TREATMENT SEEKING BEHAVIOUR AMONG POOR URBAN WOMEN IN KAMPALA UGANDA

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By

Grace Bantebya Kyomuhendo, BA[hons], Makerere University Uganda; Mphil[Social Anthropology] Cambridge University UK

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This thesis examines women's treatment seeking behaviour for their own illnesses and that of children underfive in Kamwokya. The focus is on the extent to which women's access to money and time use patterns affect treatment seeking. It has been argued that women's treatment seeking behaviour is influenced more by their time use than their access to and availability of money.

The findings obtained through the use of case histories and in-depth interviews indicate that though women in Kamwokya have access to their own money, mainly through participation in income generating activities (business), illness management for children under-five and even more for the women themselves, remains problematic. Women are overworked and manage fragile businesses that require their personal attention and presence. Hence, treatment seeking is done in a manner that will ensure minimal disruption of businesses. Consequently children's health, and even more so, that of women, is compromised for the sake of other family needs.

This thesis demonstrates that illness management is not context free, and that no one factor can explain the whole process; it both affects and is affected by other things happening in the family. Due to the multiple roles women have to fulfil, "time use" is found to be the organising and central factor in illness management for both women and children in Kamwokya, whether from rich or poor households.

The thesis concludes by suggesting that policy makers, health care providers and professionals ought to take into account the daily routines of family life in their plans and programmes. Strengthening of private sector health providers, health education programmes and increased awareness raising of male responsibilities towards their families are recommended as a way of improving the health of women and children in Uganda.
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MAP IIIA KAMWOKYA I AND II ZONES
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The household a centre of and smallest of series of concentric circles extending outwards. Each circle represents a general geographical area.
ABBREVIATIONS

AIDS Acquired Immune-Deficiency Syndrome
ASL Above See level
CHDC Child Health and Development Centre
DHS Demographic and Health Survey
IMR Infant Mortality Rate
MMR Maternal Mortality Rate
MOH Ministry of Health
NRM National Resistance Movement
NCC National Council for Children
ODA Overseas Development Agency
OPD Out Patient Department
ORT Oral Rehydration Salts
SAP Structural Adjustment Programmes
STD Sexually Transmitted Diseases
UN United Nations
UNICEF United Nations Children's Fund
GLOSSARY

Ajon ---- An Iteso word for millet beer
Ebinyo ---- False teeth
Jaja ----- Grand parent or an elderly person
Lukusense --- Measles
Matooke --- Green Bananas
Musujja ---- Fever, sometimes associated with malaria
Mulokonyi --- Cow hooves dish
Musawo --- Healer
Muzigo----- Single room
Tonto --- Local beer made out bananas
Waragi --- Local gin
Yabwe -- Sudden convulsions
CHAPTER ONE

BACKGROUND AND THE STUDY PROBLEM

1.0 INTRODUCTION

Among those concerned with comprehensive health care there is increasing awareness that women are the primary health providers for the family and that many of the women burdened with this responsibility, especially in the developing world, are among the poor and impoverished [Brydon and Chant 1989]. In the face of these difficult circumstances their health care choices afford clues as to how women rank their health concerns and exercise their options. These choices may include whether or not to consult health care providers, to use medicinal herbs or pharmaceuticals, or to consult traditional healers during sickness of their household members or themselves.

This thesis examines treatment seeking behaviour of women in low income urban situations in Kampala, Uganda. The focus is on the extent to which a woman’s access to money and time affects her own treatment seeking behaviour and that for her children under five during illness episodes.

A premise of this study is that health care is part of the domestic economy, moulded by relations which govern everyday life in the family and community [Graham 1984]. Several studies related to health care choices point out the various demographic, socio-cultural, economic and need factors based on an individual’s perception of personal illness as being important determinants of

People seek treatment from different types of health care practitioners depending on their perceptions and beliefs about a particular set of symptoms. These perceptions and beliefs, in turn, are influenced and defined by social surroundings and network relationships [Sage 1992; Justice 1981]. Given that women are the primary health care providers, the situation is more complex as they are constrained by so many factors.

The fact that in most African households decisions involving expenditures in cash or in kind tend to be made by the senior male may make it difficult for women to make independent decisions on the selection of treatment. However, this situation is changing due to increased access to income for women in both rural and urban areas [Bantebya Kyomuhendo 1992; Obbo 1980; Tadria 1987]. Many women are now contributing to household incomes. Some are even the sole contributors, while others are household heads solely supporting themselves [ibid.]. This changing situation is bound to have implications not only for gender relations in households but also for women's health care decisions.

1.1 The Problem

In Uganda, women's involvement in the labour market, particularly in the informal economy, is not a recent phenomena and is well documented [see Obbo 1980; Little 1973]. However, the last two decades have witnessed a
rapid increase in the number of people entering the informal economy, with 
the majority being women [Mwaka et al 1994, Bantebya 1992, Basirika 
1992]. The situation reflects Uganda’s economic crisis which, triggered by 
political instability and economic mismanagement, has led to increased 
pressure on the population and social services. As many male bread winners 
have lost their jobs, due to the country’s economic decline and the 
subsequent adoption of structural adjustment by the government, many 
women, particularly in low income urban situations, have had to engage in 
all sorts of income generating activities to support themselves and their 
families [Basirika 1992]. This has not only meant a double work load for 
women who may work long hours, day and night, to support their families 
but also raises questions regarding women’s health situation and that of their 
children.

As more women enter the labour market, the evidence available shows that 
health conditions are progressively deteriorating. Uganda’s social indicators 
are reported to be deplorably low, with health indicators being among the 
world’s worst [World Bank 1993a, NCC 1994]. In 1991, Uganda’s infant 
mortality rate [IMR] was 122 infant deaths per 1000 live births, and its 
under five mortality rate was 203 deaths per 1000 live births [NCC 1994 
World Bank 1993a]. A new born Ugandan baby has only 80% probability of 
reaching the age of five years. The Current National Demographic and 
Health survey reports similar trends [UDHS 1995].
Maternal mortality in Uganda is also high, estimated to be at least 600-1000 maternal deaths per 100,000 live births [Kadama 1993; Kasolo 1992; NCC 1994, UDHS 1995]. Life expectancy from birth, which ordinarily increases as countries develop, is projected to decrease in the next decade. It is estimated that life expectancy at birth, currently 47 years for men and 50 years for women, will be only 40.7 years by the end of 1990s, one of the worst in the world [World Bank 1993a].

These poor social indicators, as pointed out by the reports, are a reflection of a low level of human welfare and a reflection of the economic constraints which many women counteract through participating in income generating activities. The irony of the situation, as suggested by the reports, is that for all practical purposes the leading causes of illness and death are preventable, although with varying degrees of difficulty and requiring a variety of interventions [World Bank 1993a p 53]. AIDS has of course contributed to this bleak picture. Uganda is one of the worst hit countries by AIDS in the developing world [NCC 1994]. For the year 1995 a cumulative total of 48,312 AIDS cases (children and adults) were reported to the STD/AIDS Control Programme Surveillance Unit. Among the adult cases, 46.9% were males and 53.1% females [Ministry of Health 1996].

The two trends, i.e. of worsening social indicators, and the increased participation of women in income generating activities, seem to be interrelated. It is this interrelationship that is the main basis of this thesis. It is examined by focusing on how women's time use and access to money
affect the decisions they make about treatment seeking in the case of their own illness and those of their children under-five. Given that women may have access to money income through various means (e.g. allowance from spouse or relatives; own earnings; or both) the significance of different sources of income for treatment-seeking behaviour is examined.

The thesis also postulates that time use for women, particularly that involved in businesses to earn income, is a crucial factor in determining their treatment seeking behaviour. Women’s entry into the labour market, especially in the informal economy, has not relieved them of their reproductive role. It is still the obligation of women to perform all household/domestic chores and care for the children and the sick and their responsibilities are hardly supported by improved technology. The heavy workload and increasing time constraints borne by women are demonstrated by this comment from a woman in Tanzania: “In my office we don’t have closing hours“ [Caplan 1995 p 118]

Women’s time is required for both business and treatment seeking. While time spent by women participating in income generation activities benefits their families in terms of making money available for the family (including health care) it may not be easily available when needed for seeking health care during an illness in the family. Similarly, money meant for business may not be available for treatment seeking. In summary, women’s dilemma is that, time spent on treatment seeking is no longer available for business and money spent on illness is not available for business, and vice versa. The trade-off between these two obligations is explored in the family context. Although
time and money variables are central to the argument, the analysis also takes account of each individual woman’s definition of an illness and of the other factors which they describe as influential when making treatment choices.

Although all children are vulnerable and cared for by women, the under-fives are more vulnerable and need close attention and care of their mothers. Consequently, mothers’ care or the lack of it is bound to have great implications, not only for their general health but also for treatment seeking when they fall ill. It is the under-fives’ vulnerability that has always been and remains a major area of concern and debate in relation to women’s employment outside the home, the question being, “Can children’s needs including health be met when their mothers work for cash income in Third World countries?” [Leslie 1992] The question being asked is how women’s access to money and time use affects treatment seeking behaviour for children’s illnesses, especially in the case of the under-fives? Attention is also paid to women’s treatment seeking for their own illnesses; because health care is culturally their responsibility, and an integral part of their spousal and maternal roles, they are managers of their own illness.

1.2 Study Objectives

In summary, the specific objectives of this study are

1. To identify the ways and means through which women have access to money income.
2. To assess the effects of women’s access to and control over money on their decision-making in relation to treatment seeking during their own and their children’s illnesses.

3. To examine women’s time use and its effects on decision-making in relation to treatment seeking during their own illness and that of their children, underfive.

4. To identify other factors that influence women’s decisions about treatment through examining particular episodes.

Treatment seeking in Uganda is part of both the domestic and public economy, moulded by relations which govern everyday life in the family and community [see, Graham 1984]. Women’s treatment seeking behaviour ought to be seen and linked to the opportunities and constraints set by the general women’s status and position in Uganda’s socio-economic system and in particular that of Kampala Kamwokya, the focus of this study, which influences the disease burden and access to resources.

The assumptions made regarding the relationship between poor social indicators and women’s participation in income generating activities are that: Treatment seeking behaviour will be more influenced by women’s access to and availability of money than their time use; and women with access to and control of money have greater scope for seeking “appropriate” treatment when they or their children fall ill.

Decision making theories argue that, within the household, there is unequal distribution of power and access to resources [Whitehead 1981; Sage 1992].
Focusing on household dynamics, therefore, serves to de-construct the household and to move the analysis beyond the “black box” conception of a unit collectively engaged in a single form of production [ibid.]. The de-construction of the household, it is argued, is accomplished through recasting neo-classical paradigms. In these paradigms the basic unit of analysis is the individual and the household is a variable which intervenes to maximise the individual’s capacity to acquire scarce resources [Standing 1991]. Under this conception, therefore, gender inequality inside the household, which is constituted in terms of the relations of power and dominance structuring the life chances of women and men, cannot be ignored [Ostergaard 1992]. These relations are neither necessarily nor obviously harmonious and non conflicting. On the contrary, the socially constructed relations between men and women may be ones of opposition and conflict [ibid.].

1.3 Defining the household

The household has for long been a focus of attention as the primary site for structuring gender relations and inequalities [Townsend and Momsen 1987; Brydon and Chant 1989; Ostergaard 1992] and it has been defined in many ways. The distinction between a family and household has, however, in most cases been glossed over and thus used inter-changeably [Jaquette 1993]. Jaquette, argued that the two are distinct, with the household as the location of a set of activities that reproduce members daily (through the domestic work) and of inter-generation (not only through biological
reproduction) but also through the socialisation of children. The family on the other hand, refers to kinship and it presents a normative system whereby people are recruited into the household. She argued that families organise households through the rights and duties defined by kinship and they also regulate the activities of the household members [Jaquette 1993 pp 48]. However, she noted that the household cannot be understood apart from the family norms of gender and generation because they reflect and distort material relations in the family [ibid.]

Brydon and Chant [1989] define a household as a residential unit whose members share ‘domestic’ functions and activities, a group of people who eat out of the same pot or who share the same bowl. However, they caution that sharing of residence and consumption does not always apply and the interactions with the household do not necessarily entail co-operation among members. Consequently, a household could be seen as an arena of conflict and co-operation or as a site of bargaining and negotiating of dominance [Becker 1981]. Sen, in his model of co-operative conflict, adds that individuals in the household do not bargain solely on the grounds of their self interest or utility; instead, individuals’ bargaining strategies depend on perceived notions of what they are entitled to [Sen 1990; Jaquette 1993]. Women more than men are said to internalise family welfare rather than personal welfare as their measure of utility [ibid]. This is particularly important in understanding women’s treatment seeking behaviour for their own illness and that of their children, discussed later in chapters 6, 7 and 8.
However, applying Sen’s model to households in developing countries poses some difficulty due to the problem of household definition [See Omari 1995]. Also, Brydon and Chant[1989] draw our attention to the importance of inter-household networks of reciprocity which make it impossible to draw boundaries of household functioning. Inter-household networks of reciprocity and exchange are regular features of multi-family compounds and low income neighbourhoods in Africa[Mitchell 1969]. Consequently, to understand adequately the functioning of households in Africa, such relations ought to be taken into account.

In this study, the household is considered as the location of a set of activities that reproduce members daily (through domestic work) and inter-generationally not only through biological reproduction but also through the socialisation of children[Jaquette 1993]. However, we argue that the household as a unit of analysis on its own is not adequate to explain women’s health care behaviour. Inter-household networks are considered to play a vital role in shaping women’s treatment seeking behaviour. By virtue of this consideration, all factors both within and outside the household are examined in relation to women’s treatment seeking behaviour. However, specific reference will be made to the effects of women’s access to money and their time use on their treatment seeking behaviour.
1.4 Thesis Structure

This chapter has described the background to the problem, the study's objectives and the unit of analysis which is the household, including inter-household relations and networks.

Chapter Two examines decision-making and health care theories as the theoretical background to the study. Studies on health care and women's access to income in urban situations and resource allocation within households are discussed.

Chapter Three describes the setting of the empirical. First, it looks at Uganda in general, discussing historical, political and economic developments. The health care system, health situation of children and women are examined. The second part of the setting is Kamwokya where the study was conducted, and the area's physical, social, economic and health conditions described.

Chapter Four reviews the research methods used, including a discussion of the study design, study population, selection of respondents, data collection and research instruments, data processing and analysis, and field experiences.

Chapter Five presents a number of detailed case histories of women conducted during the field work.
Chapter Six examines extracts from these case histories showing the income
generation strategies of women in Kamwokya, the nature of their
businesses, the locations and constraints.

Chapter Seven, using the case history material, deals with women’s time use
patterns and the constraints they face.

Chapter Eight analyses the whole treatment seeking process for each woman
in the case of her own illness and that of children under five. Specific
illness episodes and the factors influencing the choices made are discussed.

Chapter Nine assesses perceptions and definitions of symptoms and their
effects on women’s treatment seeking behaviour.

Chapter Ten discusses women’s general social support networks and their
implications for treatment choices.

Chapter Eleven presents an extended case analysis, “Yatek’s story”, which
puts into context the whole treatment seeking process.

Chapter Twelve concludes the thesis, drawing conclusions regarding the
important resources in women’s treatment seeking behaviour. The
relationship between money and treatment seeking on the one hand, and
time and treatment seeking on the other are discussed. Recommendations
are made and suggestions offered for further research.
CHAPTER TWO

THEORETICAL BACKGROUND AND LITERATURE REVIEW

2.0 Introduction

Illness management in families is affected by and affects the functioning of the household and the context under which it takes place. This chapter reviews literature which provides the theoretical background for the analysis of later case studies which show the whole cycle of treatment seeking for women themselves and their children under five. Decision-making and health care theories have been selected to provide a basis for the argument developed in this study that treatment seeking cannot be examined in isolation from all other things happening in the household and community at large. Each of the two perspectives makes its own contribution to the understanding of illness management in the household.

2.1 Decision making within the household

Decision-making in the household is a critical element in the status of its members since it involves the allocation of resources and the distribution of roles within the household. Decision-making among other things affects general health care and treatment seeking in particular. Two major theories of decision-making that have been used extensively in studies examining power relations in households [Blood and Wolfe 1960; Rodman 1972; Safilios-Rothschild 1970; Oppong 1981; Mustafa 1990; Omari 1995] are examined in this thesis.
2.1.1 Resource theory

This theory was initially presented by Wolfe in 1959 but later developed and expounded on by Blood and Wolfe [1960]. It was later developed and transformed into what is now referred to as the Normative Resource theory, the second theory of decision-making relations within households by Rodman [1972].

The Resource theory (1st theory) by Blood and Wolfe, is premised on the hypothesis that the balance of power in decision-making depends on the resources an individual can offer. The greater the resources one has, the greater the decision-making powers within the household [Blood and Wolfe 1960 pp 12]. They identified income, education and occupation status as the key resources in influencing decision-making within households. In their study of Husbands and Wives in Detroit in Canada, they found husbands’ mean average authority score increased with education, income and higher occupational status. Decision-making powers increased still further if the wife was unemployed and dependent on her spouse [Ibid.].

They used eight decision making items to estimate the relative balance of power between husbands and wives. These included husbands’ job, type of car, life insurance, where to go for vacation, wife’s employment, what doctor to use when sick and amount of money to spend on food [Ibid. pp 19]. They found decisions about the husband’s job and car were predominately male, while those on food and doctors were made by wives. Despite this glaring
gender role association, they went ahead to conclude that "the power to make decisions stems primarily from the resources which the individual can provide to meet the needs of his marriage partner" [Ibid. pp 44]. They argued that because it is based on tangible and relevant criteria, the balance may be found to be adapted to the interpersonal relationships of the two partners [Ibid.]. In other words culture and customs had little influence if any. The authors pointed out "today's marriage has a variable balance of power which is not determined by the assignment of authority to one sex but by the interplay of dynamic forces which affect the marriage from within and without" [Ibid. pp 45].

Their model has been and is still widely used all over the world with some variations [See Oppong 1981; Omari 1995; Mustafa 1990; Safilios-Rothschild 1982; Munachonga 1988]. However, though widely used and recognised, it sparked off a number of arguments and questions as to the extent to which it can adequately be used as a basis for explaining decision-making in households all over the world, especially in developing countries where the concept of the household itself is beset with problems [Omari 1995].

Safilios Rothschild [1970] pointed out the limitations of the resources theory in that it does not cover the full range of resources exchanged between spouses. She argued that the over emphasis on income, occupation and education neglected the non-material resources like love. Safilios Rothschild further drew attention to the importance of women's status which she
distinguished from women's power. Status refers to women's overall position in the society, while power refers to women's ability to influence and control at the interpersonal level [Safilios-Rothschild 1982 pp 117], a factor which the resource theory does not take into account. She argued that in developing countries, which are predominantly patriarchal with a high degree of sex discrimination, women find it difficult to translate their work and earning into power [Ibid.].

Studies from developing countries seem to support Rothschild’s argument. For instance, Omari found that in Tanzania, decision-making was influenced predominately by labour based on age and sex. He comments that, Tanzania like many African societies, is still dominated by patriarchal relations and male domination is regarded as a prerogative right by many people- male and female alike [Omari 1995 pp: 217]. Wright [1993], too, studying unemployment, migration and changing gender relations in Lesotho, showed that despite the relative economic independence of women, men still enjoyed enormous power and monopoly of decision making within their household. In South Africa, money management and continued dominance by men over women, despite the latter's main contributions in the household were found to be central to household conflict, finally leading to divorce [Sibongile 1995]. Mustafa[1990], in Iraq, observed that economic activities carried out within the home were made invisible by the cultural norms and hence did little to increase women's power, while those women working outside the home in
traditional male occupations had more power. Consequently the Resource theory alone cannot explain power relations in developing countries.

2.1.2 Normative Resource theory

The limitations of the Resource theory gave birth to the Normative resource theory developed by Rodman[1972]. According to this theory, decision-making powers in the household depends both on the comparative resources of a husband or wife and the cultural and sub-cultural expectations about distribution of marital power [Rodman 1972]. Rodman, in an effort to explain his theory, developed a typology of four types of societies with each responding to a stage of societal development and thus marital power and decision-making status.

In the first type, which is the patriarchal societies, with low levels of income and economic development, patriarchal family norms are strong and dominant, and individuals socio-economic attributes are irrelevant to decision-making patterns. In the second type, that is countries which have begun to industrialise, modified patriarchal attributes exists, the superior authority of the man within the family is changing and socio-economic factors are equally important in decision-making. In the third, which is industrialised societies, a person's esteem and power are achieved through education, occupation and income. At this stage, resources are more important than cultural norms in decision-making. The fourth type of society is the egalitarian, where economic development has reached it's highest level, the
egalitarian family norms are strong, with power shared between husband and wife. One's resources and ascribed status are all irrelevant to the patterns of decision-making within the family [Rodman 1972].

Rodman's model introduces an element of historical and societal developments which brings the cultural attributes into decision-making. He argues that decision making within the household depends on cultural norms which change as the country becomes industrialised and, by implication, individuals' socio-economic attributes improve the end result being egalitarian decision-making principles [Ibid.].

However, the Normative resource theory falls into a similar trap to that of the Resource theory. It assumes that tradition and cultural attributes disappear with industrialisation, which is not the case [see Hardesty and Bokermier 1989]. Rodman also focuses on the family, ignoring other actors who are relevant in the case of developing countries [See Omari 1995]. The theory also does not take into account the sexual division of labour and responsibilities that are culturally defined. Further, the theory ignores the bases of patriarchal relations which are unequal distribution of resources favouring men. Because men have access to the vital resources like land, education and income, they have been able to dominate in decision making in the family for decades and that has become a right in itself. When men can no longer provide for their families, their right as decision makers is
challenged. These unstable relations are said to be responsible for increasing numbers of female headed households [Sibongile 1995].

The feminist literature also focuses on resources as a factor in the marginalisation of women in the larger economy and the loss of control by women over the means of production [Mustafa 1990; Townsend and Momsen 1987; Standing 1991]. They argue that inequalities persist within modern marriages and that these inequalities arise out of unequal access to resources between the sexes in favour of males [Ibid.]. Others, however, argue that despite the inequalities, that although the formal authority structure of a society may declare that women are impotent and irrelevant, close attention to women's strategies and motives, to the sort of choices they make, to the relations they establish and to the ends they achieve indicates that, even in situations of overt sex role asymmetry, women have a good deal more power than conventional theorists have assumed (Rosaldo and Lamphere 1974 pp: 9). This, hence, means that women may have other bases of power which are neither resources or culturally sanctioned.

In urban situations, most households decisions hinge around money, to which the majority of women in the developing world have less access than their male counterparts. Factors like education and employment opportunities which favour men (Brydon and Chant 1989; UN 1989), as well the weakening of the traditional complementary sexual division of labour (by elevating the husbands' position to that of chief breadwinner) have all
combined to make the woman dependent on her husband economically, and consequently to weaken her relative power position within the household.

Recently, however, this situation has begun to change due to increased access to income by women in both rural and urban areas [Bantebya Kyomuhendo 1992; Obbo 1980; Tadria 1987; Townsend and Momsen 1987; Brydon and Chant 1989]. Many women are now contributing to household incomes. Some with a resident male partner are even the sole contributors; those without a resident partner may be household heads supporting themselves (Ibid.)

Debates on the relationship between women's access and control of money and decision-making within households rages on and is far from being conclusive. While some studies show it has improved, others show it has not, For instance, in Tanzania, Tripp [1989] reports that women's access to income has made them more assertive in decisions about resources, extended their social networks outside the home, modified power relations within the household and even begun to alter patterns of socialisation [Tripp 1989; Creighton and Omari 1995]. Mwaipopo [1995], also in Tanzania, reports on the contrary that despite women's greater autonomy, men's authority within the household still seems supreme and most women claimed that wealth should not make one disrespectful to one's husband, because men are 'heads of household' [Mwaipopo 1995 pp 170]. She further points out that despite its significance for the household, and to women's own lives, women's wealth in money is not publicly acknowledged [particularly by men] as significant. This
is because fixed assets such as houses or boats have more social prestige than cash, whatever its daily purchasing power [Ibid.].

It has been argued that while it can be accepted that women's economic contribution to the household may provide potential for change, it does not follow that this potential will necessarily be realised [Creighton and Omari 1995]. The effects of women's income will be mediated by a range of socio-cultural variables which depend on how women use their earnings [Ibid.].

Omari [1995], while discussing decision making in Tanzania urges caution on the imposition of models of the family which are based on western experience and which focus on husband and wife to the neglect of other relevant actors and transactions across household boundaries [Omari 1995]. Omari argues that decision making about the allocation of resources and patterns of investment are not just based on the western notion of economic maximisation. Cultural factors may be very significant. Further, the concepts of utility value and cost benefit analysis often do not come into the picture when these decisions are made for they may involve several people, including some living outside the household unit. The relations of reciprocity that exist at the unit level and outside might be the basis of the decision-making process in this case. The inter-household and intra-household dynamics of decision making do not prioritise the application of western economic criteria to household investment and resource allocation in many African societies [Omari 1995 pp 204]. There is a need to know more about the mechanism of
resource allocation and decision-making before we can draw firm conclusions about the directions and degree of change [see Creighton and Omari 1995].

In discussing the theories of decision making, it becomes evident that each of them makes its own contribution to understanding power relations within the household. No single theory can give a clear cut explanation, due to the contextual settings in different countries. It is apparent that decision-making is an outcome through which the relative power of husbands or wives may be or may not be assessed, especially in developing countries. Lacking in the theories of decision making are the bases of women's power and authority in the household. Decision-making theories do not offer much help in explaining decision-making related to gendered responsibilities like household chores, child care, food and health care done by women. They have tended to be male biased, highlighting resources most accessible to men (income, education and employment). The bases for women's power are ignored by the theories.

In relation to health care, particularly treatment seeking behaviour, decision-making theories do not offer plausible explanations. They, however, give a general trend in household decision making in relation to various activities including health care. To fully understand health care decisions within the household, we move beyond decision making theories and discuss health care theories to explain the behaviour of people when seeking treatment during illness episodes.
2.2 Health care decisions within households

Treatment seeking has been subject to numerous investigations worldwide, the literature providing insight into the possible factors that impact on the treatment seeking process. There are differences in the ways people perceive, evaluate and act with respect to health and illness. Further, as Mechanic pointed out, illness behaviour follows from the manner in which persons monitor their bodies, define and interpret their symptoms, take remedial action and utilise the health care system [Mechanic 1962 pp: 1].

There are two main categories of health care models developed by many researchers to demonstrate the variations in illness management in different settings. They are (I) pathway models, which have tended to describe different steps in the process of illness management; (ii) determinant models which focus on a set of explanatory variables or determinants which are associated with the choice of different forms of health services [Kroeger 1983 pp 147-148].

The proponents of the pathways models include Suckman[1965], who first described illness behaviour as a logical sequence of steps starting with definition and perception of symptoms to use of different health care providers[Kroeger 1983 pp 148]. This was further developed to nine stages by Frabrega[1973] who also stressed the importance of different illness concepts and medical orientation in developing countries. The model was further developed by Igun [1979] to ten steps. Chrisman [1977] and Geertsen
The determinant models on the other hand stress the importance of the 'determinants' and explanatory variables in illness management. The proponents of these models include Ludwig and Gibson [1969] who pointed out that utilisation of services depends on recognition and significance attached to symptoms and faith in medical care; Shuval [1981] on the other hand identified perceived seriousness and potential consequences of symptoms and perceived cause. Further, Unschuld [1975] in reference to developing countries identified economic factors, communication gaps and structural and conceptual differences as important for health seeking behaviour. Young [1980] in his model of illness treatment decisions in a Tarascan town identified gravity, knowledge of a home remedy, faith, and accessibility (cost and transportation) as key factors in treatment decisions. These explanatory variables now widely used in health care studies are divided into (a) predisposing factors i.e. demographic characteristics, household composition, education, attitudes, (b) enabling factors e.g. access to regular source of health care, income, insurance (c) health service system factors i.e. structure of the health care system[Kroeger 1983]

Unlike the decision making theories, health care theories present multiple possible factors that can be used to explain the illness behaviour of people in different settings. Many studies in developing countries have used the models
to examine treatment seeking behaviour within households highlighting different factors as shown below:

Kleinman [1980] sees therapeutic choice as the outcome of a sequence of transactions. In his Taiwan study, two major patterns in health seeking are identified; one, "Simultaneous" resort occurred when several treatment options were used at the same time, usually in the case of a serious childhood sickness. The other, "Hierarchical" resort, occurred when different health care choices were made in sequence through the various sectors of health care.

According to Kleinman, the two patterns of health seeking in Taiwan varied with different types of illness problem, the type and severity of symptoms, the course of the illness and the labels and aetiologies attached to it.

Young's research in rural Mexico [1980], on the other hand, demonstrated that people's perception of the gravity of the illness episode, their knowledge of the illness and its remedy, and in the faith in the efficacy of the various therapies interacted with their assessment of the costs involved in the treatment.

Similarly, Cosminsky [1987] in her study of the role of women as family health care providers and decision makers on a Guatemalan sugar and coffee plantation, found that women's health care decisions are based on the interaction of several factors, such as the characteristics of the services (distance, price, time costs), the characteristics of the illness (severity and persistence) and access to and control over cash, food, time and energy resources. She argued that it is women's management and allocation of scarce
household economic and human resources, and the strategies they use to extend these resources, that enable them to obtain health care for themselves and members of their households.

Finnerman [1984] in her study of health care decisions among the Saraguros, an Andean Indian community in S. Ecuador, found that most Saraguros hold mothers responsible for the welfare of the family. The women, she points out, must balance the treatment needs of sick family members with other household and personal interests.

In a study of health care decisions at the household level in rural Kenya (Meru), Mwambu (1986) explored the patterns of patient visits to health care providers. The overall picture that emerges from the data collected is that in the event of an illness, a patient is likely to use more than one provider, depending, among other things, on the nature of illness.

Similar to Kleinman, Mwambu explained that the patients' tendency to consult different providers in a given illness episode may be due I] to their inability to tell, with certainty, which treatment provider will cure their illness; hence the need to search among the health care providers for effective treatment, and ii] to the belief that successful treatment of some illnesses requires more than one provider. In the study area, no government clinic or provider was an important source of treatment. The majority of patients sought initial and follow up care from clinics other than those owned by government.
In a case study of factors influencing choice of hospitals in northern Oyo state in Nigeria, Egunjobi (1983) points out the inappropriateness of the emphasis usually placed on linear distance as determining the attractiveness of health care provision facilities. About 70% of patient behaviour in the study area is explained by other factors, e.g. quality of services, relatives living in hospital town, finance, religion and connections with hospital staff. It is evident from this study that patients are apt to test consequences of alternative choices before arriving at the one they consider most beneficial.

Data from rural Mali shows that the question of who pays in terms of time when a child is ill is as important as who pays in terms of money [Castle 1993]. Examining who pays in monetary terms would indicate a degree of mutual support and co-operation between marital partners, whereas examining who pays in terms of time presents an entirely different picture. Castle points out that though cash is received from socially powerful individuals within the marital household, time is given by members of the mothers’ own kin units within their extended family or from outside members such as their natal kin and networks.

From the evidence of the communities, Castle argues that it is women's social position within their family circumstances in relation to each other, rather than in relation to men, that is crucial in determining their access to household resources for child care and in influencing their need and capacity for external independent economic activity. While beliefs influence behaviour, the behaviours themselves are governed as much by access to and
control over necessary resources, especially cash, information, time and labour. In Saraguro, mothers choose to rely initially on home based care because the costs of using potentially more effective alternatives are perceived to be excessive [Finnerman 1984].

In Uganda, different categories of costs in search of health care have been identified, i.e. direct charges, transport, indirect costs. Direct charges include services and medical supplies. These charges, whether formal or informal "under the table", consume much of the limited resources of the families of ill patients [Barton and Bagenda 1993].

In terms of transport, many studies have revealed that travel cost to formal government health care facilities is the highest, averaging three times the cost of consulting informal sector providers, and about ten times the cost of going to intermediate sector providers like drug shops and markets [NCC 1994; Barton and Bagenda 1993]. The most commonly reported strategies for obtaining funds for health care during an illness episode were: sale of subsistence crops, short term borrowing and sale of cash crops. These strategies can be unreliable. For instance, subsistence crops depend on season and a ready buyer, loans depend on the presence of someone willing and able to lend out money [NCC 1994; Barton and Bagenda 1993]. Relatively few households reported having any cash at hand in the form of savings to use for health care costs. Borrowing was used by more than four times as many households as savings [Ibid.]
In Rwanda women's responses to their own and their children's illness were found to vary with the duration of a child's illness episode. Most women were of the opinion that five days represents an approximate minimum duration for mothers to regard illness episodes as very serious [Csete 1993].

In her study of intra-household differentials in women's status, which examined household function and focus as determinants of children's illness management and care in rural Mali, Castle [1993] found that ethnic differences in mortality between the study populations did not reflect variations in beliefs about illness management and disease causation, nor social economic disparities. Rather, these resulted from real variations in women's social power within their domestic environment. She attributed the lower mortality among the Dagon (one of the communities studied) to the greater proportion of laterally structured households, where women are free to pursue outside economic activity and yet have social support from household chores. Higher Fulani mortality, by contrast, reflected the more isolated nature of women's household circumstances, their lack of time and autonomy to become financially independent and their lack of social support within the domestic environment.

More importantly, Castle's study demonstrates that mothers have different types and degrees of social and financial assistance at their disposal when their children fall ill than they have for their daily care. She notes that data which analyses only household determinants of illness management and ignores the nature of daily care may be misleading, as mothers are entitled to different
household resources, and indeed to resources from different households, depending on the perceived health status of their children. Castle concludes that variations in health behaviour and mortality outcomes in Mali, reflect not simply 'ethnic' differences in beliefs or culture, but rather real differences in mothers' social positions within their family environments and in their access to household resources for children's treatment and care[ Castle 1993]

In Uganda, definitions and interpretations of illness symptoms were identified as important factors considered by mothers in determining the severity of the symptoms and seeking treatment. They included the following - . See Table I
Table I Factors considered in assessing the severity of symptoms or illness

<table>
<thead>
<tr>
<th>SYMPTOM</th>
<th>FACTORS CONSIDERED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td>-persistent high fever</td>
</tr>
<tr>
<td></td>
<td>-presence of severe diarrhoea and vomiting</td>
</tr>
<tr>
<td></td>
<td>-severe sore mouth</td>
</tr>
<tr>
<td></td>
<td>-severe persistent cough</td>
</tr>
<tr>
<td>Diarrhoea and Vomiting</td>
<td>-sunken eyes</td>
</tr>
<tr>
<td></td>
<td>-duration of diarrhoea exceeding one week</td>
</tr>
<tr>
<td></td>
<td>-loss of skin elasticity</td>
</tr>
<tr>
<td></td>
<td>-child passes very little urine</td>
</tr>
<tr>
<td>Convulsions</td>
<td>-when occurs with very high fever</td>
</tr>
<tr>
<td></td>
<td>-sudden development in a child who was well</td>
</tr>
<tr>
<td>Fever</td>
<td>-steadily rising temperatures</td>
</tr>
<tr>
<td></td>
<td>-convulsions develop</td>
</tr>
<tr>
<td></td>
<td>-deep fast breathing</td>
</tr>
<tr>
<td></td>
<td>-child becomes confused</td>
</tr>
<tr>
<td>Cough</td>
<td>-difficulty in breathing</td>
</tr>
<tr>
<td></td>
<td>-child cries while coughing</td>
</tr>
<tr>
<td></td>
<td>-associated with high fever</td>
</tr>
<tr>
<td></td>
<td>-associated with vomiting</td>
</tr>
<tr>
<td></td>
<td>-presence of wheezing</td>
</tr>
<tr>
<td></td>
<td>-persistent dry cough</td>
</tr>
<tr>
<td></td>
<td>interfering with sleep</td>
</tr>
<tr>
<td>New-born</td>
<td>-refusal to feed</td>
</tr>
<tr>
<td></td>
<td>-develops vomiting</td>
</tr>
<tr>
<td></td>
<td>-difficulty in breathing</td>
</tr>
<tr>
<td></td>
<td>-crying excessively</td>
</tr>
<tr>
<td></td>
<td>-restlessness and not sleeping</td>
</tr>
<tr>
<td></td>
<td>well</td>
</tr>
</tbody>
</table>

Source Jitta :1996

The above table shows a very high level of consistency in the way symptoms are assessed by mothers. A number of these factors are the signs of severity used in standard medical practice as indicators for mothers to seek treatment from health units[Jitta 1996]. Jitta concludes that although mothers can
identify some legitimate signs of severity for each of these symptoms or illnesses, there are knowledge gaps in their ability to distinguish the really dangerous stages which lead to delay in seeking help.

The above treatment-seeking studies indicate a wide range of behaviours and factors that account for them. Graham [1984] while discussing women health and the family in UK, drew attention to the relationship between a woman's role as the provider, negotiator and mediator of health within the household. She argued that while artificial boundaries can be imposed on those areas of health responsibility, in practice they are inseparable activities and integrating them is not always a straightforward matter [Ibid. pp 150]. In other words, to isolate treatment seeking from all the other activities is unjustified because those responsible for caring for the family are also the ones responsible for care during sickness. In real life, as argued by Graham, responsibilities do not always dovetail so neatly; instead responsibilities are often in conflict [Graham 1984 p 151]. She argued "Caring is thus about reconciling as well as meeting commitments, it is about containing demands and conserving supplies to ensure that needs and ends meet" [Graham 1984 p 152].

All the responsibilities demand time. Consequently, some activities are compromised for the others to make ends meet. Time use studies have shown the strategies adopted by women, which sometimes prove contradictory in their effects, jeopardising health in order to protect it. Frankenberg [1976] suggested that an occurrence of illness has social significance because it affects social relationships by disrupting the performance of social roles. He
pointed out that this necessitates accommodative adjustment of actions of other social actors. Consequently a mother has to balance her own needs or that of a child against the needs of others in the family.

