

# **RURAL WOMEN AND THE FINANCING OF HEALTH CARE IN NIGERIA**

A thesis submitted by

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(Nigeria)

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*Dedicated to*  
*Loes Keyzers & Eric Ross*





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## Abstract

*Rural Women and the Financing of Health Care in Nigeria* investigates how rural women in an Eastern Nigerian village make attempts to access health care for themselves and their households. The study explores how rural women finance health care needs through the social agency of household and kinship solidarity, and locally bred women's organization. Ethnographic approaches are used to explore the constraints and opportunities women encounter in deploying these social relations in the effort to overcome financial barriers to health care access at a time when health care services have gone beyond the reach of most rural Nigerians. The study explores the possibility of incorporating locally bred community organizations (as independent titular members) in community-based health insurance (CBHI) schemes.

The findings of this study show that the economic situation of most households in Ukete is stagnant or declining, and poverty is widespread. In the current contexts of user fee-based health care and pervasive poverty, access to even quite basic forms of health care is beyond the reach of the majority of the women and their households in the community. As a consequence, many cases of sickness go untreated, or treated by recourse to inappropriate sources (such as patent medicine vendors). Contrary to what might be expected, informal/traditional relationships and networks within the households and kin groups generally do not provide emergency funds for medical treatment, and certainly cannot be relied on. Local-level formal savings-and-loan associations, in which membership is not based on kinship and political factors, can survive and flourish. Poor women are capable of modest levels of savings in such associations, and the take-out dividends (or loans made against them) are frequently used to access professional and hospital treatment in cases of sickness.

As regards the possibility of incorporating community-based organizations in CBHI schemes, findings of this study suggest that in relatively remote rural communities with widespread poverty (in Sub-Saharan Africa), local-level mutual aid associations may provide a stable basis for the estab-

lishment and operation of CBHI schemes. Such a model would incorporate community-based organizations as independent titular members in CBHI schemes. The author suggests that such an approach to CBHI schemes may offer greater financial risk protection to members, minimize burden of premiums, lower operational costs, and provide forum for mutual social influence, social support and social engagement for members.

# Maps

*Map of Nigeria showing 36 states and the Federal Capital Territory*

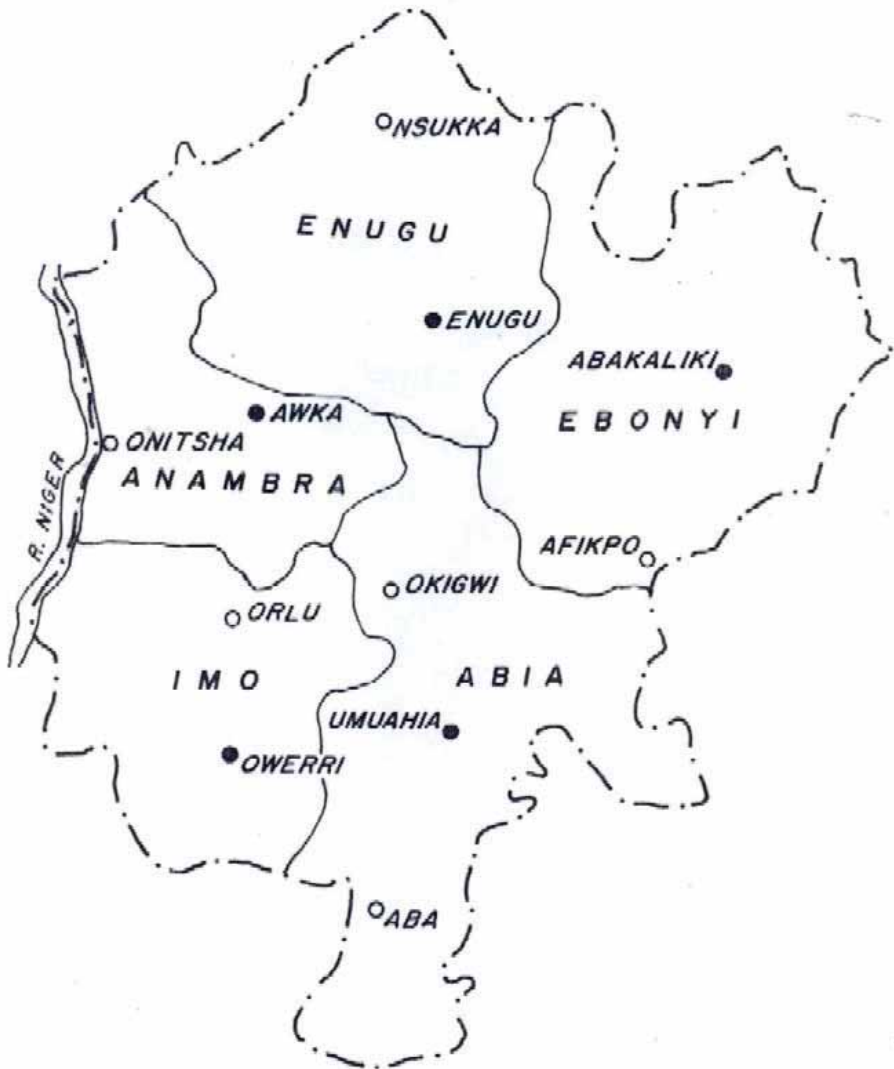


Map of Enugu State showing Ukete (the study community)





*Map of Igboland (Southeastern Nigeria) showing the various states, their capitals and important cities/towns*





# Introduction: Rural Women and Access to Health Care in Nigeria

## 1.1 Introduction and Research Problem

This is a study of the problems rural women in Eastern Nigeria face in availing adequate health care for themselves and their households, based on field research in Ukete, a remote rural Igbo community in Enugu State. The study investigated how rural women finance their health care needs through the social relations of household and kinship solidarity, and group reciprocity obtained in women's associations. The Igbo society in Eastern Nigeria has been selected for this study because, to the knowledge of this researcher, there has not been any research addressing these issues in Igbo society, despite the Igbo being the third largest ethnic and geopolitical group in Nigeria. In addition, this researcher has practised medicine for a couple of years among the Igbo in Eastern Nigeria and has observed first-hand the problems of access to health care encountered by poor women.

It is hoped that this study will provide insights into, and make a salient contribution to, the ongoing academic and policy debates on the provision of community-based health insurance (CBHI) for the rural dwellers. It is also hoped that it will provoke healthy reactions and discussions in this field, and spur, as well as serve as a baseline study for, further study in this field and geographical area.

The choice to focus mainly on women is based on the notion of gender and health, which posits that women are worse off in access to and utilization of health care services (see Standing 1997: 11, Hanmer 1994b: 15).

The current health care policy context is one in which health care is 'marketized' and therefore people are supposed to pay for their health care; the problem of affordability thus becomes a major constraint to access to health care for low-income groups (Harrison 1997, Waddington & Enyima-yew 1989, 1990). According to Vogel (1993), the rural poor utilize health care services less than urban dwellers, and especially women and children within the rural poor. In Eastern Nigeria, Oshi (2001) documents that the

number of women attending health care facilities for antenatal care services and childbirth declines significantly with the introduction of payment for maternal health services. There was also an associated increase in morbidity and mortality among women. Ekwempu et al. (1990) report that between 1983 and 1988 when payment for health care was introduced in Nigeria, the number of obstetric deliveries declined by 46 percent in the hospital they investigated in Zaria region in Northern Nigeria while maternal deaths increased by 56 percent in the same area. There was also an associated marked increase in pregnancy-related complications.

Socioculturally, in Eastern Nigeria and other parts of Nigeria, the primary responsibility for the health care of the household members especially dependent children lies with women. Agbasiere (2000: 41) observes that upon the Igbo woman 'devolves the burden of family sustenance and health care of the matrifocal group'. Nigerian women, in keeping with sociocultural norms, usually spend much of their earnings on household needs including health care. This reduces their ability to accumulate assets or keep savings (Odebode 2004: 156-7), and this further aggravates their vulnerability.

The question then is: What health financing options could be best used to improve rural women's, especially poor women's, access to health care services?

Arhin (1994) reports that a prepayment scheme in Burundi apparently increased women's utilization of health care services. She however, notes that the increased utilization of health care services by women was actually mainly for their children's health rather than for their own health. Oshi and Oshi (2007) report a study conducted in eastern Nigeria in 2002 on an attempt by a rural women's association to improve their access to maternal health care services. However, there were two major draw-backs in the associations' generalized reciprocity and finance-pooling scheme: (i) The benefits package covered only major obstetric emergencies and pregnancy-related hospitalizations. It did not cover other health problems that women could encounter, and could also not be used for health care seeking for members of a woman's household. This therefore tended to limit the scope of benefits women derived from the scheme. (ii) The scheme covered few women who could afford to make the contributions, and therefore, there was a high level of self-selection and exclusion. In Nigeria, particularly, studies that investigate approaches to improve women's access to health care are few. This is one of the reasons why this current study was embarked on. Another reason is that I practiced medicine in rural areas of Nigeria and observed first-hand the difficulties rural dwellers (especially poor women) encounter to gain access to health care services. I also grew up in the remote

rural Aninri Local Government Area where this study was conducted and experienced the difficulties in gaining access to health care services. I did not initially set out to study community health insurance, but to explore how rural women (attempt to) gain access to various forms of health care and particularly the role of social agency (reliance on social relations of household/kinship solidarity and women's group solidarity) in these efforts. I then thought that in exploring how women make attempts to gain access to health care, it is also important to investigate, in further details, the role of community-based organizations (endogenous associations) and the possibility of linking up such local efforts with more formal community-based health insurance. This is especially so given the recent calls for the use of community-based health insurance as a system of providing health care for the rural dwellers (see Atim 1998).

There are also other problems of access to health care including availability and quality of care provided by the health facilities. Availability of health care concerns the distribution of health facilities in relation to the target community. Issues of urban versus rural distribution of the various types of health care facilities as well as regional distribution of health care facilities are considered within the framework of availability of health care. Quality of care refers to the structure of the health care delivery system, the process by which health care is delivered and the outcomes of the health care. The structure of the health care delivery system concerns those characteristics of providers, communities and individuals associated with the likelihood of providing high quality health care. The process of care includes the content and method through which services are rendered by health care providers, while the outcomes of care concerns clinical status, functional status and satisfaction with care although factors other than quality of care can also affect outcomes. Quality of care can also be viewed from the perspective of technical quality and interpersonal relationships (Strobino et al. 2000: 6-7). In Nigeria, attitude of health workers, prolonged waiting times, under-staffing and lack of medical equipment have been noted as quality of care issues that may influence health seeking especially in government hospitals (Okeibunor et al. 2007). While the problems of quality of care and availability of health care are not insignificant in Nigeria, and will be touched upon in some parts of the study, this study does not *mainly* focus on them.

Returning to issues of affordability of health care, in the context of community-based health insurance, CBHI has grown progressively in SSA countries over the past two decades. This growth has attracted attention from governments, nongovernmental organizations and international agen-

cies, especially those with an interest in 'new and innovative approaches to the difficult issues of health care financing in the subregion' (Atim 1998: xiii). According to Atim health care financing policies in SSA countries have gone through many phases, from free health care in the post-independence era, through introduction of user fees to the current focus on health insurance (including CBHI) (Atim 1998: 1–2).

The prevalence of mutual health organizations (MHOs) varies from country to country. Bennett (2004) estimates that there were about 157 MHOs in Ghana. Ndiaye reports the existence of 79 fully operational MHOs in Senegal (cited in Atim et al. 2005: 5). CBHIs have been reported elsewhere in SSA countries, including Burundi, Mali, Benin, Uganda, Kenya, Democratic Republic of Congo, Cameroun, Togo, etc. (Arhin 1994, Atim 1998, Atim & Sock 2000, Fairbank 2003, Juttig 2003, Criel 2000). A few are discussed here to highlight their basic features and lessons learned.

In Nigeria, more formal attempts at providing access through CBHI started with the establishment of Community Women's Association of Nigeria (COWAN) Health Development Fund in 1989, Lawanson Community Partners for Health (CPH) and Jas Community Partners for Health both of which were established in 1995 (Atim et al. 1998: 13–14). COWAN Health Development Fund targets rural women and has an approximate membership of 78,000 women. The contributors are organized into small groups of 5–25 members. Revenue is mobilized through savings for health care loans for members. Benefits package covers catastrophic illness including admissions. Lawanson Community Partners for Health targets peri-urban and deprived communities in Lagos. Titular membership is through 21 community-based organizations (CBOs). It has an estimated membership size of 58,000. Revenue generation is through savings and third-party subscription payments. The scheme offers primary health care (PHC) services. The Jas Community Partners for Health has similar target population like the Lawanson Community Partners for Health. Its titular membership is through 13 community-based organizations. It has a membership size of 10,000. Like Lawanson CPH, service package covers primary health care services. The community Partners for Health insurance schemes are supported by United States Agency for International Development (USAID) BASICS Programme in Nigeria (Ibid). Atim et al. (1998) note some features of CPH which offer useful lessons: (i) The schemes 'are organized through existing community-based organizations of all kinds'. The CBOs are exemplified by local trader unions, petty traders associations, associations of blacksmiths, carpenters, battery chargers, tenants associations, etc. An individual cannot gain membership directly but through her/his local association. The authors

argue that this feature is salient because it helps in the management of social control problems and minimizes defaults in payments. Social control is thus handled through a bottom-up approach. (ii) The scheme is based on the concept of savings for health rather than on the notion of insurance. The authors observe that '[t]he idea of saving for health is apparently better understood (as an extension of traditional savings concepts such as *esusu* or *ajo*)'. They further stress that this approach offers an advantage in that it reduces administrative costs for the scheme and helps to minimize fraud. (iii) The planners of the schemes started out by first carrying out 'a preliminary identification of the top ten health priorities of the communities concerned', and the CBOS participated in this activity. The scheme members are offered 50 percent discount for the identified health priority areas. This design feature helps to improve access to health care, as well as improve equity and efficiency. The authors conclude that the high participatory nature of the schemes may be key to their success and is also well suited to understanding and responding to the health priorities of the communities and the overall health sector goals of the country.

Ghana's experience in CBHI is exemplified by the Nkoranza Community Health Insurance Scheme, the pioneer scheme in the country. The scheme was established to 'encourage the people of Nkoranza to pool their financial resources ... to cater for their hospital bills' and to 'improve the district's population's economic accessibility to curative care by making health care delivery accessible and affordable' (Atim & Sock 2001: 1). After eight years of success, the scheme was noted to have made modest progress in providing access to quality health care to vulnerable households in the district. However, there was still a problem of coverage of the population attributable to inappropriate registration period and community misperception of the scheme. Adverse selection was also noted to be massive in the scheme.

In Tanzania, the Community Health Fund (CHF) was established by the Government of Tanzania through collaboration with the World Bank and represented a 'new approach to improving the financing and provision of health care to households in rural areas' (Shaw 2002: 2). According to Shaw, the CHF

- would (i) collect prepayments from the households on a voluntary basis,
  - (ii) receive a matching grant from government equal to the prepayments, and
  - (iii) contribute to the financing and provision of services for CHF members.
- (Ibid.: 2002: 1–2)

One of the key structural features of the scheme is the prepayment financing mechanism by which members would make financial contributions once

in a year while the government would provide matching grant to subsidize subscribers' payment. Another key feature is the mechanism to enlighten subscribers on the service package, help them to imbibe a sense of ownership and control of the scheme through their representatives and to make an input in ensuring the quality of care of services they receive from providers. Entitlements in the benefits package include preventive and selected curative services at health centres or outpatient clinics in local hospitals. The scheme was noted to have improved access and quality of health care for rural dwellers.

Juttig (2003: 275–77) documents a study of about 16 CBHI schemes, which are operating in an institutional relationship with St. Jean de Dieu Hospital in the Thies region in Senegal. He reports that members of the health insurance schemes had better access to health care services than non-members: the members visit health facilities more frequently and pay less per visit than non-members. According to him,

The results seem to confirm our hypothesis that community financing through prepayment and risk-sharing reduce financial barriers to health care [...]. In addition, it shows that risk pooling and prepayment, no matter how small, can improve financial protection for the poor' (Ibid 2003: 282)

The remaining parts of this chapter discuss mutual aid mechanisms for managing health risks, user fees and access to health care, and health-seeking. The last part of the chapter outlines research objectives, research questions, research methodology, and reasons for choice of study location, and ends with a description of the organization of the study. In the next section, the mutual aid mechanisms for health risks will be discussed.

## 1.2 Mutual Aid Mechanisms for Health Risks

Mutual aid mechanisms are strategies for managing health (and other) risks based on solidarity. Solidarity in this context is 'the awareness of unity and a willingness to bear its consequences' (Dunning 1992, cited in Criel 2000: 16). Criel classifies mutual aid mechanisms for individual health risks into two broad categories. The first category consists of mutual aid mechanisms without insurance, which includes systems of family and clan solidarity with inherent moral responsibility for support; informal systems of mutual aid with inherent expectation of reciprocity (e.g., ROSCAs); arrangements based on prepayment modality with group risk-sharing. The second category comprises state-run compulsory social health insurance (SHI) schemes (Bismarckian model); and voluntary health insurance systems, which may be



public (with insurance and solidarity) or private (insurance without solidarity) (Criel 2000: 17–19, Atim 1998: 9–10).

One of the concerns of this current study is how women get access to health care through household mechanisms and kinship mutual aid based on solidarity. There is an increasing debate on the relevance and degree of this type of mutual aid in handling risks. Criel (2000: 17–18) states that household and kinship solidarity mechanisms are based on the moral obligation to provide support for members of the group. It is an exclusionary mechanism since non-members of the group may not avail the support.

Writing more than 35 years ago, Uchendu (1971: 183–85, cited in Uchendu 1995) argued that kinship in Igbo land functions as the first institutional framework for mutual assistance and support (material and moral) in times of crisis. In his earlier work, Uchendu (1965: 92–3) argued that ‘the principle of reciprocity dominated the kinship spheres of the economy’ while exchange based on the market principle were meant for extra-domestic relations. Arguing in the same vein with Criel and Uchendu, Hausman-Muela et al. (2003) posit that households and kinship relations should assume a greater role in the management of health risks. The assumption of their position is that solidarity and risk-sharing occurs within households and kinship relationships. This is probably the same assumption of Igun (1979), who also emphasized the role of households and kinship in managing health risks.

However, there have been arguments that these traditional notions of solidarity are merging with market-oriented notions of economic rationality and self-interest in household and kinship social relationships in the rural areas. Already more than 30 years ago, Martin Igbozurike observed: ‘Although exchange takes place within the networks of traditional kinship relations, it is not necessarily of the traditional kind governed by scrupulous reciprocity’ (Igbozurike 1976: 85). Igbozurike argues that although the traditional flow of resources will continue to take place in rural areas, it has lost its ‘scrupulosity characteristic of a purely traditional exchange’ and that ‘[m]uch of the ritual quality of its obligations has been lost in the interplay of forces of traditional and modern market relations’ (ibid.: 85; for a similar argument for a rural Ghanaian society, see Schott 1988).

On the other hand, endogenous associations (community-based organizations) refer to a variety of locally formed associations with membership drawn from people who share common features. Following Criel (2000: 1), endogenous association (used synonymously with community-based organization) is defined in this study as an indigenous organization or social movement formed by individuals with similar characteristics for the purposes of

promoting solidarity and advancing their cause. Implicit in this definition is that endogenous associations are created by the local people and not introduced from outside, hence the local people have ownership and control of the organization. The associations may engage in various forms of mutual aid, including aid for health risks (Criel 2000, Atim 1998: 9–10). One of these forms of mutual aid is prepayment. Prepayment refers to the making of advance payments for health when money is available in the household. The payments are subsequently used to access health care (Criel 2000: 19).

According to Criel, the state-run compulsory social health insurance schemes are predicated on risk-sharing and solidarity. Only a few SSA countries have been able to introduce SHI. In countries where this is operated, the tendency has been to cover civil servants, who constitute only a fraction of the total population. Voluntary health insurance, on the other hand, if public-oriented, is usually of the mutualistic or participatory model. In this model, a member organization/association functions as an active purchaser or insurer—using the money contributed by members/households to pay health care providers on behalf of the contributors. As a third party, the community-based health insurance (otherwise called mutual health organization or MHO) protects the interests of the contributors through ensuring quality of care and negotiating the benefits package vis-à-vis the costs of care (Criel 2000: 20–5, Erkman 2004: 254).

### 1.3 User Fees and Access to Health Care

Shortly after independence in the 1960s, Nigeria and some SSA countries introduced a policy of free health care. However, the international economic crisis of the 1980s caused fiscal deficits, which resulted in the collapse of service provision by the state. The SSA countries also resorted to borrowing from IMF, the World Bank and bilateral agencies as a means of dealing with the deficits.

In Nigeria, a number of economic recovery measures have been undertaken by successive governments to stabilize the economy, and perhaps get money to repay the international loans. One of these measures was the structural adjustment policies (SAPs). A key prescription of the SAPs was the shifting of provision of social service from the state (as the only provider) to the market.

The paradigm shift from the state to the market as the provider of social services—with the state mainly playing regulatory roles—resulted in the abandonment of the policy of free health care provisioning in developing countries (NewAge Online 2003, Colclough 1997, World Bank 1993, World

Bank 1987). In Nigeria, as well as other SSA countries, user fees for health services were introduced as component of health sector reforms within the overall framework of SAPs (see, for example, Russell & Gilson 1995, Hamner 1994a, 1994b, Harrison 1985). It was argued that user fees would curb the inefficiency and financial wastage prevalent in the public provision of free health care since general subsidies for health care mainly served to favour the rich and urban dwellers. Conversely, by charging the rich for their utilization of health care for which they have the ability and willingness to pay, equity will be promoted since the money generated will be used to provide services for the poor (Shaw & Griffin 1995). Raising money through user fees and reinvesting it into health services would lead to a more efficiently functioning health sector. To Shaw and Griffin, fees for health services increase public confidence in government health facilities, which provides an incentive to make use of the facilities. Again, they argue that by collecting fees, governments would be able '(i) to allocate scarce funds from curative services to preventive measures... and (ii) to reallocate resources to needed subsidies for the poorest segments of the population with the worst access to health facilities' (Shaw & Griffin 1996: 2).

Although user fees policies may be well-intended, and the objectives ostensibly sound, the outcomes may be negative for the poor if they are unable to afford user fees or to obtain exemption through social safety net programmes. For these groups, safety nets may be ineffective since the safety nets in the forms of exemption policies are either ambiguous, with no clear criteria for implementation, for example, in Nigeria, Kenya, Burundi, The Gambia (Shaw & Griffin 1995: 42); or targeting may not be feasible because of pervasive poverty, lack of political will and corruption. The opposition to user fees has been based principally on its unintended effects. These unintended effects—such as reduced access to and utilization of health services, particularly on women and children, resulting in declining women's health among poor urban and rural dwellers in Nigeria—have now been documented (Oshi 2001, Harrison 1997, Harrison 1985, Kisseka et al. 1992, Ekwempu et al. 1990). In Ghana, Waddington and Enyimayew (1989, 1990) observed that the inverse relationship between user fees and health utilization was worse in the rural areas. To remedy the situation, a number of health financing options were suggested by international and national policymakers. These include health insurance and other cost-sharing mechanisms. In line with these, the World Health Organization (WHO) proposed the 'community financing' approach which includes microinsurance, community health funds, mutual health organizations, etc. It is believed that CBHI, which is a form of community financing, will provide a viable means

of getting access to health care while placing less financial burden on the people.

## 1.4 Health-seeking

Getting access to health care by individuals and households involves a process of health care seeking. Much research has been conducted in the area of health care seeking, with different studies focusing on different aspects of the issue. (For detailed reviews on health care seeking and the various approaches taken by researchers, see for example, Hausmann et al. 2003, Tipping & Segall 1995 and Igun 1979.) One way of looking at approaches that have been taken in researches on health-care seeking is to differentiate them into those that investigate the utilization of health-care services, those that investigate the processes of health-care seeking, and those that use both approaches.

Studies on utilization of health care services focus on the final choices made by individuals or households on which health care providers to receive treatment from. Frequently, the studies are conducted in the health care facilities and take into account those who have been able to make use of the services provided by the facility. When a study is focused solely on those who actually use or have used a health care facility, there is the tendency to overlook those who are sick but do not use the services of the facility, or those who utilize other types of services, such as medicine vendors, traditional healers, or who do not receive any type of treatment at all (Tipping & Segall 1995).

Other studies concentrate on the actual process through which sick individuals or households gain access to treatment. The studies examine the determinants of individual and household's response to an illness event, and how these shape social action or actions which may result in the utilization of one or more levels or types of health care. Such studies are usually focused on households and data are collected on the processes taken by household members to gain access to health care. Thus, the studies are able to capture utilization or failure of utilization of various types of health care services: home treatment, public and private health care facilities, and traditional healers. Some studies combine the two approaches, but usually tend to lean more on one approach (Tipping & Segall 1995).

Health seeking behaviour models from various disciplines allow for considerable extension to capture the determinant factors that influence an individual's response to an illness event. In the 1995 version of the Health Belief Model by Sheeran and Abraham, an individual's response to an illness

is influenced by 'beliefs about the impact of the illness and its consequences which in turn are determined by perception of vulnerability to a particular illness and perception of degree of severity and potential complications of the illness. Response to an illness is also influenced by an individual's perception of the benefits of treatment vis-à-vis perception of the barriers to treatment. The barriers could be material or psychological. Gender, age and other demographic variables tend to condition health beliefs and actions (Hausmann et al. 2003: 9).

While the health belief model (HBM) may be useful in capturing people's beliefs about health problems and how these influence their first response, it does not seem to go much further than that. In the developing countries, health seekers tend to switch from one type of care to another (Okeibunor et al. 2007: 95, Ojanuga & Lefcowitz 1982). And there is a need to capture this in health seeking models.

The One-Sequential and Decision and Action Model (OSDAM) is a somewhat extension of the health belief model to enable it to capture shifts in health seeking by individuals. Like the health belief model (HBM), OSDAM model views health seeking as influenced by people's perceptions about health problems, but also views the [sick] individual as constantly evaluating [her/his] response. The sick person takes health seeking decisions and action on the basis of this evaluation (Okeibunor et al. 2007b). In other words, sick persons make decisions on how to respond to an illness, one at a time, and evaluate each action. Based on the results of their evaluation, they may take another action, and this process may continue until they get results that satisfy them (Ibid: 2007b). The health belief model and OSDAM seem to have the weakness of not explicitly factoring barriers to access to health care, although barriers are mentioned in the models.

A model that more robustly captures the various barriers to health care services is what has been termed the 'Four A's' model. The model actually uses some categories to group key determinants for health seeking. The Four A's are: (i) Availability: which concerns the spatial distribution of health facilities, pharmaceutical products, etc. (ii) Accessibility: which refers to transport, roads, etc. (iii) Affordability: which refers to economic and financial costs of treatment for the individual and/ or the household. Economic costs include direct medical costs, indirect costs and opportunity costs. (iv) Acceptability: concerns social and cultural distance, including the characteristics of health care providers (Hausman-Muela et al. 2003). Included within acceptability are issues of interpersonal aspects of quality of care. Health workers' behaviour may be perceived by health seekers as un-

pleasant and this may repel the health seekers (Okeibunor et al. 2007a, 2007b).

Gender roles in health seeking are often not explicitly captured by health seeking models despite its importance in health seeking or failure of it. In cultures where women are generally neglected and accorded inferior status, their health will also be neglected. Similarly, in cultures where the burden of health care for the household is placed on women, they may be forced to suppress their own health problems in order to meet the health needs of other household members. Sociocultural norms may also deny women access to treatment by male health workers (including doctors). This may become problematic in contexts in which most of the health workers are males since a social barrier to health care is thus created for women.

There is also a tendency to ignore or down-play the role of social agency in health seeking in both conceptual health seeking models and in empirical studies.

Studies conducted in Nigeria and elsewhere—whether on utilization of health care services as an end point of health care seeking process or on the actual process of health care seeking—tend to overlook the role of social agency in health seeking. Social agency has already been defined in this study as reliance on household and kinship solidarity and group-based solidarity. For example, Igun (1979) describes and analyses the involvement of household members and relations at the stage of diagnosis and choice of treatment, but does not explicitly consider the involvement of kinship networks in the mobilization of financial support for medical treatment. Another study conducted by Stock (1983) takes the utilization approach to investigate the relationship between distance and access to health care in rural Kano State in Northern Nigeria. He notes that per capita utilization of health care facility tended to decline exponentially with distance, and the factors that influenced this were the type of health care facility, gender and generation differentials, and the perceived severity of illness. However, kinship and social networks as salient factors in getting to the health care facilities were not explored. In other studies in Nigeria (e.g., Kisekka et al. 1992) and Ghana (Waddington & Enyimayew 1989, 1990), the dynamics of mobilization of financial and economic assistance from non-kin social networks and traditional associations were not captured.

This research combines analysis of the *process* of health care seeking and analysis of the *utilization* of health care services. However, the main emphasis is on the ‘process’, since the research is about how women reach (or fail to reach) the end point of service provision, which is the health care facility. It describes and analyses the involvement of social agency in the process of

health-care seeking. This is in the context of providing financial assistance, economic assistance and social support (in the forms of free cash, reciprocal gifts, loans, means of transport, domestic chores, child care, etc). In the health-seeking process, the kinship, dyadic and group social networks form the ‘significant others’ for the individual or household experiencing an ill health event. Indeed, Hausman-Muela et al. (2003: 15), drawing from Janzen (1978), argue that the concept of ‘significant others’: ‘challenges the strong emphasis on the [ill] individual and stresses the pivotal role of extended groups of relatives and friends in illness negotiation and management’.

## 1.5 Research Objectives and Questions

The two main objectives of the study are:

- (1) To critically investigate the various strategies which women employ in confronting health risks for themselves and household members.
- (2) To critically investigate the strengths and weakness of endogenous (women’s) associations in mobilizing support for health care.

The main research questions posed in this study include:

- (1) How and to what extent do rural women get access to health care using strategies of *household mechanism based on moral obligation for support?*
- (2) How and to what extent do the rural women make use of *kinship solidarity with moral responsibility for assistance* to obtain access to health care?
- (3) How and to what extent do rural women use mechanisms of endogenous associations with inherent reciprocity in their health-seeking? What is the extent of coverage of health care by the group-based mutual aid mechanisms? How and to what extent are such endogenous associations suitable as a basis for community-based health insurance?
- (4) How effective are the above strategies and mechanisms in facilitating access to health care?

## 1.6 Research Methodology

### 1.6.1 Reasons for choice of study location

Detailed description of the social, cultural and economic organization of the study location, Ukete, is provided in Chapter 3. Ukete is selected for this study for the following reasons:

- (1) Ukete is a relatively remote rural community, which does not receive as much information (including health-related information) as communities in the urban and semi-urban areas.
- (2) Ukete has no modern health facility from the level of dispensaries upwards. Therefore, the residents must go outside to seek modern health care (excluding patent medicine vendors).
- (3) The community is not linked by asphalted road to semi-urban/urban areas. This means that those seeking care from the community will not find easy transportation to modern health care facilities.

Another feature which makes Ukete the choice for this kind of study is the economic decline which the community is experiencing. While other rural communities also experience economic decline, there are compensatory mechanisms such as availability of modern infrastructure (health facilities, secondary school, asphalted roads, etc.), particularly for villages that are within easy reach of urban centres. As mentioned above, Ukete lacks these. The specific choice for Ukete (among many other villages with similar features) was also influenced by the fact that I grew up in Oduma, which Ukete was politically a part of, and had some personal acquaintance with the difficulties of living in the Oduma region especially as it pertained to obtaining health care. Therefore, when the opportunity came to conduct this study I thought it worthwhile to study my own people.

### 1.6.2 General considerations on approach and method

There is no single 'correct' method of investigating the processes of health-seeking and health care utilization. Managing health care crisis through household, kinship solidarity and group-based risk-sharing mechanisms is complex. The difficulties in choosing the method(s) for the exploration of these issues are compounded by the culture of silence on individual and household deprivation in the study location. Therefore, to capture the experiences of women in managing health crisis in the area, this study had to rely on a mix of multiple methods of data collection.



The main methodological approach adopted was qualitative. Specific techniques used for the field data collection included naturalistic observations (non-structured observations, structured participant and non-participant observations), in-depth interviews (IDIs), informal conversational interviews (ICIs), focus group discussions (FGDs) and case/health histories. Qualitative research design was used for the study because the methods enabled the researcher to investigate, describe and explain how women arrive at lay diagnosis of ill health, conceptualize the prognosis of the illness, and make decisions on health-seeking. Qualitative methods also enabled the researcher to explain the processes of getting to the health provider and receiving care. Health-seeking among rural dwellers is often iterative, involving movement from one level of health provider to another level, or from one type of care (e.g., modern health care) to another (e.g., traditional care). The researcher found qualitative methods useful in exploring and describing these processes. According to Rossman and Rallis (2003: 18), qualitative methods are appropriate to ‘depict complex social processes and understandings through detailed description’. Although qualitative methods cannot be used to extrapolate findings to the general population, quantitative methods such as sample surveys would be insufficient to explore and describe these processes.

One quantitative technique, household mapping, was used as a supplementary approach to collect demographic data and other salient information that would help in recruiting participants for the qualitative study.

The field research started with casual observations, and informal discussions with key informants and local elites. The information collected at this initial stage was used to refine the research instruments to make them more relevant to the specific local contexts. This was also a way of gaining the confidence of the villagers and building up rapport.

The field research was done in phases. The first phase was conducted between April 2004 and November 2004. The second phase took place between March 2005 and April 2005. I was assisted in carrying out the various tasks and activities by three female and one male research assistants who are all social sciences graduates.

### 1.6.3 Methodological approaches and tools

#### *Household mapping*

This consisted of brief, pre-tested, structured questionnaire interviews, covering all 213 households in Ukete. Household mapping was used to ‘identify whether the household contains [a woman] who belongs to the study group

and if so to collect further information relevant to sample selection' (Ritchie et al. 2003: 91). It served as a gateway into locating and mapping women's associations in the community. It was also used as an avenue of informing the members of the community of the study, and to obtain their co-operation in the research (Agyepong et al. 1995: 25).

The household mapping was also used to give specific code-numbers to each of the households. The code-numbers made it easier to identify, visit and revisit households during observations, interviews, case histories and follow-up interviews.

### *Interviews*

Interviewing helps to understand the meaning people make of their experiences, and provides a useful avenue of inquiry (Seidman 1991: 4, cited in Locke et al. 2000: 257–8). The interviews focused mainly on issues of experience of ill health by individuals and households, deciphering of symptomatology, lay diagnosis, decision making for health-care seeking, treatment seeking and the use of mutual aid mechanisms for managing health risks. There were 30 respondents in this group. The researcher interviewed women about themselves and their households in respect of health seeking experience, and sociocultural and economic issues that affect health-seeking.

Key informant interviews were also conducted among health personnel, namely the patent medicine vendor (PMV), the village midwife (VMW), traditional birth attendants (TBAs), medical doctors and nurses at various levels of health institutions, as well as the traditional ruler (chief) of the community, the former headmaster of the village primary school who also hails from the village, and village elite. There were 23 key informant interviews. 'In health research, ... the term key informant may be used for those who provide [the researcher] with detailed information on the basis of their special expertise or knowledge of a particular issue' (Agyepong et al. 1995: 34).

In-depth interviews (IDIs) utilized open-ended questions based on the interview guide approach (Patton 1991: 288), and were conducted in the Igbo language, except for the cases in which educated respondents preferred to be interviewed in English. On a number of occasions, the researcher conducted repeat interviews with women. This occurred when it was obvious that the respondent was very sparing with information, or persistently evaded questions. Some women started out giving answers they felt were acceptable to the researcher. Repeat interviews after more efforts at establishing rapport with the respondents yielded richer and more relevant data. Interviews made it possible to collect data not only on complex social proc-

esses and events but also on the meanings the respondents attached to them. This would have been difficult with sample surveys.

Informal interviews, as Agyepong et al. (1995: 43) note, 'may occur at any time: the time they occur may not be predetermined, and the subject for discussion is not necessarily set in advance'. Rossman and Rallis describe them as 'casual conversations, incidental to social interactions' (Rossman & Rallis 2003: 181). Apart from formal IDIs, 'informal conversational interviews' (Patton 2002: 342–7, cited in Rossman & Rallis 2003: 181–2) were held with many villagers and provided much contextual data on village social organization, farming practices, gender divisions of labour, prevalent illnesses, etc. Informal interviews were not pre-planned and an interview guide was not used. Most frequently, they occurred while interacting informally with the villagers in the village square in the evenings. A casual conversation while sharing palm wine in the village square yielded rich information, which the researcher would probably have found difficult to obtain through other methods. Stories, innuendos and gossips about several aspects of village life contained information that was relevant to the research. Under such relaxed social environment, villagers felt freer to pass comments, make casual remarks and express nuances, all of which provided relevant materials. Informal conversational interviews also took place in the church after worship services, and on other occasions. Worshipping together in church made the members more at ease with the researcher. After worship services, the members would cluster in small groups to exchange greetings and engage in chit-chat before dispersing. The researcher seized upon such opportunities to obtain relevant information, without the members feeling that they were under investigation. Notes on the informal interviews were made either immediately or shortly after, depending on the circumstances. Had the researcher relied only on more systematic and structured methods of data collection, rich information got through ICIs would probably have been very difficult to obtain.

### *Selection of respondents for interviews*

The researcher used the purposive sampling technique to select respondents for the study (IDIs, FGDs). According to Ritchie et al. (2003: 78), purposive sampling allows the researcher to draw sample units which have 'particular features or characteristics which will enable detailed exploration and understanding of the central themes [...] which the researcher wishes to study'.

A sampling frame was used to select respondents across different age groups (18–29 years, 30–44 years, 45 years and above) and primary occupations (farming, trading, semi-skilled and civil servants). It allowed the re-

searcher to include respondents who possessed different characteristics, such as literacy (literate and non-literate women), association membership (women who belong to associations and those who do not), household heads (women who are household heads and women are not household heads), and hospital attendance (no attendance, attendance, and childbirth). Therefore, the sampling frame enabled the researcher to include respondents from diverse groups and respondents who possessed different characteristics. While purposive sampling was appropriate for the research questions, it is limited in its application in studies that seek to achieve statistical generalization.

### ***Case/health histories***

Case histories are a composite methodological approach involving a combination of techniques. To build a case, the researcher conducted interviews, observations and sometimes documentation (see Agyepong et al. 1995: 36). Cases were selected based on the awareness of the cases as illustrations of the problems under study; that is, their relevance for the research questions. Case histories can be used to build up knowledge and understanding of an event or situation, with the possibility of explorations of the incidents or processes from different perspectives (ibid.). Using this approach, ill-health events and treatment-seeking processes (or failure of it) were explored. Case studies enabled the researcher to explore social events within real-life contexts, and to further knowledge on decision(s) and decision making on health-seeking: 'why they were taken, how they were implemented, and with what result' (Yin 2003: 13, Schramm 1971, cited in Yin 2003: 1). While sample surveys could possibly be used to collect information on social events, their ability to explore the contexts of the social events 'is very limited' (Yin 2003: 13). On the other hand, although case histories offer detailed understanding of events, social processes and/or situations, information obtained through this approach cannot be used to generalize about the population.

During the first phase of field research, 13 case histories were explored. Six additional case histories were explored during the second phase, giving a total of 19 case histories.

### ***Focus group discussions***

According to Dawson et al. (1993: 1) focus groups are 'valuable methods for understanding about ideas and beliefs...'. Focus groups also afford a convenient way to get individual knowledge of the focus group members, and they help synergistically to acquire insights and solutions that would otherwise not be possible.

Eight focus group discussions were conducted. Each focus group consisted of six to eight respondents. Below is a list of the focus group topics. It is not presented in chronological order; rather, the idea is to attach reference numbers to the FGDs. Later in the text, direct quotations from the FGDs are identified by the numbers below.

FGD1: Common and severe health problems

FGD2: Norms of health-seeking

FGD3: Gender and generational differences in health-seeking

FGD4: Gender and generational division of food

FGD5: Gender and generational division of labour

FGD6: Perceptions of wealth and poverty

FGD7: Mutual aid mechanisms for health risks

FGD8: Mutual aid mechanisms for health risks.

### *Case study of an endogenous mutual aid association*

Umuchu Women's Association (UWA) is one of the three women's mutual aid associations in existence in Ukete. The others are Nneoma Women's Association and Nwayo-bu-Ije Women's Association. The associations were first identified during household mapping as women were asked to indicate if they belonged to any mutual aid association, and if so, to give the name of the association. Thereafter, I conducted a pilot case study of the identified associations to obtain basic information that would help me to decide which ones to conduct further and detailed case study on. The pilot case study consisted of interviews with the leaders of the associations to get basic information on membership size and recruitment, organizational objectives, financial pooling/mobilization, financial support for members.

My original design and intention was to conduct detailed case studies on two or more mutual aid associations. I thought that such a multiple-case case study would serve a comparative purpose and enable me to describe the key differences and similarities among the mutual aid associations, and the implications of the differences for using the associations as bases for CBHI schemes. However, the information I obtained from the pilot study led me to change the design for the case study. I decided to go for a single-case case study. The reason was that the information revealed that the associations are very similar and that only few, insignificant differences exist between them. Had I continued with the multiple-case case studies, I might have ended up merely repeating the same information for the three associations.

For the single case study, I chose UWA. Details of the practical reasons for my choice of UWA among others are given in section 6.1 of Chapter 6.

The remaining part of this subsection will be focused on the theoretical rationales for my use of single-case case study, and how I collected evidence for the case study.

There are two main rationales for the use of single case study in this study. The first rationale is that this study has a clear set of policy assumptions on CBHIs, which it seeks to challenge. And a single case study can be useful in achieving this. According to Yin (2003: 40), a single case study can fulfil the requirements to ‘confirm, challenge or extend’ a theory or its proposition. As a corollary, therefore, a single case study can fulfil the requirements to interrogate policy assumptions on CBHI schemes. Yin further states that when a single case is used to test an assumption or theoretical proposition—to see if they are true or ‘whether some alternative set of explanations might be more relevant [...] the single case study can represent a significant contribution to knowledge...’ (Yin 2003: 40). The second rationale is that, based on the information obtained through the pilot case study on the existing mutual aid associations in Ukete, UWA appeared a *typical* case. Therefore, the lessons learned from UWA as a single case may be informative about the characteristics and experiences of the other mutual aid associations (see Yin 2003: 41).

In the main phase of this single-case study, I used multiple methodological techniques to obtain multiple sources of data for the case study. These helped me to ensure data triangulation and methodological triangulation (see Patton 1987). I repeatedly interviewed the present and past leaders of UWA. To do this, I cultivated strong rapport with them and their households so that I could visit them at any reasonable time. I conducted interviews with the members of UWA. I also used both in-depth interviews and informal conversational interviews techniques.

I reviewed the documents of UWA, from which I obtained information on membership contributions, money generated from secondary sources, loans and repayments, expenditures, annual redistributions, etc. The records also contained names of those who had borrowed from the association. This helped me to track them and interview them. I directly observed events taking place in the association; for example, I observed their annual redistribution meeting. I was thus able to obtain information on this event in real time. I also had the opportunity of conducting informal conversational interviews on the event with the members at the meeting. The observation helped me to understand the contexts of the event better.

I also observed (sometimes with limited participation) incidents of health crises among members of UWA and the processes of managing them with financial support from UWA. I also observed a child presentation ceremony

by a member of UWA and the collective involvement of UWA in the social event.

### ***Naturalistic observations***

Living in the community, taking part in assorted activities—markets, sharing drinks in the village square, child presentation ceremonies, church worships, marriage ceremonies, sickness events—provide ‘many opportunities to chat with community members informally, and build a rich understanding of their way of life, their values and beliefs’ (Agyepong et al. 1995: 31). The researcher found naturalistic observations very useful in generating contextual data on the community at large. It was also a very useful technique for understanding the specific real-world contexts in which specific health-seeking events and mutual aid risk-sharing occur in the community. For example, the researcher conducted observation of the annual redistribution meeting of Umuchu Women’s Association (see Chapter 6), which yielded rich data on how this type of reciprocity is practised in the association. This observation also provided the opportunity to interview the members on how they use their take-outs in the management of health risks, and the meanings they make of such social actions.

Other contexts in which observations were conducted included: (a) within the household: decision-making process, sourcing for money, transport; (b) women attending antenatal/maternity clinics (with focus on modality of payments); (c) patent medicine vendor/village midwife’ interactions with their customers (with focus on payments), home consultations and modality of payments; (d) case/health histories (on-the-spot observation and follow-up of the handling of ill-health events).

Had the researcher foregone observations, much of the real-world contexts of the events in this study would probably have been missed. Despite its usefulness, naturalistic observation has weaknesses. Observation may influence the way people behave, and this may result in bias. Those who are being observed may modify their behaviour to suit what they feel is acceptable to the researcher. In this study, the researcher made attempts to prevent this. First, he tried to build rapport with the respondents. He tried to ensure that the respondents felt at ease with him. Second, he tried to be as unobtrusive as possible.

### **1.6.4 Data analysis**

Throughout the field research period, the theories, research questions and objectives were re-visited from time to time to keep track of the direction of the research.

Data analysis started in the field, indeed, early in the process of data collection. This helped in self-reflection and assessment of the direction and progress of the research, leading to modifications of tools and additions of new tools (Rossman & Rallis 2003: 271–4). The first stage of the analysis was the transcription of recorded interviews and FGDs. The recordings were transcribed directly from the Igbo language into English. To ensure accuracy of transcriptions, the transcribed interview/FGD was occasionally given to a sociologist to read and cross-check with the recording.

The transcribed and handwritten interviews and FGDs were subjected to descriptive and thematic analysis. Descriptive analysis focused on particular cases of individual or household's experience of illness event, and the processes of health-seeking and the outcomes of health expenditure for the health and income-generating activities of the individual and household. In the thematic analysis, individual cases were first analysed along categories, codes and themes generated from the theories and from the field. Brief memos were written for these individual cases. Then cross-case analysis was carried out; and memos from the cases were written into coherent sections. This sequence of analytical steps helped in the understanding of individual cases before aggregation was carried out (Locke et al. 2000: 258; see also Layder 1998).

## 1.7 Challenges and Limitations

'Qualitative researchers work in the field, face to face with real people... They try to understand people through **multiple methods**. These methods are interactive and humanistic' (Rossman & Rallis 2003: 9, emphasis original). Dealing with people in real time involves dealing with the sometimes complex social realities of people, some of which may be considered by the subjects as private and not to be discussed with outsiders (researchers). How to get the interviewees to trust and confide in the researcher becomes a problem the researchers frequently have to deal with in the field.

A problem that was frequently encountered was reluctance to divulge information on their (household) income. Igbos generally do not want to be seen by other community members as deprived, hence they have a saying: *onye machie uwa akwa ndi ozo agagbi ama ka obara ya*. This means that when one covers up her economic and social situation, others will be unable to decipher the real situation. For the Igbo, this is important, because as a status-seeking society, people desire to be accorded prestige, and so they fear that if their real 'deprived and vulnerable' situation (for the poor) is known, their fellow villagers will not respect them and accord them prestige. Conse-



quently, opinions on issues touching on personal poverty, ill health and coping mechanisms are highly guarded, and people prefer not to discuss such personal issues with outsiders because of fear of possible leakage to their community members. I asked a woman why this is so. She said it is not uncommon for women to use the information they have on other's deprivation to embarrass them in the event of bickering. Some women initially showed reluctance to discuss with the researchers but later consented to be interviewed. Every respondent had to be assured—in fact repeatedly—that no other person in the village would get access to the information provided by them. They were also assured that their real names would not be mentioned in the book using their personal information.

Yet, some were not fully convinced, which was obvious from their uneasiness and body language that showed they were apprehensive. These persons also appeared to evade questions, often giving 'shallow' answers that did not contain useful information. For these cases, the researcher resorted to follow-up interviews. In a few cases, in which the women showed serious signs of apprehension, the researcher paid social visits to the couples during which no mention was made of the research issues. This helped to allay fear, build confidence and improve rapport. Thereafter, the interviews were repeated, with success.

Another strategy was employed to help some of the women to feel more relaxed during the interviews. The researcher chose evenings to conduct some of the in-depth interviews. This corresponded with the time people usually came back from farm work or market. The timing also made it possible to get the men in the house; the presence of male spouses seemed to bolster the confidence of women and helped them to speak more openly in most cases. However, in some cases, women were observed to feel insecure talking to the researchers while in their husbands' presence. In one instance, I tactfully called off the interview when it became obvious that the woman was afraid to talk in the presence of her husband. Three days later, when her husband was seen in the village square drinking with friends, two female research assistants accompanied the researcher to conduct the interview. The woman spoke frankly and freely of the relationship between her and her husband in health-seeking, farming, asset ownership, etc.

For some women who were interviewed in the absence of their spouses, my being a male researcher posed a potential problem. However, the presence of my female research assistants during the interviews helped to allay tension.

The researcher also conducted the interviews in the local Aninri dialect, in attempts to bridge the divide. This brought its own challenges because

the researcher is from the locality (Oduma) and many of the villagers knew or have heard of the researcher as a medical doctor (as mentioned earlier, Ukete used to be a political unit within Oduma). On a number of occasions, the respondents digressed from the interview to ask questions on perceived or actual health problems in the household. Questions were even asked about illness experience of others such as relatives or friends. A young woman said her friend had been married for five years but had not had a child yet. She wanted the researcher to explain the possible medical condition and the possible solution. During another interview, a woman said her sister married in another village lost two babies, each of them having experienced episodes of yellowness of the eyes, severe leg pains and ankle swelling before dying. Why did they have similar types of illness? What could be done to prevent such occurrences in future? A woman in her fifties complained of moderate to severe waist pain which was beginning to disrupt her farming. Apart from these questions, there were attempts by some of the villagers to come for consultation in my residence. My approach to solving the problems was two-pronged. In the former cases, I offered advice, and in the case of the woman with waist pain, money was also added. In the latter case, I made it clear that although I am a medical doctor, I stopped practising some years previously, and therefore, I was not in a position to offer medical consultations. To dissuade others from coming, I was firm in not offering medical advice or consultations to those who came to my residence. With time, they stopped coming.

I made efforts to explain the objectives of my research to the traditional ruler, the gate keepers, rural elite, key informants and women respondents. I discovered from their reactions that issues of access to health care generate curiosity and interest, so I was confronted with many questions on this. During one of the focus group discussions, a woman asked me if I was preparing the grounds to bring government health insurance to them. I told her that it was not the objective of the research. A woman respondent in an IDI wanted to know if the research would lead to increased health access for them. I told her I wished it would, but that my study was in faraway Europe. Other questions I encountered included: Would there be free medical care for the villagers? Was I sent by the government to collect the information? If not, who gave me the money to carry out the research? I also heard that a man told his friends in the village drinking parlour that the government gave me money for the research. My response to each of these questions and insinuations was that I was studying abroad and that the research was part of my study; and that I had nothing to do with the Nigerian government as far as the study was concerned.

Of importance to this study also is whether my being a native of the locality would bias my results. My answer is no. I rather think that it gave me more insight.

Finally, in fulfilment of the promise made to the respondents, confidentiality in this research is provided through carefully maintained anonymity. Therefore, the real names of respondents are not used.

## **1.8 Organization of the Study**

Chapter 2 will discuss the theoretical and conceptual tools necessary for the analysis and discussion of management of health risks. These include social networks, collective action, reciprocity, health-seeking and households. In Chapter 3, contextual information on the social and economic organization of the study is given. A brief description of the Igbo ethnic/language group is given. This is followed by information on Enugu state in which this study was carried out. Thereafter, the study focuses on the specific community where the research was conducted. Patterns of unequal access to land, which is central to the social and economic organization and inequality in the community, are outlined. The chapter then discusses livelihood activities of the members of the study community. It also describes some of the sociocultural events and practices that impoverish the villagers in their quest for status in this Igbo status-seeking society.

Chapter 4 discusses the health care providers to which women and their households in Ukete may turn to for care. These include both traditional healers and modern health care providers. It classifies health care providers into two main levels, determined by the availability of qualified and trained health care professionals as well as medical equipment. The two main levels are the lower level of health care providers and the higher level of health care providers. The former comprises patent medicine vendors, traditional birth attendants and traditional healers, all of whom may be found within the locality (the community and its environs). The latter consists of primary health care centres, district/general and private hospitals, and tertiary/teaching hospitals. A detailed discussion of health-seeking at the lower level is done.

Chapter 5 analyses and describes the role of household and kinship mutual aid mechanisms in the handling of health risks. It starts with an exploration of the Igbo cosmological basis of household and kinship solidarity and mutual obligation for health-seeking. It then goes on to examine the opportunities and constraints of using household mechanisms (including consumption/cash income, savings and sale of assets) in health-seeking. A simi-

lar inquiry into the uses and limitations of the kinship/extended family support mechanisms for health-seeking is carried out.

