no medical care, no special diet, no lighter workload or other considerations. SAPs worsened this situation.

Kenya has high rates of maternal and infant mortality. Reliable data are lacking but estimates based on the 1989 national census are at 74 per 1000 persons. Indications are that maternal and infant mortality increased with the economic recessions of the 1980s and the introduction of SAPs. A report by UNICEF points to a clear relationship between poor health among women and the introduction of SAPs (UNICEF 1990).

Family planning services help in reducing the rate of infant and maternal mortality. One of the immediate causes of major complications in pregnancy and childbirth is many or frequent births. Before the introduction of SAPs, family planning services were free of charge but that is now history. There is also the poor accessibility to medical facilities and essential services. The majority of rural women trek long distances to and from health facilities. Before the introduction of SAPs, health facilities were on average 6-7 kilometres away from most households, but many of them closed down while those that remained open lack basic amenities. At Nakuru District Hospital in Kenya, for example, expectant mothers are required to buy gloves, surgical blades, disinfectants and syringes in preparation for childbirth. In addition, they have to bribe hospital personnel in order to be attended to. This is usually too expensive for many women and they opt for traditional birth attendants.

Maternal mortality poses a major threat to women of reproductive age in Kenya. Data on maternal mortality are scanty, but in 1992 it was estimated to range between 150 and 300 per 100,000 births. The positive achievements in

reducing mortality rates between 1960 and 1980s appear to have been reversed. Breman and Shelton (2001) have demonstrated the relationship between SAPs and the deterioration in healthcare services. There is a direct relationship between reduced government spending on healthcare because of structural adjustment policies and increased rates of child and maternal mortality as well as malnutrition.

One of the major causes of maternal and infant mortality in Kenya is lack of prenatal care. Statistics indicate that the majority of the women who die in childbirth, or whose children die before, during, or shortly after birth, had not been visiting prenatal clinics. For example, a study of maternal deaths at Pumwani Maternity Hospital in Nairobi shows that 66 percent of these deaths occurred in women who received no prenatal care or received it late. One of the major reasons why women do not visit prenatal and postnatal clinics is lack of resources. As already noted, while there was a steady improvement in reproductive health in the 1970s, the introduction of user charges in government hospitals in the 1980s has led to a decline in reproductive health (Kamara 2000).

Besides, many government hospitals lack essential amenities. Once machines and equipment such as incubators break down, they are rarely repaired. A fee is required from patients who are already too sick or poor to afford it. As a result, many turn to traditional birth attendants (TBAs) who are cheaper. Moreover, drugs are either unavailable or corruption makes them difficult to get as corrupt medical personnel sell public hospital drugs to private clinics. Cases of drugs in government hospitals expiring before use are also common. All these problems have led to the search for alternative therapies as people lose faith in public health facilities.

Family planning services also help in reducing infant and maternal mortality. One of the major causes of complications in pregnancy and childbirth is many or frequent births. Closely related to this issue is abortion, which causes a significant number of deaths in Kenya. Suffice to say that abortion is a thorny issue in Kenya today. Induced abortion, for example, accounts for 50 percent of all maternal deaths recorded at Kenyatta National Hospital in Nairobi. Illicit abortions in Kenya are carried out by quacks in backstreet clinics because of the lack of reproductive health facilities and the fact that abortion is illegal in Kenya.

Besides problems related to reproductive health, there are other health problems among women in Kenya. Women, like other social groups, require healthcare if they are to remain healthy. But a Kenya Demographic Health Survey (1998) shows that a significant portion of the gains made during the first 25 years of independence rapidly eroded in a short period due to the introduction of SAPs. The factors undermining women's health included deterioration in the quality and quantity of health services, decline in nutritional status, increased poverty, and impact of the HIV/AIDS pandemic.

Other factors include inadequate facilities and poor service. The physical set up of any health facility determines patient flow. Most of the facilities in public hospitals are rundown and the privacy of patients, especially in maternity wards, is lacking. Overcrowding and congestion increases the risk of infections. Health

establishments also lack basic equipment. Where equipment is available, it is non-functional. Supplies such as protective clothing, cotton wool, and surgical gloves are inadequate.

Recent studies have shown that women are the major users of health services. They are also the main providers and promoters of preventive and curative healthcare. However, they do not make optimal use of the existing health services. The factors contributing to this include the inadequate quality and quantity of services, increasing cost, long distance to the medical facilities, negative attitude of medical personnel and lack of time and heavy workload. Furthermore, women bear the social and health burdens of their family. They cope with the increased burden of disease and hunger. SAPs resulted in increased burdens on women.

The Impact of Cost-sharing on the Health of Women

The Bamako Initiative introduced user fees or cost-sharing in many developing countries. This aimed at relieving governments of the financial burden of providing public services. This resulted in cutbacks in budgets for social services, including healthcare. Given the centrality of healthcare to a nation's well being, the introduction of cost-sharing would definitely hurt the poor and other vulnerable groups such as women and children. This would be the case in Kenya where women form the majority of the unemployed and are thus outside the scope of insurance schemes. How were women in Kenya expected to cater for their health needs?

Decline in government spending on healthcare means a decline in well being, especially for the poor who cannot afford the services offered by private healthcare providers. Studies have shown that the introduction of cost-sharing in the public health sector led to a decline in the utilisation of formal health services. In a situation of deteriorating service delivery and worsening household budgets, the question of introducing user fees is difficult. There is a need to ask consumers to supplement government expenditure on health services. But in a situation of low household incomes, user fees for health services can bar many people from such services. In the rural health centres studied, the utilisation of services remained substantially low. When discussing the utilisation of government clinics, the cost of the services is cited as an important determinant for the quality, accessibility and acceptability of the services available. Similarly, availability of drugs and outreach services are important considerations. Low morale among health personnel due to poor motivation is also an important factor in the quality of services provided in public heath facilities.

This situation makes the introduction of user fees a double-edged sword, potentially affecting service delivery as well as utilisation of the services. In January 2004, Kenyatta National Hospital, the largest public health facility in Kenya, introduced user fees for children under five years of age. This has had serious consequences. It has been reported that after the introduction of user fees at Kenyatta National Hospital, utilisation of services has gone down (*Daily Nation*, January 2004).

It is clear that the introduction of user charges in the public health sector has had negative effects on the poor, the majority of who are women. The partial privatisation of public healthcare, through the introduction of user fees, constitutes an assault on both the physical well being and dignity of poor women. Kamara (2000) reports that since the introduction of user fees in Kenya, there has been a dramatic drop in the number of hospital visits, while the infant mortality rate has risen and life expectancy has dropped. The introduction of user charges in the public health sector is in many ways a retrogressive measure. It makes healthcare cease to be a basic human right. Since these measures came with SAPs, the programmes may be considered to have been unjust and unethical.

Engendering Women's Health

In view of the impact of recent changes on the health of women, there is a need to integrate gender into health research, both conceptually and methodologically. Research that analyses the health problems of communities anywhere in Africa can no longer afford to neglect gender issues. Since women play important roles as informal healthcare providers and educators, as they seek to meet the health needs of their families, their significance for social well being can never be underestimated. For women to be able to fully perform their social roles, it is necessary to focus on issues that affect their health (Kamara 2000).

The production and reproductive activities of women makes their role as providers and consumers of healthcare the most critical aspect in a debate regarding gender in health research. However, the prevailing concept of health is not gender-sensitive. Women's health is directly or indirectly related to their reproductive health status. McFadden (1992) argues that women are often assumed to have no specific health needs outside of their mothering roles, an assumption borne out by most of the existing health programmes that target women only during their reproductive years. The safe motherhood initiative (SMI), mother and child health (MCH), primary healthcare (PHC), all include the mother because of her productive function vis-à-vis the survival and development of the child. When a woman is not expectant or lactating, she is essentially marginal to the health system.

Thus, women's reproductive roles largely serve as the basis for the definition of what health means for women at the personal, household, community and national levels. Consequently, the idea of health as a basic human right is rarely extended to women. Nor do women themselves perceive it in this holistic sense. Yet, African women as a group are the least healthy people in our communities. They are stressed, overworked, depressed, and generally unhealthy. As this paper has shown, the effects of SAPs on women's health went beyond reproductive health. There is therefore a need for a broad-based concept of health that goes beyond the narrow focus on women's reproductive health.

Women's health needs should be redefined to mean the totality of well being: reproductive health as well as other health needs. Health as defined by the WHO

is a concept implying the totality of physical, emotional and psychological well being. For women, this concept means the right to a healthy existence as a human being whether one is lactating or not. The concept also empowers women as human beings. Health after all is a human rights issue and women everywhere are entitled to healthcare like everybody else.

Conclusion

This paper has tried to show the impact of SAPs on women's health in Kenya. It has argued that there was a direct link between the introduction of SAPs and deterioration in women's health as the SAPs led to a decline in public expenditure on healthcare.

The paper recommends that the following issues be urgently addressed in the quest for health for all, including women. First, there is a need for the evaluation of the existing medical facilities currently available in Kenya, and challenges to the government as a steward of the people to provide affordable healthcare for all. Secondly, medical services should be made both accessible and affordable to all, especially to poor rural women. Lastly, women's health needs, special or otherwise, should be given prominence.

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16

Should We 'Modernise' Traditional Medicine?