To balance their responsibilities, women have had to work much longer than men [Caplan 1995]. Women work over fourteen hours daily on average merely to survive [Mbilinyi 1991; Mwaka et al 1994]. Women carry out their multiple roles within the household simultaneously in order to balance competing claims on their limited time [Ibid.]. These choices and trade-offs in time allocation are at the core of interrelationships between different activities, including health and treatment.

The pressure on women's time has a wide range of important implications for their own health and that of household members. The important question being raised by this thesis is how do the effects of a woman’s time use patterns affect her capacity to seek appropriate health care? One key factor seems to be the degree of flexibility when time costs are incurred.

In her study of women and health care on a Guatemalan plantation, Cosminsky [1987] identifies several components of time spent in relation to health seeking. There is time spent waiting, transport time (bus versus walking), the time or duration of treatment and the time lost from other activities, such as wage labour, cooking, farming, fetching water, marketing and child care. Cosminsky argues that since the majority of health care activities involve the participation of mothers, their time constraints must be
considered. These she argues are rarely taken into account in the delivery of health care services, especially in the structuring of the clinic schedule or in the care given by medical personnel.

In Ethiopia, critics of government health services have drawn attention to the problem of inconvenient clinic hours. Ayalew [1985] pointed out that a major reason for the lack of success of health services in Ethiopia was the failure to understand and accommodate to normal patterns of women's time use in the community and he recommended preparing a community time budget to help decide when and how services should be offered.

Leslie [1992] also suggests that one of the simplest reforms that could be made to increase health service usage and decrease inconvenience to women is extending clinic hours and/or keeping clinics open at times that are particularly easy for women to be away from home or employment.

A great deal of opportunity costs in terms of travel, waiting and foregone leisure time are incurred by women seeking health care for themselves and their children. A study in Tanzania revealed that health care seeking is the single most time consuming task for women, with most of the time being spent in queues despite the fact that walking time was often 2-3 hours [Kisango 1990].

Cosminsky [1987] reports in a Guatemalan Plantation, that the time spent waiting, often several hours, was one of the most common complaints concerning the clinic there. The long waiting time was contrasted with the
brief consultation or examination time that followed it, usually only a few minutes. She noted that because of the long wait, women often went directly to the pharmacy where there was no waiting. They then either requested a medicine with which they were already familiar or asked for advice from the pharmacist [Ibid.]

The same study found that some traditional healers also did not consider women's time constraints and work burdens. Interestingly, although the waiting time was the same or even longer at the traditional healers, people did not complain about the wait, nor did they complain about the brief consultations. It was argued here that the negativity of waiting at the traditional healer might be mitigated by the friendly atmosphere and socialising that takes place among the clients, to which the impersonality and silence of the clinic waiting room provided a sharp contrast. [Ibid.]

Cosminsky further pointed out that time constraints vary seasonally as do other variables such as income, availability of cash and food supply. All these affect the use of medical services. During the lean season from April to July, both cash and maize are scarce but women have more time [Ibid.]. This season also marks the beginning of the rainy season, when diarrhoea diseases are most prevalent.

However, although at harvest time more cash was available, women's time constraints were greater. Some women specifically stated that they did not go for health care because they did not want to lose time from coffee picking.
They could not spare time to spend the day at either a clinic or at the traditional healer's. Thus they had to choose more convenient, although more expensive methods, such as buying directly from the pharmacy or from the travelling vendor or going to a local practitioner who held consultations in the evening.

A series of studies attempting to analyse factors that influence the use of child health services in Haiti has led Coreil to conclude that household composition and age of the child interact significantly to affect maternal time demands [Coreil 1991]. For instance, she points out that it is the combined effects of maternal time constraints and the absence of alternate caretakers that limits the use of child health services, particularly services that must be used outside the home, such as immunisation. In addition, she notes that the effects of maternal time constraints on the use of child health services are stronger for infants than for older children, and in households with more children. This, she attributes to the greater necessity of infants being accompanied to health clinics by their mothers and the difficulty of doing this when they have other children to care for at the same time. Coreil observes that other competing demands and constraints arise because mothers and children are part of the household which includes other members, problems and responsibilities. The needs of the family members have to be met and problems sorted out.

Some complex analytical propositions have been suggested. Coreil (1991) has proposed that research on participation in health related activities in general and on the effects of women's time constraints in particular, be desegregated
along two dimensions, which she identifies as the setting or domain in which
the care takes place, and the level of care.

In Uganda, too, it has been found that the search for health care takes
time. There are lengthy trips to reach health facilities, which are generally
followed by extended waiting before being seen only briefly by a health
provider [NCC 1994; Barton and Bagenda 1993]. The time costs of getting
health care is both a constraint and a determinant of public opinion about the
quality of care being received. Nationally, the usual waiting time at any kind
of caregiver’s place of service has been estimated to be about an hour for most
patients [Ibid.]. In the formal sector [clinics and health units] the average
waiting time is 1.5 hours. This is about one and a half times the wait for
informal sector caregivers such as herbalists [Ibid.].

Time remains a major constraint on women’s lives as they endeavour to fulfil
their combined reproductive and productive roles. Time constraints in relation
to treatment seeking are well documented, especially in relation to children’s
illnesses. Time is mostly discussed in relation to health facilities being far
away and not opening at the appropriate hours. Though this kind of analysis is
useful and draws near to understanding the integrated nature of women’s
responsibilities, there is a gap as regards the other contextual issues that make
time a constraint in terms of seeking treatment. This thesis will examine
women’s time use in a holistic way, to identify the interplay between
treatment seeking and other activities within the household.
The next section examines women's employment situation in the urban areas, constraints faced and opportunities available to women.
2.3 **Women and the urban labour market.**

Analysis of women's participation in the urban labour market has always been complicated by many factors, the most prominent of which are the deficiencies normally found in the existing data, due to problems in methods used and government policies on employment which do not count most of women's work [Brydon and Chant 1989; UN 1989; Townsend and Momsen 1987; Hay and Sticher 1995]. Many economic activities, mainly those of women, often go unnoticed and unrecorded because they do not fall neatly into prevailing official perceptions of what constitutes employment [Ibid.]. Hence, what is presented below reflects a general trend of women's situation in the urban labour market in developing countries.

Women's participation in the labour force is related to a complex set of social and economic factors, either inducing them into the labour force or limiting their propensity to work outside the home. Different groups of women have different sets of needs, opportunities, qualifications and personal familial conditions so that their labour participation varies accordingly [Mustafa 1990]. Consequently, worldwide, women's participation in remunerated labour has been reported to be lower than that of men, mainly because of their greater share of reproductive work [Brydon and Chant 1989 p161].

In sub-Saharan African, cities women are known to work inside and outside the home in a variety of occupations [Hay and Sticher 1984 and 1995; Nelson
1988; Obbo 1980]. In Asia and Latin America, a similar situation is observed [Standing 1991].

Women's participation in the urban labour market falls into two sectors i.e. formal and informal sectors. This dualistic way of analysing the urban labour market has been challenged by many scholars [Moser 1978; Brydon and Chant 1989]. The dualistic view of urban employment, it is argued, is inappropriate because it obscures an intrinsic interdependence between various economic activities: the formal sector depends directly and indirectly on the existence of the informal sector for sources of labour, goods and retail distribution and hence the two are very much interrelated [Moser 1978; Brydon and Chant 1989]. A strong case has been made for conceiving urban production as a continuum, whereby small scale enterprises and independent workers [petty commodity enterprises] are linked through a chain of exploitative activities to large scale capitalist establishments [Ibid.].

It is not our intention to review debates regarding urban employment but to recognise that there are obvious linkages between the formal and informal sectors. For analytical purposes, the two sectors are discussed in terms of the general kinds of conditions under which different activities of the urban labour force are carried out.

2.3.1 Women in the formal economy

Formal sector employment has been described as one which is likely to be recorded in official census and survey data and hence it is easy to establish the
proportion of the labour force involved in it. In Africa, the percentage of women who have formal sector wage or salaried employment is estimated at about 30% on average, varying from lows of about 10% in countries with few paid employment opportunities to much higher levels in South Africa [Sticher 1995]. For instance in Kenya 1990, 21.9% of all employees were women in salaried and wage employment, in Botswana 1991 34.2%, in Niger 1989 9.1%, Malawi 1989 14.2%, Swaziland 1988 30.3% [Ibid.]. Stichter [1995] notes that, there is a general lag of employment behind population growth, which has led to higher numbers of unemployment in many African countries and women have been hardest hit. For instance, in Angola women's unemployment levels moved from 33.2% in 1984 to 37.1% in 1991; in Ethiopia from 37.9 in 1981 to 43.8% in 1991 [Ibid.]. Some countries, however, have shown improvements e.g. Ghana moved from 29.5% in 1980 to 10.0% in 1989. There are variations in employment patterns in terms of sectors, with lower levels in industry and higher in the service sector.

2.3.1.1 Women in industry

Women's share in industry in the third world has been found to vary greatly, ranging from between 30 to 40% of the total industrial labour force in South East Asia to less than 10% in North Africa, the Middle East and certain South African countries such as Namibia and Angola. Women in Latin America, South Asia and East and West Africa represent 10-30% of industrial
labour force participation [Townsend and Momsen 1987; Brydon and Chant 1989].

In Uganda women's employment in industry, which here is broadly defined to include both modern and traditional manufacturing as well as construction, electricity, gas and water supply, now employs only 3% of all workers; 13% of the urban workers and 2% of rural workers [World Bank 1993b]. Of the 96,600 urban workers employed in industries only 13400 are females [see Table II]. This situation is being attributed to the collapse of the formal economy (see Chapter 3 on Uganda).

Table II Estimated mid year distribution of labour force 1992[000]

<table>
<thead>
<tr>
<th>Category</th>
<th>Urban Uganda</th>
<th>Rural Uganda</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male  Female</td>
<td>Male  Female</td>
</tr>
<tr>
<td>Agriculture</td>
<td>53.6 75.8 129.4</td>
<td>2530.0 2573.1 5103.1</td>
</tr>
<tr>
<td>Industry</td>
<td>83.3 13.4 96.7</td>
<td>98.4 17.9 116.3</td>
</tr>
<tr>
<td>Service</td>
<td>264.2 206.7 470.9</td>
<td>437.3 139.7 613.0</td>
</tr>
<tr>
<td>Unemployed</td>
<td>14.1 14.7 28.8</td>
<td>9.8 6.2 16.0</td>
</tr>
<tr>
<td>Total</td>
<td>415.2 310.6 725.8</td>
<td>3111.5 2736.9 5848.4</td>
</tr>
</tbody>
</table>

Source World Bank [1993b]

Since only 0.8% of the labour force is employed in formal manufacturing enterprises, a very large proportion of those employed in industries are actually engaged in informal and rudimentary activities providing low output and income [Ibid.].

In 1988, females were found to make up only about 20% of the formal employment with 76% of them in the private sector and co-operatives. The
majority of the 76% were teachers and nurses. Among the skilled workers, women comprised 26% [Min. of Planning 1988]

Throughout Africa, industry has been found in general not to have favoured the female workforce. For the period of 1980-1990, in Kenya of the total females employed, only 21.7% worked in industries; in Zambia 7.3%, in Tanzania 26.4%, Botswana 29.4%, Gambia 15.2%, Malawi 14.8%, Mauritius 34.5%, Niger 7.1%, Swaziland 27.7% and Zimbabwe 16.6% [Robertson 1995]. Men are usually employed in modern industrial activities employing high level technology while women are confined to traditional and labour intensive industries, such as textile production, food processing and garment production [Sticher 1995, Brydon and Chant 1989] For example, in Morocco, the percentage of women working in the clothing industry increased from less than half in 1969 to three quarters in 1980 [Joekes 1985]. In Mexico, one third of women industrial workers were employed in the clothing trade [Cunningham 1987]. Cunningham observed that women are not only confined to less dynamic or low technology industrial sectors, but that, within those sectors, they are also segregated into semi or unskilled activities where earnings are far less than those of men [Cunningham 1987]. In the Moroccan clothing industry, Joekes found that, despite women's higher educational qualifications and managers' high regard for female productivity, their wages on average are only 72% of those of men [Joekes 1985].

The reasons for women being segregated into low paid industrial occupations include among others, stereotyping of gender aptitude in machine
maintenance, low education and skills and women's domestic roles which impinge upon their ability to take on certain jobs [Hay and Sticher 1995. Brydon and Chant 1989 UN 1989]

2.3.1.2 Women in services

Services cover a far wider range of activity than industry. Formal sector services range from construction, commerce, transport, finance, to government personal and social services. In Latin America and South East Asia, women have the highest rates of participation in services in the third world, and make up 30 to 50% of the total labour force engaged in tertiary activities [Ibid.] In Nigeria and Ghana women, represent over 50% of the work force in services but in most of sub-Saharan Africa, rates are under 30%. In North Africa and the Middle East less than 10% of the population employed in services are female. South Asia also displays low levels of women's participation in the service sector, at under 20% of the total [Townsend and Momsen 1987; Brydon and Chant 1989].

Currently in Uganda, females comprise 33% of the formal labour force and 39% of all government employees but only 0.05% of the senior positions in the civil service. Women generally hold low cadre positions [Mwaka et al 1994] see Tables III and IV below:
<table>
<thead>
<tr>
<th>Ministry/depart.</th>
<th>Total No</th>
<th>No of Women</th>
<th>% of Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presidents office</td>
<td>974</td>
<td>141</td>
<td>14.9</td>
</tr>
<tr>
<td>Judiciary</td>
<td>983</td>
<td>149</td>
<td>15.2</td>
</tr>
<tr>
<td>National assembly</td>
<td>61</td>
<td>25</td>
<td>41.0</td>
</tr>
<tr>
<td>Audit</td>
<td>177</td>
<td>9</td>
<td>5.1</td>
</tr>
<tr>
<td>Public service</td>
<td>205</td>
<td>52</td>
<td>25.4</td>
</tr>
<tr>
<td>Foreign affairs</td>
<td>289</td>
<td>91</td>
<td>31.5</td>
</tr>
<tr>
<td>Justice</td>
<td>203</td>
<td>66</td>
<td>32.5</td>
</tr>
<tr>
<td>Finance</td>
<td>1183</td>
<td>255</td>
<td>21.6</td>
</tr>
<tr>
<td>Commerce</td>
<td>246</td>
<td>49</td>
<td>19.9</td>
</tr>
<tr>
<td>Agric and Forestry</td>
<td>3319</td>
<td>147</td>
<td>3.8</td>
</tr>
<tr>
<td>Animal Resources</td>
<td>2066</td>
<td>151</td>
<td>7.3</td>
</tr>
<tr>
<td>Lands and Mineral</td>
<td>882</td>
<td>57</td>
<td>6.5</td>
</tr>
<tr>
<td>Education</td>
<td>731</td>
<td>129</td>
<td>17.6</td>
</tr>
<tr>
<td>Health</td>
<td>7912</td>
<td>4147</td>
<td>52.4</td>
</tr>
<tr>
<td>Culture and Dev.</td>
<td>1002</td>
<td>267</td>
<td>26.6</td>
</tr>
<tr>
<td>Works and Housing</td>
<td>413</td>
<td>59</td>
<td>14.3</td>
</tr>
<tr>
<td>Trans and Communication</td>
<td>727</td>
<td>57</td>
<td>7.8</td>
</tr>
<tr>
<td>Information</td>
<td>741</td>
<td>57</td>
<td>7.7</td>
</tr>
<tr>
<td>Industrial &amp; Power</td>
<td>47</td>
<td>10</td>
<td>21.3</td>
</tr>
<tr>
<td>Labour</td>
<td>327</td>
<td>66</td>
<td>20.2</td>
</tr>
<tr>
<td>Defence</td>
<td>348</td>
<td>203</td>
<td>58.3</td>
</tr>
<tr>
<td>Internal affairs</td>
<td>170</td>
<td>39</td>
<td>22.9</td>
</tr>
<tr>
<td>Police</td>
<td>13112</td>
<td>553</td>
<td>4.2</td>
</tr>
<tr>
<td>Prisons</td>
<td>3787</td>
<td>368</td>
<td>9.7</td>
</tr>
<tr>
<td>Local govt</td>
<td>313</td>
<td>19</td>
<td>6.1</td>
</tr>
<tr>
<td>Plan. Econ. Dev</td>
<td>205</td>
<td>45</td>
<td>22.0</td>
</tr>
<tr>
<td>Cop. &amp; Marketing</td>
<td>1181</td>
<td>113</td>
<td>9.6</td>
</tr>
<tr>
<td>Tourism and Wildlife</td>
<td>73</td>
<td>11</td>
<td>15.1</td>
</tr>
<tr>
<td>Reg. Co-operation</td>
<td>376</td>
<td>46</td>
<td>12.2</td>
</tr>
<tr>
<td>Power post and Telecom</td>
<td>40</td>
<td>8</td>
<td>20.0</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>148</td>
<td>32</td>
<td>21.6</td>
</tr>
<tr>
<td>Supplies</td>
<td>10</td>
<td>4</td>
<td>40.0</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>19</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Consolidated fund</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>43330</td>
<td>7424</td>
<td>17.1</td>
</tr>
</tbody>
</table>

Source: Mwaka et al [1994]
TABLE IV PERSONS IN THE CIVIL SERVICE BY MINISTRY/ INSTITUTION SEX AND OCCUPATION 1987[000]

<table>
<thead>
<tr>
<th>MINISTRIES AND ORGANISATIONS</th>
<th>PROFESSIONALS</th>
<th>ADMINISTRATIVE AND MANAGERIAL OCCUPATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td>Presd. Office</td>
<td>378</td>
<td>53</td>
</tr>
<tr>
<td>Judiciary</td>
<td>23</td>
<td>1</td>
</tr>
<tr>
<td>National assembly</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Audit</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Public service</td>
<td>143</td>
<td>34</td>
</tr>
<tr>
<td>Foreign affairs</td>
<td>65</td>
<td>11</td>
</tr>
<tr>
<td>Justice</td>
<td>96</td>
<td>24</td>
</tr>
<tr>
<td>Commerce</td>
<td>52</td>
<td>6</td>
</tr>
<tr>
<td>Agriculture and Forestry</td>
<td>206</td>
<td>31</td>
</tr>
<tr>
<td>Animal Industry &amp; Fisheries</td>
<td>128</td>
<td>16</td>
</tr>
<tr>
<td>Lands &amp; Surveys</td>
<td>78</td>
<td>8</td>
</tr>
<tr>
<td>Education</td>
<td>1705</td>
<td>264</td>
</tr>
<tr>
<td>Health</td>
<td>184</td>
<td>54</td>
</tr>
<tr>
<td>Youth Culture &amp; Sports</td>
<td>43</td>
<td>11</td>
</tr>
<tr>
<td>Works</td>
<td>111</td>
<td>6</td>
</tr>
<tr>
<td>Transport &amp; Communication</td>
<td>43</td>
<td>6</td>
</tr>
<tr>
<td>Information</td>
<td>32</td>
<td>6</td>
</tr>
<tr>
<td>Industry &amp; Technology</td>
<td>29</td>
<td>1</td>
</tr>
<tr>
<td>Labour</td>
<td>108</td>
<td>13</td>
</tr>
<tr>
<td>Defence</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>Internal affairs</td>
<td>471</td>
<td>41</td>
</tr>
<tr>
<td>Police force</td>
<td>555</td>
<td>28</td>
</tr>
<tr>
<td>Prison service</td>
<td>105</td>
<td>6</td>
</tr>
<tr>
<td>Local government</td>
<td>1021</td>
<td>210</td>
</tr>
<tr>
<td>Planning &amp; Economic development</td>
<td>28</td>
<td>3</td>
</tr>
<tr>
<td>Cooperatives &amp; Marketing</td>
<td>225</td>
<td>37</td>
</tr>
<tr>
<td>Tourism &amp; Wildlife</td>
<td>40</td>
<td>5</td>
</tr>
<tr>
<td>Regional Cooperation</td>
<td>38</td>
<td>4</td>
</tr>
<tr>
<td>Primeministers office</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>Environment Protection</td>
<td>41</td>
<td>1</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>31</td>
<td>12</td>
</tr>
<tr>
<td>Energy</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Mulago hospital complex</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Housing &amp; Urban Dev.</td>
<td>55</td>
<td>5</td>
</tr>
<tr>
<td>Water &amp; Mineral Dev.</td>
<td>47</td>
<td>5</td>
</tr>
<tr>
<td>not stated</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Finance</td>
<td>508</td>
<td>59</td>
</tr>
<tr>
<td>Total Precentage of Female to Male</td>
<td>5.8</td>
<td>16.9</td>
</tr>
</tbody>
</table>

Source: Manpower Planning Department 1988 Census of Civil Service Ministry of Planning and Economic Development
There is a far greater percentage of men than women in professional, technical, administrative and clerical jobs than women in Uganda's service sector. In Kamwokya, 53.7% are service workers and 89% are engaged in handicraft such as making like baskets and mats, but only 0.2% were managers, and 1% professional (see table V below).

Table V Kamwokya II The occupational distribution of Males and Females 10 years of age and over returned by the Census as having an occupation 1991

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Males No</th>
<th>Males %</th>
<th>Females No</th>
<th>Females %</th>
<th>Total No</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>managers</td>
<td>30</td>
<td>1</td>
<td>4</td>
<td>0.2</td>
<td>34</td>
<td>0.7</td>
</tr>
<tr>
<td>professional</td>
<td>56</td>
<td>1.8</td>
<td>19</td>
<td>1.0</td>
<td>75</td>
<td>1.5</td>
</tr>
<tr>
<td>technicians</td>
<td>269</td>
<td>8.5</td>
<td>116</td>
<td>6.4</td>
<td>385</td>
<td>7.8</td>
</tr>
<tr>
<td>clerks</td>
<td>175</td>
<td>5.6</td>
<td>138</td>
<td>7.6</td>
<td>313</td>
<td>6.3</td>
</tr>
<tr>
<td>service/ workers</td>
<td>946</td>
<td>30</td>
<td>975</td>
<td>53.9</td>
<td>1921</td>
<td>38.7</td>
</tr>
<tr>
<td>agric. workers</td>
<td>67</td>
<td>2.1</td>
<td>65</td>
<td>3.6</td>
<td>132</td>
<td>2.7</td>
</tr>
<tr>
<td>crafts making</td>
<td>594</td>
<td>18.9</td>
<td>161</td>
<td>89</td>
<td>755</td>
<td>15.2</td>
</tr>
<tr>
<td>machine operators</td>
<td>237</td>
<td>7.5</td>
<td>7</td>
<td>4</td>
<td>244</td>
<td>4.9</td>
</tr>
<tr>
<td>elementary occupations</td>
<td>778</td>
<td>24.7</td>
<td>325</td>
<td>18</td>
<td>1103</td>
<td>23.2</td>
</tr>
<tr>
<td>total</td>
<td>3152</td>
<td>100</td>
<td>1810</td>
<td>100</td>
<td>4962</td>
<td>100</td>
</tr>
</tbody>
</table>

Source Ethnographic Survey Wallman 1996

2.3.2 Women in the informal economy

The informal sector, by definition, includes unremunerated activities which fall outside the boundaries of social and legal legislation. Workers in this category include petty traders, illegal brewers, small scale producers and providers of personal services like domestic maids, etc. Wages in the
informal sector vary widely, but one common feature of most informal jobs is that income and profits or earnings are irregular [Brydon and Chant 1989]

Women in developing countries work predominantly in the informal economy, but as Moore [1988] pointed out, women's involvement in petty commodity production and commerce is more forcefully illustrated with regard to women's activities in the urban areas. Further, women's struggle for economic independence has been found to be more prevalent in urban areas [Obbo 1980]. Within the informal sector itself, there is further manifestation of the sexual division of labour with women not only being confined to certain types of jobs that are mainly household based or associated with their domestic skills, but also ones with least status and lowest pay.

In Brazil, for example, Schmink [1986] found that half of all women workers were self employed compared to only one fifth of their male counterparts. It was also established for the same city that 85% of all female household heads were engaged in informal economic activities, compared to only 25% of male heads.

In West Africa, 93% of retail traders are market women, 87% in Lagos Nigeria, and 60% in Dakar Senegal. It is important to note that, notwithstanding these high percentages, women tend to concentrate on the sale of small quantities of home produced items in local markets, while men control wholesale and long distance trade in manufactured goods [Momsen 1991]
The informal economy tends to absorb certain people more easily than others, For example in Sao Paulo, while women were forced into domestic service, cleaning jobs and under employment, male workers were much more likely to avoid the informal sector altogether, or only make limited excursions into it [Gilbert 1994]. In Maseru Lesotho, migrant women are so disadvantaged with respect to employment opportunities that they are often forced into illegal informal activities such as starting a sheebeen for the illicit brewing and sale of beer or into prostitution [Wilkinson 1987]. These activities are also common in low income settlements in Nairobi, Kenya, among poor urban women [Nelson 1988].

Similar to other countries in the Third World, the informal economy in Uganda embraces unregistered small business enterprises which operate outside the recognised formal economy and go untaxed by government. They include food stuffs marketing, hair dressing, local brewing, repairs and petty trading.

In Uganda, the informal sector has recently grown to unprecedented proportions such that the sector has been estimated to employ 1.5 times the labour employed by the formal sector [Basirika 1992]. Among the reasons given for the influx into the informal economy, are unemployment and the downward pressure on wages under structural adjustment [Ibid.]. The situation has necessitated engagement in informal activities to make ends meet. The sector currently accounts for over 60% of national economic activity and 60%
of the employees in this sector are women. Table V below shows the composition of women in market trading by the period of entry into trade.

Table V I Composition of women in market trading by period of entry into trade

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prop'n</td>
<td>37.5%</td>
<td>7.1%</td>
<td>10.2%</td>
<td>14.9%</td>
<td>14%</td>
</tr>
</tbody>
</table>

Source Basirika E [1992]

The table shows how the sector has been growing in the last six years, attracting more women. Over 60% of women in market trading joined after 1987, compared with only 37.5% before 1987. Another survey done in Kampala shows that most women in Kampala began their projects more recently; about 80% started their business between 1982 and 1987 compared to only 50% of men who started business in the same period [Mwaka et al 1994].

In Tanzania a similar trend has been observed; many women have responded to the economic crisis and the decline of real wages and the standard of living it has brought with increased pursuit of income generating projects. Only 7% of the urban women involved in the study done in 1971 were self employed; seventeen years later 66% of women surveyed in Dar es Salaam were self employed [Tripp 1989].
2.3.2.1 Nature and location of activities

Throughout the Third World, there is considerable similarity in the areas of informal sector work that women do. First, their activities are usually situated within or very near the home and second, they tend to be closely associated with the routine domestic activities of women, such as the preparation of food and drink, cleaning, washing, serving, child care [Hay and Sticher 1995; Obbo 1980; Brydon and Chant 1987; Townsend and Momsen 1987]. Whatever the background of women, the occupations they pursue tend to fall into a narrow range of categories.

Being tied to the home as mothers and housewives, renders women far less flexible and mobile than men; hence, they are more likely to be able to tailor their productive labour load to a household based activity than one away from the home [Robertson 1995; Brydon and Chant 1989].

By the same reasoning, when women are unable to pursue informal kinds of income generation in or near their houses, they opt for jobs where hours are shorter or flexible, and for jobs to which they can take their children. In West Africa, for example, where marketing has traditionally been a female occupation and usually involves working from centrally located market stalls, flexibility of hours and baby sitting by other market women allows them to combine their productive and reproductive activities [Peil and Sada 1984; Suderkasa 1977].
The preparation and sale of homemade food stuffs and fruit juices is a common informal occupation for women in Mexico, as are activities such as taking in washing, sewing or selling sweets and soft drinks from the front room of their shanty dwellings [Arizpe 1977; Chant 1987]. In La Paz, Bolivia, women are very actively involved in a range of informal income earning strategies such as stitching and making wall hangings and coverlets, or baking bread, cakes and pastries [Bechler 1986]. In Windhoek, Namibia, low income women like their counterparts in other African countries, not only brew beer but also engage in basket weaving, doll making and hawking food products [Simon 1984].

In Uganda, women bear the brunt of trying to make ends meet because ultimately they have to ensure that their dependants and families are fed, clothed and receive medical care and education. Women with babies are ubiquitous in low income jobs, as street traders and sweepers and public garden maintainers. Women continue to predominate in providing cooked food to office workers, and they are the principal sellers of eggs, fruits and vegetables [Mwaka et al 1994]. These days, men are increasingly involved in the informal sector. The main activities include repairs, masonry, carpentry, hawking, petty trading.

"The over crowding in one physical place of the same line of business, locally referred to as 'tonninyira mu kange' [literally Don't step on mine] is the predominant pattern in the busy parts of the city. Kikuubo [corridor] businesses are also characterised as 'katimba'[hang to show] because the merchandise is put up in the morning and packed up in the evening. Clothes, cosmetics, shoes, bags etc are some of the items. The operatives are predominantly employed by middle class people who have
salaried jobs—some wives of prestigious men such as civil servants or university professors own stalls and sell in them. This is not a threat to the family name because these wives are usually less known than their husbands. Some of these "anonymous" wives even sell vegetables or second-hand clothes at the markets. The reality is that not all wives of even educated people can own large hair dressing salons in the desirable parts of the city, nor can they own butcheries, piggeries, diary farms or bakeries. [Obbo 1991 pp 104]

These activities provide the much-needed cash for many families in Uganda.

As to the effects of women's income on household decision-making status in developing countries, the evidence is far from conclusive as different reports from different countries show conflicting trends. For instance in Tanzania Tripp has argued that, however small a monetary wage, it is a powerful weapon which, whatever its destination, affects the bargaining capacity of the women in the family [Tripp 1989]. Women often utilise their available time and labour to the full, to earn income which, although meagre, helps to maintain their families at or just above subsistence level [Ibid.]. Women use their earnings to buy clothes for their children or pay for their education and health costs, and some have been able to save to build houses [Tripp 1992]. Tripp concludes that women's economic interactions, however small scale and petty they may appear, have in the case of Tanzania proven to be the backbone supporting the entire urban population in the face of industrial decline [Ibid.].

In Zanzibar, the development of seaweed farming, in which women can engage with little help from their husbands, provides earnings over which they have considerable control and enables them to buy many previously un-
affordable goods. This is said to have increased women's status and bargaining power, both within and outside the homes [Mwaipopo 1995].

In Uganda, women's income projects support their families [Obbo 1980; Tadria 1987; Bantebya 1992]. In Lesotho, Wright [1993] found women were involved in a variety of activities like selling beer or agricultural produce to support their families. In Kenya, women brewers in Mathare valley supported their families through brewing Buzaar [Nelson 1988]

2.4 Household resource management

The allocation of money between family members has claimed the attention of researchers worldwide. Jan Pahl's concepts for enquiries into household finances have served as a basis for many studies [Jan Pahl 1982; Munachonga 1988; Oppong 1981; Morris 1984; Whitehead 1981; Fapohunda 1988]. Pahl's model identifies three different functions which she labelled "Control", "Management" and "Budgeting" [Pahl 1982]. Control involves decisions about the allocation of funds to different areas of expenditure, whilst management is essentially concerned with implementing these control decisions. Budgeting refers to spending to achieve minimal consumption requirements within particular expenditure categories. Findings in this area lead fairly consistently to the conclusion that control commonly rests with the husband, whilst management and budgeting are more likely to be the province of the wife [Morris 1984; Hoodfar 1988; Safilios Rothschild 1988; Munachonga 1988; Mustafa 1990].
The distinction between control and management at least suggests the possibility that one household member may retain power of access to funds in areas of spending not usually included in his or her area of responsibility.

The allocation of money to particular areas of spending and our understanding of its implications is enhanced by a further distinction made by Morris between 'household' and 'domestic' income. In his terms, household income refers to the total amount of money received by various household members from whatever source. Domestic income refers, on the other hand, to the total income available for spending on the collective needs of the household e.g. food, fuel, accommodation or health care [Morris 1984: 494].

Gray [1979] makes a similar distinction between 'collective' expenditure made on behalf of the household and the expenditures made on behalf of individuals which Morris [1984] terms as 'personal'. The assigning of money to each of these categories of spending would be a function of control.

Generally, the identification of an area of home focused spending does seem to be a central organising principle in the management of money and accordingly is useful for our understanding of financial motivations and responses.

Further research by Pahl [1983] yielded a typology of allocation systems which has become a benchmark for much subsequent work in this area. Models of finance management include: i) the whole wage system ii) the
allowance system iii) shared management system and iv) independent management.

Regarding the whole wage system, the main earner or benefit recipient hands over all income to the housekeeper, who is then responsible for all expenditures. For the allowance system, the main earner hands over a set amount to the housekeeper and uses the remainder for their own designated areas of spending. In the shared management systems, both partners have access to all household income and are jointly responsible for management of and expenditure from a common pool. An independent management system is characterised by the absence of access to all household income by either partner. This model depends on there being separate incomes for each member of a couple, which are not pooled, and for which different areas of expenditure are designated.

Studies from Africa using Pahl’s typology have yielded a wide range of financial management systems. In Tanzania, Campbell and others [1995] found no examples of common pooling and whole wage system of income in Dar es Salaam. They found, however, among high income waged or self-employed households an allowance system whereby the husband provided his wife a non-negotiable daily [rarely monthly] allowance to cover the household necessities like food, and cooking fuel [Ibid. p233]. Partial pooling was found, especially in households where partners were of the same social
status; and the independent systems was also found in households where both husband and wife were earning income[ibid.]

In Zambia, Munachonga [1988] identified four income allocation systems. They were, doling out, allowance, separate spending and pooling systems. Under the doling out system, the husbands kept and controlled all the money and the wife was only given a small amount of money for specific items. The wives never had direct access to the family income. In the allowance system, husbands gave a fixed amount of money every month and kept the rest of the money. For unemployed women, it was only barely enough to cover household expenditures and no personal money. Working women used their earnings to supplement the fixed allocations and for their personal use. Under the separate spending system, which was more prevalent among couples where the wife had a high income, husband and wife spent their respective earnings independently and shared financial responsibilities. Neither spouse had exclusive access to the family income.

In Cairo, Hoodfar [1988] identified six categories of budgeting and financial arrangements. These included, women as financial managers, women as bankers, women receiving full housekeeping allowance, women receiving partial housekeeping allowance, men as financial managers and guest husbands [Ibid. pp 129]

Under the system of women as financial managers, men handed over the whole of their income to their wives, who then had to meet all the family
needs. Men would be given a small amount of money for personal use. In the system where women were bankers, the wives had physical access to money but no unilateral authority to spend it. Husbands were reported to do the major shopping and to allocate money for the different household items. In the full allowance system, women received either a monthly, weekly or daily allowance to cover all family expenses. In the partial housekeeping allowance, women received a fixed daily or weekly or monthly allowance for a few items like vegetables, and the husbands were responsible for all other expenditures in the family. Under the system where men were the financial managers, men bought everything except a few things like vegetables. The amount given to wives for these items was neither regular nor fixed amount. In the guest husband system, women had their own income, and were responsible for most of the family expenditures. Men only contributed irregularly on a few items like rent.

In describing the characteristics of Yoruba financial management and domestic consumption behaviour, Fapohunda pointed out that over 75% of households studied did not pool their incomes or jointly plan expenditures [Fapohunda 1988]. She further noted that the majority of the traditional Yoruba wives had limited knowledge of their husbands financial resources and did not know how they disbursed their funds.
As shown by the above studies, applying Pahl’s typology to African countries poses some problem indicating the need for a less static model so as to capture some of the more dynamic aspects of money management.

Associated with the financial management system are expenditure patterns. There is a wealth of literature which indicates that by far the commonest use of married women's earnings is on household and child-related spending [Tripp 1989; Hoodfar 1988; Munachonga 1988; Ostergaard 1992]. Gender based responsibilities have been widely observed in Africa, where husbands are primarily responsible for things like housing, education and furniture, while women are responsible for food needs and clothing. Many descriptive accounts of women's expenditures in poor households emphasise the very small quantities of money that pass through their hands, and the countless ways they try to expand their income, e.g. by preparing cooked food, handicrafts, providing services, etc. Most of this income appears to go towards children or the family in general. The literature also emphasises the small amounts of personal spending mothers allow themselves, even when their needs are pressing [such as medical care] while fathers claim a right to personal spending money whether or not they earn a wage.

In Tanzania, personal spending patterns were found to be strongly gendered, with men retaining more of their income for personal use while women used their income on household necessities [Campbell et al 1995]. In Nigeria, Rothschild [1988] found patterns of specific gendered expenditures in all the three neighbourhoods she studied. Children's clothing and food were
consistently female expenditures and furniture was for men. Rothschild concluded that gender specific expenditures is the basis for discerning a pattern of divided conjugal financial responsibilities [Rothschild 1988 pp 150]. Similar trends have been reported in Zambia [Munachonga 1988], Ghana [Oppong 1981] and Cairo [Hoodfar 1988].

Ostergaard too, points out that in a number of West African societies, for example, both husband and wife have their own resources and maintain separate budgets. Men's and women's incomes are rarely allocated to the same expenditure categories: cultural traditions broadly determine which aspects of collective expenditure each must cover, supplemented by agreements between husband and wife [Ostergaard 1992, p.149]. A common pattern in urban areas in West Africa is for women's income to be allocated for the day to day food (which includes feeding all kin living in or visiting the household), clothing needs and domestic goods, cooking utensils, basic materials for house maintenance, etc.. Men's wages or income is used to cover regular bills, rent, etc. Children's schooling may be paid for by either parent but often fathers cover fees while mothers cover day to day costs, e.g. books [Ibid. pp. 150].

Dwyer and Bruce [1988] suggest that for most women, the central impetus to their earning is attaining a better life for their children, and this could possibly explain the allocation priorities they apply to their own income and other income that they control. Morris [1988] also argued that the explanation for women's spending pattern may lie in the gendered responsibilities emerging.
from a traditional sexual division of labour which associates the woman with
the running of the home, and which seems to be substantially unchallenged.