Chapter 6 investigates the role of women's associative movements in providing mutual aid for health risks. It focuses mainly on a specific women's association and uses it as a framework for exploration of issues arising from such group-based mutual aid arrangements. The issues include formation and membership recruitment, contributions and financial pooling, and mutual aid activities (savings and redistribution, annual take-outs and health-seeking, insurance-contingency loans). Other issues are social control problems, financial risk protection, exclusion, and social and emotional support. In Chapter 7, syntheses of empirical finding are presented and some conclusions are drawn.

# 2

## Managing Health Risks: Theoretical and Conceptual Approaches

### 2.1 Introduction

The objective of this chapter is to critically discuss the theoretical approaches and concepts with a view to identifying the key approaches and concepts that will guide the study. The chapter discusses social networks, collective action, social capital and reciprocity. It then discusses conceptual approaches to risk and risk mitigation strategies and community-based health insurance. The chapter goes on to discuss gender and patriarchy, rural differentiation, and households. It then ends with a summary of the theoretical approaches and concepts.

### 2.2 Social Networks<sup>1</sup>

One of the important issues in this research is how women use risk-sharing mechanisms in endogenous associations to manage health risks. Since endogenous associations are clearly a form of social networks—or formed on the basis of social networks—the theory of social networks allows us to analyse how women utilize the resources inherent in social ties to manage health risks.

Social networks, for the purposes of this study, are defined as the social relationships between persons on the basis of their embeddedness in shared and common social communities that transcend spatial neighbourhoods, kinship and friendship ties, and mediate the flow of resources and information, and regulate norms and social behaviour (Wellman et al. 1988: 131, NIH 2001).

The usefulness of this theory to this study is that it enables the location of social relations involved in reciprocity for health within the perspective of ‘social community’, to which women can resort to, or associate with in paying for their health care (handling health risks). The social networks to which women in the study location belong are approached from the per-

spective of kinship networks and rural women's associations. The analysis focuses on whether, how and to what extent these social groups are employed by the women with respect to getting access to health care for themselves and their family members.

It has been argued that the idea of social networks does not constitute a single theory but rather a set of approaches. Berkman and Glass (2000: 41) note that theoretical approaches to social networks emerged from three different academic fields: that of the British anthropologists in the mid-1950s, the work of American sociologists who introduced the quantitative approach to social networks, and later, the work of social epidemiologists. However, while the different schools emphasize different approaches to social networks, the point of convergence is that, as an analytical tool, social networks offer a 'way to view the structural properties of relationships among people with no constraints or expectations that these relationships occurred only among bounded groups defined a priori' (ibid.: 140).

Researches into communities defined by social networks usually aim to investigate the features of the network that exert important influence on social support, informal social control, etc. (Wellman et al, cited in Berkman & Glass 2000: 140). The first attribute, social support, is of interest to this research because it concerns how members of a network mobilize resources from their networks to manage social risks. In the African context, Boswell (1969) investigated the mobilization of resources from social networks for the management of social crisis. Although Boswell's study was conducted in an urban setting in Zambia, it has implications for this current study. First, the way Boswell conceptualized a crisis situation is useful to this study. Following Boswell, ill health crisis is defined in this study as a situation of considerable distress which may be beyond the capacity of individuals or individual households to cope with in the absence of external support. Second, Boswell's research reveals that mobilization of support from social networks may not necessarily be taken for granted in contexts in which the ties within the networks are loose. Third, his study shows that in situations in which networks are not well coordinated, organization of mutual aid may become problematic.

Connections have been made between social networks and health (NIH 2001, Kern & Ritzen 2001, Morris 1994, Berkman 1986). However, these links have not yet been fully explored or understood. Berkman and Glass (2000: 142–58) propose a conceptual model for the analysis of the links between social networks and health. The model indicates that the mechanisms through which social networks may influence health are multiple. The

model also indicates that the mechanisms are shaped by factors at macro, mezzo and micro levels.

Berkman and Glass suggest that the macro level factors are usually social-structural conditions. These conditions include culture (norms and values, social cohesion, etc.), socioeconomic factors (inequality, conflict, poverty, etc.), politics and social change. The social-structural conditions influence the shape, extent and nature of social networks. They argue that mezzo level factors which include social network structure and characteristics of network ties 'provide opportunities for' the psychosocial mechanisms operating at the micro level. The psychosocial mechanisms are social support, social influence, social engagement, person-to-person contact, and access to resources and material goods.

They suggest that the structure of the social network ties influences health through provision of opportunities for diverse social support, which includes instrumental support, emotional support, appraisal, and informational support. Instrumental support concerns help, aid, or assistance with material goods, money and/or labour. Emotional support refers to mutual sympathy, love, caring, understanding, etc. within a social network. Appraisal support concerns help in decision-making, such as on which course of action to take. Informational support refers to sharing of knowledge, advice or information (Berkman & Glass 2000: 145).

Social influence refers to the occurrence of mutual influence between network members. Members compare their behaviours and attitudes with those of others who are their peers or whom they look up to in their network. This may shape their health behaviours, such as utilization of health care services (*ibid.*: 146).

According to Berkman and Glass (*ibid.*: 146–7), social engagement refers to the opportunities provided by the network for participation in social activities and for companionship. Social and economic opportunities inherent in the networks and between networks may directly and/or indirectly improve access to resources.

The psychosocial mechanisms influence health via behavioural, psychological and physiological pathways.

However, social networks also have weaknesses as support mechanisms for poor and marginal groups or individuals. Solidarity, trust, reciprocity and norms within social networks may go hand-in-hand with mechanisms of exclusion of those outside the groups. Therefore, social exclusion may actually be created or perpetuated by social networks.

But how do persons involved in social networks behave in respect of providing mutual financial support to the members of their networks, espe-

cially when the network is a group social network? What possible problems of social control may arise, and how may they be tackled? These issues could be examined with collective action as a tool. This is discussed in the next section.

### 2.3 Collective Action

Collective action is used in this study to analyse and interpret social actions of women engaged in negotiating access to health care through group-based mutual support mechanisms. It looks at such issues as the occurrence of moral hazards, free-riding and adverse selection in women's associations. Free-riding refers to a phenomenon by which individuals attempt to benefit from the collective efforts of others in their groups without making their own inputs. Moral hazard refers to an attitude of unnecessarily increasing the benefits one derives from a group effort/scheme, simply because one is a member of that group and has contributed to the effort. The concept of collective action will be used to examine issues such as: To what extent do the social control problems of free riding, moral hazard and adverse selection occur in women's mutual aid associations? To what extent do the social control problems undermine the mutual support activities of groups? How and to what extent do women control such anti-social behaviour? Collective action theory will guide the exploration, analysis and understanding of group efforts and group activities of rural women in Igboland in their provision of mutual aid particularly for health risks, and the problems they encounter in so doing.

Collective action may be taken by groups to provide salient mechanisms for risk-sharing among women. This could be in the form of giving interest-free loans, loans with insurance contingencies, ad-hoc rotating group contributions based on health need and contingent on conditional risk-sharing (contributions can only be made for a woman in health need; Morduch 1998).

However, social control problems may arise in carrying out mutual support activities. Some have argued that if the social control problems are unchecked, they may undermine collective efforts aimed at providing mutual aid. (Olson 1965, Gleason, n.d., Fadiga-Stewart 2000, Christie 2000, Offer 2003). Olson opines that the magnitude of the problem differs in small and large groups:

In a very small group, where every member gets a substantial proportion of the total gain simply because there are few others in the group, a collective



good can often be provided by the voluntary, self-interested action of the members of the group. (Olson 1965: 33–4)

Since small groups are usually made up of people linked by ties of friendship or neighbourhood, fear of social sanction (social pressure; Olson 1965) may well be all that is required to control free riding. In addition, it has been argued that in small groups the organizational costs are lower, there is more palpable impact of each individual's contribution coupled with large per-capita benefit, and there is the tendency of frequent engagement in repeat play (Anon1, n.d.).

Olson argues that large groups are confronted with greater problems of social control (*ibid.*). Muller (1986) agrees with Olson's proposition, and states that self-interested behaviour in large groups is influenced only by the nature of pay-off structure and the external constraints and opportunities (Muller 1986: 1). Besides, since self-interested rational individuals use every available strategy to maximize their utility (*ibid.*, Gleason, n.d.), the result is that large organizations often fail to achieve their common goals (Offer 2003).

Proponents of the hypothesis that large groups usually fail to produce common goods may be right. However, it is doubtful if this is the case for mutual aid mechanisms for health risks operated by associative movements. In essence, it is an open question if this will be the case for community-based health insurance schemes. This is because managing severe illness usually involves large expenditures. And in rural areas in economic decline, it may be only largely populated associations that are able to pool enough money to finance huge health costs. Therefore, lack of large membership size may actually be a setback for practice of mutual aid for health risks. In fact, community-based health insurance as a mutual aid mechanism will arguably need a large population of contributors to boost the finance pool, and ensure financial sustainability. Indeed, the problem may well be whether rural women will be able to get large populations in their associations to increase their financial pool.

Besides the issue of population size of endogenous associations, the issue of trust also begs attention. Associations usually consist of members who come together because they desire to produce common goods which, as single individuals, they cannot produce at all or cannot produce efficiently (Hechter 1987). But if they are to be able to efficiently produce such goods, they need not only financial capital, but also 'social capital', which is discussed in the next section.

## 2.4 Social Capital

While attempts are being made to more concretely operationalize the concept of social capital for academic and policy research, there seems to be a long way to go, as the concept still remains more or less elusive.

It is a useful concept for this study because it helps in understanding what keeps mutual aid risk-sharing groups of the CBHI type intact and operational. It also provides insights into conceptual links between trust and norms within social relationships and health.

There have been many definitions of social capital (Fukuyama 1999, World Bank 1998, Coleman 1994, Putnam 1993, Putnam 2000, etc.). However, drawing from Putnam (1993), social capital in this research will be defined as the trust, reciprocity and norms which facilitate mutual aid within a social group.

Narayan (1999) classifies social capital into ‘bonding’ social capital and ‘bridging’ social capital. Bonding social capital refers to the social cohesiveness within a social group, while bridging social capital denotes connections between social groups and communities. This suggests that an individual’s bonding social capital strengthens her support network, while bridging social capital broadens and increases the potential support she can obtain from her support network. They also indicate that social trust and shared values, which are cognitive aspects of social capital, increase an individual’s perception of security and self-esteem in her social group.

On the basis of a research conducted by the United States National Institutes of Health, Harpham et al. (2004: 107) suggest that social capital may influence health-improving feature of social support. In his analysis of the relationship between health and social capital, Putnam (1993) compared a range of health indicators with the Social Capital Index (SCI) he generated and found a positive correlation between the two variables. By contrast, he observed that SCI correlated negatively with mortality rates. Kawachi et al. (1997) and Wilkinson (1996) are of the opinion that the influence of socio-economic inequality—such as income inequality—on health status is through the pathways of social cohesion and social capital. Thus societies with more egalitarian distribution of income—(and therefore stronger social cohesion) have better health status. In communities with strong social cohesion (and therefore high social capital), there is usually a high level of reciprocity and thus there is high health status (see Green et al. 2000). It is reasonable to expect that such levels of reciprocity leads to increased access to health care because individuals and groups can receive information, moral support (encouragement), physical support (e.g., transportation), economic

support (help with payment in cash or kind) and social support (visits to the ill person receiving treatment).

In the context of community-based health insurance, Franco et al. (2004) suggest that social capital indirectly improved the performance of a community-based health insurance scheme because it served as a form of informal social control. They postulate that social capital checks fraud and abuse in the CBHI scheme.

Despite its attraction as a general framework for conceptual discussion and analysis of social, political and economic problems, Field (2003: 71) has drawn attention to negative consequences of social capital. He comments that social capital may reinforce inequality and encourage anti-social behaviour. Putzel (1997) has also pointed to its 'dark side' (weaknesses). Social cohesiveness and trust within social groups may pose the real danger of exclusion of those outside the reciprocity networks. Reciprocity is discussed in the next section.

## 2.5 Reciprocity

In this study, reciprocity is used as a tool to analyse the norms and actual practices of women who use a variety of mechanisms of mutual aid for managing health risks. It is used in examining how women make use of mutual support from own households, kinship and associative movements for coping with health risks.

Following Sahlins (1972: 195–6), reciprocity can be broadly classified into generalized, conditional and balanced reciprocity. When reciprocity involves more than two people, a situation of 'pooling' or 'redistribution' occurs. Pooling involves a general collection by the members of a group, usually under the responsibility of one person, but with the understanding that the collected materials will be shared by the parties who made the contributions (Sahlins 1972). Sharing of the contributions are effected either immediately or in the future, and could either be generalized (in which the goods are distributed to every member who contributed) or it could rotate among individual members of the group (as seen in rotating credit and saving scheme).

In generalized reciprocity, individuals are viewed as 'putatively altruistic' and engage in transactions with the intent to give assistance to the needy, and the extent of this form of reciprocity is inversely proportional to kinship, social and physical distance (Sahlins 1972: 195–6). Put another way, it is more likely to be seen among close kin and as the distance (social and physical) increases, the weight of generalized reciprocity decreases.

Conditional reciprocity occurs when members of an associative movement make contributions to help any member who falls into misfortune, and expect to receive help from their association if and *only* if they themselves fall into misfortune. If the contributions are made for health, a contributor receives money from the pool, if and only when she has health problems. One-way flow is hence tolerated (Thomas & Worral 2000) or even expected by the members. This contribution could be carried out on ad-hoc basis, or it could be a regular contribution that goes on an agreed time frame. Implicitly, conditional reciprocity involves delayed reciprocity (ibid.). This mode of reciprocity underpins the risk-sharing mechanism in community-based health insurance (CBHI). One major advantage of conditional reciprocity in risk-sharing is that it helps to redistribute risks between high-risk and low-risk individuals, and the costs of handling the risks are thus shared between those who can comfortably handle the risks and those who may not be able to (Morduch & Sharma 2002, Arhin-Tenkorang 2001).

Balanced reciprocity arises when there is a direct exchange for which the receiver is obligated to reciprocate either immediately or in future. It becomes perfectly balanced if the parties simultaneously exchange identical kinds of goods in the same quantity. Balanced reciprocity often takes place between persons who have less intimate social relations (Sahlins 1972). When balanced reciprocity takes place between persons, it is predicated on the understanding that there will be reciprocation, not to a third party, but to the donor. In dyadic relations, it becomes a two-way exchange, and therefore, a one-way flow is not tolerated (Thomas & Worral 2000).

Frequently, reciprocity is necessitated by the apprehension of risks in the near or distant future. People attempt to devise strategies to avert or mitigate the risks. Risks and mitigation strategies are discussed in the next section.

## 2.6 Risks and Mitigation Strategies

Analysis of risks and risk mitigation strategies allows the study to focus on the types of risks prevalent in the study community. It also enables us to look into the emergence of risks, including sociocultural practices that may predispose rural dwellers to financial risks. It also enables the examination of the various strategies used by rural dwellers to manage risks including risk-sharing forms of community-based health insurance.

People are threatened by risks, and everybody is vulnerable to risks. However, some are better equipped to handle the risks than others (Centre

for Micro-Finance [CMF] 2000). While risks are universal phenomena, there are those who are especially vulnerable to them.

CMF (2000) classifies risks faced by rural women into life-cycle risks, crises and structural risks. Life-cycle risks are those related to different social, reproductive and economic events during the life course, such as marriage, childbirth, building a house, social and religious activities, and death. Wright et al. (1999, cited in CMF 2000) posits that life-cycle risks are predictable, and therefore, ex-ante preparations are possible. This may seem plausible, but the ability and capability to make ex-ante preparations for such life-cycle risks still depend on the social and economic group of the individuals or households.

The second type of risks according to CMF classification is crisis risks. Crises are those risks resulting from sudden and unanticipated events, which lead to disruption of the household income generation (CMF 2000). Such crises cause undue sale of assets, which may be productive assets, or allocation of consumption income. Because of the nature of the shocks, crises can mostly be handled ex post.

Poorer women may find it difficult to cope as they lack the necessary savings and asset base (Wagstaff et al. 2001). Even when women and their households attempt saving, one can hypothesize that crises such as severe illness will still amount to a major jolt to them and they will require external sources of succour to be able to cope with the risks. A common example is where a woman has to undergo emergency operation (so-called caesarian section) to have her baby delivered. The costs of the operation and the medical consumables (such as blood transfusion, anaesthetic packs, infusions, etc) are usually beyond the capability of poor households.

The third type in the CMF classification of risks is the structural risks. These include risks that have to do with seasonal agriculture, festival seasons, enterprise risks, loans and other risk such as crop failure, death of live-stock, etc. The import of the structural risks in the context of Igbo women is that exposure to such risks impair their ability to handle other types of risks, especially sudden shocks/crises.

Individuals and households undertake a number of activities to protect against future risks, and to handle losses after their occurrence (Dunn et al. 1996, CMF 2000, Sebstad & Cohen 2000). The strategies employed depend on their social and economic capabilities and on the availability of appropriate services accessible to the households (and individuals; *ibid.*). These strategies are sometimes referred to as self-insurance strategies. Apparently, the first strategy employed by women in handling risks is individual or household savings. This strategy could be especially useful in handling anticipated

risk, if the amount of savings is high enough to handle the risks or if the level or severity of risks is low such that the savings could provide sufficient coverage. But in rural areas in economic decline such as Ukete, saving may be an arduous task, and it will be interesting to see to what extent this strategy is effective in managing health risks.

Another strategy is taking loans to deal with financial shocks and risk events. However, borrowing in itself is a kind of risk. The costs and risks associated with borrowing from associative movements to which women may belong may be less than with borrowing from moneylenders (CMF 2000). However, loans, especially from moneylenders, also take time to negotiate.

Sales of assets are another way poor rural women handle risks. This is usually quite a difficult choice, given the fact that sold assets are very difficult to replace. Some of the assets may be productive assets and their disposal may further cause impoverishment and increase vulnerability to risks. In crisis situations requiring immediate access to money, sale of assets may not be a solution (*ibid.*) as selling assets requires looking for effective demand from members of the village society or taking the asset to the village or district market, which may lead to wasting of valuable time.

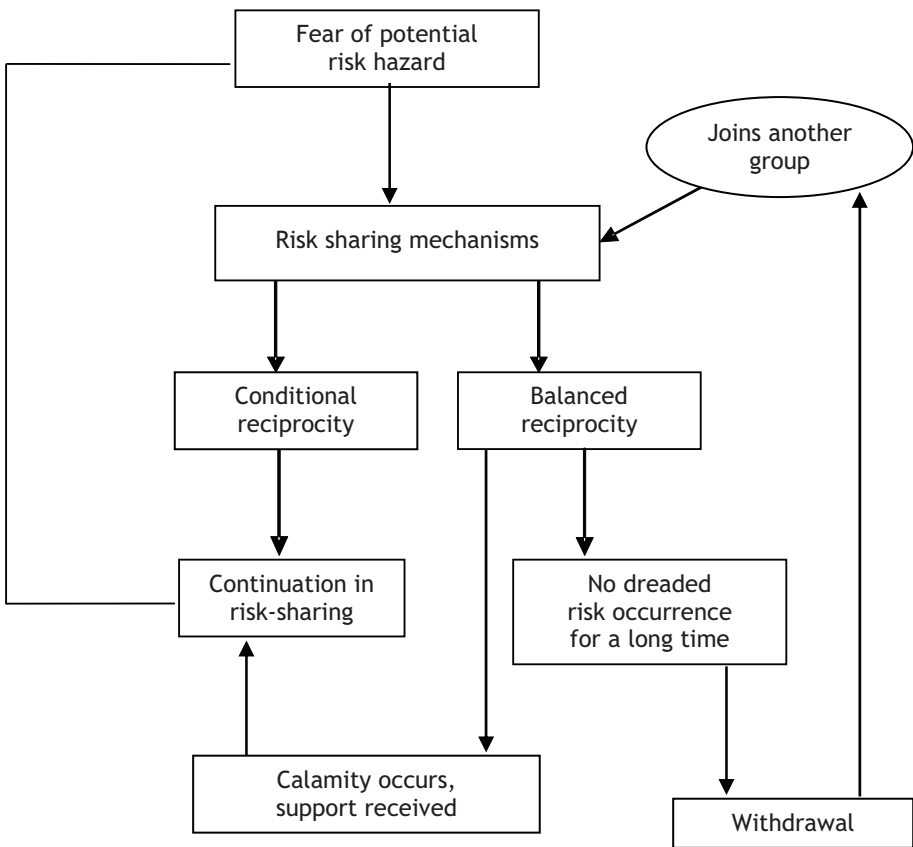
The major problem with self-insurance is that there is no pooling of risks and risk-sharing. Risks are not spread among a bigger group. The resources for managing the risks are often meagre.

### **Risk-sharing attitudes of rural groups**

Platteau (1997) studied a group of rural fishermen in the West African coast of Senegal who operated a risk-sharing arrangement. By the arrangement, each fisherman contributed to mutual support for any member who fell into adversity in the course of their fishing. The arrangement, however, prescribed that a member of the mutual aid scheme was entitled to assistance if and only if he experienced an adversity. The scheme operated for some time, and some members did get support when calamity befell them. However, as time passed and some members did not experience any adversity and therefore, were not entitled to receive support, they started feeling cheated. Some of those who did not experience any calamity decided to exit the scheme. Platteau concludes that rural people prefer arrangements that guarantee that they will benefit from their contributions. In other words, when they contribute to a risk-sharing arrangement, it is on the notion that they will get back their contribution. If they contribute to a mutual risk-sharing group for sometime and do not have misfortune befalling them to qualify them to benefit from their contributions, they tend to leave the

groups (Platteau 1997). This proposition could be represented in the form of a diagram above. See Figure 2.1.

**Figure 2.1**  
*A diagram showing a hypothesis of risk-sharing mechanism among rural dwellers*



Source: Literature review

As depicted in the diagram, fear of occurrence of calamity (i.e., risk) may drive a person to join a risk-sharing scheme. In the balanced reciprocity model, if a woman experiences calamity and receives support from the scheme to manage it, she continues with the scheme. If this support ceases for a certain period of time, she decides to exit the scheme. If there are other groups operating similar arrangements, she may decide to try out one of them. In this balanced reciprocity model, she receives an equivalent of the contributions she makes to the scheme. In the conditional reciprocity, she makes contributions to the scheme, but may not receive any support or dividend from her contributions. She can only do so if she experiences crisis. She does continue with the scheme whether or not she receives support from the scheme. This is the model that underscores community-based health insurance, as will be explained in the next section.

## 2.7 Gender and Patriarchy

The concepts of gender and patriarchy provide conceptual explanations of the social construction of inequality between women and men in terms of power, prestige, status and wealth especially in developing country societies where patriarchy is the central organizing factor of the sociocultural, economic and political systems. Using these concepts, the study focuses on unequal ownership of, access to and control over land, money and other resources in the study location. This approach also allows us to look into how gender division of labour may increase women's financial risks. Gender inequality in decision making and in other spheres of household and community life may have implications for women's participation in social networks such as women's associations.

Gender refers to the characteristics of men and women that are shaped by social forces, or to the meaning a society attaches to the differences between women and men (Lorber 1994: 13). Gender then is not the biological differences between males and females *per se* but rather how these differences/physical characteristics are viewed and socially constructed. Giddens (2001: 107, 689) defines gender as the socially-constructed cultural, social, and psychological differences between females and males.

Marx Ferre and Hess (1987: 17, cited in Jarviluoma et al. 2003) state that gender is a relational concept and has to do with the manner in which females and males interact with each other. Gender relations are in turn constructed, shaped, transformed or reproduced by means of day-to-day interactions between females and males in the society and through other social processes (Jarviluoma et al. 2003). According to March et al. (2003: 18), gen-



der relations 'are simultaneously relations of cooperations, connection, and mutual support, and of conflict, separation and competition, of difference and inequality'. This last attribute particularly applies to developing countries where patriarchy predominates and sustains gender inequality.

Gender inequality, according to Giddens (2001: 113) concerns how women and men differ in their status, power and prestige in particular societies and social settings. It therefore refers to the unequal distribution of assets and control of society's resources (food, money, power, time, etc.) and unequal life opportunities between women and men as well as negative prejudice against women in valuation of women's and men's tasks and duties.

Gender inequality exists in various degrees at various levels of a society. At the household level, in patriarchal societies, Ellis (1993) observes that women are usually under the subjugation of men. Men control the household property (assets and resources including land). But subordination of women goes beyond control of economic resources. According to Sen (1997) men also seek to or actually control women's social behaviour, such as women's ways of dressing, women's movements, friendship, etc. The implication for this study is that, in societies like Ukete, the study village, men may be a very important factor in determining whether women will participate in generalized reciprocity networks and mutual aid associations. This may mean that even if a woman has money to enrol into a finance pooling network, she may need her husband's approval before she may join the group.

In trying to explain how gender inequality and male dominance over women evolved, some authors have proposed that this starts insidiously in traditional societies through the socialization process. They argue that the mentality of dominance over women is inculcated in boys early in life. Through the process of socialization, females and males learn to behave in those specific ways which they feel the society expects them to behave in their roles as females or as males. According to Kaufman (1997, cited in Hailonga 2005), it is usually at this early stage in life that boys develop the thinking that females are inferior to them and that they are expected to dominate and control them. He states that the feeling of being in control boosts the ideology of dominance in males especially as they use this to appropriate resources to themselves.

Arguing in the same vein almost 30 years earlier, Uchendu (1965) observed that among the Igbo, boys and girls are socialized differently both in their leisure role plays and in labour and productive activities. According to him the preference for a male child in child bearing further entrenches the

ideology. 'To have a male child is to strengthen both [one's] social and economic status, for it is the male child who inherits the father's property' in Igbo societies (Uchendu 1965: 57). He further noted that during socialization, females engage in the so-called feminine activities while males engage in masculine activities. Through defining division of labour by gender, with each gender specializing in the production of specific kinds of goods and services, Igbo traditional social structure impose economic and social inequality between females and males. Fapohunda (1983) notes that women's subordinate position in the household is exacerbated by women's inability to 'control, use and dispose of the fruits of economic resources'. In such societies, women are unable to own land, yet they must get their husbands' approval before they can sell their crops'. In Hausa society in northern Nigeria, Schildkrout (1983) reports that male control extends over the activities of wives and daughters outside the home by mainly restricting women's spatial mobility. This economically disempowers the women and makes them dependent on their husbands for their basic needs. Schildkrout further argues that being dependent on their husbands means that the women must 'defer to and obey their husbands' (Schildkrout 1983: 111). To Schildkrout, female dependency is lifelong: they move from depending on their fathers as young girls to depending on their husbands as married women.

More recently, Izugbara (no date, cited in Taiwo 2004) used cultural and religious discourses to depict how different patriarchal societies in Nigeria entrench and reproduce the dominant position of men over women.. He used passages from the Bible and Quran to show that the dominant position of men is maintained through religious discourses. He argued that both Christianity and Islam disseminate the ideology that God preordained man to rule over woman. He further stated that the state implicitly legitimizes and validates dominant discourses that promote men's dominance over women. This is through bureaucratic practices which portray men as leaders and women as followers.

Of importance to this study, however, is how patriarchal ideologies and practices in the household and in the wider society in the study community influence women's ability to participate in group-reciprocity social networks and how gender roles and ideologies influence health seeking by women.

## 2.8 Community-based Health Insurance

In recent years, a lot of interest has risen on community-based health insurance (also called mutual health organizations—MHO or *mutuelles*) (Atim, Diop & Bennet 2005: 1). In this study, the terms community-based health

insurance (CBHI) and mutual health organizations are taken to be synonymous and, accordingly, will be used interchangeably. The term has been defined as a 'voluntary, non-profit insurance scheme, formed on the basis of an ethic of mutual aid, solidarity and the collective pooling of health risks, in which the members participate effectively in its management and functioning' (Atim 1997, cited in Atim 1998: 2; see also Bennett 2004: 1). Fairbank (2003: 3) conceptualizes CBHI as a form of health insurance scheme originating from and operated at the community level by a community or a local community organization. Fairbank stresses that financial risk-sharing is central to the emergence of CBHI. Financial risks arise because the sick are required to pay out-of-pocket fees to obtain health care. He categorizes financial risks along two dimensions: the frequency of the risks and the cost of medical treatment. He goes on to argue that risk pooling among members of a CBHI scheme will vary along a spectrum that incorporates these two dimensions.

The general objectives of CBHI is to provide financial risk protection to people with increased access to health care, while at the same time mobilizing money for the health providers. CBHI seeks to cover people in the rural areas, and urban and semi-urban areas who are not public servants and so are not covered by 'formal' social security schemes for government employees (Atim, Diop & Bennett 2005: 4). For these categories of people, CBHI provides financial risk protection against catastrophic health expenditures. According to WHO (2001: 61), CBHI 'would offer a degree of risk spreading, so that households would not face financial catastrophe in the face of adverse health shocks to household income'. CBHI also has a health systems objective, which is the mobilization of additional finances for health systems (Arhin-Tenkorang 2001). In addition, Atim (1998: 6), observes that CBHI, as a system of social solidarity, may have other objectives (such as to organize visits to sick people) especially when they originate as self-help groups from the grassroots level.

Bennett, Gamble, Kelly and Silvers (2004, cited in Atim, Diop & Bennett 2005: 1) summarize the objectives thus:

CBHI schemes have a common goal of finding ways for communities to meet their health financing needs through pooled revenue collection and resource allocation decisions made by the community. CBHI schemes [allow] members to pay small premiums on a regular basis to offset the risks of the need to pay large fees upon falling sick.

There is increasing advocacy for integration of CBHI schemes into the national health financing system. For example, the Government of Tanzania has already integrated CBHI into the national health financing strategy

through the establishment of Community Health Fund (CHF) (Shaw 2002: 1). Bennett (2004: 147–58) proposes a conceptual framework for the analysis of interactions between CBHI schemes and national health care financing policies. She suggests that the differences between the scheme-level objectives and government-level objectives should be adequately factored into any analysis of CBHI operations using three criteria, namely: equity, financial sustainability/revenue mobilization, and efficiency. She argues that such analysis should also examine the effects of CBHI schemes on non-members' utilization of health care in two contexts. The first context is when there is no government subsidization of health care providers, while the second context is when government provides subsidy to providers.

Many authors have raised the issue of sustainability of MHOs. Sustainability refers to the 'ability of a system to produce benefits valued by users and stakeholders to ensure enough resources to continue activities with long term benefits' (International Development Management Centre at University of Maryland, cited in Fairbank 2003: 32). Lafond (1999) observes that sustainability goes beyond the issue of financial sustainability and includes adequate organization and management, planning and policymaking. She, however, argues that in the context of CBHI, financial sustainability is the most crucial. She identifies the following as factors that can affect financial sustainability: (i) small risk pools which implies that even a small number of expensive medical cases can negatively affect the finances; (ii) Reliance on individual and voluntary membership which implies that adverse selection may occur; and (iii) weak financial management which may make CBHI vulnerable to fraud and abuse (cited in Atim, Diop and Bennett 2005: 2). Atim's (1998: 25) findings in MHOS in nine West and Central African countries corroborate Lafond's position. He reports the following as factors that may impair the financial sustainability of MHOs: moral hazard, adverse selection, cost escalation, and fraud and abuse. Moral hazard refers to the danger that MHO members may utilize health care more than necessary or than would be the case if they did not have health insurance. This results in overconsumption of services which may endanger the financial stability of the scheme. It is experienced more often in schemes in which there are no co-payments. Adverse selection refers to the propensity of those who are at a greater risk of falling ill (high risks) or who are already ill to join MHO scheme in greater numbers than those who are at less risk of falling ill (low risks). Cost escalation is the danger of rapidly rising expenditures for reasons that have to do with the attitude of both the members and health providers after the take-off of the scheme. In the context of fraud and abuse, Atim states that free-riding is the worst threat. Free-riding refers to the situ-

ation in which individuals attempt to enjoy the benefits of an MHO without contributing to the financial pool (Atim 1998: 25).

The question here is: to what extent do these risks occur in endogenous movements that operate risk-sharing movements, and to what extent do the anti-social behaviour patterns undermine mutual aid risk-sharing in such associations.

Additionally, one of the concerns of the research is the implications of rural differentiation on risk-sharing and community-based health insurance. Rural differentiation will be discussed in the next section.

## 2.9 Social and Economic Differentiation in Rural Societies

The relevance of rural differentiation approaches to this study is that they offer an analytical perspective for understanding the emergence of social, economic and political inequality in the study location and the implications of this rural inequality for reciprocity and risk-sharing.

Based on his studies of peasants in the Russian countryside, Lenin (1967: 169–75) argued that social differentiation occurs through alteration of the social division of labour and changes in the patterns and magnitude of the ownership and control of the means of production. According to him, the emergence of unequal social groups in the rural societies was an effect of capitalism on rural agriculture. He further argues that the bad economic situation of the peasants was exacerbated by the commoditization of the rural economy. The commoditization not only changed rural labour relations but also resulted in an unfavourable economic situation which forced the poor to dispose of their lands to the rich.

Deere and de Janvry (1979) identify seven mechanisms through which surplus extraction occurs among peasants. These include surplus extraction through rents—namely rents in kind, rents in cash, and rents in labour services. Another set of mechanisms comprise market mechanisms including market for labour, credit and money. Surplus extraction also occurs through state tax. (Deere & de Janvry 1979: 601–11). Besides surplus extraction, Deere and de Janvry also indicate that peasant households also engage in reproduction, among other activities. However, while surplus extraction is rooted in social relations of production, the engagement of peasant households in reproduction is largely responsible for the renewal and regeneration (persistence) of the peasant households.

Besides conceptualizing rural differentiation from the perspective of class formation, rural differentiation has also been looked into from the perspective of ‘de-agrarianization’. In Sub-Saharan African, according to Bry-

ceson (1996), de-agrarianization is 'a long-term process of: (1) occupational adjustment, (2) income-earning reorientation, (3) social identification, and (4) spatial relocation of rural dwellers away from strictly peasant modes of livelihood' (cited in Bryceson 1997: 4).

In the process of income diversification and occupational shifts, there are increasingly large shifts from agricultural to non-agricultural activities as sources of livelihood in the rural areas. Such activities include selling of firewood, fodder and water; petty trading in food and beverages such as brewed drinks, transportation activities, tailoring, carpentry, brickmaking, metal work, mineral excavation, pottery (Bryceson 1997: 5–7).

Factors which influence shifts to non-agricultural rural employment (NARE) include increasing population pressure on arable land and natural resources, economic crisis with consequent structural adjustments causing contraction of urban employment opportunities for would-be emigrants, sedentarization of agricultural systems (from shifting cultivation), provision of rural infrastructure with generation of employment in the construction, operation and maintenance activities, commoditization of common property resources, availability of transport facilities, the increasing demand for health, education, agricultural marketing services and productive inputs (Bryceson 1997, Meagher & Mustapha 1997), climate change and agricultural policies and practices (Gaidzanwa 1997: 157).

Meagre and Mustapha (1997: 67) argue that in the context of rural Nigeria, '[t]he trends towards de-agrarianization proceeded in the context of severe pressure on agricultural and non-agricultural income sources, or in response to the policy distortions of the oil boom', and not 'from the development of stable income opportunities outside agriculture'. They maintain that although structural adjustment policies (SAPs) were introduced to correct the distortions, the policies did not do much in practical terms since the greater proportion of the rural farming is on food crops rather than export crops. SAPs did however force small-scale farmers to diversify into non-farm activities although it was wiping out the profits of many of the activities, leaving wealthier farmers better placed to profit from non-farm diversification since they have the resources to invest in new opportunities (Meagre and Mustapha 1997: 74).

With regards to the implication of rural differentiation on reciprocity and risk-sharing, Uchendu (2004: 79) posits that social and economic inequality among the members of a mutual aid association tends to concentrate powers (of decision-making) in the hands of the richer members. He states that the few richer and powerful members have a tendency to abuse their powers. The implication of such unequal power relations is that reciprocity and

risk-sharing within such associations may be hindered. Discussions of rural differentiation in the context of title-taking societies in Igboland provides further insights into the implications of rural differentiation for reciprocity and risk-sharing between members of an association and other members of the society at large. The societies are for ‘powerful, wealthy, and politically ambitious men’, and women have their own equivalent societies to those of men (Amadiume 1987: 55–6). These societies provide mutual aid that is accessible to only their members (Uchendu 2004: 82, Amadiume 1987: 55–6). This cannot be said to be peculiar to rural Nigerian societies. However, what is relevant to this study is that the high fees required of the members have an exclusionary effect, since the poor cannot join such societies.

## 2.10 The Household

Household is used both as a concept and as a unit of analysis in this study. As a conceptual tool, household allows the study to focus on how bargaining on the management of health risks is influenced by intrahousehold gender relations.

Discourses on the conceptualization of the domestic units appear inevitable not only because macroeconomic conditions and reforms exert direct and indirect effects on individuals through their influence on the domestic units such as households, but also because of conceptual difficulties in the definitions of the units of analysis in academic and policy researches. Furthermore, domestic units such as the households in turn help to produce and reproduce the effects of macroeconomic changes in the process of responding to the macroeconomic reforms through household behaviours. For example, Hanmer (1994b: 13) posits that the effect of cost recovery for utilization of health care is mediated by decisions made within the household and argues that in the situations in which households lack access to increased income, the variability of the demand for health care by the households is determined by the willingness of the household to forego spending on other necessities.

But what constitutes the household in different cultures and regions and how these are applied in research, discourse and policy remains controversial. Feminist researchers have continued to argue that any conceptual approach, definition and use of the household should be concretely embedded within specific cultural contexts as policy-makers capitalize on generic, ambiguous and culturally non-specific definitions to marginalize women. For example, Fapohunda (1987) argues that such generic conceptualizations of the households constitute a potent (political) tool used by elite men to main-

tain the status quo of domination of women. She shows how in Nigeria the official definitions of households which form the basis for policy-making, land allocation, provision of public sector-based social security, etc are at stark variance to the situation on the ground, because while households are officially conceptualized to be nuclear, the vast majority of the domestic groupings are not.

What then are the conceptual definitions of households? The concept of household has been a contested terrain among sociologists, anthropologists and feminist economists. Though progress has been made in the shift away from the traditional conception of the household as a generic term that applies across all cultures and societies, and in the development of a prototypical family or household model in particular societies (Guyer & Peters 1987), the conceptual difficulties are far from being solved. Guyer and Peters suggest that the challenge is to 'bring the principles and processes which generate variation and change into the theoretical and analytical centre' of households (*ibid.*: 202), which is a clear departure from the perspective of the 'New Household Economics' theory.

Gary Becker's (1976) conceptual definition of the household as a basic unit where decisions on distribution of household resources are made in the best interest of the household, thereby conceptualizing the household as a unitary entity with 'single welfare function' (Hanmer 1994a: 18) was based on assumptions which have attracted criticisms from feminist economists, anthropologists and sociologists. Three of these assumptions, according to Bridget O'Laughlin (1999: 4) are:

- There is a domestic domain within which relatively enduring groups are defined by activities concerned with everyday biological reproduction—residing together, preparing and eating food, sleeping, having sex, having children, caring for the dependents.
- This private and intimate domain is sharply divided from the public political domain.
- Within the domestic domain there is such a strong degree of interdependence, pooling of resources and commonality of interest, such that we can ascribe agency to the groups formed there.

The bottom line of the critique is that the household is not a cooperative, homogenous, egalitarian unit made up of altruistic members who have the same needs, and think alike, and are coordinated by a benevolent household head. Rather, the household is seen to be an arena of cooperation and conflict involving power relations that are sanctioned by social norms, beliefs and regulatory framework, with differential impacts on the



male and female members of the household (Guyer & Peters 1987, Russell 1993, Moser 1998).

The outcome of the critiques was the evolution of the theory of the bargaining model of the household. The bargaining model of the household creates an avenue for capturing the temporal and spatial variations in household composition and structure, the power differentials, negotiation of division of labour and sharing of resources, involving both cooperation and conflict, with unequal outcomes (see Moore 1994, Sen 1990, O'Laughlin 1999). Within the bargaining model of the household, decision-making is conceptually determined by both intrahousehold dynamics and relationships and the broader social, cultural and economic institutions and structures. For example, the reproductive decision-making of a household is an outcome of intrahousehold relations as well as the economic, social and cultural factors that shape the behaviour of the household members towards each other, such as, for example, in respect of child-bearing. As regards intrahousehold gender relations and access to health care, Kisekka et al. (1992) conducted a study to investigate the determinants of maternal mortality in northern Nigeria and they found that unequal intrahousehold relations had measurable consequences. For example, husbands' disapproval accounted for 9 percent of the women not receiving prenatal medical care, mother and mother-in-laws' disapproval accounted for 45 percent; however, broader social, cultural and economic factors (e.g., cultural barrier, excessive cost) accounted for 21 percent of the decision not to make use of available prenatal care. These are pointers to how gender relations may act as strong barriers to health seeking by women. In this study, women were clearly denied access to health care by men, and fellow women who were under the influence of patriarchal ideology.

Looking more closely at households in the Nigerian and in the wider African context, it will be observed that there is a dichotomy between the official colonial legacy of nuclear household model and the social reality. The official characterization of the household is that of a monogamous, discrete, co-residential unit in which economic resources and budget are mutually owned and controlled. The legal system considers the husband and wife as sharing mutual interests and preferences and thus forming one single entity. The husband is viewed as being responsible for the needs of his dependent wife and children, and this confers on him the role of the decision-maker, while the wife is conferred the role of the home-keeper upon whom falls the responsibility of taking care of the children. (Fapohunda 1987: 283).

This model of the household deviates from what is the social reality in both the southern part of Nigeria (Fapohunda 1987) and the Muslim-

dominated northern part where polygyny is predominant. Further in her thesis, Fapohunda shows that the differences between the official unitary model and the observed social model in southern Nigeria include the historic and economic independence of women of their spouses, the non-pooling nature of the households, the gender division of budget and allocative priorities and the extension of the financial responsibilities of the spouses to their extended families.

Following that, Ekejiuba (1995) argues for the consideration of the domestic unit that is gender-sensitive and that takes into account the reality of women living in their own units where consumption takes place and where they and their dependents may be co-resident, with or without men. She proposes the term 'hearthholds' for such units. These 'hearthholds' may include the woman, her children and friends or relatives who may be eating and sleeping under the same roof with her. Hearthholds are found generally in rural Igbo societies, and may co-exist with households in both monogamous and polygynous settings (Ekejiuba, 1995). While domestic units where the women are in marital union have both households (often headed by the male spouses) and hearthholds (usually headed by the female spouses), domestic units where women are not in marital union often have only one of the two, often hearthholds.

The foregoing debates on the concept of the household suggest that there is indeed no universal definition of the household. Bold and Bird (2003) thus argue that what is more crucial is for a researcher to adopt a definition that is appropriate for the context of the study. They further state that it is essential for the researcher to explicitly state the assumptions or basis for their definition.

Accordingly, this study will define household as a domestic unit in which a woman and her children/relatives are co-resident, with or without a husband, under the same roof or in the same compound. The bases of this definition are:

- i) The woman is central to the definition of the household;
- ii) The absence of male spouse does not invalidate the conceptualization of the unit as a household;
- iii) The definition allows for existence of multiple forms of households on the basis of membership composition and/or physical residence (e.g., co-residence under the same roof or in different houses/huts but within the same compound).
- iv) The co-residency may be continuous or may be temporarily or seasonally interrupted. Temporary or seasonal interruption may occur

in the cases of children/relatives attending schools outside Ukete or migrating outside Ukete for labour.

- v) The woman in the household is still (normatively) responsible for the health care of such children/relatives as they may come back to the village if they fall sick.
- vi) Therefore, despite such temporary/seasonal interruption of co-residency, the children/relatives are still regarded as members of the household.

## 2.11 Summary

A number of theoretical approaches and concepts were discussed in this chapter. The objective of this summary is to identify core aspects of the theories and concepts that will guide this study.

- i) This study focuses on how women get access to health care through mutual aid, based on solidarity and risk-sharing. Social networks enable us to examine how women utilize (or fail to utilize) the ties in their social relationships when such social relationships are not predicated on bounded groups. It enables us to understand how and to what extent such social ties mediate risk-sharing within endogenous association, and how this may have implications for CBHI. Social networks are also useful in understanding the relationship between social ties and health (including access to health care).
- ii) Collective action is used to capture group behaviour in the provision of common goods for the members of the group. It is useful in the analysis of what shapes the attitudes of the members of an association toward provision of access to health care through risk-sharing mechanisms. It draws attention to the possibility of occurrence of social control problems such as free-riding, moral hazard and adverse selection in women's associations operating mutual aid. It is useful in analysing how women control such anti-social behaviour within their association, and how this social control may help them in achieving their collective objectives of increasing access to health care through risk-sharing.
- iii) Social capital is used in this study to help understand what keeps mutual aid risk-sharing associations intact and functioning. It provides conceptual explanations for the social cohesion these associations show. Since the study also focuses on who joins the association and who fails to join, and why, social capital is a relevant tool

for analysing inclusion and exclusion within women's association. It allows the study to examine why some women may fail to join a mutual aid group even when they may be capable of making financial contributions to the group.

- iv) The concept of reciprocity is a tool used in this study to examine the norms and practices of giving and receiving assistance on dyadic basis and within women's associations. It also enables the study to analyse the patterns of pooling and redistribution in women's associations and to investigate if reciprocity which underpins CBHI (i.e., conditional reciprocity) is also inherent in rural women's associations.
- v) The perspectives on risks and mitigation strategies enable the study to focus on the risks that are prevalent in the study location. The study applies it to examine status-seeking practices of the community that increases their vulnerability to risks and weakens their financial ability to manage risks. The concept allows the study to explore whether women involved in health risk-sharing strategies would withdraw if health crisis does not occur in their households for a long time or whether they would continue with the scheme.
- vi) Perspectives on community-based health insurance allow the study to examine how rural women manage their health risks through collective pooling of money and through sharing their risks. It allows the study to explore how rural women can make affordable contributions at defined intervals so that when they experience health crisis, they can receive health care and yet will not suffer catastrophic health expenditure. The perspective enables us to understand how CBHI can provide financial risk protection with increased health care access and resource mobilization for members and health providers respectively. It also enables the study to look into the assumptions and policies of the social basis of mutual aid.
- vii) The concepts of gender and patriarchy provide conceptual explanations of the social construction of inequality between women and men in power, prestige, status and wealth in specific contexts. They allow the study to focus on unequal ownership of, access to and control over land, money and other resources in the study location. Male dominance over women may have implications for women's participation in social networks such as women's associations.
- viii) Rural differentiation provides a tool for the examination of the emergence of hierarchical groups in the study location. The study

looks into the economic and social factors that influence the differentiation of the lineages (patrilineal descent groups), households and individuals in the study community. It allows the study to focus on the implications of rural inequality for risk-sharing between better-off people and poor people.

- ix) The concept of the household provides an understanding of the household as a domestic unit where there may be unequal gender (power) relations, selfish interests, and unequal access to resources. The concept also allows the study to look into whether and to what extent women get access to health care using household mechanisms based on moral obligation for support. Household is also used as a unit of analysis in this study.

## Note

<sup>1</sup>. It is often difficult to make clear-cut delineations of what constitutes a network, and how resources flow along network pathways. Mathematical sociologists have attempted to use complex models to measure boundaries and pathways. However, measurement of flow of resources remains elusive to researchers. In this research, it is not my intention to carry out detailed mapping of networks or to delineate network boundaries and mathematical measurement of flows along pathways. Therefore, I have not indulged in detailed discussion of the theory, but have concisely discussed it as it applies to this study. My interest lies in the use of social network as a tool in exploring women's use of mutual aid mechanisms for health.

# 3

## Social and Economic Organization in the Study Location

### 3.1 Introduction

This chapter describes the social and economic organization of the study location. The chapter starts with a discussion of the Igbo of Nigeria; it then discusses Igbo social structure (marriage) and Igbo social structure (kinship/extended family). It then goes on to discuss Enugu State, which is followed by a brief discussion of relevant cities in Enugu State and neighbouring Anambra State. The relevance of the cities to this study is that they serve as destinations for young migrants from the study community. The chapter then focuses on Ukete, the community in which the study was conducted. It discusses topography, transport, population, land control and socioeconomic differentiation, households, marriage, income-generating activities, intra-household relations (gender and generation), consequences of land inequality, and contexts of financial risks to women. It then ends in a concluding section in which the salient findings in the chapter are summarized.

### 3.2 The Igbo of Nigeria

The Igbo,<sup>1</sup> who are the subjects of this study, are found in the southeastern part of Nigeria. The Igbo tribe is one of the three major language groups in Nigeria, the other two being Hausa/Fulani and Yoruba. In the words of Meek (1937: 1),

The [Igbo] are not strictly homogenous. They may be described as a ‘tribe’ because they speak a common language, occupy a common territory, and on the whole share a common culture and common outlook on life. But there are marked dialectal and cultural variations.

Igboland lies within the tropical rain forest, though the northern fringes of the territory have guinea savannah vegetation. There are two distinct seasons—the rainy season and the dry season; the rainy season spans six months, from April to October, while the dry season is from November to

March. The southern parts receive more precipitation than the northern parts, and in the absence of irrigation schemes, farming is dependent on rainfall patterns (Uchendu 1965: 1–2, Korieh 1996: 8).

There is also a geo-social demarcation of the area into southern and northern Igboland based on social and cultural differences between the two areas. For example, there is a marked absence of elaborate rituals of title-taking systems in the southern Igboland, whereas the southerners practise the ritual *osu* slavery system (Korieh 1996). In reality, the separation is not rigid and there are overlaps; in fact today title-taking has also infiltrated the southern Igboland too. The title-taking or the *ozo* system is the way Igbos come to receive a public recognition for their achievements in wealth. As Amadiume observes, it is ‘voluntary and achievement-based’, and taken ‘when a man becomes financially successful, [and] seeks power and prestige’ (Amadiume 1987: 132–3). According to Uchendu (1965: 16) ‘It is a fair assessment of the Igbo world to say that the most important commodity it offers and for which the Igbo strive is the *ozo*, or title system. The Igbo are status seekers’. This shows that the cultures from the northern parts of the land has been taken on by the southern parts and vice versa, giving rise to a cultural mix which then forms the totality of the Igbo culture. The Igbo are notably open to such cultural change. Writing about the Igbos, Uchendu (cited in Agbasiere 2002: 1) observes that ‘the very idea of culture implies change—adaptation and re-adaptation’ and that ‘cultural change ... implies ... choice-making’ because ‘the contact of different cultures tends to multiply the alternatives from which bearers of cultures in contact can make their choices’.

Therefore, though the vast areas of the southeast of Nigeria are referred to as Igboland, the Igbo are themselves not a homogenous ethnic entity. In fact, before contact with the Europeans, the Igbo were living in scattered village communities organized into clans (Talbot, cited in Meek 1937) and were often described as lacking centralized authority or a higher political unit (Meek 1937).

The pre-European traditional social structure was a status structure as opposed to a class structure. Status was based on achievement rather than on being born into a particular social group. The social structure was based on a principle of egalitarianism. The principle was expressed by corporate groups, such as families, lineage and associative movements through major social organizations, namely, the ideology of lineage equality and ‘social conversion’. Social conversion refers to the process through which individuals and groups could convert their wealth into social prestige symbols. Members of the rural society must hustle to undergo social conversion in

order to enjoy the social benefits of a higher status (Uchendu 1995: no page).

Uchendu further argues that the ideology of egalitarianism or near-egalitarianism among lineages and the lack of literacy hindered the development of 'rigid political and cultural stratification' and authoritarian political culture.

Western influence brought a lot of changes to Igboland. The ideology of equality of lineages was eroded and replaced by inequality in social and economic characteristics. Education and concomitant Western-style employment gave rise to socioeconomic differentiation in the society (Uchendu 1995, Amadimume 1987).

In the context of social and political development in Nigeria, the enthusiastic embrace of Christianity and Western education by Igbo resulted in 'their later speedy development and progress which finally enabled them to overtake the other ethnic groups in Nigeria in terms of European-style development' (Forsyth 1969: 16). Igbo took a leading role in the federal civil service after independence, and constituted the large majority of the graduate officer corps of the newly formed Nigerian army. However, in the wake of a coup led by Igbo military officers that resulted in the killing of some political leaders, there were pervasive massacres of the Igbo living in the especially in the northern and western parts of Nigeria. A secession bid by the Igbo led to the Nigerian civil war in 1968–70 (Forsyth 1969: 18).

Among the outcomes of the war for the Igbo was the loss of their leading position in the civil service, academia and military (Forsyth 1983). It became relatively more difficult for them to get jobs. Interest in further education consequently declined since it became very difficult to get white-collar jobs. Education consequently became neglected in Igboland in the post-civil war period and young men preferred trading and 'informal' business activities to spending many years at school after which they would not find jobs anyway. This negative change in attitude to education was later reinforced by the effects of the structural adjustment programmes of the mid-1980s and 1990s and the on-going economic reforms which worsened the unemployment situation. This change, which comparatively affects boys more than girls, had been dubbed 'Boy-child Drop-out Syndrome' by the Nigerian press (*Thisday Online*, 2005: Internet).