Mugisha M. Mutabazi

Introduction

Traditional medicine plays a big role in the Ugandan health system, and the fact that government is committed to working with this sub sector to ensure good health for the population is a clear reflection of the good leadership the country has had for the last nineteen years. Efforts to bring the 'modern'[1] sector closer to the 'traditional'[2] health sub-sector began as far back as 1993, when reforms in the health sector were introduced. Available evidence suggests that important milestones in the search for a partnership between these two sectors have been reached (Birungi et al. 2001, Ministry of Health 2003, National Health Policy 1999, GoU 1995). Thus, the platform for partnership has been set. However, the form the partnership should take remains a bone of contention. While the government is of the view that this partnership should culminate in the integration of traditional medicine into the overall national health services, a close look at the dynamics in this sub-sector suggest otherwise. Moreover, there is clear evidence that unlike other actors in the private sector whose integration does not present immense bottlenecks, the traditional medicine sub-sector has unique circumstances and qualities that do not easily render it amenable to integration with modern health services, especially in the case of Uganda (Mugisha et al. 2004).

Nationally, the regime's aim at integrating these two sectors has for long been involved in a war of semantics as to what form this partnership should take. While some would prefer 'formalisation', others, want 'collaboration'. In fact, some have even talked of 'co-habitation' and 'co-existence' as if the two sectors have not always co-habited and/or co-existed. Hand in hand with other problems that afflict the country's health sector, the war of semantics on the form of partnership to be pursued has continued and the implications this issue may have on the entire health system are very obvious. In view of the above, this paper presents an alternative approach, which posits granting traditional medicine

practitioners autonomous status, so as to drive the sub-sector towards 'modernisation'. The paper is divided into seven major sections: the introduction and background; the problem; the context of the public-private mix reform process, a critique of the existing model of integration; a review of empirical literature on challenges of integration; the model for the 'modernisation' of traditional medicine and practice, and lastly, conclusions and recommendations for the way forward are suggested. Where possible, the author has tried to capture local political issues pertaining to the sub-sector and how they fit in with the current debate on integration.

Background to the Problem

One third of the world's population still lacks regular access to affordable, modern, essential drugs. Traditional medicine is often the widely available and used alternative (Amai 2002). According to the World Health Organisation (WHO), 'traditional medicine' generally refers to ways of protecting and restoring health that existed before the arrival of modern medicine. 'African traditional medicine' has been conceptualised by the WHO Centre for Health Development as:

> The sum total of all knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental, or social imbalance, and relying exclusively on practical experience and observation handed down from generation to generation, whether verbally or in writing.[3]

Traditional medicine and traditional healers form part of a broader field of study classified by medical anthropologists as ethno-medicine. Ethno-medicine entails a study of the full range and distribution of health-related experience, discourse, knowledge and practice among different strata of the population; the situated meaning the aforementioned have for people at a given historical juncture; transformations in popular health culture and medical systems concordant with social change; and the social relations of health related ideas, behaviours and practices (Nichter 1992).

Traditional medicine therapy includes medication therapies, which involve the use of herbal medicines, animal fats and/or minerals, while non-medication therapies include acupuncture, manual therapy and spiritual therapy (Amai 2002). The Ministry of Health of the Uganda government has categorised traditional medicine practitioners into herbalists, spiritual healers, bone-setters, traditional birth attendants, hydro-therapists, traditional dentists and others. Of late, a number of non-Ugandan traditional medicine systems have been introduced such as Ayurvedic, Reiki, Chiropractic, Homeopathy and Reflexology and those who are involved in these practices are also recognised. However, traditional medicine practitioners do not include people who engage in harmful practices, such as casting of spells and child sacrifice (MoH 2004).

In Africa, up to eighty percent of the population use traditional medicine to meet their health care needs. In sub-Saharan Africa, the ratio of traditional healers

to the population is approximately 1:500, while it is 1:40,000 for medical doctors (Abdol, K. et al. 1994). On the other hand, the ratio of traditional medicine practitioners to the population in Uganda is between 1:200 and 1:400, which significantly contrasts with available trained medical personnel for whom the ratio is 1:20,000 or slightly less (WHO 2001). These ratios underscore the importance of traditional medicine in the overall health care delivery system. However, compared to other parts of the world such as China where up to forty percent of both modern and traditional health care has been integrated, (Hesketh and Zhu 1997), traditional medicine in Uganda is still largely operating independently of the modern health services.

The government of Uganda formally recognised the importance of traditional medicine way back in 1997 when it initiated a project to integrate[4] it in national health services as part of the public-private partnership in health approach (PPPH)[5] (MoH 2004, MoH 1999, HSSP 2000). Through the public-private partnership, government aims at providing an enabling environment that allows for effective coordination of efforts among all partners, increase efficiency in resource allocation, achieve equity in the distribution of available resources for health, improve quality, ensure sustainability of health services and increases effective access by all Ugandans to essential health care. For this, a sector-wide approach (SWAP) has been adopted in which a common framework for health sector planning, budgeting, disbursement, programme management, support supervision, accounting, reporting, monitoring and evaluation is used according to agreed national development objectives and the main strategies for attaining them (MoH 2004). Strengthening the collaboration and partnership between the public and private sector in health is an important guiding principle of the National Health Policy of 1999.

Traditional medicine is gaining popularity in the country because it is easily accessible, affordable, sometimes free and there is a strong belief in its curative effect (Amai 2002).[6] Elsewhere, efforts to enhance collaboration between modern health services and traditional medicine are based on the fact that traditional medicine provides client-centred, personalised health care that is culturally appropriate, holistic and tailored to meet the needs and expectations of the patient. Traditional healers are culturally close to clients, which facilitates communication about disease and related social issues (UNAIDS 2000).

Despite all these efforts and recognition of its importance, traditional medicine has not fully been integrated into national health services and for some, it is even doubtful that the model of integration being pursued will yield the anticipated results.

The Context of the Public–Private Reform Process in Uganda

Before tackling the challenges of integrating traditional medicine into modern health services, it is warranted to comment on the context of the public-private partnership. Several factors have interacted in Uganda to present a complex context

for a public-private partnership policy to evolve in. These factors include the dynamic changes that are ongoing in the health care system such as decentralisation, the weak revenue generating capacity of the public sector, and the breakdown of public health services. These factors were in turn a result of the following landmarks in the history of the country in general and the sector in particular: (i) political upheavals the country experienced in the years after independence up to the 1980s, which had profound implications for the health sector such as declining government expenditure on health care delivery, poor management, planning, control and massive brain drain from the health sector. These effects ultimately led to the proliferation of private profit-oriented health care providers who lacked regulation. Lack of proper management in the sector also culminated in the informalisation of public health care services and loss of public confidence in the system (Obbo 1991, Munene 1992, Birungi 1994, as reported in Birungi 2001), (ii) the establishment of a referral health institutional framework predominantly based on provision of curative health care, without corresponding capacity building measures for its management and staffing, also after independence; and (iii) the debilitating effects of the structural adjustment programmes of the international finance institutions, which further reduced government spending on health.

These problems led to the decline in public health care delivery in the country and encouraged the emergence of a weak but increasingly important private sector. The private sector that emerged was weak because it lacked any standards, had no policy to regulate its practice and was poorly funded. On the other hand, the sector was becoming increasingly important because it was providing a large percentage of curative health services compared to the public sector (Hutchison 1998). The private sector is composed, as already seen, by many actors, some of who were licensed and recognised by the government, while others were not licensed, but appreciated and legitimised by the communities. Despite the significant role played by the private sector, it remained isolated from district/national planning and information until recently - there were no programmes, official subsidies or incentives to influence the direction of private practice, and the relationship between government and the private sector was one of isolation interspersed with attempts at regulation and control (Birungi et al. 2001).

The Problem

Although the policy on public-private partnership is still in draft form, the public-private partnership approach to governance of the health sector in Uganda has been ongoing for some years. A partnership between the public and private sectors, which is deeply entrenched in the National Health Policy and the Health Sector Strategic Plan, is manifested in financial assistance, technical support, supervision and regulatory mechanisms, among others. While some actors in the private sector, notably the Private Not For Profit and Private Health Providers, have to a large extent been integrated (the above mentioned areas of collaboration affect these

actors); traditional health practitioners are largely operating independently of the other actors in health delivery. Efforts to bring them on board have at best been implemented half-heartedly; they are still ridiculed, despised and treated with much cynicism.[7] Coupled with political interference and lack of support from outside the sub-sector, infighting, and the absence of meaningful involvement of traditional medicine practitioners in policy formulation has taken place, nursing some doubt as to how integration will be possible (Birungi et al. 2001).

The existing policy framework does not adequately acknowledge the diversity of traditional medicine, which, in fact is both heterogeneous and monolithic, that is, while there are different cultural groups and different cultural notions of healing, traditional medicine is a unique system of health care.[8] Traditional medicine has, as a result, remained fragmented, polarized and 'under developed', with serious negative implications for its future. This situation raises a number of fundamental questions, which this paper endeavours to address: (i) Is the existing model of integration relevant and applicable to traditional medicine and practice in Uganda? (ii) What are the challenges of trying to bring together modern and traditional medicine systems using the existing model of integration? (iii) Should we 'modernise' traditional medicine so as to make it more acceptable and competitive vis-à-vis modern medicine? (iv) What model of 'modernisation' is relevant in the prevailing context? Based on this analysis, solutions, which explore how traditional medicine and practice can be 'modernised' so as to make them acceptable to those who ridicule and undermine them on the one hand, and those who wrest life and a living from them on the other, are considered.

A Critique of the Existing Model of Integration

The current model of integration purportedly aims at bringing all stakeholders into national health services by providing an enabling environment that allows for effective coordination of efforts among all partners, increases efficiency in resource allocation, achieves equity in the distribution of available resources for health, improves quality, ensures sustainability of health services and increases effective access by all Ugandans to essential health care. However for this to succeed, an effective regulatory and institutional framework through which the various actors can collaborate is necessary.