Morris, however, cautions that generalisations of this kind should not blind us
to women's attitudes and employment. With different money systems,
women’s attitudes towards their own earnings and the constraints on their use
may be governed by different norms of access and control. There seems to
be a normative acceptance of the priority to be placed on items of collective
expenditure. However, even here, there is considerable effort made by the
woman to accommodate some degree of male personal spending. This seems
to occur on the grounds that men and women's needs differ; with a man
needing to spend time (and therefore money) away from home whilst a
woman does not [Pahl 1983; Morris 1984].

One point which emerges very clearly is that where women are able to gain
access to cash income, it is generally used for domestic welfare or on the
needs of children [including health-care]. In poor situations, they have
succeeded in addressing immediate and practical needs and ensuring the
survival of their families.

2.5 Conclusion

This chapter has examined decision making and health care theories as a
framework within which this study is conducted. Resource and Normative
theories show the bases of decision making within households. According to
the resource theory, the balance of power in decision making depends on the
resources an individual can offer. The greater the number of resources one has, the greater the power within the household [Blood and Wolfe 1960]. The normative resource theory says decision-making powers in the household depend on both the comparative resources of a husband or wife and the cultural and sub-cultural expectations about distribution of marital power [Rodman 1972]. Both theories, though widely used throughout the world, have been found inadequate in explaining decision-making within households in developing countries. They focus on husband and wife and fail to take into account other actors in the household who could influence decision making. Decision making theories have focused exclusively on resources that are mainly accessible to men (at least in developing countries), and neglected women's bases and resources for power and decision making. While the theories offer much insight in terms of general decision making status within households, they were found lacking in relation to health care.

Health care theories offer a further insight into decision making related to illness management. The two major categories of health care models discussed were pathways models which describe different steps in the process of illness management, and the determinants and explanatory models which focus on explanatory variables or determinants associated with the choice of different forms of health services [Kroeger 1983]. These have been widely used all over the world. The various studies reviewed showed that illness management depends on the setting and situation. Women are central players.
in illness management, and the resources available to them and constraints they face greatly determine their illness management behaviour.

In Urban areas, studies from different countries in the Third World, despite data limitations, show that women are more likely to be employed in the informal sector than the formal sector, for reasons ranging from lack of education to employers’ discrimination and women’s reproductive activities, that keep them confined to the homes. The economic crisis suffered by many African countries has forced many women to engage in various income generating activities or projects in order to support their families. The pros and cons of the situation remain a major subject of debate, as conflicting trends are reported from different countries or even in the same country. What is significant, is that however small women's income, it makes a difference to their families and many households survive on it.

Literature on household resources allocation has demonstrated the different typologies and nature of resources allocation within families in different parts of the world. The differences in expenditure categories by women and men have been highlighted, with women's income mostly spent on food and other basic necessities of the family. Resource allocation to health care is more complex and little information is available on how resources are allocated to health care and in particular treatment seeking, when an illness occurs in the family.
This thesis contributes to the debates by examining both the mother's and children's illnesses within the whole family context, visualised as a process that involves cognitive negotiations and re-negotiations among mothers themselves and other actors. As rightly put by Kroeger [1983], any health care research ought to take into account the wide range of interacting variables, even if the actual research interests are focused on only a few of them. This research recognises the importance of the many factors that influence treatment seeking process but focuses on women's access to income and time use.

The next chapter discusses the setting where the study was conducted.
CHAPTER THREE

THE STUDY SETTING

3.0 Uganda

The Republic of Uganda, located in East Africa, is a small land locked country straddling the equator. It covers an area of 241,038 sq. km, one sixth of which consists of lakes, rivers and swamps. Uganda is bordered by Kenya in the east, Tanzania and Rwanda in the south, Zaire in the west and Sudan in the north (see Map 1). According to the National population and housing census of 1991, Uganda has a population of 16,671,705, of which 1,843,754 are urban based. Uganda has a population growth rate of 2.5% per annum.

Since attainment of independence from Great Britain in October 1962, Uganda's political history has been characterised by violence and instability [World Bank 1989, Holger and Twaddle 1991, Wiebe and Dodge 1987]. There is consensus, however, that this turmoil started in earnest in 1971 with Amin's military dictatorship. This change radically reversed the economic and social progress attained since independence.

In 1972, Amin launched the 'economic war' and expelled the Ugandan Asians who had dominated much economic and social activity in the country. This period in Uganda's history was characterised by scarcity of consumer goods, a balance of payments deficit, rising inflation, increased dependence on coffee exports, deteriorating social infrastructure and
budgetary constraints. Obbo [1991] notes that by the late 1970s the formal economy had to all intents and purposes collapsed. In spite of the continued existence of the public service, things were increasingly done in the private sphere. This became known as a "magendo" economy, which combined black marketeering in foreign exchange with over charging to make up for losses incurred during the process of doing business in Uganda [ibid.]

The ensuing civil strife and economic mismanagement continued throughout the post-Amin and subsequent regimes. Confronted with the deepening economic crisis both the Obote II (1981-85) and the NRM (1986 to date) regimes adopted structural adjustment programmes [SAPs] in an attempt to cope with the harsh economic realities. These programmes included reduction of government expenditure on social services, de-subsidisation, de-regulation, periodic devaluation of currency and retrenchment of civil servants [World Bank 1993b].

However, the instability of the 1980s engulfed the stabilisation and adjustment which had been attempted. According to Holger and Twaddle [1991] there was no serious structural adjustment in Uganda until May 1987 when the NRM regime began its current programme of economic recovery. The main policy positions were embodied in a short document 'The Ten Point Programme', with economic recovery aimed at establishing an independent, integrated and self sustaining economy [NRM 1986].

Stabilisation policies adopted were designed to restrict demand to the confines of the overall resource envelope and thereby restore financial
equilibrium. The structural policies were designed to increase efficiency, stimulate the supply side of the economy and encourage growth. On the stabilisation front, the government has adjusted the value of the Uganda shilling and moved to a market determined exchange rate; contained the fiscal deficit by implementing numerous revenue enhancing and expenditure measures, and implemented measures to curb inflationary crop financing. On the structural front the government has liberalised the trade regime by abolishing export and import licensing; dismantled all price controls, promulgated a new investment code, returned properties expropriated by the Amin regime and begun privatising public industrial enterprises. The government further embarked on a major overhaul of the civil service, restructured the tax system and shifted public expenditures towards critical economic and social services [World Bank 1993b pp 42].

Although the country has registered economic recovery in some sectors (e.g. increased industrial investment and improvement in physical infrastructure, especially roads), at the micro level there is growing realisation that these achievements have been at the expense of equity, growth and economic transformation. In particular, severe cuts in government social spending have dealt a crippling blow to vulnerable social groups like women and children [World Bank Report 1993a; NCC 1994].

Other effects of SAPs like the retrenchment of public servants and commoditisation of traditional social welfare systems have compelled
many people to participate in the informal economy. As a result, more women, in both rural and urban settings in Uganda, are in one way or another engaged in income generating activities to counteract the economic pressure exerted on their families [Tadria 1987; Bantebya 1992; Obbo 1991]. Mwaka also noted that there has been an influx into the informal sector of both men and women due to SAPS[Mwaka 1994].

3.1 Health care system in Uganda

The health care system inherited at independence in 1962 was based on a well distributed network of hospitals and health centres [NCC 1994]. This system concentrated, however, on the provision of curative medicine and it was not until the late 1960s that programmes oriented to primary health care began to be developed[ibid.]. By 1971, Uganda had developed one of the best health care systems in the region, both in the number and distribution of health units and in the content of health programmes. The network of government hospitals was supplemented by mission hospitals, and by largely urban based private practitioners[UNICEF 1989].

Like other sectors, during the 1970s, Uganda's health sector deteriorated. The government hospital infrastructure and many health centres were destroyed, leaving health care mostly in the hands of NGOs, missionary and private practitioners. Funding for the health sector almost disappeared and by 1986 the value of the public health budget was only 6.4% of its 1970 levels [World Bank 1993a].
The geographical distribution of health personnel and health facilities in Uganda still does not reflect the actual needs. The government runs 60% of the 1398 health facilities but some of them are ill equipped and in a poor state of repair [UDHS 1995]. Without support, many trained health personnel abandoned government employment. This loss, coupled with poverty, constrained recruiting practices and has created a health sector in which half of the employed staff are untrained. This has left many indices of general health care - such as the number of persons per doctor, sources of ante-natal care, the number of babies delivered by trained personnel, - still very unsatisfactory. For example, in the best served part of Uganda, Kampala, there are 12 hospitals, 7 health centres, 233 people per hospital bed, 28,160 people per doctor, 1,123 people per curative inspector, and 1,357 reproductive age woman per maternity staff [NCC 1994].

Nationally, the ratio of population per physician is 25000:1. This is greater than in any other developing country and is twice the ratio of 1965 [World Bank 1993a].

In terms of expenditure and financing, health has absorbed a relatively small share of the financial resources from government. According to the World Bank Social Sectors report, locally controlled expenditure on health was only 0.5% of GDP in 1989/90 and 0.6% in 1990/91. Donor disbursements account for the bulk of government expenditure in the health sector. Uganda’s recurrent expenditure on health is less than US$ 2 per capita per annum, as compared with Kenya which spends US $ 6, Zimbabwe which spends US$14 and Botswana which spends
Furthermore, an important feature of expenditures on health is that the share of expenditures on preventive health care is very low as compared to expenditures on curative services. In general, about 10% of the expenditures on health go to preventive health care while curative services receive the remaining 90% [ibid.].

Since 1986, most of the resources for health have been used to rehabilitate hospitals and health centres [capital costs] and to support single focus vertical programmes such as the control of diarrhoea diseases. It has been noted that this rehabilitation, though essential, has led to major crises of financing and donor dependency, with the government being unable to raise sufficient recurrent funds to sustain the rehabilitated facilities and vertical programmes [Macrae et al 1993].

Faced with such a situation, a government inter-ministerial task force on health financing recommended, in early 1990, the introduction of a 'cost sharing' mechanism where patients would be required to contribute to the cost of delivery of health services. These recommendations were not implemented, due to political controversy that developed over them.

In January 1993, with increased pressure from donor agencies, the Ministry of Health directed that health facilities should design and manage their own cost recovery mechanisms. Most hospitals and other health facilities have subsequently introduced formal user fees, although official policy and guidelines regulating cost recovery in government health services are not yet in place. The few studies that exist on the effects of the
introduction of user fees on health service provision and utilisation present a mixed picture. A study in Kasangati health centre near Kampala indicated that introduction of fees led to drops in patient load, but staff absenteeism was unaffected, suggesting the incentive was too low to affect behaviour [Wamai 1992]. Another study in the different setting of Arua, found that there was no drop in patient load with the introduction of a user fees; the staff were, however, motivated by sharing the revenue collected [Dervee and Madina 1993]. Responding to poor health services, there has been an unprecedented mushrooming of private clinics, drug shops, pharmacies and private individuals operating in their own houses all over the country. The consequences for these on the people have yet to be explored adequately.

The government recognised the issues in the current planning/policy document entitled "The Three Year Health Plan Frame 1993-1995; financing for all". The strategy proposed included the following four objectives:

- Restoration of existing services by rehabilitating war damaged units and increasing operational expenditure, so that they operate at a minimum acceptable level of quality.

- Reallocation of resources to focus more on preventive health care, including especially MCH/FP, immunisation, water and sanitation, nutrition, HIV/AIDS and malaria control.
- Increasing resources for the health sector, through the collection of significant amounts of revenue from user charges by government health units.

- Reduction of the duplication of efforts between the government and non governmental sectors through selective funding of those NGO facilities that have difficulty in breaking even.

The way forward was for planners, funders and implementers to think broadly about how to make and use inter-sectional linkages to address inter-sectoral health problems. They also needed to think deeply about the health sector in its entirety, including component groups which had not received any biomedical training. This thesis identifies components and issues that need urgent consideration by planners and implementors in order to improve the health conditions of the poor, particularly women and children in low income urban situations.

### 3.1.1 Major causes of illness and death among the under fives

In 1992 the Ministry of Health planning unit identified the major causes of morbidity for infants as ARI 25.8%, malaria 25.7% diarrhoea 13.0%, intestinal worms 6.1%, skin disease 5.5% others 23.9%. The causes of morbidity for under fives were malaria 29.0% ARI 20.3%, diarrhoea 9.5%, intestinal worms 8.6%, skin disease 4.9% and others 27.7% [NCC 1994]. Other reports indicate similar causes of morbidity and mortality in Uganda. For instance, for the period 1988-1990; malaria, AIDS, diarrhoeal diseases, acute respiratory tract infections/pneumonia,
anaemia, non-meningococcal meningitis, nutritional deficiencies, tuberculosis and tetanus were reported as the major causes of morbidity and mortality [World Bank 1993a]. (See Table VII)

Table VII Major causes of morbidity in Uganda 1988-1990

<table>
<thead>
<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>DISEASE</td>
<td>RANK</td>
<td>PERCENT</td>
<td>RANK</td>
</tr>
<tr>
<td>Malaria</td>
<td>1</td>
<td>20.2</td>
<td>1</td>
</tr>
<tr>
<td>Upper Resp. diseases</td>
<td>2</td>
<td>13.8</td>
<td>2</td>
</tr>
<tr>
<td>Trauma / injuries</td>
<td>3</td>
<td>9.7</td>
<td>3</td>
</tr>
<tr>
<td>Worms</td>
<td>5</td>
<td>7.6</td>
<td>5</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>4</td>
<td>9.1</td>
<td>4</td>
</tr>
<tr>
<td>Lower Resp. diseases</td>
<td>7</td>
<td>6.3</td>
<td>7</td>
</tr>
<tr>
<td>Skin</td>
<td>6</td>
<td>6.7</td>
<td>6</td>
</tr>
<tr>
<td>Eye infections</td>
<td>8</td>
<td>5.1</td>
<td>8</td>
</tr>
<tr>
<td>Ear infection</td>
<td>10</td>
<td>2.3</td>
<td>9</td>
</tr>
<tr>
<td>Anaemia</td>
<td>9</td>
<td>3.4</td>
<td>9</td>
</tr>
<tr>
<td>STD’s</td>
<td>10</td>
<td>2.8</td>
<td>11</td>
</tr>
<tr>
<td>Other diseases</td>
<td>15.3</td>
<td>14.4</td>
<td>18.0</td>
</tr>
<tr>
<td>NO of recorded visits</td>
<td>2,840,448</td>
<td>4,208,705</td>
<td>6,952,681</td>
</tr>
</tbody>
</table>

Source; World Bank 1993a.

The 1995 Uganda Demographic and Health Survey reported three current major causes of illness which affect infant and child survival in Uganda. The first one is acute respiratory infection [27%]. Common symptoms associated with it include fever, cough and difficult or rapid breathing. Similar findings were reported in Kamwokya which is the locus of this
research [Jitta 1996]. Early diagnosis and treatment with antibiotics can prevent a large proportion of deaths from respiratory infection, especially pneumonia. Second is fever [46%] which is closely associated with Malaria. Malaria is endemic in much of Uganda and accounts for a significant proportion of morbidity and mortality. Third is diarrhoea [24%] which leads to dehydration and is a major cause of morbidity and mortality among Ugandan children. Diarrhoea is more common among children aged 6 to 23 months, than among the older children [UDHS 1995]. In general it is evident from the reports, that the under-fives are affected by a number of diseases many of which if well managed and appropriate treatment sought in time, would reduce the high levels morbidity and mortality being reported.

3.1. 2 Women's health situation

The health condition of Ugandan women has long been a major concern, as they are reported much of the time to be in poor health [UNICEF 1992]. Surprisingly, women's health situation in Uganda is predominately discussed in the literature in relation to their reproductive health [Kirumira 1994, UDHS1995]. Recently HIV/AIDS has also attracted a lot of attention [see UDHS 1995, MOH 1994; 96 ;NCC 1994]. Unlike the case of children, diseases affecting women are frequently left out and only morbidity and mortality related to their reproduction status is reported. Maternal mortality estimates for the mid 1990s from the Ministry of Health indicated 600-1000 rural mothers’ deaths and 300-500 urban mothers’
death per 100,000 births. Elsewhere in the country hospitals show rates as high as 1,700 per 100,000 live births [Kasolo 1992]. The national 1995 estimates of the maternal mortality ratio were 506 per 100,000 live births [UDHS 1995]. The causes of maternal deaths in hospital based studies include prolonged labour leading to ruptured uterus, haemorrhage, abortion and increase blood pressure in pregnancy [Wassa 1991]. District reports indicate the absence or poor distribution of maternity units and the lack of trained attendants [midwives and trained TBAs] as key factors in maternal mortality [NCC 1994]. However, as will be discussed in Chapter 8, the reasons are more complex than those which have so far been reported.

Maternity care is being strongly promoted to ensure a safe pregnancy and delivery. In the four years prior to the 1995 UDHS survey, mothers received ante-natal care from a doctor, nurse or midwife for 91% of births. Professional assistance at delivery is, however, less common. Two out of three births take place at home and less than 40% are assisted by medically trained personnel. One third of births are assisted by relatives and 12% of women deliver without assistance from anyone. These same trends were reported in the demographic and health survey of 1988 [UDHS 1988/89 ; NCC 1994].

In terms of HIV/AIDS, Uganda was the first developing country to recognise publically the AIDS epidemic and define a national policy. By 1993 Uganda was reported to have the highest rates of AIDS cases per population in Africa. Of the total cases reported by 1993, 8.2% were
children and 91.8 were adults; of the adults, 47.7 were male and 52.3 female [STD/AIDS1994]. Female youths aged between 15-19 years old were six times more likely to have AIDS than their male age mates [ibid.]. HIV/AIDS is now among the leading causes of deaths of adults in Uganda. Girls and women are said to be more at risk of being infected with AIDS. According to a recent survey, women perceived themselves at greater risk of getting AIDS than men. One third of the women said they had a moderate or greater risk of getting the disease compared to only 16% of men; 65% of women said that they had changed their sexual behaviour as a result of AIDS, compared to 89 percent of men [UDHS 1995].

Reasons put forward as to why women are more susceptible to AIDS are: [i] biological (greater mucosal surface lining the vagina and the prolonged period of contact with the male partner's fluids after intercourse); [ii] cultural practices such as formal and informal polygamy, inheritance of widows; [iii] poverty. Many women do not have access to adequate income and many economic survival strategies like selling alcohol which they are engaged in have been linked with high risk sexual behaviour [NCC 1994].

3.2 Kamwokya II Ward : The study site

Kamwokya II Ward, the study site, is located in the Kawempe Division of Kampala, the capital city of Uganda [see map II]. It is one of the numerous peri-urban high density areas surrounding the city. It lies approximately four miles from Kampala city centre on the slopes of Kololo hill at an
altitude of 3850 -3925 feet ASL (see Maps IIIa and IIIb), and just outside the old municipal boundaries.

Although it is presently a well established settlement, according to local residents and Kampala city council officials, its expansion as a residential and commercial area is quite recent and dates from the early 1970s. This expansion continues to the present, with swampy fringes being reclaimed for construction of houses.

Kamwokya II is for local administrative purposes subdivided into ten RC 1 villages[zones] viz Kisenyi I, Kisenyi II, Church area, Green Valley, Central, Kifumbira I, Kifumbira II, Mawanda Road, Market area, and Contafrica zones. [see maps IIIa and IIIb]

The population of Kamwokya II, according to the 1980 population census was 7,800, 4,085 were males and 3,715 females, yielding a sex ratio of 110. By 1991 the population had risen by 55% to 5,944 males and 6,135 females, a total of 12,079 and the sex ratio had dropped from 110 to 97 [Uganda Population and Housing census 1991].

Kamwokya II ward covers an area of 0.53 sq. kms and thus has a population density of approximately 23000 persons per sq. km. This makes it one of the most densely populated areas of Kampala. The Baganda are the dominant ethnic group in Kamwokya II, followed by the Batoro and Banyankole. The remaining population is made up of a great variety of
smaller ethnic groups e.g. Alur, Basoga, etc. [for details see Wallman 1996]

In terms of physical infrastructure, Kamwokya II is characterised by an absence of regular roads within its area. However, there are murram tracks and paths and some of the former can be used by motor vehicles, [See Pons 1996]. The houses, shops and other structures in Kamwokya II include permanent and semi-permanent buildings and temporary structures.

Kamwokya II ward is an important centre of commercial life and activity, not only for its residents but also, in varying degrees, for inhabitants of some of its neighbouring parishes and other passers by. Business activities are observed throughout the ward on verandas, open stalls, in houses, shops, bars, open drinking places and "night shift" markets. The main market and other commercial areas of the settlement provide a far greater range of goods and services. The sizes of businesses range from big market stalls and shops to just a few items at the veranda and mobile shops.

Formal [biomedical] health care facilities and providers in Kamwokya II include health units like clinics, drug shops and pharmacies. Some of these facilities are officially registered and others are not. They are supplemented by friends working in hospitals and clinics who offer services on an informal basis. Other services include indigenous therapies e.g. diviners, traditional healers, herbalists and spiritual healers. Many of these indigenous therapies are not clearly visible to an outsider but local people acknowledge their presence in their areas [Wallman 1996].
According to a survey conducted in 1994

"most of the drug shops are small with one room establishments and operated both by medical personnel and lay people. The shops/clinics are commonly left for long periods with one or two non medical, junior, shop assistants to serve customers or clients. A number of drug shops also offer unofficial clinical services. Most clinics appear to be larger than the drug shops with a number of them having two rooms, one serving as a waiting room. These offer a range of services, general clinic, laboratory, dental, paediatric, x-ray and maternity. Most of the unofficial clinics and health providers like medical personnel working in hospitals, operate in their homes, many of which are small and crowded." [Pons 1994 pp 15]

In addition to all these facilities in the ward itself, Kamwokya is close to Mulago the main teaching and referral hospital in the country. It is located within a distance of 2 to 4 kms and is easily accessible by road and even on foot. A number of diseases have been identified as affecting Kamwokya people: 83% malaria, 71% AIDS, 31% dysentery/diarrhoea, 30% pneumonia, 18% malnutrition, 15% TB and 3% STD's [Wallman 1996].

3.3 Conclusion

The chapter has reviewed Uganda's social, political and economic history. The poor health care system and indicators are a result of the political and economic developments the country has been going through for over two decades. The repercussions of the turmoil have been felt not only in the health care sector, but equally in other sectors like the economy, education and agriculture. The infant and under-five morbidity and mortality rates are reported very high and being the worst in the region of East Africa. Women's health situation is no better with unacceptably high rates of maternal mortality - over 500 per 100,000 live births. With the
deterioration of services and the collapse of the economy, private
clinics, drug shops and private laboratories mushroomed to fill the vacuum
all over the country. Kamwokya is no exception [see Wallman 1996 pp
115]. Nationally, there is evidence that there are more private practitioners
than the 341 doctors and 425 midwives last registered in 1987. The
majority of private health care is provided by health workers employed
within the public sector but seeing patients privately [Gisu 1993].

It is now recognised that the private sector provides an important service
to the population. Consequently, free health care services, formerly
provided by the government, are sought from private practitioners charging
fees. The implications of this trend on the general health of the population
need to be explored fully ie whether people can afford to pay for the
services and the quality of services being offered and received. This thesis
addresses some of these questions through examining women’s access to
money and its implications for treatment seeking behaviour for their own
illness and that of their children under-five.

The next chapter discusses the methodology used to examine women’s
treatment seeking behaviour in Kamwokya Kampala.
CHAPTER FOUR

METHODOLOGY

4.0 Introduction

This chapter addresses the research process in relation to the main question of women's treatment seeking behaviour in Kampala, Uganda. It covers the study design, study population, selection of respondents, data collection techniques, data processing and analysis and my field experiences as a researcher. As pointed out by Wright [1993 pp: 51], "it is essential that all knowledge accounts for its own production". This description of the research process is therefore intended to provide a grounded context for the research findings discussed in this thesis.

In examining health seeking behaviour, one view is that the ideal method would be to carry out a prospective study monitoring a sample of individuals and families and observing any differences in patterns of illness behaviour and help seeking behaviour according to who was involved in the consultation [Calnan 1983]. However, the practicalities of such a design pose problems particularly because of the large sample needed to embrace enough episodes of illness ... (ibid.). This study adopted a retrospective approach based on case histories of women, and analysis of the logic of situations relating to treatment of illness among the women themselves and among their children underfive. The methods used sought to map the context within which their own or children's illness is experienced and managed by women.
The case study in social anthropology/sociology is described as "a detailed examination of an event[s] which the analyst believes exhibits the operation of some identified general theoretical principle" (Mitchell 1983:192). Its principal use is in providing an unusually detailed exploration of all possible causes, determinants, pathways, processes and experiences that might have contributed, directly or indirectly, to the known outcome (Bulmer 1984). The approach rests on the assumption that "the principal existing means of successful explanation of human action is the logic of the situation in which meaning of certain actions to the actors is of course part of the situation as they see it" (Jarvie 1972:14). In other words, the logic of the situation concerns itself with intentions, and the individual's perceptions of his/her situation as well as the structure of the situation itself.

In this study, case histories permitted collection of data on the sequence of actions taken by women in response to a particular illness episode. For each illness episode, data were recorded in the order in which attempts to cure an illness were made. These data trace out a history of treatment during an illness period. During these recalls, women recounted the duration of each episode in days, the treatment they sought, the cost of treatment and time spent on treatment seeking. Women also reported more than one treatment response for each illness episode. The point at which treatment became necessary in the course of the illness episode, and the nature of treatment given or sought was reported by the respondent. Discussions also explored how far the
particular treatments sought or given were related/influenced by the time and money available at that particular moment and how far by other factors.

Informed and supported by more qualitative data (from focus group discussions, informal conversation and observation) these case histories illustrate the patterns of treatment seeking behaviour of women and their children, and the factors responsible for actions taken during an illness episode.

This thesis also draws on and feeds into a larger ODA sponsored project on the informal economy of health in Kampala\(^1\). The project's aim was to document the factors affecting the response of ordinary women to their own symptoms of sexually transmitted diseases (STD) and to acute symptoms of illness in their children under five. The project mapped out the options and resources available in the community at different levels and examined their effects on women's response to illness symptoms. The different levels included, national, county (Kampala City), division (Nakawa), parish (Kamwokya), zones (villages) and households. It is at the household level that this thesis feeds in to examine an aspect of the family context under which illness management takes place. The interaction of the household context and outside factors as it relates to illness management for women themselves and their children under five is examined to map out the process of treatment seeking when an illness occurs.
4.1 Sample population

A total of twelve case histories are presented in this thesis. The informants were selected purposively to test the main hypotheses of the study. The key participants were women, as they are considered the main health providers and givers in families. The cases were selected to reflect different marital status and socio-economic range. The four categories were:

a] Married women earning own income with a husband earning income

b] Women heads of households

c] Married women earning income with resident men not working

d] Married women relying entirely on their husbands' income.

There are four cases in category A, three cases in category B and C and two cases in category D. Each category comprises of women with little reliable income and one with relatively secure economic resource base. These families represent broad categories of families found in Kamwokya: the Women's Survey completed in phase two of the larger project showed 15.3% of those surveyed were divorced or separated, 74.9% were married or cohabiting, 3% had never married and 6.8% were widowed [Wallman 1996 pp: 92]. Similar to what Southall and Gutkind [1957] found in Kampala much earlier, many of the families in Kamwokya never kept accounts and spent their money on living expenses as it came in. It was therefore impossible for them to give any accurate assessment of their earnings. The difficulty was even greater with those in petty trade, e.g. dealing in food stuffs, beer, etc. for
they could not remember what proportion of their sales of goods they had consumed.

Categorisation of the women was done in collaboration with local officials, depending mainly on the type of job or enterprise held or engaged in, type of house lived in and household items held by the families. The categorisation became clearer as the study progressed. Identification of families was facilitated by the fact that I had been in the community for over a year, prior to the commencement of the study, participating in the ODA project; This also made it easier to solicit their co-operation. The life histories of individual women contained in this study show experiences and circumstances that are both unique to them and shared by many women in Kamwokya. All the women had children under the age of five and had lived in Kamwokya for at least three years.

4.2 Data collection

This study adapted and refined research strategies that were developed for the larger ODA project and previous studies[see Wallman 1984 and 1996 Ch 5] These included lifelines/reproductive history, treatment seeking charts and in-depth interviews on topics like time use and, household expenditure and an observation check list of items and events in and around the house.

The first phase of data collection, in which life lines/reproductive history and treatment seeking charts (See charts I and II) were prepared, took five or six sessions with each respondent. Follow up interviews, without prior
arrangement, were conducted with most of them after every three to four weeks after the last visit. In case of a "new" illness in the family, follow-ups would continue until the respondent considered the patient cured. The follow-up enabled the researcher to observe and note all the treatment options being tried, and to document all the changes which occurred in the family that could have a bearing on treatment seeking. These separate research tools are briefly described in the following paragraphs.

4.2.1 Life lines / life history

The model used for collection of the life history enables the researcher to see the significant life events, movements and situations of an individual in relation to each other. As Sundstrom [1990] argues, in relation to a similar model for use among gynaecological clinic patients in Sweden "a life history provides insights into the influences that form us and steer our actions and will reveal previous experiences, and the current situation along with dreams and thoughts of the future ...It [They] present[s] a picture that we recognise and are able to absorb and which leaves us to draw our own conclusion" [Sundstrom 1990]. In this study, life histories provide enormously rich data moving from the remembered past into the present, showing the changes an individual has experienced and their relationship to treatment seeking behaviour.

The life history interviews were semi structured with questions based on an interview guide. Charts were drawn on large manila papers in a design adapted from the larger project. On the first half of the chart, age, place,
household composition, house type and employment were recorded for each life stage. The time intervals were left open for respondents to demarcate them according to significant change that occurred in their lives. On the second half of the chart, details of the woman's reproductive history were recorded. Information included pregnancies/miscarriages, and births/deaths of children. In this manner when the chart is opened up events can be seen in relation to each other in a way that can richly inform analysis of the overall context of the woman's life situation (see chart I).

4.2.2 Treatment seeking chart

Two treatment seeking charts were used in this study; one shows choices/resources general treatment seeking and advice during unspecified illness; the other documents the treatments sought for specific illness episodes: the last illness episode of the respondent and one of her children. Each ring of the diagram represents a general geographical area. The innermost ring represents the household; the second innermost, the village; the third, the parish; the fourth, Kampala and the outer ring, the rural/home area. The aim was to identify how close or far away were the treatment sources preferred and used by respondents. Other data solicited and recorded in the spaces to either side of the circle on the chart are whether the source was a non professional or professional, what treatments were administered, the location of treatment source and characteristics of the treatment provider, and why
that provider /source was used, cost of treatment and how the woman came to know of that specific provider (see chart II)

4.2.3 In-depth interview guidelines

In-depth interviews were conducted covering personal and family history, employment patterns for family members, illnesses affecting the family, household expenditures, and time use for women, especially as it related to treatment seeking during an illness episode.

4.2.4 Observation check lists

Observation check lists were made to note the nature of the household, available assets, environment, and the treatment the ill person was receiving. Observations were also made at the clinics where I accompanied the respondents who were ill or with ill children. This made it possible for me to observe at first hand the kind of treatment received by the respondents and the costs incurred.

In combination, these qualitative techniques facilitated exploration of the unfolding events or issues in the treatment seeking process. The use of charts and diagrams not only made the respondents feel at ease but also generated a lot of information about the whole context of treatment seeking. There are, however, also limitations to these methods; they are time consuming and demand a lot of patience, both from the respondent and the interviewer. The fact that most of the respondents were busy women and constrained by time meant the whole process took longer. Women preferred to be interviewed
while they were working, but that meant little attention would be paid to the charts. Subsequent visits were therefore focused on brief interviews and informal chats on the issues I was following up.

4.3 Data analysis

In data analysis, attention was focused on the integration of the case history material with other sets of data in order that the whole process of treatment seeking could be described. The analysis proceeded on four levels:

[i] The first level focused on women's access to money income. Participation in business came out prominently as one of the major ways women have access to income. More analysis was therefore carried out on the nature of business - its type, location and viability. The focus was about whether decisions on treatment choices were influenced by business characteristics per se, by the availability of money or by both.

[ii] The second level dealt with time use and treatment seeking patterns. Given the fact that most women were found to be very actively engaged in business, the question addressed was whether the decision to use given treatment options was influenced by the time available and/or the opportunity costs of utilising a specific treatment option.

[iii] At the third level, other factors like women's definition of illness, social support networks and spouse’s influence were examined in relation to treatment seeking patterns.
Finally the unfolding picture of women's treatment seeking process was examined, conclusions drawn and recommendations made.

4.4 Field experiences: working in impoverished areas

As a researcher who was already known to a number of respondents as a result of my involvement in the ODA project, I had the advantage in gaining quick acceptability when this research process began. My fluency in the local language [Luganda] enabled easy communication with the respondents.

However, I found it challenging to work in a field situation where life or survival is a struggle. Even where the poverty is compensated by the presence of an aggressive and dynamic informal economy with everybody selling something to survive, still, there were many poor people who often could hardly afford a meal. The sanitation system was appalling with stinking and open sewers, and the homes were overcrowded. At times I felt compelled to assist the women with money for food and treatment. A number of times I had to accompany women to the clinics and thereafter pay the bills. Often, during my regular visits, the respondents would be found to be very ill but without money for treatment. In most such cases, they would already have tried cheaper treatment options like using local medicinal herbs or some of the medicines in the house, but to no avail. I often encountered them in pathetic and desperate situations, as will be described in some of the case histories, waiting for the illness to become 'serious enough' to warrant attention at Mulago Hospital in the Acute Care Unit for children or the
Casualty Ward for adults. In these units, treatment is officially free and the patient is dealt with as a matter of urgency. In such circumstances I would personally intervene to ensure that my respondents were attended to.

These acts were incidental to my role as a friend. To the women I became a friend and a sister in whom they could confide. An indirect positive effect was that as the study progressed, the women became increasingly enthusiastic about it. They would keep mental notes of what transpired during illness episodes and pass on the information to me. The informal chats and discussions with women about various issues in their families proved very useful as the whole process of treatment seeking was gradually seen to be entangled in the family context.

The following chapter describes in detail the case histories of the individual women covering their social, reproductive, economic, time use and illness management.

1. The project The Informal Economy of Health in African Cities: Structural, Cultural and Clinical Dimensions of the management of STD and Pediatric Crisis by women resident in Kampala (ODA project R5397) was directed by Professor Sandra Wallman. I was part of Ugandan team based at Child Health and Development Center. The details are reported at length in Wallman [1996].
5.0 Introduction

Illness management in families has been and still remains a woman's responsibility worldwide [Castle 1993; Cosminsky 1987; Mwenesi 1993, Young 1980]. To understand the nature and magnitude of this responsibility, it is important to understand the circumstances under which women operate. Different settings present different challenges and opportunities to women as they endeavour to fulfil their role. The cases presented here demonstrate the challenges faced by women and existing opportunities in Kamwokya.

Kamwokya as an urban system has been described as

vibrant, crowded, mixed, ‘open’. These features are the bones of it as an urban system and have important implications for identity and the way resources are managed... Its people are mixed by ethnicity and economic status, cluster in different parts of the parish, and associated with different style.. Residents value its mixed housing options and therefore the possibility for improving without moving; movement in, out and within is linked to opportunities in the vibrant informal economy [Wallman 1996 pp: 227-228]

The cases described in this chapter ought to be seen in this context. The respondents, all women with children under five, had lived in Kamwokya for at least three years. As noted, these women reflected a wide economic range and autonomy with some of the women being supported financially by men and others with primary responsibility for themselves and their children; some
had relatively secure economic resources while others had little reliable income of any sort. Each case comprises biographical data, economic status, time use and accounts of treatment seeking in general, and of the most recent specific illness episode. Accordingly the cases have been divided into four categories i.e. a) married women with spouse working; b) women heads of households; c) married women with unemployed spouses and d) unemployed married women with spouses working (see Chapter 4).

Mildred (case 1), Yatek (case 2), Betty (case 3) and Aisa (Case 4) fell under category A. Among them Betty (case 2) had a fairly secure economic base with viable income generating projects. Although Mildred (case 1) and Yatek (case 2), were not as poor as Aisa (case 4), their economic status more or less fluctuated throughout the year. Under category B Jemima (case 6) was the best off, while Phina (case 5) and Sophia (case 7) had fairly unreliable economic resource bases. Their economic situation was heavily dependent on the market. In category C there were Resty (case 8), May (case 9) and Sarah (case 10). Of the three, Sarah was the best off, but like Resty and May who were also poor, her economic situation fluctuated and was heavily dependant on the market. Lastly in category D there was Maria (case 11) and Ana (case 12). Maria’s economic status was fairly secure as her spouse ran a private firm. Ana was a poor woman with minimal support from her spouse whose business could not effectively provide for the two families which he maintaind. Of all the cases, Betty (case 3) and Jemima (case 6) had the strongest economic bases. Below, the twelve case histories of individual
women are presented in detail. For purposes of presentation I will refer to the cases in each category as “Rich”, “poor” and “poorest” to reflect their economic status.

5.1 Category A: Married, both husband and wife working

5.1.1 Case 1 Mildred: Category A: Poor

(i) Personal history

Mildred, aged 24 years, was born in October 1970 at Kasangati near Kampala. Both her parents (now deceased) were subsistence cultivators on a small piece of land. Her father also worked as a night watchman at the nearby University farm at Kabanyolo. Mildred was the 2nd born in a family of five children; two boys and three girls. Her father was the sole bread winner for the family.