### 3.2.1 Igbo social structure: marriage

Marriage in Igboland is primarily exogamous including village-exogamy as well as lineage exogamy with virilocality. The marriage process is a long and tortuous one, and involves rituals celebrated between the family of the bride



and that of the groom, with full participation of the lineages of both. This is, in principle, intended to ensure that the new bride becomes a full member of her husband's lineage, with all privileges, rights and duties.

Broadly, two types of marriage are contracted: the traditional marriage (also known as native law and custom marriage), and the modern marriage. Within each broad category there are different sub-types with varying frequency of practice, which are determined by religion, education and economic status.

The Igbo traditional marriage system allows the practice of monogamy and polygyny. Consequently, men may marry more than one wife at one time, and they may also keep concubines. The levirate practice is also permissible under the customary marriage (Korieh 1996: 11).

The most common form is the one between a young man and a young woman, but marriages between a widower and a previously unmarried woman do take place. Less frequently though are marriages between a widow and a young man who had never been married before, as this will evoke strong objection from the lineage of the young man. Levirate marriage, in which surviving men 'inherit' the widows of their dead brothers or step-brothers, is normatively possible, but not practised frequently nowadays. Such is also the case of women marrying other women. There is also the practice by which a woman marries another woman. The 'female husband', as she is called, (Amadiume 1987, Uchendu, 1965) may marry a wife because she cannot not bear a son for her husband. Uchendu posits that the institution offers women the opportunity to assert their social status. He states,

Although there is a high correlation between economic power and female husbands, other categories of women who play this role include barren women, those who have lost all their male children by death, and who have only female children. There is no doubt that the institution of 'women marriage' benefits capable women by neutralizing the harsh effects of the Igbo inheritance law, which excludes women who have no male children from inheriting from their deceased husbands and excludes most women from inheriting from their agnatic lineages. (Uchendu 1965: 50)

Indeed, it takes a combination of factors for a female husband to emerge. A woman who does not have the desired wealth, social power and prestige is incapable of marrying another woman even if she has no male children because of barrenness or death of her male children. In such instances, the alternative may be to allow one of the daughters to forego marriage, and remain in her father's house to bear sons who will perpetuate the

lineage of the man. While traditional systems allow women marrying women, the modern system of marriage does not.

Modern marriage is largely a colonial legacy, and practised by educated people. It is strictly monogamous in nature, and forbids many of the marriage types permitted by the native law and custom, such as polygyny, levirate and female-female marriages. It is often called statutory marriage, but church marriage also belongs to this class. The Nigerian Marriage Act of 1914 and the Matrimonial Causes Act of 1970s are among the legal instruments backing this type of marriage (Korieh 1996: 11).

### 3.2.2 Igbo social structure: the kinship/extended family

Patrilineage is strongly emphasized in Igbo society, except in a few areas where matrilineage is the norm. Patrilineage is traced through agnatic groups, which are lineages 'with an unbroken continuity of descent in the male line' (Uchendu 1995: no page). The agnatic group, alongside its constituent members, is called *umunna*. In *umunna* as an exogamous agnatic group, all the female members are required to relocate to their husbands' homes when they marry. Literally, *umunna* means 'children of the father'.

According to Uchendu, the extended family may be viewed as synonymous with the *umunna*. From this perspective, the extended family consists of either or both: (i) agnates who can trace their descent to a common ancestor (about fifth to seventh descendant generations), (ii) ascendant and descendant generations from a person. Implicit in this notion of extended family is the existence of blood relationship. In deed, this also has an implication for composition of households because households in Igboland may have members of the extended family in co-residence with a woman, her children and husband. From another perspective, the extended family includes both agnates and affines. Thus, there are blood relations as well as social bonds created as a result of marriage. Extended family may then be defined as 'a social system lacking a fixed number of specifiable positions [...] but consisting of two or more positions of which one or more resulting dyads is not a nuclear dyad' (Uchendu 1995: no page).

Uchendu posits that extended family is the focal point of solidarity and management of risks, the nucleus of reciprocity mechanisms. Following Goode (1963: 273–55) and Gelia Castillo et al., (1968: 1–40), he comments that the following attributes are inherent in extended the family:

- i) Members of the extended family may exercise reciprocal rights among themselves when necessary;

- ii) Members of the extended family may practise pooling and joint ownership of resources;
- iii) There is usually recognition of shared and moral responsibilities;
- iv) There are reciprocal assistance patterns.

However, more than 30 years ago Igbozurike (1976: 85) questioned the extent to which such assertions still held true in contemporary Igbo communities. Igbozurike's hypothesis suggests that Uchendu might have idealized the role of kinship in risk mitigation. It might be more useful to conceive kinship as an institution that is continually interpreted and adapted to situations rather than kinship as a set of fixed rules and regulations.

### **3.3 Enugu State**

Enugu State is situated in southeastern Nigeria. The 1991 national census puts the population of the state at 2.1 million people. The majority of the inhabitants of the state are of Igbo origin. Igbo is therefore the predominant language, though with a variety of dialects. Approximately 59% of the population reside in the rural areas. Seventy-eight per cent of the working population are self-employed. Agriculture accounts for 55% of the total workforce, and 70% of the workforce in the rural areas. The proportion of the female workforce employed in agriculture is 61%, while that of men is 41% (Ministry of Human Development and Poverty Reduction 2004).

Two of the cities in Enugu State and neighbouring Anambra State are relevant to this study, as destinations for most young people migrating from the study community.

#### **3.3.1 Enugu City**

Enugu city is an administrative and commercial city located in the Igbo heartland. It serves as the administrative and political capital of Enugu State. Migrants to Enugu city mainly go there to seek white-collar jobs, but some engage in self-employment in the informal sector. Most of the migrants from the study location to Enugu are young men. However, in the last decade, an increasing number of young women have also begun migrating to Enugu. This is said to reflect the increasing number of educated young women.

#### **3.3.2 Onitsha**

Onitsha is a city located on the Niger River, in Anambra State, on the western border of Enugu State. It is the largest commercial centre in Igboland,

and in fact, in the whole of eastern Nigeria. Onitsha offers many economic opportunities especially in the distributive commercial sector. The commercial nature of Onitsha is associated with a large informal sector. This makes the city attractive for young people who have little education. Young people either engage in self-employment or work for others in the informal sector. Some go into contractual apprenticeship with rich traders from Anambra State. The terms of the agreement are usually that after learning the business and working for the rich traders for between five and seven years, the traders will 'settle' them. 'Settlement' means that the rich traders will give the outgoing apprentice enough money to start his own business. This is an attractive proposition for young school dropouts, as their families at home do not have the means to raise capital for business. However, only few apprentices have been fortunate enough to be 'settled'. Although the proportion of females migrating to Onitsha has increased in the last ten years, respondents stated that the greatest proportion of migrants to Onitsha has remained young males. According to them, Ukete women living in Onitsha are those who are married to the male migrants.

Having given an overview of the Igbo and Enugu State, the study now focuses on Ukete, the village community where the study was based.

### 3.4 Study Village: Ukete

Ukete is located in Aninri Local Government Area of Enugu State, Nigeria. It is a rural community and the vast majority of its inhabitants are indigenes. The community is linguistically homogenous. Community structures and social institutions are active and help to organize many aspects of social life. One such institution is the Ukete Development Union, which has its own elected leaders. The traditional *Igweship* is a social institution in which cultural leadership is invested. The *Igwe* is the traditional ruler who is generally regarded as the father of the community. He and the members of his cabinet are the custodians of the village's cultural heritage and traditional practices, and are consulted in matters that concern the community. There are also other institutions such as women's associations. The community has very few modern social facilities. The Community Primary School (CPS) was about the only social facility until recently when a borehole, provided under the Japan International Cooperation Agency (JICA) development assistance, was drilled for drinking water.

Ukete presents the features of a typical, relatively remote rural community. It is remote in location, lacks asphalted roads and has no modern health facilities.

Unlike many rural communities in Enugu State where the influence of urbanization has modified the typicality of rural environment, Ukete has little urban-rural communication and has largely retained its rural characteristics. Though there have been changes in Ukete, these are relatively insignificant when compared to some other communities in Enugu State where modern development has basically turned the communities into emerging semi-urban environments.

### 3.4.1 Topography

The topography of Ukete consists of lowlands, with flat plains running from the western border with Nenwe to the eastern border with Oduma. A large expanse of land separates Ukete on the west from Nenwe and on the south from Ndeaboh. This expanse of land is called *Agu-Ofia*, which means 'forest farmlands' or 'bushy farmlands'. And it serves as the main location for agricultural productive activities. However, there are also land areas for farming found closer to the homesteads and these serve for less intensive gardening purposes. *Agu-Ofia* is so named because it was once was a tropical rainforest. Villagers recollect that it once provided an abode for many kinds of mammals such as lions, tigers, antelopes and primates as well as reptiles. With the exception of antelopes which are seen occasionally, the primates and mammals and most of the big reptiles are long gone, due to human activities, which have led to deforestation. What remain of the vegetation are the sparsely distributed shrubs, occasional iroko trees, palm trees and grassland. A small zone of marshland at the extreme southern end of *Agu-Ofia*, very close to their border with Ndeaboh, serves for cultivation of rice during rainy season, but dries up during the dry season. It is observed that ecological changes in the farmlands are ongoing and, at least in the opinion of the residents, environmental degradation is irreversible, characterized by longer dry seasons, occasional droughts, poor and decreasing soil fertility, worsening crop yields and increasing necessity to apply fertilizer.

The *Abu* stream is the only body of surface flowing water and is intermittent in nature: it gets filled with water during the rainy season and becomes dry during the dry season. People's means of livelihood and domestic utility are closely tied with the *Abu* stream, which flows in a west-easterly direction and meanders around the village. At the point where the stream is closest to the Community Primary School, it gives rise to a section that forms a pond (called *Ogba*) containing sacred fish which are ceremonially worshipped during the *Iri-Ogba* festivals. Young men and boys fish in the stream. Fishing hooks are baited with cylindrical pieces of earthworms, pieces of bar soaps, grasshoppers or crickets. Fishing nets are also used for

fishing. The net is strung at its upper end by a small rope which is tied to two wooden poles. These are spread apart, and with the poles stuck into the floor of the shallow parts of the stream, the net is left in place. There are no boats in the village, and so no fishing is done on boats. Fishing is done as a seasonal off-farm activity, and was originally intended largely for domestic consumption. However, as in many other activities in the village aimed originally at production for consumption, people now sell the 'surplus' for cash. Indeed, the villagers stated that the households of the young men and boys often choose to smoke the fish and take it to the market to sell to get cash, rather than consume them within the household. This is because the catch is decreasing every year. The mass deforestation occurring in the village and its environment has affected the stream. The banks have virtually been laid bare, and without the protection of large trees and its roots, the banks are giving way and the stream is becoming shallower. Consequently, those engaged in fishing are no longer able to secure enough catch for household consumption and for the market, and hence the choice to sell the catch for cash.

### 3.4.2 Transport

Transport infrastructure is in a rudimentary stage of development with an unspasphalted road running in a west-northeasterly direction from Nenwe through Ukete to Oduma, crossing the railway at Oduma-Achara, Ukete's most immediate neighbour on the northeast. Educated villagers have it that during the Second Republic (1979–83), the governor awarded a contract for the construction of the road to a fake, nonexistent company. During the Second Republic, Nigeria made what became her second attempt at operating a democratic regime after several years of military regime. After the first four years of civilian rule, the elections which were won by the then ruling National Party of Nigeria, were widely viewed as marred by electoral fraud and irregularities. Consequently, a few months into the second term of the ruling party, the military struck again, in a bloodless coup d'état and commenced another period of military regime. The military had alleged not only electoral irregularities but also pervasive corruption among other reasons for their overthrow of the civilian government. Such corrupt practices were exemplified by the award of contracts to companies belonging to the politicians or their cronies who were usually paid the whole amount for the contracts without executing any jobs. It seems that the road passing through Ukete was among those whose contracts were deliberately awarded to contractors who would not execute the contracts after being paid. The villagers

reported that they saw the signpost signalling the beginning of construction of the road but that was the only thing they ever saw about the contract.

The road usually gets almost inaccessible to motor vehicles during the rainy season, except for minibuses used by outside traders who go there to buy okra and other farm produce to sell in the urban areas. But immediately after rainfall and for a few days after that even the buses fail to pass, and must wait for possible sunshine before attempting to access the roads. During the okra harvest, if it rains on the *Eke*<sup>2</sup> and *Orie Market* days when harvested okra are sold and prevents the passage of minibuses coming from the urban areas, the consequence is usually a glut that leads to severe fall in the prices of okra for those who are fortunate enough to sell theirs. For others their inability to sell okra may mean total loss of the produce as it is very perishable and cannot last for many days. In any case, the harvesting of more okra in another four days means that the stale ones will have to be taken out of the market. This type of structural risk may, however, occur more frequently than other types of structural risks encountered by women traders who buy okra from the farmers and take them to the city to sell (see section 3.4.6).

In the prevailing situation of inaccessibility by motor vehicles and the degeneration of the railway system, much of the local transport depends on commercial motorcycle taxis, popularly called *okada*. Only a few men own *okada* in Ukete but since Ukete is situated on the road from Nenwe to Oduma, the villagers avail themselves of the *okada* plying between Nenwe and Oduma. To get an *okada*, the villagers have to wait for hours because the motorcycles are usually fully loaded with passengers, usually three (and the cyclist making the occupants of an *okada* four). The waiting time to get an *okada* is further prolonged on *Orie Market* days when the cyclists have a field day ferrying traders and other passengers from Oduma and Ohafia to Nenwe and back. Carrying four people on a motorcycle on the dirty road is fraught with risks, but the operators and their union insist on this practice to make more money. If you are a new visitor to the place and you object to being carried with other passengers, the operator will charge you the fare of three passengers. They are usually delighted to receive such new visitors, and will happily tell you that carrying you alone is an express service. But carrying only one passenger makes it safer for them also on the dirty road and reduces the risk of accidents, which occur not infrequently on the road. The prevalence of bone fractures has risen in the village since the introduction of *okadas* as the major means of transport in the mid-1980s. Before then, the major causes of fractures were falls from palm trees by wine tap-

pers, but *okada* accidents have taken over as the major cause of traumatic fractures.

Leaving Ukete for Oduma, one sees houses scattered in the midst of farmlands, and as one gets closer to the railway station in Oduma-Achara, modern houses with concrete walls and long-span roofing sheets of varying colours are seen. These belong to urban migrants from Oduma-Achara; it is usual for the Igbos to go back to their villages to build houses before building any house in the city. This is one of the outcomes of the civil war when the houses of Igbos in cities in other parts of Nigeria were seized by their then 'enemies'. Since then it became a common practice to build houses in their own communities which could not be easily seized by enemies. Beyond the railway station and the railway track, clusters of village communities are passed by on the way; these are interspersed with stretches of farmlands. The landscape changes as one gets close to Ohafia where the road ends. Undulating plains give way gradually, and merge with low hills; hillside springs are seen occasionally by the roadside.

On the other hand, as one leaves Ukete, from the Community Primary School, for Nenwe, one passes the *Abu* stream before approaching the last fringes of human settlement, which are some clusters of compounds surrounded by farmlands and gardens. Leaving these behind takes one through a continuous stretch of farmlands which spans about one hour of walk before getting to Nenwe communities. During the dry season, one sees burnt grass stumps, burnt shrubs, palm trees, and sparsely distributed trees. The middle of wet season is characterized by a scenario of alternating yam farms, rice fields, okra fields and cassava farms, etc, with villagers engaging in their farm work.

Inside Ukete, the different quarters are interconnected by paths. Paths also connect the different parts of the village to the meeting places such as the primary school, the village square, the small evening market, as well as to the main road. Bush paths are constructed to lead to far-away farmlands such as *Agu-Ofia*, to nearby farms and to the *Abu* stream.

*Okada* and bicycles are made use of mostly when travelling outside Ukete. Within Ukete most villagers go about their business on foot along bush paths.

### 3.4.3 Population

Household mapping done in 2004, as a part of this study, revealed a total of 213 households in Ukete. According to the Local Government Service Commission (2003), the total population of the community was 1483. Fe-



males accounted for 52% of the population, with a figure of 771. Males were 712 (48%). Official figures for 2004 were not available.

Ukete people belong mainly to two religions, namely, Christianity and traditional African religions (animism). Members of the younger generation are mostly Christian while the older generation has more animists. Among the older Christians, the Catholics are by far the majority, while among the younger generation Christians, there is an increasing proportion of Pentecostal adherents.

#### **3.4.4 Land control and socioeconomic differentiation**

In order to understand present-day Ukete society, we must first look to land as the major scarce commodity.

An issue of keen interest when interacting with the villagers on land ownership and access is that some patrilineages have much land, while others have barely enough to farm, and yet others have no land at all. The farmland in Ukete has never been officially surveyed, so estimates of relative land ownerships by various extended families can best be taken as rough approximations. However, in the absence of empirical methods of measurement and the lack of availability of records, the estimations of village leaders have been taken here, though with caution. According to key informants (enlightened community leaders), the Umunwedu lineage owns roughly 30% of all arable land. This is followed by Umuonovo which owns approximately 10% of arable land. The remaining approximately 60% of the arable land are under the possession and control of the 13 other lineages. For 13 lineages to own 60% of arable land in comparison to 40% of arable land being under the ownership of only two lineages would ordinarily be seen an invitation to conflict and social disharmony. However, traditionally, the Igbo always strive for maintenance of social equilibrium within their village communities. Contentment with what one owns is one of the cardinal points of socialization during childhood. That contentment is lost from time to time, leading to crisis, both within the lineages and between the lineages.

In the past, most extended families usually distributed land, sometimes, on rotational basis, to their members. This applied to both the land-rich lineages and lineages who own less land. However, intra-lineage land distribution was highly skewed between land-rich and landless or land-poor households. Distribution also differed in terms of who had access to the more fertile lands. Because of this inequity in land distribution, many of the land-owning lineages have been rocked by serious internal crisis, involving both physical violence and court litigations. Social crisis following rotational

access to lineage lands caused some of the lineages to share the lineage lands on permanent ownership basis. Within such lineages, farmland was shared based on locally agreed measurements called 'portion' or *oke*. An *oke* is a portion of land containing eight 'person-labour partitions'. A 'person-labour partition' is a fraction or piece of an *oke* which an adult female or male working at community-sanctioned speed will completely weed, working from morning [about 8.00 a.m.] till late afternoon [about 4.00 p.m.]; or a piece of *oke* which can contain about 25 to 30 'standard' yam mounds.

Only adult males were entitled to get an *oke*. In other words, the unit of land ownership and control is the adult male. Land under the control of an adult male may be used by his wife, with his permission. He may also give permission to his adult sisters to cultivate a portion of his land. Women are not entitled to ownership and control of land. Their right to use land is through the adult males. Women whose husbands do not own land have to rent land to cultivate from males who own land.

Beyond the *Ahu* stream, about 30 minutes walk, the land formed part of the open access forest till the 1970s. Hunting and gathering, and slash-and-burn farm activities were carried out by indigenes from both Ukete and neighbouring Ndeaboh. Intercommunal skirmishes broke out from time to time as Ukete people wanted to push back the Ndeabohs, carry on further slash-and-burn and claim ownership of the areas so cleared.

Some elders held the opinion that during the time the battle for *Agu-Ofia* was going on, some of the villagers felt less inclined to take part. Therefore, those who fought hard in the battle were able to claim large parts of the land. But as in every human society, there would always be the weak who would not be able to take part in the battles. So, why would the land not be shared equitably among the weak and the strong, queried some elders who felt that the rich landowners were not only strong but also greedy. They argued that there were some who did not take part in the physical battle not because they were weak or that they displayed a *laissez-faire* attitude but because they were actually blocked from taking part by the more powerful families. Power, the villagers stated, lay in having within an extended family a large population of strong and able-bodied young men who could fight battles. Those who argued that the land ought to have been shared more equitably, after the battles, pointed to the fact that there were not only physical battles but there were also legal battles fought over many years. The powerful families could not foot the bills alone, and there were village-wide levies, on the basis of every *ezì-n'ulo* headed by a male.

Today, the vast fields of the middle segments of *Agu-Ofia* are owned by individual adult males (and not lineages) who have absolute control over

them. The segment further south and closer to Ndeaboh, where the marshlands for rice farming are found, remained open access until about late 1990s when individual claims started, by way of clearing and cultivation. Open access in this context refers to the practice whereby any adult male who first cleared a portion of land at the beginning of a farming season had the right to cultivate the portion during that particular farming season. He did not own it; his right to use it terminated at the end of that particular season. At the beginning of the following season, any adult male (including him), could clear it first, and thus exercise use right over it for the farming season. Open access has ended, and nowadays, individual adult males have occupied different portions of the marshland permanently, and exercise absolute ownership and control over their portions. Elsewhere in the farmlands surrounding the community, individual ownership and control rights prevail.

Land may be available in the village, but land is certainly not available<sup>3</sup> to every villager. Land is not even available to every lineage. To many of the villagers, it is a case of ‘starvation in the midst of plenty’. While land is available and relatively plentiful, many Ukete are landless. Many cannot afford to lease land from their fellow Ukete indigenes who own land. Yet, owning land does not always solve one’s problems. It is not just land but arable land that matters. In many other farm lands outside *Agu-Ofia*, land is less fertile, sometimes to the extent that it is considered a waste of labour and time to cultivate such lands.

### 3.4.5 Households

In a monogamous unit in Ukete, a woman lives in a room with her children, and this may be located within the house. Almost as a rule, she usually has a relation who may be her own or her husband’s relation, co-residing with her and her children. Harvested crops which are to be preserved soon are stored within a specially prepared overhead granary called *uko*. With the assistance of her children and co-resident relations, preparation of food is done in her hearth. Processing—partial or complete—of raw food materials takes place within her hearth and under her direction and control. In many instances, she eats with her co-resident children and relations in her hearth, while food is taken to the man in his own room. Daughters remain co-resident with their mother until they get married, but male children may move to share their father’s room when they come of age, that is, when they attain the cultural age of adulthood and perform the appropriate rites.

In the past, women lived in separate huts which constituted their hearth, while the men had own separate houses. Houses then, the villagers pointed

out, were cheaper and easier to build because the roofs were thatched with speargrass (*imperata cylindrica*), and extended family solidarity and village-level social networks made it easier for men to build own huts and build separate huts for their wives. Now, many villagers strive to roof their houses with corrugated roofing sheets. Costs of the wood, nails, roofing sheets and other accessories have made it nearly impossible to have two separate residential units in a monogamous setting. Consequently, the practice is for the hearth and the man's section of the house to be within the same building.

A woman's hearth is her *ekwu*, while the unit of her consumption, production and child-rearing/reproduction—that is, her hearthhold—is her *onu-ekwu*. *Onu-ekwu* is, in a sense, her physical, economic, social and political space, but it is not divided from the public social, cultural and political domain.

### 3.4.6 Income-generating activities

To the villagers, everybody resident in the village is a farmer, to a greater or lesser extent. The primary occupation of the vast majority of the villagers is farming. Those whose primary occupation is not farming engage in farming to produce food for consumption in their *ezi n'ulo*. They also cultivate crops to sell for augmentation of the income from their primary occupation. This sub-section describes the major income-generating activities of the villagers, with a focus on the place of women in these activities.

#### *Okra farming*

By March, the clearing and burning of the farm bushes start in earnest. Women, men and children are involved. Clearing is followed by a short period during which the grasses and twigs are allowed to dry up, and are then burnt. The onset of rainfall in April brings about the planting season. Planting starts with the making of mounds. The okra mounds are flat compared to yam mounds. They may be raised to about 15 centimetres high, and circular in shape. This pattern is usually found in low-lying farms close to streams and drainage areas. Alternatively, cultivation could be done on flat soil by breaking up the soil without raising it into mounds. (Rich households may hire labour to assist in soil preparation.) The sowing of okra follows the soil tilling. Four weeks after sowing, the okra fields are weeded. It falls to the women in household to do the weeding. Harvesting comes about two months after the weeding, about early June. Okra is harvested every four days. Harvesting and sales of okra are carried out by adult females, assisted by the older children (adolescents).

Okra harvest is looked upon as a welcome relief to the period of scarcity that prevails from April to July, during the planting season. However, okra prices may fluctuate within a season, and from season to season. Since every woman in the village is not on equal economic footing, fluctuations in okra harvest and in the pricing/sales of okra do not affect them equally. Poor women often bear disproportionately more negative consequences than rich women and women married to landowners.

### *Rice farming*

Informants indicated that the importance of rice to household consumption and rural cash economy has been on the increase since the late 1980s. By the late 1990s, rice had overtaken every other crop as the single most important cash crop. Over the years, negotiations between tenants and landlords have shifted slightly to the favour of the tenants. This is because tenants have been able to get the landlords to concede to their request that payments for lease of land for okra and rice should not be separate and independent if both crops will be planted sequentially, on the same land. In fact, most tenants use same plot of land for okra and rice, with okra first and rice following immediately after okra harvest. For tenant farmers, it is economically advantageous to cultivate okra and rice sequentially on the same farm land. Only landowners can afford to use separate plots for okra and rice. When sequential cropping is applied, farmers make their rice nurseries while okra harvest is just starting. Clearing of the old okra plants and weeds starts once the okra harvest is over. This is followed by soil tilling. Clearing of the field and soil tilling are done manually.

Field preparation is followed immediately with transplanting of the rice from the nurseries. Transplanting is done with the use of a locally-devised instrument called *nzo*. *Nzo* has a wooden handle and bi-forked metal end. Transplantation is done in June, during which the first peak of rainfall occurs. Informants indicated that some innovations have been introduced by the large farm owners. One of them is the introduction of *zero-tillage* techniques in rice farming. This technique, which was first used by Oti, a rich landowner and farmer, in the village, is based on a species of rice which grows very well on soils that have not been tilled, and the species does not require preliminary planting in the nursery. Thus, the seeds can be sown directly in the soils. Oti acquired the seeds from Ministry of Agriculture in Enugu; they are very costly compared to conventional seeds. But this species offers the richer farmers the opportunity to cultivate even larger rice fields. On the other hand, prohibitive costs prevent poor farmers from venturing into zero-tillage farming. Informants stated that since zero-tillage

farming is best suited to large fields, it does not make much sense to the poor to practise it on their small rice fields.

Weeding of rice fields is the next event after the planting. Weeding is done with small hoes. Women and children are usually charged with this, though men may offer assistance when they have the time. To complete the weeding on time, women often resort to rotating labour exchange. Weeding offers an opportunity to the poor women to make some money.

Women labourers are again in demand when the rice harvest begins in early November. Rice harvest is not mechanized, as there are no tractor harvesters in the village. Labour costs for rice harvest are cheaper than for weeding. During the field research, it cost 400 Naira to hire a woman for a day, whereas young men were paid 500.

The dynamics of rice farming seems to reduce the capacity of the poor to produce large amounts of rice for household consumption and for cash. Costs of land, inputs and labour frequently reduce the productivity of the poor. Villagers indicated that, of all the factors, land ownership and access are the most important determinants of the productivity. Women who are married to rich landowners plant large portions of land with their husbands. In contrast, poor women and/or women married to landless farmers can only obtain small portions of farm by lease or sharecropping and are able to get only small harvests. The exceptions are well-to-do women and their husbands, who though may be landless, are able to rent *oke* they need to cultivate the land.

Nevertheless, rice is more important to the poor farmers for the cash it fetches than for consumption. Women may sell their rice as raw, unmilled rice, usually to fellow villagers or people from neighbouring towns and villages, who parboil and mill the rice themselves. Actually, when rice is parboiled and milled, it fetches more money than raw rice. This is a practice associated with poor women.

I observed well-off, better-off women and households process their rice before taking it to the urban markets themselves. They hired local labour to assist in fetching firewood and in parboiling the rice. Subsequently, the members of the household spread the rice of mats for drying. The rice was then taken to mills in Oduma. The women later took the milled rice to Enugu to sell.

According to respondents, there has been a significant change in gender dimensions to rice farming. In the past, when rice was cultivated mainly for household consumption, rice was regarded as women's crop. However, presently, rice is cultivated mainly for cash. This commoditization has attracted men to rice farming, and so rice is no longer viewed as women's

crop. Women and their husbands now carry out rice farming jointly or separately.

### *Yam farming*

Being in northern part of Igboland, where the practice of making large yam mounds prevail over the digging up of holes in the soil for the planting of yams, the making of the large yam mounds is exclusively masculine, not so much for the big size and the large weight of the hoes used as for the social construction of masculinity and femininity in farm work. Here masculinity is equated with carrying big farm implements and doing the so-called 'heavy' labours, and so a man is defined in terms of how big his hoe is. Men and young adolescent males start making the mounds in early March, about the same time the women and girls are preparing the soil for okra. Migrant male labour, hired by the rich, come to the village from Ebonyi State to engage in mound-making; the poor are incapable of hiring migrant labour. It is not uncommon to see new faces, able-bodied men, coming in trickles into the village, often walking the long distance from Nenwe to Ukete, carrying jute bags that contain their hoes and few personal articles. These are the Ezza men, and constitute the major migrants into this remote village. As, indicated earlier, they are engaged by the well-off yam farmers to do their mound-making.

Yam is primarily regarded as 'men's crop'. When the mounds have been dug and the yams sown, the men's wives plant vegetables—such as the *amaranthus* species, melon, pumpkin, okra, but also cassava, maize, cocoyams—on the slopes of the yam mounds. These are regarded as women's crops. The women also weed the yam plots about twice in the season.

Interview respondents stated that there have been changes in the pattern of yam farming in the village. The soils no longer give adequate yield, and yam harvests get poorer almost every year. This is against the backdrop of increasing labour costs and rising prices of seed yams. Fertilizer application has also become *sine qua non* in yam farming. Elderly farmers recollect that yam cultivation used to be cheap. Much of required labour in the past came from free labour from extended family members and friends. This was supplemented by labour from associations to which the men belonged, and this was also free. Mahiu, a one-time rich yam farmer and landowner, stated that he usually met all his labour needs without spending much money. He only needed to feed those who came to offer labour assistance. He had no use for fertilizer because the soil was fertile. He said the circumstances changed so much now that extended family labour is no longer available for free. Many able-bodied young men have migrated; those living in the village will

only work for you if pay, and the payment is not small. The Ezza seasonal labour migrants are expensive to hire. These days, he is no longer able to cultivate enough yams to last his polygynous family throughout the year. Like many men, Mahiu has shifted to cultivating other crops, such as cassava.

### *Cassava farming*

Cassava has established itself as a staple substitute for yam, providing opportunities for household consumption and for cash. Cassava was once regarded as women's crop to be intercropped on the slopes of men's yam mounds. Women still cultivate cassava, but not in the context of intercropping on slopes of yam mounds. Nowadays men also cultivate cassava plots, either as farms jointly owned with their wives or singly owned by them. The villagers stated that there are more cassava plots today than yam farms. Rich farmers like Gabi and Oti cultivate large plots of cassava, which are mainly for commercial purposes. For example, Oti's cassava farming in 2004 was embarked upon with the objective of exporting them to China. Therefore, cassava, like rice, is today not socially constructed as women's crop as in the past.

Respondents complained that there were occasional epidemics of mealybugs, which cause crop (cassava) failure. They stated that this is a major setback to farmers, especially poor farmers, when it occurs. This kind of structural risk clearly worsens financial insecurity of poor women. By implication, it weakens their ability to effectively participate in social networks that practice reciprocity. By extension, the ability of such women to participate in CBHI schemes may also be weakened.

### *Off-farm and non-farm income-generating activities*

#### **Trading**

Trading in farm-related products is influenced by agricultural seasons. During the rainy season, traders deal in fresh produce such as okra, pepper, local tomatoes, cocoyams, green leafy vegetables, etc., with okra constituting over 90% of the total produce being traded. They buy produce directly from the farmers, or from small-time local traders who buy from the farmers to sell to the traders who take produce to the cities to sell. The produce is transported in mini-buses or mammy-wagons to the cities. According to the informants, the major setback suffered by traders of farm produce is the lack of access roads. During the rainy season, the roads can get so muddy that the mini-buses and mammy-wagons are unable to get to Ukete. This hinders the traders from moving their products, and because of lack of



technology for preservation, the produce may get stale and the traders lose their money when this happens.

Respondents indicated that when traders lose money due to failure of vehicles to reach the village in order to buy the produce for the cities, they are often unable to buy produce for a long time. This in turn affects the local farmers who are unable to sell their produce. Indeed, a middle-aged woman, Nme, recall that she was forced out of the trading business by huge losses she incurred five years ago when she bought a large quantity of okra to take to Enugu, and heavy rainfall stopped vehicles from reaching Ukete for almost one week and she lost the entire purchase. Women who experience this type of structural risk may be put out of business for the rest of the agricultural season because of loss of trading capital. Despite the constraints, women still engage in trading in farm produce. However, informants indicated that the traders try as much as possible to refrain from buying produce when they suspect it may rain. However, predicting rainfall is often not accurate, and it remains a risk.

Traders who were interviewed indicated that the profits from trading on farm produce are usually marginal, especially if they do not belong to the retail traders associations in the cities, because they are usually compelled to sell their produce to retail traders in the cities who, as members of these associations, may sell directly to the consumers. Besides, they are unable to sell to the consumers because that would entail their staying long in the cities. According to the informants, it is actually the retailers who make real profits.

In the dry season, trading shifts to rice. Parboiled and milled rice is carried to the Orié Market where the traders buy it in measures of basins or bushels and bag it into jute bags. Unlike okra, the traders may take them to the cities same day in the vehicles or they may store them and move them to the cities later. However, informants and the researcher's own observations reveal that the traders prefer to transport the rice to the urban market the same Orié day because more vehicles come to the village that day than on any other day, and thus transport fare is cheaper. It should, however, be stated that on occasion, transport fares on Orié days are higher if fewer vehicles are available. It was observed that some women were busy buying unmilled rice, much more than would be expected for household consumption. Inquiry on that revealed that these were the *apitiko* women, the local middle-women. They would buy the cheaper unmilled rice, take it home and parboil and mill it and then bring it back to the market to sell to the urban-bound traders.

### **Gender Issues**

Naturalistic observations and interviews show that trading in farm produce is mainly done by women. Women from richer households dominate the trade compared to poor women.

There are other traders who buy and sell non-farm articles. These are mostly women. They take mammy-wagons to the urban centres, buy their wares and come back to the village, but what distinguishes them from the former category are that they do not usually have shops, but display their wares in the markets on the market days, in the village square in the evenings, and their homes. Dominated by women, they concentrate mainly on cooking essentials that are not produced in the village, which include vegetable oil (as distinct from palm oil), beans, crayfish, dry mangara fish, frozen mackerel (which inevitably defreeze by the time they are brought to the village, and have to be smoked by the women), etc.

Trading in non-farm products is also undertaken by relatively well-off men in the village. Two types of trading in non-farm products are practised in Ukete, namely, sale in grocery shops, and trading in household cooking products. The grocery shop owners typically go to the urban areas and buy basic household items such as matches, Maggi cubes, kerosene (mostly for bush lamps), soap, detergents, sweets, exercise books, pens, pencils, rulers, polythene bags, and so on. Their underlying attraction is that they are able to dispense these items in basic units which are affordable to the villagers. This type of trading is dominated by men, particularly young men. In one or two of the shops, they usually extend the front corrugated aluminium roof to provide makeshift drinking joints. Thus, beer is a significant component of their wares. In the evenings, their shops serve also as relaxation and male gossiping joints. On the other hand, women dominate trading in household cooking products. Such women go to the cities to buy articles such as vegetable oil, fish, kerosene, etc. They display their wares on stalls in the market. Of importance in this implicit gender divisions in the types of goods traded on is that men dominate high-profit non-farm goods while women are concentrated in trading on less profit-generating goods and cheaper goods. This further marginalizes women and increases the economic gap between women and men. It also implies that women are less able to make enough profits to accumulate savings or assets.

### ***Other income-generating activities***

Cassava processing occupies an important place in the income-generating activities of women and girls in Ukete. Cassava is processed in various ways in the village. One of these methods is garri processing, which the rich far-

mers prefer to invest in. Garri refers to a type of sourish grainy cassava meal. Cassava tubers are peeled and washed. They are then grated, and tied in sisal bags and allowed to undergo partial fermentation for about 3–4 days. During this period, water is squeezed out of the mass of grated cassava by placing heavy objects (such as big stones) on them. Partial fermentation is followed by dry frying, which is done in large frying pans. Palm oil may be added during the frying to produce red garri which is costlier than white garri.

There are various phases in garri processing, including cassava harvest, peeling and grating of the tubers, gathering of the firewood, and frying. Because the processing is not mechanized, it requires many hands. Labour is primarily obtained from the members of the co-resident household, but supplementary labour is gotten by hiring women and girls from poor backgrounds. However, interview respondents complained that although the jobs involved are tedious, the wages are meagre. A benevolent farmer may complement the labourers' wages by giving them some garri, but the monetary wage remains derisory. The sale of the garri, which follows the processing, is the sole responsibility of the adult female members of the co-resident household. A woman, her children and co-resident relations carry the garri to the Orié Market to sell to the traders and local folks who may not produce their own.

Apart from cassava processing women also engage in processing of oil bean (*ukpaka*). This is mostly done by women and children within the co-resident household. *Ukpaka* is prepared by splitting the pods of African oil beans. The flat roundish beans are boiled for several hours, and then soaked in water over night. The following day, the processing continues with the slicing of the bean using long knives. The long, slender slices are then soaked for about a day. The processed *ukpaka* is used locally to prepare sauces for yam. It can also be used to prepare local soup that is taken with palm wine. Sold locally in the market, it fetches little cash for the household. Women also engage in processing of oil palm and palm kernel, while men engage in palm wine-tapping. Broom-making and weaving of mats are also activities undertaken but only by very few women. Brooms and mats are not easily sold and are also quite cheap.

### 3.4.7 Intrahousehold socioeconomic differentiation: gender and generation

Gender and generational relationships within the household influence the opportunities and constraints open to the individual members of the household. With respect to generational differences in access to assets within the

household in Ukete, children are obliged to contribute unpaid labour to the household's farming activities. The type and amount of labour depends on the age and gender of the child. Grownup male children are expected to assist in the 'male' types of farm work—such as cutting shrubs, bush-clearing, mound-digging, soil cultivation, etc.—while the female children take part in the 'female type' farm work. Because they are not paid for their labour, working children still depend on their parents for purchases of personal needs.

Traditionally, male children are not given access to land for own farming until they become young adults and are preparing to build their own houses and get married. At this point, males are given plots to cultivate. But females are obliged to remain attached to their parents' household until they get married, and thus, are obliged to continue to offer unpaid labour to the productive activities of the household. Social tension begins to build up within the household as the children begin to demand for greater amounts of money or greater share of the household resources.

By the time the boys finish primary school—usually in late adolescence since they do not start going to school early—they begin to demand that rice harvests should be sold and a good proportion given to them. In a number of instances during the fieldwork, boys actually took a step further to sell rice from the household harvest, without permission from their parents. In a particular case that happened some time before the fieldwork, the boy's father in collaboration with his uncle had him arrested by the local police for selling the household rice. When the case was settled, the boy ran off to Lagos, and swore that he would never come back to the village until his father died (his mother was already dead before the incident). But during the fieldwork, in 2005, he changed his mind, and started sending remittances to his father who is now old. Boys who have finished primary school and are not moving on to secondary school start trying to raise money to commence petty trading. They may work as paid labourers on other people's farms. Preparations for onward movement to the cities for apprenticeship or to seek informal sector jobs start in earnest. Meanwhile, their female counterparts are socialized for marriage, though a small proportion now join secondary schools. Among the youth, the differences in gender in regard to migration and engagement in urban productive activities (in the formal or informal sector) are an indicator of the social reproduction of unequal gender opportunities.

Between the married partners in the household, economic opportunities open to the woman depends on her bargaining skills and also on the socio-economic position of the household. But the latter takes precedence be-

cause of the nature of pooling of resources among household partners in the community. Women in monogamous marriages from land-rich families have greater economic opportunities than women from polygynous households. The reason is fairly simple. In monogamous households, the norm is for a woman and her husband to operate joint farms, but in addition to the joint farm, the woman also cultivates her own farm where she plants any crop of her choice.

The norm is that men do not demand the money generated by women through own productive activities; and that women are entitled to keep such money. Keeping the money would give them power and control over their own lives and that of their children. However, women live in the face of many contradictory norms. Therefore, in an apparent bid to live up to the normative gender stereotypes of being the hardworking and enterprising women, they surrender their revenues to their husbands. This could be in bits as they make the money or it could come in bulk at the end of the harvest season, which is celebrated with close family members and friends. If the woman knows that her man is nursing the ambition of building a new house or taking a status title, she announces to their small gathering that she is giving her man the money (a named amount) to build a house or take a title. Although there may be no direct exploitation, women's assets are appropriated indirectly through their unpaid household and farm labour, and by the fact that, normatively and in practice, they are responsible for the purchases of everyday cooking ingredients and for health care of their household members; the daily expenditures may, over time, impair the ability of the women to diversify their income. On the other hand, the social construction of health care as women's responsibility has implications for their participation in generalized reciprocity social networks. It suggests that women actually need to participate in mutual aid risk-sharing schemes, including community-based health insurance schemes.

### 3.4.8 Consequences of inequality in access to land

Land has very important implications for wealth. The rich landowner who is industrious cultivates many plots of land and plants diverse crops yearly. The diversity of crops, in addition to being a source of cash, also serves as a type of insurance, for if one fails, he gets his harvest from the other crops. Almost every rich landowner can also afford to plant yams, which are becoming increasingly expensive to plant. He plants rice for consumption and for cash. The well-off landowners are also able to cultivate rice on large plots of land. In 2005, a *basin*<sup>4</sup> of rice sold for 250 Naira, early in the harvest season (about November). In the post-harvest period, between March and

May, the price of a *basin* increased to 400 Naira; a bushel went for between 1200 and 1700 Naira. One landowner, Gab Imoh, cultivated 49 *oke* of land and harvested 184 bushels, that is, 460 *basins*. As a landowner, he did not have to pay for land lease and in fact, he earned from leasing out some *oke* to tenant farmers. He did not state how much he realized from the lease, but conceded that it was enough for him to pay for the tilling of the soil and to buy fertilizer for his rice field. His tenants also assisted in the harvesting; two of his female tenants each contributed two days of work as members of rotating labour associations. There are other ways landowners benefit from their tenants; for example, each tenant brings a specific measure of the harvest to the landlord. Each of Gab's 18 tenants brought a *basin* of rice for each *oke* on lease for that season which was not an unusual practice. Gab Imoh is indeed a rich farmer, although farming is not his primary occupation. The case of Gab Imoh brings to the fore the economic leverage enjoyed by larger landowners in the village. It shows that land provides means of getting income from agriculture, acquiring assets, and educating one's children.

### *The case of Gab Imoh*

Gab is a teacher by profession, and was the first indigenous head teacher in the village primary school. He is educated to the level of National Certificate in Education (NCE), a level just below Bachelors degree.

Gab owns a house, which is situated in the same big compound where his father's is. His father, whose age Gab put at 80 years<sup>5</sup> at the time of the fieldwork, was a rich farmer, and one of the large landowners. Though the old man could not personally do the farm work in his old age or even supervise his workers, he carried on his farming up to the time of data collection for this study. His children had to do the supervision of the farm work. Gab's father was said to have had contacts with the Catholic missionaries who came to the village. He was one of the few initial converts to Christianity and had also had some primary (then called 'standard') education. He rose to become a catechist of the St. Luke's Catholic Church in the village. His association with the Catholic priests who visited the village, and his trips to the parish headquarters in Awgu had served as impetus to send his children to school. He was a large-scale farmer, by the standards of the village, and could produce enough yams to fill the two mammy wagons in which he took his yams to the urban areas to sell in the 1970s. Two of his children have attended higher education institutions, including Gab.

Gab rides one hour daily on his bicycle to Oduma for his teaching job. He chooses to live in his own house in Ukete, though quite distant from his

working place. Living in Uketé allows him to coordinate his farming with his job as a teacher. Upon returning from his job, he has his lunch, and together with his wife, they take off for their joint farms. In addition to their joint farms, his wife also has her own farms where she plants okra and other vegetable crops. But unlike many men here, Gab himself does not have a separate farm. He spends time on his school work when they return from farm, while his wife prepares supper with the children. Mr Imoh is one of the largest rice farmers not only in Uketé, but also in Oduma. The villagers who had participated in poverty and wealth ranking rated Gab and his sibling as a wealthy member of the community. In his father's compound are found two brick houses, which are plastered, and roofed with corrugated aluminium sheets. One of the houses belongs to Gab and the other belonged to his father, who died in 2005, after the fieldwork. Gab's own building, which has many rooms, also has a modern ceiling with ceiling boards. The floor is cemented and plastered. One of the rooms in Gab's building serves as storage for the harvested crops. In one of the visits to Gab, two women were observed negotiating the purchase of raw rice with him and his wife. It is well known that not only could one purchase raw food stuff from the Imohs, people could also take out loans for different purposes from them. Such debtors were known to contribute labour to the farming of Gab's father and Gab seems set to follow suit.

After the 2005 rice harvest, Gab bought a generating set during a visit to Lagos. His household already owns a television, cassette player, radio, bicycle, plastic water tanker, sewing machine, kerosene stove, among other assets. His younger brother, who is an urban migrant, owns, among other assets, a motor car and a two-storey building in a compound quite close to the obi of Imoh.

It may be pertinent to present yet another case which illustrates the influence land has on wealth acquisition and on education. It is a case of Oti Sohil, who was listed during the wealth and poverty ranking exercise as rich. Oti's father, Sohil, was one of the Umunwedu landlords. Though not a very wealthy man, Sohil had used proceeds from his land to educate his children. Many of his children are university graduates, and two are lawyers.

### *The case of Oti*

The first son of the family, Oti, has had secondary school education. He lives in a well-furnished brick house with corrugated sheet roof and plastered walls and floors. In the 2004 farming season, Oti's farming was geared towards commercial farming, with a plantation containing 2600 mounds of

cassava. He said he wanted to take an advantage of the scheme introduced by President Obasanjo to encourage local farmers to export cassava to China. However, he was not able to complete the processes required by the Nigerian Export Promotion Council (NEPC) to be able to participate in the scheme. He also cultivated 41 oke of rice, with a very large harvest, totalling 160 bushels (400 basins). He once owned a motorcycle, though when it got old he did not replace it because, according to him, he is sending his children in the best schools in Enugu. He owns electronic appliances, a bicycle, kerosene stove, a plastic water tank; and he is the chairman of the local branch of the Development Union.

The two cases illustrate the importance of control over land in helping landowners to expand both their farm and non-farm income-generating activities. In these cases, Gab and Oti accumulate cash which they reinvest in farming, and in the education of their children, which is a kind of generational trend. In addition to the social reproduction of the mechanisms of capital accumulation and human capital investment (education), the two men also have high social status in the community. Gab rose to become the first headteacher in the Community Primary School, while Oti was once the chairman of the local branch of Ukete Development Union.

In the wealth ranking exercise by the villagers, there was a consensus among the participants that most of the students in the secondary schools in the community belong to the households of landowners, so also university undergraduates and graduates. The children of the rich landowners stay longer at school, attend better secondary schools, and have better chances of moving up to the tertiary institutions.

The implications of being rich as a landowner for women's participation in mutual aid schemes such as women's associations (and thus community-based health insurance) are also evident in these cases. The wives of Gab and Oti demonstrate this. Gab's wife, a secondary school graduate, belongs to two different women's social networks in the community. She is the secretary of Catholic Women's Association and also a member of Umuchu Women's Association. Similarly, Oti's wife belongs to these two social networks.

Consequences of lack of access to land are quite common and may be severe. The landowners appropriate both cash, crops and labour from the landless. Landless people pay not only the annual lease cost, but are furthermore obliged to give an agreed fraction of their harvest and often to contribute labour to their landlord's own farm. The conditions are harsher for sharecroppers. Frequently, the individual labour or household labour of



sharecroppers are not deemed sufficient to satisfy the conditions of the contract; consequently, the sharecroppers must engage their rotating labour associations or other groups to which they may belong to work on the farms of their landlords.

The poorest households in Ukete are almost invariably landless, but this does not mean that every landless household is very poor or even poor. But landless households are more likely than landowning households to belong to the poorest group. The poorest may have their own houses which have mud walls and thatched roofs, but almost invariably, they are circular in form, and they may have only one tiny window or none at all. Wooden stools constitute their basic furniture. The children of the landless and other poor people tend to drop out of school, and at quite an early age, either before finishing primary education or immediately after its completion. To this group belong Ngwama Nnadi's household. Ngwama's case illustrates how landlessness brings about impoverishment, deprivation and lack of education (inability to educate one's children).

#### *The case of Ngwama Nnadi*

A middle-aged woman, she is married with six children (five girls and one boy). Three of her daughters dropped out of the village primary school without getting to the fifth grade, and got married to men from Oduma. The fourth daughter was in the fourth grade during field research, and the fifth daughter was in the second grade. The last child and only son was yet to start school, at seven years of age. Ngwama is uneducated, and combines subsistence farming with working as a hired labourer on other people's farms. Her husband, Ikpendu is a man of many skills. He knows how to thatch roofs, but with the decreasing trend to use thatch for roofs in the village, at present he gets less contracts for roof thatching. Roof thatching is a business undertaken during the dry season, during which Ikpendu also works as a labourer on farms, helping with the harvest of yams and rice. The couple sometimes take common farm labour contracts. At other times, they individually seek out whatever labour contracts they may get, especially towards the end of harvest when labour hiring reduces. Ikpendu also does hunting of bush meat, such as nchi (grasscutter) and bush rabbit (ewi). The catch is purely for cash, but the money realized from sales is dwindling significantly since bush clearing progressively leads to less catch. Ngwama, assisted by her young daughters, makes brooms from palm fronds provided by Ikpendu.

During the rainy season, the members of Ngwama's household change their strategies to fit in with main livelihood activities of the season, which

are cultivation of soil and planting of seeds, transplanting of seedlings, weeding, fertilizer and herbicide application, etc. Years of labour on people's farms have earned Ngwama a reputation as a hardworking woman. She is hired regularly for weeding of yam farms, cassava plots, rice fields, etc. Her reputation ensures that she does not lack menial jobs and casual labour on the farms. She recently decided to join her husband to till soil for other farmers, a job that used to be almost exclusively reserved for men. Ngwama also attempts to get some income by assisting other women in processing their palm fruits into red oil, a job that pays very little.

Ngwama and her husband take annual sharecropping from Lazarus, one of Okoro's children. Okoro was one of the rich landowners, possessing the greater proportion of the farmland which lies on the approach to Ukete from Nenwe. Through this arrangement, they are able to plant cassava, cocoyam, okra and other vegetables such as pumpkin, amaranthus, garden egg, etc. At home, Ngwama keeps two hens which she hopes will breed some chicken for sale at Christmas.

Lack of access to land could put the poor in difficult positions when they face calamities. For poor women, their impoverished position becomes worse. The case of Ugochi Makuo is presented to show the links between landlessness, impoverishment and protracted indebtedness.

### *The case of Ugochi Makuo*

Ugochi Makuo is a 35-year-old widow, with four children who are still young, aged 14, 11, 9 and 5 years. She lives in a mud house with thatched roof. Ugochi dropped out of primary school after grade two, and went to be attached as a dress-making apprentice to a woman from Obeagu Oduma. Her parents could not complete the payment for the apprenticeship, and she had to abandon it. She continued farming with her parents until she got married to her late husband, Calistus Makuo, a primary school dropout. Calistus was from a landless family, and had dropped out from primary school to learn trade in Onitsha, on the arrangement that after serving his master, he would be 'settled' by his master. This means that his master would give him financial support to start his own trading business. As often happens, in his seventh and last year of service, his master picked a quarrel with him, accusing him of stealing his money. Nobody knew whether this was true or not, but there was gossip that the money Calistus used to marry Ugochi might have been taken from his master's shop. Calistus was thus sent away without 'settlement'. He hung around in Onitsha with friends for a while, hoping to find work. Without success, he returned to the village. Supported

by Ugochi, he started out doing casual farm labour, then went to sharecropping and borrowing to lease farm plots. He later learned to be a bicycle mechanic from a man from Oduma. In his sixth year as a bicycle mechanic, a calamity befell his household. There was no money to take him to a hospital. Calistus' parents were already dead. Ugochi recounted her experience,

We had only his bicycle and the few tools he used to work. Nobody was interested in buying the tools. We sold his hoe and machete, but the money did not amount to anything. He became more and more sick. I ran around for loans but I could not borrow from anybody. A neighbour advised me to seek assistance from her association, in the form of a loan. When I went to them, the leaders told me that I was not a member but they would give me the loan because I was referred by one of their members. However, I needed to provide collateral, and I would have to add 50 Naira to every 100 Naira per month. We had none of the materials acceptable to them as collateral, and so I could not get the loan. My husband was ill for six months, and died in this house. The worst is that we had not completely paid off the debts we owed to our landlord when my husband fell ill and died. The man would not forgive us, and I am still paying the debt up to this day. I use the little money I get from selling okra cultivated through sharecropping arrangement to pay the debt. This makes me unable to save to lease land and farm so that I will be able to feed my children. Now, I frequently borrow small things like salt, palm oil, and garri because of these problems.