Over the years, such a regulatory and institutional framework has evolved, although its content does not favour participation by all stakeholders in health and goes against the grain of some, particularly those in the traditional medicine sub-sector. The current regulatory framework does not consider the unique nature and diversity of traditional medicine. For instance almost every ethnic group in Uganda practices a particular form of traditional medicine, deeply entrenched in its cultural past and indigenous knowledge systems, but the current model of integration ignores this fact. Therefore the issue of standardisation becomes a daunting task, if not impossible, within the framework of integration and partnership being pursued in the country.

The question of who controls or regulates whom remains a big challenge to integration, given the fact that the values, philosophies and practices of modern and traditional medicine are in direct contrast with each other. Trying to regulate traditional medicine using the standards and principles of western medicine is a fundamental flaw in the existing framework and will not achieve its intended goals. According to the Secretary General of the National Council of Traditional Healers and Herbalists Associations (NACOTHA), in a workshop held in Kampala, the issue at hand is that those that are pursuing the current model of integration have:

> ... mixed cultural issues with religion. Cultural issues should not be mixed with religion or modern science. People should leave traditional medicine practitioners to explain these issues. For example, not everyone can explain things like 'ejjembe'[9] or 'emizimu'.[10] While these things are considered horrible, they are not necessarily bad as they are portrayed.

It seems from the above that efforts to incorporate traditional medicine into the cultural hegemony of western medicine will not be the best way forward for developing the sub-sector. Already, there is vehement opposition from practitioners to any attempts to streamline their practices into the fold of western medicine. Practitioners who attended a workshop held in Masindi town highlighted the extent of disagreement thus:

> This belief has taken long. It stems from colonialism. It was brought by the whites. They are the ones who branded everything African satanic. That is why our medicine is not developed, that is why we do not cooperate with modern practitioners. They emphasise tablets, but we insist on herbs and spiritual healing.

Although still in the doldrums, the public-private partnership has evolved in a reformed regulatory environment, which began in 1993, with the updating of the Uganda Pharmacy and Drug Act of 1970. These regulations have been reviewed relative to the private sector, and in a bid to increase its participation in health care delivery. In 1993, the National Drug Policy and Statute was passed, followed by the adoption of three professional bills in 1996 (now acts): the Uganda Dental Practitioners Bill, the Uganda Nurses and Midwives Bill, and the Allied Health Workers Professional Bill. The bills established for each category of health workers, a council - a public body to regulate and exercise general supervision and control over professionals and other provisions (Birungi, et al. 2001). However, this regulatory framework affects only health professionals in the public and 'formal' private sectors, but not traditional medicine practitioners. Failure to have an institutional and legal framework for traditional medicine means that it is difficult to regulate traditional medicine from the point of view of modern medicine, since the actors in this sector do not appreciate the dynamics of traditional medicine.

Other weaknesses in this regulatory framework have been raised by Birungi et al. (2001) and seem to emphasise the fact that the laws relating to traditional medicine and practice are old, archaic and have been overtaken by "events on the ground". Existing regulations treat traditional medicine practitioners as actors who are supposedly involved in wrong practices and must be controlled in the public interest. In an earlier study conducted in Kasese and Masindi districts (Mugisha et al. 2004), the views of the District Community Development Officer revealed the stark reality and extent to which traditional medicine practice is held in contempt. He noted thus:

> They have an association, which is not run well because these are illiterates. They are also recognised nationally. Given the support they have nationally, they would be strong, but sometimes, their activities undermine their strength, because some mix traditional healing with witchcraft. They would influence events because people believe in them, but poor management undermines them.

Thus, traditional medicine practitioners are very suspicious and sceptical of the intentions of public officials who have often victimised them. With this scenario, it is difficult to see how the much hyped partnership can work.

While collaboration between the public and private sectors has been ongoing, there is a lack of a comprehensive institutional framework enshrining this partnership in all matters of health service delivery such as planning, decision-making and resource mobilisation. In the present situation, the Ministry of Health is responsible for formulation, coordination and implementation of the national health policy, while districts, through the district health teams, implement policy and plan district health services. There is only a limited role played by 'formal' private sector actors through the expanded district health management teams, but not traditional practitioners.

Failure to not only consult but also provide for traditional medicine practitioners in these institutions at the district level means that big gaps exist, which could have strategic implications for the implementation of the partnership. Traditional medicine practitioners may oppose such structures, not because they do not want them but simply because they were not privy to their establishment and the fact that they do not cater for their interests. No wonder during workshops in Kampala and Masindi, practitioners expressed total disagreement with the proposed structures in the envisaged dispensation that will govern the sector. For example, members and the leadership of NACOTHA were of the view that instead of establishing a new council to oversee progress towards integration, their council should be formally empowered to take leadership through an act of parliament or be institutionalised in the policy being formulated.

Although traditional medicine practitioners have been encouraged to form associations and institutions through which they can articulate their interests, it appears these associations were not organised with regard to their terms and conditions. As has been the case in the past, government in collaboration with key

individuals in this sector set the agenda on which these associations and institutions were hastily organised, 'supposedly to start benefiting from the new partnership that was going to evolve'. The associations did not evolve as indigenous people's organisations/associations with a local agenda aimed at improving the lives of members. There is no doubt that the majority of the traditional practitioners have shunned them, and those who operate within their framework do so out of necessity but not choice. Commenting on the need for locally initiated people's organisations, one of the participants in the workshop held in Masindi had this to say:

> When I was a teacher, we had a teachers' association. We would ask for salary increment and get it, but if we are not united as traditional medicine practitioners through an association, be it Kamengo, Uganda herbalists association or... we need to make an association whether we like it or not. We must unite and have objectives. How can we be assisted unless we are one?

Despite calls for unity made by some practitioners, it seemed as though others were sceptical about the intentions of the leaders of local associations. Local associations were said to have evolved into money-making ventures and extortion machines and their original aim of forging unity seemed to have been eroded. According to practitioners who took part in the workshop that was held in Masindi, 'There is a power struggle in the association (Uganda n'edagala lyayo). So this results in exploitation, whereby leaders connive with local defence force personnel to extort money from practitioners. A person may be asked to pay license fees for all the years he has operated as a TM practitioner at once'.

An important challenge posed by all these developments is the question of intellectual property rights that has taken centre-stage in the new development paradigm of promoting indigenous people's knowledge. In its document on the 'Protection of the Heritage of Indigenous Peoples', the United Nations Commission for Human Rights notes that industrial property laws only protect 'new' knowledge and that 'old' knowledge like herbal remedies that have been used for ages, may not be regarded as patentable. In yet another twist to the problem, delegates at the Nairobi conference argued that the following problems may impede the patenting of some traditional medicines: regional specificity and short duration of the patent rights, the issue of bio-piracy, the lack of official recognition of community rights (as distinct from those of an individual applicant), and the lack of emphasis on availability and access of local communities to medicinal plant resources (Richter 2003).

Based on historical precedents, and mistrust and suspicion of governments' intentions, traditional medicine practitioners are very sceptical of divulging their sources of knowledge, documenting it and sharing it. They fear (and with reason too) that once they divulge their knowledge and practices, the government would turn it into a gold mine for the modern physicians who consider them conservative, subjective, backward and unscientific. Practitioners, in the workshops held in

Kampala and Masindi, succinctly and emphatically argued for protection and granting of property rights to them for their products.

> If I take my herbal drug for testing, my name should be inscribed on it. If it is approved, I should be able to benefit from it. People have drugs, even those that can cure cancer. But they need to be given property rights or at least benefit twenty per cent from them.

Traditional healers also thought that their knowledge is worth being protected since it has withstood the test of time, having been passed on from generation to generation. In addition, it has allegedly been used to cure different ailments, even some that have proved a menace for western medicine such as cancer. The challenge then is to find ways through which indigenous people's intellectual property rights can be safeguarded, since in the absence of economic capital, their knowledge is the only pillar of refuge to lean on.

From the foregoing observations, it is evident that the model of integration being pursued by the Ministry of Health is not relevant and applicable to the development of traditional medicine and practice in Uganda. In the circumstances, it is not rash to propose that the Ministry consider another way of bringing traditional practitioners into the main fold of health service delivery in Uganda.

Some Empirical Evidence on the Challenges of Integrating Modern and Traditional Medicine

The experiences of integrating the public and private sectors in national health service delivery are many, and they manifest great differences in different parts of the world. However, they are even more problematic when we consider the traditional medicine sub-sector. For instance Birungi et al. (2001), from whom this paper has borrowed considerably, conclude thus: "[T]here has been no policy dialogue between policy makers, consumers and informal providers. Yet the latter constitute a significant source of care for both rural and urban poor.... while communities recognise and appreciate such providers, authorities continue to blame and ridicule them. By failing to recognise and consult with this category of provider, the integration policy seems not to be interacting, or catching up, with some of the realities of the Ugandan health care system'.

Boerma and Baya (1990) in *World Health Organisation Centre for Health Development* (2002) have noted that before commencing collaborative effort in health care between modern and traditional sectors, a careful assessment of potential benefits and obstacles should be made. The medical services utilisation patterns of the communities need to be ascertained and the specific role of the traditional health practitioners considered. In such efforts, the ideas of healers themselves about possible collaboration are crucial. Chi (1994) in WHO (2002) outlined six recommendations for effective integration. They are: promotion of communication and mutual understanding among different medical systems that exist in a society; evaluation of traditional medicine in its totality; integration at the theoretical

and practical levels; equitable distribution of resources between traditional and modern western medicine; an integrated training and educational programme for both traditional and modern western medicine; and a national drug policy that includes traditional drugs.