Mildred was enrolled in 1977 at a nearby primary school. According to her she was a promising pupil and had ambitions of going far. Obtaining school fees was always a problem, however, and Mildred would often temporarily drop out of school. Her schooling career abruptly ended in 1982 when she was twelve years old and in Primary 5. This was the time of the insurgency and her father was tragically murdered while on duty. Her mother then fell ill and also died a year later.

Orphaned at an early age, Mildred moved to Kampala to stay with her maternal aunt. Her other sisters and brothers were fostered by other relatives.
During the day time, Mildred's aunt operated a stall in the nearby Bukoto market, mostly selling fresh vegetables and sugar cane. After work she would sell *waragi* and *tonto* in her house. Mildred said that her aunt used to make sufficient money to keep the family going comfortably. They were never short of food. For her part Mildred would provide domestic help, doing all the home chores and caring for the children.

Early in the evenings between 7 and 9.00 p.m. Mildred's aunt would give her the left over stock from the days market to go to the candle-light night market, locally known as "*kidoomole*" or *toninyira mukange*,¹ in front of the main market. "This is how I learnt business," she said. She always managed to dispose of everything and then returned home to assist her aunt with the beer selling business.

In 1986 when 16 years old, Mildred got a serious partner. He was a fishmonger residing in the Green Valley zone who sold fish in the candle light market at Kamwokya. Mildred duly introduced him to her aunt and the latter had no objections to their relationship. A few weeks later, she moved in to cohabit with him.

For a year up to 1987, Mildred stayed at home as a housewife. Their home, where they resided at the time of the study was a rented single room, locally referred to as *muzigo*, one of the many in a large temporary structure. There was hardly any privacy and sanitation and hygiene standards were poor.
In 1988 Mildred got pregnant and produced twin boys. She said that though she was overjoyed to be “nalongo” this was the beginning of real hardships. She later had two other children, a boy and a girl. Her reproductive history can be summarised as follows:

1988 1st pregnancy live[twins] still living
1991 2nd pregnancy live still living
1993 3rd pregnancy live still living

(ii) Economic situation

Mildred needed to earn her own income soon after she gave birth to the twins as her husband’s fish selling business could not effectively support the now expanded family. His business was not bringing in much due to stiff competition from other business rivals. They lived on his daily earnings which varied with the sales of the day. Daily allowances ranged from Shs 500 to 1500 ($ .5 to 1.5) which was not enough to cater for the family’s needs. Her husband acknowledged that period as a very difficult time for him too. There was hardly any money to cater for the twins and they were always half starved as her breast milk was not sufficient. Her husband was always irritable and moody, at times blaming her outright for producing two children at once. Mildred herself was malnourished; she remarked "I was emaciated due to malnutrition".

With such a situation prevailing, as soon as the twins were weaned, Mildred decided to start her own business to supplement her husband’s income.
However, implementing this decision was not easy since she not only had to borrow start up capital, but also had to look for a baby sitter. She succeeded in the former by borrowing Shs 20,000 ($20) from her aunt but failed in the latter. Given the circumstances, says Mildred, the only rational option was to start a business at home on the veranda which enabled her to cover child care, perform household chores and run her business concurrently.

Mildred chose a business of frying and selling pancakes, cassava chips, and fish. Her customers were, and are still, mainly her neighbours and passers by. By 1990, Mildred's business had successfully taken off and was at least making sufficient money to cater for basic family needs like food, clothes and health care. At that time she would make a profit of about Shs 1000 ($1) per day, which supplemented her husband's income. Her husband was happy with her progress and encouraged her by investing more money in the business.

In mid 1990 somebody started a car repair shed not far from Mildred's home, and with her business acumen she quickly offered to prepare and sell tea, plus her pastries, to the shed at any time of the day. This, she said, improved her business greatly and she even engaged a small girl to help out. To date Mildred is the sole caterer for the garage hands. She says on average she makes a profit of Shs 2000 ($2) per day.
(iii) Household expenditure patterns

The major expenditure items in Mildred's family include rent, schooling for the two boys, food and other basic necessities like sugar salt, clothing and health care. In terms of expenditure patterns, there is no formal agreement between herself and her spouse on who should cover what. Mildred says, since she began working, she has been increasingly covering food, health care, clothes for the children and sometimes school fees and requirements like uniforms and books. Her spouse mainly covers rent and schooling for the children and sometimes passes on some money to Mildred to supplement hers. The latter amount of money varies and has reduced considerably since Mildred started working. On some days nothing is provided by the husband. It was difficult to estimate the amount of money coming into the family per month as different amounts of income came in every day. Mildred does not know her spouse's income, neither does he know hers. Mildred's family can afford to meet the basic needs of the family provided the equilibrium remains

(iv) Time use

In terms of time, Mildred says her business is quite demanding. She wakes up very early, often at 5.00 am, to prepare the pastries and tea for the early morning passers by and the garage workers. Her helper comes in at around 8.00 a.m. The twins, who go to a local school, are ready by 9.00 a.m but the other children are still too young to go to school and therefore "do not bother her much"; she looks after them while working. Mildred's business goes on
throughout the day as customers keep on demanding tea and snacks all the time. It is only late in the evenings (7.00 p.m.) and on Sundays that she rests. Her husband leaves in the morning at around 9.30 am to look for fish and returns back in the night after 9.00 p.m.

(v) General treatment seeking and worries about illness

Whenever Mildred's child falls ill she normally consults her partner, usually to inform him as the father of the children. Since Mildred started working he does not often provide money for treatment, but advises her to visit Mulago hospital. Mildred's next step is to watch over the child. If the symptoms persist she gives the child anti-malaria drugs purchased from a drug shop nearby. Mildred, however, stressed that what she does depends on the symptoms and how she interprets them. She pointed out that any fever or discomfort of a child is at first interpreted as malaria, due to the nature of the environment in which they live, and appropriate treatment is given. If the situation does not improve, Mildred takes the child to Muna clinic in the market area which she says is cheap and effective. The clinic was recommended to her by her aunt and a neighbour.

The next step, Mildred says, is normally to visit Mulago hospital. She has actually been in Mulago hospital a few times, mostly for immunisations. However, Mildred says there are some symptoms which are non medical and require non medical attention. Whenever she suspects such symptoms she consults her aunt in Kisenyi I zone, who either personally procures the
required remedies for her or introduces her to the local healer. Mildred admits having consulted traditional healers or used herbs several times, either during illness episodes of her children, or just for protection i.e. even when the child is not ill.

In the case of own illness, Mildred does not consult anybody, not even her partner, unless the illness is very serious. A proper woman, she says, "does not complain about minor illnesses but goes on as usual with her chores". In cases of serious illness, she consults both her partner and aunt. The latter mostly advises her to consult a herbalist or diviner, while the former usually advises her to seek professional care from the hospital or clinic. Mildred has rarely been to hospital for her own illness, but has visited local healers/diviners several times. She says that there are many envious neighbours who would like to bewitch her because of her successful business and therefore she has to get ‘protected’.

(vi) Specific illness episodes: child

The young child aged 4, sustained serious burns while trying to get a piece of fish from a frying pan one evening. Mildred, who was the only person around, administered first aid by applying paraffin to the boy's hand. Soon after, on a neighbour's advice, she also poured cold milk on the burnt hand. Meanwhile, she says, the child was in severe pain, as most of the skin had peeled off. At that time she was supposed to serve her customers but, instead, delegated the job to her helper. She then rushed the child to Muna clinic where an injection
was given immediately. The boys hand was then cleaned, smeared with a soothing ointment and later dressed. Mildred was asked to bring the child consecutively for three days for injections and a change of dressing. Mildred did not pay immediately but asked for credit, as she did not have the money at that particular time. She spent approximately one hour at the clinic on the first visit, and less than an hour on the subsequent visits.

The treatment costs were as follows:

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 injections</td>
<td>Shs 3000</td>
</tr>
<tr>
<td>Burnem ointment</td>
<td>&quot; 1000</td>
</tr>
<tr>
<td>Consultation</td>
<td>&quot; 500</td>
</tr>
<tr>
<td>Dressing</td>
<td>&quot; 500</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5000</strong></td>
</tr>
</tbody>
</table>

(vii) 2nd illness episode; child

Waswa, one of the twins aged 6, fell sick and the symptoms included restlessness, high body temperature, shivering and headache. For these symptoms Mildred gave the child anti malarial tablets. She then put the boy to bed. Her diagnosis was fever *(omusujja)*.3

When she checked on him an hour later, Mildred found that the boy's temperature had gone up and that he was near to convulsing. She hurried him off to the clinic in the market area, where he was immediately given a cold sponge bath to lower his temperature. He was also given an injection which, Mildred says, was to prevent convulsions. After taking the child's temperature and monitoring his breathing, the nurse at the clinic advised her to take the
boy to Mulago hospital. The time spent at the clinic was about one and a half hours.

However, Mildred did not go to Mulago hospital immediately. She went home to pick up some money and to give instructions to the girl regarding the business and what to prepare for the family. "I knew if I stayed in hospital for even three days, my business would collapse and that worried me very much. However I had no option but to take the child to hospital".

Mildred says that this was the first time her child had been admitted to Mulago hospital and everything was difficult and strange. The admission was in the Acute Care Unit where, she says, many children were being brought in all the time, a number of them dying. Her child spent one day in that unit and was the following day transferred to the paediatric ward where he spent one week. The child was discharged when his condition improved. During the course of treatment, observes Mildred, several injections were given and blood samples taken for testing. On discharge she was told to take the child back for check up the following week, but she never did so due to lack of time.

Back home, her friends brought several kinds of herbs for drinking and bathing the child. They said this was the real remedy for ”Yabwe” [convulsions]. Waswa steadily recovered.
The treatment costs were as follows.

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tablets</td>
<td>700</td>
</tr>
<tr>
<td>Injection at clinic</td>
<td>600</td>
</tr>
<tr>
<td>Mulago [informal]</td>
<td>1000</td>
</tr>
<tr>
<td>Treatment costs[drugs on discharge]</td>
<td>1000</td>
</tr>
<tr>
<td>Herbs [free]</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3300 [$ 3.3]</strong></td>
</tr>
</tbody>
</table>

Mildred says that during this illness episode, her business ground to a halt, compelling them to rely on the husband's meagre income for some time. She had to start all over again. Her husband paid half the hospital bills.

(viii) Mildred’s illness

"I have fallen ill several times" says Mildred, “but I don’t consider it worth mentioning”. The only time she fell really ill was when she had symptoms of chest pain, fever and difficulty in breathing. She treated herself with anti-malaria drugs (chloroquine and panadol tablets) thinking that she was suffering from fever. Then, two nights later, she could hardly breathe with severe chest pain and thought she was dying. It was during the rainy season, she says, and their house was always wet. Her husband called in a nurse at night who treated her with two injections.

The following day she stayed in bed and was given another painful injection. After four such injections and some tablets, she felt better and was able to resume her business. She noted that, though her business suffered, it was not to such an extent as when she was away in hospital with the child. She could
tell the girl what to do while recuperating. After complete recovery she consulted a diviner to find out if any foul play was involved. Mildred declined to disclose the outcome of this consultation.

<table>
<thead>
<tr>
<th>Treatment costs</th>
<th>Shs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chloroquine tablets</td>
<td>800</td>
</tr>
<tr>
<td>Panadol</td>
<td>500</td>
</tr>
<tr>
<td>Five injections</td>
<td>4000</td>
</tr>
<tr>
<td>Consulting diviner</td>
<td>500</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5800 [5.8]</strong></td>
</tr>
</tbody>
</table>

The partner helped in paying part of the bill.

5.1.2 Case 2 Yatek: Category A: Poor

(i) Personal history

Yatek was born in Kungu village, Kyadondo County, Kampala in October 1962. She is thirty two years old. She was the last born in a family of five children. Her father died when she was very young. Yatek therefore lived and grew up with her mother who was a subsistence cultivator. On top of farming she used to make a variety of handicrafts e.g. mats, baskets and table linen for sale. Her mother's brother (Yatek's uncle) would, however, help out with finances whenever the going got too tough.

Yatek was enrolled in primary school in 1969 when she was seven years old. Her relatives contributed to her school fees. She left home in 1977 and moved to Kamwokya (Mawanda zone) to stay with her elder sister and to be within
close proximity to a day secondary school where she was enrolled. Her sister was the sole bread winner.

Yatek got pregnant in 1978 while in Senior 2 class. Her partner, whom she refers to as 'muganzi' (lover), was a fellow student in the same school. He refused to take responsibility for Yatek's condition though many years later he accepted the child. Because of the pregnancy, Yatek dropped out of school and temporarily returned to her mother's village Kungu.

Ten months after delivery, Yatek left the child with her mother and returned to Kampala to continue with her education. She was enrolled in a different school and completed her O-levels in 1982. She still lived with her sister in Kamwokya. Soon after completion of secondary schooling (O-levels), she temporarily worked with the Uganda Company as a Clerical Assistant but soon gave up the job due to poor pay. She then got another job with the Bata Shoe Company, but was later sacked as a result of a week's absence when she was nursing her child, who was ill. At this time, Yatek got another partner who is her current husband. He was at that time employed as a storekeeper and used to provide her with financial support.

In 1983 Yatek left her sister's place and moved to another part of Kamwokya (Kifumbira) zone to live with her partner. They lived in two rooms built of semi-permanent materials. Their household was composed of three people: Yatek, her partner and her sister-in-law. Soon Yatek got pregnant and
produced her second child. Yatek's reproductive history can be summarised as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1983/84</td>
<td>2nd &quot; - do -</td>
</tr>
<tr>
<td>1986</td>
<td>3rd &quot; - do -</td>
</tr>
<tr>
<td>1990</td>
<td>4th &quot; - do -</td>
</tr>
<tr>
<td>1992</td>
<td>5th &quot; - do -</td>
</tr>
</tbody>
</table>

(ii) Economic situation

Although Yatek had always worked to support her first child, her economic situation worsened when she moved to reside with her spouse and had her subsequent children. Yatek says that, in this period the family suffered severe economic hardships as her partner’s wages were negligible and the family was expanding. The sky rocketing inflation [233%] at that time in Uganda had rendered his wages inadequate. Yatek had to continue supporting her first child, at her mother’s place in the village. She therefore took a job as a sanitary cleaner at Mulago Hospital. While off duty, she would sell boiled eggs and pancakes to passers by at the roadside.

In 1991, Yatek got another job at the University as a messenger, a job she has kept to date. She supplements her monthly wages by selling soft drinks and snacks at her place of work. She also provides casual labour as a domestic cleaner whenever she gets a chance. Her husband was retrenched from his job in 1992 and now works as a casual labourer. Their household is now quite large, composed of nine people i.e. Yatek, her husband, four children, and Yatek's three relatives.
(iii) Household expenditure patterns

Yatek's family main expenditures include, fees for three children and Yatek's cousin, food, clothing, health care and rent. Like Mildred (case 1) no formal agreement exists on who covers what, but Yatek says before her husband lost his job as a store keeper, he used to pay rent, school fees and buy food, especially meat. Yatek would cover school fees for her cousin, food and all the other basic necessities in the family. With the husband's loss of his job, every thing has fallen on Yatek's shoulders. Whatever her husband earns is sent to the village where he maintains a second family of a wife and six children. He claims that what he earns cannot meet all the requirements of the two families. This, according to Yatek, causes a lot of rifts between them. Yatek's salary at the university of about Shs 30,000 ($30) plus income from other activities enables her to maintain her children in school and provide the basic necessities of the family. Yatek says her salary is always reserved for school fees and income from her other activities is used for daily survival.

(iv) Time use

Yatek is a busy woman. She wakes up at 5.00 a.m., and with the help of her cousin and sister, does household chores, attends to the children and prepares snacks for sale at her place of work. At 8.00 a.m she sets off on foot to the University campus where she spends most of the day. During the lunch break she does casual chores (mostly washing and general cleaning) in homes within and around the campus. After work, at 5.00 p.m., she continues with the
casual chores and often returns home after 9.00 p.m. Her husband leaves home before 6.00 a.m. to work as a casual labourer at a construction company and returns between 8.00 p.m. and 10.00 p.m.

(v) General treatment seeking and worries about illness

When a child falls ill, Yatek first informs her husband and then treats the child either with traditional remedies or over the counter drugs. She says that the nature of remedies used depend on the ailment afflicting the child. Most of the home remedies used are to cure fever, headache, stomach upsets and other obvious symptoms.

If illness symptoms persist, Yatek consults a doctor at a nearby clinic where she was introduced by her husband. She says that the doctor is a family friend and often treats her children on credit. When illness symptoms do not disappear, after visiting the clinic, the child is either taken to Old Mulago hospital or to the Acute Care Unit at New Mulago hospital depending on the time. For non-clinical symptoms, Yatek consults a traditional healer who lives nearby. For complicated cases, she consults another healer who lives outside Kamwokya, 5 kms away from her home.

For her own illness, Yatek mostly treats herself or consults the neighbour who is a traditional healer, for non-clinical symptoms. She only goes to hospital for ante-natal care. This is to be on the safe side, in case of complications arising during delivery, as women who do not attend ante-natal clinics are
often not admitted at delivery time. If admitted they are ridiculed for having ignored ante-natal clinics.

(vi) **1st illness episode** (see chapter 11 Extended case analysis)

(vii) **2nd illness episode : child**

Julius, aged 4, fell seriously ill. His symptoms included high body temperature and headache. Yatek diagnosed them as malaria symptoms and therefore administered anti malarial drugs. The boy however did not respond to this treatment and the following day was not only running a very high temperature but was breathing badly and delirious. Yatek took him to a nearby clinic where the child was treated with injections and she was advised to take him to Mulago hospital.

Yatek thus took Julius to Mulago Hospital where severe malaria was diagnosed and he was admitted for five days. Yatek did not consult any lay healers because she said the symptoms were clinical.

<table>
<thead>
<tr>
<th>Treatment costs:</th>
<th>Shs</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 injections</td>
<td>2500</td>
</tr>
<tr>
<td>Unofficial charges</td>
<td>3000</td>
</tr>
<tr>
<td>Total</td>
<td>5500 [$ 5.5]</td>
</tr>
</tbody>
</table>

Yatek’s husband paid part of this bill.
(vii) Yatek’s illness

At the time of Liz’s illness (the first illness episode of a child, reported in Chapter 11), Yatek also used to suffer from severe headache, fever and dizziness. She says that her illness was similar to Liz’s. Had she not been an adult, she said, she would also have had convulsions. She did not seek specific treatment but claimed to have been treated concurrently with Liz and cured.

Case 3 Betty^4: Category A: Rich

(i) Personal history

Betty, aged 39 years old, is of Ganda ethnic origin. She was born in Kasana village, Kalungu county, Masaka district in a poor peasant family. Her parents were subsistence farmers, though they also grew some coffee for sale. Betty was the last born of the nine children in the family (five boys and four girls). Occasionally, some extended family relatives would also stay in their household.

Betty says that financial constraints were persistent in the family, due to the lack of any meaningful income on the part of the father and the large number of children. Consequently, Betty was only able to be educated up to Senior one. On dropping out, she applied and was admitted to a nearby vocational training school where she studied and successfully completed courses in infant
teaching methods, ante-natal care, elementary paediatrics, nutrition and family planning. This training period lasted two years.

In 1970, on completion of her vocational training, Betty obtained a job as a health worker at Kitovu Mission Hospital where she worked in the maternity and paediatric wards. She was accommodated near the hospital and used to earn 250 Shs [$0.25] per month which she says was then sufficient to cater for her needs and even left a surplus to save. While at Kitovu, she got a partner whom she refers to as a ‘muganzi’ [a lover]. The man was known to her, as he was a family friend. Later, he made her pregnant and she had her first child in 1971.

After delivery she gave up her job at the hospital, took the child to her mother and then moved to Kampala to continue studying or look for a job. The father of the child facilitated her migration to Kampala and assisted her to find a school. Betty enrolled in a commercial college for one year and studied elementary accounts. She initially shared a room with a girl friend but later moved on to stay with an uncle in Bugolobi flats. Her first employment in Kampala was teaching at a kindergarten where she was paid Shs 350 [$0.35] per month.

At this time she got another partner who is her current husband. She left her job and obtained another, also as a teacher, at Bukoto church nursery. Betty recalls that it is at this time in 1974 that she shifted residence from her uncle’s and moved in to cohabit with her partner. They later formalised their
relationship with a church wedding. They moved to Kamwokya Kisenyi I zone where they now reside.

Currently, Betty's family is composed of 13 people; ten children, Betty, her husband and an elderly woman relative. All the ten children belong to Betty. Her reproductive history can be summarised as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
<th>Outcome</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1971</td>
<td>1st pregnancy</td>
<td>live birth</td>
<td>still living</td>
</tr>
<tr>
<td>1974</td>
<td>2nd</td>
<td>&quot;</td>
<td>&quot;</td>
</tr>
<tr>
<td>1976</td>
<td>3rd</td>
<td>&quot;</td>
<td>&quot;</td>
</tr>
<tr>
<td>1979</td>
<td>4th</td>
<td>&quot;</td>
<td>&quot;</td>
</tr>
<tr>
<td>1981</td>
<td>5th</td>
<td>[twins]</td>
<td>&quot;</td>
</tr>
<tr>
<td>1983</td>
<td>6th</td>
<td>&quot;</td>
<td>&quot;</td>
</tr>
<tr>
<td>1985</td>
<td>7th</td>
<td>&quot;</td>
<td>&quot;</td>
</tr>
<tr>
<td>1987</td>
<td>8th</td>
<td>&quot;</td>
<td>&quot;</td>
</tr>
<tr>
<td>1991</td>
<td>9th</td>
<td>&quot;</td>
<td>&quot;</td>
</tr>
</tbody>
</table>

The youngest child aged 3 is a boy.

(ii) Economic situation

Betty began working at an early age of 16 when she dropped out of school and joined a vocational training school and later got a job at a mission hospital. She then moved to Kampala and worked as a nursery teacher in two schools. When she moved to Kamwokya with her husband, Betty started her own nursery school (St. Maria Gorreti Kindergarten) which is surviving to date. Her partner was then employed in Masaka as an accounts clerk and was always away during weekdays. He, however, lost his job early 1993 and started a private car hire business using the family car. In 1993, Betty got a loan from the church and established a poultry unit within her backyard. She
also purchased a pig and a cow which they keep around the homestead. Betty earns more than Shs 100,000 (\$100) a month.

By local Kamwokya II standards, Betty and her family are considered prosperous. They own their four bedroomed permanent house which has a spacious yard. The kitchen and toilets however are detached. Within the yard there are units for the pig and cow respectively, and a poultry unit.

(iii) Household expenditure patterns

The biggest expenditure item in Betty's family is school fees. Out of ten children, nine are in school. The next greatest items of expenditure are food, clothing, health care, support to her mother-in-law and her own mother. They do not pay rent because they live in their own house. For a long time before the husband was retrenched from his civil service job, both Betty and her husband contributed to school fees and other requirements like uniforms, books and pens. In terms of food both contributed, with the husband bringing food twice a month from up country where he was employed. Clothing was mainly covered by Betty. Health care was covered by Betty as she was always with the children. However, when her husband lost his job in Masaka and began running a special car hire with the family car, Betty took over most of the responsibilities. The older children are encouraged to set up their own small projects like keeping pigs or chickens at home for sale. Two of the older boys have two pigs and have a few local chickens for sale. The girl has a small garden of yams and sugar cane to sell. The money they get is used for their
own personal requirements. Betty's projects generate enough funds to support her family. This has brought a lot of tension in the family and the husband sometimes turns violent, not only to Betty but the children too. The car he runs frequently breaks down and in most cases Betty has to step in to have it repaired. Betty says she helps out because he is still the head of the family and also to avoid violence, although the husband does not contribute anything to the family. Betty suspects that her husband has another woman somewhere, and that he spends most of his money there.

(iv) Time use

Betty's main business is operating the nursery school. Her other businesses include managing a dairy cow, a pig and poultry (broiler chickens). All these enterprises are situated within her backyard. She says that her day starts quite early, just before 6.00 am. She ensures that there is sufficient fodder for the cow and pig and enough feed and water for the chickens. Betty assists in cleaning the water and feed troughs. Most of the children participate in these activities. Before leaving for the nursery at 8.00 am, she makes sure that all the children are ready for school. Her husband also helps in these early morning activities, especially with the cow and pig.

At the nursery school, Betty supervises the cleaning and ensures that everything is ready for classes starting at 9.00 a.m. She is assisted by three teachers. School closes at 12.30 p.m. but Betty stays around up to 3.00 p.m., preparing lessons for the following day and supervising the marking done by
the teachers. From 3.00 p.m. onwards she stays at home doing household work, child care and managing the animals, or attends to community obligations like meetings with women with problems in her role as a secretary for women affairs in Kisenyi I zone.

(v) General treatment seeking and worries about illness

Whenever a child falls ill, Betty usually consults her husband, who advises her to take the child to hospital or clinic. However Betty's next step is determined by the nature of the symptoms. If they are not considered serious (e.g. slight headache or mild body temperature) she treats the child herself, either using drugs available in the house or procured from a friend who is a health worker affiliated to Mulago hospital.

Betty's friend, the 'nurse', operates her business from her house, though it is not advertised as a health facility. This 'house clinic' does not appear to be licensed and apparently the nurse attends only to close acquaintances. I later learnt that in addition to being Betty's friend, the nurse has children attending Betty's nursery. Betty is fond of her nurse friend because the latter sells her drugs at subsidised prices.

If illness symptoms persist, in spite of Betty's self treatment and the 'nurse's' attention, Betty takes the child to Kisenyi Valley clinic which is owned by a professional doctor and managed by two trained nurses. The doctor is normally around in the evenings and early mornings. Kisenyi Valley clinic also offers some laboratory services. In complicated cases the doctor refers
his clients to Mulago Hospital, where he continues to attend to them. Betty says that Kisenyi Valley clinic is usually her last resort. In other words, if symptoms persist, she keeps on switching between the clinic and her 'nurse' friend. Betty's children have never been admitted to Mulago hospital.

Whenever Betty is worried about persistent, non specific [non medical] illness symptoms, afflicting either herself or child, she consults either her elderly mother in law or her sister in law but not her husband. These two women are reputed to possess a lot of knowledge and vast experience about children's health problems. They can also determine whether illness symptoms require other than medical attention.

(vi) Specific illness episodes : child

3 year old John was ill. Betty says that his symptoms included coughing, high body temperature and restlessness. When she noticed these symptoms, she interpreted them as those of malaria and bought anti-malarial drugs (quinine mixture and aspirin) which she gave to the child. She left the child under the care of the old woman relative with instructions to watch over him, then hurried off to her nursery school.

On return after work Betty found that John's situation had worsened. She took him to Kisenyi Valley Clinic where he was treated with other anti malarial drugs (comaquine tablets). Betty says that, in spite of this treatment, the illness symptoms persisted and after two days she took the child to her 'nurse' friend where he was treated with different anti-malaria drugs (chloroquine
and penicillin injections). Betty says, after this treatment, the child improved and gradually was cured. Both at the clinic and the nurse’s premises, total treatment seeking time did not exceed one hour.

<table>
<thead>
<tr>
<th>Treatment costs</th>
<th>Shs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kisenyi Valley Clinic</td>
<td>3000</td>
</tr>
<tr>
<td>Nurse</td>
<td>2000</td>
</tr>
<tr>
<td>Total cost</td>
<td>5000</td>
</tr>
</tbody>
</table>

Betty paid this bill.

(vii) 2nd illness episode: child

John fell ill again with symptoms of a high body temperature, pale eyes, stomach pains and loss of appetite. Betty took the child straight away to Kisenyi Valley Clinic where malaria was diagnosed and chloroquine injections were given. Prior to this visit she had treated the child at home with over the counter drugs, suspecting ordinary fever.

The child improved a bit but after two days similar symptoms reappeared. This time Betty visited her 'nurse' friend who diagnosed intermittent malaria and put the child on a course of quinine injections. At both premises Betty again estimated that total treatment seeking time amounted to less than an hour. The child did not improve at all. He developed acute stomach pains and his eyes became very pale. Betty got very worried and consulted her mother-in-law who straight away diagnosed 'obulogo' i.e. that the boy had been bewitched. She advised Betty to take the boy to the traditional healer for the extraction of the 'poison'.
Betty immediately took the child to the healer in Ntinda, two miles away from Kamwokya. By this time, says Betty, the child was in great pain. At the healer's premises, there were many other people waiting for their turn. When her turn came, the healer (an old woman) asked her to wait until evening saying that that was the time when the therapy for the child's condition would be effective. At six o'clock in the evening the child was treated and Betty was told to return the following evening for further therapy, which she did. She was also advised to stop treating the child with any pharmaceutical drugs.

Betty says after this therapy the child improved rapidly. Each respective therapy lasted about one hour. She suspects the child had been charmed when she went with him to her home village in Masaka.

<table>
<thead>
<tr>
<th>Treatment costs</th>
<th>Shs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kisenyi Valley Clinic: 2 injections</td>
<td>1500</td>
</tr>
<tr>
<td>'Nurse': 3 injections quinine</td>
<td>3000</td>
</tr>
<tr>
<td>Traditional healers therapy</td>
<td>2000</td>
</tr>
<tr>
<td>Transport</td>
<td>1200</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7700 [$7.7]</strong></td>
</tr>
</tbody>
</table>

(viii) Betty's illness

Betty says her major ailment is hypertension (high blood pressure). However, she has been afflicted with other illnesses several times like when she scalded her arm with boiling water. "It was a minor accident", she says, and "I did not bother seeking professional help. I treated myself." Betty's self treatment was quite strange and I had not encountered it before. She dressed the wound with rabbit fur which stuck there. With such treatment, she said, the fur peels off when the wound heals. Betty showed me this 'unique'
dressing on her arm. At the same time, I observed two deep fresh cuts on her arm as well. Asked about the cuts, she smiled and said they were sustained in the process of being immunised against HIV-AIDS by a certain healer on Gayaza road about 7 kms from Kamwokya. She enthusiastically pointed out that many people were getting immunised against the killer disease. After one week Betty's wound healed and the rabbit fur peeled off. No treatment costs were incurred.

(iv) Betty's second illness episode

Betty's illness symptoms included sharp pains in the rib cage and painful joints. With such pains she diagnosed "kinsimbye" [localised acute pains which may at times restrict movement of the affected parts]. Soon, she says sitting, walking and movement of other body parts became a problem.

She consulted her husband who advised her to go to hospital. Betty, however, ignored the advice and decided to treat herself with a concoction of herbs which she took orally. Then she prepared another concoction which included crushed tomato leaves mixed with paraffin and applied it on the affected parts, especially the rib cage. With this treatment, she says, there was only a temporary relief and the symptoms persisted. Next she applied Vicks Vaporub, but also to no avail.

Betty then visited Kisenyi valley clinic where she was attended by the doctor. She was given some white capsules and assured that she would get better. She says that she was relieved of pain for some time and even managed to go to
her school. After two days however, her symptoms suddenly recurred and she became paralysed while at school.

She quickly sent for her nurse friend who treated her with injections and recommended a bed rest. Back home, Betty sent for her mother in law who consulted a diviner on her behalf. The latter said it was Betty's co-wife who was bewitching her and sent medicine (both curative and for protection). Her husband was not informed of this therapy. Betty, however, continued getting treatment (mostly injections) from the nurse and after a week she recovered.

<table>
<thead>
<tr>
<th>Treatment costs</th>
<th>Shs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vicks vaporub</td>
<td>400</td>
</tr>
<tr>
<td>Kisenyi Valley Clinic</td>
<td>1000</td>
</tr>
<tr>
<td>Five injections [nurse]</td>
<td>2500</td>
</tr>
<tr>
<td>Medicine from diviner</td>
<td>2000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5900 [$5.9]</strong></td>
</tr>
</tbody>
</table>

Betty paid all the bills herself.

**Case 4 : Aisa Category A: Very Poor**

**(i) Personal history**

Aisa is a Japadhola woman in her late twenties. She was born in 1966 in Busimba village, Bunyole county, Tororo district in Eastern Uganda. Her early childhood was characterised by extreme poverty and deprivation. Her parents were poor peasants, relying on subsistence cultivation for survival.

Aisa's mother, disgusted with her father's poverty and hopelessness, deserted him early in 1970. Aisa was then four years old. They moved to Kayunga
town together with her mother's two other children. In Kayunga town, they settled down quickly, living in a single room which was much better than her father's. Her mother started a business, selling green bananas "matooke" in the market. Aisa was enrolled in primary school in 1973 when she was seven years old, but she only went up to primary five, due to the lack of school fees.

In 1980, when Aisa was 14 years old, her mother sent her to Kampala (Najjanankumbi) to stay with her paternal aunt. This was her father's younger sister who used to visit them occasionally at Busimba village.

Though Aisa moved to Kampala with great expectations, life in the city turned out to be hard. During the day her aunt operated a road side stall selling fruits to passers by and in the evenings she sold "waragi" and "tonto".

Aisa, who used to look after the children and do the cooking, says she would have tolerated the situation had it not been for one night when her aunt's partner took advantage of the aunt's absence and raped her. When this happened, Aisa felt she could no longer live with them and fled to Kamwokya II, market zone, to live with another maternal aunt who operated a business in the market area.

Aisa recalls that life in Kamwokya was relatively better. This aunt was more respectable and operated a big stall in the main market, selling a variety of fruits and vegetables. Aisa used to assist her aunt at the market stall especially
with cleaning and displaying the merchandise, and at times selling when her aunt was not around.

When she was 17 years old in 1983, Aisa met and eloped with a Moslem man who later became her husband. He lived in Kisenyi I zone in a small, semi-permanent two roomed house. He later legalised their relationship in the mosque (*Kuwoowa ceremony*). Asia’s household currently consists of her husband, six children and a sister-in-law. Her reproductive history can be summarised as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Pregnancy</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1983</td>
<td>1st pregnancy</td>
<td>live birth still living</td>
</tr>
<tr>
<td>1985</td>
<td>2nd pregnancy</td>
<td>live birth still living</td>
</tr>
<tr>
<td>1986/87</td>
<td>3rd pregnancy</td>
<td>&quot; still living</td>
</tr>
<tr>
<td>1989</td>
<td>4th pregnancy</td>
<td>&quot; still living</td>
</tr>
<tr>
<td>1991</td>
<td>5th pregnancy</td>
<td>&quot; still living</td>
</tr>
<tr>
<td>1993</td>
<td>6th pregnancy</td>
<td>&quot; still living</td>
</tr>
</tbody>
</table>

(ii) Economic situation

After a few months of work with her aunt in the market, Aisa felt conversant with the business and requested that her aunt advance her some money to start up her own business and to support herself. Her husband, to whom she had just got married, unfortunately had never had a steady job and worked as part-time mechanic charging car batteries at a nearby car repair workshop. Asia’s aunt advanced her a loan of Shs. 30,000[$30] which enabled her to start her own fruit and vegetable business in the same market. She says that,
initially things were not easy, especially due to stiff competition and petty jealousies between business colleagues, and the loan repayment to her aunt. However, she somehow managed and, to date, still operates the same stall in the market. She earns on average a profit of Shs 1500 ($1.5) per day.

(iii) Household expenditure patterns

Asia's family is big, with six children of whom only four attend school. Aisa spends most of her income on food and basic necessities in the family. Both she and her husband contribute to school fees and other requirements. School Fees are a major problem for the family and the children are frequently sent out of school for failure to pay fees. Rent is also paid by whoever has money at the time it is due and is always paid in arrears. Clothing is mainly covered by Aisa who normally buys second hand clothes. Asia's family barely survives and both her own and her spouse's income fluctuate depending on what is sold or done for the day. Most of the daily earnings and sometimes part of the capital is spent on the family.

(iv) Time use

Asia's day starts early, usually at 6.00 a.m. On Mondays, Wednesdays and Fridays she has to procure fresh produce for her stall. Thus, on those days, she travels to Kalerwe market between 6.00 and 7.00 a.m. where she buys the fresh vegetables and fruits from the upcountry lorries which unload at that
time. She says that the prices of the fresh produce depend on how early one is. Those who come late buy poor quality produce at even higher prices.

Aisa usually hires a wooden cart (ekigali) to transport her purchases from Kalerwe market to Kamwokya II. By 8.30 a.m. the produce is delivered at the market. Between 8.30 and 9.30 a.m. Aisa cleans and displays her merchandise, and business proper starts after 10.00 a.m. She does not return home for lunch but stays at the market throughout the day. Her sister-in-law takes care of the family and helps Aisa with household chores, especially taking care of the children in her absence. If she is breast-feeding, the baby is brought to the market. Business continues throughout the day until 7.00 - 8.00 p.m. in the evening when the market usually closes. Aisa, however, stays longer, storing her produce, cleaning and locking up. She usually leaves the market at 8.30 p.m. and heads straight for home to rest and prepare for the following day. On Sundays, she does not go to the market, although it remains open. Aisa pointed out that this routine may be disrupted in case of illness of herself or child. Her husband works within Kamwokya and goes off to work after 9.00 am.

(v) General treatment seeking and worries about illness

When Aisa notices illness symptoms in her child, her response depends on the nature and seriousness of the symptoms. If the child is not considered seriously ill, e.g. if the body temperature is just mild or if the child is only
coughing slightly, then she just watches over him/her without informing anybody. In such cases she takes the child along with her to the market.

On the other hand, if the illness symptoms are considered serious, e.g. high body temperature, loss of appetite, diarrhoea, vomiting, incessant coughing or laboured breathing, Aisa promptly informs her husband as the family head. She does not usually ask him for treatment money, since he is not expected to have any. At the same time she consults her aunt in Kisenyi I zone for advice.

The next step is that Aisa treats the child, using either drugs available at home or bought from the drug shop. When illness symptoms persist, she takes the child to Mulago hospital. She says the alternative is Kisenyi valley clinic, nearby, but she rarely goes there due to financial limitations.