Indeed, it is much more difficult for women to borrow from moneylenders when their husbands are incapacitated if the husbands are not landowners. Landlessness had already rendered Calistus and his wife incapable of absorbing shocks on account of their deprived status. In Ugochi's case, though other moneylenders did not lend them money, they were able to borrow from their landlord since they had maintained good relations with him. The amount borrowed was too meagre to take Ugochi's husband to the hospital, yet it has been difficult for her to pay back, and the landlord would not forgive Ugochi the debts after her husband's death. She is caught in a situation in which she is struggling to pay her debts and therefore unable to save money to lease land for farming.

This case also shows the implications of landlessness and deprivation for participation in mutual aid schemes. Ugochi told this researcher that she felt she was too poor to join a women's association, which could have provided her a loan to take her husband to the hospital.

The cases of Gabi and Oti, and Ngwama and Ugochi illustrate the stark differences in wealth (and/or poverty) caused by inequality in ownership

and access to arable land. The cases show that while the landless poor suffer worsening deprivation, the landowners use their land to further improve their material and educational status. This is a pattern that is likely continue if not worsen in the future. The reason is found in the trend of the price of farmlands.

The general trend presently is an annual increase in the costs of farmlands. Both landlords and tenants anticipate a rise each new agricultural season. In the 2004 farming season, an *oke* went for between 3000 and 4000 Naira, depending on the location and perceived soil fertility. In the previous year, tenants had paid 1500 Naira for an *oke*, while *oke* in choice fertile areas went for between 2500 Naira and 3000 Naira. This amount is reported to be beyond the reach of the poorest women. Therefore, many couples from these categories who availed one *oke* or two got themselves indebted either directly to their landlords or to other individual creditors. The debt cycle is a vicious one, with indebtedness frequently leading to more debts and more expropriation of debtors' labour by their creditors. This is further aggravated by the fact that such poor women do not belong to the type of associations that might lend them money without interest. They also lack assets such as electronics, transport facilities (motorcycles and bicycles) or productive assets which they could sell or which they could use as collateral.

### 3.4.9 The contexts of financial risks to Ukete women

Economic decline, poor crop yields, higher costs of land lease and the need for farm inputs and their rising costs are by no means the only factors that contribute to the financial risks among women in the village. Being a status-seeking society, every woman seeks to show to the society that they are doing well. No woman wants to be regarded as too poor to do what other members of the society do. This attitude of status-seeking in a society which is economically heterogeneous is certain to leave some members of the society more deprived and more financially insecure. In Ukete, villagers attempt to conduct life-cycle events at 'befitting' village standards and celebrate festivals on terms that will show the society that one's household is not worse off. This was noted during FGDs and interviews to worsen the deprivation and vulnerability of poor people. It is argued that these contextual social events, norms and principles frequently lead to increased financial insecurity, such that by the time the poor are faced with adverse health care situation, they are already economically incapacitated.

## *Life cycle-induced financial risks*

### **Childbirths**

Among Ukete people, the arrival of a newborn is a big social event, because it is taken that the child belongs not only to the immediate household but also to the entire village society, as expressed in their saying, '*Nwa bu nwa ora*', (a child belongs to the entire society). Social norms prescribe that every member of the woman's (and her husband's) extended family and friends living within a reasonable distance (including those from surrounding villages) should come to celebrate with the household in which a child is born. Members of associations to which the woman belongs may come singly first to extend their good will, and secondly, the association may send a delegation to pay a formal visit to the household.

However, the celebration of such an event in a household (that is, childbirth) may turn out to become a serious financial risk to poor women. The social context of childbirth may precipitate financial crisis that could lead to vulnerability. Besides the brief visits from kin and friends, the woman's mother is expected to come to stay with the woman who has given birth, ostensibly to take care of her and her new baby. This particularly applies to young women during their first to third childbirths, but there are no hard-and-fast rules about it. What is noteworthy, however, is that whether or not the visiting mother comes any gifts, there are clearly prescribed gift items which the couple must buy for her on her departure. These include high quality textile fabrics (between N800 and N3000 per cloth), dry stockfish (N1500), tobacco snuff (if she chooses), and cash, in appreciation of her giving birth to the young mother who has given birth to a new baby, and for coming to coach her daughter on child care and norms of family life. It is expected that at the very least, a young man should give his mother-in-law N5000 when she is leaving after the visitation. The husband's mother could play the role of this special visitor if the wife's mother is unavailable (usually by death). The visit is called '*omugwo*' in folk parlance.

Furthermore, some couples also organize child presentation ceremonies, usually on the twentieth day of confinement or thereafter. This typically entails invitation of family members, friends, members of associations, church members, and so on. Based on norms and principles of social relations within the extended family, it is not necessary to formally invite extended family members the way others are. They are automatically welcome on the basis of their membership of the extended family.

Child presentation is by no means inexpensive, the very reason for which not every couple does it. The costs of drinks and food have been conservatively put at 10,000 Naira for low key celebrations, and up to 25,000 Naira

for lavish celebrations. Some women tried to justify the expenditures, arguing that it is more about social than about economic benefits. Socially, they said, it affords them the opportunity of establishing their social status, renewing old social ties, and possibly establishing new ties. These ties may become handy in dealing with adversities in the future. While that may be true, such heavy expenditures may weaken the financial ability of poor women to take part in mutual aid schemes. This is because even though the women receive gifts in cash and kind during such celebration or lifecycle events, the value of the gifts are usually a far cry from the money spent on the social events. A naturalistic observation conducted during the child presentation ceremony of Mrs Enyidiya Ogbonna revealed that the gifts are rather tokenistic. In fact, women who were interviewed during the ceremony about gifts conceded that the gifts do not compensate for the expenditures. A possible outcome is that celebrants will incur financial losses. Thus, paying back loans taken to organize the event, as in some cases, would further deepen any financial crisis. Where loans are not taken, money spent on the event will definitely not be available for productive investment by the household, nor for health care seeking. For poor women, this kind of expenditure makes it more difficult for them to take part in mutual aid schemes like community-based health insurance.

### **Marriage**

In the past in Ukete, it was the responsibility of parents to choose spouses for their children, and to find wives for their sons to marry. Today, this is no longer so, as young adult males and females make their own choice of life partners. Young men too have to contribute the largest proportion of the costs of their marriage. Marriage is a long and iterative process between two families and not merely between the bride and the groom. What follows is a brief description of the procedures in Ukete, and how and why it may lead to deprivation.

In a nutshell, a young man spots a girl of his choice. He discloses his intention to the girl and if the girl gives her consent, the process starts when he discusses his intention with his father or guardian who then takes a keg of palm wine to broach the matter to the girl's parents. This is followed by a cascade of visits, negotiations, and re-negotiations, culminating in the payment of the bride price.

During the many visits, the suitor and his family are given a list of both cash and material requirements for the different phases of the marriage rites. Each list is for a specific visit and contains, among other things, a wide variety of assorted drinks (local gin, modern whisky, beer, palm wine and soft drinks which are locally called minerals) and food items for the entertain-

ment of the guests. But while the suitor provides the raw food items, the women on the bride's side do the cooking. Some bride's families have been known to go to the extent of charging the suitor for the labour costs of the food preparation. There was the story of a bride's family which charged the suitor for the labour costs of the cooking, but it was later discovered that in fact the women did the cooking on a reciprocity basis rather than on paid-labour basis.

The cheapest estimate for marriage, not including the church wedding, is more than 40,000 Naira, if cash, materials, farm and non-farm labour put into the process are factored in. With an increasing inclination to church weddings, the cost of marriage is put grossly at over 80,000 Naira. Though these are high costs, respondents argued strongly that they have one of the cheapest marriage processes in Igboland, an assertion that was confirmed by interviews with people from other areas. Yet, given the economic context of Ukete, such costs are well beyond the financial capacity of the ordinary villagers. Therefore, to meet these costs, families have leased out their own farmlands, borrowed money with high interest rate from moneylenders, sold valuable productive assets, etc. Ironically, villagers reported that it is easier to borrow money from moneylenders for marriage than for health-care seeking. Apparently, the young couple constitutes assets which could be exploited by the moneylenders. The couples are usually able-bodied and could therefore be used as a cheap source of labour on the farms, as a way of partial loan repayments. Moneylenders are also well aware of the practice of gift-giving to the new couple by the parents, friends and relatives, who give them individual and collective gifts such as sewing machines, bundles of aluminium roofing sheets, radios, cassette players, bicycles, etc. These could be appropriated by the moneylenders at their whim in the event of failure of repayment of loans, even if they had not been mentioned at the outset as collateral for loans. Therefore, the marriage process often leaves not only the parents of the new couples but also the new couples themselves in difficult economic positions. Respondents stated that many a new couple started their newly married life on a platform of indebtedness. Thus marriage constitutes a life-cycle risk to the poor. Although Wright et al. (1999, cited in CMF 2000) hypothesize that a life-cycle risk such as marriage can be handled ex-ante, evidence from Ukete shows that the poor are hardly capable of making ex-ante preparations for handling these risks. This indicates then that the capability to make ex-ante preparation for marriage as a life-cycle risk is a function of the social and economic status of the individuals involved.

The financial risk resulting from marriage expenditures may have consequences for participation in generalized reciprocity social networks and in CBHI schemes. Indebtedness will most probably pose difficulties to a newly married woman to join such a scheme and to pay her contributions. Yet, her need for such mutual aid schemes for health risks increases once she marries and starts bearing children.

### Deaths and funerals

The attitude of Ukete people to death and dying can be described as ambivalent. Terminal illness, dying and death involving a person who is not elderly is viewed with grief, sorrow, and bitterness. It is different in cases when the deceased is of an advanced age. It is not infrequent to hear an elderly woman or man joking openly that their peers have gone and that they look forward to joining them soon, without such a statement provoking serious reactions such as sadness. In fact, when such elderly people die, the reaction to their passage is not grief and crying, as for younger people, but preparations to celebrate their passage.

The funeral of a young person who has not married or who is married but without a child is as brisk as it is grief-laden. No sooner has the person died than the family and friends arrange for the digging of the grave and the interment. The associated costs derive from alcoholic drinks taken by the young men who carry out the grave digging.

However, when an elderly man dies, the children, in consultation with the extended family, quickly fetch the village drum-beater, who subsequently announces the person's passage by a special tune of the drum. It is celebration. Virtually every notable palm-wine tapper in the village is immediately contacted for any available palm wine, and to place orders for the coming days. The *umuada* and *ndiyom* gather together in the bereaved home; they also contribute food items such as yam, foofoo, garri, rice, etc. In the case of a woman, drum-beat is not used to announce her death.

In contrast with surrounding villages, there is no formal wake-keeping. While the body is being prepared, and other arrangements are being made for the interment, people troop in and out, while the extended family members spend the nights with the bereaved household. The interment takes place and is over, but the festivities continue, according to the capacity of the household. There is usually yet another funeral rite. This second rite is more expensive than the first burial rites. In Ukete, there is a strong ritual connotation to it, and so only some traditional worshippers care to do it. The churches strongly disapprove of it.

It is observed that there is much more extended family solidarity in the handling of funeral costs than in handling of health care costs. Extended



family members contribute money, materials, food items and physical labour for funerals. It is not uncommon for some members of the extended family (usually women) to stay for days with the bereaved household, assisting in everything from cooking, serving meals, fetching water, fetching firewood, sweeping the compound, to going to the farm to dig up yam, cassava, and cocoyams for the event. However, interviews with the *Igwe* and members of his traditional cabinet reveal that despite extended family solidarity, a bereaved household spends approximately N15000. If the household is rich, they may spend as much as N60000 or even more. It can therefore be inferred that the status-seeking attitude makes the rich attempt to satisfy what they perceive is the society's expectation of them during such events as funerals.

Despite solidarity and support from kin and agnates, death and funeral costs constitute severe financial risks for the bereaved poor households: they may slide into dependency as they struggle to offset their debts and secure their livelihoods once more. This is worse still when it is the woman who survives a man, because of the economic difficulty which accompanies widowhood. I observed that relatively few widows belong to mutual aid women's associations. Women who belong to such associations were found to possess certain characteristics. They have grown up adult sons, or they are from rich households, and they also tend to be in the older age group. This suggests that it is such women who may not be easily driven into severe deprivation by expensive funeral rites. In the final analysis, cutting down on the expenditure on funeral rites in this village may enable poor women to join mutual aid schemes such as community-based health insurance.

### *Festivity-induced financial risks*

In Ukete, the villagers try not to be left behind in social events that involve the whole society, whether modern or traditional festivals, despite the many uncertainties that confront them. Modern festivals include Christmas and Easter, while the traditional ones include the *Omwa-asa* and *Iri-ogba*; but other ritual festivals are also celebrated such as the New Yam festivals, the extended family festival of ancestral worship, etc.

Christmas, Easter and *Omwa-asa* are celebrated at a higher profile level (widely and more expensively), and every household seeks to celebrate it as much as they can, both at intra-family level and within the village community. A brief description of Christmas celebration is illustrative of how it may turn out to increase the deprivation and vulnerability of poor households.

New clothes, popularly called Christmas uniforms, are sewn for both adults and children, since everybody must appear in their Christmas uniforms while attending Christmas church services (for Christians), while strolling out singly or in groups to watch masquerade display, and while visiting with friends and kin, or receiving and entertaining guests in their own houses. Guests are usually many and frequent and they are usually entertained with varieties of food, snacks (traditional and modern), palm wine, beer, soft drinks, etc.

As each woman and her household set out early in the morning to prepare rice, stew, soup, garri, foofoo, fried meat, etc., they seek to prove to their guests who would normally start coming in later in the day, about the time the church services would be over, that they are equal to the task of the expected Christmas entertainment. The rich kill goats, or sheep or pigs, while the less rich make do with fowl from their own stock or they buy from the market. It is a sign of being the poorest of the poor not to cook meat at Christmas, or better put, not to entertain your guests with meat, particularly if the household also fails to cook frozen mackerels they popularly call 'friji' (fridge, to denote that it is frozen), brought in from the urban traders by village traders. Women try to cover up the deprivation and not to be labelled miserly or too poor to celebrate Christmas.

Most adult visits are planned and prepared for, whether the visit is between agnates, kin or friends. The village norms of gift-giving and entertainment prescribe that the adult visitors should take a gift along with them for their hosts. However, what the guest presents to the host depends on the strength and intimacy of their social relations, the social and economic status of both the host and the guest, and the gender of the parties involved. On average, a male guest usually adds to his pack of gifts, alcoholic drinks (either beer, gin, or most popularly palm wine). A female guest may bring, among other things, a dish containing cooked food considered desirable and delicious by village standards.

A couple or an individual adult who, by reason of a specific social arrangement, is a guest at another home invariably has to go home to play host to his own visitors who could be anybody but usually not his immediate past host that day. The norms of visitation and reciprocity, however, are such that the wealthy and the powerful are more often hosts than guests. Villagers reported that this is because it is on such celebrations that their clients (in patron-client relationships), leasehold tenants (for landowners), beneficiaries, god-children (and their parents) and so on, often go to express their gratitude to their benefactors (the wealthy). It is also the wealthy who receive non-edible items such as clothes as well as agricultural items that

have not been cooked, such as goats, cocks, yam, beans, rice, etc., in addition to the usual cooked food and alcohol as gifts. In turn, they entertain their guest 'lavishly' by village standards, and implicitly or explicitly pledge their continued benefaction and support to their guests of lower status. Of course their promise is not binding, and their guests are not ignorant of that.

While the villagers look forward to each festival and approach it with apparent excitement, the festivals (particularly Christmas) often leave a trail of financial dearth, adversity and dependency. While they satisfy the social and cultural yearnings of the villagers for a break from the hoe-based toil, and for maintaining and strengthening close social relations within their social networks, the financial risks and their consequences are palpable, often not long after the celebrations. The heavy expenditure also affects the ability of the poor women to handle health costs, if they arise.

It may also reduce the capability of poor women to take part in mutual aid schemes (CBHIs). As in the other instances, cutting down on the costs will free money for participation in community-based health insurance. On the part of the CBHI institutions, explicit consideration should be taken of the financial insecurity and fluctuation caused by these life-cycle events and ceremonies.

### **3.5 Conclusion**

The chapter introduced the reader to the Igbo society in Nigeria. It gave a brief description of the organization of the social structure in the Igbo society. It then focused on the study community to bring out the essential features of the place of women in the economic and social organization of the village life. The salient findings of this chapter are:

- i) The chapter depicts a rural community in economic decline. It shows the relationship between women and land, the key factor in social and economic differentiation in the community: women do not own land get access to farm lands through their husbands or brothers. Otherwise they have to pay rents to get plots of land to farm, a particularly problematic experience. In spite of these constraints, the majority of the women still engage in farming. Gendered construction of crops as women's or men's is fast disappearing.
- ii) Women from well-to-do and rich households are able to diversify into off-farm and non-farm income-generating activities. Better-off women engage in trading of farm produce and also of consumption

goods that are not produced in the community. Poor women augment their income through paid labour on farms and in non-farm activities.

- iii) Women's vulnerability in facing health risks mainly arises from social construction of gender division of health expenditure which makes women responsible for purchases of basic cooking ingredients and medicines for health care. This may threaten the financial security of poor women.
- iv) Women's financial security may also be threatened by the nature of expenditures on life-cycle events and ceremonies, which constitute serious financial risks to poor women and their households. There is a propensity among women and their household to try to protect their pride by expending more than necessary during life-cycle events and ceremonies. The effects of these are especially felt by poor women.
- v) Factors that constitute financial risks to women also affect their ability to participate in generalized reciprocity social networks, and thus their ability to take part in community-based health insurance schemes.

Having provided the contexts for understanding women's health-seeking experiences, the next Chapter (4) of this study will describe the levels of health-care providers where Uquete women and their household members may seek care. It will then present initial discussions on the constraints faced by the women in their health-seeking attempts.

## Notes

<sup>1</sup> There have been controversies over the use of the terms 'Igbo' and 'Ibo'. The early European writers preferred to use the latter (see, for example, Meek 1937). Following their European academic mentors, early Nigerian academics used the term 'Ibo' which was much criticized. In the words of Isichei (1976: no page): 'The overwhelming majority of the Igbo now prefer the form "Igbo", which they regard as indigenously, in contradistinction to the inaccurate "Ibo" of colonial days.' In agreement with Isichei, and also, '[o]n the grounds that people should always be referred to by the name with which they prefer to describe themselves' (ibid: no page), I will use the term 'Igbo' in this research. (See also Uchendu 1965: 3 and Basden 1966: xxi.)

<sup>2</sup> Eke, Orie, Afor and Nkwo are the names of the days of the Igbo market week, which are usually four days, but could also be eight days in some com-

munities. In Aninri, the markets hold on Orié during the dry season, and on Eke and Orié during the rainy season.

3. In rural areas of Sub-Saharan Africa, besides being used for farm and agricultural non-farm purposes, land could serve as a source of social security, being given as a form of security to obtain loans and other assistance. However, the system of communal land tenure in the rural areas has raised doubts on how effective this social security function could serve the poor, in a period when the clash and/or fusion of modern and traditional values are exposing the poor to new types of oppression by the richer, more powerful fellow villagers. Van Donge has questioned the practicality of the assumption that the communality of claim on land ensures access to it, and that consequently, land could serve as an important source of social security, 'as people are guaranteed a fall-back position in times of economic hardship, and consequently, it is argued, individual tenure is resisted with good reason' (van Donge 1999: 50). Van Donge goes on to argue that, 'This presupposes, however, that the communal claim on land is secure, but that is not the case if the processes through which land can be claimed are not secure. People may profess that land is a source of social security, but such a statement does not reflect reality' (van Donge 1999: 50). Indeed, van Donge's caveat over the unquestioned assumption of the notion of land as a social security is very relevant to Ukete. Increasing human pressure on land is bringing up new angles to the claim of land as social security in the village. Land may indeed be a source of social security in this village, but clearly the poor members of a lineage who actually need land as social security are frequently sidelined by the wealthier kin members.

4. A *basin* is a local measure used by the villagers for rice and other farm produce, and two and a half *basins* make up one bushel

5. This is a guess as no birth registry ever existed in Ukete and his illiterate grandparents did not record his father's date of birth.

# 4

## Health Care Providers

### 4.1 Introduction

This chapter analyses the different levels of health care institutions where people from the study location could seek care. It starts with discussion of the national health system in Nigeria, including rationalization of health care and gender dimensions of the rationalization. It examines the dynamics of seeking care at the lower level of health care providers (namely the patent medicine vendor/village midwife and the traditional birth attendant) and the higher levels of care (primary, secondary and tertiary health care facilities). It analyses and describes the constraints faced by the people under study, especially the poor, in seeking care at the different levels. It argues that poor women and their households usually have no household savings and when they need to seek care, they explore various avenues to obtain the necessary funds, often without success. The relatively well-off families still find health-care seeking difficult because of the amount of money involved; however, they might be able to obtain money as loan from associations to which they may belong.

Health care providers (traditional and modern) to which the villagers can resort for treatment of illnesses are classified in this study into two major levels: lower and higher level health care providers.

After this brief introduction, the chapter discusses the lower level of health care providers, then the higher level of health care providers, and then ends with a conclusion.

### 4.2 National Health System in Nigeria

Nigeria possesses a pluralistic health system which includes both traditional medicine systems, modern health systems and the ‘in-between’ activities of patent medicine vendors. The traditional system is very diverse with various types of practitioners employing different methods and materials. The na-

tive doctors (*dibia*) use divination and traditional herbs and roots in their practice (see Arinze 1970). The traditional birth attendants are concerned with pregnancy and childbirth while the traditional bone healers focus on bone fractures (Ojanuga and Lefcowitz 1982; Onokerhoraye 1984).

The modern health care system includes both public health system and private health care system (private-for-profit health facilities, and private not-for-profit health facilities run by churches [mission hospitals]). According to the National Policy on Health, 'There is a three-tier system of health care, namely: Primary Health Care, Secondary Health Care, and Tertiary Health Care' (Federal Ministry of Health, no date: Internet).

*Primary Health Care:* This level of care is largely provided by the Local Governments. The local governments receive technical and financial support from the state ministries of health and within the overall national health policy. There are also private health facilities at this level of care.

*Secondary Health Care:* Secondary health care facilities are responsible for provision of specialized services to patients who may be coming to the health facilities on referral from the primary health care level. Facilities at this level of care provide general medical, surgical, paediatric and community health services. Secondary health care facilities are found at the district, divisional and zonal levels of the states. They also provide supportive services such as laboratory, diagnostic, blood bank, rehabilitation and physiotherapy.

*Tertiary Health Care:* This level consists of highly specialized services provided by teaching hospitals and other specialist hospitals which provide care for specific diseases such as orthopaedic, eye, psychiatric, maternity and paediatric cases. Appropriate support services are incorporated into the development of these tertiary facilities to provide effective referral services. Similarly, selected centres are encouraged to develop special expertise with respect to modern technology to serve as a resource for evaluating and adapting these new developments in the context of local needs and opportunities.

There is also the non-formal health care system dominated by patent medicine vendors. As will be seen in Section 4.3, the services of the patent medicine vendors are heavily utilized by the poor and rural dwellers.

#### 4.2.1 From free services to rationalization

The public sector health services were derived from the colonial era, and in the immediate post-Independence era, were largely urban-based and mainly focused on provision of curative services. In the first decade after Inde-

pendence (in 1960), the public sector health system enjoyed rapid growth which was boosted further during the oil boom period in the 1970s. There were remarkable increases in the number of health facilities, equipment and staff strength. New training institutions, including university teaching hospitals were established. Health care services at all tiers of health facilities were free of charge. There were no charges for medical consultations, admissions, surgical operations, antenatal care services and deliveries, etc. Patients on admissions had free feeding and nutritional care (Alubo 2001).

Alubo (2001: 314) observes that public sector health care provisioning started experiencing difficulties from 1984. The crisis was characterized by shortages of drugs, medical equipment, laboratory reagents, and trained personnel. Alubo argues that the crisis in the health sector was a reflection of Nigeria's overall underdevelopment, especially her dependence on imports to run her medical services. Consequently, when national economic crisis occurred and affected Nigeria's foreign exchange, it impaired the government's ability to import medical consumables and equipment. The crisis in the health sector was therefore a reflection of the deeper national macro-economic crisis.

To contain the crisis in the health sector, various government regimes since 1984 have introduced a number of policies including introduction of user fees (see Section 1.3) and rationalization in the health sector (Alubo 1990). *Rationalization in this context refers to the introduction of changes in the health system to reduce costs and improve efficiency of the system.* Rationalization of the public health sector was also necessitated by excessive bureaucracy and lack of skilled management which crippled public sector health services. Funding health care provisioning through tax also posed a threat to the public health sector (Ogunbekum 1991). Ogunbekum suggests that an innovative management, greater efficiency in health sector spending and the introduction of risk-sharing arrangements were necessary to bring about significant improvement in the public health care services.

Among the components of rationalization were community financing and drug revolving fund operated within the framework of the Bamako Initiative, which was a strategy adopted by African Ministers of Health to encourage community financing and cost recovery for strengthening of health systems. An essential drug list was prepared by the government and the essential drugs would be sold at regulated prices by the government health facilities to recover their cost (Ransome-Kuti 1992). Hospitals were also given authority to recover costs of consultation, surgeries, and other services. There was also more active decentralization of decision-making (Ogunbe-



kum, 1991), and hospital chief executives were given more powers to take decisions in the interest of the health facilities.

Further rationalization was done through encouragement of private sector participation in health care provisioning. Administrative bottlenecks for registration of private health facilities were minimized. All grades and levels of private health care facilities came into existence. The private-for-profit centres (otherwise called private medical enterprise) cater for people who can afford their services since they charge higher fees than the public health facilities. Mission hospitals also charge fees, and tend to be located closer to the rural populations than the private-for-profit hospitals.

To cater for those who are not in the public sector employment and so are not covered by the government health scheme for its workers, the Government passed a decree creating the National Health Insurance Scheme in 1999, but the scheme remained dormant and never took off until 2004 when the Government of President Obasanjo amended the Legislative Act and gave it more powers (Monye, no date). The National Health Insurance Scheme was designed as a composite insurance scheme with separate schemes for public servants, urban informal sector, children, rural population, etc (Ibid). Information I collected during the field research shows that the National Health Insurance Scheme in practice covers only public servants. The component schemes for the rural dwellers, urban informal sector, and children are yet to become operational.

Rationalization potentially can serve to keep costs of accessing treatment relatively low through introduction of health insurance (including community health insurance) and through encouraging managed competition among private care providers.

#### 4.2.2 Rationalization and gender

Systematic evidence on the effect of rationalization of health care on gender in Nigeria is difficult to come by. From my own findings in the field, the opening of space for managed competition in health care is associated with improvement in quality of care women receive. Women who have the means can choose to seek care either in the publicly funded health facilities, in the private-for-profit health facilities or in the mission hospitals. In the study community, women belonging to social networks that practice generalized reciprocity are able to access money to seek care in private health facilities. Women who belong to well-off households also tend to choose to go to private health facilities. Interview respondents who made use of private health facilities during the field research stated that the health staff in the facilities had better attitude toward them (patients/ respondents) than

what obtains in the public health facilities. They also stated that they did not experience delays in receiving treatment.

Rationalization has also been associated with improved provision of medical equipment and drug supply in hospitals. At the University of Nigeria Teaching Hospital and the ESUT Teaching Hospital (Park Lane), doctors and nurses who were interviewed stated that there has been considerable improvement in provision of medical equipment and drugs, although they added that there is still a lot of room for improvement. In the pre-rationalization period, the X-ray machines were usually out of service and patients had to go Hansa<sup>1</sup> clinic for their x-rays. The government-owned tertiary hospitals did not have ultrasound machines, again necessitating patients' referrals to the same clinic (Hansa Clinic) for ultrasound examinations. Today, however, women who are referred from the peripheral hospital for major illness/ health problems can have their x-rays, ultrasound and other radiological examinations done in the government tertiary hospitals.

However, costs still remain a problem in terms of access to health care at these and other health facilities. Only women from rich households and women belonging to generalized reciprocity risk-sharing social networks may be able to seek treatment there. In a rural community in economic decline such as Ukete, poor women who also constitute the vast majority that do not belong to generalized reciprocity networks may yet not be able to access care.

It is as a result of these costs that poor women have had to forego their own health needs so that the health needs of their household members could be met. During the field work, some women who belonged to generalized reciprocity networks received financial support from their group and spent the money seeking treatment, not for the women themselves, but for their children or husbands while their own health problems were yet to be solved. This is not surprising since Ukete (and indeed Igbo) women are normatively responsible for the health of their household members.

A rationalization step taken by the Nigerian government at the national and state levels has been to reduce workforce. Successive federal and state regimes carry out staff rationalization in all ministries including the Ministry of Health. I discovered during my field research that staff rationalization usually affects the junior cadres and the middle level cadres and these are the cadres in which women are disproportionately highly represented. In other words, women are worse affected by staff rationalization than men. On the one side, the number of doctors is usually not reduced but there are fewer women doctors, compared to male doctors in all public health facilities I visited during my field research. On the other hand, rationalization of

nursing staff usually necessitates re-working of job schedules with increased frequency of shift duties. This increases the work load of nurses. In the public health facilities in eastern Nigeria, my observation shows that the vast majority of nurses are women.

In terms of decentralization and management issues, in Eastern Nigeria there are five federal tertiary health facilities and five state tertiary health facilities. None of these ten tertiary hospitals is headed by a woman, and none has ever been headed by a woman. Males not only monopolize the positions of Medical Directors/Chief Medical Directors (as doctors) of these tertiary hospitals, they also monopolize the positions of Directors of Administrations, which are positions reserved for non-doctors. In Enugu State, specifically, no secondary level care facility is headed by a woman. Women are only found to be in charge of primary health care facilities in rural areas too remote for doctors to accept to be posted there. However, many women reach senior positions in the nursing profession in both the secondary and tertiary level facilities.

In the sections that follow I will explore health seeking at the various levels of health care. In order to capture health seeking in both the modern health care system and traditional health system, health care providers are classified into two major categories, namely, the lower levels of health care which includes patent medicine and traditional healers while the higher levels range from primary health care to tertiary health care. This classification is mainly for convenience of analysis and discussion.

### 4.3 Lower Levels of Health Care Providers

There are three forms of lower level health care provision: patent medicine vendor's (PMV) shops, traditional birth attendants, and traditional bonesetters. There are 3 PMV shops in the village: Mr Ukah's shop, which is popularly called the 'chemist' shop by the villagers; the shop of Prossy who is also a village 'midwife' (VMW); and a third shop, owned by an outsider, which was almost completely closed down by the time of the field work, as the owner, after joining local government partisan politics and making some money from it, relocated to a market in another town where he hopes to get larger clientele. There are traditional birth attendants in the village, but the traditional bonesetter is from outside the village and may be sought in the cases of fractures of the bone. In the immediate sections, these forms of lower level (sometimes also called informal) health care providers will be described in the context of health-care seeking which takes place at that level.

### 4.3.1 Patent medicine vendor/village midwife

The patent medicine shops owned by Mr Ukah and Prossy are the most frequently utilized health care providers by the villagers. Mr Ukah's shop is centrally located, about five minutes walk from the the Community Primary School (CPS), along the Nenwe–Oduma Road. Mr Ukah trained as a patent medicine dealer outside Uquete after which he came back and set up his practice. He reported that practising in his own village is quite challenging but has some positive sides. He knows everybody and everybody knows him, and he understands the cultural norms of seeking health care and also the economic and financial constraints his people face when they are sick. For example, they frequently are not able to pay in full when they buy medicines from him, and he knows he must allow credit sales if he is to retain a good name and not turn his clients away. Medicines observed in his stock include paracetamol, panadol, maladrin, hedex, nivaquine, aspirin, profen, flagyl, furadantin, chloramphenicol, tetracycline, piriton, fersolate, folic acid, multivite, vitamin B complex tablets, among others, in different formulations (tablets, capsules, caplets, syrups, etc).

From a gender perspective, it is important to note that the vast majority of villagers who go to seek care at the medicine shop are women and adolescent girls. It is only occasionally that men go to seek care from the private medicine vendors. It is women who take sick children to the PMVs or go there to buy medicine, while their husbands may actually be socializing with their friends in the village square. It was observed that some men actually used part of the household money to drink local gin (*kai kai*), smoke cigarettes or take goat-head pepper-soup (*ngwo-ngwo isi-ewu*) at the time their wives and children sought care at the PMVs.

Observations of Mr Ukah's interactions with his patients reveal a variety of consultation patterns, each with social and medical implications. A few will be described here. The predominant pattern is where the patient goes to the medicine shop, and gives the history of her/her sickness to Mr Ukah, who listens and asks questions, and may conduct quick examination (often as the patient is standing or sitting on the stool inside the shop, as there is no couch for examination). She/he doubtlessly trusts Mr Ukah's clinical knowledge and judgement and believes any diagnosis Mr Ukah makes, receiving any prescription from him with faith, but whether the prescription will be taken exactly as prescribed by Mr Ukah is not certain. Indeed, some of them reported that they do not necessarily use up the prescribed medicines, as they stop taking them once their 'illnesses' (symptoms) subside, not only because they do not see any reason to keep taking them but, more importantly, according to them, because they keep the leftover medicine for

use in the event of a similar illness in the future, thereby saving some money. The treatment often consists of pain-relievers, anti-malarial drugs, antibiotics, and vitamins. He also frequently administers injections. The second pattern of interaction is where the patient or the person sent in her/his place—often a child or other household member—tells Mr Ukah they want to buy a particular drug, or drugs for a particular illness (or better put, a symptom). In this case, he merely sells the drugs to the buyer, but may also offer advice on the need to add two or more other drugs ‘to increase the effectiveness of the drugs’, according to him. In both cases, a particular practice is observed, called ‘mixing’ of drugs. Mixing of drugs entails giving a cocktail of sub-standard doses of drugs (indeed a few tablets of each) mostly including anti-malarials, analgesics (pain-relievers), vitamins, sedatives (if in the evening), and if the anti-malarial given is chloroquine he adds piriton (to prevent chloroquine-induced itching, according to him). Mr Ukah may also be called to see a patient at home, but the caller gives him a brief history of the case so that he knows what medicine to take along when he goes to see the patient. Participant observation of this mode of interaction was carried out in a case of a young child who was convulsing.<sup>2</sup>

Villagers who want to make use of the ‘modern’ types of lower health care providers alternate between Mr Ukah and Prossy. Prossy, the village midwife, provides first level care for women and children in her home. Although she is called a ‘midwife’ by the villagers she has only been trained by working in a private clinic and had never attended any formal school of midwifery, and so is not a formally qualified licensed midwife. Prossy lives with her husband who has returned to the village after living in a city, Ondo, where he was trading in building products. He returned to the village to settle after his business collapsed. He had married Prossy from outside Uketé shortly after her apprenticeship training in ‘midwifery’ in a private clinic. Since she finished her training, she has been able to undergo one training course organized by the Red Cross in Ndeaboh, the headquarters of Aninri Local Government. In the training, they were encouraged to organize women in their local communities to share with them information on basic hygiene.

She does make referrals to hospitals. However, she said many patients fail to go for the referrals, citing lack of money as their reason. She is frequently owed by the patients; while some pay in instalments; some are never able to complete the payment.

Many factors affect the decision by women to seek care at the level of village health providers. Respondents identified these factors to include cheapness of the medicines, proximity of the providers (within easy reach),

possibility of purchasing medicines on credit, and most importantly, lack of money to go to the hospitals for treatment. Clearly, these factors are related to financial costs of health-seeking. The respondents also identified other costs that are not cost-related. These include perceived mildness of the illness, short duration of sickness, and politeness of the care providers.

It is important for the women to conserve their income and stay healthy to continue their income-generating activities. To this end, when they perceive symptoms to indicate mild illness, they opt to seek care within the village. Information obtained from the respondents suggests that there is high awareness among the women of the need to seek care at higher level providers in the cases of sickness perceived to be severe. This awareness, however, is usually not translated into concrete action of reaching the higher level providers to obtain treatment by poor women. The women do not have the savings to undertake such action. Although this may not be a serious problem for the rich, it poses a great difficulty for poor women. Out-of-pocket expenditures for treatment at the higher level hospitals are out of reach for most women in this category. Community-based health insurance, which would have provided access to health care at this level, is not available. Mutual aid associations exist, but offer services mostly to their members. The implication is that poor women who do not belong to such mutual aid groups are compelled to stop their health-seeking at the level of village care providers. The inability to pursue health-seeking beyond this level of care is illustrated by the case of Mrs Nma Nweke, who despite clear perception of the severity of her sickness, could only afford to buy medicines from the PMV.

### *The case of Nma Nweke*

Nma is a 39-year-old woman with no formal education. She has five children. She and her husband are farmers and complement their farming activities with seasonal casual labour. She does not belong to any group-based reciprocity mechanisms or other mutual aid-practising social networks.

During the farming season of 2003, she came back from the farm one evening and felt unusually weak. She sent her son to buy medicines from Mr Ukah. She took the medicines and felt a little better that night. The following morning, she was able to make it to the farm. However, toward late afternoon, she started feeling feverish, with a severe headache. She could no longer continue working and so she and her children went home. By the time she reached home, she developed joint pains, general body ache and prostration. She took the remaining medicine and a little food but vomited. Throughout the night she was restless and vomited two more times.

Mr Ukah came in the morning and gave her two injections and some oral medicines. He advised her to try and get to a hospital. The medicines helped to control the vomiting and she was able to eat little food. But her condition otherwise showed no signs of improvement. She spent seven days in bed before she began to feel slightly better, but one full month passed before she resumed normal activities. In the first week, she felt she would succumb to the illness, and her mind was always on the thought of leaving her children motherless. Yet, she could not go to the hospital because there was no money in the house. So, she had to continue her treatment with the 'chemist' [the PMV]. The treatment from the chemist was partly paid for with the household consumption income, but this could not cover the total cost and so they are still indebted to the chemist.

In this case, Nma spent N600 for treatment at the PMV. While treatment lasted, she was able to pay N300 to Mr Ukah and owed N300 which she paid four months after recovery. Clearly, N300 was grossly insufficient to seek care at higher levels of care. But although Nma could not have sought care at hospitals with N300 of her own household money, participation in a CBHI scheme would have provided her access to hospital care. In the absence of CBHI in Ukete, mutual aid in endogenous women's association such as Umuchu Women's Association (UWA) would have provided her with a facility to get access to health care beyond the PMV level. The implication of this is that, when poor women are not protected by CBHI schemes or endogenous mutual aids, their health-seeking may be arrested at the level of village care providers, and that even health-seeking at PMV could cause depletion of their consumption income and lead to indebtedness.

### ***The Health Belief Model (HBM): perception of severity versus affordability***

The health belief model holds that an individual will take action to seek care in line with her perception of the severity and potential complications of an illness. The HBM model also holds that an individual will seek care if she perceives that the care will be beneficial to her for that particular illness (Hausman-Muela 2003). In Ukete however, care seeking is also heavily dependent on other factors most important of which is *affordability*.

There is a general awareness among the respondents of the link between long duration of illness and the need for health-seeking at the higher levels of care. It is common knowledge among them that long duration of sickness connotes poor prognosis. Going by the health belief model, one would

then expect that the perception that protracted illnesses connotes severity and potential complications would be associated with higher rate of health-seeking in hospitals. However, this is clearly not the case in Ukete. Interviews and naturalistic observations show that poor women who do not belong to mutual aid groups generally stop their health-seeking for protracted illnesses at the level of village health providers. Mr Ukah and Prossy maintained that their pleas for such patients with protracted illnesses to seek treatment in hospitals hardly yield any results. Lack of money is usually implicated as the major constraint to seeking hospital care. These constraints are illustrated by the case of Mrs Nene Okorie, presented below.

### *The case of Mrs Nene Okorie*

Nene Okorie is a middle-aged, illiterate woman. She is a widow with seven children. Nene's late husband belonged to the landless poor in the village. Presently, Nene and her grown-up children scratch out a living mainly from working as labourers on people's farms. The first son, who could not complete his primary education, supplements their income by fishing in the Ahu stream during the rainy season and selling his catch. He also does hunting of bush rabbit and grasscutter through setting of local traps he makes himself during the dry season. The household lives in a two-room mud house with thatched roof. Nene has not had any experience of social networking involving generalized reciprocity and mutual aid. When she was much younger she used to participate in labour exchange associations.

Nene developed cough toward the end of 2002. The cough started out as dry cough without production of sputum. Nene thought it would soon go. After three months, the cough persisted and rather than show signs of improvement, sputum started coming out during coughing. Then Nene noticed that she was also coughing out blood. She recalled that her husband had similar symptoms for a long duration before he died. However, she has not sought any treatment except buying medicines twice from Mr Ukah at the onset of the illness. She desires to receive appropriate treatment at a hospital but she does not have the money.

This case shows that awareness that symptoms suggest ominous, even life-threatening, diagnosis does not mean that the sick person can seek care at the hospital. Mrs Okorie has had worrisome symptoms for well over one year. The symptoms are also akin to the ones that presumably killed her husband. She has been told clearly by Mr Ukah that he cannot cure her illness and that she needs care at a hospital. Yet she has not sought treatment beyond the PMV.



Medically speaking, Nene's symptoms are presumably suggestive of pulmonary tuberculosis. It does appear too that she contracted it from her husband. Curative therapy for tuberculosis is free of charge but only at hospitals. The patient undergoes what is called directly observed therapy (DOT), which means that the patient must take the medicine under supervision by a qualified health professional. Despite the fact that DOT is free of charge (because it is funded by international agencies), Nene would still encounter *affordability, availability and accessibility* problems. First, she must reach the hospital which is the only point of service. Second, she would have to undergo laboratory tests for confirmation of diagnosis, and to get baseline indices for monitoring the progress of the therapy. This, too, involves money, and only after the laboratory tests would she be eligible for free DOT.

Participation in a generalized reciprocity social network would have provided Nene with the means to overcome these *affordability, availability and accessibility* barriers to receive DOT, about which she would have gotten information if she had been able to go to the hospital. Staying alone without group mutual aid networks is one form of vulnerability in poor rural areas. When I discussed this very case with a medical doctor colleague, and opined that CBHI scheme might have been helpful to Nene, he disagreed, saying that since DOT is free, the CBHI would not have given Nene money for transport and laboratory tests. And he was correct. However, if a CBHI scheme were based on an existing endogenous mutual aid association, cases such as this would not be too problematic. The endogenous association could assist their member with transport fare and money for laboratory tests using funds earmarked for other objectives. This suggestion is predicated on the fact that since endogenous mutual aid associations usually keep a reserve fund for other objectives, it might not be too difficult for them to give an insurance contingency loan from such a fund while they still maintain the fund earmarked for payment of CBHI premiums for its members. Although this section is not devoted to exploration of mutual aid associations, the analysis of Nene's case in relation to participation in mutual aid gives an insight into how poor women might benefit from cultivating social obligation by belonging to risk-sharing groups.

In some protracted illnesses, the severity does not generate an apprehension of possible death. However, the illnesses last long enough to cause serious concern. It may also impair the ability of the sick person to engage in income-generating activities. The little income earned by the household for their consumption is spent on buying medicine from the PMV. The two cases below are illustrative of these constraints.

### *The case of Chibuzor Ndu*

Mrs Chibuzor Ndu is a 31-year-old woman who had dropped out of primary school. She is married with four children. The household is co-resident in a two-room mud house with thatched roof. She and her husband are 'sharecrop' farmers. They also engage in paid labour on other people's farms. Chibuzor's social networks consist primarily of the members of her church, the Apostolic Faith Church of Jesus Christ. However, they do not practise financial pooling as this is against the doctrine of the church. She does not belong to any other group that practises generalized reciprocity or mutual aid.

During the farming season of 2003, Chibuzor was clearing the bush when a piece of dry shrub broke off and hit her right eye. She stopped work because of the intense pain and returned home. Prossy gave her an injection and some tablets. Although the stick did not pierce her eyeball, it took several days before the swelling subsided. Thereafter, there has been abnormal lachrymation (excessive tearing from the eyes), persistent discharge and occasional severe pain. When the severe pain comes, it affects Chibuzor's sight and prevents her from working on the farm. Only almost two years after the accident, has Chibuzor been able to obtain treatment from Mr Ukah. She and her husband have not got money to go to the hospital for treatment.

### *The case of Amarachi Njoku*

Mrs Amarachi Njoku is a 46-year-old woman who has no formal education. She is married with six children, three of whom are adolescents. Amarachi and her husband are impoverished farmers. They live with their children in a three-room mud house with thatched roof. What constitute their productive assets are two old machetes and four hoes. Amarachi's experience of group social networking was rotating exchange labour. She has never been a member of social networking groups that practise generalized reciprocity or associative movements that engage in mutual aid schemes.

Eight months ago, Amarachi's third child, Kosiso complained of passing blood in her urine. Blood usually came at the end of urination. Blood was initially little but has increased steadily in volume. By the end of the eighth month, Kosiso started to complain of being unduly tired, weak and occasional faintings. Since the exacerbation of the symptoms, Kosiso has been unable to go to school.

Amarachi and her husband have not yet been able to take Kosiso to a hospital for treatment. Rather Amarachi occasionally uses their meagre consumption income to buy her medicines from Mr Ukah.

In both cases, there is clear perception of the long duration of the illnesses and the deterioration caused by the long duration. The two women also perceived the necessity to move beyond the PMV in their health-seeking. In Amarachi Njoku's case, the continuous loss of blood through the urine suffered by her daughter has become complicated as a result of waiting too long to get proper treatment. The symptoms of complication are suggestive of anaemia. Amarachi was most probably aware of the occurrence of similar symptoms in many other adolescent children. The children from well-off households were taken to the hospitals and treated, while the poor ones went without proper treatment. A public health physician told this researcher that the occurrence of passage of blood at the end of urination (terminal haematuria) affecting many people (especially adolescents) in a rural community is presumptively suggestive of schistosomiasis infestation of the bladder. The treatment is usually on outpatient basis, but the medicine is very expensive. But in Amarachi's daughter's illness, the bladder infestation is now complicated by shortage of blood (anaemia). Therefore, there is the need to treat the anaemia. As the cost of care increases, it gets farther beyond the capability of Amarachi and her husband. So, they find succour in treatment at PMV level although they are aware that the treatment does little or no good in health crisis like this.

In the case of Mrs Chibuzor Ndu, in spite of her worsening condition, she sticks to health-seeking at the PMV, which, according to her, is the only health provider she can afford. In fact, the lack of proper treatment for a prolonged period has resulted in symptoms that interfere with her productive activities. The tendency to end up in worse degree of the poverty trap is increased. The two cases of Amarachi and Chibuzor portray the fact that neither awareness nor the experience of the consequences of the long duration of health crises can drive the poor to seek treatment beyond the PMV if they cannot access money from their own sources or from external mutual aid mechanisms to overcome *affordability* barriers.

#### 4.3.2 Traditional birth attendants

These are usually local women who assist their neighbours and fellow village women during labour and child birth. They are usually recruited into the practice either by passage of the art from mothers to daughters or by the younger and newer entrants entering into verbal contracts of apprenticeship with older, experienced and practising traditional birth attendants or TBAs. According to the community norms, the TBAs are always women.

Because of their social and physical (spatial) embeddedness within the society in which they practise, they know and are known by their clients and

their households. Through various social interactions with fellow villagers, TBAs build up social capital which helps to sustain their practice. When a woman goes into labour, her spouse, or a grown up child or the nearest relative goes to call in the TBA, who arrives with her paraphernalia, usually a knife for cutting the umbilical cord, a local white chalk (*nzu*), and so on. On a few occasions, the woman in labour may go to the house of the TBA.

There was general agreement in the focus groups on health-seeking that many women still give birth at home, and so TBAs are still patronized in Ukete.

Birth attendants have always been a part of us. A lot of women still call them when they are in labour. The birth attendants are the only ones that can conduct labour here, and so as long as women give birth at home the attendants will be used. (Martha Bunike, FGD 1)

I think that many women will continue to call the birth attendants when they are in labour. In fact, my neighbour gave birth last week, and it was a birth attendant that conducted the delivery. (Udo Osisio, FGD 2)

Participants indicated that women who had never had any hospital delivery but were delivered by the TBA previously were very likely to seek care at the TBA during next childbirth.

Any woman who has been delivered by an attendant before will want to call her again. I know women who have been delivered of all their children by the same attendant. Unless something has caused a woman to go to the hospital, she will not cease to call her attendant when in labour. (Anulika Umah, FGD 1)

If a woman is in good terms with the birth attendant who delivered her once, she will retain her as her birth attendant. She will not want to go to the hospital. (Oby Nnama, FGD 2)

From the respondents' accounts during these focus group discussions and in-depth interviews, it is clear that there is not only a tendency for women to keep utilizing the services of TBAs, there is, in fact, a reversal of a health-seeking trend that started to emerge in the late 1970s and early 1980s. Then women had started to embrace modern health facilities for antenatal care and childbirth. Nowadays, women who had had hospital childbirth are resorting to home deliveries conducted by TBAs. In focus group 8, four of the seven members had had hospital births before resorting to home deliveries by birth attendants. I therefore sought their perceptions on home deliveries conducted by TBAs vis-à-vis using the village midwife and hospital deliveries. The four women resented the idea of patronizing the village midwife<sup>3</sup> (Prossy), whom they would pay more money, whereas they were

aware that she is not a qualified midwife. They therefore preferred to be attended to by the TBAs.

I did not leave hospital delivery for the fun of it. I wanted all my deliveries to be done by trained midwives and doctors. So, if I could not achieve this, I did not see any reason why I should pay a woman who calls herself midwife when I could be delivered by a traditional attendant and I give her whatever I can afford. (Nelly Okuh, FGD 8)

I sought their opinion on the possibility that their health-seeking action serves as a disincentive for those who had never experienced hospital delivery to seek hospital delivery. But one of the respondents argued that though a woman should desire to deliver in the hospital, it is expensive, and the heavy costs were the reason why she and others had had to abandon the idea of hospital delivery. The other three women agreed with her assertion.

The reasons put forward for the persistence of home births are more clearly understood in terms of a complex interplay of economic forces and social factors. Economic costs of home delivery are easier for the women and their families to bear. In the first instance, TBAs usually do not ask for payments before attending to their patients, which implies that their services could be availed of promptly once they are physically available. Even after providing services to their patients, they do not ask to be paid huge amounts of money, if they ask at all for any specific payment (many of them do not ask to be paid a specific amount of money). In most instances, they accept any amount paid to them (usually as a token of appreciation) in cash or material items such as salt, soap, clothing, food items (rice, yams, palm oil, etc.). The goodwill the TBAs enjoy from their former clients, families, neighbours and the community serves to offset any material or financial gains they miss by not placing specific charges for their services. For example, raw food items, cooked food, and occasionally, cash are sent to the TBAs during festive periods by their former clients and other villagers.

A TBA stated that her services were to God and humanity, and that her real payment consists of the joy she derived in helping women in child birth and the goodwill she enjoys. In her words, 'what monetary payment could be more than that?' Until the present time, that may be true, but it may be useful to add that the custom of non-monetary rewards for services of the TBAs may change with changing economic and social relations in Ukete.

All five TBAs who participated in this study are advanced in age (all are post-menopausal). None of them is literate, a finding that is not very surprising. None of the women had ever received any formal training in any modern health institution. In fact, it was noted that none of them had ever heard of the possibility of receiving training. In any case, they expressed no

desire for such training, citing old age as a reason. It is illustrative to note that none of them has ever referred any of their patients to modern health institution. Why would they not refer complicated cases to modern care facilities? One TBA reported, 'It is not for me to tell a woman, her household that they should go to the hospital. If they feel that they have the money to go to the hospital, and that they want to go to the hospital, can I prevent them?' When prodded on why she would not proactively advise the household of a woman having difficulty in labour to take her to the hospital, she queried, 'If they had the money to go to the hospital, why did they send for us anyway?'

Another TBA put her response more subtly, but made a case that their practice was just as good as that of hospitals. She told of one woman who was taken to the hospital six years ago while she (the TBA) was still attending to her during labour, apparently against her (the TBA's) approval. And she asked, 'What happened after?' The woman died, and in her view, this was suggestive of the fact that hospital care was not better than theirs. She admitted she had never been to the hospital and had no knowledge of what goes on there. However, she was quick to point out that she heard that it takes a very long time before a patient is attended to in the hospital, especially poor people like the ones from her village, who do not know any of the health professionals working in the hospital. Therefore, in this situation where TBAs viewed modern obstetric care as competing with their practice, it would be difficult to expect any referral to go from them to the hospitals.