Planning for the formalisation of traditional health services has many dimensions that need to be addressed, depending on the state of current sectoral development, level of political will, budget resources available, training infrastructure, the model of formalisation suitable to and preferred by the country, and the traditional health care community. It has been argued that underlying the general proposition for a mix of traditional and modern medicine is an agenda of incorporating the former into the political economic arena and cultural hegemony of bio-medicine (Morsy 1990, cited in Kagwanja 1997, also cited in WHO 2002). Clearly, if traditional medicine is to be given a formal place in national health care, this process needs to be done not only in close consultation with the traditional health sector, but taking direction from it as to appropriate models of partnership, formalisation and training.

A challenge to integrated health care is the need to conduct research to determine which illnesses are best treated through one approach rather than the other. In a study conducted in Zheijang, China, it was reported that simultaneous use of modern and traditional treatment is so commonplace that their individual contributions are hard to assess. Research to disaggregate the contributions of each medical system, in traditional medicine itself, and its integration is therefore, crucial (WHO 2002).

According to Chaudhury (1997), it is generally recognised that the regulation of traditional systems of medicine, the products used in these systems, and the practitioners of these systems, are weak in most countries. This leads to the misuse of the medicines by unqualified practitioners and loss in the credibility of the system. In traditional medicine, practitioners and manufacturers (particularly small ones) usually oppose any steps to strengthen regulation by health administration. Their fears are that regulation as applied to allopathic medicine is not suitable for traditional medicine and may stifle the ancient systems of medicine. Thus, they need to step up the systems themselves.

Important challenges to the integration of the two systems of medicine are the power differentials that occur after integration. Van Kirk, (1993) and Moffat and Herring (1999) as cited in Letendre (2002) have alluded to issues of a racial paradigm in relation to the health needs of the Aborigines of Canada and the fact that traditional medicine remains subject to the policies and regulations of Health and Welfare Canada. Western medicine has continuously demanded legitimisation from any other system of medicine and to see the scientific basis of medical care of the aborigines. The method of systematic recording of knowledge is in direct opposition to the philosophies of traditional medicine (Morse et al. 1991, Reynolds 1997, Shestowiski 1993 as cited in Letendre 2002). Furthermore, the complex structure of today's economic and political climate emphasises that

accountability be outlined in measurable terms in line with the philosophies of western medicine, which conflict with traditional medicine.

A fundamental problem to integration is the way the two systems conceptualise illness prevention. While western medicine develops large programmes for illness prevention based on its medical models, and participates in activities directed toward this goal, this system is incompatible with that of traditional medicine. Traditional medicine emphasises the prevention of illness, but it is not known how traditional healers engage in this activity. For instance, among the Aborigines, illness prevention is not a meaningful concept; on the other hand, western medicine encourages patients to come for regular checkups to ensure normality (Morse et al. 1991 as cited in Letendre 2002).

Others (Myat 2004) have pointed to the disruption of traditional medicine systems by the colonialists and differences ingrained in the values and philosophies of the two models of health care. While traditional medicine approaches disease from a holistic point of view, taking into consideration multiple causal factors for a particular disease, modern medicine is disease oriented. In addition, traditional medicine practice encourages a close relationship between physicians and patient, which may not always be the case with modern medicine.

Should We 'Modernise' Traditional Medicine?

The response to the question posed by this paper is as daunting as understanding the dynamics and processes of traditional medicine and practice. However, to break the ice, this paper will take a firm but cautious path to discussing the issues at hand. The concept of 'modernisation' is not to be understood in its literal sense; instead, it is to be given a contextual meaning that implies a desire to reinforce the position of traditional medicine practitioners by granting them autonomy to develop their own knowledge systems, practices, capacities and capabilities through training, documentation, regulation, peer evaluation and monitoring systems, in the light of the diversity and unique circumstances that most practitioners find themselves in.

Conceptual Framework

This paper posits two sub-sectors within national health services - the modern (sector) and traditional medicine (sub-sector). Traditional health practices are grounded in the social and cultural milieu of the societies in which they are uniquely practised; in the beliefs, norms, values and healing philosophies of particular societies. On the other hand, the link between modern health services and socio-cultural context, especially in Africa and other continents where traditional medicine is very central to health care, is weak. In addition, the link between the two sectors, although vital, is also weak. Yet, for meaningful integration to take place, the relationship between government and the traditional sector, through the modern health sector, must be strengthened. Practitioners who took part in the study

conducted in Masindi and Kampala argued that failure by government to popularise traditional medicine before crafting the National Health Policy was a glitch in the policy making process. Increasing knowledge and pledging support for the sector, they argued, could have increased its legitimacy as a knowledge system and healing practice. Besides, there are several outstanding challenges that stand in the way of meaningful integration (as reviewed in the previous two sections of this paper). For this reason, the paper proposes a new model, a new way of looking at the issue of cooperation between the traditional and modern health sectors - that of granting autonomy to traditional medicine practitioners to develop a future for the sector.

The new model - the model of 'modernisation' - is based partly on the challenges to integration referred to above, and on the desire to allow traditional medicine to grow as an independent system of healing with a unique and culturally relevant knowledge base and practice. However, it presupposes an active traditional medicine sector interested in cooperation with other actors not only in the health sector, but also other sectors of the economy (since health cuts across all sectors). This means that any efforts to improve it must take cognizance of this fact. 'Modernisation' of the traditional medicine sub-sector also implies that there will be an improvement in other sectors of the economy, in view of the linkages between health and other sectors. However, to 'modernise' the traditional medicine sub-sector requires that the actors (practitioners) in it take centre-stage, design the agenda and execute it themselves.

A model that seeks to 'modernise' traditional medicine within its context forsakes negative stereotypes that portray traditional medicine practitioners as backward, conservative and unscientific. It conceives healers as masters in their own field, and as individuals, groups and actors who have something to contribute to the development agenda. Therefore, to 'modernise' traditional medicine and practice requires efforts that increase practitioners' sensitivity to their place in the development agenda and health care, given the specific milieu of their communities.

This paper argues that to grant autonomy to traditional medicine practitioners, the village should be taken as a microcosm on which higher societal level organisation of the sub-sector should be based. This is because most of the key social processes on which traditional medicine practice are based stem from the way of life in the village. What may be observed at higher levels of social organisation may significantly differ from what takes place at the village level. Therefore if autonomy were to be granted, then the most appropriate starting level would be the village. In terms of operationalising the model, the following is proposed:

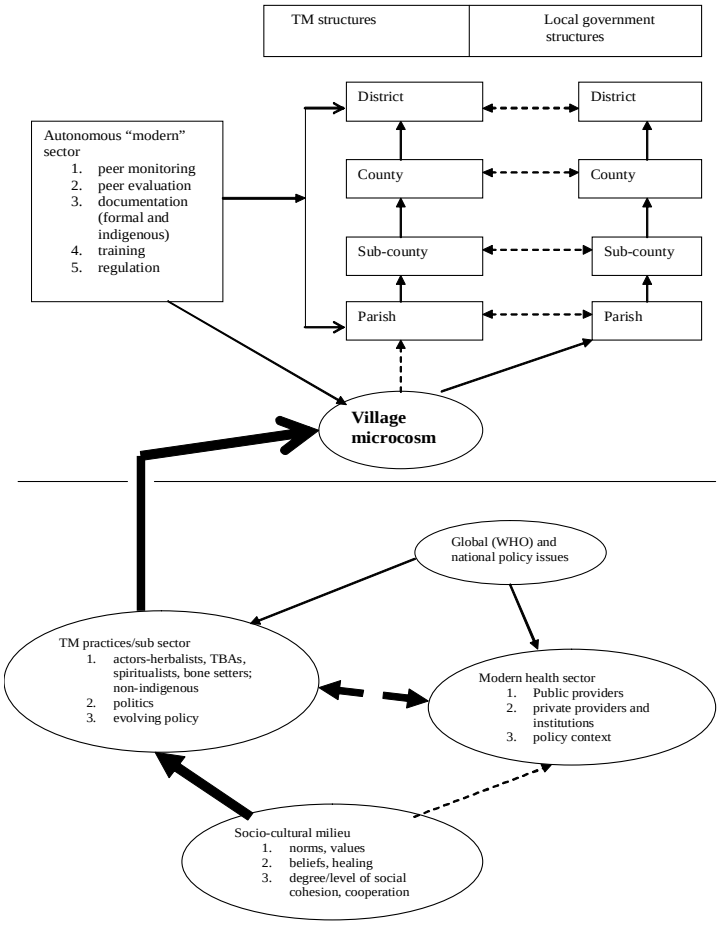
- A village in any district of the country could be selected as a pilot, and a specific area or 'speciality' of traditional medicine such as bone-setting selected. This would enable testing of the idea of autonomy for the 'modernisation' of traditional medicine. Although the idea of autonomy is emphasised, according to practitioners with whom the author had long

discussions, it would work well within the general framework of the National Health Policy, a policy on traditional medicine and under stewardship of the Ministry of Health.[11] Autonomy is simply to evolve local solutions for local problems without much outside interference and programming - to give the practitioners a voice.

- An independent civil society organisation, preferably a local community-based organisation rather than government, could take on the onus of mobilising the bone-setters and initiate an association/network of bone-setters in that village. However, once the association takes off, this organisation could leave it to take its course and only make available its human resources for consultation.
- Through the network or association, the bone-setters could discuss issues pertaining to their practice so as to gain common ground of the similarities and peculiarities in their practice. The network would also act as a forum for setting an agenda for training, reporting, information dissemination, documentation of practices, evaluation, monitoring, research and development and regulation, which are the major components of this model. However, efforts must be expended to ensure that all these aspects of the 'modernisation' project of traditional medicine practice are as indigenous as possible, springing from the cultural milieu of the society, such as the sanctions, normative regulations and belief systems.
- A system of financing the activities of this association could be designed in such a way that the members of the association through their earnings finance the core activities of the network/association so created. Moreover, once the itinerary of the so-called modern world such as fancy cars and complicated gadgets are not built into the system from the beginning, the desire for resources to acquire such things does not arise and cannot be used as a basis for frustrating activities of the practitioners. The resources collected from the members can jointly be managed for the common good, like many local associations are doing.