If the child does not improve after a visit to Mulago hospital, Aisa consults her neighbour and landlord, commonly referred to as "jaja" who treats Aisa like a daughter. Jaja and Aisa became closely acquainted from the time Aisa became her tenant. Jaja is locally reputed to possess a vast knowledge of remedial herbal medicine and a wide experience with children's health problems. Aisa has much confidence them. She points out that it is out of fear of being deprived of Jaja's close acquaintance, and therefore attention during illness and especially those of children, that they have remained her tenants for so long.

If Jaja's remedies fail to heal the child which, Aisa says, is rare, then she consults her aunt again. The aunt may advise her to take the child to
her (Asia’s) grandfather at Kisasi over 5 kms away from Kamwokya. Aisa says that this is usually her last step. She has much confidence in her grandfather as a healer/diviner.

Regarding own illness, Aisa rarely seeks treatment from biomedical practitioners. In any case she insists that she rarely falls seriously ill. On the few occasions it has happened, she consulted her partner and Jaja (the landlord) respectively. The latter often prescribes and provides Aisa with local medicinal herbs which are either administered orally, smeared on the body or mixed with bathing water. If Jaja’s remedies prove ineffective, Aisa consults her grandfather, the diviner/healer at Kisasi.

(vi) Specific illness episodes: child

The 3 year old boy, Musa, fell ill. His symptoms included loss of appetite, lack of sleep, rapid breathing and a high temperature. On noticing these symptoms, Aisa consulted her husband who immediately administered antimalaria drugs. At the same time she consulted Jaja, who diagnosed malaria and convulsions [yabwe], saying that although the child had not yet convulsed, he was bound to. She therefore provided various herbs for drinking and bathing to prevent this situation. Meanwhile Aisa continued normally with her business.

Aisa says that there was no significant improvement and the following day the boy not only became delirious but also suffered convulsions. Aisa rushed the child to Old Mulago hospital (OPD) section, after delegating her business to a
friend. At Mulago the boy was immediately admitted and put on a drip. Blood samples were taken for examination and severe malaria was diagnosed. Musa was also found to be severely dehydrated.

The boy was put on a course of injections and various types of tablets. After three days of treatment Musa steadily recovered and was discharged on the fourth day. During this period, Asia’s aunt went to Kisasi to consult the “great” healer/diviner about the child's illness. The healer "found out" that one of Asia’s co-wives (Asia’s husband has two other wives) was responsible for the child's illness i.e. that she had charmed the boy. He said he would send away the evil, even without the child being brought to him. Aisa believes that it was her grandfathers 'distance healing' that finally cured Musa.

In her absence, Aisa’s business suffered terribly. Though she delegated it to a friend, the latter could not replenish the supplies when they were depleted. In fact, Aisa had to start all over, but with less money, as most of it had been spent at hospital.

<table>
<thead>
<tr>
<th>Treatment costs</th>
<th>Shs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jaja’s remedies</td>
<td>200</td>
</tr>
<tr>
<td>Treatment costs (drip, lab</td>
<td>7,000</td>
</tr>
<tr>
<td>injections and tablets)</td>
<td></td>
</tr>
<tr>
<td>Unofficial costs</td>
<td>3,000</td>
</tr>
<tr>
<td>Transport</td>
<td>800</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11,000 ( $ 11)</strong></td>
</tr>
</tbody>
</table>

Aisa paid most of this bill. At the time her husband had no money but provided emotional support and brought food to the hospital.
2nd illness episode: child

The youngest child, Sanyu, 14 months old, fell ill. Her symptoms included pale eyes and diarrhoea. With such symptoms, Aisa thought that her child had been charmed (evil eye) and consulted Jaja who prepared and administered a liquid concoction which included cow butter, salt and roots. The child continued drinking this concoction for three days. A tea cupful was administered three times a day. Aisa was strongly advised not to treat the child with pharmaceutical drugs during this time.

Jaja's remedies proved ineffective and Sanyu's condition continued to deteriorate. Aisa remained convinced that her child had been charmed and therefore visited her grandfather at Kisasi who provided amulets and fetishes to protect the child. In fact, he advised Aisa to get all her children to drink the medicine for protection. The grandfather assured Aisa that he would send away the evil and heal the child.

Aisa happily returned to Kamwokya, sure that Sanyu would be cured in a short time. However the symptoms persisted and the child even started choking and vomiting. Aisa wanted to go back to Kisasi or to try another healer, but her husband insisted that she take the child to Mulago. Aisa delegated her business and took Sanyu to old Mulago Hospital, Out Patient Department (OPD)wing.

Again the child was sent to the laboratory for stool and blood tests. Sanyu was found to be anaemic and malnourished and severely infected with various
kinds of intestinal worms. She was treated with de-worming tablets and recommended a special diet. The health workers wanted to admit her to the Mwana Mugimu (Nutrition clinic) but Aisa refused, saying that she would provide the special nutrition at home. She says that an admission at this time would have been disastrous for her business and family.

At home Aisa administered the de-worming tablets and tried her level best to improve the child's diet. She says that for a whole week the child was passing adult worms. After two weeks, when I checked on her, Sanyu was in good health and Aisa had resumed normally with her business.

<table>
<thead>
<tr>
<th>Treatment costs</th>
<th>Shs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jajas remedies</td>
<td>300</td>
</tr>
<tr>
<td>Grandfathers treatment</td>
<td>2,000</td>
</tr>
<tr>
<td>(amulets &amp; fetishes)</td>
<td>300</td>
</tr>
<tr>
<td>Mulago (transport)</td>
<td>1,500</td>
</tr>
<tr>
<td>Lab tests</td>
<td>2,000</td>
</tr>
<tr>
<td>De-worming drugs</td>
<td>1,000</td>
</tr>
<tr>
<td>Other drugs</td>
<td>7,100</td>
</tr>
<tr>
<td>Total</td>
<td>[7.10]</td>
</tr>
</tbody>
</table>

Both Aisa and her husband shared this bill. Aisa says that compared with Musa's illness (which included hospital admission), this illness did not affect her business as much, "I was wise to refuse the admission" she says.

(viii) Aisa's illness

Aisa complained of suffering from intermittent fever. She insisted that it was not serious since it did not interfere with her routine business activities and she declined to be interviewed about it. However, soon after Sanyu's illness, Aisa fell seriously ill and was admitted at New Mulago Hospital (Gyne & Obs.
Ward). She had been ill for the whole week, with pains in the lower abdominal region. The night she was admitted, the pains had suddenly intensified to the extent that she could not even sit up. Her husband decided to seek help from Mulago at that point.

Aisa was admitted to hospital in a critical situation and taken to the casualty word. Later she was transferred to the Gyne and Obstetrics ward where an ectopic pregnancy was diagnosed. Aisa successfully underwent the operation and spent three weeks in hospital. At the same time a traditional healer was consulted by her aunt, who provided various medicines which were surreptitiously administered during the hospitalisation period. She estimated the treatment costs of this illness to be shs. 100,000 ($100).

When I visited her at home, she was demoralised. Her husband had no job and her business had collapsed. Her entire savings had been spent on hospital bills and she even owed money to friends and relatives. Worse still, her stall at the market had been rented out to someone else. Asia’s children were in a pathetic condition; two of them had dropped out of school. She was looking for money to start up another business elsewhere to enable her at least to pay off her debts. She wondered what would happen if an illness struck again in her home. I was indeed moved by Asia’s situation and I lent her shs. 30,000 ($30) to enable her to start afresh.
Category B: Women heads of households

Case 5 Phina: Category B: Poor

I | Personal history

Born in 1963, Phina is currently 31 years old. She was born and grew up in Ntenga labour camp, in the Lugazi sugar plantations, Mukono district. Her parents are migrant workers from Southern Sudan who still live in Lugazi, though in another labour camp, Line Murefu. Phina's family was composed of seven children (3 girls and four boys), her parents and grandmother.

Phina was never enrolled in school, though facilities were available in the plantation. Since she was the eldest girl her mother required her to stay at home full-time to take care of the family while the parents were away, labouring in the plantation.

Phina left home in 1978 when she was 15 years old. Her parents sent her to Kampala to stay with an aunt who lived in what is now the Green Valley zone of Kamwokya. Phina's aunt was married to an Itesot man who was a brewer of 'ajon'. Phina's role was to help her aunt prepare and serve the beer. Initially she did not like this role because of her religion [Christian] but later came to accept and like it.

Phina got a partner in 1980 when she was seventeen years old. He was an older man of the same tribe, one of her aunt's regular customers. He was employed as a guard at the fire station in Kampala and often worked at night.
He lived in Kisenyi II zone in a small single room. Phina eloped with him but he paid the fine later, which to some extent formalised their relationship.

The only snag was that Phina could not conceive and produce a child. She tried all sorts of traditional medicines to no avail. It was only in 1986 when, as if by a miracle, she conceived and produced a baby boy. This, she said, was after drinking certain medicine provided by her grandmother at Lugazi. Since 1986, Phina has delivered a number of children. Her reproductive events can be summarised as follows;

<table>
<thead>
<tr>
<th>Year</th>
<th>Pregnancy</th>
<th>Outcome</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986</td>
<td>1st</td>
<td>live birth</td>
<td>still living</td>
</tr>
<tr>
<td>1988</td>
<td>2nd</td>
<td>&quot;</td>
<td>&quot;</td>
</tr>
<tr>
<td>1990</td>
<td>3rd</td>
<td>&quot;</td>
<td>&quot;</td>
</tr>
<tr>
<td>1992</td>
<td>4th</td>
<td>&quot;</td>
<td>&quot;</td>
</tr>
</tbody>
</table>

(ii) *Economic situation*

As soon as Phina settled in her new home, she asked for and received a loan from her husband to start an 'ajon' business. She was not only a good brewer but also attracted customers, ensuring that all the brew was sold. The inputs for the business, she says, didn't cost much. She only needed to buy the ingredient [millet], and some pans and pots. The customers provided their own drinking straws.

Phina says that life was fine; her husband was kind and considerate. They were making good money and planning to build a house of their own. In July 1992, when she was expecting her fourth child, her husband fell ill and died after a short illness. Though the medical report indicated that he died of
meningitis, Phina suspects foul play. Whatever the cause, his untimely
demise signalled a turning point in Phina's life. She not only had to fend for
herself and the children but also some extended family kin who were at the
time living with the family.

Phina says that she was lucky to have been established in business already.
She changed residence and resumed her *ajon* business with renewed vigour.
She did not shift far way from her former residence, for fear of losing her
customers.

Currently Phina's business is still surviving. She says it would be booming if
they were not relying entirely on it for survival. Everything including
children's school fees, daily subsistence, rent etc. is supported solely by her
business. Phina jealously safeguards her business saying that it keeps her
family not just buoyant but also independent. She earns a profit of between
5000 to 10,000($5-10) a month. She has no plans to remarry.

(iii) Household expenditure patterns

As a widow, with no partner, she covers all her household expenditures. These
include rent, food, clothing, school fees and health care.

(iv) Time use

Phina's business keeps her permanently busy as clients have to drink every
day. Thus, she usually stocks large quantities of millet, which she prepares
into brew, according to projected customer demand. Every day she starts early,
around 6.00 a.m, cleaning the pots, pans and the drinking shed. She also
ensures that there is sufficient water, charcoal and fermented millet flour to prepare the brew. Phina collaborates with two other women and they brew on alternate days. Phina brews thrice a week, and on the other days she gets the brew from her colleagues. Selling of the brew is done daily.

Phina's customers drink in groups [clubs] and always pay in cash. Unlike other businesses, says Phina, with *ajon* nobody can cheat you. Some groups even pay in advance. Usually, the last group disperses between 9.00 and 11 p.m when Phina closes up. The *ajon* business can be done concurrently with domestic chores like cooking, child care and cleaning. Phina has two girls (relatives) who assist with these chores and the business itself.

(v) General treatment seeking and worries about illness

Phina is aware that her business and therefore family survival depends on the good health of herself and children. She also believes that most children's illness can be controlled by good nutrition and a clean environment. Thus, in spite of prevalent financial constraints, she strives to ensure that her children feed well and live in clean conditions.

All the same, she says, the children do fall ill and "what I do in such instances depends on the nature and severity of the symptoms". She says that all her children have been immunised against complicated non clinical diseases like evil eye and false teeth. This was done by her grandmother at Lugazi. None of her children has suffered from these ailments and therefore it is only diseases like malaria, diarrhoea, vomiting and skin disorders which worry Phina. Whenever symptoms indicate such diseases, Phina reacts promptly by
taking the child to a nearby drug shop which is owned by her late husband's friend and kinsman. The premises, though advertised as a drug shop, are actually a clinic, attending only to clients closely acquainted with the owner. The owner is a retired medical assistant. He is not only related to Phina's late husband but also a regular and special customer of Phina's business.

Whenever Phina visits the clinic, the children are treated on credit if she has no money. Furthermore, she gets advice [medical] from the doctor who knows her burden and is always sympathetic. The doctor's wife provides Phina with emotional support. If the illness cannot be handled at the clinic the doctor advises her to visit Mulago hospital. He sends or "connects" her to his friends there. This ensures that Phina is promptly attended to.

Concerning her own illness, Phina insists that she never falls seriously ill since she drank protective medicine prepared by her grandmother when young. Her only malady is back pains which she attributes to postures like too much bending when preparing the ajon. When the back pains become unbearable, she visits the drug shop where she is usually given white capsules to buy. When worried about persistent non-specific illness symptoms, she consults both her mother and grandmother at Lugazi.

(vi) Specific illness episodes: child

The child who was last ill is Paula, the two-year-old girl. Phina says that the child's symptoms included rapid breathing, high body temperature, loss of appetite and restlessness. This was around 10.00 a.m. in the morning. Phina reacted promptly by temporarily suspending her brewing activities and taking
the child to the clinic where she was attended to by a nurse. The doctor was not around.

The nurse diagnosed malaria fever, and dispensed chloroquine and aspirin tablets. Phina estimated the time spent at the drug shop to be around 20 minutes. At home she tried unsuccessfully to administer the bitter tablets to the child. Each effort resulted in vomiting. She eventually gave up and decided to wait for evening time to return to the clinic since the doctor would then be in attendance. However she was compelled to return to the clinic earlier since Paula's condition had worsened. Fortunately the doctor was there and attended to the child promptly.

Pneumonia and malaria were diagnosed and the child put on a course of injections. The doctor advised that Paula be taken to Mulago hospital if there was no improvement by the following day. During the night Paula's illness became acute and Phina, with the assistance of the doctor friend, rushed the child to Mulago hospital where she was admitted to the acute care unit and later taken to the paediatric ward. After three days of treatment, which comprised mostly injections, Paula improved and was discharged on the fourth day.

<table>
<thead>
<tr>
<th>Treatment costs</th>
<th>Shs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug shop</td>
<td>1500</td>
</tr>
<tr>
<td>Mulago hospital</td>
<td></td>
</tr>
<tr>
<td>Transport</td>
<td>2500</td>
</tr>
<tr>
<td>Treatment</td>
<td>6000</td>
</tr>
<tr>
<td>Other charges</td>
<td>2500</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12500</strong> [$$12.5$$]</td>
</tr>
</tbody>
</table>
Phina borrowed money from a friend and cleared the bills. The charges at the clinic were on credit. During the four days she was away she gave instructions to her assistants[girls] to brew the ajon and keep the business going. But all the same, without her presence in person, the business greatly suffered and almost came to a halt.

(vii)2nd illness episode: child

Paula was again ill, suffering this time from a boil in the neck region and in much pain. At that time, Phina's mother had visited and insisted on applying some local medicine [crushed leaves] on the abscess to make it 'ripen' faster. Phina, however, insisted on taking the child to the drug shop/clinic where she was put on a course of injections. After seven days the boil got ripe and required surgical therapy. The doctor advised Phina to take the child to Mulago hospital where it was dealt with. Phina was advised to change the dressings frequently, which she did at the drug shop/clinic. Treatment with capsules continued for another week until the child's incision wound healed.

On the doctor's advice, Phina refused to allow her mother to apply the traditional medicine to the wound.

<table>
<thead>
<tr>
<th>Treatment costs</th>
<th>Shs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug shop/clinic</td>
<td>4000</td>
</tr>
<tr>
<td>Mulago hospital</td>
<td>3000</td>
</tr>
<tr>
<td>Drug shop</td>
<td>2000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9000 [# 9]</strong></td>
</tr>
</tbody>
</table>

Phina paid the Mulago bills in cash and promised to pay up at the clinic/drug shop later. This time, her business was not much affected since no hospital admission was involved.
(viii) Phina's illness

Phina categorically denied ever having fallen seriously ill throughout the research period. Backache was the only symptom she experienced.

Case 6 Jemima; Category B : Rich

i] Personal history

Jemima was born in March 1958 in Toro district. She is now aged thirty six. Jemima says that her parents were fairly well-off by village standards. She grew up in a decent home, together with her five brothers. Her father was a primary school teacher and her mother a housewife.

Jemima was enrolled in school in 1964 when she was six years old. She says that she was a bright pupil and managed to attain advanced level education in 1978. When she failed to qualify for the University her parents enrolled her in a commercial college in Kampala to study business. After two years in the business college she graduated with a Diploma and soon after got a job with a clearing and forwarding firm in 1980.

Jemima got a serious partner in 1980 after completing her studies. He was a colleague at her place of work and a tribe-mate. He was also ten years older than her. Jemima says that their relationship would have lasted longer if he had not became frustrated at the work place and resorted to alcohol. He never introduced himself to her parents and therefore was not considered a legal partner. Their relationship, however, lasted five years, up to 1985, when he
deserted her. Since then, Jemima has had no contact with him and suspects that he could even have died. Even at the place of work from where he absconded, nobody has ever traced his whereabouts. Jemima notes that, while their affair lasted, they produced three children, all girls.

In 1992 after waiting for him for so long and in vain, Jemima got another partner, became pregnant and produced another child. But this partner denied responsibility for her pregnancy. “Once again”, Jemima says, “I was left in the cold”. The problem, she says, is that this partner was already married and was intimidated by his wife. Jemima’s reproductive events can be summarised as follows:-

1983 2nd " " "
1985 3rd " " "
1992 4th " " "

The last born, also a girl, was almost two years old at the time of the first interview.

(ii) Economic situation

With the coming of the fourth child, Jemima says that she could no longer survive on what she was earning at her job. She also had to plan for the older children. Therefore she decided to go into business where she could expect greater income. With savings accumulated over the years, she rented a premise in ‘katimba’ near the Buganda Bus Park down town and started a business dealing in wax prints and fabrics for dresses. She had to give up her paid employment as this business took all her time.
The business, says Jemima is not easy, as one must have a lot of contacts who include people with import licences and reliable customers. She cannot yet afford an import licence and uses that of a friend to whom she pays a commission. Her friend, a long established business lady, imports all sorts of fabrics from Dubai, Zaire, W. Africa and Kenya. Jemima longs for the day she will get her own import licence.

After almost two years in business, Jemima says that it has picked up, in spite of the difficult beginning. She is definitely earning more compared with her previous paid employment and is saving to build her own house in Kampala. She earns more than Shs 100,000 a month. Currently she lives with her four children, a sister and a house girl in a rented house in Contafrica zone Kamwokya.

(iii) Household expenditure patterns

As a single mother she covers all the household expenditures alone. These include rent, school fees and other requirements, food, health care and clothing. She also supports her sister who resides with her.

(iv) Time use

Jemima emphasises that her business is taxing in terms of time. She is grateful to have an efficient maid and helpful sister. Otherwise she would not cope with managing her family and business concurrently, even though all the children, except the last born, attend school.
Jemima wakes up early at around 6.00 a.m., attends to household chores, gets the children ready for school and leaves for her business premises at 8.00 am. For the first hour she unpacks and displays her merchandise at the stall. This is an elaborate activity since large quantities of cloth have to be arranged and displayed in a limited space.

Real business starts at 9.00 a.m. through to 6.00 a.m. in the evening. Jemima does not return home for lunch but depends on snacks which are sold around the 'Katimba'. After 6.00 p.m. she collects and packs her unsold wares in a large trunk which she entrusts to a friend living nearby for safe keeping at night. This is the friend whose import licence Jemima uses to procure merchandise. Jemima usually leaves town at 7.30 p.m. and returns directly home.

(v) General treatment seeking and worries about illnesses

Jemima has one child under five, Sheila. She says that it is Sheila who disturbs her most with health problems for she has sickle cell anaemia and is prone to all sorts of ailments. Apart from her landlord and business colleagues, Jemima says that she is not closely acquainted with many people and therefore has more or less nobody to consult during illness episodes in her family.

When a child falls ill, Jemima always seeks treatment from a paediatric clinic (St Catherines) in the City centre which is managed by a professional female paediatrician. She does not believe that any practitioners within Kamwokya or neighbouring environs can handle serious illness, especially not Sheila's
condition. Over the years, she has become closely acquainted with the doctor and her child can be treated on credit if necessary. Occasionally Jemima gives beautiful 'bitenge' materials to the doctor as gifts. This clinic is quite expensive and is mostly patronised by the well-to-do.

The doctor usually refers complicated cases, e.g. surgical therapies, to Mulago hospital where she continues to attend to her patients. Sheila has been referred to Mulago several times. In the case of Jemima's own illness, which she says is not common, she consults the same doctor, usually after self treatment proves ineffective.

Asked about traditional healers/diviners, Jemima says that she feels they are not capable of handling children's illnesses because, in most cases, the symptoms are clinical. However, for adult illness, she believes that traditional healers/diviners remedies can be effective, especially on a preventive basis. Almost all her colleagues in the 'Katimba' are protected, she says. She declined to reveal whether she is also 'protected'.

(vi) Specific illness episodes: child.

The two year old child, Sheila, fell ill. Her symptoms included laboured breathing, high temperature and cough. This time the symptoms started at night when St Catherine's clinic had closed. Faced with such a situation she took Sheila to a family doctor's clinic in Kamwokya I which opens up to midnight. Fever and pneumonia were diagnosed and treatment, which included an injection and tablets, provided. Jemima spent roughly an hour at the clinic. She was asked to take the child back the following day but never
did, preferring the St. Catherines clinic downtown, where treatment was completed after three days. Sheila recovered after treatment. At St Catherines clinic she spent less than an hour per visit.

<table>
<thead>
<tr>
<th>Treatment costs</th>
<th>Shs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Doctors clinic</td>
<td></td>
</tr>
<tr>
<td>Consultation</td>
<td>2000</td>
</tr>
<tr>
<td>Injection</td>
<td>1000</td>
</tr>
<tr>
<td>Tablets</td>
<td>1000</td>
</tr>
<tr>
<td><strong>Sub Total</strong></td>
<td>4000</td>
</tr>
<tr>
<td>St Catherine's</td>
<td></td>
</tr>
<tr>
<td>Consultation</td>
<td>2000</td>
</tr>
<tr>
<td>Injections</td>
<td>2600</td>
</tr>
<tr>
<td>Tablets</td>
<td>1000</td>
</tr>
<tr>
<td><strong>Sub Total</strong></td>
<td>5600</td>
</tr>
<tr>
<td><strong>Grand total</strong></td>
<td>9600 [9.6]</td>
</tr>
</tbody>
</table>

Jemima paid both bills in cash.

(vii) 2nd Illness episode: child

Sheila became critically ill and was admitted at Mulago hospital on the advice of Jemima's friend, the doctor at St Catherines. The symptoms, Jemima says, started at around noon when she was in town attending to her business. Her sister came for her when Sheila's temperature went up and there were signs of convulsing.

Jemima hurriedly delegated her stall to a friend and went home to find Sheila with a very high temperature. She rushed her to St. Catherine's clinic where the doctor immediately referred her to Mulago hospital and even offered transport. At Mulago, Sheila was admitted to the Acute Care Unit by which
time she had lost consciousness and was put on various machines. Jemima did not expect the child to regain consciousness but eventually she did. Cerebral Malaria was diagnosed and the child was admitted for two weeks into the paediatric ward.

Sheila's treatment was intense and a lot of bills were incurred during the fortnight of hospitalisation. During this time, Jemima stayed by the child's bed most of the time and her business, although delegated to someone, suffered a great deal. Nobody would attend to her special customers, for instance, and she feared she would lose them.

<table>
<thead>
<tr>
<th>Treatment costs</th>
<th>Shs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transport to St Catherine's</td>
<td>2,000</td>
</tr>
<tr>
<td>Mulago to home</td>
<td>2,000</td>
</tr>
<tr>
<td>Treatment costs</td>
<td>24,000</td>
</tr>
<tr>
<td>Unofficial expenses</td>
<td>7,000</td>
</tr>
</tbody>
</table>

\[
\text{45,000 \ [\$45]}
\]

Jemima paid the bill from her savings in the bank.

(iv) Jemima's illness

Jemima fell ill soon after Sheila's last illness. She attributes the ailment to the unusual hospital environment and exposure during the time spent nursing Sheila. Her symptoms included headaches, fever, body pains, fatigue and dizziness. She took some pain killers (Panadol) with no improvement. The following day she visited St Catherines clinic in town where she spent about 40 minutes. Malaria was diagnosed and treatment (one injection and tablets) given. A two day bed rest was recommended but Jemima ignored it. She had
to attend to her business after one week's absence. Eventually she recovered any way.

<table>
<thead>
<tr>
<th>Treatment costs</th>
<th>Shs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transport to St. Catherines</td>
<td>300</td>
</tr>
<tr>
<td>Consultations</td>
<td>2,000</td>
</tr>
<tr>
<td>Treatment</td>
<td>2,500</td>
</tr>
<tr>
<td><strong>----------</strong></td>
<td><strong>4,800 [$4.8]</strong></td>
</tr>
</tbody>
</table>

This treatment was on credit, with Jemima promising to pay up in the near future.

**Case 7 Sophia Category B: Very Poor**

(i) **Personal history**

Sophia is a widow. She was born in 1954 in Kisoro near the Uganda-Zaire boarder. Her parents were both Bafumbira of Rwandese origin who migrated to Uganda Kisoro, in the late 1940s, before she was born. Her mother was a cultivator and father, as well as being a cultivator, would indulge in "cross-border trade" (i.e. smuggling basic consumer items in small quantities either to Zaire or Rwanda). Sophia was the last born in a family of eight children and, according to her, this automatically made her a favourite of her then ageing parents.

Sophia was never enrolled in school and she is not sure of the exact reason why. However, she speculates that this was due to a number of factors, probably the most prominent of which was her sex. None of her sisters ever went to school while all her brothers did, although they never got far. When
14 years old she was married off to an old Mukiga man and moved to a village near Kabale town where her husband had his home.

Within her new homestead she says there were four other huts [homes] belonging to her co-wives. Sophia says that though life was extremely hard she got used to it and in the end was happy 'in a way'. The major problem, she recalls, was that she failed to conceive and produce a child.

After five years of marriage in 1973, she got desperate and started feeling terribly insecure. She recalls that her husband, co-wives and in-laws all begun to ridicule her, calling her a witch. The co-wives, in particular, were worried that she would bewitch their children. Three years later, in 1976, the situation became unendurable. She was frequently abused and battered by her husband and when her parents refused to accept her back [they could not afford to refund the bride wealth], she decided to run away to Kampala. Luckily, she says, one of her sisters was married and living in Kamwokya at the time.

Thus, in 1977, the year of centenary as she refers to it, she arrived in Kamwokya with only a few personal effects. She was twenty three years old then and, according to her, still very attractive since she had not been 'spoilt' by child bearing. For the first two months, she lived with her sister's family who had a small house in what is now Kifumbira II zone of Kamwokya II ward.
In early 1978, Sophia got her first serious partner in Kampala, a soldier with the then Ugandan Army. He wanted her to move to the barracks at Lubiri to cohabit with him but she declined since there was already a co-wife there.

However, the soldier rented her a bigger place, still in Kifumbira II with a bedroom, sitting room and a store. This is the place where Sophia lives to date. It is a medium-sized, semi permanent house, better looking than the surrounding structures. Sophia and the soldier were married officially. In 1978 she managed to conceive and produce a child. She says that when she explained her problem of infertility, her husband took her to a doctor who treated her with tablets and "washing the womb". Sofia’s reproductive history can be summarised as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1978</td>
<td>1st pregnancy, still living</td>
</tr>
<tr>
<td>1981</td>
<td>2nd miscarriage</td>
</tr>
<tr>
<td>1983</td>
<td>3rd still living</td>
</tr>
<tr>
<td>1985</td>
<td>4th</td>
</tr>
<tr>
<td>1987</td>
<td>5th stillbirth</td>
</tr>
<tr>
<td>1990</td>
<td>6th still living</td>
</tr>
<tr>
<td>1993</td>
<td>7th</td>
</tr>
</tbody>
</table>

In summary, in a period of 14 years, Sophia had seven pregnancies of which one ended as a miscarriage and another as a stillbirth. Right now she has five children, two of them under five.

(ii) Economic situation

After living with her sister for three months, Sophia borrowed Shs 5000 ($5) from her sister and rented a room, "muzigo". She also started local gin "waragi" selling business. She recalls with a smile that her business boomed then because she was young and beautiful and therefore not short of...
customers, many of whom were less interested in her business than in seducing her. Her only problem she says, was that she was often cheated as she did not know how to count, add or subtract figures.

When she got married, her husband the soldier also supplemented her business by bringing in "bitanda" beer\(^\text{13}\). At that time it was a lucrative business as bottled beer was scarce and expensive. Unfortunately, this second husband fell ill and died in 1992.

Sophia says that when her husband died, he did not leave her with either much property or money, as he was no longer in the army and was only doing casual jobs. The little money that was available was spent on his hospital bills. Currently Sophia has indeed fallen on hard times. She says that, burdened with caring for five children, the past three years of widowhood have not been easy. She laments that she is utterly alone, as all her in-laws and own relatives have deserted her. She still runs her business which earns her a profit of between Shs 500 to 1000($0.5-1) a day.

(iii) Household expenditure patterns

Like the other female heads of households, Sophia meets all her household requirements which include food, rent, clothing, school fees, health care.

(iv) Time use

Sophia's business has no opening or closing hours. Whenever a customer needs a drink he/she has to be served, often late at night or early in the
morning. Therefore, she tries to be at home most of the time. She rarely delegates her business.

(v) General treatment seeking and worries about illness

Sophia strongly believes that diseases or other misfortunes do not simply happen but must have a cause. Therefore, whenever her children fall ill, especially her two under-fives, the first person she consults is a woman neighbour who, though not formally practising, is a traditional healer. She says that as well as ‘diagnosing’ the illness, the healer also provides herbal cures, emotional support and advice on where to seek further care if necessary. Sophia says that her late husband did not approve of the woman and would always insist on taking the children to hospital whenever they fell ill.

If the healer's therapies and advice prove ineffective Sophia consults her sister's friend Maggie, who works at Mulago hospital as a nursing Aide.

If the child’s illness symptoms persist, Sophia does two things concurrently. She takes it to Mulago hospital and, at the same time, sends her sister to a traditional healer at Kyengera (on Masaka Road) for consultation. Sophia believes that she and her children are haunted by her first husband's ghost because the bride-wealth he exchanged on her behalf was not refunded when she deserted him. The traditional healer always sends her herbs for drinking or bathing and other medicines which are used concurrently with the drugs.
from the hospital. He also provides amulets and fetishes. Sophia says all her children have and often wear the fetishes "for protection".

In case of her own illness, Sophia rarely goes to hospital or clinics. She normally treats herself, using either over-the-counter drugs or herbal medicines provided by a traditional healer or prepared by herself.

(vi) Specific illness episodes: child

The youngest child, one and a half year old Joseph, was sick. He was suffering from boils all over his body. At the same time he had a high temperature and painful swollen lymph nodes. Sophia says that the symptoms started as skin rash which she treated with a herbal bath. The herbs were provided by the neighbour woman healer. This therapy lasted two days with no significant improvement.

Sophia then consulted her Nursing Aide friend who provided some tablets. At the same time however, Sophia continued administering the herbal baths. By this time the boy was in great pain. The tablets provided by the friend were so nauseating that the child could not take them. After several fruitless efforts to force the child to take the medicine Sophia gave up and decided to take him to hospital. On her request, he was treated and discharged on the same day. She was advised to bring the child to hospital for four consecutive days for treatment until he got better. She says she did not take him for the last injection and examination since she felt he was better. During this period she continued to administer the herbal therapy.
All through the illness her business did not suffer greatly because she was 
around the home. That was why she refused to have the child admitted, as 
there would be no one to take charge of the business and the children.

<table>
<thead>
<tr>
<th>Treatment costs</th>
<th>Shs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transport</td>
<td>1000</td>
</tr>
<tr>
<td>Treatment costs[informal ]</td>
<td>2000</td>
</tr>
<tr>
<td>Ointment</td>
<td>500</td>
</tr>
<tr>
<td>Drugs from nurse</td>
<td>300</td>
</tr>
</tbody>
</table>

Total 3800 [\$3.8]

Sophia borrowed money and paid cash.

(vii)2nd illness episode: child

The same child, Joseph, fell ill again. The symptoms included loss of
appetite, diarrhoea and high body temperature. This time the child's condition
was so serious that she did not contact her healer friend but hurried to
Mulago hospital where Joseph was admitted, put on a drip and treated with
other medicines. He improved steadily and was discharged after three days,
again at Sophia's request." I was terribly worried about home and more so my
business. If I spent many days at the hospital all the money would be used up
and there would be none for business".

After a few days at home, however, there was a recurrence of similar
symptoms. This time, Sophia consulted the neighbour who checked the child's
mouth and gums and diagnosed "false teeth" which she said were also the
cause of the diarrhoea and fever. She advised immediate extraction of the
false teeth and directed Sophia to take the child to a woman healer in
Kyebando who specialised in the treatment.
Sophia did as advised and took the child to Kyebando. She says that at the false teeth extractor's premises she met six other women with young children having similar problems. The extractor was an Alur woman and on learning that Sophia was a widow of an Alur man, treated her well.

Sophia does not want to think about or remember the therapy of extracting the false teeth. She says that after extraction of the false teeth she went to her 'musawo' friend who injected the child. The child was cured but has gaps in the gums where the tissue was removed. Total treatment time was estimated to be three hours.

<table>
<thead>
<tr>
<th>Treatment costs</th>
<th>Shs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mulago [treatment]</td>
<td>3000</td>
</tr>
<tr>
<td>Take home drugs</td>
<td>2000</td>
</tr>
<tr>
<td>Transport</td>
<td>500</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5500</strong> [$ 5.5]</td>
</tr>
</tbody>
</table>

**False teeth extraction costs**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Transport</td>
<td>600</td>
</tr>
<tr>
<td>'Surgery' fee</td>
<td>3000</td>
</tr>
<tr>
<td>Injection</td>
<td>500</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4100</strong> [$ 4.1]</td>
</tr>
</tbody>
</table>

**Grand total** 9600 [\$ 9.6]

(viii) Sophia's illness

Although Sophia routinely complained of general body pains, fatigue and headache throughout the course of the interviews, she never wanted to admit being ill. She, however, reported one time developing lower abdominal pains and a smelly vaginal discharge. Initially, for this condition, she used herbs provided by her herbalist neighbour but these did not improve the situation. Consequently, the traditional healer at Kyengera on Masaka road was
consulted. He told Sophia that an evil spirit of her first husband was the cause of her problem, and that it wanted to ensure that she never remarried. He further told her that, unless her family refunded the bride-wealth exchanged on her behalf, her problem would become chronic.

Sophia was treated with traditional medicine orally and also asked to offer a sacrifice of a white cock to appease the malevolent spirit. She says that, though she took the medicine and offered the sacrifice, her condition did not improve and she feared that her waragi customers would sense the offensive odour and desert her.

Finally, on the advice of her friend, Sophia visited Mulago hospital where she was attended by a female doctor who told her that she had boils and other growths on the uterus which could be cured by a surgical operation. Two weeks later she underwent that operation and remained in hospital for two weeks.

<table>
<thead>
<tr>
<th>Treatment costs</th>
<th>Shs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine from herbalists</td>
<td>3000</td>
</tr>
<tr>
<td>Medicine and sacrifice at diviner</td>
<td>5000</td>
</tr>
<tr>
<td>Mulago treatment</td>
<td>2000</td>
</tr>
<tr>
<td>Operation</td>
<td>10000</td>
</tr>
<tr>
<td>Drugs</td>
<td>3000</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23,000 $23</strong></td>
</tr>
</tbody>
</table>

Sophia says that this single illness episode depleted her money. She had to borrow money to start her business afresh.
Category C: Married women, working but with unemployed partner

Case 8 Resty: Category C: Poor

(I) Personal history

Resty is a young 22 year old Muganda woman. She was born in Kisenyi I zone of Kamwokya and grew up as an orphan. Her mother died when she was an infant and her father was too poor to take care of her. She was therefore fostered by her maternal aunt who at the time lived in Ndeeba, Kampala and operated a business selling pineapple juice to passers by at the Queen's clock tower, along the Kampala Entebbe road. Resty used to do the household chores and care for the children when her aunt was away operating the business.

When Resty was around 12 years her father, who was then employed with the Uganda Police Force, demanded her back, saying he was going to enrol her in school. Her aunt agreed and Resty went to live with her father, still in Kisenyi I zone Kamwokya. She bitterly recalls that, contrary to his promises, her father never enrolled her in school. She wonders why, since he appeared to have the financial means.

Resty, at the time, took care of her young step brothers and sisters, as her step mother was away most of the day time operating a stall in Owino market in the city. She also started making handicrafts (especially mats, baskets and table linen) for sale so as to support herself and to contribute to household upkeep, especially when there was shortfalls in food supply.
When Resty was 15 years old she got a partner who lived not far from their residence. He is also a Muganda and at the time had no steady job, though he later got temporary employment as a truck driver. Resty's father did not object when she moved away from home to cohabit with this man. She feels that her departure was see as a good riddance, since she never got on well with her father's wife. To date, her father has not even demanded any bride-wealth from Resty's partner.