What do modern health care practitioners think of the TBAs? The attitudes of the modern health professionals are ambivalent. Some doctors are of the opinion that because of the social status and trust TBAs enjoy in their communities and because of their proximity to the people, they would prove useful in primary health care delivery if they are given basic training and equipment. 'In any case, they will continue to practise in their villages whether or not you train and equip them. So, why not train, equip and integrate them?' a public health physician at the University of Nigeria Teaching Hospital argued. Non-medical researchers have also made similar appeals. Onokerhoraye (1984: 145) has argued that,

Traditional healers, when trained, have a major contribution to make in the area of midwifery services in which a large number of them are proficient. Additional training should emphasize such skills as the recognition and prompt referral of high-risk cases and complications—particularly haemorrhage, toxæmia and infection—together with asepsis and proper cord care—to avoid tetanus infections at delivery—and family planning.

On the contrary, some health professionals opposed to the idea view the TBAs as ignorant, dangerous and a menace to maternal health. A visiting medical officer to one of the health centres in Aninri Local Government said, 'How do you train old women who are uneducated in modern obstetric care?' He went on to argue that TBAs should rather be banned from practice, and in their place, more community health workers should be trained, sent to the village communities, and given motivating incentives and equipment to practice. This medical officer's view was shared by the village midwife, Prossy who sees the TBAs as serving no useful purpose. She obviously sees herself as occupying the professional high-ground in the village as far as maternity care is concerned.

While traditional birth attendants may help women during labour and childbirth, in Ukete, respondents' accounts suggest that many of the outcomes of TBA practice continue to be a cause for concern. Respondents stated that maternal deaths and morbidity associated with TBA-conducted deliveries are rather high. In the focus group discussion on common and severe health problems (FGD1), there was a consensus that pregnancy-related complications constitute the single most common cause of death among women in the child-bearing age group. Almost all these deaths were associated with TBA-conducted deliveries.

### 4.3.3 Traditional bone healing: health seeking and gender

Traditional bone healing is utilized by various categories of patients, including children, adults, males and females. The closest healing home to Ukete is located in Amokwe, another community in Aninri Local Government. It is currently run by a middle-aged woman. The healer is married with four children. The oldest child, a daughter, is in secondary school.

In an interview with the healer, she said that she inherited the art from her father. She stated that she does not use charms, but uses the healing powers God endowed her lineage with, and which has been passed from generation to generation. She stated that it has not been very easy for her to run the home because of financial difficulties. She said she would like to like to expand her wards (the buildings) and make them more suitable for receiving and treating patients. She has no nurses and said she received assistance from her daughter when she is on holidays. Her husband is not a healer, but primarily a farmer.

The healing home consists of two mud buildings with a corrugated sheet roof. Each has two rooms, and one central area (like a lounge) without a door. Each building has a hearth where the patients or their relations looking after them do their cooking. One building was for male patients and the

other was for female patients. A large 2000-litre plastic water tank is situated in front of one of the buildings. In the hot afternoon, the patients were observed lounging in the central area. Observation also captured two female relatives who just came back from the local market where they had gone to buy raw food materials to cook for their sick relations.

### *Gender issues*

Health seeking at the bone healing centre appears to reflect gender roles in health seeking and in providing nursing care for the sick members of the household. Observations at the facility and respondents' accounts show that sociocultural norms of health seeking devolve provision of nursing care for sick household members upon the female members of the household. Male members of the household are not normatively required to provide nursing care for sick members of the household and they rarely do.

In the bone healing facility, three women were receiving care at the time of field research. None of them had a husband or other male household member providing nursing care for her. Their nursing needs were provided by their grown up daughters in the case of two women while the third woman had her younger sister rendering nursing care services for her. Their husbands carried on with their businesses and only visited the women from time to time.

In contrast, each of the five male patients on admission had a female providing nursing care for him. The two women who came back from the market on the day I visited the facility were providing nursing care for their husbands. The third man had his eighteen year old daughter catering to his nursing needs. The women providing nursing care for the other two men were not available during the observation and interviews.

In-depth interviews and informal interviews conducted with the patients revealed that there were two major types of patients. The first category consists of patients from rural areas. For these ones, the healing home was their first point of health-care seeking. The second category consists of patients who were primarily resident in the urban areas, and who got their fracture injuries in the cities. These patients were first taken to hospitals in the city. However, because of the high cost and the prolonged nature of orthopaedic care (which further increases the expenditure), they opted to come to the traditional healer.

The traditional care at the healing home is not necessarily free. It does involve money. The patients are billed at the end of the healing. However, the healer told this researcher that some of the patients even fail to pay her. She lamented that some patients want to cheat her. They want her to treat



them and thereafter, they would leave without payment. Indeed, this social control problem has affected the woman's attitude toward patients. She now tries to get the patients to make a partial payment shortly after their admission. This is contrary to the past when she did not bother about payment until the patient is completely healed.

## 4.4 Higher Levels of Health Care Providers

To access modern, higher-level health care, the villagers need to seek medical attention outside Ukete. This entails walking long distances in the case of the health care facilities found within the local government, and/or taking transport by motorcycles or motor vehicles if the health care facility is outside the local government. The category of health facilities where treatment could be sought ranges from primary health centre (for example, Oduma Comprehensive Health Centre and Nenwe Cottage Hospital), secondary-level hospitals (e.g. Awgu General Hospital, private hospitals in Awgu and Nenwe), and the tertiary-level hospitals which are all located in the state capital city of Enugu. Public and private units are found within the first two categories.

### 4.4.1 Primary and secondary health care facilities

The regime of General Ibrahim Babaginda which introduced structural adjustment policies (SAPs) in Nigeria in the mid-1980s was also the first regime in Nigeria to liberalize the establishment of private health care facilities. Before then, health professionals who worked for government were prohibited to establish and own private health care facilities while in the government service. However, with the introduction of SAPs and accompanying reforms, doctors, nurses, midwives and all categories of health care providers could legally simultaneously work as civil servants and own private health care facilities. This brought its own problems such as divided attention between government work and private work, diversion of patients and equipment from government facilities to private ones. Private facilities also charge higher fees for medical care than public health facilities.

However, the private health facilities possess some qualities which make them preferable to the public facilities. The private facilities have more drugs in their stock. The nursing staff in private facilities are more polite and friendly. The doctors usually spend more time with the patients. The waiting time to see the doctors is much less. From visits made to the health facilities, I observed that many of the private facilities belonging to doctors who are in the government services have full-time doctors covering the fa-

cilities while the owners are at work in the government hospitals. The facilities which belong to people who are not in the government employment are covered by the owners themselves, and in instances where the centres are large, the owners employ more staff on part-time or full time basis.

Even the villagers are aware of the differences in quality and costs of care between government hospitals and the private ones. Therefore, in principle, many of the villagers would prefer private facilities. However, in practice, among the well-off who should be able to afford to seek higher level health care, most can only seek care at the public health institutions, because even they cannot afford the costs of care at private facilities. I observed that some of the well-off who can actually only afford health care in public hospitals are able to get mutual aid assistance which enabled them to seek care in private facilities. This will be further discussed in Chapter 6.

In section 4.2, rationalization of the health care system and its benefits were discussed. However, the benefits of rationalization had not trickled down to many of the facilities at the primary health care level and some secondary health care level facilities at the time of this research.

I carried out naturalistic observation in a public health facility located along one of the main roads within the local government. At the time of the field work, there was only one doctor and five nurses serving in the clinic. It was observed that on a typical working day patients came in a trickle and only one or two nurses would come to work. The medical officer lived in a suburb near Enugu where he ran his own hospital, but claimed that this did not affect his duties in the government centre. According to a nurse who has worked there for over 15 years, the health facility once enjoyed high patronage before the late 1980s, and the doctor and nurses were busy each morning attending to patients till late afternoon. Then the patients could get most of the drugs prescribed for them from the functional mini-pharmacy, and the side-laboratory was equipped to handle basic laboratory investigations. Laboratory technicians, pharmacy technicians and occasionally intern pharmacists complemented the services of nurses and doctors in the 1980s.

Today, the side laboratory and the mini-pharmacy are virtually abandoned; consequently, virtually all drugs prescribed by the doctor have to be bought from PMV shops in the community or in the capital city of Enugu. Laboratory specimens taken from patients are given to the patients' relatives if the patient is confined in the clinic or to the patients themselves for outpatient cases to take to Enugu for laboratory analysis. In many outpatient cases, the doctor simply writes out the required investigation and gives the lab form to the patient or her relative to take to Enugu where the laboratory staff will then examine the specimens. Respondents (patients) stated that it

is usually private laboratories in Enugu that they could go to for laboratory analysis since government laboratories are those situated within the public hospitals in Enugu which will only attend to the patients of the hospital itself of which the laboratories are an integral part. This has a number of implications.

- The cost of transport<sup>4</sup> to Enugu adds to the costs of treatment for patients seen at the government-owned local hospital but required to undergo laboratory investigation in private laboratories in Enugu.
- The time taken is another heavy cost to these people sent to Enugu for laboratory investigation since it would take a whole day to go to Enugu, queue for attention and finally get attended to in any good private laboratory.
- Private laboratories charge higher fees than laboratories within the government hospitals in Enugu, and finally
- One needs a referral from the peripheral hospitals to Enugu government-owned hospitals before they would avail laboratory services in these hospitals.

Though this government facility suffers from many deficiencies, the cost of its services is too high for the poor women who were interviewed there, who said they find it difficult to raise money to access care there. Thus, *affordability* barriers are created for the poor even at the level of primary and secondary health care facilities. The next level of care, which is indeed the highest level in Nigeria, is the tertiary level.

#### 4.4.2 Tertiary health care institutions

All the tertiary health facilities in Enugu state are located within the capital city of Enugu. They are owned either by the federal government or the state government. Some of them are established for particular specialities: e.g. National Orthopaedic Hospital provides services for only orthopaedic, trauma, plastic and burns cases; Federal Neuropsychiatric Hospital provides services for only psychiatric and mental illnesses. Others have a variety of specialists on their staff: e.g. the University of Nigeria Teaching Hospital has virtually every medical field and serves as the centre of education and training for undergraduate/postgraduate medical and health professionals; the Park Lane Specialist Hospital runs clinical services for most medical fields, and is currently being converted to serve as the teaching hospital for the Enugu State University Medical School. Medical cases that require specialized expertise and special medical equipment are handled at these tertiary

care facilities. In principle, the facilities accept only cases referred from the primary and secondary care facilities. In practice, they accept and treat patients who approach them directly without referrals. Each of these hospitals has its own laboratories which provide services only for registered patients of the hospital.

Many of the villagers are aware that such high-calibre hospitals are available in Enugu. Information on this has been spread through hearsay and stories from well-off families who have been able to access health care in one of the tertiary facilities. For the poor, only illnesses perceived to be fatal if not treated would make them seek care in the tertiary level facilities.

Patients face a lot of treatment-related expenditure. They are first required to pay consultation fees; if the problem necessitates admission, they are required to pay admission deposit. Admission deposit varies from hospital to hospital, but is in the range of N10000 (80US\$) to N20000 (160US\$). The patient is then given a bed. The cost of drugs prescribed by the doctors is covered by this deposit. However, doctors and nurses interviewed at a teaching hospital stated that very often many of the drugs the patients need are not available in the hospital pharmacy, and so the patient's relations have to buy them from outside pharmacies. These pharmacies are privately owned (many by hospital staff) and drugs are expensive.

Patients are frequently asked to do laboratory investigations. The admission deposit does not cover laboratory tests, some of which are very expensive. A patient going for a major surgery must undergo a laboratory protocol, consisting of (but not limited to) electrolyte, urea and creatinine (E/U/Cr) status at N1500 (12US\$), full blood count N300 (2.4US\$), grouping and crossmatching of blood N2500 (20US\$), HIV screening N1000 (8US\$). A pint of blood may be required in the event of excessive bleeding during the surgery; a pint of blood costs between N4000 (32US\$) and N4500 (36US\$). Blood is not available in the hospitals' blood bank. When this occurs, patient's relations are asked by the doctors to go and buy the blood from private laboratories, where blood is more expensive.

Besides laboratory and drug expenditure, patients pay N200 (1.6US\$) per night throughout the duration of the admission. They are also charged utility fees, namely water and electricity. An accountant with the teaching hospital stated that the utility bills became necessary because money was needed to buy diesel to run the hospital's standby generating set because of unstable power supply by the government-owned electricity corporation, and because the hospital has to make its own arrangements to supply water to the hospitals.

Food is provided for the inpatients. The hospital warders bring the food from the kitchen and distribute to the patients. At the teaching hospital, one patient complained to this researcher that she did not always like the meal she was given. She said when she brought it to the attention of a nurse, the nurse told her she was free to ask her relatives to bring her food from home. But she said she comes from a distant place. When an accountant in the hospital was interviewed on that, he stated that patients' relations were free to bring food from home if they lived close to the hospital. However, the hospital would still charge them for the three meals supplied them since the hospital must recover the costs of food cooked for patients.

The heavy skewing of distribution of medical facilities in favour of the urban areas in Nigeria has been observed by Onokerhoraye (1984) and Okafor (1984). They argue that even within a local government area, or indeed, a large rural area, there may be sharp inequality in distribution of modern health facilities. Spatial distribution of health institutions could also be indicative of the access to them. It determines the physical distance between the client and the health provider, which is clearly related to and is a functional measure of access barriers such as time spent to reach the health institutions, and indeed travel costs, and therefore, the aggregate costs of obtaining health care. Onwujekwe (2005) observes in another rural Igbo community in Enugu state that poor rural dwellers are hindered from seeking health care from higher-level health care facilities not only because of lack of financial means but also because these institutions are physically distant from them, and therefore more costs are incurred in the transportation.

Travel time and travel costs even between two fixed geographical points in the rural areas could vary markedly between season, and between times of the day (see Okafor 1984 and Scott 1983). In Ukete, informants indicated that travel time and costs differ by season. It takes a longer time to get to Nenwe and costs more since the unpaved roads are muddy and less vehicles reach Ukete from Nenwe. Travel time and costs vary according to the days of the modern week and the Igbo traditional market week. It is more difficult to get motorcycles and motor vehicles on Sundays, even in the dry season. Conversely, in the Igbo market week, it is easier to get means of transport on Orie days to convey one from Ukete to Nenwe for onward vehicular journey to the urban areas, but much more difficult on the other days of the traditional market week.

To avoid repetition, detailed analysis and discussion of management of health calamities at the primary, secondary and tertiary levels will be carried out in Chapters 5 and 6. This will be done while exploring the role of

households, extended families and associative movements as mutual aid mechanisms in health risk management.

## 4.5 Conclusion

This chapter analysed the different levels of health care providers at which women from the study location may seek care for themselves and their households. It describes the constraints women face when they need to get access to health care. This is a summary of the key findings:

- i) The most commonly used level of health providers is the lower level, particularly the patent medicine vendor and the village mid-wife. Women seek care from them for both mild and severe illnesses, and for both brief and protracted illnesses. As cheap as health-seeking at this level is compared with higher levels, it may still lead to loss of consumption income and indebtedness for poor women.
- ii) There is awareness among the women that severe illnesses and protracted illnesses may be associated with poor outcomes unless treatment is obtained from hospitals (and not from PMVs and TBAs).
- iii) Despite this awareness, women frequently stop their health-seeking at the lower levels. The main reason why women arrest their health-seeking at the lower level is lack of money to go the higher level. There are usually no household savings.
- iv) The problem of health-seeking arresting at the lower level mainly affects poor women, especially those who do not belong to any mutual aid risk-sharing groups.
- v) In the next chapter, the study will focus on how and to what extent Ukete women use household and kinship mechanisms to access health care.

## Notes

<sup>1</sup> Hansa clinic is one of the first and few clinics that were privately owned before the era of rationalization. The proprietor studied abroad, bought medical equipment abroad and was able to offer radiological services that were not available in government tertiary institutions then.

<sup>2</sup> The problem of generating apprehension in Mr Ukah's practice during observations was carefully tackled by allowing him to operate freely while the observer remained as unobtrusive as possible. Observations were done over many

months to ensure rapport building and to make it relatively impractical for the PMV to keep deviating (if at all) from his usual practice from which he derives his sustenance. Besides, where any suggestion was made it was carefully weighed and passed through to Mr Ukah in the absence of his patients, this way his self-confidence and the trust his patient has in his practice remained intact.

<sup>3</sup> Prossy is not a qualified midwife but got some training in a private hospital. Therefore, in a true medical sense, she is a charlatan or what Nigerians call a 'quack'. She professes to use modern equipment, treatment and remedies, and therefore, her fees are higher than the cost of obtaining care from the TBAs. TBAs are also unqualified. Unlike Prossy, they use traditional equipment, treatment and remedies.

<sup>4</sup> It frequently happens that due to the level of development of clinical laboratory services in Nigeria, and to the nature of some investigations such as culture and sensitivity testing of microbial agents, the investigations cannot be completed in one day; this usually necessitates patients from rural areas to go to the urban areas more than once in pursuit of laboratory services. This further increases both financial and time costs for the patients and their relatives.

# 5

## Household, Kinship and Mutual Aid Mechanisms for Health Risks

### 5.1 Introduction

This chapter seeks to analyse and discuss the various strategies which women employ in managing health risks for themselves and household members. It seeks to answer the research questions: (i) How and to what extent do rural women get access to health care using strategies of *household solidarity based on moral obligation for support*? (ii) How and to what extent do the rural women make use of *kinship solidarity with moral responsibility for assistance* to obtain access to health care? The chapter starts with a sociocultural background of the discussion by examining the place of Igbo cosmology in the household and kinship mechanisms of managing health risks. Household strategies for management of health risks are then discussed. This is followed by an exploration of the use of kinship mechanisms for handling health risks.

### 5.2 Igbo Cosmology, Household and Kinship Solidarity in Health Risk Management

In the Igbo worldview, human existence was perceived as a continuum: birth, living and death comprising different stages of one long eternal existence. The dead were a component of the world and social space of the living. Those who died in old age, and had thus become part of the ancestors were regarded as members of the kin. They were responsible for guiding and guarding the living, and for ensuring reproduction and fecundity, continuity and compliance with the cultural norms. The ancestors were thus worshipped for protection (Arinze 1970: 17–20), health and healing, harvests, etc. The annual ancestral worship festival, which usually took place during the rainy season just as harvest was starting, was usually done at a collective family or lineage level. The interweaving of religion and morality among the Igbo situated ill-health and other misfortunes within the cosmological



framework of violation of taboos and norms and disobedience to ancestors (ibid.).

The in-depth interviews with village elders show that the elders tend to romanticize the significance of their cosmology in treatment-seeking and healing. This is suggested by their statements below, which seem rather ideological. The respondents stated that treatment-seeking and treatment were founded on the investigation of the exact cause of the disease by the native doctor (*igba afa*). This usually entailed the native doctor (*dibia*) deciphering which taboo was broken, by whom, and if necessary, when, where and how. He deciphered which deity or ancestor was aggrieved, and very importantly, the requirements for appeasing the deity or ancestor. The treatment therefore consisted of provision of the requisite materials enumerated by the aggrieved deity or ancestor through their messenger—the native doctor—and the consequent performance of ritual sacrifice, '*ichu- aja*'. The native doctors who also served as their arbiter could negotiate the requirements for the *ichu-aja* on behalf of the patient.

In this traditional context, the costs of *ichu-aja* were tailored to suit the specific circumstances of the patient: the ability of the patient to pay; the season of the year; and the local resources at the disposal of the sick or her *ezi n'ulo*. In addition, for the *ichu aja*, the health-seeker could ask the native doctor to implore the deity to reduce the costs and requisites, since the offender who was sick had shown remorse for the offence that brought the illness. The native doctor, at the behest of the deity or ancestor, could reduce the costs and could spread out the instalment payments. It is important to note that the health-seeker might be different from the sick person. An *ezi n'ulo* might be the spouse of the sick person or the traditional head of the sick person's lineage (the *okpara*).

Village elders pointed out that in the old system of blending religion with social security, health-care seeking was not individualized. In fact, traditional healing was a matter for the whole or part of the extended family than solely for the particular person or household who was afflicted. The *okpara* of the lineage usually mobilized solidarity support for the afflicted person, and might take responsibility for the health-seeking. According to one elder, Udeh Anyi, who is a member of the *Igwe* cabinet,

When a person fell sick in an *ezi n'ulo*, the entire household and *umunna* were usually affected. Nobody was left out in the health-seeking. The *dibia* must be consulted to carry out *igba afa*. The *ezi n'ulo* and *umunna* would have no rest until the cause of the calamity had been unravelled by the *dibia*. The *dibia* would definitely ask for a number of items for the ritual of *igba afa*. Every *ezi n'ulo* was levied proportionately for the requirements for the *igba afa* and the subse-

quent *ichu aja*. It was an abomination for a head of a household to refuse to contribute to the rituals' requirements when an *okpara* approached him. (Mr Udeh Anyi, key informant, IDI)

Mrs Nnenna Eko, a farmer in her sixties told the researcher she felt nostalgic each time she remembers the past and how the *umunna* helped each other.

### *The case of Mrs Nnenna Eko*

Mrs Eko is an elderly woman. She is married to Mr Ekpe Eko. The couple are farmers, though they no longer engage in active farming themselves. Much of the farm work is done by their two married daughters within the village. Co-resident with them in a two bed-room mud house is their granddaughter who attends a primary school close to their house. Mrs Eko recalled an event that occurred shortly after her marriage. In her words,

When I was young, people helped each other mutually. Your first point of help was your brothers and sisters, and your *umunna*. Shortly after I got married, my husband fell down from a palm tree while he was tapping palm wine and he broke his left leg. This happened when I was pregnant with my first baby. My husband's two brothers and their *umunna* were on hand to help. They all went to the bush to bring my husband home. From home it was decided which of the bonesetters to take him to. All of them, and including our neighbours then, together carried him to the bonesetter in Amokwe [another community in Aninri Local Government]. (Nnenna Eko, IDI)

Mrs Eko said that her husband spent three months at the bonesetter's healing home, and that although the cost he incurred was relatively small, it was borne by the *umunna*.

These statements, of course, reflect a remembered, and probably, idealized, past as filtered through memory. As such they are as much a comment on the present as a reflection on the past. According to them, no fees were required for consultation. Drugs were given to patients free of charge. Surgical operations were also without charge. However, sick people still had to spend some money to access health care at the hospitals. This was because money was required for transportation to the hospital and for food. Patients who were admitted were fed by the hospitals and the hospitals charged token fees for the food. Because of the traditional worldview of perceiving illness and other calamities as upheaval for the whole *umunna*, members assisted each other with raising money for going to the hospital. This was evident in the case of Mrs Obaji.

### *The case of Mrs Obaji*

Mrs Obaji is an elderly widow who is co-resident with her two grandchildren in a two-room mud house. She still engages in farming for consumption and cash, assisted by her two grandchildren, who, although their parents are alive, live with her to render some help. She experienced prolonged labour in her second childbirth during the time that health care was free in Nigeria. She recalls:

I was in labour and the baby just did not seem to be coming out after two days of labour. I got exhausted by the evening of the second day; in fact, I did not have any strength to push again. Everybody knew there was trouble. My first childbirth had been very smooth, and relatively fast. For this second childbirth, the traditional birth attendant did not know what to do after two full days of labour and getting into the third day. We were not even sure the baby was still alive. Everybody was worried. Family members, relatives and friends were all there.

My husband's extended family consulted together and decided to take me to the hospital in Awgu. We were not prepared for this kind of event, given that my first pregnancy and childbirth had no problems. We had little money on hand. The money would not even be enough for transporting me to the hospital. My own brothers were called in. The whole family contributed small amounts of money as each person could afford. Then there was no road that motors could pass easily to get to our village. I was taken on a bicycle to Nenwe where we boarded a motor to Awgu.

I was seen by the doctor immediately we arrived at the hospital. He told my husband that I would be admitted. We already knew this was going to happen. The doctor operated on me later same day, and we were very happy to receive a live baby. I did not see the baby when I woke up from the operation. I was told it was a baby girl, and that she had been taken to a special section of the hospital for treatment because she was weak from the prolonged labour. By the fourth day I was able to go and see the baby. I recovered fully from the operation by the tenth day but my baby was still on admission. Finally, two of us were discharged on the fifteenth day. The nurse on duty told us we were to pay some money for the feeding. I can't remember how much, but it was a very little amount. The money was paid and we came back home.'  
(Mrs Obaji, IDI)

Mrs Obaji's case is indicative of the easier access to health care when it was free. It also suggests how apparently stronger social bonds among members of an extended family were instrumental in health-care seeking, as she paints a picture of prompt mobilization of extended family mutual aid.

In an interview with the traditional ruler, Igwe, he said such mutual support was possible only because people felt connected to each other through a supernatural world in which their ancestors were a part, and so they would not want to offend their ancestors. It seems then that much of the mutual aid was predicated on superstition. Traditional systems and institutions including those based on superstition and traditional religion were affected by the Western influence through media such as Christianity and education. As some of the community members got converted to Christianity and some got educated, they were expected to abandon the traditional world view based on superstitious beliefs. Logically, that would lead to abandoning the kinship-based mutual aid which the beliefs shaped and perhaps sustained. But has that been the case? To what extent have these mechanisms changed or persisted? And what other factors might have impacted on the dynamics of mutual aid mechanisms within the household and extended family?

### 5.3 Household Mechanisms for Health Risk Mitigation

Besides holding idealized views of the past pertaining health-seeking, respondents who were interviewed on current mechanisms of managing health risks hardly mentioned traditional religious beliefs as exerting any influence. On the contrary, they situated their discussions within the prevailing economic conditions in the community.

From in-depth interviews and naturalistic observations of health-seeking, the household mechanisms for managing health crisis are mainly (i) household income/savings, and (ii) sales of assets—consumption/farm produce, household assets and productive assets. Although borrowing from money-lenders is strictly not a household mechanism, some women resort to this as a last resort.

#### 5.3.1 Income/savings as risk mitigation strategies

Most instances of health-seeking are through out-of-pocket expenditure, rather than prepayments or modern social insurance. This requires paying for health care directly. From the focus groups on health-seeking, there was a consensus among the participants that poor women find it very difficult to pay for health especially when it involves seeking care beyond the village health providers. This is due to the inability of poor women to keep savings.

Health calamities are therefore grappled with as they occur, using whatever income may have been earned immediately before the occurrence of the calamity. Because of income fluctuations, women often do not have money on them at the time that they experience health crisis. It is therefore

by chance that an income has just been earned and not yet spent at the time a sickness occurs. Even at that, the available income is often far below the amount required for health-seeking. The case below illustrates how an income that has just come in may be used to handle a health crisis. It also illustrates the inadequacy of such income that has not been accumulated and earmarked for health risk management. I made participant observation of this case, and it is presented below.

### *The case of Mrs Onyinye Ene*

Mrs Onyinye Ene is a 28-year-old women. She is a farmer and seasonally combines farming with petty trading. She is married to Mr Marcellus Ene. Mr Ene is 34 years old, and combines farming with working as a commercial motorcyclist. The motorcycle belongs to a man from Oduma, while Marcellus Ene operates the motorcycle for the owner on an agreed basis of weekly returns. Mr Ene uses the motorcycle (okada) to ply between Nenwe and Oduma. The couple has two boys and one girl, the last child being just a few months young.

Onyinye's first daughter, Maria had started complaining of headache and loss of appetite four nights previously. No medicine was given to her that night. The following morning she seemed to have improved; she had her breakfast but still ate much less than what she used to eat. She played to some extent with her friends from the neighbourhood and her kid brother. In the evening of same day, her body became hot, she vomited the food that was given to her and felt weak. Two days later, she continued running temperature, and was given paracetamol that had now been bought from Mr Ukah, the patent medicine vendor, and the fever subsided. She played a bit. Paracetamol was repeated the following morning and evening, and then the paracetamol got finished. In the third night her body became very hot, and she started shivering. Then the next morning, she started rolling up her eyes and stretching her hands and legs, and foaming from her mouth [convulsion].

Her father went and called the patent medicine vendor. By the time the PMV (and the researcher for whom the PMV sent immediately to accompany him) arrived at their house, she had stopped convulsing but was obviously weak. She was treated with chloroquine injection and her parents were advised to take her to the hospital where proper clinical management would be done.

However, the couple did not take Maria to the hospital. When the PMV learnt that the couple did not take Maria to the hospital, he went back to their house to give another injection in the evening and to reinforce his ad-

vice on the need to take Maria to the hospital since she has had convulsion. They had told him that they could not find money to take Maria to the hospital in Nenwe, the neighbouring town. On follow-up interview with the couple, they reiterated that it was lack of money that hindered them from taking Maria to a hospital. Mrs Ene, Maria's mother, said she owed her association six months contribution and that there was no way they would even lend her money. 'I owe them six months' dues. They won't listen to me. They can't give me any loan'. She added, 'The business of motorcycle transport had been very bad for her husband as frequent rains had made the road too muddy for transport. These days we get about N900 from his transport business. From our farming, we make about N700'.

Mr Ukah had charged them for the treatment he had administered, to which Maria was responding, but they were not able to pay him completely. He has been paid 450 Naira [3.6US\$] out of N1,500 [12US\$] for the full course of the treatment. He said that he had had to bring down the bill on sympathy grounds since the woman was then nursing a baby. The N450 paid to Mr Ukah had been made the previous market day from groundnuts Onyinye sold at the Orié Market. That was their consumption income for the market week.

This case illustrates the relationship between health care expenditure and health-seeking in poor households. It shows that among women from low-income households, the income is grossly insufficient for health-seeking. On closer scrutiny, one sees a total monthly income of Mrs Ene's household to be approximately N1600 (12.8US\$). Their two sources of income are irregular, and highly dependent on vagaries of the weather. When the rains fall too heavily, Mr Ene is unable to run his *okada* business; Onyinye's farm produce also yields less income because of low demand. From an (expected) income of N1600, an illness crisis took N1500; this leaves N100 for the handling of other household demands (consumption, future illness, etc.), which is very insufficient. Almost all the income for one month had to be spent on a single health crisis. The indebtedness to the PMV would mean that as future income was earned, it would go into the payment of debt. The household might also embark on the strategy of cutting down on consumption of food items not produced in the household. From a social control perspective, Mrs Ene's household could decide to default in payment of the debt to Mr Ukah, but such behaviour might backfire since illness occurrence is not infrequent and they might require the services of the PMV again.

This type of experience is not peculiar to the Enes or to the study community. It occurs in any society in economic decline in the developing world, particularly to individuals and households who do not belong to mutual aid schemes for health risks. Although some sort of mutual aid can be obtained from associative movements in this study community and in fact, Mrs Ene belongs to one of them, her inability to contribute regularly disqualified her from accessing aid. That made her vulnerable to using income that just came in to seek care for her child. In the final analysis, the household strategy of using income for health-seeking among the poor is inadequate. As seen in this case, Mrs Ene's daughter could not be taken to the hospital for further treatment.

The next case is similar to that of Mrs Ene's. The two cases depict the circumstances very typical in households of similar socioeconomic backgrounds. In the face of deprivation, an income of one month obtained from sales of farm produce means a lot for a poor woman and her household and could be lost to a health crisis in a matter of days. This was the type of experience Mrs Ndidi Anikpa passed through when her daughter had fever, *Iba*. The case is presented below.

### ***The case of Ndidi Anikpa<sup>1</sup>***

Mrs Ndidi Anikpa is a 30-year-old woman. She is married to Mr Anikpa, a primary school-educated farmer. Ndidi herself also completed her primary school before her marriage. The couple has three children (two daughters and one son). Apart from their household farming, she also keeps a few chicks which she said are for festivities like Christmas and onwa-asa. As regards social networking, Ndidi does not belong to any associative movement. She does not participate in any group mutual aid scheme.

In August 2004, Ndidi Anikpa noticed that her daughter had fever. Medicines were bought for her from the PMV, which relieved the fever for the night. The following day, the fever recurred and was worse. They made the decision to take the girl to the Oduma Health Centre. She recounted her experience:

It was last week Tuesday that my daughter started having hotness of the body in the night. I went and bought some medicines from the "chemist shop" [PMV], and we gave it to her. Her body cooled that night but became hot again the following day. We brought her here [to the health centre]. She was treated and we went home, also with the medicines we were discharged with to be giving her. Hmm, they charged us N2,500. When we went home, and she finished taking the medicines they gave us, her problems started again and we had to bring her to this place again. They charged us N2,000 [for the sec-

ond treatment]. It has been quite a struggle. It took the little money [we] got from our okra sales for many 'market weeks' [one month]. All our money is gone, and the annoying thing is that I don't know what type of treatment they gave her that did not cure her during the first treatment. So, that money just went like that, and they are charging us so much again. (Mrs Ndidi Anikpa, Exit IDI)

The case illustrates the consequences of minor but repeated illnesses on household income. In this case, a monthly household income of approximately N4500 [36US\$] was expended on health-seeking for a minor but repeated illness. This again portrays a catastrophic health expenditure that would impair a woman's ability to manage future illness or other crisis or even to meet consumption and other basic needs. In a low-income farming household, catastrophic health expenditure minimizes woman's command of food for household consumption and cash by forcing her to sell a greater than usual proportion of food produced through own farming. The following scenario is created in such cases: income is depleted by illness. Food for immediate consumption and cash is sold. In addition, food for storage for future use is also sold. These strategies are geared to 'compensate' for the catastrophic health expenditure.

In the case of Ndidi, the income from household sources was enough to handle the health risks. From the accounts of the symptomatology of the illness given by Ndidi, her daughter most probably had malaria and a relapse. Relapses of malaria treatment are not uncommon due mostly to usage of adulterated drugs which have been rampant in Nigeria. But the issue here is that relatively lower cost of malaria treatment poses an economic burden for the poor when the illness occurs in quick succession.

This case also helps us to understand how precarious it can be to rely on household strategies for health, which is why there is a necessity for alternative strategies such as mutual aid groups. Had Ndidi used mutual aid risk-sharing strategies for her child's treatment, income from her okra and her chicks would have been spared. It suggests that in the context of small and fluctuating incomes, a community-based health insurance, which allows for very flexible modes of contributions as the income is earned, would be very useful to poor women.

In some cases, poor women do not have consumption income/savings to obtain health care at all and they can only seek health care by selling their assets. Depletion of assets has serious consequences for income-generating activities and household welfare.



### 5.3.2 Sale of household/productive assets as risk mitigation strategies

Respondents told me that some of the assets took many years to acquire, while for some, the assets were acquired when ‘the going was good’ for their households. According to them, most of the assets lost in the attempt to pay for health care are never replaced. The case of Mrs Helen Akpa is illustrative of this.

#### *The case of Helen Akpa*

Mrs Helen Akpa and her husband live in a partially dilapidated mud building with a rusty roof which leaks on the front side facing the foot path. Despite belonging to the younger generation, Helen did not spend more than three years in primary school before dropping out. Her husband is also a primary school dropout. He participated twice in seasonal migration to Western Nigeria for palm wine-tapping, and had bought a bicycle during the second and final time. He has now settled to farming with Helen. Unlike many couples in their generation, they do not combine farming with any other livelihood activity. They experienced a severe health crisis that made them dispose of their bicycle since they did not have any money on them. In addition to having to sell the bicycle, they also lost their child.

By way of social networking and participating in reciprocity and mutual aid activities, Helen had a brief stint with a rotating savings and credit group in the second year that her husband migrated to Western Nigeria. Since he returned and could not migrate again, she has not been able to join any associative movement or reciprocity group.

Below are excerpts from an interview with Helen:

Our child was ill for just a few days before he died. It started with a swelling in the right side of his belly [abdomen], which was increasingly getting bigger. There was no money in the house to take him to the hospital. You know, it was during the planting season, and the planting season is the worst period for us in this village. We usually say that there is nothing in the house and nothing in the farm to eat. The money my husband was getting from working on other people’s farms as a labourer was being used for our feeding. We tried borrowing money from people for our son’s treatment, but we were not successful. Relatives of my husband like his uncles would have been eager to help if they had [money], but they did not have [any]. My own family did not have [money] to give us. On the fourth day of the sickness, we decided to sell our things to raise money for the treatment. My husband started looking for potential buyers. He succeeded in getting a buyer for our bicycle which we readily sold on the evening of the fourth day. We were getting ready to leave for

hospital on the morning of the fifth day. On that morning, our son woke up, and asked for his breakfast, which we gave him. He ate and asked to wear his Christmas dress, and I put it on him. While we were still preparing to leave that morning, he went inside the room, and lay down and died [she started sobbing]. (Helen Akpa, IDI)

The case above demonstrates the difficulty poor women and their households encounter in raising money to pay for treatment of a sick member, to the extent of even selling a household asset. In this case, a young woman and her husband had no money and could not receive any assistance to commence treatment-seeking promptly enough. In Mrs Akpa's household, no consumption income or saving was available when an episode of severe illness occurred. Poor women move from one source to another to look for money when they experience severe illness. In Mrs Akpa's case, the first action was to look for assistance from relations, but both filial and agnatic kin were too poor to offer support. Even though this section is not on extended family and mutual aid for health risks, Mrs Akpa's case gives us an insight into the experience of many women in that direction. We also see that Mrs Akpa and her husband's efforts to obtain loan from moneylenders was unsuccessful. In fact, key informants stated that it is difficult for the poor to obtain loans for health-seeking from rich moneylenders. The key reasons given include the apprehensiveness by the lenders that the poor would not be able to pay back, and the poor are also unable to provide collateral for the loans. The case therefore points to the insecurity of seeking loans from moneylenders in times of health crisis especially when the needy is poor, and may be deemed not to be creditworthy by the moneylenders.

Selling assets is described by respondents as a very bitter experience. They said that, in times of distress, assets were usually priced very low by potential buyers. These buyers know that the seller is in distress and needs money urgently, and rational selfishness propels them to bargain at the cheapest possible price. Thus, sale of assets under exigency brings little returns.

Important productive assets disposed of to manage health risks may damage the ability of a woman to continue with her income-generating activity. A woman who has such livelihood-dislocating experiences may be forced to change from a more lucrative income-generating activity to one that generates less income. This happened to Ogosi Ekwe, a 27-year-old woman with three children. Her case highlights on how women struggle to overcome, with little success, the effects of sale of productive assets due to occurrence of a health calamity.

### *The case of Mrs Ogosi Ekwe*

Mrs Ogosi Ekwe originally hailed from Ameke, one of the communities in Aninri Local Government. She has secondary education, and while living with her elder brother in Onitsha, she had learnt hairdressing. She was working as a employee hairdresser when she met Celestine Ekwe, an Ukete man who had just completed his apprenticeship in used vehicle spare parts and started his own business. They got married and settled in Onitsha. A hairdressing business was started for Ogosi Ekwe, and to ameliorate the frequent power outages, a portable generating set was bought for Ogosi.

President Olusegun Obasanjo, the then democratic President of Nigeria, banned importation of used/second-hand vehicle spare parts as a part of his economic reforms. The price of used spare parts rose astronomically because only smuggled ones get into Nigeria. Celestine Ekwe could not cope with these changes, and his business began to dwindle.

The couple relocated to the village when Ogosi was two months pregnant. They used the money they had to start a hairdressing business for Ogosi in Orié Market in Oduma. When Ogosi gave birth seven months later, the baby was born with a swelling in his groin. The baby did not seem at first to be affected by the swelling which was off and on. However, as he turned four years, he started complaining of occasional pains in the swelling which also seemed to stay longer when it appeared. Ogosi and her husband could no longer ignore the swelling. They decided to seek health care, but had no money on them. They had made no savings from the hairdressing business, since they used it to feed, complemented by their small farming activity.

They went to Enugu for treatment and were told that the surgical correction of the diagnosed inguinal hernia would cost them N11,300 [90.4US\$] (inclusive of laboratory tests and medicines). They brought the child back. Then they started looking for a buyer for Ogosi's hairdressing equipment. Her former apprentice, Mrs Dorothy Osu indicated an interest in buying them. The transaction was concluded, and Ogosi obtained the money for her son's surgery. Ogosi's son was taken back to the hospital where he underwent operation and recovered well.

Ogosi could not continue with hairdressing business after the surgery. She could not buy another set of equipment. She rather started trading on small items of food stuff. This fetched much less income than hairdressing business.

Ogosi Ekwe's experience is indicative of the trade-off between health expenditure and income-generating activity when there is no effective mutual

aid for health risks or community-based health insurance to protect women and their households from catastrophic health expenditures. Consumption income is frequently wiped out without any significant effect on the health-seeking process. Then sale of assets may become a *sine qua non* mechanism of raising money for the health risks. In the absence of an effective mechanism, the effect of managing health risk may push a household at the margin to living in deprivation. Loss of critical income/productive assets leads to loss of economic opportunities.

### 5.3.3 No savings and no assets to sell

Discussions with respondents show that some women have neither savings for health-seeking, nor any assets that are worth selling to obtain money. Such women end up not seeking care beyond buying cheap medicines from the PMVs. From such women's experience we can gain further knowledge of the effect of deprivation and vulnerability on poor women's health-seeking. Among such women were Mrs Chinyere Eze and Mrs Kaka Onwe.

#### *The case of Chinyere Eze*

Mrs Chinyere Eze is 52 years old. She is married with eight children. She and her co-resident children and husband live in a two room mud house, with thatched roof. Her husband, Oranu Eze, is landless and scratches a living, working as casual labourer on farms. Mrs Eze is also a labourer. She and her husband take seasonal sharecropping arrangements with landowners. She does not belong to any group social network that practises mutual aid.

She developed an ulcer on the outer side of her right ankle. The ulcer is painless but has refused to heal. It spreads slowly but steadily. Mr Ukah started dressing it when it first appeared. After six months there was no sign of improvement, and besides, Mr Ukah, who received no payment for the treatment he had already given, decided to stop further treatment. He advised her that in the light of the chronicity of the problems she should seek further care at a hospital. But two years on, Mrs Eze has not been able to go to the hospital. According to her:

I do not have any money to go to the hospital. There is nothing in this house to sell to raise money. We are struggling to eat. I have nothing else to do than to continue with my life. I know that it is getting worse. I have started feeling pain in my groin. Mr Ukah told me that it may be due to the sore. (Mrs Chinyere Eze, IDI)

This case illustrates the typical experience of many women who belong to the poorest households in the community. Their income is meagre, infrequent and seasonal. Their ability for own production of crops for consumption and cash is ominously undermined by landlessness. Health-seeking even at the level of PMV is hindered by lack of income as well as lack of assets which could be sold to get money. The failure to access health care has consequences for their physical health and therefore for their ability to continue to do farm work or other economically productive activity. This is seen in the next case, in which a curable eye problem could not be treated because of lack of money resulting in physical and economic incapacitation of the woman involved.

### *The case of Kaka Onwe*

Mrs Kaka Onwe is a woman in her fifties. She is the second wife in a polygynous household. In spite of the fact that her husband is a rich landowner and farmer, Kaka remains a poor farmer as she does not farm with her husband. She and her husband have two teenage daughters. Kaka and her children reside in a separate mud building.

Kaka developed bilateral cataract with poor vision almost ten years ago. But she has never gone to the hospital for treatment. At present, she is almost totally blind and has skin rashes. She stated that she does not have the money to go for treatment, and that she does not have anything that she could sell to get money.

Kaka's case illustrates that absence of savings and household/productive assets that can be sold makes a health problem that is otherwise curable become protracted and incurable. The ill-health further makes it impossible for Mrs Kaka Onwe to engage in income-generating activities. She has been forced to depend on her teenage children. This results in further deprivation and vulnerability. A vicious cycle of poverty and illness ensues, with each reinforcing the other, and further compounding itself. Among the low income rural women, illness and poverty are linked together in complex ways, to produce a trap of deprivation and vulnerability.

We also learn much about the other side of operation of mutual aid within the household. It tells us that financial support from spouse for health care may not be assumed to be always there within a household. An extract from the transcript of an interview with Kaka is reproduced here.

*Researcher:* I would like to know how much help he (your husband) has offered?

*Kakab:* Nothing, absolutely nothing.

*Researcher:* Do you think he is able to do something by way of helping you?

*Kakah:* Yes, he can help. He has money, but he would rather not help.

In summary, it is clear from the foregoing that among the low income groups, using household mechanisms as security for health risks is unreliable and fraught with problems. Many women from such households who use their income for health-seeking find out that it is not enough to cover the direct health costs, not to mention indirect costs (transport, feeding, etc). As a consequence, because of the income depletion, they must adjust consumption. Women and their households who mobilize assets for health-seeking suffer asset depletion, loss of productive capacity and exacerbated vulnerability. The poorest of the poor and their households are neither able to use consumption income nor able to mobilize assets for health-seeking. Their health-seeking fails even at the level of the PMVs.

In the next section, analysis and discussion of these issues will focus on extended family and mutual aid for health risks.

#### 5.4 Extended Family Mechanisms for Health Risk Mitigation

Following the definitions of extended family in Chapter 3, extended family can be decomposed into filial generation, step-children, siblings, agnatic and affinal relations. For the purposes of analysis, these components can be grouped into three mechanisms of mutual aid, namely (i) filial duty; (ii) sibling solidarity; and (iii) extended relations solidarity. Filial duty is defined in this study as the moral responsibility of adult children to take care of their parents (including step-parents) in times of calamity, including health crisis. It should be noted that implicit in this definition is that the parents are aged, frail and can no longer fend for themselves. Following Dunning (1992, cited in Criel 2000: 16), sibling solidarity is defined here as an awareness of sibling affection and the willingness to carry its burden. Similarly, extended relations solidarity is defined as the awareness of unity among the extended relations and the willingness to share the inherent burden. The exploration of these mutual aid mechanisms is done by presenting cases and then analysing the presence or otherwise of these three mechanisms, how they were used or failed to be used for health risks. The cases of Uzam Okafor and Mamalu Ezenta are presented first.

The following cases provide insights into constraints and opportunities (if any) women face when their main or only source of strategy for handling health risks is one or more of the extended family mechanisms.

### *The case of Uzam Okafor*

Uzam's age is not known exactly but she is probably in her mid-sixties. She was married off by her parents as a young girl to a much older man who already had two wives. She was thus the third and youngest wife. Her husband was a rich landowner, and he gave her access to the farmland. She and her hearthhold did their own farming, but contributed to the labour of her husband's farming when needed.

Uzam has four daughters. Though the first two of her daughters did not go to school, Ebere, the third daughter was sent to school. Ebere started school, and as was usual with education in the village then, she had to go to Oduma Central School after the first three grades for the completion of her primary education. There she was spotted by one of the teachers, who became insistent about marrying her. He approached her family on the issue and they accepted his proposal. But Ebere objected to marrying the man. They tried putting pressure on her. Her reaction was to run away from the village. She was not seen for over ten years, and then came back with a baby, and said she had the baby for a man she was living with in Enugu. She returned to the city after her brief visit. She then had a second baby, and visited the village again, at which time she took her mother to visit with her briefly. It was during the visit that Uzam discovered that Ebere was no longer living with the man. Uzam spent a brief period with her daughter and returned to the village. Life was not easy for Ebere, as a single mother who had dropped out of primary school, bringing up two children alone, without support in the city. The oldest daughter was married to a man outside Ukete, but with no child, resulting in marital disharmony. The last daughter completed primary school and continued to live in the hearthhold. Uzam's husband died over ten years ago.

Uzam has been having chronic waist pain for the past ten years, and about five years ago she started having left abdominal pain and a feeling of 'unwell', with intermittent fever. She got a little money from Ebere with which she went to the General Hospital. The doctors there referred her to the Teaching Hospital because they thought she had kidney problems. She then had a clinical consultation at the Teaching Hospital, some medicines were prescribed and then she was given a list of laboratory tests to have done.

That was three years ago, and she has not been able to go to the hospital. Besides, she does not have money to buy medicines or to pay for the gamut of tests. Her daughter in the city has not been able to offer any more assistance. Uzam appealed to her step-sons for help but they did not help be-

cause they said they have their own problems. Uzam's surviving brother and sister cannot offer any help because of poverty, she said.

### *The case of Mamalu Ezenta*

Mrs Mamalu Ezenta is an elderly widow. She is an uneducated farmer. As a young couple, she and her husband joined the Catholic Church. This contact with Christianity influenced them to send their daughters to school in the immediate post-Independence era (early 1960s). Both of them completed primary education before marriage to men from outside Ukete. Her son, Kanu, also completed primary school. He migrated to Enugu to learn trade but later returned and settled in the village. Mamalu's social networking has primarily been within the Catholic Church. She never belonged to an associative movement that practises financial pooling/reciprocity.

In the early 1980s, Mamalu's first daughter died. A few years later, Mamalu lost her second daughter. Having already lost her husband much earlier, she has Kanu as the only other survivor. Four years ago, Mamalu had a fall in her compound and broke her left leg. Although she has been advised by Mr Ukah on the necessity of seeking care at a hospital, she has not gone to any hospital. She also has not obtained any care at a traditional bone healing home. According to her,

Kanu does not have money though he desires to help. If they [Kanu and his wife] had money to take me to the hospital they would have done that since. (Mamalu Ezenta, IDI)

About receiving assistance from her own siblings and her husband's siblings, she said,

As much as they would like to help financially, they are just as poor. I mean, both my natal family and my husband's family. It is poverty all over. (Mamalu Ezenta, IDI)

Filial duty implies that the children/step-children should provide aid to their parents/step-parents for the management of health risks. It is based on the principle of the role of children as social security, especially in old age. The above two cases helps us to see whether (and to what extent) old women can depend on filial duty as a mutual aid for their health risks

Uzam's case demonstrates that filial duty may be unreliable to depend upon for aid in times of health difficulty. Initial money provided by her daughter was inadequate, and she has not been able to render any further assistance to her mother for years. Despite the fact that Uzam's illness is chronic, she has not been able to get money for treatment from step-



children. So, it can be established that filial duty as a mutual aid for health risk has failed in Uzam's case. The next issue is why did it fail? Is the lack of aid due to absence of a sense of duty of care towards their mother/step-mother or is it a result of financial/economic deprivation and vulnerability?

Uzam told this researcher she could not obtain aid from her daughters because they are poor and incapable of offering help. As regards aid from her step-sons, one can infer from discussions with her that they could have offered assistance if they wanted, although Uzam was tactful not to say this categorically. Therefore, while deprivation is the apparent reason for failure of mutual aid from her own sibling, lack of sense of duty to extend care and erosion of moral obligation are the probable causes of failure of mutual aid from step-sons.

Mrs Mamalu Ezenta has similar experience to Mrs Okafor in the failure of filial duty as mechanism for health risk. Like Mrs Okafor, deprivation is implicated in the failure of filial duty. Therefore, the cases portray the fact that filial duty does not occur in the abstract. It is rather, in practical terms, a function of the socio-economic status of the children.

In both cases, the women were failed by *sibling solidarity* and *extended relations solidarity* (in the specific case of Mrs Ezenta). The factor underlying the failure is poverty. Each of the women expressed the willingness of their relations to help. However, one point that becomes clear here is that the willingness to bear responsibility for a relation is a function of one's own financial/economic state. Willingness then is not enough. Accordingly, sibling/extended relations solidarity and moral obligation lose their effectiveness if there is no financial capability.

When cash is not immediately available, landowning lineages may decide to lease out a piece of land as a mechanism of managing a health calamity for their members. On the surface, this seems like simple mutual aid which extended relations promptly apply immediately when a member of their extended family is in health distress. However, many cases recorded in the field challenge this altruistic notion of kinship solidarity. Let us examine a case which involved leasing out land for health-seeking for a sick lineage member.

### *The case of Mrs Tagu*

Mrs Tagu is an uneducated farmer. She has five children, and is co-resident with her children in a three-room mud apartment with corrugated sheet roof. She and her husband cultivated their own portion of the (Umunwedu?) lineage land, for consumption and for cash. Mrs Tagu does not belong to any associative movement. Her experience of group-based social

networking dates back to her early years in marriage when she practised rotating labour exchange with other young women married into Ukete from her natal village.

Her husband developed painless swelling of the groin while working on the farm. About two days after, he started experiencing pain around the swelling. This was followed by inability to pass stools. Extracts from her interview transcript are used to complete the history.

His brothers already knew he was sick. However, when he became very seriously ill I sent for his immediate younger brother, Oboh, who came to our compound. Then we sent for Eze their brother. We put our heads together, and as my husband was in no position to take decisions, we decided to take him to the hospital. But money was now the problem as nobody had enough money to handle the situation. So, more members of the Umunwedu extended family were contacted—the oldest member Ahamefule and Sosoh's oldest son Oti were called next; these were followed by Okere and younger family members. It was decided that my son-in-law and his daughter should be sent for and they arrived in the evening of same day. My husband's relatives then sent for one of their farm tenants. When he came, they negotiated with him for a piece of farmland so that he could pay immediately. Since it was getting late and the man had come from another town, he said he would bring the money the following morning.