In terms of political organisation, once this initial experimental group succeeds, there would be an opportunity for other groups to succeed too. It is therefore argued that for full scale 'modernisation' to take place, there would be need to horizontally and vertically scale up the model by encouraging similar associations to blossom at parish, sub-county, county and district levels and in other forms of traditional practice. It is envisaged that this model would, in terms of such organisation, replicate so fast since the country is already politically organised at the said levels. Therefore, traditional medicine structures would simply run parallel to formal local government structures as shown in the conceptual diagram.

Conceptual Diagram



The proposed system of political organisation of the traditional medicine sector already exists within NACOTHA - one of the national umbrella organisations of traditional medicine (although yet to be formally recognised in the new dispensation). Therefore, these could be adopted in whole or with modification to please those who feel that NACOTHA is not legitimate.[12] From the structure of NACOTHA, it is evident that practitioners are capable of organising themselves

and that they have already made important strides in the direction of autonomy. Probably what is needed (and as they rightly argue) is a policy within whose context autonomy could be operationalised. Thus the words of the Secretary General, NACOTHA become instructive in concretising our idea of autonomy. He said: 'We did all this without any support in terms of funding, we were self sustaining... we need support through a law and funding'. Therefore, autonomy is possible, since with minimal resources, practitioners were able to achieve a high level of organisation (in terms of establishing necessary governance structures).

Although the model may appear utopian at first sight, there is need to pay very close attention to its underlying arguments which include views on the role traditional practitioners play in health care delivery, cultural sensitivity, contextual relevance, emphasis on diversity and the centrality owed to traditional practitioners in solving their own problems. In the final analysis, the idea is to have a national movement of traditional medicine practitioners' associations/networks whose bargaining powers are greatly enhanced, whose practices and processes of health care delivery are improved through systematisation, and whose initiative to participate in development is bolstered, not by anybody but by and for the practitioners themselves.

The Main Tenets of the 'Modernisation' Model

(a) Autonomy

As mentioned above, it is envisaged that granting autonomy to traditional medicine practitioners would increase their self-awareness, highlight their central role in society, and enable them to exercise their rights as traditional practitioners and citizens. Autonomy would enable them to develop structures and institutions through which they could govern themselves and chart a path for their future. Through these structures, practitioners could confront issues of regulation and enforcement of the regulations that have proved to be a nightmare for the public health officials.

The model of 'modernisation' that this paper posits and whose central concept is autonomy is grounded (through this concept) in the contribution of Foucault to our understanding of government. To him, government is 'conduct of conduct'. However, the idea of autonomy encapsulates related ideas of self-policing, self-management and self-governance. However, government or 'conduct of conduct' can be seen in different perspectives. Borrowing from Foucault, this author takes the perspective of government as an ethical and moral enterprise. Thus autonomy, or self-government, becomes an ethical and moral endeavour on the part of traditional medicine practitioners concerned with the form of direction appropriate to their trade. Morality is understood as the attempt to make oneself accountable for one's own actions, or as a practice in which human beings take their own conduct to be subject to self-regulation.

To grant autonomy to traditional practitioners is to accept that there is a peculiar rationality surrounding the domain of traditional medicine, which only the

traditional practitioners can exercise in their 'conduct of conduct'. Granting them autonomy is like giving them a stick to police and discipline themselves, which is opposed to the existing model of partnership where the public officials, through their own lens, are trying to govern traditional medicine and practice.

Governance of traditional medicine practice needs to go beyond individual conceptualisation of self-governance, to the governance of a society[13] - that is, there is movement from the governance of a multitude to the governance of a society and community - a society of traditional medicine practitioners. The idea is to have traditional medicine governed, but governed outside the public realm. This is because in the past the public officials have always emasculated the sector and demeaned it, regardless of the fact that it plays a crucial role in health care delivery.[14]

Granting autonomy to traditional medicine practitioners would have a number of advantages including the following: (i) it would not only enable them to govern themselves and channel their energies to improving their lot, but would also reduce their fear of being swallowed up, fear that has characterised interaction amongst themselves and between them and modern health services in the country to date. Commenting on the above, in the study conducted in Masindi and Kampala, practitioners cited power struggles, the politicisation of local associations, exploitation and connivance with local political leaders to extort money from them as key problems facing the sub-sector:

> The reason why TM is not developed stems from our associations. For example 'Uganda n'edagala lyayo' is like a political party. For one to stand for the post of chairperson, he has to use a lot of money. You must therefore recoup your expenses once you are voted into power. So you go to a computer person and make forms, which you sell expensively and arrest those who do not buy.

Self governance and autonomy through structures created by the practitioners themselves will help increase the bargaining power of the practitioners and predispose them well to constructively engage with government which has further advantages such as gaining a political niche, representation in national decision-making (parliament and executive), and lobbying, so as to increase resources going to the sector.

However, since autonomy cannot be secured while the sector is still fragmented, the starting point is mobilisation and organisation within the sector via the creation of local structures and institutions. Practitioners who took part in the studies conducted in Masindi and Kasese and Masindi and Kampala in 2004 and 2005 respectively strongly supported the formation of local associations of practitioners. For example in the first study, it was noted thus:

> If we can have a recognised association through which we can pass on our proposals, then the better, but today you find the assistance got is given to individuals... and if funding is given, it should not pass through our district because the officials there are corrupt, we can't get the assistance.

During the second study practitioners called for the formation of both local and umbrella organisations bringing together traditional medicine practitioners. The contributions of one participant are noted:

> We need to be one, just like a finger. You cannot split it. We were behind some years back, but when Museveni came - who depended on herbs during the war - he remembered us. I am asking that we get one way, one umbrella, one association of Masindi.

Therefore autonomy as envisaged in this model requires a number of pre-conditions and cannot be obtained cheaply. Rather, together with government, actors in both traditional and modern health sectors need to abandon hitherto cherished philosophical, colonial and practice oriented notions that provide the platform for the marginalisation of traditional medicine. But above all, lack of unity and infighting amongst practitioners, which strongly undermine them, need to be addressed urgently.

(b) Training

The 'modernisation' of traditional medicine will remain a wish unless training to improve traditional knowledge systems, practices, capacities and capabilities is carried out. While there is wide diversity in traditional medicine and practices in different parts of the country, it is still possible to undertake training in the different communities where traditional medicine is practiced. The need for training becomes more crucial given the fact that due to changes occurring in different countries, the young have increasingly migrated to the cities, leaving the old and infirm in the rural areas. The majority of the existing traditional medicine practitioners are aging and are likely to go to their graves with their knowledge. Capturing this knowledge before it is lost is very important and can be done only by those who own it. The million-dollar question is how this is to be done. How incentives are to be created to convince the old generation that their knowledge will not be 'stolen' and how to interest the young generation in a form of medicine that many consider archaic? Training is important also because of the need to create a critical mass of traditional medicine practitioners that can meaningfully engage with government and other actors in the health sector.

Training of traditional medicine practitioners could involve identifying diseases that can be effectively cured by traditional medicine, so as to avoid making traditional medicine appear to be a panacea for all illnesses. This would not only help to focus the activities of traditional medicine practitioners, but would also help in the development of knowledge systems and practices around these illnesses and develop comparative advantages in their management. Where there are national chemotherapeutic laboratories as in the case of Uganda, creating strong linkages between these laboratories and various institutions of traditional medicine practitioners would enhance training, research and development of appropriate cures for illnesses. Through such linkages, a national healing system based on traditional medicine is likely to evolve making actors in the traditional sector even

more crucial and central in national health systems. However, for collaborative efforts between practitioners and national laboratories to succeed, practitioners should be assured of direct benefit from their products.

(c) Documentation

Probably one of the major weaknesses of traditional medicine in Africa and other parts of the developing world is that it is not documented. Evidence from countries such as China and India points to the fact that for traditional medicine to gain status in national health services, it must be documented. Documentation has a number of advantages, including making practices of traditional healers available for future generations, dispelling the false and imperialistic notions that traditional medicine is not scientific, showing evidence of the efficacy of traditional medicines and systematising the discourse. To date most of the traditional medicine practices in Africa in general and Uganda in particular are not documented. Accordingly, the Uganda National Council of Science and Technology (UNCST) in its draft Indigenous Knowledge Bill noted thus:

> ... whereas a traditional birth attendant may keep her record by tying knots around her waist, other people may not easily understand this form of record keeping. As a result of this, many IK bearers are dying with vital IK that could be useful in national development. Inadequate documentation of IK is attributed to secretive practice and low levels of education (illiteracy) of the practitioners (UNCST 2004:7).

However, it should be noted that some physicians such as Dr Jjukko trained in modern medicine in Uganda have crossed over to traditional medicine, and together with other colleagues have started documenting traditional medicine and its practice.[15]

It is important to note though, that for training and documentation to be possible, there is a need to offer basic education skills of writing and numeracy to practitioners for developing and systematising indigenous knowledge systems. In the case of Uganda, adult literacy education is a well developed and well supported aspect of the education sector from which traditional medicine practitioners can benefit.