In 1989 when sixteen years old Resty became pregnant and delivered her first child. Resty has two children out of four pregnancies. Her reproductive history may be summarised as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Pregnancy</th>
<th>Outcome</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1988</td>
<td>1st preg.</td>
<td>live birth</td>
<td>still living</td>
</tr>
<tr>
<td>1989</td>
<td>2nd</td>
<td>miscarriage</td>
<td></td>
</tr>
<tr>
<td>1991</td>
<td>3rd</td>
<td>live birth</td>
<td>dead</td>
</tr>
<tr>
<td>1993</td>
<td>4th</td>
<td>&quot;</td>
<td>still living</td>
</tr>
</tbody>
</table>

(ii) Economic situation

When Resty had her first child, her husband lost his job. Their situation became so desperate that Resty was compelled to look for work, though in vain, soon after delivery. They hardly had anything to eat and her breast milk was not sufficient for the baby. She tried making handicrafts for sale but sluggish consumer demand for the products compelled her to abandon the business. Resty borrowed Shs 10000 [$10] from her aunt in Ndeeba and started a business selling fresh vegetables and basic consumer items in small quantities from her veranda. Her husband helped her construct a makeshift stall from which she could display her merchandise. Resty says that though
her stock did not amount to much, the business kept the family going in terms of food and rent. Unfortunately, a year later in 1990, Resty's stall was destroyed and her meagre stock confiscated by city council authorities as she was unlicensed. At the time all her money was invested in the stock and she lost everything.

Subsequently, Resty had no means of raising start up capital to initiate another business. She bitterly recalls that even her husband, who was then employed as a driver of a special hire taxi, deliberately refused to give or lend her money. As a last resort, therefore, she joined a women's self help group "Munno mukabbi" where they would make a large variety of handicrafts for sale. In spite of their hard work and enthusiasm, low consumer demand and lack of organised market outlets for their products soon compelled them to wind up their business and the group sadly disbanded.

Resty's husband again lost his job and gave the rest of his money to her to start up a business again. She started making and selling local pastries (sumbusa, chapati and pancakes) but this business proved unprofitable and she soon abandoned it. Resilient as ever, however, Resty started another business selling cow hooves "mulokonyi". Resty's customers are evening drinkers at a nearby open air pub. It is a hard business she says, but then observes that she has no other options.

(iii) Household expenditure patterns

Resty's family expenditures on household requirements vary with who ever has money at a given time. Her husband's jobs are temporary and very often
he is unemployed. Unlike the other women, Resty shares her earnings with her husband and they usually discuss family priorities. However, the husband does not discuss his earnings with Resty unless he is about to run out of money. Then he offers it to Resty to manage the budget. When Resty's husband is employed, he buys food and other basic necessities and is always seen in the evening carrying something for his family. Whenever his out of job the family depends on Resty's meagre earnings. Rent is always paid in arrears and keeping the little boy in school is also difficult. Meeting health care bills is also a problem.

(iv) Time use

In terms of time, Resty says her business is quite taxing. She wakes up very early in the morning between 5.00 and 6.00 a.m. and walks over 8 kms to the central abattoir in Industrial Area to buy the fresh cow hooves. She arrives by 7.30 a.m., purchases the hooves and then walks back to Kamwokya with her often heavy load. Resty cannot afford public means of transport and therefore has to walk the round trip of about 16 k.m every morning to buy the hooves. She normally arrives back home before 10.00 a.m.

Preparation of the hooves and cooking takes the whole day. Cooking has to be continuous for over six hours if the *mulokonyi* is to be tender and palatable. Thus, Resty usually gets through with the preparation just before 6.00 p.m. after which she takes the stuff to a popular drinking place near her home. Business proper starts from 6.30 p.m. and on some good days (weekends) she sells everything by 9.00 p.m. During weekdays there are fewer customers.
and usually she gets home late (between 10-11.00 p.m.) having waited, often in vain, to sell off everything.

(v) General treatment seeking and worries about illness

When Resty's child falls ill, she initially consults her partner to inform him and ask for treatment money. She feels it is his obligation to provide such money, irrespective of his employment status. Her next step depends on the seriousness of the symptoms and usually involves either watching over the child or administering tablets purchased from a neighbouring drug shop.

When the illness symptoms persist, and funds are available, she takes the child to Kisenyi Valley clinic, near her home where she/he is attended to by a professional doctor or nurse, depending on the time she goes there. She was introduced to this clinic by a neighbour's wife who is of the same ethnic group [basoga] as the owner of the clinic. The neighbour is her friend and since the introduction, Resty has been treated well, sometimes on credit.

When she fails to raise treatment funds, she takes the child to a clinic in the Market Area zone which is owned by an elderly doctor who is a close friend of her husband, and often treats the child on credit. Resty says that, of late, she has lost confidence in the nurses at Kisenyi Valley clinic because often they have prescribed and administered drugs which have later been rejected by the doctor as being the wrong prescriptions. Interestingly, despite such feelings, she continues to visit the clinic. This, she emphasises, is only due to its close proximity, and thus convenience, especially in case of emergencies.
When the child does not improve after treatment at these clinics, Resty visits Mulago hospital, usually the Acute Care Unit where children are treated as a matter of urgency, regardless of financial considerations. This means that she has to wait for the symptoms to become acute so as to warrant treatment at the acute care unit. Resty says if one visits Mulago before symptoms are serious, no proper treatment is given and most of the time one gets prescriptions after waiting in the queue for over one or even two hours. Rather than going there, other options are tried and it is only when they fail, or in absence of funds for treatment in clinics, that she goes to Mulago Out Patients Department.

Resty says that before visiting Mulago hospital, depending on the child's illness symptoms, she often consults either her aunt in Ndeeba or her sister-in-law who lives in Green Valley Zone for advice as to whether extra medical attention is required or not. On a few occasions, Resty has consulted another aunt who lives in Mityana town, over fifty miles away, on such issues. She noted that since losing her child she is always keen on consulting traditional healers early. She believes that it was delay which resulted in one of her children dying in 1993.

Regarding own illness, Resty normally informs her partner and then treats herself with tablets she has available at home or purchases from drug shops. The next step, if the illness persists, is determined by the nature of the symptoms. If they are obviously clinical, like fever or stomach pains, then she visits a friend believed to be a nurse in a neighbouring zone (Contafrica) who
operates from her home. This friend treats Resty on credit and usually with injections.

If, on the other hand, the symptoms are non-specific, like dizziness, restlessness, lack of sleep or bad dreams (nightmares), Resty consults a number of people who include her aunt in Ndeeba, a sister in Nsambya or a friend (a Munyakole woman called Mama Joy). Mama Joy is a neighbour and family friend. She is reputed to have vast knowledge of herbal remedies and often procures some for Resty.

Lastly, if there is no improvement, Resty visits her aunt in Mityana who takes her to a diviner/healer. She is then given medicine either for protection or healing. Such medicine is either buried in a strategic position in the house or can be taken orally. At times it is introduced into the body by means of deep skin cuts. Resty has several scars of such cuts.

(vi) Specific illness episodes: child

The youngest child, 12 month old Janet, fell ill. She had a high body temperature, and could not breast feed. With such symptoms, Resty diagnosed malaria and she administered anti malarial drugs (aspirin and maxaquine tablets) from a drug shop. Then she applied a moist sponge to lower the temperature. This was at the time Resty was operating the hooves business. She left the child with the father and hurried off to buy the hooves. Thereafter she continued to watch over the child while operating the
business. Unfortunately, the child's condition worsened and Resty could not sell her hooves that evening.

The following day the child's condition had not improved, Resty was just watching over her since she didn't have money to visit either a clinic or hospital. Her husband had gone to look for funds to have the child treated. I accompanied Resty to Kisenyi Valley clinic where the child was treated at my expense. The time spent at the clinic was between 20 and 30 minutes and by the following day Janet had greatly improved.

Treatment costs were as follows: Shs
Tablets 200
Consultation 500
2 injections 2000
Tablets 1000

Total 37000 [$3.7]

(vii) 2nd illness episode: child

The same child, Janet, fell ill again. The symptoms included loose stools and loss of appetite. With such symptoms Resty diagnosed diarrhoea and proceeded to treat her with anti diarrhoea mixture which she had in the house. The child, however, did not respond to this treatment. The following day, Resty then took her to Kisenyi Valley Clinic where she was attended to by a nurse. Acute diarrhoea was diagnosed and four sachets of ORS, panadol and other tablets which Resty does not know were provided, to be administered at home.

Resty says that in spite of doing all this the child's condition did not improve. The diarrhoea continued unabated; "The child was passing just water," she
says. Next, with the child almost unconscious, Resty rushed her to Mulago hospital to the Acute Care Unit where diarrhoea and dehydration were diagnosed. Resty says the child was immediately put on a drip and also given some liquid medicine. Resty was harshly scolded for the delay in bringing the child to hospital. The child was admitted to the paediatric ward for three days, after which she steadily improved. On the fourth day she was discharged. Resty was instructed to continue treatment at home with the medicines provided.

<table>
<thead>
<tr>
<th>Treatment costs</th>
<th>Shs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kisenyi valley</td>
<td></td>
</tr>
<tr>
<td>ORS 4 sachet</td>
<td>400</td>
</tr>
<tr>
<td>Tablets</td>
<td>700</td>
</tr>
<tr>
<td>Mulago</td>
<td></td>
</tr>
<tr>
<td>Medicine</td>
<td>1000</td>
</tr>
<tr>
<td>Unofficial costs</td>
<td>1000</td>
</tr>
<tr>
<td>Transport</td>
<td>600</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3700</td>
</tr>
<tr>
<td><strong>($ 3.7)</strong></td>
<td></td>
</tr>
</tbody>
</table>

(viii) 3rd illness episode: child

The same child, Janet, fell ill again. Initially the symptoms included a high body temperature, coughing and laboured breathing. With such symptoms, Resty immediately diagnosed fever and cough and proceeded to treat the child with anti-malarial drugs. Resty asked the child's father to provide some money for treatment since she did not have any as her business was not doing well. The drugs were purchased from a nearby drug shop.
The child did not respond to this treatment and, worse still, Resty did not have enough money to take her to the clinic. Her husband had promised to get some but had not yet returned. She had used up her last 600 Shs(.$6) to buy the above drugs. All attempts to borrow money or even to have the child treated on credit were in vain. She already had a lot of debts at the clinic and neighbours, knowing her business was not doing well, would not risk lending her money. She continued doing her work while watching over the child. When her condition deteriorated so much she desperately sought help from the clinic where, on humanitarian grounds, they treated the child with an injection and advised Resty to take her to Mulago. Immediately, Resty then took the child to the Acute Care Unit at Mulago where acute pneumonia and malaria were diagnosed and the child was put on a course of injections. At the same time Resty sent for some traditional medicine to supplement the treatment. This medicine was administered surreptitiously, early in the morning before the nurses came and late in the night when everyone was asleep. After a week in hospital the child was discharged.

Treatment costs were as follows

<table>
<thead>
<tr>
<th></th>
<th>Shs</th>
</tr>
</thead>
<tbody>
<tr>
<td>At drug shop</td>
<td></td>
</tr>
<tr>
<td>Chloroquine tablets</td>
<td>200</td>
</tr>
<tr>
<td>Vicks vaporub</td>
<td>500</td>
</tr>
<tr>
<td>Injection at the clinic [free]</td>
<td></td>
</tr>
<tr>
<td>At Mulago</td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td>3000</td>
</tr>
<tr>
<td>Treatment (unofficial)</td>
<td>1000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4700 [$4.7]</td>
</tr>
</tbody>
</table>

Resty's husband borrowed money and cleared the bill at Mulago.
Resty laments that the child's illness has disturbed her a lot and has cost a lot of money. Her business has been adversely affected by it. She notes that the problem is that her businesses cannot be delegated and, as a result, is adversely affected during illness episodes which means loss of income for the family. As a result of this particular illness episode, the business collapsed.

(iv) Resty's illness

In almost all the interviews, Resty asserted that she rarely falls ill, i.e. ill enough to warrant attention by a health worker. However on many occasions, I found her very ill, at times too weak to be interviewed but at the same time working. On all these occasions she would claim to have treated herself with some drugs in the house or bought from the drug shops. She would further insist that her ailments were too trivial to be discussed. As far as she was concerned she was not ill at all.

Resty says the only time she fell really ill, i.e. to the extent of being incapacitated, was when she had a miscarriage. Her symptoms included acute abdominal cramps, restlessness, sweating, profuse haemorrhage and eventually a miscarriage.

When she started bleeding, she informed her partner who was so alarmed that he just hurried off (it was at night) to look for transport to take her to Mulago hospital. By the time he returned (without transport) Resty had already miscarried, was still bleeding and feeling faint. By this time it was morning.
and transport was mobilised by a neighbour. She was escorted to Mulago by both her husband and the neighbour.

On the way they passed Mulago village where a relative to the husband who is employed in Mulago lives. They asked him to come with them to the hospital. Resty was admitted and stayed in hospital for two days during which she says her womb was "washed". She was also treated with injections and tablets. She asked to be and was discharged on the third day when she felt better. Two days later she consulted a local healer to ascertain the cause of the miscarriage. She declined to disclose the results of this consultation.

<table>
<thead>
<tr>
<th>Treatment costs</th>
<th>Shs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transport to Mulago</td>
<td>2500</td>
</tr>
<tr>
<td>Treatment costs</td>
<td>2000</td>
</tr>
<tr>
<td>Other expenditures</td>
<td>1000</td>
</tr>
<tr>
<td><strong>Total cost</strong></td>
<td><strong>5500</strong> [ $ 5.5 ]</td>
</tr>
</tbody>
</table>

Resty says that had it not been for her husband's relative who was then working at Mulago hospital, these costs, especially for treatment, would have been higher. When she was away, her business ground to a halt and most of her capital was used up. She does note, however, that her husband spent much more on her treatment than herself because at that time he was employed.

**Case 9 : May : Category C; very poor**

**(i) Personal history**

May is a 27 year old Muganda woman. She was born in Mulago, a Kampala suburb neighbouring with Kamwokya II Zone. She says that her father died in a motor accident when she was still an infant and she grew up with her
mother. Her mother was the sole breadwinner, operating a 'business' selling cooked local foodstuffs to workers of Kampala City Council in the city. She operates the same business to date.

May was never enrolled in school. When she was ten years old in 1977, her mother sent her to stay with her paternal aunt in Green Valley Zone in Kamwokya II. She does not know the reasons for this but suspects that her mother wanted to ease her domestic burden by sending some of the children away. Her other sister was also sent away, but to other relatives.

May's aunt lived in two small squalid rooms. She had two children and no steady partner. She was a tonto and waragi seller. During the day her business site was a local tavern nearby and at night she operated from her residential premises. On top of assisting with the business May would also care for the children and do domestic work. The household survived solely on income earned from the business.

May lived with her aunt until she was sixteen. She says that at this time her aunt and mother together coerced her into marriage with a man who had unsuccessfully been courting her. He is a Mutoro and was, at the time, employed as a night watchman.

By 1987, May had produced three children and was expecting a fourth. She says it was at that time that her husband secretly enlisted in the army and deserted her. He 'resurfaced' in 1993 after demobilisation and, surprisingly, May readily accepted him back, even though in his absence May had another
man and produced another child. May's Reproductive history. She has had six pregnancies with one miscarriage.

1984, live birth still living
1985, " "
1987, " "
1988, " "
1991, " "
1993, miscarriage
1994 She is currently expecting.

(ii) Economic situation

May's problems began when she was deserted by her husband in 1987. Life became difficult indeed. On top of suffering the socio-psychological effects of desertion, she had no means at all of supporting herself and the children.

She was compelled to do all sorts of odd jobs, e.g. digging in other people's gardens, washing clothes, baby-sitting, fetching water etc., so as to survive. At one time she tried to start a business selling green banana fingers (*emyera*) collected from lorries off loading *matooke* (green bananas) near the market. This, however, proved difficult as she could not effectively compete with energetic young men when it came to off loading the bananas and physically struggling to collect or 'steal' the banana fingers.

In 1990, May says that life in the city became intolerable, especially so after being evicted out of her room/house for defaulting in rent payment. She temporarily became destitute, relying on friends' and neighbours' goodwill for accommodation. Faced with such a situation, May decided to leave the
city and headed for her husband's village near Fortportal town in Toro district, Western Uganda.

In the village, May was given a cold reception by her in-laws. She also soon discovered that she had escaped from urban misery in Kampala only to end up in abject rural poverty. This, coupled with the hostile in-laws, prompted her to return to Kampala prematurely. She returned to Kamwokya where she rented a tiny room. She sold some personal effects (clothes) and raised some money to start a business selling cassava chips, to passers by. May later moved to Kisenyi I where she rented a small room and started selling cassava chips a business she still carries on today. She earns between Shs 300 to 500 ($0.3-5) a day.

(iii) Household expenditure patterns

May's family is a very poor one and they struggle, merely to obtain the basic necessities. Though married, she foots all the bills because the husband is unemployed. The expenditure items include food, rent, health care, clothing, school fees and other requirements. In most cases her family cannot afford three meals a day, so she normally sends them to their grandmother. They are very poorly dressed. In her room there is no furniture, just old mattresses on the floor. The rent is always paid in arrears. May's mother sometimes assists with school fees but frequently the children are sent out of school.
(iv) Time use

She wakes up at 5.00 a.m. and starts preparing the cassava chips which are ready for sale by 6.30 a.m. From 6.30 a.m. she sits along the road near her home selling the chips to passers-by. At times, selling and preparation are done at the same time. She normally stops selling at about 10.30 a.m. She needs to avoid confrontation with the city council authorities since her business is illegal. Also, this is the time when business colleagues with legal enterprises start selling their cassava and other items, and she has, by mutual understanding, to leave room for them. Whatever remains is sold at her home to neighbours and friends who know her business. All this time, her five children are left on their own. Their breakfast consists of leftovers from the cassava chips, if any. No wonder they are severely malnourished.

At 3.00 p.m., May goes to the market about 2 kms away to buy fresh cassava tubers for the following day’s business. This takes a lot of time; more than 2 hours. She walks slowly due to her advanced pregnancy. She comes back before six in the evening and prepares supper for the family. When she is away, her youngest child stays around the house with the neighbours watching over him, and the other children go to the grandmother who also resides in Kamwokya.

(v) General treatment seeking and worries about illness

When May’s child falls ill, what she does depends on her perception of the nature and seriousness of the illness. However her first step is always to watch over the child. The next step, if illness symptoms persist, is to treat the
child herself using drugs available at home or bought from the drug shops. If the child fails to respond to this treatment and money is available she visits a clinic (Kisenyi Valley) but if she has no money she waits until the child is critically ill and then takes him/her to Mulago hospital in the Acute Care Unit where he/she will be urgently attended to, regardless of whether or not funds are available.

May says she would have preferred to take her children to private clinics which are nearer and more efficient but cannot afford to due to lack of money. Because she feels that most traditional healers/diviners are cheats and therefore not capable of handling children's illness, she rarely takes her children to traditional healers' premises.

For her own illness, she usually consults her mother when she feels persistently ill. The latter does not provide May with treatment money but gives her emotional support. The next step is to visit a nearby drug shop where the owner, a nurse, will treat her on credit. May and the nurse are friends. Some time ago, May used to sell her fresh cassava tubers on credit. May says she has never been to Mulago for her own illness, except for ante-natal clinics.

(vi) Specific illness episodes: child

The three and half year old boy John was ill. He looks severely malnourished and had at one time attended the nutrition clinic at Mulago. May says that the child had malaria related symptoms which included fever and lack of appetite, and therefore she treated him with anti malarial drugs (chloroquine tablets). However, the symptoms persisted and the child even developed skin blisters.
May then visited the Nutrition clinic, locally called "Mwana mugimu" ward in Mulago Hospital where chicken pox was diagnosed. He was admitted for one week, put on a course of injections and got better.

(vi)2nd illness episode: child

John fell sick again and the symptoms included cough, high temperature and laboured breathing. May diagnosed malaria and treated him with anti malarial drugs (chloroquine tablets). However, the child did not respond to this treatment and his condition worsened. He stopped eating and drinking. By the third day his condition was critical and May took him to Mulago in Acute Care unit where he was admitted. On top of Malaria and acute tonsillitis, severe malnutrition and dehydration were diagnosed.

On learning that the child would be admitted for a number of days, May sent a message to her mother to collect the other children and lock up the house. She also borrowed Shs 5000 [$ 5] from her mother, promising to refund it soon after leaving the hospital.

John was successfully treated and discharged after 5 days. However, he was referred to the Nutrition clinic at Old Mulago hospital where mothers are taught about elementary nutrition and provided with free powdered milk and soya flour to feed their malnourished children. May had no time to attend this clinic. Doing so on a previous occasion had resulted in the loss of many customers.
May paid the bills using the borrowed money. Her husband was not around.

She says that even if he had been around, he would not have paid anything.

(viii) May's illness

May suffers from Pneumonic asthma. One night she slept badly, wheezing, but still forced herself to go to the Market. On the way back she got worse and was hardly breathing by the time she reached home. She hurried to her nurse friend who injected her immediately and dispensed some tablets. She also recommended a two day bed rest. May says that though the injection made her very weak, she recovered very fast. On that day she did not transact any business but she ignored the recommended two day bed rest and went back to work the next day as she had nothing to eat. When I met her on the fourth day she was again not feeling well but had not sought other treatment because she had no money. She was, however, busy preparing cassava chips. When asked how it was that she had money to purchase ingredients for preparation of cassava chips and none for treatment, she merely retorted "you do not understand".

The treatment was given on credit which May was expected to pay back in instalments.
Case 10 Sarah: Category C: “Rich”

(i) Personal history

Sarah is 25 years old. She was born in 1969 in Katikamu village, Bukoto county, Masaka district. Her parents (both deceased) were cultivators growing mainly coffee and bananas for sale, and other crops like cassava, sweet potatoes, maize and beans for subsistence.

Sarah was enrolled in primary school in 1975 when she was six years old but her schooling was disrupted three years later when the 'liberation' war with Tanzania broke out. By that time she was in primary 3. Sarah says that the consequences of the war were severe on her family and marked a turning point in her life. For instance, both of her parents were killed and the rest of the family displaced. Sarah and a few relatives survived and fled to Kampala. Sarah ended up in Kamwokya II, Kifumbira zone where she was taken up by a paternal uncle. After the war in 1979, Sarah, now eleven years old, opted to remain in Kamwokya. She was not re-enrolled in school.

At sixteen years old, Sarah got a partner who persuaded her to cohabit with him. He is a Mufumbira and at the time was employed as a clerical Assistant in the Ministry of Labour. He lived with a sister in a small two bedroom council house in Contafrica zone. Sarah learnt later that he was married, his wife staying up country in Kisoro, over 300 km away. However she continued living with him and they are still together. He has so far not shown any signs of formalising their relationship, and this is an embarrassment to Sarah. At the time of the first interview, Sarah had four children aged 8, 6, 4 and 2
years. She is currently expecting another child. Her reproductive events may be summarised as follows:

1985 1st pregnancy live birth still living
1988 2nd "
1990 3rd "
1992 4th "
1993/94 5th "

(ii) Economic situation

In 1984, Sarah's uncle advanced her a loan and with her aunt Peggy's assistance, she started a business selling charcoal from their backyard. Sarah says that their business boomed because her uncle used to bring in large quantities of charcoal bought cheaply from upcountry and transported freely to Kampala on the railway wagons. Sarah and Peggy would therefore undercut their business rivals by selling their charcoal at subsidised rates. In 1985, Sarah and aunt Peggy rented a space in the main market where they continued selling charcoal. The profits were equally shared out between them. Sarah's uncle and husband were both retrenched from public service in 1993 and both are currently unemployed. This situation has had severe repercussions on Sarah's life. Her charcoal business with aunt Peggy was badly affected since they no longer had access to cheaply transported charcoal. Secondly, with her husband demoralised and redundant, Sarah became the sole breadwinner for the now expanded family. On top of this they were evicted from the government house and had to look for cheap accommodation which they obtained in Kifumbira I zone. With only Sarah's income to rely on, they could only afford to rent a single room. The husband...
was, at the time of the interview, looking for another job. Sarah earns between 10,000 to 30,000 ($10-30) a month.

(iii) Household expenditure patterns

Sarah’s family has gone through a number of development that have changed their economic situation. When her husband was still employed, the family was well catered for. Her husband covered school fees, clothing and health care and would give Sarah some money for the food. Sarah used to spend most of her money on food and clothing. They lived in a government house and no rent. Everything has changed and Sarah is now the main breadwinner of the family. She works hard to make sure the children are in school and rent is paid. Her husband is frequently absent and stays in the village most of the time.

(iv) Time use

Sarah and aunt Peggy operate their business only from the market (the backyard premises being no longer available). The lorries which deliver charcoal come twice a week but Sarah can afford to replenish her stock only once a week, usually on Saturdays, when she wakes up early and walks to the market and buys her stock at around 7.00 a.m.

Otherwise, her daily routine involves waking up early at around 6.00 a.m. to perform home chores and prepare the older children for school. She usually leaves for the market at 9.00 a.m. where she spends the whole day, up to 7.00
p.m. She then returns home for routine housework and waiting for the next day’s business

(v) General treatment seeking and worries about illness

Sarah says that when her child falls ill her behaviour is determined by the nature of illness symptoms afflicting the child. If the symptoms are not perceived to be serious enough, she watches over the child or requests someone to do so. If the symptoms persist, she treats the child using drugs available at home or purchased from drug shops. At times she consults aunt Peggy who often provides traditional medicine which is either administered orally or mixed with bathing water, depending on the nature of illness symptoms.

If the home remedies and traditional remedies prove ineffective, Sarah consults her partner who then decides whether to seek help from the clinic or hospital. Sarah says, however, that it is not often that she visit hospitals, preferring clinics. She usually visit Muna clinic in the market area. The doctor who owns this clinic and Sarah’s husband have been acquaintances for quite a long time.

Sarah believes that professional medical help alone has limitations when dealing with either children’s or adult’s illness. Therefore she always supplements treatment at the clinic either with traditional medicine or advice from a healer/diviner. On aunt Peggy’s advice she consults a healer at Manyangwa 20 km out of the city. Sarah has consulted this healer a number
of times for own and the children's protection. She suspects that her co-wife may bewitch her and the children.

For her own illness, Sarah mostly relies on home remedies which include over the counter drugs, and traditional medicine. She rarely visits hospitals or any other health facilities except for antenatal care. Her husband often advises her on which tablets to use.

(vi) Specific illness episodes: child

The four year old girl, Alice, was ill. Her symptoms initially included loss of appetite, fever and headache. With such symptoms, Sarah diagnosed malaria and proceeded to administer anti-malarial drugs (an aspirin and chloroquine). She then prepared and gave the child a herbal bath.

Sarah, believing that this therapy would be effective asked her sister-in-law to watch over the child and hurried off to the market to attend to her business. However, early in the evening she was called back as Alice's condition had worsened. She requested aunt Peggy to stand in for her and hurried home to find Alice very ill with a high temperature.

Sarah rushed the child to Munna clinic, where a nurse attended to her. Severe malaria was diagnosed and the child was put on a course of injections for three days. Two days later, however, Alice's skin developed pimple-like swellings, characteristic of chicken pox. Sarah took the child back to the clinic where treatment was changed. On top of the injections, a white ointment was provided for the skin. The visit to the clinic lasted less than 30 minutes.
same time, Sarah resumed the herbal bath and oral administration of traditional medicine. She would apply the ointment after the herbal baths. Alice gradually responded to treatment and was cured.

<table>
<thead>
<tr>
<th>Treatment costs</th>
<th>Shs</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 injections</td>
<td>3500</td>
</tr>
<tr>
<td>Ointment</td>
<td>1500</td>
</tr>
<tr>
<td>Consultation</td>
<td>500</td>
</tr>
<tr>
<td>Herbs and other traditional medicines</td>
<td>500</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6000 [$ 6]</strong></td>
</tr>
</tbody>
</table>

(vii) 2nd illness episode: child

Soon after Alice's illness, the two year old boy John also fell ill. Sarah says that his illness started so abruptly that she was taken completely unawares. It was at night when the child suddenly developed a high temperature and started vomiting. Soon also diarrhoea set in and the anti malaria and anti diarrhoea medicine which they tried to administer orally was vomited. Sarah waited for morning and hurried to Mulago hospital. By this time, John was in a critical condition almost convulsing. He was admitted to the Acute Care unit and immediately put on a drip. Other medicines were also administered orally. After some time the child was put on a course of injections. After three days, he improved and, on Sarah's request, was discharged. At home, aunt Peggy's prepared herbal medicines which Sarah administered to the child orally. This therapy was meant to prevent the recurrence of convulsions, locally referred to as yabwe.
Sarah says that the consequences of this illness episode were severe for her business. Her meagre operating money was spent on hospital bills and she could not replenish her stock. She had to borrow from aunt Peggy to boost her operating capital. Her husband was unable to assist throughout this period. He is still unemployed.

(viii) Sarah's illness

Sarah symptoms included severe coughing and flu. She said that her illness must have been caused by the inhalation of too much charcoal dust at her business. With such symptoms, Sarah consulted aunt Betty who prepared a strong concoction for her to drink. She drank it in two days and felt better. She said that she did not use any pharmaceuticals. Peggy’s medicine cost a token fee of Shs 200($ 20 cents)\(^{16}\). Since that time, Sarah says she has not fallen seriously ill again.

Category D: Married women relying entirely on their husband's income

Case 11 Maria: Category D: Rich

(i) Personal history

Maria is aged 30 years. She was born in March 1964 in Nakatooke village, Ntenjeru county Mukono district. Maria's father was a bricklayer and was for most of the time selfemployed. Maria recalls that when ever he had no
building contracts, he would engage in the production of a variety of petty commodities, e.g. stools, cane chairs etc. for sale. According to Maria, he was quite a skilled man. Maria's mother on the other hand, was an ordinary housewife, performing all sorts of domestic chores on top of subsistence cultivation.

When Maria was seven years old in 1971, they moved to Makindye Kampala where she was enrolled in a nearby primary school. She completed primary school in 1978 and joined Kololo secondary school in 1979. Maria later joined Nakasero secondary school where she completed advanced secondary education. In 1986 Maria joined Temple college Nairobi (Kenya) to study stenography.

Soon after her return from Nairobi, Maria's father died in an accident at a building site. Maria recalls that this was the saddest event and signalled a turning point in her life. The family now had to fend for themselves and her brothers and sisters were yet to complete their education.

Fortunately, Maria got a job as a stenographer in a private company. Her mother also intensified her income seeking activities (making and selling handicrafts) and somehow they managed to survive. At this time, Maria got a serious partner who was bent on marrying her. She says that though they loved each other and even produced two children, she could not co-reside with him as he wanted for fear of leaving her mother alone. Their affair lasted up to 1989 when he was tragically killed in a motor accident. He used to contribute to the upkeep of Maria's family.
With an increased domestic burden, Maria had to look for a better paying job. She got one with a private law firm, again as a secretary. She worked there for four years, up to 1992, when she fell in love with her boss and was compelled to leave. This 'boss' is her current husband.

As he was rather prosperous he convinced Maria not to look for employment. He rented her two rooms in Kamwokya, Kisenyi I zone. Maria became pregnant but unfortunately had a miscarriage. She blames this misfortune on her "barren" co-wife who she believes bewitched her. In early 1993 she became pregnant again and this time had a live birth. At the time of interview the baby was 8 months old. Currently Maria is pregnant again.

Maria's reproductive events can be summarised as follows:-

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1987</td>
<td>1st preg. live birth and still living</td>
<td></td>
</tr>
<tr>
<td>1988/89</td>
<td>2nd preg &quot;</td>
<td></td>
</tr>
<tr>
<td>1992</td>
<td>3rd preg miscarriage</td>
<td></td>
</tr>
<tr>
<td>1992/93</td>
<td>4th preg live birth and still living</td>
<td></td>
</tr>
<tr>
<td>1994</td>
<td>5th preg still pregnant.</td>
<td></td>
</tr>
</tbody>
</table>

With regard to employment, Maria has suggested several times that she goes back to work but her partner has adamantly refused, indicating that he resents the nature of her profession (private secretary). Instead, he has purchased a sewing machine for her so that she can work at home. Currently, her family is composed of four people: child, partner, housekeeper and herself. Maria's partner provides all the financial support to the family; she is completely dependent on him and complains that the money given is inadequate. She normally has to save some money from her allowance to send to her mother.
General treatment seeking and worries about illness

Whenever Maria's children fall ill, she initially consults her husband both to inform him and to ask for money for treatment. When he is absent, as is usually the case, she consults her friend and neighbour Mama Junior. Their friendship started a year ago when Mama Junior assisted in the delivery of her current baby at home.

Maria says that the advice given either by her husband or Mama Junior depends on the seriousness of the child's illness symptoms. If they are not regarded as serious, she is usually advised either to watch over the child and/or use drugs available at home or purchased from the drug shop. If the illness symptoms are interpreted as serious, she will be advised to take the child to a clinic. In most cases, her husband provides money for treatment. If he is unable to do so or absent, Maria uses her savings, which her partner reimburses.

Maria usually takes the child to Kisenyi Valley clinic next door to her home. She was not introduced to the clinic by anybody but simply went there one day when the child was ill and the condition was well handled. Since, then she notes, a friendly relationship has been forged with the personnel at the clinic, to the extent that her child can be treated on credit when she has no money. Maria does not visit Mulago hospital unless the child's condition is critical. Most of her children's health care needs are catered for at Kisenyi Valley clinic.
If the child's illness persists, even after visiting Kisenyi Valley clinic, Maria gets very worried and again consults Mama Junior who will now recommend use of traditional remedies. In most cases she provides Maria with local herbs which are either used to bathe the child or are administered orally. If necessary, Mama Junior recommends a diviner/healer and consults him/her on Maria's behalf. Maria says that in spite of Mama Junior's advice and/or remedies, she continues treating the child with medicine provided at Kisenyi Valley clinic. Maria's husband does not believe in traditional remedies and thus whatever Maria does with Mama Junior is kept secret.

When Maria falls ill, which she says is not common, she informs her husband. If the illness symptoms are persistent and non-specific, she consults her friend and neighbour, Mama Junior, who often recommends traditional therapies. Maria says that Mama Junior is a genuine herbalist, though not formally practising. She helps only close friends or relatives. Apart from her partner and Mama Junior, Maria does not consult anybody else when ill or worried about illness.

(Vi)Specific illness episodes: child

Maria's youngest child fell ill at eight months old and her husband was not around. The child's symptoms included high temperature, cough and restlessness. Worried by such symptoms, Maria immediately took the child to Kisenyi valley clinic where malaria was diagnosed and a chloroquine injection given. Maria was also advised to apply a cold sponge to the baby's body at intervals, until the temperature lowered and stabilised.
In spite of this treatment, there was no improvement and in the evening, Maria took the child back to the clinic. This time the doctor who owns the clinic was in attendance and examined the child. Malaria and pneumonia were diagnosed and the child was put on a course of injections for three days.

Maria says that during that period, the child's condition improved a little but then on the third day, he developed a skin rash. When she noticed this she consulted Mama Junior who immediately diagnosed measles. She advised Maria to stop administering any pharmaceuticals if her child was to live.

Mama Junior then procured a local medicine which is a well-known remedy for measles. It included fresh leaves, strips of bark from a tree and cow butter. The leaves were boiled and added to the child's bathing water. The strips of bark were pounded, boiled and sieved. The resultant liquid medicine was administered orally to the child and the remnant brown paste was smeared on the child's body like ointment.

On top of this treatment, Mama Junior advised Maria and any other household member to refrain from sex, eating any type of meat except mutton, and not to make a noise, especially in the evenings and night. Further, nobody was to refer to the child's disease by its real name, i.e. but by other names like 'mulangira' (prince) or 'kabaka' (king). This Mama Junior said would appease the disease and prevent it from spreading or killing the sick child. Maria says she strictly followed Mama Junior's advice and used her remedies only. The child was so ill that even her husband observed mama
Junior's instructions out of fear. After a fortnight, the child's condition improved.

<table>
<thead>
<tr>
<th>Treatment Costs</th>
<th>Shs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kisenyi Valley clinic</td>
<td></td>
</tr>
<tr>
<td>Consultation</td>
<td>1000</td>
</tr>
<tr>
<td>4 injections</td>
<td>4000</td>
</tr>
<tr>
<td>Tablets</td>
<td>1500</td>
</tr>
<tr>
<td>Mama Juniors medicine</td>
<td>1000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7500[$ 7.5]</strong></td>
</tr>
</tbody>
</table>

Maria's husband paid the clinic bill but she personally paid Mama Junior's fee of Shs 1000, as a token of appreciation.

(vii) 2nd illness episode: child

Maria had delivered another child, a girl called Stella. Stella 4 months old when symptoms such as lack of sleep, loss of appetite for breast milk and shivering started. With such symptoms Maria automatically diagnosed malaria and hurried the baby to Kisenyi valley clinic where she was attended to by a nurse. The nurse took the child's temperature, which was slightly above normal, and treated Stella with an injection. She advised Maria to watch closely over the child and to report back the following day. That night Stella developed a high temperature and started convulsing. For the first time Maria visited Mulago hospital, the Acute Care Unit, where Stella was admitted.

The child was put on a drip and a course of injections for two days. On the second day Stella improved and was transferred from the Acute Care Unit to the general paediatric ward where treatment continued. On the third day, she was discharged. Maria is convinced that had she not taken Stella to Mulago
she would have died. In fact, her previous negative attitude towards Mulago hospital has completely changed.

<table>
<thead>
<tr>
<th></th>
<th>Shs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kisenyi Valley Clinic</td>
<td>500</td>
</tr>
<tr>
<td>Treatment</td>
<td>1500</td>
</tr>
<tr>
<td>Mulago</td>
<td></td>
</tr>
<tr>
<td>Treatment costs</td>
<td>3000</td>
</tr>
<tr>
<td>Unofficial charges</td>
<td>2000</td>
</tr>
<tr>
<td>Transport [car hire]</td>
<td>2500</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9500</strong></td>
</tr>
</tbody>
</table>

Maria's husband paid this bill.