He came as he promised, with the money on him, then the extended family decided to delegate my son-in-law to take my husband to the hospital. He was admitted at the hospital in Enugu [University of Nigeria Teaching Hospital], but died there before he could be operated on. (Mrs Tagu, IDI)

We see that Tagu was sick for some time and that his brothers were aware of his condition, but that they did not offer to help him, knowing(?) that he and his wife did not have money to seek hospital care. As Tagu remained in the house, it became obvious to Mrs Tagu that the symptoms were not improving and that Tagu's general clinical condition was deteriorating. She probably decided that if Tagu's brothers and extended relations would not act spontaneously to assist, then she must bring them around to help. Mrs Tagu then decided to send for her husband's immediate younger brother, Oboh. The duo sent for the sick's second sibling, Eze. The immediate siblings deliberated on the sickness and took a decision to seek treatment at a teaching hospital. Significantly, none of Tagu's brothers brought money for the task. The *umunna* were called in. Like Tagu's brothers, members of the *umunna* did not come with money. Rather than donate money from own households, they decided to raise the money by leasing a piece of

Tagu's own portion of lineage land. The decision was made to fetch one of Tagu's farm tenants and lease a piece of farmland.

Tagu was taken to the teaching hospital with the money from the land rent, but died in the hospital. This researcher followed up the case at the teaching hospital to find out what disease Tagu had had, and if he could have survived if he had been taken to the hospital on time. The researcher found out that Tagu had had obstructed inguinoscrotal hernia. This is a clinical problem with nearly 100% survival rate if the patient is taken to the hospital on time and receives treatment (usually a surgical operation). However, when delays occur, hernia may become complicated by gangrene and septicæmia, with a fatal outcome.

This case begs some questions on the extended family solidarity in mobilization of funds for treatment seeking. Why did none of Tagu's brothers and his *umunna* contribute money to help his wife in seeking treatment for her husband? Why did they rather choose to lease out land, and in fact, Tagu's own portion of land? Why did they wait to act until Tagu became moribund from complicated hernia? Evidently, there was a failure of sibling solidarity if the definition adopted in this research is strictly taken. There was also a failure of extended kin (*umunna*) solidarity. This proposition is based on the premise that Tagu belonged to a landowning lineage, and if his brothers and *umunna* had made small contributions on time, Mrs Tagu might have used it to take her husband to the hospital, while they made arrangements for more money. It seems siblings and *umunna* rationally did not want to venture into putting money into Tagu's health-seeking. Could they have been apprehensive that their money would not be paid back? This is possible. This researcher was told that free riding exists within extended families. People who are helped out of calamities are known not to want to participate in bailing others out. The researcher also heard of instances in which interest-free loans were given to fellow members of extended families when they experienced calamities. Then when they recovered they tried to dodge paying the loans. In one of such instances, the debtor asked the lender to convert the loan to a free gift.

Renting out Tagu's own portion of farmland as a means of getting money suggests the perception among his *umunna* that the responsibility of handling his calamity largely rested with him and his household. No member of an *umunna* would want to lease out his or her own portion for the health risks of another member. It is pertinent to note the significance of social conflicts and rivalry which may weaken the level of support that could be received within the extended family. For example, there were serious land

conflicts within Tagu's extended family. The conflicts involved physical violence, police intimidation, and protracted litigations. Although the conflicts were resolved, some respondents argued that the effects on cooperation and reciprocity within the lineage still linger on, albeit insidiously, producing jealousy and rivalry. A respondent queried the level of reconciliation that would make members of an extended family who had had physical fights, police arrests and court litigations to ever trust each other again, share bonds of social solidarity and financial support. She summed up her opinion thus,

It can never really be the same again. They might have reconciled or claimed so but I strongly doubt the extent to which they will be willing to give each other free financial assistance. I believe that any assistance given in such families will either be only tokens or they will be outright loans. (Mrs Omasi, Informal conversation interview, ICI)

Other extended families, Mrs Omasi stated, also had bitter feuds. According to her, after such conflicts, members of the extended families become mutually suspicious of each other, more withdrawn, and less proactive in seeking the welfare of the other members.

The constraints and opportunities faced by women in obtaining assistance from the extended family can also be seen in the case of Mrs Nancy Okereke. It shows that some extended family members may be reluctant to assist fellow members unless there is some hidden gain for them. It also highlights once more the influence of poverty on extended family mutual aid for health-seeking.

### *The case of Mrs Nancy Okereke*

Mrs Nancy Okereke is a 50-year-old woman with no formal education. She is married to Mr Okey Okereke, a middle-aged man. Both Nancy and her husband carry out tenant farming for consumption and for cash. When he was younger, Okey used to migrate to Western Nigeria, like many men of his generation, where he engaged in palm wine-tapping. Nancy, during the periods her husband used to migrate, engaged in trading on farm produce such as okra and rice, among others. Their socioeconomic situation had changed negatively when Mr Okereke was no longer able to do the seasonal migrations and, consequently, Nancy could not carry on with her trading. Farming is now their sole livelihood activity. She recounts her experience:

My husband calmed down and slept after a bout of serious convulsions, and after a while I slept also. Early in the morning, I woke up with a start to find my husband struggling again. I was initially terrified, and so I ran out to call

my neighbours. When we came back he was violently convulsing now. We tried holding him down, without any success. He then on his own calmed down in a terrifying manner, because he was limp and appeared lifeless. He was no longer breathing or moving any part of his body. We thought he had died and, as it is customary to do, my neighbours told me to leave him. I got my cloth and covered him properly as was customary for the dead. I was told to leave the room. I started crying, wailing loudly and lashing myself on the ground. I actually got myself injured. I told them to allow me to be with him, to touch him and see how he was doing, but my neighbours refused. This was cultural. I sent for Mr Ukah and for the pastor. Both came and started a round of prolonged prayers. When they finished, Mr Ukah touched my husband and told me he was going to be just fine, that he was not dead. As we were talking my husband came to, and joined us, but he was weak. He talked briefly with the pastor and others, and they all left. This time around, Mr Ukah gave him an injection and some tablets to take. It was also during this episode that I also called my husband's kinsmen. I told them that I was going to take my husband to Enugu. They refused on the grounds that an injury I had sustained while wailing and lashing myself on the ground would not allow me. They were somewhat right. I had injured my left hip.

Throughout the daytime and evening, nothing happened to my husband, but I was poised to still take him to the hospital. However, there was nothing I could do, as I was still recovering from my hip problem. In the second night we had supper as usual. The night appeared as if it was going to be uneventful till about midnight. The convulsions started again. I went and called his (my husband's) kinsmen and our neighbours. I was terrified. We all gathered again, and prayed. Mr Ukah administered some medicines and he calmed down again. At this juncture, I told them I could no longer stay with their brother (I mean my husband) alone in our house. So we were all taken to the house of one of his kinsmen. There were no convulsions during the daytime. I had recovered somewhat from my hip problem and I was determined to take him to Enugu. But there was no money in our house to transport my husband and myself to Enugu. Fortunately, Mr Ukah who has been wooing my daughter for marriage brought N2500 [20US\$] for the journey. Two young men, our relations, volunteered to take my husband to Enugu while I stayed at home, but when they were given the money, they changed their minds and decided not to go because, according to them, the money was not enough. When the two volunteers backed down from the trip, I had to take the trip myself.

...We reached Enugu and first went to see my daughter where she works, and she went and fetched her elder brother. They gathered and we all took my husband to a clinic where he was admitted. We spent a total of 10 days there, and incurred a huge bill. My children started running around, trying to raise

the money to pay the bills. They were finally able to raise the money, the bills were paid and we went home.

It's a terrible situation. In the first instance, at that time of the year, virtually everybody is broke. People have sunk their little money into renting land for cultivation of their plants, buying seeds and seedlings, hiring labour (which has been progressively expensive), and so on. It is a time of *unwun*, a local situation of acute severe scarcity for most households here, in both financial and material terms. Many households do not have even food to eat. They live from hand to mouth. So, the people who would have helped were all in similar or even worse situation. (Nancy Okereke, IDI).

Despite the severity of the health crisis in this case, the extended family relations close-by did not provide any financial assistance. The series of events and the attitude portrayed by the relations suggest that there was no intention on their side to proactively take him to a hospital. If Nancy did not insist on seeking care outside the village, whatever fate her husband would face did not seem to jolt the relations into rendering financial assistance for health-seeking.

In cases like this, a number of factors may be responsible for lack of mutual aid from the extended family relations. First, the relations may be too poor to help, as we have already seen in previous cases. Chronic severe deprivation makes it impossible to render any financial assistance, either as free gift or as interest-free loan. Poor people who are not able to render financial assistance to their relations just hope that the worst would not happen. This is what is observed in Nancy's case. Second, selfish relatives may think only of what directly affects them and what they will gain from their social interactions, even with members of the extended family. Thus, they may view sickness in the household of other relations as a distant risk, and not something to worry about. They may thus dodge financially assisting their sick relation since it will not bring immediate return. For such people, there must be reasonable certainty, if not definite assurance, of a return of the financial assistance. One-way flow of assistance is not tolerated. And in financial assistance to very sick relations, such certainty of return is not obtainable because of the probability of death. If the very sick relation dies, it will be very difficult for the household to repay assistance received during health-seeking, whether such assistance is a loan or a free gift. My discussions with many of the villagers show that they are acutely aware of this probability and take cognizance of it when considering giving financial assistance. It was possible that Nancy's extended blood relations were doubtful of the possibility of survival of her husband after the first episode of convulsion and brief coma, and had adjusted their mindset on their social rela-

tions accordingly. The assistance from Mr Ukah could be interpreted as goal-oriented solidarity, geared toward achieving his objective of marrying Nancy's daughter. In that case, the assistance might have been given on the premise of balanced reciprocity; giving financial assistance in return for parental consent for marriage.

Indeed, that assistance is not usually or always given altruistically as shown by the attitude of the extended family relations who had volunteered to accompany Nancy's husband to the hospital. It is strange that the two of them backed down when they felt that the money provided by the yet-to-be in-law (Mr Ukah) was not enough. Yet, the same money was used by Nancy and was sufficient for the same purpose. It is a matter for speculation then if the volunteers intended to reap some financial benefit from the trip. But it shows that extended relations solidarity may mean different things to different people. People may attach meanings that will suit their selfish interests. Fortunately, Nancy was assisted in her health-seeking for her husband when she reached Enugu by her children. However, interviews and the researchers' naturalistic observations indicate that due to economic constraints that urban migrants with little education—such as Nancy's children—encounter, and due to other attempts to avoid social control problems such as free riding, financial aid from urban migrants are few and far between. In Nancy's case, she could be considered fortunate. In many instances, the migrants do not give assistance to their rural-based relations.

I interviewed an urban migrant to get his view on why financial aid from such migrants is insecure and hard to come by. The migrant, Esco, is a 27-year-young man. I chose to interview him, though he is a male, because his case illustrates free-riding from fellow extended family relation to whom was given financial aid for health crisis.

### *The case of Esco*

Esco has attained university-level education and is a son of Sohil, one of the Umunwedu large landowners. He is single and holds a middle-level position in the state civil service. He narrated his experience,

In 2002, Eme, a daughter of my extended family relation was very sick and brought to a hospital in Enugu by her elder brother, Alodd. When they got to the hospital, they were asked to pay N7000 as emergency fee, and they did not have the money. Alodd came to my office and narrated their problem to me, and asked me for assistance. I gave him a loan of N4000. I told him to tell his parents that they should pay me back when they got back to the village after the treatment. He agreed. But after the girl's treatment, Alodd told his parents that I had given them N4000 as free gift. When I travelled to the village,

Eme's parents told me point blank that they would not pay me. They said Alodd told them the money was a free gift. I insisted I must be paid. It brought about quarrel, and they eventually paid me piecemeal. (Esco, ICI)

This is evidently a case of free-riding by an extended family member who had been assisted financially. Such behaviour is evidence that apprehension among extended family members over rendering aid for health crisis may be real and not imaginary. For example, it may be difficult for Esco to easily give money to another extended family relation, whether as free gift or as a loan. Earlier, it was indicated that this type of free-riding may be one of the reason for failure of solidarity among extended relations resident in the rural community.

From interviews and observations, the free-riding prevalent among extended relations takes either of two forms. In the first form, a member who experiences crisis receives mutual aid from a family member. and whether the sick person survives or dies, the debtor becomes adamant that he will not pay the loan. In the second form, a member gives a free gift to a relation in health crisis, but when the giver experiences a calamity her former beneficiary refuses to reciprocate.

Returning to the issue of getting aid from urban relations, this is further complicated by either of two patterns/processes. In the first, the rural dwellers who need money for health-seeking actually have to first get to the urban area where their urban migrant kin is living, and where also the hospitals they may wish to go are probably located. The urban migrant is thus approached and then they may take up the payment for the health care costs. There are a few issues here that warrant consideration. The rural dweller who needs such help must first find money to be able to pay transport costs to the urban area where the kin to offer financial support lives. Second, such social action on the part of the village resident embarking on the health-seeking this way are based on assumptions, which include: (i) that there is a strong social tie or bond; (ii) that the urban dweller will act altruistically and offer their assistance for health-seeking; (iii) that the urban kinsperson has enough money and or will borrow money to assist in the health-seeking process; and (iv) that the kinsperson is physically within the urban centre of residence at the time of health-seeking, particularly as people may not be able to phone the kinsperson in advance of the trip to find out whether or not he has travelled out of the city. These uncertainties underscore the unpredictability of such assistance. The second pattern is where the rural dweller that needs to embark on health care-seeking sends a message to the urban migrant kin, asking for financial remittance for health



care-seeking, and waits in the village for the remittance to be sent from the urban centre.

These factors show that dependence on urban extended relations for health risks is precarious. This is illustrated by the following two cases, Ozzy Obioma and Chinazo Edu.

### *The case of Ozzy Obioma*

Ozzy Obioma is a 29-year-old mother of four children. The oldest child is 10 years of age, while the rest are eight, five, and three. Ozzy is married to Nonso Obioma and both husband and wife completed primary education. The primary occupation is farming. Ozzy's experience of group-based social networking was a two-year stint as a member of a rotating credit and savings scheme. She currently does not belong to any associative movement or other generalized reciprocity group. She has an uncle who had been working with the Nigerian Railway Corporation in Enugu for many years. Although Ozzy knows her uncle's residence in Railway Quarters, she last visited him shortly after her marriage to introduce Nonso to him.

Over a decade later, she had a need to visit him again. Her 10-year-old daughter took ill. After an initial treatment by Prossy, she advised them to take her to a hospital. Ozzy and her husband did not have the money to do so. They also did not have assets they could sell for the same purpose. Ozzy decided to seek financial aid from her uncle. She set out with her daughter to her Uncle's house in Enugu. When she got to Enugu she did not meet her uncle because he had travelled to Abuja (the federal capital) to complete his retirement formalities. She stayed with the household for two days. Her uncle returned on the third day but told her that he was owed five months salary prior to his retirement that month. He did not know when the salary arrears would be paid not to mention when he would receive his gratuities and pensions. Ozzy returned to the village without having obtained any help for the costs of treatment for his daughter.

### *The case of Chinazo Edu*

Mrs Chinazo Edu is a 37-year-old woman with no formal education. She is married to Mr Kelechi Edu who dropped out of primary school. She has five children. Chinazo and her husband are primarily farmers, but Kelechi does palm wine-tapping during the wet season to supplement their income. Chinazo and Kelechi decided that since they did not get formal education, they would do their best to give their children as much education as possible. Consequently, when their first daughter, Angela, was 10 years old (and in primary school), and Chinazo's cousin Ebuka asked them to give her to

him for baby-sitting of his children, they turned down his request. They told him that they would rather have Angela with them because they intend to send her to secondary school in the future. Ebuka lives in Onitsha where he trades on electronics.

A few years later, Chinazo started losing weight gradually. She also developed chronic cough. Mr Ukah advised them to seek care at a hospital. Having no money in the house, Chinazo decided to go and ask for financial assistance from her cousin, Ebuka. She travelled to Onitsha. However, Ebuka told her he could not help her. He asked her if she remembered they were cousins when she refused his request for Angela. Chinazo came back to the village.

In these two cases, extended family solidarity once more failed women who had experienced health calamities. None of the women obtained mutual aid. In each case, the women sought aid on the basis of the assumptions discussed above.

In Mrs Ozzy Obioma's case, seeking mutual aid from her uncle was based on the assumption that her uncle who has put in several years of work into the Nigerian Railway Corporation (NRC) would surely have money to assist her. She also assumed that he would be physically present in Enugu when she would get there. None of her assumptions was true. Even when her uncle returned to Enugu from Abuja, he did not have money to assist her. (In fact, since the NRC became moribund as an aftermath of SAPs programme in the 1980s, members of staff who survived retrenchment had to face long delays in payment of their salaries.)

In Mrs Chinazo Edu's case, she had assumed that her cousin who is a prosperous electronics trader in Onitsha had a strong enough social bond with her, and therefore would act altruistically to help her out of her health crisis. Evidently, her cousin had not forgiven her for refusing to give her daughter as a baby-sitter. Chinazo's refusal had changed her cousin's perception of their social relations. In this case, kinship is redefined and modified to suit individual preferences, personal needs and selfish interests. Kinship solidarity becomes solidarity-only-in-principle rather than in actual practice. There is no moral obligation. Loss of moral obligation was demonstrated when Chinazo's cousin wanted her to terminate the education of her daughter so that she could 'baby-sit' his children. Ebuka's action suggests a selfish attempt to unduly benefit from or take advantage of her relationship with Chinazo.

In summary, extended family mechanisms for coping with health risks are insecure and unreliable due to a number of factors. First, deprivation

and vulnerability undermines the ability of otherwise willing relations to give assistance for health-seeking. Second, there is erosion of kinship moral obligation and solidarity. Selfishness, free-riding, loss of trust, and social conflicts, have become commonplace in intra-kin relations. The consequence is that reciprocity and mutual aid are extremely limited in Ukete and women hardly make use of them in their health-seeking.

## 5.5 Conclusion

This chapter focused on analysis of (1) household and (2) extended family mechanisms for managing health risks by women in Ukete. It explored how and to what extent Ukete women make use of household and extended family strategies to get access to health care. The section summarizes the salient findings:

- i) Women face severe constraints in their attempts to make use of the two strategies in their health-seeking efforts (mitigation of health risks).
- ii) The household risk-mitigation strategies consist mainly of household income/savings and sale of assets. Household income is irregular for poor women, and they hardly have any savings. Therefore, household income/savings as mechanism for managing health risks are precarious for poor women. Selling assets to manage health risks leads to loss of income-generating assets, which in turn exacerbates deprivation. Many poor women do not have either savings or assets. These women are not even able to seek care at the level of the village care providers.
- iii) Many poor women who lose critical/consumption income and/or assets due to health emergencies would probably not have done so if they had belonged to mutual aid schemes.
- iv) Household mechanisms for health seeking may fail because of many factors, especially:
  - a) Household members may not be altruistic in their social relations, in this context, as it pertains to health seeking by and/ or for women.
  - b) Economic deprivation compounds the situation by reducing the financial capacity to seek health care.
  - c) Sociocultural factors such as polygyny create tensions and social conflicts in the household and these further impair health seeking by women.
- v) Extended family risk-mitigation strategies in Ukete can be broadly classified into filial duty, sibling solidarity and extended relations solidarity.

Filial duty and sibling solidarity fail poor women in their health-seeking because of economic deprivation and lack of sense of solidarity and moral obligation. Extended relations solidarity also fails poor women in their health-seeking efforts for three main reasons: First, deprivation undermines the ability of few relatives who might otherwise be willing to help. Second, there is erosion of extended relations moral obligation and solidarity. Third, selfishness, free-riding, loss of trust and social conflicts are presently commonplace in extended family relationships.

The next chapter will focus on a mutual aid women's endogenous association as a mechanism for getting access to health care by women. It will examine whether the association inheres features that will make it suitable as basis for CBHI schemes in Ukete and similar contexts.

## Note

<sup>1</sup>. I first conducted an exit interview with Ndidi Anikpa after her daughter's discharge from the Health Centre. I later followed up the case for more information.

## 6

## Women's Associations and Mutual Aid Mechanisms for Health Risks

### 6.1 Introduction

In this chapter, a woman's association is used as a case study to examine how it provides mutual aid for handling health risks. Its salient features and operations are analysed to determine how group-based mutual aid mechanism works in practice. To achieve this, the chapter explores the association's formation, membership/recruitment, contributions and financial pooling, and mutual aid activities in the management of health crises. Problems of social control are then discussed, examining how the associative movement takes steps to check the problems of adverse selection, free-riding, social capital and membership stability. The chapter also explores other problems of associative movement-based mutual aid such as inadequacy of health coverage and problems of exclusion.

As noted in section 1.7.3, three women's mutual aid associations presently exist in Ukete, namely, Umuchu Women's Association (UWA), Nneoma Women's Association (Nneoma), and Nwayo-bu-Ije Women's Association (NIWA). Information obtained through a pilot case study shows that the three associations, UWA, Nneoma and NIWA, have membership sizes of 23, 17 and 21 respectively. This shows insignificant differences in membership size. Operational objectives of the three associations are essentially the same. Each of them has an objective of financial pooling and annual redistribution. For financial pooling, all the three associations operate monthly direct out-of-pocket individual contributions. In this regard, a small difference exists. While UWA reduces monthly contributions to one-quarter during the *umwu* season, Nneoma and NIWA reduce theirs to one-half. The three associations also practice collective paid labour as a means of getting additional income. The mechanisms of financial support are also largely similar, with only a minor difference. While all three associations grant insurance-contingency loans, Nneoma gives a collective gift of N500 to mem-

bers during life-cycle events whereas the other two associations do not do this. The mechanisms of social control are also similar.

Given the very few insignificant differences between the associations, it seemed to me more useful to focus in detail on only one of the associations. One reason for selection of UWA for detailed study is that it has more complete records<sup>1</sup> than the other associations, although record keeping is still rudimentary. At least it was possible to obtain basic records from their first year to this year (2005). On the contrary, the other two associations had missing records. NIWA's records for two consecutive years—2000 and 2001—were missing. There was no clear explanation for this by the leaders. Nneoma's records for the first three years of operation could not be obtained. The current secretary, Oleka, said they were not handed over to her.

According to Rossman and Rallis (2003: 105), 'one case study may [...] shed light on, offer insights about, similar cases'. Besides, using UWA as the only case helps to avoid unnecessary repetition of information, and yet enrich knowledge about the features of mutual aid social networks in Uketé.

## 6.2 Umuchu Women's Association: A Group-based Social Network

### 6.2.1 Formation, membership and objectives

In August 1987, eight women held a meeting in the house of Mrs Nnenna Mgborie to discuss the possibility of forming an association. It was at this meeting that the Umuchu Women's Association (UWA) was formed. During this first meeting, it was decided that Mrs Mgborie should serve as the first chairperson. The pioneer members decided that membership should be open; that is, there would be no restrictions on the basis of religious adherence, academic, social or economic status. The pioneer chairperson, Mrs Mgborie told the researcher,

We deliberated on who should be allowed to join us. We finally decided that we should allow anybody who feels she is up to it to become a member. We will not reject any woman because of her background [socioeconomic status], religion, education, and so on. As long as a woman feels at home with what we what we would be doing, she is free to join us. (Mrs Nnenna Mgborie, IDI)

More women from various social and economic backgrounds later joined the association. Mrs Mgborie and the pioneer secretary, Mrs Ellen Eki attributed the increase in their membership to the flexibility and nondiscrimination. Mrs Eki argued that although the eight pioneer members were from relatively well-to-do backgrounds, their association now boasts of inclusion

of women from poor backgrounds. According to her, educated and nonliterate women, farmers, traders, teachers, dressmakers, etc. presently belong to the association. Women from the younger age group as well as older women are members. In Mrs Eki's opinion, this diversity attests to the fact that any woman is free to join them. Speaking on the objectives of the association, the pioneer chairperson, Mrs Mgborie, said their original objective was savings. However, there was a controversy on what to do with the savings: whether it would be targeted savings or savings with redistribution. Details of this are given in the next subsection. She added that the idea of giving loans [insurance-contingency loans] for health care came up later. After discussions on the modality, providing insurance-contingency loans was adopted as one of their objectives in 1991.

### **6.2.2 Contributions and financial pooling: generalized reciprocity in the social network**

At the outset members wanted to decide what to do with the pooled finances, but they could not reach a consensus. Some argued that the contributions should be redistributed at the end of the year so that individuals would use their own as they wished. Others argued that the contributions should be used to buy necessary household items; the purchased items may then be shared among the members. The stalemate resulted in the postponement of financial contributions.

In January 1988, four months after the formation of UWA, members finally started making financial contributions. This was the result of a decision reached in the meeting of December 1987 that the association would alternate financial redistribution with collective purchase of household assets for sharing among members. Members started out paying N20 per month. According to key informants, in 1988, N20 equated to the daily wage of an able-bodied woman working as a casual labourer for weeding of a rice field. It could be used to prepare a moderate pot of soup that would last two to three days for a poor household of six co-resident members.

Members were required to make their contributions during the monthly meetings of the association. However, some members took their contributions to the home of the secretary/treasurer. These were members who were absent during the meeting or who although present did not yet have their money. In the first year of the contributions, every member was able to complete their monthly payments by December (1988). A week before Christmas, a special meeting was held in the house of Mrs Ellen Eki, the then secretary/treasurer. The contributed money was redistributed as 'take-out' among the members.

The monthly contributions and annual take-outs appeared as a very good way of saving. It seemed appealing to the members to increase the annual take-outs. So, a decision was taken to raise the monthly contributions from N20 to N40. This would double the annual take-outs for members. The new monthly payment took effect from January 1989. According to Mrs Mgborie and Mrs Eki, the new amount created problems for poor women. Two major reasons were given for this difficulty. There was poor harvest in the preceding agricultural season, and this had not been taken into consideration when the decision to raise the contributions was made. The financial deprivation caused by the poor harvest was accentuated during the dearth season (*umwu*). Between March and June 1989, many women were lagging behind in their contributions; all of them were from poor socioeconomic backgrounds. It seemed that only the well-off could keep pace with regular monthly payments. Most of the defaulters, however, completed the 'missed' contributions by the end of the year. Interestingly, although the defaults in payments in 1989 were attributed to poor harvest of the preceding season, defaults in payments by poor women during the *umwu* period became the trend up to 1992.

In December 1992, there was change in leadership. Mrs Ellen Eki became the chairperson while Mrs Amaka Onweli took over the post of secretary/treasurer. On assumption of office as the chairperson, Mrs Eki suggested to the members that the *umwu* period could be made contribution-free. About the challenges of this period, she told the researcher,

When I was secretary/treasurer, many members continually complained to me that it was very difficult for them to pay during the *umwu* period, and many of them defaulted during this period. Although they made up the payments during the harvest, they always grumbled that it increased their financial burden. So, when I took over as the chairperson I felt I could do something to reduce this burden. I suggested to them that we could suspend contributions during the *umwu* season. (Mrs Ellen Eki, IDI)

The suggestion was appealing to the women and so it was decided that no contributions would be made during the *umwu* period. Therefore, in 1993 and 1994, there were no contributions during the four months of *umwu*. The association did not record any defaults in payments for the two years. Mrs Eki and Mrs Onweli stated that there were outcomes that some better-off members of the association did not like. The most significant outcome that worried better-off women was that less money was pooled and so, the annual take-out per individual was reduced. Some better-off women complained that the events were tantamount to retrogression in achieving the association's objectives. A particular woman took a special interest in en-



couraging others to endure the hardship of making contributions during the *umwu* season, and campaigned for the reintroduction of contributions during this period. She was from a better-off household, and so some poor women felt that she did not sympathize with them in their plight. The poor women insisted that the status quo of noncontributions during the *umwu* season must be maintained. Mrs Eki asked each group to make concessions so that a common ground would be reached. Contributions during the *umwu* season were to be reintroduced; however, members would pay only one-quarter of the normal monthly contributions, that is, N8. This was acceptable to the members. This new arrangement was practised in 1995 and 1996.

Some women felt again that the yearly take-out was just too small, and that the *umwu* season contribution should be raised. But most of the poor women were adamant that raising the contributions would increase their difficulty. Mrs Eki stated that she found herself in the midst of a controversy that was threatening to tear down the association. She was visiting with a member of the association when she got an idea. The association could make extra money through group paid labour. They could get a contract to work on rich farmers' fields for money. This would help them to raise the annual income and yet not increase the *umwu* period contributions. For each labour undertaken, any woman who could not attend and did not send any representative (such as her daughter) would pay a fine. This suggestion was discussed and adopted. This arrangement was introduced in 1997, and it enabled the retention of the one-quarter contributions during the *umwu* season.

Although the monthly contributions were raised in 2002, the arrangements of reduced contributions during *umwu* and income generation through paid labour were retained. Since the inception of paid labour as a source of income generation, it has constituted a significant proportion of the total financial pool of the organization. For example, in 1999 and 2002, it accounted for 16% and 22% of the financial pool respectively. By 2005, the amount of money generated through paid labour rose drastically, and accounted for nearly one-third (32.3%) of the total pool. This amounted to N110,000 (880US\$). The increase in the proportion of income raised from paid labour was attributed to the rise in wage for daily labour in the village.

The amount of money generated by the association has been increasing over the years. From N2,640 in 1988, the total annual income has risen to N340,000 (2,720US\$) in 2005. The large increase was probably caused by three factors. The first factor was the increase in membership. The number of members increased from 8 in 1987 to 23 in 2004. The second factor was the increase in the contributions made by individual members. The monthly

contributions had been increased over the years, with a concomitant increase in total annual contributions by members. The total annual contribution by each individual in 1988 was N240 (total N2,640 for 11 members). In 2005, each member's total annual contribution had reached N10,000, which means a total direct membership contribution of N230,000 (1,840US\$). It is, however, necessary to understand the importance of inflation to the increase in contributions. Key informants stated that it would take about N200 to buy commodities, which one could have bought with N20 in 1988. The third factor is the introduction of paid labour as a form of income generation.

### 6.2.3 Mutual aid mechanisms for health risk mitigation

As in the case study above, contributions to associations may be transformed into mutual aid for the members. For the purposes of analysis and discussion, mutual aid mechanisms inherent in an association are classified into (1) loans (insurance-contingency loans), and (2) annual take-outs, and (3) savings and redistribution. These categories are not mutually exclusive; on the contrary, there are overlaps in scope and function.

#### *(i) Insurance-contingency loans and health risks*

Loans constitute a very important mutual aid function of this association, and some of the features of the loans do help to make them function well in health care access and financial protection. Thus, I preferred to call the loans insurance-contingency loans (loans with insurance contingency).

Giving of loans to members started in 1991. In principle, every member is eligible to be granted a loan. However, a member must meet certain criteria before obtaining a loan. She must be financially up-to-date in her contributions. The association takes this to mean that she must not have defaulted in her monthly contributions for three months cumulatively. A member who does not meet these criteria might be granted a loan; but in this case, she would have to fulfil some conditionalities. These include consent to pay back the loan with interest; to present collateral; and to come with a guarantor who would undertake to repay the loan with interest in the event the debtor defaults. As indicated above, the requirement of being financially up-to-date created problems in the early 1990s when many poor women could not make their contributions during the *umwu* months, leading to the introduction of a number of measures to enable poor women to be able to keep pace with their contributions.

To take a loan, a member meets with the chairperson and secretary/treasurer. She discusses with them a number of issues: why she needs the

loan; how much she needs; and when she expects to pay back. The leaders then tell her how much the association will be able to give her vis-à-vis the available money. In principle, there is no limit to the amount of money a member can borrow. But the record of the association shows that no member has received more than N5000 [40US\$]. The current chairperson, Mrs Esther Ndukwe, defended this, stating that the practice of giving no more than this amount is aimed at reducing defaults in payments of loans. According to her, it would be more difficult for poor women to pay back bigger loans. The irony, however, is that it is the poor women who need bigger loans when faced with health risks, because they may not be able to raise significant amount of money from own intrahousehold sources. Besides telling the prospective borrower the amount the association will be able to give her, the leaders attempt to counsel her on the need to pay back the loan before or on the agreed time. Thereafter, they give the money to the borrower and the secretary/treasurer records it. No agreements are signed. According to the leaders of the association, the transaction is based on trust; however, it is also based on strong social control mechanisms, as will be seen in a later section in this chapter.

Recording of purposes for which women take loans is absent from the documents of the association. This is despite the fact that the leadership usually discusses this with the potential borrower with a view to determining the relative amount of money to grant her. Consequently, the researcher had to interview both the leaders of the association and members of the association whose names appeared in the records as having obtained loans to ascertain the reasons for loans.

Loans were taken to handle various types of risks and adversities but in this study, discussion will be focused on the management of health risks.

Loans are taken for payment for health care at both traditional and modern health facilities. For traditional health care, loans have so far been mostly used to access traditional bone healing. Even though traditional bone healing is not as expensive as modern orthopaedic care, it is nevertheless the most expensive traditional care in Aninri Local Government. The case below is illustrative of how women make use of insurance-contingency loans to handle health risks at traditional healing homes.

### *The case of Nwaka Nkwo*

Mrs Nwaka Nkwo is in her fifties and married to Mr Udo Nkwo. Nwaka is a farmer, and in addition, keeps livestock in her backyard. Mr Nkwo is a vulcanizer living in Onitsha. However, he returns and spends some time in the village during the planting season to carry out farming with his house-

hold on his own piece of lineage farmland at Agu-ofia. Nwaka Nkwo is resident in the village. The co-resident household lives in a three-room mud house, with corrugated sheet roofing and plastered with cement. They own a bicycle, cassette player, plastic chairs, among others. Nwaka and her husband have seven children (four boys and three girls). The household is co-resident with Nwaka's 11-year-old niece. The oldest child, Emma, now 25 years, joined his father in Onitsha after completing his primary education. Emma hawks various items such as bread, biscuits, snacks, and so on.

Emma went out to hawk one day and was knocked down by a hit-and-run driver. He sustained a fracture of his left leg in the accident. He was taken to a hospital for treatment. The emergency medical care helped to stop the bleeding and to make Emma clinically stable. However, it was very expensive. So after one day of admission, Emma was brought back to the village by his father. He was left in the care of Nwaka who subsequently took him to the traditional bonesetter's healing home. He spent three months there and incurred a bill of 6,300 Naira [50.4US\$]. By the time Emma was discharged, his father was still trying to recover from the huge expenditure he made for Emma's emergency treatment in Onitsha. Consequently, he had no money for payment of traditional healing bill. Nwaka obtained a loan of N4500 [36US\$] (which she had to make up from her own sources) to pay for the traditional healing.

Ojanuga and Lefcowitz (1982) state that among the different consumers of health care in Nigeria, people may switch over from one type (e.g., modern medicine) to another (e.g., traditional healing). They argue that the reason people switch from one type of care to another is lack of satisfaction. In the above case, we see a switch from modern medical care to traditional bone healing. However, contrary to Ojanuga and Lefcowitz's proposition, the reason for the switch-over in the case above was financial cost. Emma's one-day treatment in a modern hospital in Onitsha was enough to cause financial distress for his father, thereby prompting his decision to take him home. This social action was most probably underscored by the following assumptions: (i) that traditional bone healing was cheaper and therefore easier for the household to handle; (ii) that Nwaka would be able to obtain financial aid from her mutual aid association for the health-seeking; and (iii) that Emma would be receiving care at the traditional healer pending the time Nwaka would get money from her association.

These assumptions actually held true, and thus suggest that economic and financial considerations were fundamental in the decision to seek care in the traditional healing home.

### Affordability issues and gender

The Four A's model of health seeking helps to explain the health seeking of Nwaka Nkwo and her household. The model postulates that barrier to health care access could be caused by affordability, availability, accessibility and acceptability of health care services. Evidently, when Emma had fracture in Onitsha and was taken to the hospital there, accessibility, availability and acceptability were in favour of their health seeking at the hospital. However, affordability element was unfavourable and therefore, despite the other three elements being favourable, health seeking could not be continued there. The case also reflects the OSDAM health seeking model, which states that individuals keep evaluating their treatment and taking actions based on the results of that evaluation. This case shows that people who seek care do not only evaluate the *result* of the treatment, but that they also evaluate the *costs* of treatment and may also take action based on their evaluation of the cost of treatment, and not solely on how they feel they are responding to treatment. Upon evaluating the cost of treatment, Emma's father decided to take him home for further care.

Gender roles also seem to interact with affordability, health seeking decisions and actions in this case. Taking Emma home to the mother in the village might have been spurred by *affordability* barriers at the hospital in Onitsha. However, the action clearly increased the burden of reproductive duties on Mrs Nwaka Nkwo based on the gender mores in the community. First, she shouldered the responsibility of looking for money for Emma's health seeking at the bone healing facility. Second, it was Nwaka and her daughter (Emma's younger sister) who provided nursing care for Emma while he was on admission at the bone healing facility. Thus, the affordability problem in the far away urban centre of Onitsha created gender problems in the remote rural community.

Besides the gender implications of the case, it also contradicts the proposition that rural dwellers seek traditional care because traditional medicine is a component of their culture and 'has all the sacredness of all traditional things' (Hawkins 1958: 156). While Hawkins' assertion might have been correct in the 1950s, it is doubtful whether it still holds true today. The case of Mrs Nwaka Nkwo portrays that in this rural community, the financial cost of treatment overrides superstitious beliefs and indeed other factors in the choice of where to seek care or in moving from one type of health care to another. In the case in point, the traditional healing had cost Mrs Nkwo N6300 (50.4US\$) for the three-month inpatient bone treatment. My investigations at the tertiary hospitals show that the same case would have cost over N60,000 (480US\$). In a famous specialist hospital in Enugu, I was told

the same care would incur a bill of over N130,000 (1040US\$). While Mrs Nkwo borrowed from her association and made up the deficit from own sources to pay for the traditional healing, it would have been absolutely impossible for Nwaka (and/or her husband) to obtain a loan of N60,000 (480US\$) from any source within the community; as regards N130,000 (1040US\$), interview informants insisted that the only practicable means of getting such an amount in the community is through outright land sale. This was not a viable option because the land under Mr Nkwo's land tenure is owned by the lineage, and so it is unthinkable for him to attempt to sell it as this would be met with stiff opposition from his lineage members.

Gynaecologic emergencies such as miscarriage of pregnancy (threatened or incomplete abortion) may be life-threatening and demands prompt medical care. Such emergencies are also beyond treatment at the lower level of health care. In fact, they cannot be handled at primary health care centres. In October 2004, I had the opportunity of conducting participant observation of the management of such a gynaecologic emergency with support obtained from women's association. The patient, Mrs Agnes Okoro survived perhaps because she was able to obtain immediate financial aid (loan) to go to the hospital. The second case is that of a woman who obtained a loan for surgical delivery of her baby. Mrs Okoro's case is presented first.

### *The case of Agnes Okoro*

Agnes Okoro is a 31 year old farmer. She is married to Greg Okoro, who is also a farmer. In addition to farming, Mr Okoro trades in palm wine. On the Orie market days, he buys from the wine-tappers and takes to the market to sell. They have three children and co-resident with them is Mr Okoro's younger brother who is in the last year of his primary school. The co-resident household lives in a two-room mud apartment.

Early in the morning on 8th October 2004, Agnes noticed she was bleeding through her vagina in her fourth pregnancy. The bleeding was increasing, and was associated with lower abdominal pain. The PMV/midwife, Prossy, was called by the couple, and Prossy sent for me (the researcher). Both of us went to the home of the Okoros together. I took a quick clinical history and conducted a brief general examination, and advised them to take her immediately to a hospital. I seized the opportunity to interview Mrs Okoro and her husband on their financial preparedness for going to the hospital. I was told Mrs Okoro belongs to a woman's association and that they had already decided to go and ask for a loan from the association. I probed further on how much they intended to borrow from the association. They told me they would ask for N5000 [40US\$]. I decided to

join the trip to obtain the loan. Mr Okoro and I went to the home of secretary/treasurer of Agnes association, but she had gone for the Sunday worship service. Since she lives close to the church where she had gone for service, we quickly marched to the church. She was called out and briefed on the problem. We went back to her house where she did some recording and handed Mr Okoro N5000 (40US\$) he had requested on behalf of his wife. We went back to the Okoro home and they prepared immediately and set out for the hospital in Awgu. Agnes received medical care in Awgu and returned home healthy.

### *The case of Mrs Mary Iko*

Mrs Mary Iko is a 25-year-old woman, and a farmer. She is married and a mother of one child. Mr Monday Iko, her husband, completed primary school, and went to Onitsha where he served an apprenticeship term of seven years under the agreement that he would be 'settled' (given financial assistance to start his own business). Like many other young men from the village, his 'master' disappointed him. He tried his hand at a number of 'odd' jobs before coming back to the village to reside and farm six years ago. He married Mary four years ago, and a year later they had a baby.

During her childbirth, which was through caesarean operation at Awgu General Hospital, doctors informed Mary and her husband that her pelvis was contracted and so would not allow normal passage of babies. Consequently, her subsequent deliveries must be through caesarean operations. Mary was due for delivery of her second baby in 2004. It was to be through surgery, as doctors had advised her. She and her husband decided to go back to Awgu General Hospital where the first surgical delivery was done. On 30<sup>th</sup> October 2004, she felt slight labour pains. She went to her association, and obtained a loan of N4000 (32US\$). On 1<sup>st</sup> November, she and her husband made their trip to Awgu. She was admitted and delivered of a baby boy through caesarean surgery. The medical care costed them N8,750 (70US\$). While Mary and the new baby were recuperating in the hospital, her husband came back to the village and embarked on rice harvest, assisted by Mary's sisters. They parboiled and milled the rice. They took it to Orié market where it was sold. The money got through rice sale was used to make up the money got through loan. Mary and her new baby returned home on 8<sup>th</sup> November. I asked her why she did not rather harvest rice prior to the onset of labour and use the proceeds for her medical costs. She responded,

I was very sure my association would give me the loan once I asked them. As my pregnancy approached term I started making preparations. I even bought baby's clothes, powder and other items. But I asked my husband not to commence rice harvest ahead of my anticipated operation. The reason is because a week matters a lot in rice sales. The money you get from the sales increases almost each week. Therefore, it is better to delay rice harvest as long as one can. So, since I have been making my contributions, I felt it was better to use loan and delay rice harvest and sales even if for one week. (Mary Ikoh, IDI)

Pregnancy-related crisis is very well known in this community. IDI respondents and key informants opined that pregnancy is the most common cause of death among women. Hence women who have the access to mutual aid loans do not defer their health-seeking for pregnancy problems, but rather take the option of the loans. For example, before Prossy could arrive at the home of Mrs Agnes Okoro, she had already decided that she would take a loan to go to the hospital. It is also evident in the case of Mary Ikoh that she had decided to obtain a loan for her operative childbirth long before she went into labour.

In these cases we see a kind of preparedness for health-seeking based on an assurance of mutual aid. The mutual aid in UWA generates a sense of certainty of financial availability and accessibility to handle health risks among scheme members. This is especially important to poor women who otherwise will not be able to find money for health-seeking. The UWA mutual aid provides an immediate and secure access to health care. In Mary's and Agnes' cases, there was no doubt in their minds as to whether or not they would get the loans. They were very sure. In a sense, this is what health insurance does, not in an administrative sense, but in a functional context.

It is not only poor women and their households in this village that are jolted by health expenditure to the point of borrowing. Women from households rated rich in the wealth and poverty-ranking FGD also find huge health expenditure unsettling. This is even more so if the woman prefers private health care. An experience of Mrs Rosa Anyaegbu is typical, and is presented below:

### *The case of Rosa Anyaegbu*

In her forties, Mrs Rosa Anyaegbu is educated to primary school level. She and her husband are wealthy farmers. Her husband is a large landowner and they engage in relatively large-scale crop farming. Rosa also trades in food-stuffs, going to the city to buy food items not produced in the community and selling them at home, and in the Orié Market where she owns a stall.



They have six children, two of whom are already in secondary school. Second term in the academic calendar starts in January. Rosa and her husband had paid school fees for their children in secondary and primary schools, following the second funeral rites of Rosa's father-in-law (husband's father), during which the couple had put up an impressive ceremony in keeping with their social status.

In February of that year (2003), Rosa's young daughter came down with severe illness. Upon consultation with the PMV, Rosa was told that her daughter's case needed expert treatment by medical doctors in a hospital. According to her,

She was [then] eight years old. She started complaining of severe headache, and joint pains. Then she became very weak and could not even eat at a point. We took her to Mr Ukah, and after initial treatment, he told us he could not handle the case and that she should go to the hospital. We stayed five days in the hospital; she was given some injections and tablets to take. In fact, she was given at least one injection everyday. The doctor said she had shortage of blood and so she was also given blood. The day we were discharged they gave us some drugs to take home with us. It was a private hospital. I am sure you already know the problems of government hospital, being a doctor yourself. People who had been there said they delay too long before you receive any treatment; sometimes you will even stay there for days and not see any doctor or when they come they are always in haste. I have also heard that the nurses are very rude, and insult patients and their relatives, especially people who are not highly educated, and from the villages. We were told to pay N5,700 [45.6US\$]. I borrowed N4,000 [32US\$] from them [her association]. (Rosa Anyaegbu, IDI)

Although Mrs Anyaegbu raised a number of issues about the differences in quality of care between private and government hospitals, her case also shows that although she comes from a rich household, she had to borrow from her association to be able to take her daughter to a health facility where she could be given appropriate and prompt treatment. This case therefore reveals that events other than illness work in tandem to cause financial vulnerability. In this case, an ostentatious status-seeking second funeral rite and the payment of school fees had combined to weaken the financial position of the Anyaegbus. There is therefore the need to take cognizance of such events in the household as they have become serious consequences in the context of availability of cash in the household for handling risks such as health crisis.

Again, her case demonstrates the interrelationship between availability, affordability, accessibility, acceptability of health care and generalized recip-

reciprocity/ risk sharing for health risks. Rationalization, as noted earlier, has made it possible for private clinics to spread to areas previously without such services such as Awgu. Well-off women can therefore now choose to seek care from private clinics. Waiting time is much shorter in private clinics, and the medical and health workers give more attention to the patients. They are also more courteous. Not surprisingly, they have to display sound interpersonal skills because their income comes directly from the patients. It is often said in Nigeria that the public sector health facility staff lack courtesy and interpersonal skills because they do not care whether the patients will make use of their facilities or not. This is not the same with the private clinics. They need their patients to come back when next in need. They also need the services of their patients in terms of telling other health seekers about their hospitals.

Going to the private clinic entailed paying higher fees for services, but Rosa Anyaegbu, like other rich people, prefer to pay higher fees for what they perceive to be better quality of care. Ordinarily, Rosa would be able to afford to make use of private health care without resorting to financial support from her risk-sharing social network. But as seen in Chapter Three (subsection 3.4.9), deaths and funerals are life-cycle events that induce financial crisis because of the ostentatious way some villagers tend to handle them. Ostentatious funeral rites weakened Rosa's household's capacity to handle a health crisis especially in terms of seeking care at a private clinic. They faced an *affordability* barrier that was surmounted through risk-sharing for health in a generalized reciprocity network.

In Chapter three, we saw that gender and patriarchal norms deprive women of the most important factor that determine economic differentiation, which is ownership and control of land. Women's access to land is therefore through the male members of their household and this has a grave implication for women in contexts in which they have no adult males in their households or they have conflicts with the males in their households. Women in Ukete who have no access to farm land on which to cultivate suffer severe deprivation. In this category are widows, divorcees and women in polygynous settings who are not the favourite wives. In Ukete, sociocultural practices such as polygyny often create intrahousehold tensions and conflicts which negate inter-spousal support. Total absence of interspousal support for women in economically deprived rural areas like Ukete aggravates women's vulnerable position. This cascades into reduced ability of women to seek health care.

However, women may be able to overcome the challenge of absolute lack of interspousal support by participating in risk-sharing networks. Their

participation in such risk-sharing networks is vital in supporting them in their health seeking, which otherwise would be impossible. The case of Ugo Iroegbu sheds light on these issues.

### *The case of Ugo Iroegbu*

Mrs Ugo Iroegbu was in her late fifties during this fieldwork. She was uneducated, and was the second wife in a polygynous household. She lived with her six children in her hearthhold, in a thatched hut with no windows. Mrs Iroegbu scratched out a living by farming, supported by her children who not only helped on her farms but also in her engagements as a casual labourer on other farmers' fields. Although her own hearthhold suffered deprivation and vulnerability, her husband is not poor. He is a rich farmer, and owns a brick house which he rents out. He is co-resident with his other (more favoured) wife and their children in another big brick house with many rooms, windows and corrugated sheet roofing. Her case illustrates how women who are deprived but manage to belong to and pay association's contributions can use aid from their association to cope with health adversities.

Below are transcripts from an in-depth interview with her:

I have been to the hospital a few times but they have not yet completely cured me. The problem is that I bleed much through my private part although I have reached menopause. The sickness started about four years ago. After about a year, I noticed that I was beginning to experience severe pain in my belly below my navel. The pain comes and goes. I kept enduring the pain, as I did not have the money to go the hospital. My husband would not bother much because he has another wife, perhaps a more favoured wife. At a point I could not bear the pain again, and I knew I must do something. I went to the leader of my association, told her I needed money to go for treatment. She sent and called the treasurer, and we all discussed the issue together. I was able to borrow N5000 (40US\$) to go to the hospital.

I spent about 2 weeks in the hospital, and was seen by the doctors. They did a number of tests, and the money went to the payments for these tests and hospital bills. I was told they were suspecting cancer, and I was discharged and told to visit again in two weeks. I did not have money to go back. I am trying to say that I have not even been treated. I do not have money to go back for treatment.

I have not even paid back the money I borrowed. I am still trying to continue to make my contributions, but paying back the loan is difficult for me. My association seems to understand. (Mrs Ugo Iroegbu, IDI)

In Ukete, younger wives in polygynous households are usually the favourite of their husbands, and they enjoy a lot of privileges compared to the older wives. They are the ones to co-reside with their husbands under the same roof. They jointly farm with their husbands. If their husbands are men of means, the favourite wives are given money to start off-farm income generating such as petty trading. They are also supported to participate in generalized reciprocity risk-sharing networks.

Although Ugo Iroegbu was the younger wife in her polygynous household, she did not enjoy any of the above support from her husband. In her case, in fact, her husband's disposition was that of hatred and so she had absolutely no support from him. One frequent cause of this is the failure of the younger wives to bear male children<sup>2</sup>. Ugo's major source of income was casual labour on people's farms, and she brought up her children single-handedly on the little proceeds from this.

When her children grew up and supported her in the paid labour contracts, she decided to join Umuchu Women's Association; her co-wife was already a member of another risk-sharing association with moral and financial support from Mr. Iroegbu.

Two issues beg further consideration. First, women's lack of access to health care is a gendered issue and evidently, intrahousehold gender relations may not be altruistic. Social creation of intrahousehold barriers to health care access exerts strong effects on women in contexts in which there are no macro-level (national) mechanisms of social protection for women, as obtains in Nigeria. In such contexts, health care services may be available, accessible (within geographical reach) and acceptable, but not affordable to women because of intrahousehold gender relations and patriarchal norms in terms of ownership and control of household assets and resources. In Ugo's case, gender and patriarchal norms deprived her of benefits from the household farm lands and the proceeds from the house rented out to tenants.

Second, women's participation in generalized reciprocity risk-sharing networks may not be a neutral process, but may be highly gendered. Men may exert strong influence on women's participation in such endogenous associations. When men provide financial and moral support to their wives to participate in such organizations, it reduces the burden on their wives. Oshi & Oshi (2007) found that in one community-based organization operating risk-sharing for maternal health care in Eastern Nigeria, some men tended to support their wives. In UWA, a number of women derive financial support from their husbands, but deeper exploration showed that such women were from better off households. Does this create problems of fair-

ness in stipulating financial contributions vis-à-vis women who are not supported by their husbands? A more worrisome question, perhaps, is: when men provide financial support to their wives to participate in such networks, would it also be easier to influence their wives to withdraw from such associations? Responses from women tend to suggest otherwise. Women supported by their husbands in UWA that were interviewed stated that their husbands never urged them to quit participating in the organization. The extremely low withdrawal rate in UWA lends credence to their assertion.

More importantly, the case shows that women can overcome sociocultural and economic drawbacks within their households through participation in a mutual aid social network. Mutual aid schemes can empower women to seek care where otherwise it would have been impossible. It can help women to overcome psychological and economic dependency on individuals (such as a husband) and institutions (such as marriage) where such persons and institutions fail to perform their normative functions.

Contrasting Mrs Ugo Iroegbu's case with Mrs Kaka Onwe's case (section 5.3) highlights the salient changes in behaviour associated with participation in mutual aid schemes. The two women were in polygynous households. The two women were the younger wives, but ironically were hated by the husbands because they did not have male children. However, Mrs Iroegbu participated in a risk-sharing endogenous association, Mrs Onwe did not. While Mrs Iroegbu boldly took steps to avail health care without assistance from her husband, Mrs Onwe has never been to the hospital.

### **Psychosocial elements of social networks**

In conceptualizing the mechanisms through which social networks influence health, Berkman and Glass (2000: 145) state that psychosocial elements of social networks influence health by providing opportunities for economic and financial aid or assistance, sharing of knowledge, advice and information, influencing behaviours such as utilization of health care services and improving self-esteem. These psychosocial elements are components of the wider psychosocial mechanisms which include social support, social influence, social engagement, person-to-person contact, and access to resources and material goods.