(d) Peer Evaluation, Monitoring and Regulation

Pertinent in the agenda to 'modernise' traditional medicine are issues of monitoring, evaluation and regulation, which are very important to maintain standards and gauge whether practitioners are doing what they ought to be doing and how well they are doing it. The questions that arise from pondering these issues are: what is to be monitored, evaluated and regulated, who is to monitor, evaluate and regulate whom? How are evaluation, monitoring and regulation to be accomplished? Where are the evaluated, monitored and regulated to be found? These questions are both difficult and easy to answer; difficult because the traditional medicine project is very amorphous, but easy to answer because the project has its own experts.

Peer evaluation, monitoring and regulation may involve a one-on-one stewardship by actors in the traditional medicine sub-sector. The concept of stewardship is taken as an extension of the way that not only governments must be responsible for the welfare of the population, but also how individuals become responsible for the guidance, leadership, and direction of their peers. While this may not have direct welfare implications as in the case of government responsibility for its citizens, it may have serious consequences for the conduct of daily business, enhancing legitimacy, transparency and reinforcing the social contract. Through stewardship, traditional medicine practitioners may have the capacity to exert influence on each other, shape individual behaviour and restrain insatiable private desires that may threaten the practice of traditional medicine.

Unfortunately, stewardship in Africa is biased towards bio-medical systems as if these are the be-all and end-all of health care on the continent. Stewardship as deployed here gains its basis from the deeply entrenched though fast eroding African traditions. Such traditions could bolster a regulatory framework that would evolve into a situation where traditional medicine practitioners are granted autonomy. For example, in a locality such as a village, all practitioners involved in a certain specialty like traditional birthing could organise themselves into a network, choose their leaders, set standards of practice and regulations, and put in place a reporting system (for example, of the condition of their clients, births undertaken, problems encountered, colleagues defaulting etc.). Then a high premium for defaulting, bad practice, incompetence and reneging on the network springing from the cultural milieu of the society could be set. Compliance with such regulations could be secured through the deployment of the time-tested and strict negative social sanctions that are still relevant in many societies such as blacklisting, ostracism, and ridicule through songs. These social control mechanisms may not only make one an enemy of the people, but they could also threaten his or her citizenship and in all likelihood would be respected.

However, evaluation and monitoring as understood conventionally are difficult, if not impossible to achieve with traditional medicine and practice, because of the diversity of traditional medicine and the lack of initially set programme goals and objectives as may be the case with, for example, Early Childhood and Nutrition Programmes that are implemented in the modern health sector. Probably one way would be to have practitioners identify common practices related to certain illnesses in a particular cultural setting and evolve standards for these practices based on their values and philosophy. An objective way of assessing compliance to these standards could then be easily designed from which socially institutionalised monitoring and evaluation could be undertaken. Whatever the line of argument one may take, the most important aspects to keep in mind are the values of traditional medicine and practice, its philosophy, the cultural values, attitudes of social responsibility, and peer influence that traditional practitioners hold and how these can be translated into meaningful efforts on the ground.

Shortcomings of this Model

The question posed at the beginning of whether to 'modernise' traditional medicine, seems to linger on even after espousing a model that aims at empowering traditional medicine practitioners. The main challenge this 'modernisation' model faces, which raises new research questions, is how to control an informal sector that might develop in a 'modernised' traditional sector. The fear is that some actors who may not wish to be bound by a moral responsibility to fellow practitioners and their clientele might withdraw to the underworld where they will continue practising or even engage in harmful practices that may threaten the lives of their clients.

Another challenge relates to how the sector can be linked with other actors in health without necessarily jeopardising the autonomy and eroding the gains that would have been made. This is a particularly thorny issue that may need protracted negotiation; otherwise, the government may find it difficult to relinquish all manner of regulation of the activities of the sector to actors in that very sector. Sensing this, some traditional practitioners with whom the researcher interacted in Kampala suggested that the question of regulation was one to be handled by both government and the leadership of the practitioners. They argued for example that in the proposed bill, which provides for a practitioners board, bye-laws crafted by practitioners would be enforced by government in collaboration with the board, so as to avoid a role conflict that would threaten internal democracy if the council were to be both the lawmaker and enforcer. Contention may also arise on other issues such as human rights, property rights and funding that may complicate the operationalisation of the model.

Conclusions

The integration of traditional medicine as seen in the context of the discourse on public-private mix bespeaks of the paranoia that comes in the wake of the western donors' developmentalist notions, which not only assume that what can work in the West can work in the developing world, but also that what can work in one developing country can work in another. Within this skewed thinking, traditional medicine has been lumped under the same category with private modern medicine practitioners as part of the 'private sector' as if it shared any similarities with these actors other than healthcare provision. For those in the developing world, the struggle to de-colonise the mind and shrug off the huge blanket of ignorance and lack of depth of analysis that is a hangover from colonisation is called for here. Only then will we start making sense of our reality and adopt relevant, context specific solutions that can re-direct our societies on the road to development. While there is a need for the resources which the donors dispose of, we must not close our eyes to the realities that surround us.

It is difficult to integrate traditional medicine into national health services in societies where it has not developed into a unified system, that is, in societies where traditional medicine is practised disparately according to ethnic group and

specific cultural settings. In such societies, trying to integrate traditional medicine and practices into national health services will only result in increasing the hegemony of the modern medical sector and seriously eroding the time-tested cultural medicinal practices. This is because traditional medicine is judged on the values, philosophies, accountability standards and efficiency measures of the Western model, which is just incompatible with local realities. In fact, trying out this model of integration, as is already the case in most developing countries, is as difficult to achieve as biting a bullet.

Therefore, it is imperative to consider the unique historical circumstances within which traditional medicine has evolved in Africa generally and in countries like Uganda, where it was outlawed, made inferior to modern medicine, and its practice shunned, ridiculed and castigated as backward. It is important to consider its diversity and context specificity in order to come up with policy options that give it the crucial 'space' and cutting edge it deserves in the national health systems of the country. In this breath, a model of 'modernising' traditional medicine through granting autonomy to the sector is suggested as discussed in the paper. Hopefully, through this, traditional medicine and its practice can find their place in the national health system.

Recommendations

A critical recommendation made by practitioners is that for any meaningful action to be taken in the sector (integration, autonomy or a public-private partnership), there is an urgent need to formulate and enact law and policy on traditional medicine and practice. According to practitioners, the policy would among others formally recognise traditional medicine, streamline leadership issues in the sector, provide for funding of the sector (under decentralised health service delivery funding for health comes from consolidated funding through the Primary Health Care grant), ensure representation of practitioners at all levels, attract necessary incentives for 'take-off' of the sector, and create appreciation for the environmental and socio-contextual circumstances in which traditional medicine practitioners operate.

To popularise traditional medicine and practice, it is important for government to undertake massive sensitisation of the public, including actors in the modern health sector who hold and cherish a negative and harmful colonial mentality about the activities of their counterparts. Short of this, the sector will remain operating in a context where actors are shunned by some during the day, but appreciated by the same people at night. There is a need to remove all negative attitudes of witchcraft that have been associated with the practice of traditional medicine, which in one way or the other encourages impostors to flourish.

Notes

1. The modern sector in Uganda is not based on purely bio-medical models and principles. Sometimes modern medicine has been practised in an informal/traditional manner, access is sometimes based on social networks and corruption, among others. These issues have been highlighted by Asiimwe et al., 1997 and Birungi et al., 2001.
2. Some practices in this sub-sector are at times similar to those of the modern sector. It is therefore difficult to talk about a purely modern sector or traditional sector.
3. 'Planning for Cost-Effective Traditional Medicine in the New Century. A Discussion Paper', WHO Centre for Health Development. Accessible at: http://www.who.or.jp/tm/research/bkg/3_definitions.html
4. The term 'integration' has come to be widely used to express the formalisation and official incorporation of traditional medicine into national health services.
5. The idea behind this partnership is to increase public participation in health care delivery. The PPP project implementing the partnership has categorised the different actors in the private sector into three categories: Private not for profit (PNFP) which comprises agencies that provide health services from an established/static health unit/facility and those that work in the community and other counterparts to provide non/facility based health services; Private health practitioners (PHP) who comprise all cadres in the clinical, dental, diagnostics, medical, midwifery, nursing, pharmacy, and public health categories which provide private health services outside the public and traditional and complementary medicine practitioners.
6. Traditional medicine may not necessarily be easily accessible and affordable. In fact, it may be socially very expensive and may not be accessible for social, geographical and economic reasons. A case in point is those people who are socially stigmatised for practising sorcery simply because they have visited a traditional healer.
7. Reporting the frustration some companies involved in the production of traditional medicine therapies for HIV/AIDS in South Africa are facing, Richter (2003) confirms the argument that mainstream medical organisations regard traditional medicine with much apathy or antipathy.
8. Richter also emphasises that it is important to take note of the fact that traditional healers, traditional medicine and beliefs of sickness and health, can vary from region to region and from clan to clan (p. 13).
9. Although the author cannot claim to give a thorough explanation of this form of healing, according to interaction he has had with various healers, this is a telepathic form of healing where a spirit medium intervenes between the afflicted party and the causes of his/her affliction. The healer simply aids the interaction between the patient and this supernatural power/medium since he is the only one endowed with the power to communicate with it.
10. While they may have another more structural meaning, especially from the point of view of traditional practices, these are generally considered to be spirits of departed members of the community which occasionally pay visits to the living. That is, they are the living-dead.
11. According to the practitioners, the Ministry of Health would not only attract experts from other countries to bolster efforts of local practitioners, especially in training, but it was in a better position to ensure government responsibility over the sector and continued support.