(Viii) Maria's illness

Maria's last illness, a fortnight after delivery of Stella, was fever and lower abdominal pains. She felt very ill, and rushed to Kisenyi Valley clinic where the doctor diagnosed malaria and treated her with an injection. The following day she did not feel better, and on Mama Junior's advice visited Old Mulago hospital where she was referred to New Mulago.

At New Mulago, with the assistance of her husband's friend and kinsman, she managed to get attention from a physician who examined her thoroughly. He diagnosed 'peri-sepsis' and put Maria on a course of injections for five days. He also advised thorough abdominal massage with hot water. Maria underwent this treatment and steadily improved. At the same time, however, Mama Junior gave her local medicine to drink and to mix with the hot water used for abdominal massages. She recovered after the treatment. She believes
that the two remedies combined (bio medical and traditional) were effective in healing her.

<table>
<thead>
<tr>
<th>Treatment costs</th>
<th>Shs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kisenyi Valley</td>
<td></td>
</tr>
<tr>
<td>Consultation</td>
<td>500</td>
</tr>
<tr>
<td>Injection</td>
<td>1200</td>
</tr>
<tr>
<td>Mulago</td>
<td></td>
</tr>
<tr>
<td>Transport</td>
<td>3000</td>
</tr>
<tr>
<td>Treatment</td>
<td>4000</td>
</tr>
<tr>
<td>Mama Junior's remedies</td>
<td>500</td>
</tr>
<tr>
<td>Total cost</td>
<td>9200</td>
</tr>
</tbody>
</table>

Maria's husband paid all the bills except Mama Junior's fee, which Maria paid later.

Case 12 Ana: Category D: Very Poor

(i) Personal history

Ana is a muganda woman in her late twenties. She was born in 1966 in Mityana district in a poor family. Her parents were peasant cultivators, growing mainly coffee and bananas for sale.

Ana was enrolled in school in 1974 when eight years old. In primary seven she got pregnant and dropped out of school. Her partner, a young man who used to trade between Kampala and Mityana, was coerced to marry Ana by her parents. They moved to Kampala and settled in Kifumbira zone Kamwokya II ward. They lived in a muzigo, one of many on a semi permanent structure.

Ana's husband expanded his business meanwhile and became a big dealer in agricultural produce.
Ana delivered her first child in 1982 and insisted that they change residence to a better area. They moved to Kisenyi I zone which was cleaner and less crowded. Her husband rented a three room house with private toilet facilities. Ana was happy and settled down to the life of a housewife. By 1990 she had produced three other children.

Ana's problems started in 1990 when her partner married another woman and rented her a house in another part of the city. The co-wife, according to Ana, was very demanding and soon all the provisions she used to get were diverted to her co-wife. Worse still, her husband started spending less and less time at Ana's and did not care whether her family starved or not.

Ana planned to sell off some household assets and to raise money to start a business operating a stall in the main market. Her husband would not hear of this and refused to allow her. He served her with an ultimatum, either to pursue her business in the market and consider herself a divorcee or to settle at home and retain her marriage. Ana chose the latter.

Thus, Ana continued to suffer living off the pittance from her partner. In 1992, her husband's business started slackening due to excessive competition and supporting two families in Kampala became a heavy burden. Ana, who had by now produced another child, continued to suffer, often going without food. Paying rent became a problem and she had to give up two rooms, retaining only one. School fees for the children were paid late and often they would be sent out of school. In spite of this situation Ana's husband stubbornly refused to allow her to work.
At the time of the interview, Ana's situation was indeed desperate. She was looking for money to start a business privately, without her husband's knowledge. Her children were starving and had dropped out of school. She had sold off some of her personal effects to pay for rent and meet other needs. Her husband rarely visited her. His business had collapsed and he had resorted to hawking petty items. To compound Ana's plight, she was expecting another child.

Her reproductive history can be summarised as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1981/82</td>
<td>1st</td>
</tr>
<tr>
<td>1984</td>
<td>2nd</td>
</tr>
<tr>
<td>1987</td>
<td>3rd</td>
</tr>
<tr>
<td>1989</td>
<td>4th</td>
</tr>
<tr>
<td>1992</td>
<td>5th</td>
</tr>
<tr>
<td>1994</td>
<td>6th [expecting]</td>
</tr>
</tbody>
</table>

(iii) **Household expenditure patterns**

Ana's husband is the sole breadwinner in the family. He normally gives money to Ana for maintaining the family. According to Ana it varies and since he married a second wife it has greatly reduced. The man covers the rent and Ana budgets the little she gets to maintain her family. She spend most of the money of food. The children do not attend school regularly, due to lack of money.

(v) **General Treatment Seeking and Worries about Illness**

Ana is a desperate woman and this manifests itself whenever she is worried about illness or seeking health care. The child who bothers her most is the fifth born who is now two years old. Joseph, as he is called, is not only retarded but falls ill frequently. Notwithstanding her desperate financial situation, however, Ana always strives to ensure that the child gets treated
when ill. The child cannot sit steadily on his own for without his mother's support.

When still well off, Ana was sympathetic to many people and would always assist them when in need. It is friends like these that she relies on most whenever her son is ill. One such friend is a senior nursing officer at Mulago hospital who is always ready to assist. In fact, without her help, Ana says she would not cope.

Apart from her old friends, Ana also consults her neighbour and landlord who is an old widow, providing not only advice but also emotional support. She is like a mother to Ana who refers to her as jaja. Jaja more often than not provides traditional medicine both for the children and Ana. Ana relies on her almost entirely for her own illness. She says that her partner and his relatives are never bothered with her or the children's health. Even so, she does consult her husband and ask for money for treatment.

(vi) Specific illness episodes: child

Ana's two year old son, Joseph, is constantly ill; but the most serious illness was when he started shivering and running a high temperature. She applied a cold sponge and gave him some anti-malaria drugs, but the symptoms continued. The child was then taken to Mulago hospital to the Acute Care Unit, where he was treated. The doctor wanted to admit him but Ana refused, lying that she resided within Mulago complex and would therefore bring the child anytime.
Asked about her refusal to have the child be admitted, Ana frankly pointed out that she could only not afford it financially but also had nobody to leave at home. Further she remarked that, for a child like Joseph, if she did not refuse admissions, the hospital would become her home. Joseph recovered fully within four days.

<table>
<thead>
<tr>
<th>Treatment costs</th>
<th>Shs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>3800 [$ 3.8]</td>
</tr>
<tr>
<td>Researcher paid the bill</td>
<td></td>
</tr>
</tbody>
</table>

(vii) 2nd illness episode: child

Joseph fell seriously ill again. His ailment this time was diarrhoea and vomiting. When Ana noticed the symptoms she took him to her friend at Mulago hospital. Her friend took the child to the paediatric ward where he was admitted and put on a drip. This time Ana had no way of refusing the admission and she sent a message to her husband and landlord to take care of her family. The child spent two days in hospital, improved and was discharged on the third day.

The problem was that Ana did not have money to buy the prescribed drugs but her friend assisted her and procured them for her. She did not know how much they cost. Her husband visited her once in the hospital and gave her Shs 2000[$ 2] for food only.

(viii) Ana's illness

Soon after discharge from hospital when Joseph was admitted, Ana fell ill and was in bed for four days. Her illness symptoms included fever, headache and
general body pains. She sent a message to her husband who advised her to go
to hospital which advice Ana rejected. Her landlord, Jaja, prepared her local
medicine which she drank and started vomiting. Ana says the medicine is
nauseating and is meant to induce vomiting, after which one feels better.
Jaja's therapy was administered for three days until Ana recovered. She did not
use any pharmaceuticals. Jaja's medicine cost a token fee of Shs 300[$.3],
which Ana paid.

5.5 Conclusions

This chapter has mapped out women's social, economic and reproductive
history and indicated the steps and choices women take in seeking treatment
for their own illness and that of their children under five. The findings
indicate a close link between women's socio-economic status and choices of
illness management. The differences in illness management process seem also
to reflect the different concerns of women.

The next chapter examine how women access money resources in
Kamwokya, which as discussed in chapter 8 have implications for their
treatment seeking behaviour.

1. *Kidoomole* literally means free for all and one can sell anything at any price. *Toninyira mukange* literally means do not step on mine. This is due to overcrowding of the people and merchandise of all sorts. These names are used interchangeably by the people. The markets offer goods at much reduced prices and are frequented most by the poor people and single men and women for cooked food. No taxes are levied in these markets.
2. *Nalongo* for women and *Salongo* for men is a title or name used to refer to a mother or father of twins. The title commands a lot of respect from the community and many women openly admire the *Nalongos* and would like to have the same status.

3. *Omusujja* is a local term that refers to raised temperature and is frequently used to refer to malaria whose main symptom is raised temperature. Mothers interchangeably use it refer to fever and malaria.

4. Part of this case study plus case 8 Resty and case 9 May were published in Wallman 1996 Chapter 10 pp: 189-198.

5. It is common practice in Uganda for young single mothers to leave their young children in custody of their mothers to enable them (young women) to move to urban areas in quest of better opportunities, e.g., employment or education.

6. Though the father of Betty's child facilitated her migration to Kampala and assisted her in getting enrolled in a commercial college, he was unwilling to marry and settle down with her. In fact, Betty says this is what compelled her to leave Kitovu Mission Hospital, as a single unmarried mother would not be tolerated on the staff by the Catholic management.

7. *Jaja* is a term used to refer to a grandparent be it female or male. It is also used by young people to refer to any old person fit to be their own grandparent. Under different circumstances, like traditional healing and divining, the term may be used to mean powerful ancestors not visible to the eyes of people. The term as used in this case refers to an old person fit to be a grandparent of Aisa.

8. *Ajon* is a popular local brew made out of millet and sorghum; usually drank communally from a common pot using long traditional sucking tubes.

9. Phina suspected foul play because her husband had just been promoted to a higher position at work. There is a common belief in Uganda that one can be bewitched or poisoned because of rivalry over job positions.

10. False teeth is believed to be serious condition among children below the age of two years. Its symptoms include diarrhea, fever and convulsions; it may lead to death. It is a condition health workers do not believe. The diagnosis is the eruption of primary canines in the lower or upper jaw of young children [see Jitta 1996].

11. Sophia pointed out that there was a general feeling in the community where they lived, that barren women are witches and evil and can easily bring a bad omen to the family.
12. 1977 is the year when the Christian church celebrated 100 years of existence in Uganda.

13. This was duty free beer smuggled from the army barracks and often sold from under the bed [kitanda] hence the name.

14. Mulokonyi is a popular delicacy in Kampala, especially among consumers of alcoholic drinks. Its thick, glue-like soup is also believed to have medicinal qualities, especially as a remedy for arthritis and rheumatism.

15. Mama is a term used to mean "Mother of" normally followed by a child’s name. Mama Joy "Mother of Joy".

17. Traditionally, local herbs and medicines are not supposed to be given free "eddgala terigendera bwerere". A small fee as a token is usually paid to the provider if has not charged money officially for it to be effective.
CHAPTER SIX

WOMEN'S PARTICIPATION IN BUSINESS: RESOURCES AND CONSTRAINTS

6.0 Introduction

Women's access to income has been found to be related to a complex set of social and economic factors, either inducing them into the labour force or limiting their propensity to work outside the home. Different groups of women have different sets of needs, opportunities, qualifications and personal familial conditions so that their means of access varies accordingly [Mustafa 1990]. Similarly, as noted by Mackintosh [1981], the participation of women in the labour market also varies according to their position within the household and domestic cycle. Changes in patterns of and fertility may therefore affect the supply of women in the labour market.

O'Connel, discussing economic relations and realities in the family, pointed out that evidence from many countries indicates that women do have a real need for income and that the ideal of men as sole providers for women and children is a myth. The inadequacy of male incomes is a fact of life for the majority of Third World households, as is the importance of women's earnings to the survival of many families [O'Connel 1994 pp: 55]
In Uganda, women's access to income through participation in the labour market has been on the increase for the last two decades. As described by Obbo, "the most outstanding features of the present Ugandan economy are the proliferation of petty trading in all side streets and on un-contested space in towns and rural road sides...." [Obbo 1991 pp: 98] Women are the majority in these businesses. This, it has been argued, results from changes in the economy in the last two decades that have wiped out previous sources of 'living wages' of the majority of Ugandans. Most families from all socio-economic strata need at least two or even three income generating activities to survive. Surviving means being able to pay the inflationary rates of school fees, rent, taxes, food, hospital bills etc. [bid]. The subsequent adoption by the government of Uganda of Structural Adjustment Programmes of the International Monetary Fund [IMF] and World Bank has not gone well, especially for the vulnerable groups (women and children). Currency devaluation, one of the SAP requirements, has caused progressively higher inflation, increasing the number of people unable to live within their means. Extracts from case histories (chapter five) show that women experience the struggle for a living differently, depending on their marital and social economic situation.

This chapter explores ways through which Kamwokya women have access to income and reasons for entry into the labour market. The majority of women who participated in the study have access to money through income generating
activities in the informal sector. Some women, however, have access to
money income through their spouses and others through both participation in
the business activities and from spouses. Further resources available to and
constraints faced by women in their search for money to meet basic family
needs are examined.

6.1 "We have to work": Kamwokya women accessing income

All except two of the twelve cases investigated in this study were directly
engaged in one income generating activity or another. This echoes an earlier
study in the area which showed that over 80% of the women surveyed were
involved in an income generating activity [Wallman 1996]. The two
exceptions (11 and 12) not involved in business, had access to income
through their spouses.

In Kamwokya generally the opportunity for women to generate income from a
number of sources is enhanced by the concentration of economic activity in or
near the homes [Wallman 1996]. In an attempt to broaden their incomes the
women have become “occupation pluralist”, participating in numerous
smaller businesses, or alternatively changing from one activity to another
depending on demand, anticipated profit margins or simple convenience (see
chapter 5). Apart from the visible income options, there are those which are
less visible among the Kamwokya women. Though these were not the primary
focus of this study they deserve attention as potential sources of income which
can be drawn upon in times of crisis. These depend on/are based on practical skills possessed by the women. In the women's survey all the respondents mentioned having at least one. Such skills include; knitting, making baskets, hair plaits, brewing, baking, skills in child delivery etc.[Wallman 1996 pp 92-93]. Among these twelve cases, everyone know how to make baskets and mats, and to knit table cloths, Betty delivers babies and treatment especially by injection. Maria has secretarial skills.

Men generally are not sources of the start up capital required to initiate women's businesses. In many cases the spouses of the Kamwokya women, were not even approached. It is mostly the women's relatives or friends who provided the start up capital, even if as credit to be repaid later.

Women’s reluctance to approach their husbands or other men for start up capital and the efforts they make to reimburse what they borrowed, all point to their desire for full autonomy in the business operations. This enhances the probability of their having full control over the proceeds of any transaction. Most Kamwokya women who participate in business activities have full control over the money they make, spending it at will, including for payment for health care when need arises.

Women in Kamwokya argued that participating in income generating activities was not out of choice but necessity. They needed either to supplement their spouse's income which was inadequate, or to support their families as female heads of households. The severity of these hardships varied
from one individual to another. For some women (May, Resty, Sarah, Phina) it is clear that the alternative to no participation in business activities would be destitution and probably starvation as well. Comparatively better off women, such as Betty or Jemima, took informal sector activities, not for basic survival but in an effort to diversify or improve their income options. Unlike the very poor, they were not confronted with problems like salvaging their families out of difficult financial situations. The economic history of women below show the reasons that forced women into business.

Mildred (case 1), and Yatek's (case 2) married, themselves and their husbands working; were compelled into business by poverty, income from their husbands being inadequate to support the families. Mildred borrowed start up capital, from her aunt and started operating a business at home on the veranda. Where as, Yatek was first employed at a bata shoe company. Then got another job as a cleaner at Mulago Hospital. After work she would sell boiled eggs and pancakes by the roadside to supplement her income. Later in 1991, Yatek got job as a messenger job at the University and supplements her wages by selling soft drinks and snacks there. Whenever she gets a chance, she also works as a domestic cleaner.

Aisa (case 4) also married, herself and spouse working, like Yatek (case 2) and Mildred (case 1) was forced into business by economic hardships. She, however, had advantages in that she had previously worked at her aunt's market stall and was conversant with business operations and later the aunt
advanced her a loan of shs. 30,000[$30] which enabled her to start her own business in the same market. Aisa's partner does not have a steady job. It is Aisa's business which has enabled the family to survive.

Similar to Mildred, Yatek, and Aisa, Resty (case 8) is married with her husband working. However, husband works on and off and has never had stable employment. This compelled her to engage in income generating activities to support her family. Resty begun with making of handicrafts, a venture which failed to raise enough money. Resty, then borrowed Shs 10000 [$10] and started selling small quantities of vegetables and basic consumer items first at her veranda and then at a stall. The business kept the family going for a year, until the stall was destroyed and her stock confiscated. She then joined a women's self help group making hand crafts for sale but lack of demand and market outlets defeated them.

When Resty's husband lost his job and gave her the rest of his money to start up again, she made and sold local pastries for a while then started the business selling cow hooves (mulokonyi) at a nearby open air pub.

By late January 1995, Resty had given up the hooves business and had resumed her former one of preparing and selling pastries. In early February she was back to selling fresh vegetables and mats. When asked about the lack of consistency, She pointed out that there are many factors which dictate this, prominent among which is search for larger profit margins and time convenience and that many businesses face stiff competition as everyone
deals in similar commodities. She also noted that the mulokonyi business, though a bit more profitable than, say, pastries, requires good health among family members, especially of the children, if it is to be operated at all. Her absence when treatment seeking, for example, will bring it to a halt; it is a laborious business and cannot easily be delegated.

Betty (case 3) is married, and both herself and husband are working. Her situation is different from the above cases. Betty’s education and training enabled her to get a formal job as a health worker at Kitovu Mission Hospital. She later moved to Kampala, got one teaching job, and then another, and finally started her own nursery school in Kamwokya. When her husband, who was then employed as an accounts clerk, lost his job early 1993 and started a private car hire business using the family car, Betty intensified her economic activities by purchasing a pig and a cow and also got a loan to establish a poultry unit all of which are kept in the backyard.

Phina (case 5), Sophia (case 7) and Jemima (case 6) are female heads of households. Phina is a widow, who on the death of her husband, intensified her business activities to support her family. Luckily she had always been involved in brewing a local millet brew (ajon) and took it up as a full time business. According to Phina it would be booming if the family did not have to rely on it. All family needs have to be covered by the proceeds and there are no profits that could be reinvested to expand the business.
Sophia (case 7) also a widow, first began selling local gin, before she met her now deceased husband, using the money she borrowed from her sister. When she got married, her husband supplemented the business with duty free beer smuggled from the army barracks. Since his death Sophia has indeed fallen on hard times. She is burdened with caring for five children single handily as all her in-laws and own relatives have deserted her. She now sells vegetables on her door step in addition to selling local brew.

Unlike Sophia, and Phina, Jemima (Case 6) is better off and well educated. She had a formal job which she left with the expansion of her family. Her family could no longer survive on the wages she earned. Using accumulated savings, she rented premises down town and started a wax print business which expanded to the point that she had to give up her paid employment and devoted all her time to it. Jemima earns considerably more than she did in paid employment and is contemplating building her own house in Kampala.

May (case 9) and Sarah (case 10) are married, with unemployed husbands. May began working when her husband deserted her in 1987. She took whatever odd jobs she could to survive. Her effort to sell green banana fingers collected from lorries off-loading near the market, met with little success as she lacked the necessary strength and energy.

In 1990 she was evicted for lack of rent payment and left for the village to escape destitution in town. Life was even worse there and she returned to Kamwokya. She rented a tiny room and sold some clothes to raise the small
money necessary to start selling cassava chips. The business limps along, what is earned goes to family sustenance. Her husband is living with her but is unemployed and does not contribute to family upkeep.

Sarah (case 10)'s situation is in small part a result of recent Structural Adjustment Programmes, which caused her husband and the uncle who used to support her joint business with her aunt to be retrenched from the civil service. The family was therefore evicted from the government house, and had to look for cheaper quarters. Both remain unemployed. Her charcoal business with the aunt is failing since they no longer have access to cheap charcoal and with her husband demoralised and not earning anything, Sarah has become the sole breadwinner for the now expanded family.

6.2 Other sources of income for Kamwokya women

Other sources of income available to some Kamwokya women who are married or have a resident man, was through their partners. Cases 11 and 12 (Maria and Ana) rely entirely on their partners for financial support. However, though most of the respondents in this study are married or cohabiting with a man few of them reported relying on this option.

These women are definitely not content with their situation and more often than not they strive to increasing their income by deliberately demanding more money during an illness episode than is required or spent, to ensure that something is available for a ‘rainy day’ in future (Maria, case 11).
Depending on spouses entirely can be very unreliable as is demonstrated by Ana, case 12, now in a pathetic situation. She used to be well off when her husband had a booming business and would provide her with sufficient quantities of money. In other words money was available and he was willing to provide for his wife. When, on the other hand, he acquired other interests (another wife), he became less willing to give Ana money, though he had it, and Ana had to adapt to that situation since there was no way she could formally/legally demand a budgetary allocation. Such channels do not exist for her. Even Maria (case 11) reported declining money allocations from her husband and was thinking of trying some income generating options. Even for these women, most of the food and other basic necessities are bought by men in the evenings or they are given the exact amount required or even less. Hence little surplus cash falls into the women's hands.

Another income option for Kamwokya women is possession of material items (especially personal effects) which can be pawned, hawked or bartered for the cash or services much needed in time of crisis. This is demonstrated by two women (May, case 8 and Ana, case 12) who had to liquidate some material possessions in episodes of acute financial shortage.

Some Kamwokya women try to earn a living through provision of wage labour. A number of respondents have at one time or another been employed and paid wages. Yatek (case 2) is still employed as an office messenger at the university and in the past she worked in a number of places. Betty (case 3)
also worked in many places before starting up her enterprises. This also applies to Jemima (case 6) who was in formal employment and Maria (Case 11) was also employed as a personal secretary before giving up to become a housewife.

The employment option does not attract many women as evidenced by the numbers who abandoned it or decided to supplement it with other options, like participation in business activities. This was attributed to low and meaningless remuneration, dislocation from the home, lack of autonomy at the workplace and to the lack of appropriate educational skills required to get the job in the first place.

Another income option which some women in this study and a number of women 8% in Kamwokya [Wallman 1996] have tried, is joining local self help groups/associations (Munno Mukabi). Often, one of the objectives of being affiliated to such groups is to raise money which can be used in times of stress or crisis. For instance at one time Resty (case 8) joined such an association where the members made a variety of handicrafts for sale. This association disbanded due to lack of organised market outlets and low consumer demand. Women like Resty, who were entirely reliant on it were badly affected and compelled to search for other more or less equally precarious income options, like starting the 'mulokonyi business'.

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6.3 Women's economic activities: the invisible adjustment

These cases show how women must earn a living to support themselves and their families under strenuous situations. Their resilience is demonstrated by the nature of the activities they engage in when men/spouses do not or can no longer support their families.¹ Women's nurturing roles have to be fulfilled whether the spouse is contributing income to the family or not. One woman says "abana bwe batalya gwe bavuna" literally meaning, “if the children do not eat it is the woman who is blamed”; and from a man "omukyala alina okugezako okulaba, abana bafune emmere bwemba nga sirina sente" (a wife has got to try her best to find food for the children when I do not have any money).

Most women, particularly in developing countries, when asked why they join the labour market reply with some variation of "to help my family" or "to provide for my children" [UN 1989]. The women in Kamwokya had similar responses when asked the same question, e.g. Sophia(case 1): "Nali sirina kyakola, ngasisobola kuleka baana kuffa njala" (I had nothing to do, I could not let the children die of hunger).

Yatek(case 2): "Obusente bwo mwami bwali te bumala, nga ninna okunonya ekoyo kula, okutubezawo" (My husband’s meagere money was inadequate, I had to seek something to do for our survival).
Sarah (case 10): "Omwami bwebamugoba, nali sirina kyakukola, Yee ngatayagala kukola bintu bitamuwesa kitibwa nagenda mukyalo, Nalina okusubula nyambe abana bange" (When my husband lost his job, he did not want to do anything demeaning his status, so I had nothing to do but intensify my business operations to support my children).

Adjustment measures leading to a reduction in average real wages, and more generally in per capita income, usually lead at the micro level to a reduction in the income of a family, whether as a result of decrease in the husband’s income, the husband being unemployed or an overall increase in the prices of products the family consumes. This, in turn, can result in the women finding work outside the home in order to maintain the family's standard of living. When the husbands of Betty, Yatek and Sarah, lost their jobs, their families’ income went down forcing the women to intensify their work in the informal sector. For example it was in response to her husbands unemployment that Betty started a poultry unit within her house to supplement revenues from the school.

The income earned by women varied considerably. Such variations are explained in part by whether they are self employed (own account workers) or wage workers, are operating their own business or are working at home or outside the home. The nature of the activities in which they are engaged plays a key role, too. The women involved in the study are own account workers operating their own business, and many of them work either at home.
or close by. There is a variation in activities done, i.e. from owning a nursery school; to a stall in town selling clothes to stalls in Kamwokya market selling vegetables or charcoal, to selling pastries on the veranda and by the road side.... And of course there are variations in the income earned.

6.4 Household expenditure patterns in Kamwokya

The significance of women’s income in the families manifests itself when patterns of expenditure are examined. Without women’s activities in the informal sector, a large proportion of households would not survive. Almost all women, whether married or single as exemplified by the cases, contributed over 70% towards all household expenditures. Betty, though married with a husband running a private hire car, contributes 90% of household expenditures which include school fees for nine children, food, clothing, health care.... Others like Yatek., Mildred, and Aisa cover most of their household expenditures. Some women like Jemima, Phina, and Sarah, support their families all alone. Other cases, like Sarah, Resty and May, though married were covering all household expenditures as their husbands were unemployed (See chapter five).

Similar findings have been observed elsewhere in the world. In India, self-employed women contribute 43% of the household income, and women in specific activities such as vending, have been found to make a bigger contribution to household income, suggesting that they were the main bread winners in the family [Momsen 1991]. In Tanzania, similar trends have been
observed [Tripp 1992 ]. Among the women petty traders in Asia, 65% were either chief earners in the household or shared this responsibility with men. In Srilanka, 56% of the market women interviewed were sole earners in the family [Momsen 1991]. In Uganda, according to the 1991 census, over 30% of the women were heads of household and hence the sole earner [Uganda Population Census 1991]. A women's survey in Kamwokya showed 25% of the women interviewed were heads of households and sole earners [Wallman 1996]

6.5 Conclusion

The personal economic history of the women in Kamwokya clearly demonstrates that women are not just victims, passively suffering from the economic shocks, but struggling to make ends meet for the survival of their families. As has been reported, women's entry into the workforce reflects their response to the economic shocks and their contribution to society's efforts to adapt to profound economic changes. Women are major agents of change, adapting their behaviour to the new economic environment and providing what UNICEF has called the "invisible adjustment" [UN 1989]. Women in Kamwokya are doing exactly that, by supporting their families when their husbands lost their jobs due to the harsh realities of structural adjustment programmes and decades of economic and political mismanagement of the country. They are key decision makers, managing and budgeting for household consumption, and trying to ensure that their
families manage to meet their basic needs during the good and bad times. The men are conspicuously absent, relegating all the responsibilities to women and tending to contribute to family income only when women can no longer cope or else on unregulated manner with variations in the amount contributed. Similar to what was observed by Mwaipopo [1995] in Tanzania, the rigidity in gender roles and the sexual division of labour have meant that women's work has increased. Their reproductive obligations have continued despite other changes in the social and economic environment. We are now observing signs of male backlash and as Campbell[1995] also pointed in Tanzania, the gains by women in earlier decades are being undermined by men's withdrawal of support for their families, during the 1990s, despite their high level of involvement in the informal economy. Men's tendency to ignore some of their household responsibilities needs to be challenged. There is need for both men and women to change their perceptions on household responsibilities under the changing gender division of labour and gender relations.

Given that most women are involved full time in income generating activities, there are bound to be trade offs and conflict of roles due to time constraints. The following chapter examines how women manage their time to meet the demands of household chores and child care and business activities.

1. Husbands are expected to make a financial contribution to the family, Increasingly, this is becoming less and less thus challenging men's basis of status as husbands and household heads.
CHAPTER SEVEN

TIME USE AND CONSTRAINTS FOR POOR URBAN WOMEN

7.0 Introduction

Time is an increasingly scarce resource for many women in the developing world as they carry very heavy burdens of double or even triple workload involving many hours [Momsen and Townsend 1987]. Poor women face crucial trade-offs as they attempt to fulfil their economic, biological and social roles at each stage in the life cycle [Popkin and Doan 1993]. The problem is more pronounced during their child bearing years when these roles are more likely to come into conflict. Time use data suggest that mothers go to great lengths to balance the conflict between market work and child care [Folbre 1988].

This chapter analyses women's time use patterns. The focus is on the time use and constraints women face in managing both their businesses and homes. The case history material reveals that women have different patterns of time use, which are mainly determined by the nature of work or business they engage in. The need to earn money has forced women to adapt to particular time use patterns that ensure that both reproductive and productive activities are catered for. Time can be exchanged for cash or produce valued in kind. Certainly, it is a key resource (or its absence a constraint) in treatment seeking for the women's own illnesses or those of their children. An analysis of women's time use is hence critical in understanding women's treatment
strategies during illness episodes. Extracts from ten cases (women who are involved in business activities) below show the different patterns of women's time use and constraints in Kamwokya.

7.1 Women's time use in Kamwokya

Mildred (case 1), married with children has a very time consuming business. She wakes up very early, often at 5.00 a.m. to prepare the pastries and tea for the early morning passers-by and garage workers. Her helper comes in at around 8.00 a.m. The twins go to a nearby school at around 9.00 a.m. and the other two stay with her. Her husband goes off very early in the morning. Her business goes on throughout the day as customers buy tea and pastries. She closes late in the evenings at 8.00 p.m. and on Sundays she rests. Child care, cooking and other household chores are done concurrently with the business. Overall, Mildred is occupied for over 15 hours a day at home doing business and taking care of her family.

Yatek (case 2), too, is a busy woman. She get up at 5.00 a.m., to do household chores, attend to the children and prepare snacks for sale at her place of work in her absence the children are left with her sister who lives nearby. The sister mostly works over night in Mulago hospital and returns in the morning. When the sister is not around, the children are left with a neighbour until she returns.

At 8.00 a.m., Yatek sets off to the University campus where she spends most of the day. During the lunch break she does casual chores (mostly washing
and general cleaning) in homes within and around the campus. After work at 5.00 p.m. she continues with the casual chores and often returns home late, after 9.00 p.m. Yatek is also occupied for over 15 hours day and out of her home. She spends very little time with the children and by the time she returns home they are asleep. Although the two women, Mildred and Yatek, are poor and engaged in work for over 15 hours a day, the former spends her time at home with the children, while the latter spends all her time out of the home and outside Kamwokya.

Betty's (Case 3) day also starts early, just before 6.00 a.m. Before leaving for the nursery at 8.00 a.m. she must make sure that there is sufficient fodder for the cow and pig and enough feed and water for the chickens. She also makes sure that all the children are ready for school. Her husband helps in these early morning activities and even the children participate in cleaning the water and feed troughs.

At the nursery school, Betty supervises the cleaning and ensures everything is ready for classes at 9.00 a.m. School closes at 12.30 p.m. but Betty stays around to 3.00 p.m., preparing lessons for the following day. From 3.00 p.m. onwards she is home again doing household work or attending to community activities as the RC secretary for women Kisenyi I Zone. Although Betty is busy for over 10 hours a day, she operates both at home and outside the home, all within Kamwokya. This enables her to ensure the family is well catered for and her businesses are running smoothly.
Of the three married women (Mildred, Yatek and Betty), Yatek is more constrained by time as her income generating activities are based outside Kamwokya, leaving her with very little time to spend with her family. Although she is very busy, all of Mildred's work is based at home, enabling her to carry out child care and business concurrently. Betty's time use is flexible and enables her concurrently to run her businesses and care for her family and some community activities.

Aisa's (Case 4) day starts early at 6.00 a.m. Three times a week she travels to Kalerwe market, before 7.00 a.m., to buy fresh vegetables and fruits from the upcountry lorries which off load at that time. By 8.30 a.m. she is back in Kamwokya, cleaning her merchandise ready for sale. Business continues throughout the day until about 8.00 p.m., when the market closes. Aisa stays another half hour storing her produce, cleaning and locking up, and then heads home to prepare for the following day. Her sister-in-law takes care of the family in her absence. If she is breast feeding, the baby is brought to the market. All in all, Aisa works for over 15 hours a day, mostly at the market. She spends most of the day away from her family, but within Kamwokya, and can easily be contacted in case of a problem.

Phina's (Case 5) clients drink every day, but she brews on a "rota" with three other women. She brews for three days in a week and on the other days she gets the brew from her colleagues. When it is her turn she starts around 6.00 a.m., cleaning up, and ensuring that there is sufficient water and charcoal.
Closing varies as she has to wait for all the customers to go, but it may be past midnight. She is usually assisted by her colleagues plus her two young girl relatives. On the other four days the work is less but she still has to prepare for the selling in the evening, and assist the other three women in doing some chores, like collecting water. The “rota” system enables each woman to sell all that is produced for the day and makes the business easier to combine with domestic chores like cooking, child care and cleaning. In summary Phina, like Mildred, has a busy schedule of over 10 hours a day and all her work is done at home. However, unlike Mildred who is busy throughout the week, Phina has four days in a week of less work.

Jemima (case 6) depends on a maid and her sister to cope with her family and business concurrently. They take care of the children when Jemima is not around. She, like Betty (case 3), can afford to hire a house keeper to perform household chores. This gives these two women more time to engage in other activities and even to operate away from their homes.

Nontheless Jemima wakes up around 6.00 a.m., attends to household chores and gets the children ready for school before leaving for her business premises at 8.00 a.m. For the first hour she unpacks and displays her merchandise at the stall. Business goes on throughout the day till 6.00 p.m. in the evening. Jemima does not return home for lunch but depends on snacks which are usually sold around the ‘Katimba’. She sets out for home normally about 7.30 p.m. Jemima, like Yatek, spends most of her time out of
Kamwokya and her home. She has very little time with her children. Both women have their sisters helping out with household chores. In addition to her sister Jemima has a housekeeper and in the absence of her sister, Yatek leaves the children with a neighbour.

Sophia's (Case 7) beer selling business has no opening or closing hours. Customers have to be served, even late at night. Since her business premises is also her home she can be there most of the time. This allows her also to be responsible for child care. In any case, like most women of her class, Sophia can leave her children with neighbours or with friends when she is not around. During weekends and holidays, the older children take care of the young ones in the absence of the mother. Like Phina, and Mildred, Sophia's business is based at home. However, her time schedule is mainly determined by the presence or absence of customers. Her busiest times are the evenings and at night.

The three women in Category B, female household heads, are all busy but with different time schedules. Two, Sophia and Phina, have their businesses based in Kamwokya, while Jemima's is based out of Kamwokya.

Resty's (Case 8) business is not so localised and is more onerous in terms of time. She wakes up between 5.00 a.m. and 6.00 a.m. and by 7.30 a.m., she is at the abattoir, normally returning home before 10.00 a.m. In her absence she leaves the children with her husband if he is around. If not they stay with her stepmother who owns a small shop nearby. The preparation and cooking of
the hooves takes the whole day. Resty usually gets them ready just before 6.00 p.m. and takes the food to the bar/drinking establishments where it is sold. At weekends, she sells off everything by 9.00 p.m., but on weekdays she may wait in vain, to dispose of it all, not getting home before 11 p.m. In all, Resty works for over 17 hours a day. Her time schedule varies depending on the availability of customers or the nature of the business, as Resty has frequently changed occupations.

May (Case 9) wakes up at 5.00 a.m., in order to prepare cassava chips by 6.30 a.m. She sits by the roadside near her home, selling the chips to passersby until about 10.30 a.m. when she has to stop when licensed colleagues, whose enterprises are legal, start selling their own chips. Whatever remains is sold at her home to neighbours and friends who know about her business.

At 3.00 p.m. May goes to the market, about 2 kms away, to buy fresh cassava tubers for the following day's business. This takes a lot of time; more than 2 hours as she has to walk slowly being advanced in pregnancy. During this time and all her absences the children are left on their own. She returns before 6.00 p.m. in the evening to prepare supper for the family. May's busiest time is between 6.00 a.m. to 10.00 a.m. when she is engaged in her businesses. Most of the rest of the day she is at home taking care of the children and household chores.

Sarah (Case 10) operates a charcoal selling business at the main market. On Saturday, she walks to the market to replenish her stock at around 7.00 a.m.
Otherwise her daily routine involves waking up early at around 6.00 a.m. to perform household chores and to prepare the school going children for school. By 9.00 a.m. she has left for the market where she spends the whole day returning home at 7.00 p.m. Sarah, too, spends most of her time out of her home and works for over 14 hours.

Of the three women in category C, married with unemployed husbands, May is the least constrained by time. Resty is a very busy woman but her time schedule varies, depending on the kind business she is running at the time in question. Though unemployed, none of their husbands assist with child care or household work. Resty's husband occasionally minds the children, but indoors. All men, whether employed or unemployed, spend most of their day out of Kamwokya and away from their homes. Observations made in the larger study revealed that more men leave Kamwokya during the day than women; 83% of adults who left Kamwokya between 9.00 a.m. and 10.00 a.m. were men and three quarters of the adults who left between 7.00 a.m. and 9.00 a.m. were also men. The same number are observed returning late in the evening [Wallman 1996 pp: 36].