These psychosocial elements of risk-sharing networks may explain the differences in health behaviour of Mrs Iroegbu and Mrs Onwe. The more obvious and undoubtedly the more important is the accessibility of financial aid. The assurance that one can obtain financial aid from her scheme is enough to bring about the decision for health-seeking. Mrs Iroegbu could

obtain financial assistance from her association for health seeking. This was not possible for Mrs Onwe.

Through social influence, members of an association compare their behaviours with their peers and role models within the network. Mrs Iroegbu's health-seeking behaviour would have been influenced by seeing other members of UWA going to the hospitals to seek care for themselves or their household members. This would serve as an encouragement for her to seek health care. Her network also provided her with close associates in whom to confide and obtain advice on health seeking. Some of her network members had had experience of health seeking using financial assistance from their scheme before her. These advantages were not available to Mrs Onwe.

Social engagement within UWA provided Mrs Iroegbu with opportunities for participation in social activities and for companionship. Interactions with other members of the association helped to improve her self-esteem and awaken the desire for self-actualization. As Narayan (1999) points out, bonding social capital, which operates in social networks strengthens members' support. And social trust and shared values, which are cognitive aspects of social capital, increases individual's perception of security and self-esteem in her social network. Self-actualization here refers to the consciousness to use accessible means to improve one's welfare. Therefore, it is not surprising that Mrs Iroegbu<sup>3</sup> would decide to grapple with and negotiate access to health care, while, on the other hand, Mrs Onwe who did not belong to any mutual aid group would wallow in self-pity.

### **Repayment of loans: social capital and collective action**

Concerning collective action in small social networks, Olson (1965) remarks,

In a very small group, where every member gets a substantial proportion of the total gain simply because there are few others in the group, a collective good can often be provided by the voluntary, self-interested action of the members of the group. (Olson 1965: 33–4)

He argues that small groups are usually able to provide common goods for themselves because the group members are often linked by stronger social bonds such as friendship ties. This makes social pressure an adequate mechanism for social control within the group. This also minimizes administrative costs in small groups. Friendship ties in social networks foster social capital, which in turn enables collective action by minimizing social control problems. In UWA, we see how social capital facilitates loan recovery and therefore enhances collective action within the group.

Loan recovery in the association is high, with most loans repaid within twelve months. Since 1991 when the association started granting loans, three loans were not recovered. Death was the cause of failure of recovery of loans in one of the three cases. In the other case, the outstanding amount to be repaid was considered too small to bother about when the debtor withdrew her membership. The secretary/treasurer said the association decided to consider the loan a bad debt in the interest of peace in the lineage.

The leaders of the association said the high rate of loan recovery is because they trust each other. They said their members will usually not want to betray that trust. A member of the association corroborated their account. She told me they (the members) see themselves as friends who share similar values and norms. Their responses suggest that social capital may be important in fostering loan recovery from debtors. Three members of the association who had borrowed and had completed their repayment were asked what motivated them to pay back their loans. Their responses were:

I knew my association had much trust in me when I was given the loan. I would be wrong for me to abuse that trust. You can't imagine that I did not sign any agreement with them. I did not bring anybody to stand surety for me. They just gave me the loan. That means that they felt that I would pay back. So, I had to live up to that trust. I strove to pay back although it was not easy at all. (Onachi Ede, 32 years).

I have friends in our association. In fact, I actually even brought two friends into the association. They look up to me. I had to live up to their expectation and that of the entire association. If I didn't pay, it would bring quarrels, and spoil my friendship with many people in the association. So, I had to pay. (Eva Osita, 45 years)

I have taken part together with my association members in many activities, child-naming ceremony, marriage ceremony, Christmas celebrations; in fact, so many things together. I don't think anybody would like to spoil such fun. It's a beautiful thing to associate with my members. For such a group, I would do anything to avoid trouble. I borrowed and I promised to pay, and the money was given to me without hesitation because they believe in me. They believe in me because we know each other. I had to make sure that I completed the payments before six months. I paid them every month for those six months. (Mabel Nnaji, 38 years)

These responses further buttress the role of social capital in loan recovery. However, it is likely that social capital might have interacted with social control mechanisms (such as ineligibility for a second loan unless the first one is fully paid back) in the achievement of high rate of recovery of loans.

Members who borrow are given up to six months to pay back the loans. They are at liberty to pay the whole amount at once or to pay instalments. The leaders usually emphasize that if the borrower does not pay up at the end of the sixth month, an interest of N1 for every N10 will be charged.

### *(ii) Annual take-outs and health risks*

The take-outs received by members have helped a number of them to manage health crisis. The chairperson of UWA stated that women in her association have a long history of using their take-outs for health care payments. She said that, as a pioneer member of UWA, she is aware of many instances in which women were able to go to different types of health care facilities because of the take-outs. According to her,

This is not new. It is not a new thing for us. Members of this association have been using their annual take-outs to pay for treatments. Whether it is traditional bone healing, whether it is primary health, whether it is government or private hospital, our members have gone there with their take-outs. I have been a member of this association from the day it started. So, I can tell you. In fact, I know that in many cases it would have been very difficult, let me not say impossible, for the women to make it to the hospitals but for the money they got from this association. ... For themselves when they are sick and for their household members, our take-outs have been very helpful. (Esther Ndukwe, key informant)

Mrs Ndukwe's body language and smiles as she discussed with me spoke volumes of her delight with the benefits the members derive from her association. Interviews with and naturalistic observations of women seeking health care for themselves and their household co-residents show that Mrs Ndukwe's assertions were correct. Members of the association who were interviewed indicated that the money they got from the association helped them to tackle problems in their households, including problems of health care.

Some women plan long before the redistribution to use their take-out to handle a longstanding illness. Some women encounter sudden health crisis shortly after getting their take-outs, and so they find their take-outs handy in managing the crisis. According to one such case, Mrs Andi Ikpe, who used her take-outs to handle emergency health calamity, health risk was not something she thought could be planned for; so she certainly did not plan for a health adversity that her household encountered in 2003. Her case is presented below to illustrate how annual take-out has been used to manage health crisis.



### *The case of Mrs Andi Ikpe*

Mrs Andi Ikpe is educated to secondary/commercial school level where she majored in secretarial studies. It was in her final year in the school in Enugu that she met Sunday Ikpe, doing an apprenticeship term in grocery business. They married three years later and lived in Enugu. Mr Ikpe completed his term and was one of the very few fortunate ones to be 'settled' by their masters. With the settlement money from his master, he started his own grocery business, dealing mainly in fruits, vegetables and related products (canned beans, canned mushrooms, among others).

The couple lived for five years in Enugu and had two children. However, the grocery business was not making any progress. On the contrary, it steadily declined. Their economic situation was not helped by the fact that Andi could not get a job with her certificate in secretarial studies for five years after graduating from high school. It got to the point that the whole household could no longer stay in the city, and Andi and the children returned to the village. Her adolescent younger sister joined her household. Although Sunday Ikpe continued to stay in the city, his grocery business has completely failed and he just hangs around in Enugu doing menial jobs.

In the village, Andi sells dry beans (not produced in the village), smoked fish (mangara), soup and stew ingredients. She also owns a small machine for grinding the ingredients in her stall. On the market days, she takes her wares to the market for sale. In addition, she does small farming, which she said is basically for home consumption. By way of social networking, she belongs to UWA and has her friends there too.

In December 2003, two days after receiving her take-out, her first child suffered high fever with convulsion. He was six years old. She sent for an okada rider who immediately came and took them to Nenwe, from where they boarded a mini-bus to Enugu. Her son received treatment and made full recovery. Her take-out proved very useful for the health-seeking, which cost her N4300. This amount, according to her, was enough for the feeding of her household of four co-residents for over one month. She wished her association could introduce a special contribution for health adversities. She stated that handling the health risk would have been very difficult if she did not have the take-out.

I asked her what her husband who lives in Enugu contributed to the health-seeking. She said he cooked and brought food to them in the hospital. He did not, however, contribute to fees payment because he did not have the money at that point in time. He had just paid six months arrears of his house rent and therefore had no money.

This case indicates the functional role take-outs play in the management of health risks. The take-outs provide an instant access to emergency health care. In this case, the take-out covered transport, consultations and medicines. The provision of available cash saved the woman from considerable distress that a health crisis usually brings with it. It is very unlikely that a household like that of Andi Ikpe's would have been able to obtain a lump sum of N4300, on sudden demand, from intrahousehold sources. The income from her petty trading would certainly have failed her especially given that such income is also used for household consumption.

In another case, Mrs Ene Okorie reported an experience similar to that of Mrs Andi Ikpe. She said she was planning to go to the city with her take-out to buy new clothes for her children and herself in preparation for the Christmas celebration, but had to change her plans when illness occurred in her household.

### *The case of Mrs Ene Okorie*

Mrs Ene Okorie completed her primary education in the same year with Mrs Andi Ikpe; they were classmates and friends. Indeed, it was Ene that invited Andi to join UWA when she returned from Enugu. After completion of their primary education, Ene stayed back in the village and got married while Andi proceeded to Enugu for high school education.

Ene is a farmer and married with four children. She combines farming with a small eatery she operates with her husband on Orié Market days. In the eatery, they sell mainly pepper soup with bushmeat (grasscutter) and palm wine. When the farm work is not too demanding, Ene prepares and sells moin moin (local maize pudding) in their eatery. Ene's main social networking is her membership in UWA, and she actively participates in the associative movement's activities.

December falls within the brief dry dusty windy season in Nigeria referred to as harmattan characterized by outbreaks of influenza, pneumonia, meningitis and other diseases spread by droplet infection. Yet, no household seems to make ex-ante preparation for health risks which are frequent during this season. Women and their households carry on with their normal activities, especially the frenzied preparation for the Christmas.

For Ene and her household, it was a time for Christmas preparation for which she was looking forward to use the redistribution given to the members in December. So, after receiving her take-outs, she decided to go for Christmas shopping on 18th December 2003. However, in the night of 17th December, her nine-year-old daughter started coughing. She also complained of chest pain. The next morning, the girl woke up with severe diffi-

culty in breathing. She and her husband consulted the patent medicine dealer who gave them cough syrup and other medicines and advised them to take the child to the hospital as soon as they could. She and her husband decided to take her to the General Hospital in Awgu. She was treated and made full recovery. The treatment had cost her N3800. Ene said her feelings about the incident were mixed; on the one hand, she was glad that she was able to take her daughter to hospital for treatment, but on the other hand, she was sad that she had had to spend her take-out on treatment instead of spending it on Christmas.

This case shares many features like that of Mrs Ikpe. It demonstrates how a woman can commence and successfully conclude a health-seeking process with money obtained from a mutual aid group, when her livelihood activity would not be able to generate enough cash income for the health-seeking. One may wonder why Mrs Ene was partly sad that the money she had planned to use for Christmas has been taken up by health costs. But her reaction shows the importance the rural folks in this community attach to festivities. In the absence of other savings, her hopes for Christmas rested with her take-outs. Thus it must have come to her as a rude shock to realize that the money she earmarked for the festivity would now be spent on health crisis. Fortunately for her, the cost of the health-seeking was moderate (N3800), which implies that, at least, she did not have to borrow. Besides, the amount was less than her annual take-out, which was above N10,000. She must then have been planning an ostentatious celebration, which would take more than N6000 not spent in health-seeking. This is not uncommon among the villagers, including the poor. But there is also the thinking that her emotional disposition about using part of her take-out for health-seeking instead of festival would have been different if the sickness her child suffered from had been very severe and potentially fatal. In that case, she would have been more concerned that her child managed to pull through the illness. Potentially fatal diseases are not uncommon during the dry season in the village. In the next case, we see a response to a disease that carries an ominous threat of fatality.

During the *barmattan* period, the most dreaded disease is meningitis. Because of its acute onset, fast deterioration and poor prognosis if untreated, it kills within two to three days. The respondents describe it as a dreadful disease that kills by breaking the neck of the victim, and so they nicknamed it *mbajji-onu* (neck-breaker). The occurrence of symptoms suspected to be *mbajji-onu* sets a household in extreme panic. The ability to get money immediately to embark on health-seeking is perceived by the villagers as a

most important aid. A case of handling this most distressing health emergency with a take-out is presented below. The case of Uche Okere reveals how life could be saved and anxiety relieved by the availability of take-out.

### *The case of Uche Okere*

Mrs Uche Okere is probably in her late forties (although her physical appearance makes her appear to be in her late fifties). She is married to a farmer/mason, Mr Ifeanyi Okere. The couple has five living children, having lost three children. When they were younger, Ifeanyi Okere used to migrate to the western part of Nigeria where he combined masonry work with palm wine-tapping. He prospered and married a second wife, with whom he used to migrate seasonally. He had also been able to build a brick house before the tide turned. He lost his second wife during childbirth, after having three children with her. As he became older, he was no longer able to migrate.

Uche Okere is now co-resident with her children, her late co-wife's children and Ifeanyi. The co-resident household engages in farming for consumption and for cash. Uche's social activities include her networking within the UWA. Her case history is completed from the transcripts of an IDI with her:

It was a miracle that he [her son Ogbonnaya] survived. That miracle came by way of my take-outs. I do not think Ogbonnaya would have survived mgbajionu. I know young men who died from this terrible disease in this village. Ogbonnaya came back from school and complained of severe headache. I told him to take the remnant of a medicine we bought before for iba [malaria]. He obeyed me. But the headache worsened, and within one hour, he started complaining of severe neck pain. I was no longer feeling comfortable at all. Iba does not behave like that. I remembered young men who died shortly after complaining of these problems Ogbonnaya was telling me about.

I sent his elder sister to run and call their father who had gone to cut palm fruits on our farm. I said I am not going to lose my son. I have already lost three children, and I am not going to lose another one. I helped Ogbonnaya to dress up and I prepared myself. By the time my husband returned Ogbonnaya could no longer turn his neck. I started weeping. My husband prepared very quickly and we took Ogbonnaya to the road near the school. We got an okada [motorbike] to Nenwe, from where we took motor (car?) to Enugu. Ogbonnaya was treated with injections and drips they attached to his hand. He survived the attack. Ogbonnaya spent 13 days in admission and incurred a bill of N7900. (Mrs Uche Okere, IDI)

The above case history shows that even uneducated women could be empowered to take action for health if they have the means. Having a secure

means of financial support for managing health crisis may even go a long way to reduce the high mortality rates obtained in the rural areas. And mutualization of financial support will enhance the provision of security of financial access to health care.

It is rare in Ukete for a poor woman to be able to take her child to the hospital in Enugu the same day a health emergency occurs. As seen in Chapters 4 and 5, acute health emergency causes consternation, confusion and panic if there is no available and accessible money to seek treatment. However, in the above case, the availability of mutual aid was associated with clarity of purpose. Mrs Okere and her husband understood the need to by-pass the PMVs and the primary health centres. The interpretation of the constellation of symptoms and the perception of the severity and prognosis were backed up with availability of mutual aid. If the case of Mrs Okorie and Mrs Okere are compared, in terms of their emotional disposition toward using their money for health-seeking, it is obvious that Mrs Okere was happier over using her take-out for health-seeking. This is in spite of her spending more than twice the former. The illness encountered in the case of Mrs Okere had been associated with more fatalities in the village. Little wonder then that she considered her child's survival as a miracle.

Yet, the relief obtained due to access to mutual aid does not involve only care-seeking in the expensive secondary and tertiary care institutions. Mutual aid in this village has proved useful also in seeking health care at the primary level. A woman had spent part of her take-out in preparation for the Christmas celebrations when a health crisis struck her household. She reported that even the remnant of her take-out was useful in obtaining treatment at the Primary Health Centre in Oduma.

### *The case of Ifeoma Nwani*

Mrs Ifeoma Nwani belongs to the socioeconomic group the villagers perceive as poor. She and her husband are farmers. Of their eight children, only the last three children are in primary school. The older children either dropped out of primary school or did not go at all (the two first daughters did not go to school at all). The first daughter has been married out, and the rest of the household are co-resident in a two-room mud house.

Although Mrs Nwani belongs to UWA, she finds it very difficult to make her contributions regularly. She had indeed considered quitting in 1993 but for the introduction of changes made by the then chairperson, Mrs Ellen Eki, to accommodate members who found it difficult to keep pace with their contributions.

Mrs Nwani usually makes use of her take-out to celebrate Christmas for her large family. Christmas 2004 came and went and her take-out had been helpful in their celebrations. But Mrs Nwani said she did not know that the remainder of her take-out would also be useful again in saving the life of her 16-year-old daughter, Sopuru. In January 2005, Sopuru complained of stomach upset. Her mother gave her N10 to buy Andrews liver salt (magnesium trisilicate effervescence salt) quite popular in this society for relief of stomach upset. She took it, but there was no relief. About two hours later, the stomach upset turned into gripping pain. This was followed shortly by vomiting and frequent passage of stools (diarrhoea). They called Mr Ukah, who said it was beyond his capability to help her. However, he provided his bicycle which was used to take Sopuru to the Primary Health Centre in Oduma. She was given intravenous fluids and some capsules. She made quick recovery and came back home the same day. The cost was N2360.

As noted in Chapter 3, Christmas is one of the events that aggravate deprivation and vulnerability. Even for women who belong to associations that practise financial pooling, the post-Christmas period is perceived as a very difficult period. It is not surprising then why a woman who still had a proportion of her take-out, post-Christmas, to pay for her child's health care would be very happy. This is more so when she making her contributions has not been too easy. In fact, Mrs Nwani stated that she was quite happy that she has continued in the association. Her persistence has paid off. Her take-out has enabled her to surmount two of the situations that frequently leave villagers in a state of deprivation: health crisis and festivities.

The use of take-outs for health care faces competition from demands in the household other than Christmas. While some succeed in using the money to carry out their original plans and wishes, many fail to do so because they encounter more demanding situations. For one woman and her household, the 2004 take-out was earmarked for school fees. But when she was faced with the crisis of paying for inpatient care at the General Hospital, she was forced to change her plans.

### *The case of Mercy Dija*

Mercy Dija had barely been married for ten years when she lost her husband. She was left with four children to take care of. The co-resident household reside in a three-room mud house with corrugated zinc roof. Her late husband, Mr Onyeka Dija, had got a share of the lineage land, and after his demise, Mercy has continued farming on his land without hindrance.

That has enabled her to grow food for both consumption and for cash. She cultivates rice, okra, cassava and vegetables.

By way of social networking, her early widowhood initially constituted an impediment but she overcame it. Presently, she is one of the few widows who belong to an associative movement that carry out financial contributions.

She decided to keep the take-outs each year for the purpose of paying her children's school fees. She was able to carry out this routine for three years. In 2004, she felt that this would also be the case. However, she took ill in the first week of the following year, 2005. She had developed general body weakness, dizziness and spells of fainting. She decided to use her take-out to go to General Hospital. She was admitted for inpatient care, after being told she had shortage of blood. She was given one pint of blood, and placed on assorted capsules. Her treatment had cost her slightly over N10,000 [80US\$].

Mrs Dija was described by her friends and co-members in her associative movement as a very hardworking woman. Her friends said that despite her being a widow, she makes her contributions regularly. From the researcher's own findings, Mercy is one of the very few individuals who are able to earmark income for specific household projects, such as children's school fees. But her case gives an insight again into the unpredictability of health risks, and how accessibility of mutual aid could help in managing the risks.

Some illnesses occur long before the annual redistribution time. Interview respondents and focus group participants noted that some women prefer to wait for the redistribution time (instead of taking a loan). A woman who experiences a health crisis may decide to wait for the redistribution for a number of reasons. One reason would be her perceived severity of the illness, and this perception of the severity is dependent on her previous experience of the disease or her having seen another person who suffered similar symptoms. She could label the disease as not being life-threatening in the immediate term, and thus, she could wait for her take-out. Communicating with her most significant social relations might reinforce her decision to postpone health-seeking until she receives her take-out.

Another reason to defer health-seeking until take-outs are available is the information obtained during preliminary health visit which indicates that more money than the health-seeker currently has is needed for further and more definitive treatment. The former is illustrated by the case of Maria Ogonna. The latter is illustrated by the cases of Mrs Nina Umeh and Mrs Dorothy Osu.

### *The case of Maria Ogbonna*

Mrs Maria Ogbonna and her husband are farmers in their late fifties. They cultivate their share of lineage land, but do not have enough to lease any of it out to tenant farmers. They have five children, three girls and two boys; the youngest is a teenage girl in last grade of primary school. The other two girls are married; one boy is in secondary school, while the other boy is an apprentice trader in Onitsha. The household usually grows enough food for the family, and a little extra for cash to meet some basic household needs. Mrs Ogbonna's sister's daughter who also attends the same primary school with their youngest daughter lives with them. The co-resident household lives in a two-room mud-walled apartment with corrugated sheet roofing. Mrs Ogbonna is a regular contributor to UWA pooling scheme, and participates in the social networking activities.

In September 2004, Mrs Maria Ogbonna was weeding in her rice field with a hoe. She dug the hoe into the soil about the roots of a huge grass and pulled. She felt a sharp pain in her left groin. She released her hoe, and went to rest. She called her teenage daughter to assist her pull out the grass. The pain subsided and she resumed the weeding but being careful not to pull hard at hoe or grass. She observed in the evening that there had been a mild swelling around the site she felt the pain. She took paracetamol (pain reliever/analgesic) and felt better. When she told her husband, and he looked at it, he said such a thing had happened to one of his friends when he was making mounds for yams, and that it was later said to be hernia by doctors. Though this happened when he was much younger, a number of similar cases had happened in the village. Based on this knowledge, the couple arrived at a diagnosis of hernia. The following day, Mr Uka the PMV was called in, and he confirmed that Mrs Ogbonna had developed hernia.

According to Mrs Ogbonna, the hernia did not stop her from doing her farm work, and so she decided that it was better to wait until she got her take-out in December before going for treatment, although she was aware that she could take a loan from her association to go for treatment. According to her, 'using your take-out is always better than taking a loan. Your take-out is your own property. It is your money. You do not need to pay it back. My husband and I felt I could wait till December and use my take-out to go for treatment'.

In December, after the redistribution, Mrs Ogbonna travelled to Enugu where she underwent a surgical operation. She returned a week later and had made good recovery. The cost of treatment was put at N15,600 [124.8US\$]. She stated, 'my take-out is my saving. I have used my saving to go for treatment. I feel much better about it than using a loan. Although it



was not enough for the treatment, we sold some rice and made up the money. I am glad that I belong to the association'.

### *The case of Nina Umeh*

Mrs Nina Umeh, 34 years, combines dressmaking with farming on rented land. She had completed primary school in her home village of Amohite, another community in Aninri Local Government before she got married to Mr Cosmas Umeh. She has four children (three boys and one girl). The first child, a boy, is 11 years and in primary four. The second child, the only girl, is eight years and in primary two. The third and fourth children are five and three years respectively, and have not started school. Cosmas was a professional shoemaker in Onitsha. The worsening economic situation in the country severely affected his business. He relocated to the village in 1999, and currently combines farming with shoe repairs on the weekly market days.

In March 2004, the last child, Chidozie developed a febrile illness. Three days after the onset of the illness, Nina noticed yellowness in his eyes. This was followed by painful bilateral swelling of his hands and feet. Chidozie cried excessively and was very irritable. Prossy, the PMV/midwife, was called in. She administered anti-malarial injections, and analgesic and multi-vitamin syrups. She advised Nina and her husband to take Chidozie to the hospital. They had little money on them, and fortunately as it seemed, the symptoms disappeared, and so Chidozie was not taken to the hospital.

Three months later, what seemed like a recurrence of the March illness happened. There was recovery within seven days. Nina observed something strange though after Chidozie's recovery. There was persistence of a tinge of yellowish discolouration of his eyes. Chidozie was apparently well until October 2004 when he had a bout of fever and coryza (flu/ common cold). But in addition, he developed painful bilateral swelling of hands and feet. The yellowness of his eyes was accentuated. Also present in this episode of illness was a soft palpable swelling on the left side of his abdomen. Chidozie was taken to the Primary Health Centre where he was treated, and Nina and her husband were given a presumptive diagnosis of sickle cell anaemia and referred to the teaching hospital for expert management. Though the crisis has subsided, the yellowness of the eyes persisted.

With little money in the house, but with the time for redistribution approaching (in December), Nina decided to wait to use her take-out to take Chidozie to the hospital. She finally got her take-out in December 2004, and with it Chidozie was taken to the University of Nigeria Teaching Hospital in Enugu, where he was diagnosed of sickle cell anaemia. Nina and her hus-

band were educated by the doctors on the things that cause crisis and how to avoid them. The expenditure for the treatment was N8200 [65.6US\$].

### *The case of Dorothy Osu*

Dorothy Osu is a 26-year-old woman. She has primary education. She is a farmer and a hairdresser. She is married to Mek Osu, a farmer, who also has primary education. Mek Osu is from one of the major landowning lineages; he and Dorothy are considered by villagers to be doing well in his farming. They live in a three-room mud apartment, and possess plastic water tank, stove, and twin radio/cassette recorder. Their productive assets include bicycle, Dorothy's hair dryer, rollers, hair-washing bucket, and livestock (sheep and goats). The couple has three children (two boys and one girl).

After her last childbirth, Dorothy went for apprenticeship training in hairdressing in Oduma, under another woman from Ukete (Mrs Ogosi Ekwe, who had just relocated from Onitsha). This was sequel to the couple's decision to expand Dorothy's hair dressing business. After the apprenticeship, they bought a small portable Tiger generator and an electric hair dryer. A small shop was rented for Dorothy in the Orie Market in Oduma, about thirty minute's walk from Ukete. Expanding Dorothy's business took quite some money from the couple, thereby weakening their capability to handle a health problem that occurred shortly after this business expansion took place. Dorothy started feeling pain in her stomach, in the upper part just below the rib cage. The pain was aggravated by eating spicy foods, and drinking alcohol. The pain was especially worse in the middle of the night, and was relieved if she ate non-spicy food. The pain would occur for about three to five days and then would disappear. It would, however, relapse after about two to three weeks. She obtained treatment from the PMV, Mr Ukah. But the treatment would only relieve the pain momentarily. By the third month, the pain was severer and more frequent. Dorothy was advised by the PMV to seek medical attention in a hospital. She decided to wait for her take-out in December. But in the meantime, she went to the Primary Health Centre in Oduma, where she was placed on magnesium trisilicate suspension. She was also referred to a tertiary level hospital for further treatment.

She was able to proceed to Park Lane Hospital after receiving her take-out where she underwent some tests and was given proper treatment. She spent N7400 [59.2US\$] for this health care incident.

These three cases portray the hope that take-outs give to members of a pooling scheme. The hope is kept alive by the prospect of take-outs. The

women know that their wait is not endless but time bound. They may be deemed to be saving up for treatment, which saving would be very difficult if not impossible to do within poor households.

Some similarities exist between the three cases above. First, there was awareness among the women that the illness conditions encountered in their households were not acutely fatal, that is, they would not kill immediately after onset. In Mrs Ogbonna's case, her subjective feeling of the symptoms and her husband's observation of similar symptoms led them to the conclusion that the illness would not get out of hand before the redistribution. In the case of Mrs Nina Umeh and Dorothy Osu, the sporadic nature of the symptoms and their perception of the degree of severity of the illness possibly influenced their decision that treatment-seeking could be deferred. The second similarity is a preference for take-outs to loans. The three women were regular contributors to the financial pool, and thus were qualified to take loans. However, each felt that it was better to wait for the redistribution. Apart from Mrs Umeh's case, the illnesses occurred quite close to the redistribution time. Even in Mrs Umeh's case, the worst exacerbation of the illnesses occurred in October, about the same time as the other two cases. This closeness of the onset (or exacerbation) of the illnesses to the redistribution might be one of the factors that influenced the decision to wait for the take-outs.

In summary, the pooling and annual redistribution of money by the members provide an opportunity for women to seek and obtain health care. Women use their take-outs to go for treatment for themselves and their dependent family members. Health care is accessed for both sudden acute illnesses and chronic illnesses. The mode of payment though is usually direct out-of-pocket expenditure, using individual take-outs.

Not every illness occurs close to the redistribution time such that affected women can wait for their take-out. In some instances, the perceived (awareness) and actual manifestations of the severity of the illness spell imminent danger. Therefore, it will be clear to everybody that health-seeking cannot be deferred. Taking of a loan becomes necessary, and preferable to waiting for redistribution.

### *(iii) Savings and redistribution in the social network*

In the evening of the second Sunday of December each year, a special (end-of-year) meeting of the UWA takes place in the compound of the serving chairperson. Prior to this meeting, precisely during the November monthly meeting, a small committee is constituted to prepare entertainment during

the December meeting. The account below is from a naturalistic observation.

Members began to arrive about 3 o'clock in the evening. On long benches already arranged by the entertainment committee, they sat and chatted while awaiting others' arrival. About an hour later, the chairperson declared the meeting open. The members then sang songs intermixed with ululations for about 30 minutes. The secretary then took over. She read out the financial details. This included the amount of money collected through contributions and through paid labour; the amount of money given out on loans; the amount repaid and yet to be repaid; the amount of money spent on entertainment. She then informed the members of the value of one-tenth of the net capital, which was supposed to be carried over to the following year. Finally, the time everybody seemed to be waiting for came; this was the time to receive take-outs. The secretary reminded them to count their money once they received it. She called the members one by one, and handed to them the take-outs, which she and the chairperson had already carefully counted and put in small envelopes. This was a solemn moment as each member was busy counting their take-outs. After this, the chairperson continued the coordination and guided discussions on salient matters that affect the association. This was followed immediately by a very rowdy phase of entertainment, as members ate, drank, sang, etc. Individuals left when they felt that they had had enough of the entertainment and socialization. The responsibility of clearing and washing the dishes as well as returning borrowed benches, dishes and pots rested with the members of the entertainment committee. This is clearly a heavy responsibility, hence membership of the committee is rotated on annual basis.

I conducted brief interviews with a few of the women after this event. Their responses underscore the importance of their experience of savings (by way of financial pooling) to them. One respondent likened the experience to farming. According to her, as a farmer waits for the harvest, so also she waits for her take-out.

I have looked forward to this day. It is just like we do in farming. When we are doing our farm work we look forward to the day of harvest. In much the same way, when we make our contributions we look forward to this day of redistribution. That day has come. (Ifeoma Umeh, ICI)

Another respondent was overjoyed to receive her take-out. She said it is a means of savings for her. She is learning the necessity of saving from the pooling scheme.

I am very happy. Making savings is never easy but it must be done. Savings is a necessity. That is what this experience has taught me. Now, by the grace of God, I can use my take-out for the good of my household. (Odinaka Chukwu, ICI)

A respondent narrated how her perception of saving has changed because of her participation in UWA pooling scheme. Prior to her membership, she perceived her income as too small for saving. In her words,

I was not used to any form of savings. I could not save. I never saw the need to. I usually thought that the money I got was too small to bother to make savings. I think I know better now. In this association, I have made savings throughout the year. I have just got my take-out. That means bulk money for me. That would have been unthinkable for me before. (Akunna Oluoha, ICI)

A respondent who is a teacher in the primary school indicated that the pooling and redistribution taught her the self-discipline she needed to start saving. She stated that she now even makes own savings at home too.

Before I joined this association I never considered keeping apart some of my income as savings. But this activity [scheme] has taught me discipline. I now see a need to save. I am now able to save through the [scheme]. I also apply the lesson I learnt from my association at home. I do some savings at home because I learnt it here. (Mrs Linda Ikeh, ICI)

In sum, members are encouraged to save. It has been mentioned earlier that the poor in this community do not have a culture of saving. But for those that belong to this association, making contributions forms a kind of compulsory savings. It is also changing their perceptions and attitudes toward savings. Savings made through the contributions are used in a number of ways, including using the annual take-outs as a means of managing health risks, as indicated above.

#### **6.2.4 Social control**

Most of the loan transactions in the association are done on the basis of trust. As indicated above, agreements are not signed during borrowing. No forms are filled. The leaders insisted that mutual trust is the most important factor influencing behaviour and curtailing free-riding and outright refusal to pay back loans. However, in addition to that, within the association, mechanisms of social control have been built into its operations implicitly and explicitly. An analysis of the loan mechanisms to new members gives us insight into how the association checks what would otherwise amount to social control problems.

*(i) Adverse selection*

Adverse selection has earlier in this study been stated to occur when (many) high-risk persons join a mutual aid scheme simply because of their high-risk status. Theoretically, such high-risk individuals may join a mutual aid group, obtain the aid they need and withdraw from the group once their problem is solved. Even if they stay, the inclusion/recruitment of many high-risk individuals still remains problematic. How does the association check adverse selection problems?

The association insists that new members must wait for three months before requesting for any loan. This period is not really enough for a member to have made any significant financial contribution since monthly contribution is N100 [0.8US\$], and the member may well ask for N3000 [24US\$] in her fourth month of membership. So how does this period of waiting help to achieve social control? The secretary/treasurer stated that it helps them to know whether the new member has actually made up her mind to remain in the organization. According to her, if the new member decides to remain in the association, then they are willing to share her burden with her by granting her a loan not necessarily limited to the amount she might have contributed. It is a matter of helping each other to solve problems, she said. However, a careful scrutiny of the borrowing pattern revealed a salient point. New members who borrowed within the first six months of their membership were granted small amounts of loan. In fact, one was only N800 [6.4US\$] loan in her fifth month of membership. So could it be that new members were more likely to ask for smaller loans, and if so why? I decided to interview the woman who was granted only N800 to find out the actual amount she requested, why, and what she thought about it. The woman stated that she had requested for N6000 [48US\$] and was granted N800. According to her, the leaders said that was what the association could afford then. The affected member stated that she was sorely disappointed but had to accept it that way. Concerning this, the secretary/treasurer said it is necessary to be wary of giving large amounts of money to new members.

Although the leadership of the association did not state so, it is safe to assume that the waiting period of three months and very importantly, granting only small amounts to members within their first six months would serve to check adverse selection, at least in one way. In a rural community like Ukete, information gets round quickly. Women who would have gone to join an association because they have developed a health problem which they require an immediate loan to handle would have to think otherwise. They would have heard through village gossip or even from the members of

the association that borrowing from the association within the first three months is not a reality, and that the amount they would be given within six months would not be much. This helps to control adverse selection. In this sense, control of adverse selection is similar to the mechanisms applied to check free-riding.

### (ii) *Free-riding*

The association is aware of the possibility of social control problem in the context of some members attempting to 'reap where they did not sow'. As also in the case of the problem of adverse selection, the waiting period of three months is a strategy to check free-riding. The chairperson explained this measure of social control as follows:

You can't just join today, and expect that you will receive all the benefits of those who have been making contributions for years. For a member to be entitled to financial assistance..., she must have been a member for at least three months, and *she must have been paying her contributions too.*

It can be deduced from the above statement that efforts to control such problems led to entrenching different requirements for loans for different members based on the regularity of the financial contribution. Members who fail to pay their contributions for three months either consecutively or cumulatively are asked for collateral. The collateral may be grinding machine, bicycle, goats, or any assets. They might also be asked for guarantors. On checking free-riding, the UWA Secretary/Treasurer told this researcher,

When our member fails to pay for three months at a stretch or cumulatively, she cannot obtain a loan on the same conditions that those who pay regularly do. We have discussed this issue among us many times, and we always uphold that a member who fails to make regular contributions should not be treated the same as those who struggle to be up-to-date. While we give loans to such members who default, we ask for things that we can hold on to [collateral]. We don't even do anything with the items but we want them to know that they must pay before they can borrow easily. We also ask them to come with a person who will guarantee to pay us the money if the indebted member fails. (Amaka Onweli, key informant, IDI)

This mechanism apparently works well. This is suggested by the fact that most members pay their contributions regularly. This is apparently because of the control mechanisms, but responses also suggest that social capital may play an important role in controlling free-riding. We saw above that the leaders of UWA and a member opined that trust, values, norms, and friend-

ship ties (which are features of social capital) facilitate recovery of loans in the social network.

The successes achieved in controlling adverse selection and free-riding in the UWA supports the idea that endogenous associations could be suitable basis for CBHI schemes. It shows that if a CBHI is based on an existing endogenous association, adverse selection and free-riding will be controlled at the level of association, and the problems would not reach the level of the CBHI scheme (see Atim et al. 1998, cf. Atim & Sock 2002: xv, Atim, Diop & Bennett 2005: x).

### *(iii) Multiple Loans*

Multiple loans, in the context of this analysis, imply a woman taking loans many times without first repaying the ones she owes. It is not necessarily a social control problem, however, it may affect the financial sustainability of a small risk-sharing group like UWA, hence its analysis here. In Umuchu Women's Association, for example, it is, in principle, possible for a member to obtain a second loan from an association without full repayment of the previous (first) loan. That is the first impression the leaders give to outsiders.

The chairperson told me women who are indebted to the association but have started paying (instalments) are eligible for another loan. According to her, the fact that they have started paying is evidence that they are making efforts to clear it; therefore, assisting them with another loan will help them to come out of their problems more quickly. However, two informants who were once debtors to the association stated that this is not entirely true. They averred that no woman who owes the association is given another loan until she clears the payments. One of the women stated that she had only N600 [4.8US\$] left to complete repayment of her loan when she ran into an adversity. She went to the leaders and asked them for a loan of N3000 [24US\$] and they turned down her request, insisting that she must finish the payment of the first loan before being granted another one. She asked rhetorically, 'How could I finish the first payment when I already had another problem? They should understand our plight and be considerate.' When I confronted the leaders with this assertion, they stated that the two women gave flimsy reason for asking for the second loans. According to the secretary/treasurer, 'We cannot give a woman a loan to go and buy paracetamol from Mr Ukah. When a member has a serious need and asks for a loan, she is given. They did not demonstrate a serious need for the second loan and so we told them to first complete the payment of the initial loan'. In spite of these statements by the leaders, the documents of the association



do not contain any record of lending to a borrower who had not yet fully completed her payments. Therefore, it does seem that the leaders deliberately avoid lending to debtors who are yet to complete their loans. Members of the association who were interviewed were divided in their opinion on this issue. Five of eight respondents whose views were sought on this felt that it was well-intended and should even be more explicitly stated and implemented. One of the informants who spoke in favour of denying loans to current debtors said, 'we all have problems at one time or another, so if one is given a loan to solve the problem, and she solves the problem, she should pay so that others could also have access to loans. Loans are not meant for only one person, and so if one borrows she should concentrate on completing her repayment. Why should she be given another loan when she still owes? Yes, I support that those who owe should not be allowed to borrow until they finish their payments'. Another informant saw it from the perspective of increasing the burden of the borrower. According to her, giving a loan to a woman who still owes is tantamount to adding to her burden, since she will now have to pay more money. She then asked, 'If she does not finish paying the second loan before asking for the third loan, will she still be given? When then do you say no, it's enough?'

### **Gender, social capital and membership stability**

UWA has experienced membership stability over the years. Extremely few members left the association. One member left the association because she had to join her husband in the city of Onitsha. Indeed, there was a consensus among the leadership of UWA and some members who were interviewed that indiscriminate membership withdrawal was not a feature of the association.

We don't experience frequent membership withdrawals. It does occur but very rarely. However, we do not allow withdrawals to disrupt our sequence of events. A member is free to withdraw from the association from time to time, but the association has the right to refuse giving her own contributions until the redistribution time in December. And because she would not have attended paid labour meetings through the year, we will take that into consideration in calculating her take-out during redistribution. (Mrs Esther Ndukwe, Chairperson, UWA, key informant, ID1)

The question then is: what could be responsible for the stability?

From the analysis, the stability may be attributed to the high social capital within the association as well as gender. According to Narayan (1999), bonding social capital strengthens the social ties within a network. Social capital also impacts cognitively on members of a social network by increas-

ing their perception of self-worth and perception of self-esteem. It is very likely that an individual would want to continue in a social network where she feels trusted and she trusts the other members, where she feels loved and wanted and she has same feelings towards other members, and where she shares same or similar values. The secretary/treasurer told me one of the key factors that keep them together is friendship. According to her, they love each other; they participate in each other's social activities; they receive and give gifts to each other during occasions. Her claims were corroborated by other members of UWA. These findings suggest that trust, social ties and norms of reciprocity and networking exert a strong influence on discouraging membership withdrawal and keeping the association in tact.

There is also a regulation that members who withdraw must wait until the end of the year when the annual re-distribution occurs to get the take-out. Their take-out, as indicated in the quote above, is usually calculated on *pro rata* basis. There is little doubt that this mechanism may discourage people from shuttling between associations. However, the very low rate of withdrawals from the association can certainly not be solely accounted for by the stipulation that withdrawees must wait till redistribution. If that were the case, members would withdraw more readily immediately after receiving their take-outs. That many do not withdraw immediately, post-redistribution, suggests that there is a strong measure of stability.

Gender may also be a factor for the stability of the organization. There may be a feeling of shared feminine identity or what could be called the feeling of sisterhood. This line, however, may not be pushed too far. One needs to take into cognizance the fact that women are not homogenous. This was even evident in the history of UWA when the well-off women pushed for restoration of full monthly contributions during the *umwu* period while the poor women agitated for sustained reduction of the contributions during the period. Women could also work against women in specific circumstances. A case in point is polygynous settings where women may tacitly abet men's mistreatment of fellow women (co-wives).

If men were also members of the association, could the picture be different? Would there be a definite polarization along gender lines and how would this affect the stability of the organization? It does not appear likely that there would be clear gender polarization in mixed-gender organizations. Although they were not clearly documented, Atim et al. (1998) did not observe any definite cleavages along gender lines in the endogenous associations that make up the Lawanson Community Partners for Health or Jas Community Partners for Health. This was in the context of semi-rural deprived communities in Lagos. Could that be the same for rural deprived

communities? One major issue that may be of concern in rural communities, however, is the gendered nature of financial contributions and leadership. In terms of contributions, men are usually well-off and so may push for higher financial contributions which would put much burden on women. It is such burden that may create gendered crisis. Men in Ukete, for example, are also better educated than women. This applies to most villages in Nigeria. Men also tend to be more politically active and desirous of positions and status. So, in mixed-gender organizations, the leadership may be hijacked by men. This will clearly marginalize women in leadership.

These issues have important implications for CBHI schemes. The stability of endogenous associations is indicative that CBHIs based on them will have stability of membership. It is also likely that if CBHI scheme is based on an existing endogenous association, the social capital within the association will help keep the members since they will likely view the scheme as a continuum of their socializing experience within their association.

### **6.2.5 Financial risk protection**

Does financial support obtained from associations fully cover the total expenses of health care costs? If they do not, what is the extent of coverage of health expenditure? What are the implications of partial coverage of costs for members?

It has been argued that the definition of insurance should be shifted from a narrow focus on its administrative arrangement to a more embracing one which views it as a means of minimizing the risks of incurring catastrophic (health) expenditure through risk-sharing (Arhin-Tenkorang 2001). One of the functions of such collective action of pooling risks is to protect individuals and households from making sudden, unexpected expenditures which will adversely and severely affect their critical income. Critical income refers to income for basic needs not produced by the household, such as food and nutrition, basic education, housing materials (*ibid.*), and income for life-cycle events such deaths, and childbirths, and other exigencies.

The most important determinant of the association's ability to protect critical income is the size of its pooled resources. The UWA has taken steps to increase the size of their finances. First, they have gradually increased the amount of individual contributions over the years. Second, they have introduced collective paid labour to augment the amount they get from individual contributions. With the increase in the size of the total pool, they have increased the amount given as insurance-contingency loans to needy members. More members have also been able to benefit from the loans. The in-

crease in the amount given to members as insurance contingency implies more financial protection.

On a case-to-case basis, the extent to which aid obtained from UWA offers financial protection to women depends on a number of factors: namely, the severity and the duration of the illness, and whether care is sought at a private or government hospital. A good number of women who obtained aid for moderate to severe illnesses and sought treatment at general hospitals or cottage hospitals stated that the amount of money they obtained from UWA either as take-outs or as loans were enough and did cover all the treatment expenditure. Their experiences are typically illustrated by these cases below:

### *The case of Mrs Anthonia Imoko*

Anthonia Imoko is a 34-year-old woman, who combines farming with selling of cooking ingredients which she goes to Enugu city to buy. She is married to Edwin Imoko, a 39-year-old farmer, who was retrenched as a teacher. Anthonia and her husband belong to a land-owning lineage and so they carry out their farming on Edwin's land. They have two boys and three girls.

In May 2005, her 10-year-old boy came back from school and started complaining of headache. He was given paracetamol bought from Prossy, but this brought no relief. Anthonia sent for Prossy who went and administered an anti-malarial injection. By the following morning, the headache had gotten worse and the boy complained that he had slight neck pain. Anthonia immediately set out to the home of the secretary of UWA and obtained a loan of N5000 Naira. She gave the money to Edwin who set out immediately to Awgu General Hospital with the boy. The boy was admitted and given medications, which Edwin said included injections and tablets. Edwin said the doctor told him the boy had developed meningitis. They had been charged N3,900.

Anthonia stated that she had to borrow because it was *unwu* season and she and her husband did not have any money in the house. She said even her trading business had slowed down because of *unwu*.

### *The case of Mrs Uju Egbe*

Mrs Uju Egbe is 49 years old, and a widow. Her husband, Kalu, was a migrant palm wine-tapper, who, like the men in his generation, went on seasonal wine-tapping migrations to Yorubaland in western Nigeria. Both Mrs Egbe and her husband are illiterate. However, her husband had prospered as a palm win- tapper and built a brick house. Uju and Kalu also prospered

as farmers. Kalu was a landowner. They have seven children, two of who had completed secondary school education before Kalu died. The children did not migrate but helped their mother on the farm.

Uju developed sudden headache one evening after she had been caught in a heavy rainfall while working on the farm. The headache was not too worrisome, according to her, and so she did not bother taking any medicines. Rather than improve, the headache became worse in the morning. Uju also started coughing and running a temperature. She sent one of her children and bought medicines from Mr Ukah. She took the medicines. However, she did not feel any better. By the next day, she started hurting in her left chest, and the chest pain was aggravated by coughing and deep breathing.

According to her, it was at this point she said she must go to a hospital for treatment. But she did not have money in the house, and by this time, she was not feeling strong enough to go looking for either the chairperson or secretary of her association. So, she instead sent Chiamaka, her oldest daughter, to call Mrs Ndukwe, who owns a stall in the village square and already happened to be there that morning. She followed Chiamaka to see her mother, who requested for N5000, which Mrs Ndukwe went and gave to Chiamaka.

By late morning that day, Uju, accompanied by Chiamaka, went to the Cottage Hospital in Nenwe for treatment. She made full recovery after few days on admission. The treatment had cost them N3,300.

These two cases share much in common with other cases for which mutual aid obtained from UWA were sufficient for both direct and indirect costs. Direct costs refer to medical bills while indirect costs refer to other expenditure incurred in the process of health-seeking, e.g. transport fare, feeding, etc. Although the mutual aid used in these cases were insurance-contingency loans, respondents also reported instances where they used the annual take-out to access health care, for which the take-outs were enough.

The dynamics of membership size, financial pool and financial risk protection in UWA open up an interesting debate on the relevance of Olson's (1965) theoretical proposition about membership size of groups and their success or failure to provide collective goods. Olson had stated that large groups may not be able to provide public goods for its members, while, on the contrary, small size groups are more likely to succeed in such tasks. His proposition may be true, but seemingly only in specific contexts. It does not seem to hold true in the specific context of UWA with respect to providing financial risk protection to its members. For UWA to offer greater financial

risk protection to its members, it certainly needs more money, and one of the ways to get the money (increase its financial pool) is through increasing its membership size. Even if it also increases its financial mobilization through secondary sources, increased membership size may still be necessary. One may perhaps posit that increased membership size may also facilitate financial mobilization through secondary sources. The reason why this logic of small size performing better will not work in the case of UWA is that managing severe illnesses or simultaneous occurrence of illnesses among members involves large expenditures. Therefore, contrary to Olson's view, small size will be a setback in this case because, in a rural village in economic decline, small membership size may mean small financial pool, and small financial pool will mean less financial risk protection. UWA therefore needs a large membership to increase financial risk protection, widen its coverage of health expenditure, and reduce the necessity of co-payments, discussed in the next section.

### 6.2.6 Inadequate coverage of health expenditure: co-payments

Inadequate coverage of health expenses for particular cases of health-seeking involving severe and/or protracted illnesses by a mutual aid scheme is not peculiar to UWA. It is a universal problem that characterizes mutual aid schemes and health insurance. In health insurance, this usually prompts co-payments, which refers to the extra money insurance-holders are required to pay at the point of utilization of the health care (hospital) in order to access particular services. The extra money that some members of UWA must use to make up for the deficit between their financial support and the medical bill could be equated to co-payments.

Experience with co-payments in CBHI in Sub-Saharan Africa has shown that as problematic as it may seem, it does not significantly alter the rate of utilization of hospital services by insurance members. Other factors such as distance are important in determining the responses of scheme members to co-payments. This has clearly been documented in the case of Bwamanda Health Insurance Scheme. In this scheme, co-payments were used as a variable to increase hospital utilization by insurees who lived far distances from the hospital. A sliding scale was used to decrease co-payments according to specified distances from the hospital: less than 25 km from the hospital, 25-45 km from the hospital, and more than 45 km from the hospital. The experiment was carried out for one year. An assessment of the scheme was then done. It showed that the hospital utilization rates remained unchanged for the first two categories, while, paradoxically, the utilization rate for the

third category, which had the lowest co-payment actually decreased (Criel 1998: 19–22).

In UWA, the 'co-payments' did not deter members from utilizing hospital services. No member of the UWA reported that she could not utilize her aid because of the extra money she needed to pay at the hospital. The argument here is 'co-payments' are accepted by the members as part of the scheme, and in fact many members even agree with the idea of paying this extra money when necessary.

During FGD7 (on mutual aid mechanisms for health risks), most of the participants agreed that UWA does not necessarily have to increase the size of loans given to individual members in an attempt to cover all costs for expensive medical care. According to them, doing so may jeopardize the chances of other members getting loans. According to them, the association should try to assist as many members as possible, not to expend the whole pool on a few members. The contribution of one of them sums up their position and is quoted below,

Which one is better: to spend all the money on one person or to spread the money to reach as many people as possible? You spend the whole money on one person and the person goes to the hospital, yes, the money given to her covers all her needs for that treatment. But what if while she is still in the hospital another member needs money? Ok, you will tell her, sorry, we don't have any money because we wanted to make sure the previous borrower meets all her costs. She will thank you, or won't she? Let us look at it from another side, the side of death. What happens if one member takes the entire money and goes to the hospital and dies there? I think that the money has not been enough and may never be enough, but we must try to spread it to as many as possible. (Mrs Ekene Nwafor, FGD7)

In-depth interview respondents stated that the inadequacy does not undermine the usefulness of the aid for managing particularly sudden health crisis.

The loan I took was less than the cost of my treatment. If I add the costs of my going there [transport] and my feeding, the loan was not enough. I am not saying the loan did not help. It helped me so much because I started the whole thing [process of health-seeking] with it, and while I was on admission my husband continued to search for more money. (Mrs Mary Ikoh, IDI)

According to another respondent, it would be very difficult for an average individual in the community to provide N5000 cash when it is required for treatment at a moment's notice.

Only very few rich families could get as high as N5000 from their own home savings to go for treatment in the case of sudden illness. I know most families cannot. That is why we appreciate the money we can obtain from our associations. I think every member of the association knows that it is not possible to get enough money for treatment of serious illness in the private, general or teaching hospitals. (Mrs Ebere Anih, IDI)

Another in-depth interview respondent expressed a similar opinion to that of Mrs Ebere Anih. She stated that the initial money to use to go to the hospital is the most important, and that most poor women are incapable of getting it from intrahousehold sources. So it is a significant thing to get it from their association, even if the amount will not cover the entire cost of health care. In her words,

I live and teach in the primary school here. And I am from this village, and so I know the situation very well. Ask any woman to bring out money from her household saving to go to the hospital and she will surely tell you she does not have the money. This is where the importance of getting the money from our association can really be appreciated. We all know the money you will get may not suffice for the whole treatment, but yes, you have that first money to go to the hospital. Getting that first money is a dire need. Supplying it is a great help. (Mrs Amy Nna, IDI)

A key informant, Prossy's opinion was sought on the issue of insufficiency of financial assistance. She agreed that the financial aid may be insufficient but stated that the loans functioned in the context of providing the immediate portal to treatment-seeking: transport, emergency deposit and the persuasion of the health providers to start treatment. Fortunately, she said, the final bill will only come when the treatment is completed, so the loan serves as a bridging mechanism between transportation to and commencement of treatment at a health facility, and the payment the final bill at the end of the process. The secretary/treasurer gave her own view:

I know that the money we give out for loans may not always cover all the health expenses incurred by members. This happens because treatments are very costly in the hospitals. We don't have money that will take care of such heavy treatments. But I think that treatment of moderate illnesses may be fully covered by our assistance. A few of our members have suggested from time to time that we should give enough money to cover all health expenditure. We advised them that it was certainly impossible. Take UNTH [University of Nigeria Teaching Hospital], for example, one of us borrowed money for treatment there. The whole N5000 [40US\$] went for laboratory tests. That was also because of the nature of the illness. So, when you combine severe illness with treatment at a private hospital or teaching hospital, it is not practicable



for us to give enough money that will cover the costs. (Mrs Okweli, Secretary/Treasurer, UWA; IDI)

Apparently, the respondents are aware that the mutual aid, especially in the form of loan obtained from their association, may sometimes be inadequate. But on the whole, they report that it serves an important purpose.