12. The organisational structure of NACOTHA starts at village to national level. From village to district level, the following offices exist: chairperson, vice chairperson, information secretary, youth secretary, treasurer, defence secretary, research officer, botanical section head, pharmacist section head, women representative, project manager and mobiliser. NACOTHA's structure, however, goes up to regional and national levels. At regional level, the following offices are provided for in the structure: regional chairperson, vice regional chairperson, inspector, treasurer, information secretary, women representative and secretary. At national level, the structure includes: Chairperson, vice chairperson, secretary women representative and secretary. At national level, the structure includes: Chairperson, vice chairperson, secretary general, treasurer, women representative, chief drug inspector, project manager, information officer, defence secretary, sanitation officer, secretary for youth, botanical section head, pharmacists section head, research officer, medical officer (western medicine), legal advisor and four committee members.
13. To take this notion of government/self-regulation is to accept Max Weber's thinking that 'there is no single Reason or universal standard by which to judge all forms of thought and that what we call Reason, is only the specific and peculiar rationalism of the west' (Dean 1999, p. 11). After Foucault, we know that even within western rationalism, 'there is a multiplicity of rationalities, of different ways of thinking in a fairly systematic manner, of making calculations, of defining purposes and employing knowledge' (ibid, p. 11).
14. The stifling of traditional medicine is not restricted to Uganda. In a review of the regulatory framework for traditional medicine in South Africa, Richter (2003) notes that the 'Traditional Health Practitioners Bill 2003' states that a person who 'diagnoses, treats, or offers to treat, or prescribes treatment or any cure for cancer, HIV/AIDS or such other terminal diseases as may be described, shall be guilty of an offence'. The question is; does modern medicine hold a sole preserve for curing these diseases? If so, why has it failed to end human suffering emanating from the same terminal diseases?
15. Jjuko and his colleagues have established a research centre at Kireka in Wakiso district near Kampala for conducting research in traditional medicine, and developing drugs and supplements from herbs. This group has also established a clinic for treating patients using drugs developed by the same group and a large botanical garden where they obtain the herbs necessary for the research. This garden also acts as a trial plot for herbs obtained from as far as India and China.

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17

Empowering Traditional Birth Attendants in the Gambia: A Local Strategy to Redress Issues of Access, Equity and Sustainability?

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The Resource Gap in the African Health Care System

> As an arena and a vector of power relations in society, the health system both embodies and conveys questions of access, equity, justice and sustainability that require to be followed through for a proper understanding of the functioning and functionality of the system... Amidst the crisis that has gripped the health sector, the decline in the overall health status of many Africans, the cut-back in the public health expenditure of the state, the various health emergencies facing the continent, and the challenges of reform that are posed, questions of access, equity and sustainability clearly arise both as important issues in their own right and as elements integral to the exercise of citizenship, democratic rights and the social contract. – (CODESRIA 2004:2).

The African continent, particularly the sub-Saharan region, has experienced several diverse natural and man-made calamities that widely devastated the physical infrastructure, social organisation, systems of governance and provision of public amenities. Civil wars, droughts, hunger, famines, epidemics, social upheavals, political unrest, dictates of international bodies, reform policies, dependency syndromes, corruption and multi-faceted poverty have gradually negatively impacted African communities; variously exhausting the existing limited resources which are critical to the establishment and sustenance of development efforts. Consequently, there exists a disproportionately high demand upon scanty resources, which is replicated in the health care system of sub-Saharan African countries.

The outbreak and persistence of epidemics of fatal diseases including HIV/AIDS, tuberculosis, malaria, ebola, cholera, and even preventable childhood diseases

pose a major challenge to the meagre available resources. The effects of internal and foreign policies, specifically the Structural Adjustment Policies (SAPs) of the International Monetary Fund and the International Bank for Reconstruction and Development (IBRD), have amalgamated with economic and financial crises creating bigger debt burdens, more critical balance of payments deficits and depleted government revenues. These factors challenge the practicality of efforts to budget efficiently for appropriate and meaningful health care systems in sub-Saharan African (Birungi 1997). The health care system is further impoverished by severe brain drain as professionally trained, highly qualified and experienced health personnel not only die from the HIV/AIDS epidemic, but also either seek more fulfilling careers out of Africa due to several 'pull factors' in more developed countries, or they are forced out by inherent 'push factors' including political insecurity, natural disasters, sub-standard levels of amenities or diminishing returns from service. Furthermore, there is a disproportionate number of qualified health personnel (doctors, nurses, midwives, other paramedical manpower) to provide for a large population with ill-health, particularly in the rural areas because of limited training facilities, insufficient capacity building, and the few professional elite tend to congregate in the urban centres where the benefits accruing are relatively higher (Wallace 1990, Asghar 1999).

The Gravity of Reproductive Health in Africa

Fathalla (1988) defines reproductive health as 'the ability to live through the reproductive years and beyond with reproductive choice, dignity and successful child-bearing, and free of gynaecological disease and risk'. In this definition, concepts of choice (a woman's control over her reproductive processes), dignity (social and psychological well-being from the process of reproduction) and physical health of the reproductive organs, are integrated. However in sub-Saharan Africa, as in other developing areas, access to, equity over, and sustainability of reproductive health care are limited by several inherent factors including inequitable distribution of services, patriarchal cultural dictates, inequalities, diverse social cultural mechanisms, inadequate resources, economic disparities, the vicious circle of poverty, lack of drugs, misappropriation of public resources, poor governance, insufficient physical infrastructure, and limited numbers of professional health personnel. Although the fact that the lives of women in sub-Saharan Africa predominantly revolve around their reproductive functions, and despite the reported high fertility rates (Mayell 2001), the majority of women lack access to healthcare generally and specifically to the much needed reproductive healthcare. Consequently, sub-Saharan Africa is riddled with drastically low levels of reproductive health indicators.

According to WHO/UNICEF (1996), reproductive health problems account for over one-third of the total burden of disease in women. More than ninety-nine percent of the annual global estimates of 585,000 maternal deaths occur in

developing countries; a women in sub-Saharan Africa who becomes pregnant is seventy-five times more likely to die as a result, than a woman in Europe (excluding Eastern Europe) or North America (Walraven et al. 2000). Estimates of maternal mortality rates in developing countries are at an average of about 450 per 100,000 live births (and this goes up to 2000 in some areas) compared to 30 per 100,000 live births in developed countries (WHO 1991, Paul 1993, Asghar 1999). Rates vary between different areas, regions and even within a country. For example Asghar (1999) reports a two-fold increase in maternal mortality in rural as compared to urban areas. An estimated 500,000 women die every year in developing countries as a result of complications of pregnancy and abortion (Mbizvo 1996, Fauveau 1993). The disabilities arising out of pregnancy, which drastically impair reproductive health functions of women and limit their economic activity, are often under-reported because they do not result in death. However, these are reported to be even more common: for example it is estimated for sub-Saharan Africa that for every maternal death, another fifteen women are disabled or permanently crippled by incontinence, uterine prolapse and infertility due to pregnancy or birth-related causes (Asghar 1999).

Between two and three million African women are left handicapped from obstetric complaints every year (Paul 1993). The most common causes of obstetric complications are prolonged obstructed labour, hypertensive disorders of pregnancy, haemorrhages, sepsis and unsafe abortions (Sibley 1997, Walraven et al. 2000).

Maternal mortality is also influenced by fertility rates. The fertility rates in rural sub-Saharan Africa are the highest in the world (Kirk and Pillet 1998, Ratcliffe et al. 2001, Ratcliffe, Hill and Walraven 2000). The demand for large families remains strong in most rural populations (Ware 1994, Oppong 1992). Modern family planning is uncommon in the rural areas and the continuing high levels of fertility are important contributors to the poor levels of reproductive health. Several social and cultural factors contribute to the high fertility rates, namely propagation of the family line, extension of the patrilineal clan, more children imply greater production due to more free labour, women's status in society is commonly established on the basis of reproductive performance particularly in virilocal marriage systems, religious factors, and the influence of the extended family (Bledsoe, Banja and Hill 1998, Caldwell, Orubuloye and Caldwell 1992, Oppong 1992). Cultural malpractices including female genital cutting, arranged marriages, early sexual debut, widow inheritance, levirate marriage, and ritual cleansing by sex with a virgin all exacerbate the injustices faced by African women through the abuse of their rights to reproductive health. Lastly, childhood mortality rates in sub-Saharan African are among the highest in the world (Blacker et al. 1985, UNICEF 1997). According to studies conducted in West Africa, the mortality of children aged 1-4 years is especially high (Hill et al. 1998, Leach et al. 1999).

Statement of the Problem

The reproductive health burden of African women is still a major challenge to African health systems that must of necessity be prioritised. In the light of depleted resources, shattered infrastructure and insufficient numbers of professionally trained health care personnel, traditional birth attendants (TBAs) offer a relatively low-cost, locally appreciated social group that could intervene to redress the gap in resources and improve African reproductive health.

Traditional Birth Attendants: Bridging the Gap?

According to the WHO Alma Ata definition, 'a traditional birth attendant (TBA) is a person - usually a woman - who assists the mother at child birth and who initially acquired her skills delivering babies by herself or working with other TBAs' (WHO 1978). Studies (*Maternal Neonatal Health* 2004) have classified three major types of TBAs. There is the TBA who is a full-time worker who can be called upon by anyone and expects to be paid either in cash or in kind. Secondly there is the TBA who is a woman's elderly relative or neighbour who does not make a living from the work and will only assist with the birth if the mother is a relative or a daughter or a daughter-in-law of a neighbour or close friend. This TBA assists in the birth as a favour and does not expect to be paid, but may receive a token or gift in appreciation. Lastly there is the family birth attendant who only delivers babies of close friends. In any society, the role of the TBA often reflects the culture and the social organisation.