### 6.2.7 Consequences of inadequate coverage of health costs

In the end, the strategies through which women and their households make up the deficits determine the consequences of inadequate coverage of health costs. Making up deficits with household consumption income may thus render the household unable to buy daily necessities not produced in the household. These may include food items, because many low-income households in the community, especially if landless, do not produce enough food from own farming to last throughout the year. The following few cases illustrate the experiences of women who had to grapple with the consequences of 'co-payments'.

#### *The case of Ima Obe*

Mrs Ima Obe is a young woman of 23 years. She had dropped out of primary school at the age of fifteen to marry. She already has three children, aged six, four and two years. Her husband, Mr Ogbo Obe, a 30-year-old man, is a farmer. Like many young farmers, especially back-to-land farmers, he combines farming with other livelihood activities. During rice harvest season, he trades in rice, and stops shortly after. During rainy season, he trades in okra. When there seems to be nothing in the agrarian season for trade, he helps out his carpenter friend, Eneke, in his work, for a little stipend. Ima had prolonged labour during the birth of their last child, Samson. She narrated her experience:

I had my two previous pregnancies and childbirth without problems. During this boy's [Samson] birth, my labour started on a Sunday afternoon. I passed that night expecting that I would be delivered on Monday. I was in labour throughout Monday without delivery. My friend, Agnes was here and she told me 'Why don't you go to the hospital? I don't think this traditional attendant can do anything more than she has already done. You must go to the hospital early in the morning tomorrow'. I told her we hadn't money for that. She said 'Don't you know that you can borrow from our association? I told you before that I borrowed from our association when I did operation six months ago for the birth of my baby'. Agnes and I are very tight [close] friends. It was she that convinced me to join the association two years ago.

I asked my husband to go and request for a loan for me. Agnes accompanied him. My husband and Agnes came back with N3000 from my association. My husband and I left early in the morning for Awgu, and I was admitted. The doctor examined me and put a drip [intravenous infusion] on me, and put medicine in the drip. The labour pains became stronger and I was delivered of a live baby boy, this boy you see here. Thank God for him. He was weak but they treated him. I spent four days in admission. We were asked to pay N6000. We did not have it. My husband came back home and sold the bicycle he bought while he was in Onitsha. It was a big loss for us. He used the bicycle to do his trade. We have not been able to replace the bicycle. (Ima Obe, IDI)

This case illustrates the effect on household assets of having to make up the deficit between the loan obtained from mutual aid scheme and medical bill. Many women and their households have no other option than to dispose of household assets, which may be productive assets. Depletion of productive assets negatively impacts on the capability of the household to carry on with their livelihoods. This may prolong the time it will take them to recover from the effect of the health crisis. In this community, bicycle seems to be the most frequent asset lost in the course of making up the deficiency of the assistance obtained from an associative movement. This is probably due to the fact that bicycle is both a household asset and a productive asset for traders. Bicycle could also be sold within the village.

However, sometimes women and their households lose costlier productive assets. This is illustrated by the case of Mrs Stella Ikenna whose loss of sewing machine marked the end of her income generation through dress-making.

### *The case of Stella Ikenna*

Mrs Stella Ikenna is a 47-year-old woman. She is a widow. Her husband, Ejindu Ikenna, was a well-off farmer from a landowning lineage. Stella has primary education and had done an apprenticeship term as a dressmaker before getting married. She has six children; the first two children are in secondary school and the other four in primary school. Stella had taken in her late brother's youngest son, Isima, to live with them. Things were going fine for the co-resident household whose living accommodation marks them out as belonging to the well-off in this society. Her house is one of the few brick buildings in the community.

But Stella said all has not been well since she lost her husband more than two years ago. Indeed, according to her, the problems had begun with the protracted illness of her husband and the financial toll it took on them.

Stella and her household were apparently doing very well until two-and-a-half years ago when her husband complained of a severe headache when he woke up one morning. The PMV was called in and he administered his usual cocktail of analgesic and anti-malarial medicines. But Mr Ikenna did not improve. Rather, by the evening he complained that the headache was deteriorating and that, in addition, he was feeling weak in his right hand and leg. He was not able to lift the affected limbs. Some neighbours who came said the symptoms pointed to poisoning while some said the symptoms suggested a witchcraft spell. Their opinions were informed by the fact that Mr Ikenna's illness came hard on the heels of his title-taking ceremony, a form of social conversion for him. However, the PMV was invited again and he told them that the best course of action was to take Mr Ikenna to the hospital because he suspected that he might have had a stroke.

Stella heeded the PMV's advice to take her husband to the hospital. However, Mr Ikenna's just-concluded title-taking ceremony had weakened their financial state. There was little money in the house, but, determined to take her husband to the hospital, she decided to take a loan from her association. She obtained a loan of N5000, and on the third day of the onset of symptoms, Mr Ikenna was taken to the UNTH. He was barely conscious by the time he reached hospital, and lost consciousness soon after. He was on admission for four weeks and died there. The cost of treatment was N17,500.

Within the four weeks her husband was on admission, Stella had to find means of getting money to continue his medical care. One of the key measures was the sale of her sewing machine. She could not find a buyer within the community, and so she had had to take it to the market in Nenwe where she eventually sold it. She had not been able to purchase another machine. And after two years of not sewing, she recently decided to rent out the room in their house which had served as her workshop. It is currently occupied by a teacher with the primary school.

This case, like the case of Mrs Ima Obe, shows that the inadequacy of mutual aid could mean termination of livelihood activities. This increases the deprivation and vulnerability of the affected persons. Availability of alternative sources of income is helpful in recovery, and hence cushions the effect of the depletion of asset on household welfare. In Stella's case, she had converted her former workshop into another form of income-generating activity through rental. However, the income she generates from the rental of her former workshop is far less than the income she used to generate from her dressmaking job. According to her, the income she generated dur-

ing one Christmas season from her dressmaking activity was about five times more than the annual income she will presently generate from the rental.

Russel (2004: 286) posits that serious illness is one of the circumstances and events which may place households on paths in which they are faced with harsh and nasty realities. He argues that the cost of many cases of illness may actually not be enough to significantly alter these paths 'unless they are high or persistent, although they can exacerbate existing vulnerability and struggling'. In Mrs Ikenna's case, a status-seeking event (a title-taking rite) placed an otherwise well-off household on a trajectory of struggling. This was followed by a serious illness that was expensive and fatal. The huge cost of managing the illness was far beyond the loan taken from UWA, thereby necessitating disposal of assets to make up the deficit. It should also be noted that, besides medical costs, Mrs Ikenna would surely have incurred further expenditure from the burial of her husband. This again highlights the cascading and interconnecting nature of events and circumstances within the household, and how they link with and may exacerbate deprivation resulting from expenditure on health care.

In spite of the problems of the shortfalls in coverage of health risks, many women in the community desire to have access to the mutual assistance enjoyed by members of associative members but cannot do so because they are not members. Exclusion is inherent in many associative movements that provide mutual aid. The mechanisms and consequences of exclusion are examined in the next section.

### 6.2.8 Exclusion: unintended effect of social networks

#### *(i) Definition*

Exclusion has been noted as an unintended effect in group-based social networks, especially those that practice generalized reciprocity and mutual aid. Exclusion is defined in this study as implicit or explicit prohibition of some people from enjoying services and support (mutual aid) obtained within specific social networks because they are not members of the social networks. Exclusion is also the prohibition of non-members from becoming members of a social network because of specific features or activities of the social network. In UWA, the exclusions are inherent side-effects of mutual aid risk-sharing mechanisms rather than deliberate attempts to stop others from enjoying the benefits of the mutual aid in UWA.

*(ii) Types and causes of exclusion*

Exclusionary mechanisms in this endogenous social network can be classified as implicit mechanisms and explicit mechanisms. In implicit exclusion, non-members are, in principle, qualified to enjoy mutual aid from the association. However, they must meet specific requirements, which may be beyond the capability of the poor to meet. Inability to access the aid is therefore a problem associated with deprivation and not a feature of a mutual aid group. Implicit exclusion applies mostly to loans.

Explicit exclusion occurs when simple economic and social logic makes aid from a social network (associative movement) exclusive to members of that social network. This type of exclusion applies to annual take-outs. By the logic of common sense, non-members cannot or should not desire take-outs that they have not contributed to. This researcher was told by a woman who was not a member of any associative movement that it was improper and immoral for an individual to think of going to get a take-out from an association to which she does not belong. According to her,

It does not happen. Anybody who wishes to participate in the sharing [redistribution] of their money should join them and make her own payments. They share the money they have contributed out of their own sweat. It is reasonable that only they should share it. (Betty Kanti, ICI)

There was a consensus among respondents on the propriety of the exclusivity of redistribution, but that was not the case for loans. A few respondents thought that UWA should minimize loan requirements so as to enable non-members to access the loans.

As indicated above, it is compulsory for every member to make monthly financial contributions. Contributions are the most important activity of the association, but also constitute the most important factor which excludes poor women from becoming members. Clearly, poor women who feel that they cannot make the contributions may exclude themselves; that is, they may not even make an effort to join an associative movement.

*(iii) Consequences of exclusion*

Exclusion no doubt worsens the deprivation of the poor. Poor women who do not belong to associations, and therefore, cannot easily access loans or make use of take-outs find it difficult to get money to start health-seeking. As indicated in Chapter 5, household sources and extended families do not offer secure, reliable or adequate mechanisms for handling health crisis. They are thus resorted to infrequently. Therefore, the vast majority of poor

women and their households face considerable distress when they experience health crises.

Indeed, poor women—who depend *only* on household and extended family mechanisms which, as shown earlier, are unreliable and insecure mechanisms, and cannot access mutual aid from associative movements—are implicitly excluded. The experiences of some women who belong to this category are seen in the cases presented in Chapters 4 and 5.

A further case is presented below to illustrate the difficulties excluded poor women encounter in handling health crises.

### *The case of Edna Amaku*

Edna is 42 years and has been a widow for six years. She has five children (four girls and one boy). Edna does small farming on rented land. The farming is barely enough to feed her children, and so she also does seasonal paid labour on rich people's farms. Her adolescent daughters (aged 19 years, 16 and 14 years) usually assist her in the casual labour. In the 2004 farming season, the oldest daughter, Ada, took over the responsibility of searching for and locating opportunities for farm labour. This was because Edna was physically incapacitated to do the searching herself.

Edna was apparently well until about November 2003 when she noticed she was no longer able to sleep flat on her bed. She also began to tire easily. She sought treatment from Mr Ukah. The symptoms, however, only got worse. By April 2004, she noticed she developed fast breathing (breathlessness) after mild exhaustion. She also started coughing, with production of sputum.

Mr Ukah strongly advised her to try to get to a hospital for treatment. She did not have the money to do so. A friend of hers advised her to seek assistance from UWA. She went to the home of Mrs Ndukwe (chairperson of UWA) and narrated her problems to her. She told Mrs Ndukwe she needed financial help to enable her seek treatment in a hospital. Mrs Ndukwe told her that she had heard of her health problems, but that the contributions made by the members were strictly the association's property. Therefore, inasmuch as she would like to assist her, she [Mrs Amaku] must first meet the loan requirements, since this was the regulation governing the association's financial resources. Edna Amaku returned home, and has not been to the hospital. By the time of this field work, Edna's condition had got worse. She had developed swelling of ankle joints. She no longer goes to farm.

This case portrays how a woman may suffer double consequences of exclusion from aid. First, she suffers health consequences. She could not obtain aid from UWA and therefore could not go for treatment. She stays at home and pines away from her ill health which deteriorates. She also suffers economic consequences. Her physical incapacitation has led to loss of productive capability. The case also brings out the fact that exclusion from mutual aid schemes may be intricately connected to deprivation not only as the cause but also as the effect. In fact, the deprivation is passed down to the next generation, leading to transgenerational vulnerability. The vulnerability in this case has been passed down to Mrs Amaku's children since the *de facto* 'breadwinner' becomes her 19-year old daughter who assumes the responsibility of catering for her household at an age when her age-mates from better-off homes in Ukete are still in schools.

#### (iv) *Minimizing exclusion*

Financial contributions constitute the most important factor causing exclusion. The implication is that the lower the financial contribution the lesser the cases of exclusion. Clearly, two strategies embarked upon by UWA would help to lessen exclusion. These include:

- a) Reduction of individual monthly contributions by 75 percent during *umwu* season.
- b) Introduction of collective paid labour to raise more money, which would compensate for the reduction of individual monthly contributions during the dearth season.

Evidently, the proportion of total annual pool of the association accounted for by collective labour would progressively increase. In other words, UWA would then not have to increase the individual contributions by taking this measure.

Besides these mechanisms, there are other ways that UWA could generate more income, keep individual contributions relatively constant and therefore further minimize exclusion. It has been mentioned earlier that the association can go into collective farming. They can use part of their income to rent land, buy seed crops and/or seedlings. They may use direct collective labour for the farming activities, including tilling the soil, planting, weeding, harvesting and processing. The association can also start their own grocery shop. Traditionally, grocery shops in the village are owned by men. UWA can break into this area, more so since there are not many of such shops. Alternatively, they can locate the shop in the Orié Market. Since women have shown adeptness in commercial activities in the community, the asso-

ciation can even use direct labour (own members) instead of hiring labour for the shopkeeping. The association can also go into rice-milling. This entails purchasing rice-milling machine and renting an accommodation for the activity.

These approaches to resource mobilization have important consequences for community-based health insurance schemes. It implies that endogenous associations will be able to keep membership contributions relatively low and stable, thus enabling a greater number of people to join the scheme, especially the poor, if endogenous associations were the basis for titular membership in the CBHI scheme. At the same time, the endogenous associations (as basis for a CBHI scheme) will generate extra money for premium payments through paid labour and other mechanisms. In summary, it does seem that poor women will have improved opportunities for participation in community-based health insurance schemes based on endogenous associations.

### 6.2.9 Social and emotional support in the social network

According to Berkman and Glass (2000), provision of social and emotional support is one of the key features in social networks. I found that this feature is relatively well-developed in UWA.

Members of UWA provide support to their fellow members in the form of emotional support, social services and material gifts during occasions such as childbirth, festivals and most importantly in times of calamities such as health crises.

Emotional support is rendered by way of visits to members when they are ill at home and when they are in admission in hospitals. The visiting members offer words of encouragement, companionship, and sharing of experiences they had had or observed which they think may help in handling the crisis.

In the case of hospital treatment, a member is entitled, in principle, to be accompanied to the hospital by a fellow member who may volunteer or is selected by the association. Such an accompaniment depends on whether or not the sick person asks for such help. The leaders of UWA stated that the companion's tasks include (i) to help in handling the complicated processes of admission; (ii) assist in purchasing of items which may be needed by the patient while on admission, for example, toiletries, food and drink. After the patient has taken to bed and settled down in hospital, the companion may leave. This type of aid is very rarely provided because of the additional transport fare incurred by the companion. Therefore, visitation by fellow



members mostly takes place at home before the afflicted goes to the hospital or on return from the hospital.

Provision of social services is relatively well developed in UWA, according to my own observations of members who have experienced health crisis. Services were provided in the areas of domestic chores, child care and farm work. For domestic chores and taking care of children of women who went for health care-seeking, a type of generational difference was observed in the kind of care given by the care providers. Younger women tended to go to the home of the sick women to carry out the domestic work, and or to take care of her children. This included fetching water, cooking, sweeping the house and the compound. On the other hand, the older women did either of two things: they sent their daughters to go to the home of the sick person and carry out the tasks and activities needed in the house or asked for the children of the sick woman to be brought to their own homes to be co-resident with them until the sick recovered and came back from the health facility. This kind of service was provided to very young households, without grown-up children.

### **6.3 Limits of Endogenous Associations**

This case study of UWA has shown how the problems of lack of access to health care (mainly focusing on affordability barriers) were surmounted by women through the social agency of generalized reciprocity risk-sharing for health in locally bred women's organization.

The case of UWA supports the argument that such locally founded and operated social organizations could be incorporated through titular membership in larger community-based health insurance schemes, because: (i) They will foster social interaction among members and will enable them to continue to pursue other social objectives apart from risk-sharing for health; (ii) They will enable the members to conceptualize risk-sharing for health from the local perspective of saving for health, which they very easily understand and are accustomed to; (iii) they will facilitate financial mobilization because financial contributions are handled at a local level, and the organizations have already devised their own ways of mobilizing cash; (iv) They will reduce administrative costs to the organization because social capital and social pressure within the organizations minimize social control problems especially since the component titular member organizations will be small in size, and (v) They will foster greater participation and increase a sense of ownership and control of the programme.

At the same time however, one should not overlook the possible limitations of such an approach. These limitations include:

- i) The level of education of the members of community-based organization may be too low for them to manage community health insurance.
- ii) The members lack managerial and actuarial knowledge and skills. Therefore, they will need technical assistance and training in this. As mentioned above, their level of education may be a constraint to training them in managerial and actuarial skills.
- iii) Many women and their households in the community have been excluded in the scheme mainly because of self-exclusion as a result of inability to pay the required financial contributions. However, we should recall that even formal community health insurance schemes are also associated with some degree of exclusion. Community health insurance is not an end in itself but merely one of the means to the solution of problems of health care access for the poor and rural dwellers.
- iv) As Criel (1998) points out, the amount of contributions to be paid to the association's fund is democratically bargained. There is also the possibility of payment in kind.
- v) As Criel (*ibid.*) also points out, the amount of money pooled by members may be too small to cover health expenditures if it should happen that many members are simultaneously in need. This means that it will take several small organizations to be able to pool enough finances for effective health coverage and adequate financial protection. It also implies that such schemes may need a grant or aid from governmental, donors or non-governmental organizations to raise initial take-off capital and operational costs in the immediate term.
- vi) Criel has also raised issues related to the great flexibility in running the associations which may hinder effectiveness, e.g. in mobilization of funds, and too much emphasis being placed on social control, especially since the associations are usually small (*ibid.*).

Therefore, as appealing as the approach seems, there is a need for cautious and contextualized planning and design of any community health insurance scheme that bases titular membership on endogenous associations. Evidently, despite the above-named limitations, the approach has been rated a success in Lagos. But the specific local context is very important in the design because what works in Lagos may not work in Enugu. This also

makes piloting the schemes an imperative to collect evidence for policy and programming.

## 6.4 Conclusion

This chapter focused on health care seeking through the mechanism of mutual aid risk-sharing within a women's association. It analysed and described the opportunities for health care access provided by this mechanism for its members. It also analysed and described the weaknesses of the system. It examined how and to what extent the mechanisms are suitable as a basis for CBHI schemes. The key findings are summarized below:

- i) There are two mutual aid mechanisms for health-seeking inherent in the association, which are insurance-contingency loans and annual take-outs. These two mechanisms are used commonly by members of the association for managing sudden acute illnesses and protracted illnesses.
- ii) The mutual aid mechanisms have been used for mostly curative services. These include surgical operations, labour and child delivery, gynaecological cases, moderate to severe medical cases such as malaria, meningitis, etc. Insurance-contingency loans are generally not used for health-seeking at the village level of health care providers.
- iii) The mutual aid mechanisms are usually adequate for management of brief and moderate illnesses at government hospitals. However, the aid is usually not enough in the cases of illnesses entailing huge medical costs and/or treatment in private hospitals, which are usually very expensive compared with government hospitals. In such cases, the recipient needs to make up the deficit. This is a kind of co-payment.
- iv) UWA has many features which makes it suitable as a basis for CBHI scheme: (a) The members are already recruited and have already got experience of mutual aid risk-sharing based on conditional reciprocity. (b) Social capital in the association enhances social cohesion and contributes to keeping the association intact. In turn, social capital will facilitate stability of CBHI schemes and minimize membership withdrawal. UWA is able to take steps to minimize exclusion due to financial reasons (poverty). UWA takes the specific contexts of farming cycles and seasonality with their consequences on financial insecurity into consideration in setting their membership contributions. Accordingly, the association reduced contributions during the

*unwun* season in order to reduce financial burden on members. The association compensated for this reduction by an innovative approach to resource mobilization. It introduced collective paid labour, which has progressively accounted for greater proportions of the total annual income. By implication, such features will also minimize exclusion of the poor from participating in CBHI schemes if the schemes are based on them. It will also enhance resource mobilization for the schemes.

- v) The association effectively tackles social control problems (for example, adverse selection, free-riding, etc) that may hinder their collective action, through the presence of inherent social capital and through other mechanisms of their own design. This has important implications for the financial sustainability of CBHIs (see Atim et al. 2005: 2, Atim 1998: 25).

This chapter suggests that within specific contexts described in this study, endogenous associations may be suitable for establishing and operating CBHI schemes. By this proposition I mean that CBHI scheme planners and implementers can design CBHI schemes to predicate the titular membership on endogenous mutual aid associations.

To illustrate how using endogenous mutual aid associations may form a workable basis for CBHI schemes, I will use the example of UWA to propose and discuss three hypothetical CBHI models.

### Model A

The relative success recorded by UWA in providing its members with financial support for health seeking, and in providing social and emotional support to members could be explained from Olson's perspective. Olson (1965: 33-4) proposes that small groups are usually able to provide common goods to themselves basically because of three reasons. The first reason is that the small size of the group enables every member to benefit substantially from the provided goods. Olson's second reason is that members of small groups share stronger social bonds, and therefore, sheer social pressure helps to control free-riding. Thirdly, organizational costs are lower in small groups.

It is evident that UWA members receive a substantial proportion for the total gains of their generalized reciprocity through annual take-outs and insurance-contingency loans. Social control measures are also in place fostered considerably by high social capital in the organization. Because of the small size of the group, organizational costs do not cause concern.

Harnessing such successes and advantages offered by small size groups and yet including several small size groups as independent titular members of a community health insurance constitute the backbone of what I refer to as Model A.

In this model, UWA becomes a (corporate) member of a larger CBHI scheme, which may be starting afresh or is undergoing restructuring to take this new approach to operations. By UWA becoming a member of the scheme, all of its own (UWA) members are logically, automatically entitled to the service benefits of the CBHI scheme. The CBHI scheme may be owned and/or operated by a governmental agency, nongovernmental organization (NGO), a church, a health care provider, etc.

One of the key features of Model A is that UWA, an enrolled member, retains its own (UWA) independence, identity, characteristics and its own (multiple) objectives. It relates to the CBHI scheme at the institutional level.

A number of other independent and separate endogenous associations also become members of the CBHI scheme, just like UWA, raising the target population size and therefore, financial pool of the scheme. A formal contractual relationship exists between the CBHI implementers on the one hand and UWA on the other hand. It is to be noted that UWA is the party to this contract at an institutional level. The individual members of UWA are not a party *per se* to the contract. The CBHI scheme therefore relates to UWA as an independent legal entity.

UWA has contractual obligations to the CBHI scheme, which include payment of insurance premiums to the scheme on behalf of its (UWA) members. But UWA also performs non-contractual duties for the scheme. For example, it uses its pre-existing internal mechanisms and social capital to minimize social control problems such as free-riding, adverse selection, moral hazard, etc. among its members. This results in better performance by the scheme, as many of the threats to its financial sustainability are minimized. Additionally, UWA discharges social and moral obligations to own members. UWA engages in mobilization of additional funds from secondary sources other than direct individual out-of-pocket contributions by its members. Such secondary sources of funds include collective labour, collective farming, collective grocery shops, etc. This social service reduces the burden of direct financial contributions on members. It also ensures regular payments of scheme premiums. In addition, it helps the association to mobilize and keep reserve funds for other objectives and activities of the association. These include insurance-contingency loans to members for co-payments for health care services not covered by the benefits package of the

scheme, for indirect health care costs (including transport fare which poses constraints to impoverished health-seekers), for life-cycle events, etc.

Furthermore, UWA discharges other scheme objectives in the context of the CBHI scheme in the context of the leaders representing the interests of UWA members in negotiation of premium levels, benefits package, etc. The leaders may need also to negotiate with the health care providers (if necessary) on the quality of health care provided to members. Although the leaders may not, at the beginning, have strong negotiation skills and clout, they will most likely overcome this deficiency through experience and through collaboration with other endogenous associations that are members of the scheme.

This model therefore does not suggest transforming one small single endogenous association (e.g. UWA) into a community health insurance. *It rather suggests that several endogenous associations can be incorporated as independent titular members in a community health insurance scheme.*

## Model B

In this model, UWA would start its own larger CBHI scheme with scaling up of its membership size and activities to focus principally or absolutely on health insurance operations. This model has a lot of constraints for a relatively small local endogenous association like UWA. These constraints include:

- i) The leaders may not possess adequate managerial, administrative and actuarial skills to run the scheme.
- ii) The leaders may not have the knack for meticulous and detailed record keeping, book-keeping/accounting, etc.
- iii) They may not have adequate negotiation skills and clout to bargain with health care providers on issues of benefits package and quality of care for members. They may overcome the constraints by employing professionals to manage the scheme for them. This may, however, result in high transactional/operational costs which may endanger the financial sustainability of the scheme.

*Model B is therefore not appropriate for small endogenous associations like UWA. It is better suited for very large associations or large nongovernmental organizations, especially if there is external funding attached to the programme.*

## Model C

Hypothetically, UWA becomes subsumed under a larger CBHI scheme. It loses its independent entity and existence. In this model, the integration of UWA into the CBHI essentially becomes a kiss of death for it. I do not envisage or propose this model for UWA. This is because the subsumption and dissolution of the endogenous association will clearly result in the loss of those qualities which would make it suitable as basis for CBHI in the first instance.

In summary, Model A is deemed as best suited for the working of a CBHI scheme based on endogenous associations in a rural remote village like Uketu. For clarity, the reasons are summarized below:

- i) The association retains its independent existence and separate entity.
- ii) It is able to perform its contractual obligations to the CBHI scheme by paying the premiums for its members regularly.
- iii) It is able to use its own mechanisms and inherent social capital to check social control problems. This enhances scheme performance and minimizes threat to financial sustainability.
- iv) The association protects its members from excessive financial burden of premiums by mobilizing funds from secondary sources such as collective labour.
- v) It continues to help members with loans for co-payments for services not covered by scheme benefits package, transport fare to the usually distant hospitals, etc.
- vi) It continues to provide a forum for solidarity, mutual social influence, social support, and social engagement.
- vii) The leaders of the association negotiate with the CBHI implementers and/or the health care providers for better deals and better quality of health care for its members.
- viii) Low transactional costs: The association incurs minimal, if any, costs since it does not employ the services of professionals to manage its affairs with the scheme.

It is pertinent, at this point, to examine a few critical issues that may significantly affect the working of a CBHI scheme that is based on Model A.

The first critical issue is: will the flexible, informal (often unwritten) rules and practices of endogenous associations like UWA not come into collision with the formalized rules and practices of a larger CBHI scheme? The an-

swer seems to be in the negative. Writing almost 20 years ago on the issue of apprehension over possible conflict between traditional mutual aid systems in Africa and modern systems, Lespes (1990 cited in Criel 1998: 55–6) ‘opposes a too strict dualist approach that sets traditional forms of organization against modern ones’. The UWA experience seems to corroborate Lespes’ proposition. This is because UWA has introduced some rules and practices that have their roots in modern systems, and not in traditional Ukete values, principles and practices. These include waiting period for members before they can access loans, placing the condition of insurance contingency on loans, placing a ceiling on loans. These features, according to Mrs Nnenna Mgborie, are rather alien to Ukete culture. This pioneer chairperson of UWA stated that many of the features were brought to the association by Mrs Ellen Eki, the pioneer secretary/treasurer and a one-time chairperson of UWA. When I discussed this with Mrs Eki, she told me she got the ideas in the mid-1980s when she was living in Onitsha with her husband. She had participated in a mutual aid association in Onitsha which had some of the features. This suggests that formalized rules and practices inherent in larger CBHI schemes will likely be accepted, adopted and/or modified by endogenous mutual aid associations. The experience of UWA implies that when an endogenous mutual aid association adopts external principles and practices, they enhance the association’s performance. It is also evident from UWA experience that endogenous associations are, in fact, willing and capable of accepting and adopting formalized rules and practices.

Elsewhere, empirical evidence has shown that CBHI schemes may use flexible, informal rules and practices of endogenous associations to enhance their operations. This has been reported in CBHI schemes in peri-urban communities in Lagos, Nigeria (Atim 1998: 17–8, Atim et al. 1998: 13–4).

In Bwamanda, Democratic Republic of Congo (DRC), Criel (1998: 57) reports that even though the Bwamanda Health Insurance Scheme was not based on endogenous associations, some endogenous associations still adopted the logic of insurance into their schemes by insisting that only those who have joined the health insurance scheme were eligible to join them (the endogenous associations). He goes on to argue that CBHIs and endogenous associations can actually coexist and reciprocally influence each other.<sup>4</sup>

The second critical issue is the extent of coverage of the population by a CBHI scheme based on endogenous associations. This issue begs consideration because many women in Ukete, for example, do not belong to mutual



aid associations. Let us therefore carry out a closer examination of the issue, using the contexts of Ukete as example.

Ukete has 213 households and there are presently three operational mutual aid associations, namely, Umuchu Women's Association (UWA), Nneoma Women's Association (Nneoma) and Nwayo-bu-Ije Women's Association (NIWA). In terms of membership size of the associations, UWA has 23 members, Nneoma 17 members, and NIWA 21 members. This shows that 49 women out of 213 households presently belong to mutual aid associations. However, there is a high level of awareness of solidarity and mutual assistance among Ukete women. This is because smaller solidarity-based self-help groups are spun and dissolved every year. They are formed *ad hoc* based on need, for example, need for mutual labour exchange during peak farming season, dance groups for Christmas, etc. Bringing these forms of *ad hoc* self-help groups into this analysis and discussion helps us to appreciate the fact that more women than presently belong to the larger three mutual aid associations have gained some experience and awareness of mutual self-help group. Such *ad hoc* self-help groups, according to respondents, serve as forum for mutual assistance, socialization, etc. They do not practise financial contributions, and they get dissolved immediately the specific reason for which they are spun is no longer viable.

The reason for bringing into this discussion women who are not members of any of these three associations is to suggest that the experience of participating in associations may not be totally lost on them, if at all. In fact, it may be argued that such experience may prove useful in the women's participation in larger and more stable mutual aid associations, like UWA, and through them in formalized CBHI schemes. By exploring and understanding the dynamics of membership and operations of the more stable mutual aid associations, it is possible to stimulate such women to join the more stable mutual aid associations. This could be done through well-designed information and communication programmes carried out as a part of the preparation for the take-off of a CBHI scheme.

Besides, embarking on more aggressive financial mobilization from secondary sources by the bigger associations, with further reductions in direct out-of-pocket contributions is likely going to be a major factor in attracting more women to join the associations and by extension, the CBHI schemes.

Respondents' accounts show that the idea of health insurance appeals greatly to women because of the obvious constraints in payments for health care. Therefore, a combination of informal, friendly relationships, social support, social engagement and social influence obtained in endogenous associations with more secure access to health care obtained in CBHI

schemes is likely to prove very attractive to women who are not yet members of mutual aid associations. A number of respondents who are not yet members of any of the three main mutual aid associations in Ukete said that they were eager to join any of them which would enroll in any larger CBHI scheme. In FGD7 and FG8, participants who belonged to this category almost turned it into an inquiry session, seeking to find out from me if such a CBHI scheme through which they could gain access to health care by belonging to it via a local mutual aid association was to be introduced to Ukete soon. Their eagerness was very obvious. For example, after a FGD7 session, two women in this category came back to me to ask me if I was there to prepare grounds for such a CBHI scheme. I asked them in turn whether they would not first join what are immediately available in their community (the women's associations). One of them laughed and told me she wanted the 'real thing', which I interpret to mean an actual formalized CBHI scheme, before she would join any of the existing mutual aid associations. The second woman smiled and muttered 'I will, I will'. As regards their question, I told them I was only conducting a research for my studies overseas. Similar eagerness was expressed by a number of women during IDIs and ICIs. The denominator of their position could be summarized simply as: I look forward to becoming a member of any of the associations as soon as they join a health insurance.

In summary, responses obtained from women tend to suggest that existing mutual aid associations may significantly increase in membership size if they become members of a CBHI scheme. The experience of women who engage in *ad hoc* seasonal self-help groups as well as the fear of health care payments in times of health crises are apparently important factors that may lead non-members of mutual associations to join the associations in the event of introduction of CBHI schemes based on endogenous associations.

## Notes

1. Their records basically contain information on members and their monthly contributions, names of those who took loans and when they paid, money gotten from collective labour, expenditures, what members got at annual redistributions. I described the records as rudimentary because of lack of proper bookkeeping practices such as balancing of accounts, etc.
2. See also the case of Kaka Onwe (section 5.3). Compare with Uzam Okafor (section 5.4).
3. Unfortunately, Mrs Iroegbu could not go back to the hospital for further treatment. Toward the end of this field work, she succumbed to the cancer of

the cervix. One can argue that her death does not indicate a failure of the mutual aid scheme which she in fact provided her with a loan. Cervical cancer usually starts insidiously and by the time it becomes symptomatic enough to prompt health-seeking, it requires sophisticated treatment modalities that are extremely expensive.

<sup>4</sup> Although in the Bwamanda example, coexistence and reciprocal influence occurred in a context in which the CBHI was not based on endogenous associations, it is reasonable to expect that, in a context in which a CBHI scheme is based on endogenous associations (through Model A), there will also be coexistence and reciprocal influence between the CBHI scheme and the endogenous association(s) on which it is based.

# 7

## Conclusions

### 7.1 Introduction

This study set out to investigate how rural women in Ukeke, a rural Igbo community in southeastern Nigeria make attempts to access health care, and how and to what extent household, kinship and endogenous associative mutual aid mechanisms are used.

It hoped to provide context-specific understanding and insights into health-seeking and health risk management in a rural area in economic decline. Being an exploratory study, it utilized a qualitative, case-study methodological approach.

In this chapter, a synthesis of the empirical findings discussed in the previous chapters will be provided, and conclusions will thereafter be drawn from the findings.

### 7.2 Synthesis of Empirical Findings

In Chapter 3, the study identified a rural agrarian community in which deprivation is suffered in the majority of the community households. There is also sharp social and economic inequality in the community.

The chapter argues that it is to land that we should look to see the mechanisms of social and economic differentiation as well as the mechanics of economic decline and financial vulnerability. Farming, which is the primary occupation of the vast majority, is becoming increasingly difficult to engage in. The principal reason is the rising cost of farm land. Land ownership is extremely unequal as very few lineages own and control the greater proportion of the farm land. Consequently, the majority of the people do not own land on which to farm. Ownership and access to land is through the adult males; women do not own land. Ownership and access to land ensures a field on which to produce crops for consumption and for cash. Landowners use the income from their resources to send their children to school, creat-

ing a wide disparity in educational achievement between the landowning households and the landless ones. The highest number of secondary school and university graduates comes from landed households. The landowners are richer and have more household and productive assets. By contrast, the landless, with the exception of some households, are usually poorer. Because of its effect on income generation and wealth acquisition, land indirectly exerts a strong influence on participation in group social networking and associative movements that practise mutual aid schemes that could be used for covering health risks. A majority of the women engage in farming activities. Some women from relatively rich households also engage in non-farm activities including trading, dressmaking, etc.

Women's vulnerability to financial risks arises from cultural norms which place responsibility for expenditures on daily cooking ingredients and purchase of medicines on women. Women's financial risks are also increased by expenditures on life-cycle events and ceremonies. The chapter also portrays the community as a status-seeking society. Women try to conceal their real level of deprivation and to protect their pride. Because of this status-seeking attitude, consumption and other income are spent on life-cycle events and festivities in a spurious show of well-being. Such expenditures, the chapter discovered, weaken the already vulnerable financial position of even relatively well-off women and push the poor ones into deeper deprivation. Consequently, they find health crises very distressing, and for most of them, beyond their capability to handle.

The chapter also indicates that these factors that threaten women's financial security also impact on their ability to participate in mutual aid associations, and by implication, will also affect their participation in community-based health insurance.

Chapter 4 reports the various types of health care providers found in the field. It classifies these health providers into two major categories, according to the relative financial ease of seeking care at the facilities and the availability of trained professionals and appropriate medical equipment. The two categories are the lower health care providers and the higher health care providers. The former include the patent medicine vendors (PMVs), traditional birth attendants (TBAs) and traditional bone healer.

The lower level of health care providers is the most commonly used level among poor women. Although these women know that they should seek care at the higher level for severe and/or chronic illnesses, they frequently fail to because of lack of money to do so. This problem in health-seeking particularly affects poor women who do not belong to any mutual aid group. The specific nature of the relationship between women and access to

health care, given the social and economic context of Uketé, has important implications for the approach to community-based health insurance: whether to be based on endogenous associations or on households. The findings do not support the approach of using households as basis for community-based health insurance schemes, even though this is the conventional approach.

Chapter 5 analyses and discusses the use of household and kinship mechanisms of mutual aid in health risk mitigation. Household strategies include the use of household income which is either income used for consumption or cash savings in managing health risk. The chapter found that because of pervasive deprivation and lack of savings, poor women have only their consumption income to avail of. This is usually meagre. Richer women make use of savings but such households are in the minority. The use of consumption income and savings creates financial vulnerability and pushes some women and their households into deprivation. Another strategy used by women is the sale of household and productive assets to get money for health risks. However, many women and their households do not even have assets that they can sell. For women that sell their assets, the sold assets are seldom replaced. Sales of assets diminish possible diversification of income-generating activities and reduce their non-farm income. The consequent reduction in income generation is significant and in many instances irreversible. The consequence is that many such women and their households are pushed into poverty.

For the purposes of analysis, the chapter categorizes kinship/extended family mechanisms into filial duty, sibling solidarity and extended relations solidarity/mutual aid. Empirical findings showed that filial duty as a mechanism is scant, infrequent and cannot be accessed by the needy elderly women for their health risks. Sibling solidarity is largely undependable and out of reach for many women and their household to access in times of health crises. Economic deprivation and lack of a sense of moral obligation largely account for failure to obtain aid on the premise of filial duty and sibling solidarity. Appealing to the moral obligation of extended relations is found in this study to have been used by only few women and their households for their health risks. The same problems that affect sibling solidarity also affect extended relations moral obligation. Added to this is the occurrence of social conflicts within extended families.

In Chapter 6, analysis and discussion of the application of mutual aid obtained from associative movements was done. The chapter focused mainly on a women's associative movement that practises generalized reciprocity/financial pooling and annual redistribution. The chapter discovers that

women who belong to the associative movement make use of mutual aid inherent therein to manage their health risks. The chapter reports that two major forms of mutual aid are available in the association, namely, annual take-outs and loans with insurance contingency. Take-outs come annually during redistribution while loans can be accessed anytime during the year. In some cases, women plan ahead to use their take-outs to pay for treatment of illnesses that occur before the redistribution. In other cases, take-outs are used to manage health crises that occur shortly after the redistribution.

Loans are mostly accessible to members, and are interest-free. Members who make regular contributions are not required to meet any conditions such as collateral and guarantors. The association reduces monthly contributions during the season of acute financial and food scarcity (*umwu*). This is to reduce the financial burden on members and minimize exclusion. Collective labour devised by the association as an additional method of resource mobilization helps to compensate for the reduction in contributions. The findings suggest that approaches that base CBHI schemes on existing endogenous associations may be well also suited for remote rural communities. This is because, as is evident in UWA, the endogenous association has mechanisms that reduce exclusion (not total elimination of exclusion), encourage participation, and increase resource mobilization for a CBHI scheme. Large membership size is needed for increased resource mobilization, which is necessary for improved collective action to provide greater financial risk protection for members.

### 7.3 Conclusions

This research draws the following conclusions.

#### (a) Households/kinship mechanism for managing health risks

Household mechanisms for health risks are precarious and unreliable. Pervasive deprivation in the community implies that many poor women and their households use their savings and consumption income to manage health risks, while others sell their productive and/or household assets for the same purpose. The thesis posits that, for such women, ex-ante health risk management strategies such as mutual aid groups and community-based health insurance schemes will serve them better. Adjustment of consumption income will be gradual in the instance of their participation in CBHI schemes rather than the unexpected and sudden consumption adjustment following a health crisis when there is no insurance coverage.

### (b) Endogenous association mechanisms for managing health risks

The study suggests that endogenous associations may be suitable for basing CBHI schemes. The association, through their representatives, may be able to negotiate the premium with the scheme implementers.

In the hypothetical scenario above, assuming that the critical level of premium is the negotiated amount, agreed upon by both the endogenous association and the scheme implementers, as is evident from the findings within UWA in Ukete, the endogenous association will be able to reduce the premium for her members below the critical level. Then through alternative approaches to resource mobilization, the association will be able to raise money to make up for the deficits in the premium.

The ingenious ways the UWA adopted to lessen the burden of individual contributions and yet increase the total pool size (e.g., engaging in paid labour contracts) shows that endogenous associations have the ability to evolve mechanisms to generate money for CBHI schemes while encouraging the persons from the low-income group to join. As posited in Chapter 6, besides the paid labour just mentioned, rural women may own farms. An endogenous association can use some of their money to pay for land lease and purchase seed crops and seedlings. They may then use direct (own) labour for the cultivation, the weeding, harvesting and processing where necessary. They may sell the produce and/or processed food and raise money from them.

Apart from group (collective) farming, mutual aid movements could also own grocery shops in their locality or in the markets nearest to their locality. They can use direct labour for the operation of the shop. By diversifying their sources of income, they will increase the size of their financial pool, and yet reduce the burden of direct individual financial contributions.

The findings also point to the fact that endogenous associations' mutual aid can offer financial risk protection for its members. In UWA, the use of take-outs and loans provides an immediate and necessary avenue for paying for health care. Although the take-outs are available during a particular period of the year, they are handy for health payments during the period. Take-outs used for health payments protect consumption and cash income in many cases. They also protect against the sale of household and productive assets.

Loans with insurance contingency can be accessed any time of the year. A woman who uses an insurance-contingency loan from her association for health-seeking spares her cash and consumption income. She also spares her household and productive assets.



Since women are not homogenous in the community, the level of financial risk protection enjoyed by women varies from woman to woman, mediated by their social and economic state. The financial risk protection offered by mutual aid is also a function of the severity and duration of the illness and the pooled resources of endogenous associations can be insufficient to cover health care costs for its members. However, if an association like the UWA becomes associated with a CBHI scheme which is made its primary objective, and the pooled funds from contributions are insufficient, it can embark on the other alternative sources of resource mobilization to generate much more money, which will enable it to subscribe to substantially higher levels of health cost coverage. That is, the benefits package of the CBHI scheme will increase significantly. However, the study notes that because of the direct relationship between membership size, resource pool, and financial risk protection (including wider benefits package), a larger membership population is needed.

The study also posits that endogenous associations are suitable as a basis for CBHI schemes because endogenous associations have better mechanisms for managing social control problems. It is evident from the study findings that UWA is largely able to minimize social control problems in the association. As indicated in Chapter 6, UWA has put a number of measures into place to check social control problems, which include:

- i) Institution of a waiting period for new members before they can qualify for a loan without conditionalities (applicable to non-members).
- ii) Placing a ceiling on the amount of money any member may be given as loan
- iii) Preventing any member who still has outstanding loan repayment from borrowing again.
- iv) Implicit specification of the severity of the health crisis for which loans may be given.

Even more importantly, social capital within UWA helps to minimize the social control problems within the organization. Consequently, the organization can be correctly adjudged largely successful in the achievement of its objectives to its members. The implication of this for CBHI seems to be that if CBHIs are based on endogenous associations, the associations are already equipped with mechanisms and experience to manage social control problems. This study posits that these inherent mechanisms of social control are advantageous for the operations of a community-based health insurance scheme.

Additionally, the social capital inherent in endogenous associations helps to stabilize membership within the association. As seen in UWA, there is minimal withdrawal of members, and one of the major factors is the influence of social capital. Members of an endogenous association will likely see their membership in a CBHI scheme based on the association from the perspective of their social interactions within their associations, compared with the impersonal relationship that exists between households and CBHI schemes that are based on them. The experience of participation in an already existing mutual aid scheme may also be crucial in fostering participation of members of an endogenous association in a CBHI that is based on the association. In such cases, the experience may be viewed by the endogenous members as a continuum.

An important issue, however, is how basing a CBHI scheme on endogenous mutual aid associations is going to work in rural contexts like Ukete. To address this, three alternative models were compared (see Chapter 6, section 6.3). The salient features and dynamics of the models are summarized below.

In Model A, an endogenous association (for example, UWA) becomes a titular member of a CBHI scheme. That is, it enters into an institutional contractual relationship with the CBHI scheme. This means that the association retains its own independent existence, identity, objectives and activities. The CBHI scheme has no contractual relationship with the individual members of the association, only the institutional relationship with the association. The association discharges its contractual financial obligations to the CBHI scheme through mobilization of funds (through members out-of-pocket contributions and through secondary sources such as collective labour), and regular payment of premiums to the scheme on behalf of own members. The association also performs non-contractual subsidiary duties to the scheme such as using own mechanisms and inherent social capital to exert social control on members, and thus check free-riding, adverse selection and moral hazard, among others. This helps to enhance the CBHI scheme performance and minimize threats to financial sustainability of the scheme.

On the other hand, the mutual aid association continues to discharge its social and moral obligations to its members. In relation to the CBHI scheme, the mobilization of funds from secondary sources reduces financial burden on own members, helps the association to keep a reserve fund to support her members with co-payments, transport fares, laboratory tests, etc. The association also works to protect the interests of its own members. To do this, the leaders may have to collaborate with leaders of other asso-

ciations (which are also members of the CBHI scheme) so as to increase their clout and enhance their bargaining power. The leaders may also, if necessary, confront and negotiate with the health care providers over the quality of health care services received by the members. This study posits that, although the leaders of UWA and/or other such association may not have adequate clout and strong negotiation skills at the beginning, they may overcome the deficiencies by collaborating with leaders of other associations (as indicated above), and with time, they will acquire the necessary skills through experience. With regard to collaboration, I observed cordial relationship among the leaders of the mutual aid associations in Uketu and so I think this is possible. And this may have implications for negotiations with CBHI scheme implementers.

In Model B, an endogenous association can, singly or in combination with other similar associations, establish its own CBHI. There are many limitations in this model though, which pertain mainly to inadequacy of administrative, actuarial, management and negotiation skills. Although these constraints can be surmounted by hiring professionals to manage the scheme, the transaction costs may prove too high for the financial sustainability of the scheme. I propose this model for only very large associations or NGOs, perhaps, with external funding. The model is certainly *not* suitable for small organizations.

In Model C, an endogenous association becomes subsumed under a larger CBHI scheme, thereby losing its independent existence and separate entity. In this study, I do not advocate for this model because, the endogenous association, by being subsumed under the larger CBHI scheme, is dissolved. This clearly results in the loss of its features which would have made it suitable as basis for CBHI in the first instance.

As explained in Chapter 6, there are grounds for further exploring Model A as the most appropriate approach to basing CBHI schemes on endogenous associations for the following reasons:

- i) The association retains its independent existence and separate entity.
- ii) It is able to perform its contractual obligations to the CBHI scheme by paying the premiums for its members regularly.
- iii) It is able to use own mechanisms and inherent social capital to check social control problems. This enhances scheme performance and minimizes threat to financial sustainability.
- iv) The association protects its members from the excessive financial burden of premiums by mobilizing funds from secondary sources such as collective labour.

- v) It continues to help members with loans for co-payments for services not covered by scheme benefits package, transport fare to the usually distant hospitals, etc.
- vi) It continues to provide a forum for solidarity, mutual social influence, social support, and social engagement.
- vii) The leaders of the association negotiate with the CBHI implementers and/or the health care providers for better deals and better quality of health care for its members.
- viii) Low transactional costs: the association incurs minimal, if any, costs since it does not employ the services of professionals to manage its affairs with the scheme.

A closer examination of a few issues that may affect the operation of such Model A scheme shows that, as regards the issue of possible conflict between the rules and practices of mutual aid associations and those of CBHI schemes, empirical reports from Bwamanda in Democratic Republic of Congo (Criel 1998: 57) and respondents' accounts from the UWA case study suggest that there will rather be 'coexistence and reciprocal influence' (ibid.) between endogenous associations and the CBHI schemes rather than collision of rules and practices.

Concerning the participation of women who presently do not belong to any mutual aid association, analysis of data shows that many such women will eagerly join mutual aid association if the association were to become a member of a CBHI scheme. This suggests that, although the proportion of women who belong to mutual aid associations may not be so large, one can expect that there will likely be a swell in the membership of the associations should Ukete women get concrete evidence that the association(s) have in actual fact become a member(s) of a CBHI scheme. This proposition is predicated on the responses got from the women, which suggest that there is an eagerness to join a CBHI scheme, not as individuals, but through the agency of endogenous associations. This should not be surprising, for two reasons: The women are acutely aware of the severe constraints of direct payments for health care. Second, Many Ukete women have at one time or another the experience of joining small, *ad hoc*, non-financial-pooling, self-help groups, which usually wind down after the solution of the problem for which they are formed. This study posits that the experiences may be significant and quite relevant to participation in CBHI schemes via endogenous associations. The endogenous associations offer friendship, reciprocal assistance, trust, mutual social influence and social engagement. These were observed in UWA, and will most likely be present in other associations.

Some of these might also have been experienced by women in their *ad hoc* transient small self-help groups. Actual and/or anticipated experiences of these social and material contents of mutual aid associations, coupled with the palpable threat of health care risks (and the difficulty of paying directly from pockets) are deemed important factors which may strongly motivate women to join CBHI schemes but on the platforms of mutual aid associations.

Respondents' opinions suggest that, in the event of an introduction of a CBHI scheme in Ukete with the endogenous associations becoming members, there will most likely be an influx of women into the endogenous associations for the purposes of obtaining health insurance.

This model can only be workable in situations in which several local endogenous organizations are incorporated as titular members. Such local associations do not necessarily have to come from only one community. To muster adequately large membership size for sufficient financial pool for a CBHI scheme, several associations across communities will need to enroll in the scheme as titular members.

#### 7.4 Concluding Remarks

There is no single 'magic bullet' solution to the problems of provision of health care for rural people (including poor women). Given the economic climate in Sub-Saharan Africa, and specifically, Nigeria, on the one hand, it may not be possible to provide free health care to every segment of the population. On the other hand, direct out-of-pocket payments for health should not continue as the policy of health care financing because it clearly creates affordability barriers to the poor, especially rural women.

The middle-ground solution seems to be various forms of prepayment approaches and social health insurance schemes. Again, because of problems of political will and macro-economic woes, nation-wide social health insurance is not widely implemented across Sub-Saharan Africa. This is what makes community-based health insurance imperative. Community health insurance offers some promise because it can be designed to target particular vulnerable groups in specific locations. Community health insurance can be originated by governments, non-governmental organizations, or other agencies, institutions and organizations. It can be originated from the grass-roots and operated in a bottom-up fashion. This study supports the suggestion that more emphasis should be placed on community health insurance as an approach to providing health care to the poor, especially in the rural areas. Community health insurance should be more explicitly inte-

grated into the national health systems. Governments should encourage non-governmental organizations, faith-based organizations, community-based organizations, and other such bodies to establish or link up with community-based health insurance schemes.

Existing community health insurance schemes should be given technical and financial support by governments, bilateral donors and other international organizations. This will help improve their performance and sustainability. United States Agency for International Development (USAID) has demonstrated this in the case of Lawanson and Jas Community Partners for Health (CPH) in Lagos. The CPH experience shows that donor or government technical assistance and financial support does not necessarily conflict with participatory, bottom-up, approach to community-health insurance. It also shows that donor/government technical and financial support is compatible with the Model A outlined in Chapter 6; endogenous associations which are titular members of a scheme do not necessarily lose their identity, independent existence, functions and advantages.

The experience of the Lagos schemes, though encouraging, is limited. Experiences and lessons from more pilot schemes in diverse contexts in different countries will provide an evidence base for policy making and programming on community-based health insurance.

Finally, this study makes no claim that community-based health insurance can ever be all-inclusive of populations in need of health care, not even all the poor. It is not a universal remedy for the problems of health care access for the poor. As shown in this study, and other studies, exclusion occurs in risk-sharing schemes including community health insurance schemes denying very vulnerable populations access to health care. Other measures must therefore be put in place to capture these vulnerable ones who fall through the safety nets of community health insurance schemes, The moral obligation and social contract of every government with her citizens include provision of social protection, especially for the vulnerable populations. This implies provision of free basic health care for those vulnerable segments of the population that are simply incapable of paying any contributions at all for health insurance.



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