Estimates indicate that sixty percent of births in the developing world occur outside a healthy facility and forty-seven percent are attended by a TBA (WHO 1997). In rural Africa, between sixty and ninety percent of deliveries are assisted by a TBA. High quality maternity care is often unavailable and home birth remains a strong preference for many (Butlerys et al. 2002). TBAs in many regions have been trained in midwifery and basic hygiene as part of the Safe Motherhood Initiative aimed at reducing maternal mortality. In resource-poor countries, this training has comparative advantages in attempting to provide professional health care for each birth (Walraven and Weeks 1999) because of the popularity of and easy access to TBAs who not only speak the local languages and allow traditional birthing practices, but also often have the trust of the local communities (Bij de Vaate 2002, Heeren 2001).There is a debate about the benefits of this form of empowerment of TBAs through education (De Brouwere et al. 1998).

This study investigated the role of TBAs in the health care of women in The Gambia. This paper discusses whether the empowerment packages provided to TBAs in The Gambia constitute a local strategy that redresses issues of access to, equity over, and sustainability of reproductive health.

Study Design and Methods

Library research was triangulated together with ethnography. Ethnographic fieldwork was conducted among sixty TBAs, 120 women who delivered in the presence of a TBA, twenty women who did not, and key informants including Divisional Health Team members, Village Development Committee members, and Community Health Nurses (CHNs). The research techniques included a literature review, a policy-statement review, ethnographic participant observation, participatory rural appraisal (PRA), ten focus group discussions and fifty-four individual in-depth interviews. The author participated in several birthing processes, and had babies named after her anthropological name at naming ceremonies in the study villages. Interviews conducted in the local languages of Wolof, Fula and Mandinka were recorded on audio-tape, transcribed verbatim, translated into English, entered into a computer and subjected to narrative analysis using Atlas.ti - standard computer software designed for the analysis of qualitative data.

Study Area and Population

Fieldwork was conducted in the hamlets, villages and urban centres surrounding Farafenni town, located in the North Bank of The Gambia, and approximately 200 kilometres from the capital Banjul. Geographically the area is flat Sudan savannah with wet season cultivation of rice, millet, sorghum and groundnuts. The study population is served by a hospital in Farafenni town and five dispensaries in nearby villages, and several 'trekking clinics'. Transportation is limited to walking or using bicycles, horse or donkey carts, or some bush taxis travelling on dirt roads (Greenwood 1990). Telephone services between Farafenni and the big villages were introduced in 1990. However, many of the smaller villages and hamlets still lacked telephone networks during the fieldwork period. Ambulance services are available to the main hospital. Eighty-eight percent of compounds have a reliable supply of safe water and most compounds have pit latrines (Hill et al. 1996). There are three predominant tribes: Mandinka (48 percent), Wolof (16 percent), and Fula (6 percent) (Walraven et al. 2000). The main income generating activity is subsistence farming, with a few petty traders. Education levels are mostly low for adults, with the majority of men having some basic Koranic school attendance. Islam is the predominant religion of The Gambia. The population is poor; in 1996 less than 10 percent of compounds owned bicycles, two thirds of compounds possessed a radio, 35 percent owned some form of cart, and less than half slept on iron or wooden beds (Hill et al. 1996). According to Walraven et al 2000, the total fertility rate was 7.5 births per woman, mean birth intervals were 33 months and just 9 percent of women were using either traditional or modern contraceptives. Polygamy is common with 51 percent of women with one or more co-wives, 56 percent of women aged 15-19 years are married and just over three percent of the women had attended school.

The Role of TBAs in the Health Care System in the Gambia

The Gambia adopted primary health care as the basis for national policy in 1978 (Ministry of Health 1993). This programme developed in the early 1980s and is now established countrywide. It includes classification of primary health care key villages based on size and population of 400 or more, so that they receive CHNs who are trained by the Medical and Health Department and paid from central funds. CHNs are the link between village-level primary health care services and referral health services available at dispensaries, health centres and hospitals. Each of the CHNs is responsible for the supplies, supervision and continuing education of the village health workers (VHNs) and trained TBAs in about five key villages.

TBAs are an integral part of the primary health care system in The Gambia. Before the establishment of this primary health care, several TBAs were already practising. In key primary health care villages, the community under the leadership of their development committees select two out of the existing TBAs to attend the centrally organised training as midwives. This generates resources within the community to contribute to the support of the village health system. In 1997 there were 460 trained TBAs and 52 assistant TBAs nationwide who conducted half of the deliveries (Gambia/UNICEF 1997).

All the TBAs in our study were illiterate. However, each of them had attended the initial training and more than half had attended at least one refresher course in the last two years. They reported that they gained immensely from the training sessions. Indeed there were reported differences particularly in the ability to identify complicated cases that needed immediate referral, better hygiene and sanitation practices during delivery and provision of more ante-natal monitoring and advice to pregnant women. The trained TBAs complained about some untrained women in the villages who were assisting in deliveries and often making blunders owing to ignorance because they lacked the basic training, thereby soiling the reputation of the good work of other trained TBAs. Likewise, some of the rural women stressed the fact that they valued the services of TBAs in their husband's clan because these elderly women were culturally attached to particular families. Thus they claimed in such cases it was irrelevant whether or not the TBA had received formal training. Culturally, preference was given to these familial ties. TBAs repeatedly requested more expanded programmes of training because it was impractical for an untrained TBA not to offer her services when she was urgently required to attempt to save the life of an unborn child and its mother.

Many TBAs were receiving supervision from their CHN, although a few reported they were disregarded by their CHN and two elderly women did not know who was supposed to supervise them. We observed good working relationships between the formal health care system and the primary health care system in cases where trekking, professionally trained, health personnel worked in close collaboration with the TBAs who mobilised pregnant women to attend mobile ante-natal clinics, jointly assisted in examinations of women, weighing of

infants, summoned mothers and children for immunisation campaigns, referred complicated cases or even escorted them to the health facilities. However, there were instances of some TBAs discouraging women from using bio-medical medicine in preference to herbal concoctions, specifically in the case of women who needed 'softening of bones to aid delivery'. Others openly campaigned against modern contraception because it runs contrary to religious and cultural beliefs. There were few instances of reports from the TBAs of discrimination and disregard by medical personnel in hospitals, specifically when they travelled with critically complicated cases of women whose pregnancies had begun away from the hospital setting. In addition, some TBAs felt that their knowledge was despised as inferior by educated health persons, specifically if they were working with foreign-aided health centres. Furthermore, local women who initially went for ante-natal care at the TBA and then moved to the hospital towards the time of delivery reported that they were often ridiculed by hospital midwives for seeking unprofessional help, combining bio-medical drugs with traditional herbs or Koranic portions and sticking to the traditional health care system. They commented about the frequent contradictions between information from bio-medical health professionals and the indigenous traditional knowledge of the TBAs. Several TBAs lamented that pregnant women who went to the hospital were often subjected to caesarean section from the hands of foreign doctors because they over-looked some of the traditional birthing customs, rituals and practices which were effective at reducing this possibility. These disparities need to be addressed so that the gaps in information that TBAs hold can be addressed in the training and refresher courses. Furthermore, it is important that the politics of health care systems in which bio-medicine assumes supremacy as reflected by some professional health personnel is addressed through sensitisation about the need for mutual existence, support and collaboration so as to enhance the active participation of the TBAs and other lay village health workers.

Several TBAs were the sole providers of ante-natal care, delivery assistance, birth rituals, naming ceremonies or post-natal care for pregnant women in their areas. The majority of the women in the villages reported that they preferred to deliver with the help of a TBA, although the TBAs reported that some women waited until the last minute to notify them of their pregnancies, or only called them when they experienced complications. One woman revealed that she was shy and embarrassed of revealing her nakedness to another woman and thus resorted to seeking TBA assistance as a last resort when her labour was too long to bear. A few women (particularly those in the urban area) chose to deliver in hospital. There were disparities in reports about society's perception of TBAs: while some said they were still highly valued in their villages and rewarded for their services, some other TBAs lamented that they were fast becoming despised, over-worked with meagre or no reward, and sometimes even scorned for some of their traditional beliefs and practices. The majority of the TBAs emphasised

the fact that the communal farm labour that the village is supposed to offer them on their rice fields was steadily becoming an ideal of the past. Decisions about whether or not a woman goes to a TBA, when, and how often she attends, are mostly made by the husbands. Husbands provided the money for all the women who had used the services of a TBA. The majority of the TBAs in the study did not support the use of modern contraceptives, even though they were trained about the benefits. There was evidence of widely held myths and misconceptions about the hazards of contraceptive use. TBAs provided more than reproductive health services in their villages. These TBAs were providing nutrition lessons, sanitation and hygiene information, health education against malaria, social role of leadership, collaborating in village development schemes, distributing herbal treatments, some bio-medical pain-killers, participating in income generation activities, and acted as society's gate-keepers who stored knowledge about sacred traditional norms, values and customs. The major challenges they face include lack of appropriate transport to facilitate referral of emergency cases, some resistance to collaboration with professionally trained health personnel, a shortage of refresher courses for all, and a heavy work-load for some who serve many villages and hamlets.

Conclusions

Empowering TBAs with training and support supervision backup by professionally trained health personnel bridges gaps in access to and equity of reproductive health care in The Gambia to a large extent. TBAs, although filling a big gap, may also be promoting inequity in the quality of the healthcare received by their clientele, specifically as they hold misconceptions about contraception, and believe in cultural nutrition taboos. They play a multiple role in the social, cultural, ritual, community development, and local leadership and are gatekeepers of the sacred traditional norms and values of their societies. Communities must be encouraged to support their TBAs in order to facilitate sustainability.

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