7.2 Conclusion

It is evident, therefore that the women are fully occupied, and that the nature of their businesses requires their constant attention. Similar to other studies which indicate that women in developing countries have less leisure time (see chapter 2), the women in Kamwokya are fully occupied for over 10 hours a
day, some even working late into the night. Many have tried to cope with the conflicting priorities of business and child care by setting up their businesses within or around their homesteads. Time constraints for the majority are due to their income activities which are precarious and marginal, requiring their constant presence and attention.

There are variations in experiences of time constraints by women, which are due to the nature and differences in activities engaged in. For instance, Yatek is more constrained by time as her income generating activities are based outside Kamwokya, leaving her with very little time to spend with her family where as Mildred is very busy all day, her work is based at home, enabling her to carry out child care and business concurrently. Betty is a very busy woman though, her time use is flexible and enables her concurrently to run her businesses and care for her family and some community activities.

As for the female household heads, they are all busy but with different time schedules. Sophia and Phina, have their businesses based in Kamwokya, while Jemima's is based out of Kamwokya. Of the married with unemployed husbands, May is the least constrained by time. Resty is a very busy woman but her time schedule varies, depending on the kind of business she is running at the time in question.

In describing their time use patterns, none of the women mentioned any time for leisure. Women pointed out that they relax with friends while carrying on their businesses. Local leaders complained of women's constant absence in
village meetings and projects. Even participation from women's groups or associations was very low; only 8% of the women interviewed in Women's Survey were members of a group or association [Wallman 1996]. Studies in the Philippines have identified women's time as a key adjustment factor, and show that increases in women's market participation were accommodated by reductions in their leisure time. The time devoted to domestic work and child care remained roughly the same [Kabeer 1994]. Popkin notes also in Philippines, that there is a close, one to one correspondence between an increase in maternal work time and the decrease in maternal leisure time [Popkin 1983]. In Nepal, Women worked longer hours in the economic and domestic activities and had less time for leisure and social activities than men of an equivalent economic stratum [Kabeer 1994]. Elsewhere, in Uganda, similar observations have been made; it was found that the urban poor have to be in their business places (markets, verandas, street etc.) by 6.00 a.m. and women put in more working hours per day than men who become free after work [Basirika 1992]. Women virtually have no leisure time. While Sundays are considered to be resting and socialising days, the women still have to perform many activities like cooking, fetching water, cleaning and looking after the children [Nalwanga & Natukunda 1988].

The lack of change in the intra-household division of labour, which Kabeer refers to as "stickiness in intra-household labour allocation" [Kabeer 1994 pp 106], has greatly contributed to women's time constraints when they engage
in market activities and child care and household chores at the same time. The reluctance of many men to take over child care or responsibility for household chores has left women with a heavy burden, and little time for leisure.

The situation becomes more complex when it relates to treatment seeking which may require being away from the home or the business or both. Any time spent away from economic activity means loss of the meagre income which for many is vital for the daily survival of the family. In addition, some women have no one to take care of the other children and to do household chores. The women stressed that they needed to be present in person to operate their business activities. In case of an illness episode, therefore, women were found reluctant to use options like visiting hospitals, because it takes not less than an hour to receive treatment there. They prefer visiting clinics and drug shops where time costs are much lower. Regardless of disparities in income and social status, most of the women are severely constrained by time in their business operations. Women have to utilise every minute available to them to make ends meet. Any disruption like an illness may mean starvation for the whole family. Many of the women have combined household chores and child care with business, however, an alternative has always to be found when the mother is away due to illness or any other reason. The next chapter examines women's health seeking behaviour and the factors that influence the choice of treatment.
Most men talked to indicated that, traditionally, child care and household chores is women's work. Men said, though willing to help out their wives, they feared being ridiculed by neighbors and relatives or being taken as bewitched men and thus under women's control. Most women supported the men and did not want their husband ridiculed. Sharing responsibilities like child care and household chores was not women's main concern but men's financial obligations to the family.
CHAPTER EIGHT

WOMEN'S TREATMENT SEEKING BEHAVIOUR: RESOURCES AND CONSTRAINTS

8.0 Introduction

The last two chapters (chapters 6 and 7) spelt out how women gain access to money and manage their time. It has been shown that women have access to money mainly through participation in business, and as a result, they are heavily overburdened with work and thus constrained by time. Most of the women work for over 14 hours a day, leaving them with little time, if any, for leisure. For many of the women, no business would mean starvation of their families. Many therefore have no option but to intensify the search for money through income generating activities. The question is, to what extent does this kind of situation affect women's treatment seeking behaviour when they or their children are sick?

This chapter explores resources and constraints affecting women's treatment seeking behaviour during illness episodes. The focus is on how women balance treatment seeking with their other responsibilities, already described in chapter 6 in the face of time constraints. Section one discusses the influence on treatment seeking behaviour, of the different ways women have access to money; section two considers the influence of business location; while the
third examines time use and its effects on women’s choice of treatment options.

8.1 Access to money and treatment seeking

Most of the women involved in the study have access to money through engagement in a wide array of income seeking activities. Some of these are viable and others are not. The effect of the viability/non viability of the businesses is evident in relation to the type of treatment sought, how long it takes to seek professional help and where it is obtained. The cases show a close link between the nature of business activity and its viability, and the patterns of resort when illness occurs in the family.

Betty (case 3) and Jemima (case 6) who have more monetary resources at their disposal, by virtue of operating viable enterprises, clearly have a wider range of options that require money. During the illness episodes of Betty’s children and herself, for example, she could take advantage of a number of options. These included administering drugs purchased from a drug shop, visiting a doctor at Kisenyi valley clinic, visiting a nurse at a 'house/clinic' and a traditional healer outside Kamwokya. All these options cost money and Betty paid promptly in cash.

Jemima, who has a child with sickle cell anaemia, sought treatment at the Family Doctor’s clinic at Kisementi in Kamwokya I parish, St Catherine’s clinic in downtown Kampala and the Acute Care Unit, Mulago. For all the treatment options taken during the child’s illness episodes she paid the bill in...
cash [over $55]. Both women [Betty and Jemima] sought treatment for their respective children as soon as the symptoms were interpreted as serious (see diagrams 3 A & B and 6 A&B). In both cases also, treatment seeking was not limited to local sources in Kamwokya II, but extended outside (Ntinda, Kamwokya I, Downtown Kampala and New Mulago hospital).

Though Mildred (case 1) considers her food business viable, when her children fall ill, that viability comes into question. She first resorts to the non-cash home remedies [first aid, use of drugs available at home and administering medicinal herbs]. It is only when the illness symptoms become severe that she takes the children either to Muna clinic or Mulago hospital (see diagram 1 A&B). With the latter options she finds it difficult to raise money and ends up paying the bills in instalments, taking credit or being assisted by her partner.

Sarah (case 10), too, considers selling charcoal at the main market to be a viable business, but, in terms of generating funds for treatment during illness episodes, its limitations become apparent. During the second illness episode of her child, for instance, all her operating capital was spent on paying the treatment bill and other related costs amounting to Shs 9300 [$ 9.3]. She had to borrow money to start afresh. Like the rest of the women whose businesses are only marginal, Sarah deliberately delays using the cash option and does not seek treatment outside Kamwokya II, apart from Mulago hospital in extremes. (see diagram 10 A&B)
Mildred and Sarah demonstrate that the viability of a business does not mean that money is always available when an illness strikes in the home. Further, more most of their money is for most of the time tied up in stock; any small profit is spent on daily supplies at home. Unlike Betty and Jemima, neither woman has a bank account or other savings.

Some of the other women’s businesses are more precarious and non viable. The effects of non viability of these businesses on women's treatment options are also strikingly visible. Most obvious is the limited range of cash options utilised by these women when they or their children fall ill.

Aisa (case 9), who operates a fruit and vegetable stall in the main market, uses more non cash options than those that require money. When her child Musa fell ill she utilised the non cash options first, before later rushing the child to Mulago in a critical state (see diagram 9 A&B). A similar situation occurred when another child, Sanyu, became sick. In all cases, Aisa's partner had to step in to clear the bills.

Sophia's (case 7) behaviour was no different when her child fell ill. She first exhausted all the non cash options before finally taking him to Mulago (see diagram 7A&B). During the boy's second illness episode it was only the severity of the symptoms [severe diarrhoea and high fever] which compelled her to opt for the cash options initially. For her own illness, Sophia (like the other women in this economic category) does not utilise the cash options unless, and until, the situation becomes critical.
Resty's (case 8) business of preparing and selling cow hooves (mulokonyi), is so precarious that it can hardly generate any funds, let alone treatment money. In episodes of illness, she certainly cannot afford to utilise those options which require cash. After exhausting non cash options, she will wait for the symptoms to become critical so as to warrant 'free' treatment at the Acute Care Unit at New Mulago hospital. In fact, during the first illness episode of her child, Janet, I encountered her in such a situation and helped her out (by taking the child to the clinic with her and paying the treatment bill). During the third illness episode of her child, Resty desperately sought and got treatment from the clinic on humanitarian grounds. Apart from the nearby Mulago hospital, Resty does not seek treatment outside Kamwokya ward. (see diagram 8A&B) In all illness episodes of Resty's child, she could not foot the treatment bills. Treatment was either on, credit, humanitarian grounds or money was borrowed by her husband.

May (case 9) is another desperate woman. She operates a business selling cassava chips which is so precarious that any profits, are absorbed by daily subsistence. In episodes of her own or her children's illness, therefore, she is compelled to use the non cash options, (see diagram 9A&B) and when these prove ineffective she (like Resty) waits for the illness to get critical enough to warrant 'free' attention at the Acute Care Unit. During the successive illness episodes of her child John, for example, she sought treatment at the nutrition clinic. All the same, however, some costs were incurred and she had to
borrow money to pay up. For her own serious bout of asthma, she sought treatment on credit from a nurse. Apart from Mulago hospital, May also does not seek professional help outside Kamwokya II.

As regards women who have access to income only through their spouse, Maria (Case 11) and Ana (case 12), the choice of treatment options appears to be determined by the status and income levels of the spouse. For instance, Maria, whose husband is a lawyer with a fairly stable income, readily uses options that require money, whereas (see diagram 11A&B) Ana, whose husband is poor, utilises these options only as a last resort (see diagram 12A&B).

8.2 Location of business activities and treatment seeking options

Most women's enterprises in Kamwokya are either home based or located close by. Mildred, for instance, operates her business at her doorstep. Betty has her livestock units within her backyard and operates a nursery school close to her home. Aisa runs a market stall near her home. Phina brews and sells ajen at home. Sophia sells waragi and Resty prepares mulokonyi at home. May's business is both home based and close by on the road side. Similarly these women choose treatments available at home or close by. For example when Mildred's children or she herself fall ill, her first option is self treatment at home or Muna clinic a few metres away. When she fell ill, a nurse was called in to treat her at home. A similar pattern is recognised with the other cases. Yatek, for instance tries to treat her child at home. Betty either
treats her child at home or at a nearby 'house' clinic. Even Kisenyi valley clinic, where she sought treatment during the child's second illness episode, is close to her home. For her own illnesses Betty mostly treats herself or calls a nurse to treat her at home when she does not improve.

Apart from Jemima, who sought help for her child and herself from St Catherine's clinic downtown in Kampala, there are no other cases where professional (biomedical) help was sought beyond Mulago hospital. However a number of women frequently sought treatment from traditional healers out of Kamwokya (see Yatek, Betty, Aisa)

It is thus apparent that it is not only the women's business activities which are home based, but also, to a large extent, their treatment options. Is there a common link here? My argument is that a link exists between business and reproductive activities. Together (health care in the family being included in the latter category) these are central to the survival of the women and their respective families. Women are therefore under pressure to make decisions regarding the type and location choice of businesses where they can be carried out alongside their reproductive obligations.

The way women initially opt for home therapies or visit facilities which are very close to their homes can be seen as a response to the constraints of their business choices. Treatment options which would require them to be away from their homes/businesses are only resorted to when the illnesses become
critical. The following verbatim comments of the women when describing their illness behaviour clearly illustrate the problem;

"Omwana bwa lwala okugenda e Mulango kinkalubiriza kubanga omalayo ebanga adene osanga nabandiguze ga bagenze walala" [ Going to Mulago hospital is difficult for me because one spends there a long time. You may find that potential buyers have gone elsewhere].

"Nze ngenda wano ku ka clinic, wenyanguwa nenkoma mangu nensobola ate okukola kuka sente akanatubeza wo" [ I go to a near by clinic where little time is spent, which enables quick return to my business ].

"Nze sitela kulwala, bwendwala nejanjaba wano awaka, nensigala ngabwendabirira ka business kange akatubezawo, nawe olaba omwami takola" ( I rarely fall ill. If I do I treat myself at home while taking care of the business which we survive on, as you can see my husband has no job).

The location of businesses is also directed by the nature of their operation. Most of them are one person ventures; group management or delegation are apparently rare. Even in cases where assistants are involved ( cases 1, 3, 5 and 10 ), their roles are peripheral since, in the absence of the owners, they fail to cope and the businesses/activities are detrimentally affected, some of them grinding to a halt.

When, for instance, Mildred's child was admitted to Mulago hospital for over one week, her business collapsed and she had to start afresh, in spite of having
delegated it to a helper. On the other hand, when she was ill and bedridden but at home, she managed to give instructions to the helper and the business survived. When Phina was away from home for three days attending her sick child at Mulago hospital, her business, although she had entrusted it to her assistants, almost collapsed.

Jemima's business was affected in a similar way when she was away for a fortnight attending to her critically ill child. Despite her delegating it, it suffered a great deal as nobody attended to her customers properly.

Sophia openly expresses distaste for having her child hospitalised. When, once, was unavoidable, she requested a premature discharge. To quote her verbatim, "I was terribly worried about home and more so my business, if I spent many days at the hospital. All the money would be used up and there would be none for the business."

The high opportunity cost to the business (money) of seeking treatment is characteristic of most of the cases. It is only in critical situations, (e.g. when a child is convulsing or semi conscious) that treatment options which disrupt business operations are taken up. As noted, in a number of cases such choices can result in the collapse of the businesses (loss of money) and thus severe consequences for the women and their families alike.

For their own illnesses the situation is even worse, with treatment seeking being delayed as long as possible or the women resorting to options which they know to be dangerous like calling in a quack practitioner to administer
treatment at home (see diagrams 1C to 12 C). May, for example, was encountered working even when very ill, indefinitely postponing or completely denying herself treatment.

Apart from the deterioration and collapse of the businesses, many of them cannot raise enough funds for illness expenditures when the need arises. For instance, May, whose business can barely keep them alive, resists anything which interferes with her business and even had no time to attend the nutrition clinic where food stuffs would be provided free of charge for her severely malnourished children. The one time she had attended the clinic had resulted in the loss of many customers and hence money.

Resty a number of times could not afford treatment at the clinics and had to rush the child to Mulago hospital. Further, a number of other women like Mildred, Sophia, Phina..., often had their children treated on credit because they could not raise the required cash at the time of the illness.

Given the high cost of women's absence from business activities (which means loss of money) they have to make rational decisions on whether or not to seek treatment, the type of treatment to choose and where to obtain it. A balance has to be struck between these health care choices and the operation of business activities. At the centre of it is time use, which is explored in detail below.
8.2 Time use patterns and treatment seeking

All the women engaged in business (10 of the 12 cases) have busy schedules, many of them occupied from dawn to dusk. Time use patterns were found to influence women's choice of treatment during an illness episode. There are variations in choices of treatment due to differences in time use patterns as demonstrated by the cases below:

Mildred (case 1) is a very busy woman, fully occupied by her business. When her child fell ill (1st episode), first aid was administered at home and later the child was taken to Muna clinic, almost next door, where he was treated and discharged within less than an hour. In Mildred's own words "my business was not affected because the time I spent on treatment seeking was little". Both the first aid at home and the visit to Muna clinic cost little in walking, waiting or treatment time. This is a factor in Mildred's preference for these options over others.

During the child's second illness episode Mildred initially used drugs available at home, in spite of the seriousness of the symptoms. When the child failed to respond to the home treatment, she visited the clinic in the market area, also not far from home. The time spent to get treatment at the clinic, preparing the child, walking to the clinic, waiting and getting treatment was around one hour and again Mildred's business was not much affected.

Time constraints, however, become manifest when Mildred is advised to take the child to Mulago hospital. Instantly she gets worried, as reflected in her
remarks, "I knew that even if I stayed in hospital for only a few days, my business would stall". Mildred's fear was not about visiting Mulago hospital, but the probability of admission, considering the severity of the child's illness. She knew in advance that the cost of hospitalisation would be the immediate collapse of her business and consequent loss of money; this is exactly what happened when the child was hospitalised for eight days. Business time was sacrificed for treatment seeking time, making the fate of the business inevitable. It is no wonder that Mildred refused to revisit Mulago hospital to have the child checked up after discharge.

Where her own illness is concerned, Mildred admits falling sick several times but considers it not worth mentioning and presumably not worth seeking treatment for. When she suffered a severe bout of pneumonia, which she took to be malaria, she opted for self treatment at home with over-the-counter drugs. Later when she failed to respond to self treatment, a nurse was called in to treat her at home.

All the treatment choices utilised by Mildred are home based and her reluctance to utilise other options is evident. On several occasions she even denies herself treatment on the pretext of her illness not being serious enough to mention, let alone warranting treatment.

One of the explanations for this illness behaviour was time related constraints. If she utilised options away from home, these would adversely affect not only her business but also her family's survival. Mildred points out
that, though bedridden for four days at home while recuperating from illness, she at least had time and opportunity to direct her business from her bed and to ensure its continuity. This was unlike the previous episode when she was away for eight days attending her child at Mulago hospital and the business had collapsed.

Yatek,( Case 2) points out that when she takes off time to seek treatment (especially for her children,) her supplementary income activities (e.g. casual labour) are badly affected. Once, the condition of her child was so critical that she had to seek treatment outside Kamwokya and even had to reside at the traditional healer's premises for weeks and months.

Betty's (case 3) illness behaviour also appears to be much affected by the time at her disposal. When she noticed the symptoms of her child's illness, her first option was to administer over-the-counter drugs at home and to ask a relative to watch over the child so that she could go to work at her school. When the child's illness persisted she visited Kisenyi valley clinic, near her home, and later a 'house clinic', managed by a nurse friend close by.

In this case, the fact that Betty hurried off to her business leaving a sick child at home in an elderly relative's care reflects the conflict between business time and treatment seeking time. Here, Betty weighed the opportunity costs involved and first chose a treatment option which would not interfere with her business time but would still ensure that her child got some sort of attention.
The next option taken was visiting nearby Kisenyi valley clinic when the nursery school had closed for the day. By visiting the clinic in the evening her main business was not affected. Her other (livestock) business could be managed by other family members. Total treatment seeking time at Kisenyi valley clinic [preparation of the child, travel, waiting and treatment time] was estimated to be less than an hour, which Betty considers negligible.

When the child did not promptly respond to treatment at Kisenyi valley clinic Betty went back to her nurse friend at the neighbouring “house clinic”. The child was immediately attended to since she was the only visitor. Betty estimated the overall treatment seeking time to be less than half an hour. The little treatment time spent at this facility is surely one reason why Betty prefers it to others, like Mulago hospital, which she knows offers superior services. The fact that a person like Betty with a biomedical training background chooses an inferior treatment option, so as to minimise time costs, goes far in demonstrating how crucial a resource/constraint time is both to her business operations and her treatment seeking behaviour.

During the second illness episode of the child, Betty proceeded in the same way. It was not until obulogo a more complicated ailment, was diagnosed by her mother-in-law that she was compelled to seek specialised treatment from a traditional healer at Ntinda outside Kamwokya.

That treatment "cost" included extra travel, waiting and treatment time but Betty was happy with the appointment time at the healer's 6.30 p.m. in the
evening is the time when the therapy is allegedly effective and this allowed her to operate her nursery school business from 8.00 am until 3.00 p.m. in the normal way.

For her own illness, Betty relies mostly on self treatment and when seriously ill, she visits facilities like Kisenyi valley clinic which anyway is nearby. When she suffered from sharp stomach pains, locally referred to as "kinsimbye" she could not take time off to seek care until she collapsed at school. The fact that Betty is reluctant to visit even those care facilities where time costs are low or to take even a recommended short sick leave[ 2 days] provides further evidence of how highly she values business time. She explained that time spent on treatment seeking is a sacrifice of time that would otherwise be devoted to business.

Aisa, (case 4), as already noted, has a business which is taxing time-wise. When her child fell ill (1st episode) her first option was to administer anti-malarial drugs at home, followed by medicinal herbs provided by her landlord Jaja. It is striking that Aisa chose this option in spite of the child's "serious symptoms" high temperature and rapid breathing(see diagram 4A). Three hours later, when the child became critically ill, Aisa had no alternative but to take him to Mulago hospital. According to her, other options closer to home, such as the clinic could no longer manage the child's situation.
Before deciding on this option, however, Aisa was well aware of the adverse effects her absence would have on the business. She thus tried to guard against them by delegating her business to a friend.

During her attendance on the child during the four days admission at Mulago hospital, as expected, we see the business declining and finally actually collapsing as the caretaker, due to lack of contacts, could not replenish the stock.

For the child's second illness, Aisa utilised time saving options such as traditional herbal cures and protective amulets and fetishes provided by her landlord or her grandfather. It was only after these remedies failed that the child was taken to Mulago hospital where Aisa staunchly refused his admission. She knew what the consequences of admission would be for her business and family: "I could not accept being admitted, otherwise what would my children eat?, Where would I get the money for treatment if I did not work?"

Like the other cases, Aisa admits being ill herself only when the condition is acute. When she suffered from intermittent fever she took no time off to seek treatment. However, when she developed a serious gynaecological problem and had no alternative but to stay three weeks in Mulago hospital, her illness had severe repercussions both for the business and her family.

Phina (case 5) is a poor widow and household head and has a busy daily routine managing her ajon business. Phina, unlike the others, does not appear
to have much confidence in home remedies. In fact she is so scared of children's diseases that as soon as signs or symptoms are noticed, she takes time off and hurries to the drug shop/clinic near her home. She believes that the earlier the treatment, the faster the recovery and hence the more time saved.

During her child's two illness episodes, Phina went promptly to the drug shop/clinic, having delegated her business to some helpers. By doing so she ensured that the business was not compromised by the time she spent seeking treatment for the child. Also, visiting the drug shop/clinic near her home, reduced the travel time to a bare minimum; and choosing a facility where she has contacts and is promptly attended to, ensured a reduction in waiting time. In fact, during the two visits to this facility, total treatment seeking time was less than 30 minutes on each occasion.

By contrast, when the critical condition of her child compelled Phina to attend him at Mulago hospital for 3 days, the effects on her business were immediately telling. Although she delegated it and gave instructions from the hospital, it declined and almost ground to a halt. The child's second illness episode did not involve hospitalisation, and therefore did not affect the business.

Her own only illness is backache, which she attributes to bending while brewing ajo. She treats it with time saving options like drugs purchased from the drug shop/clinic.
Jemima (case 6), a fairly well off household head is a very busy woman. Unfortunately, she has a sickly child who needs frequent health-care. How does Jemima adapt to this situation? During the first illness episode of her child she visited St Catherine’s clinic after an emergency visit to the Family Doctor’s clinic, as the former facility had closed for the night. During the second illness episode she again visited the St Catherine’s clinic and later Mulago hospital, where the child was admitted.

When Jemima utilised these options she was promptly attended to, thus reducing overall treatment seeking time. She also believes that the options chosen, especially biomedical attention at St Catherine’s clinic, bring about speedy recovery, which means saving time for business. Jemima’s choice of the expensive options may not be due just to the fact that she can readily afford them in terms of money, but also it may be an attempt to ensure increased business time in the future through the fast recovery and subsequent good health of her child.

The deleterious effects of treatment seeking on business time are also evident when Jemima takes off a fortnight to attend to her hospitalised child. Despite her delegating it, her business deteriorated considerably.

For her own illness, Jemima first opted for self treatment with over-the-counter drugs, a time saving option. When the symptoms persisted she visited St Catherine’s clinic where waiting and treatment time amounted to less than an hour. Further, she ignored a recommended two day bed rest, since that
time, as she says, would have been at the expense of business. Apparently, Jemima has to utilise most of the time at her disposal to operate her business, even if this means working before she has fully recuperated.

Sophia (case 7) is a household head but also a poor widow who operates a business with no opening or closing hours. She and her family rely entirely on this business for survival, hence her need to increase and fully utilise business time. When Sophia's child fell ill, she did not take him to Mulago hospital until all the time saving home options had been tried and found wanting (see diagram 7). The latter included the use of local medicinal herbs and tablets provided by a non professional practitioner.

When she eventually took the child to Mulago hospital she refused hospitalisation and he was discharged on the same day. She did not even complete the out-patient treatment for the child. Sophia's initial choice of the time effective home based options, refusal of hospitalisation and the failure to complete the prescribed course of treatment do not mean that she does not prioritise her child's health. Rather, her illness behaviour should be seen as a desperate attempt to strike a balance between treatment time and business time. Loss of business time, in fact, may have more far reaching consequences for family survival.

Nevertheless, as indicated by the child's second illness episode, the severity of illness symptoms may compel one to sacrifice business time. In this case, Sophia had no alternative but to visit Mulago and to accept hospitalisation
for at least three days, before requesting to be discharged. Even going for care out of Kamwokya (at Kyebando), entailed a sacrifice of time that would otherwise be spent on her business. Nor does Sophia seek professional care for herself at Mulago hospital until the situation is critical. When she was admitted for one week for a surgical operation, the business collapsed with dire consequences for her family.

Resty (case 8) though married, is a desperately poor woman trying to make ends meet by operating a precarious and time demanding 'mulokonyi' business. When her children fall ill, Resty finds it difficult to take off time to seek treatment. In one episode she had to leave a very ill child behind and hurry off to purchase the cow hooves. On a number of occasions also she waited for the child's condition to get critical enough to warrant prompt, emergency attention in the Acute Care Unit at Mulago hospital (see diagram 8). This is in contrast to the Out Patient Department where one waits in long queues and often ends up getting mere prescriptions.

Resty's illness behaviour, which may even jeopardise her children's lives, is partially to be explained as a desperate attempt to maintain the business so as to ensure family survival. The third illness episode of her child involved a week of hospitalisation and actually resulted in the collapse of her business, with dire repercussions for her family.

For herself, Resty was compelled to take off time for treatment only when she had a miscarriage and had to go to Mulago hospital otherwise she works.
It is not that Resty does not value her life but that she must try contain the effects of ill health on her vitally needed business time. When she was hospitalised she had to request a premature discharge but even, by then, her business had already collapsed.

May (case 9) is also very poor and with minimal support from her husband. Her cassava chips business demands her presence. So when her children fall ill, her initial choices are the home based options. Unfortunately, both the illness episodes of her child were severe and left her no choice but to seek care at Mulago hospital where the child was hospitalised. In all these episodes treatment seeking was at the expense of business time and led to the temporary collapse of the business. This accounts for her refusal to attend the nutrition clinic, in spite of the free milk and soya flour provided there. She reasoned that the time spent at the clinic, instead of her business, was not worth the 'free' powdered milk and soya flour.

When she herself is ill, May continues working as long as she can. When she had an acute attack of asthma she forced herself to go to the market but later called in a 'nurse' who gave her injections which she expected would minimise treatment seeking and recovery time. This option can be seen as an attempt to reduce time loss. The strategy failed, and the following day she was unable to transact any business due to the recurrence of the illness. Like other women, May also did not have time to take a recommended two day bed rest.
Sarah's (case 10) charcoal selling business at the main market requires her to be there most of the day. Her attempts to increase her business time become evident when the options she chooses when her children fall ill are examined. During the first illness episode the choices included treatment with drugs available at home, herbal baths and watching over the child. This being delegated to a sister in-law, Sarah could attend to her business. Later actions included a visit to the nearby Muna clinic which took less than an hour overall, and the resumption of herbal baths and the administration of traditional medicines at home. Time spent on treatment seeking was minimal, sparing Sarah sufficient time to attend to her enterprise.

However, the child's second illness episode was acute and left Sarah with no alternative but to accept hospitalisation at Mulago hospital. Though she requested and was granted a premature discharge, the three days absence had dire consequences for her business. She had to borrow money to start afresh. For her own bronchial congestion Sarah relied on a strong concoction of traditional herbal medicine an option which cost her little in terms of time.

Maria (case 11) is fairly well off but relies entirely on her partner's income. The fact that she has no business means that she is free of business pressure and has adequate time to spend on other issues. During the reported illness episodes of her children, for instance, Maria did not attempt any self treatment but took the children directly to health-care facilities. During the first episode, Maria even visited the clinic before measles was diagnosed.
Similarly, during the illness episode of the four month old baby, Maria did not administer any home treatment but went directly to visit Kisenyi valley clinic and, later, Mulago hospital. At Mulago where the child was admitted, Maria, unlike the business women, did not need to ask for premature discharge. Among other factors, this difference in illness behaviour can be attributed to more time resources being at Maria's disposal. She is not engaged in any time demanding business.

For her own illness, however, there does not seem to be any difference between Maria's treatment seeking options and those of the business women. For instance, in spite of seeking professional help at Kisenyi valley clinic and Mulago hospital respectively, she too resorts to traditional herbal medicine. She pointed out the traditional herbs were meant for cleaning and prevent further infections.

Ana (case 12), also has no business and relies entirely on support from her husband. Unlike Maria, however, she is desperately poor and her treatment options appear to be dictated more by shortage of money than by lack of time. For instance, when she requested an early discharge from Mulago hospital, it was not due to time constraints as in the case of the business women, but to a combination of other factors like her inability to pay, the chronic nature of the child's illness and lack of somebody to leave at home.

In the case of her own illness, Ana's refusal to visit Mulago hospital in spite of her husband's advice was again not aimed at saving time but due to
financial constraints. Throughout her own illness episodes she relied on traditional medicinal herbs which cost little time and money.

These findings are in conformity with other studies done in the country (see chapter 2 and Bagenda and Barton 1993). Observations around private clinics, and drug shops in Kamwokya revealed that most patients spent less than 30 minutes at the clinics and less than 15 minutes at the drug shops [Wallman 1996 Chapter 6]. Observations at Mulago hospital showed that patients spent about to about two to three hours before getting treatment. The fastest providers seem to be the drug sellers in drug shops and peddlers, with an average time of under five minutes.

The women show a clear preference for treatment options that take a very short time. They mostly visited Mulago hospital when the illness was severe and could not be handled by fast providers or when there was no money to seek treatment else where. A household health budget survey showed that in Uganda when the round trip travel time is added to waiting time, about a third of the respondents said it took them three hours or more to obtain care. This amounts to the loss of half a day's work. One tenth said it took them eight hours or more. They lost a full days work. The study revealed that on average, persons going to the formal sector made the biggest time investment to get treatment. With such a situation no wonder women are reluctant to utilise such facilities [Barton and Bagenda 1993].
The above factors explain the low utilisation levels of government health facilities. In Kamwokya, as already shown above, over 90% of the illness among children and women were treated at non-government facilities like private clinics, drug shops and traditional healers.

Patients are also distressed about the discrepancy between their expectations of time with the provider and what actually occurs. The women in Kamwokya stressed the in-humaneness and arrogance of the health workers at government facilities. A study in Mukono district outlined a number of factors responsible for the poor relationship between health workers and women which leads to poor services being rendered to patients and non-utilisation of services [Bantebya 1994]. These included, poor working conditions, poor remuneration, lack of facilities and drugs, overworking and negative attitudes from the patients (Women) who felt that the health workers were denying them drugs and sending the patients to private clinics [ibid.].

In Kamwokya, the situation is different both for health providers and patients. As shown by the case studies, women seek health care mostly from the facilities they know will treat them properly. Secondly, most of the providers are members of the community who rely on other members for their business and social relations.

The Family Household Health Spending Study [1994] found that, nationally people actually use the formal government facilities much less commonly (only 52% of all illnesses in a two-week recall) than their reports of either
nearest or preferred provider would suggest [Barton and Bagenda 1993 NCC 1994]. Government facilities were only used for 21% of all the illnesses episodes, despite having been identified as nearest by 32% of respondents and a preferred site by 38%. The informal sector was used far much more often than suggested by statements of nearest or preferred provider[ibid.]. The study reveals to what extent peoples' statements, can differ from their behaviours.

A similar situation is apparent in Kamwokya. While women know Mulago hospital to be the biggest teaching hospital in the country, with consultants and doctors and facilities for most illnesses, they only use it as a last resort. In the larger study over, 60% of the respondents indicated receiving treatment regularly from clinics, drug shops and pharmacies[ Wallman 1996 pp 107] In case of their own illnesses, women rarely use even the facilities that are a stones throw away. They prefer to rely on home treatment with herbs and over the counter drugs. This all points to the complexity of the time costs and opportunities.

8.4 Conclusion

In conclusion women in Kamwokya are entirely responsible for illness management in their households and have considerable power to define and decide where and when treatment is sought. Money is not always available for treatment seeking but operating an income generating activity makes them credit worthy, enabling them to receive treatment on credit. The very poor,
rely heavily on home treatment and Mulago hospital when symptoms can no longer be managed at home. However due to the multiple roles women are engaged in, time has become a major constraint with variations for different women and is a major adjustment factor. Treatment is sought in a manner that will not disrupt the harmony.

The majority of the women are faced with time constraints due to their precarious income activities which require their constant presence and attention. Any time spent off the activity means loss of meagre income which for many is vital for the daily survival of the family. The women stressed that they needed to be present in person to operate their business activities. In case of an illness they therefore were reluctant to use options like visiting hospitals, because it takes (not less than an hour) to receive treatment there. Instead other options like visiting clinics and drug shops where time costs are much lower, are preferred. As shown in chapter 7, there are variations in experiences of time constraints by women, which are due to the nature and differences in activities engaged in, which is reflected in their treatment seeking behaviours.

In general, women try as much as possible to limit the time they spend on treatment seeking. Many of them end up with serious conditions which require professional attention and often hospitalisation. For most illness episodes women deliberately underplay the severity of the symptoms so as to continue operating their businesses.
In the next chapters (9 and 10) other factors which influenced women's treatment seeking behaviour are discussed.

1. A house/clinic is a residence being used unofficially as clinic by the owner/occupant.

2. A number of studies throughout the Third World have indicated women's activities in the informal economy are situated within or very near their homes. This enables them to concurrently pursue business and carry out their domestic responsibilities (see chapter 2).
Diagram 1 Mildred's treatment seeking behaviour

1A 1st illness episode: child

Geographical locations
1 = Household
2 = Zone/village
3 = Parish Kamwokya II
4 = Kampala
5 = Outside Kampala

Treatment options/locations
A Home treatment symptoms not serious
B Neighbour herbs symptoms serious
C Clinic symptoms very serious

Diagram 1 B
2nd illness episode :child

Treatment options
A Home treatment with anti malarial drugs; symptoms serious
B Clinic symptoms serious
C Hospital (Mulago); symptoms very serious
Diagram 1 C
Mildred’s illness episode

Professional Non professional

Diagram 2 Yateks treatment seeking behaviour
2A 1st illness episode child

Treatment options
A Home treatment with anti malarial drugs; symptoms not serious
B Nurse called in the home; symptoms serious

Treatment options
A Home treatment with herbs; serious symptoms
B Neighbour traditional healer; symptoms persist
C Mulago hospital; symptoms persist
D Traditional healer; symptoms persist
E Traditional healer; symptoms very serious
2B 2nd illness episode: child

Treatment seeking options
A Home treatment; symptoms not serious
B Clinic; symptoms serious

2C Yatek's own illness

Treatment options
A Traditional healer concurrent healing with her child; symptoms not serious
Diagram 3A  Betty’s treatment seeking behaviour
1st illness episode: child

Treatment options
A Home with anti-malaria drugs ; symptoms not serious
B Clinic ; symptoms persist and serious
C Nurse friend ; symptoms persist

3B 2nd illness episode child

Treatment options
A Home treatment with anti-malarial drugs; symptoms serious
B Clinic ; symptoms persist
C Nurse ; symptoms persist
D Mother in-law ; symptoms persist diagnoses evil eye
E Traditional healer
3C Betty's own illness

Diagram 4 Aisa's treatment seeking behaviour
4A 1st illness episode: child

Treatment options
A Home with anti-malarial drugs; symptoms serious
B Mulago hospital; symptoms very serious
C Traditional healer herbs for protection and quick recovery
4B 2nd illness episode: child

Treatment options
A Home treatment with herbs; symptoms not serious
B Neighbour herbs; symptoms persist
C Grandfather (traditional healer) herbs; symptoms persist and serious
D Mulago hospital; symptoms very serious

4C Aisa’s own illness

Treatment options
A Home; symptoms not serious no treatment
B Mulago hospital; symptoms very serious
C Grandfather (healer) herbs
Diagram 5 Phina’s treatment seeking behaviour
5A 1st illness episode child

Treatment options
A Clinic; symptoms serious
B Clinic symptoms persist
C Hospital; symptoms persist and very serious

5 B 2nd illness episode: child

Treatment options
A Home treatment with home remedies; symptoms not serious
B Neighbour provides milk for burns; symptoms serious
C Clinic; symptoms serious
5 C Phina’s illness episode

Diagram 6 Jemima’s treatment seeking behaviour
6A 1st illness episode: child

Treatment options
A Home treatment with over the counter drugs

Treatment options
A Clinic; symptoms serious
B Clinic; symptoms persist
6B 2nd illness episode: child

Treatment options
A Clinic; symptoms very serious
B Hospital; symptoms persist and very serious

6C Jemima's illness episode

Treatment options
A Home treatment with over the counter drugs; symptoms not serious
B Clinic; symptoms persist
7 Sophia’s treatment seeking behaviour

7A 1st illness episode: child

Treatment seeking options
A Home; herbal birth; symptoms not serious
B Nurse friend Anti-malaria drugs and herbal birth continued; symptoms serious
C Hospital; symptoms very serious but refused admission

7B 2nd illness episode: child

Treatment options
A hospital; symptoms very serious
B Neighbour diagnosis false teeth; symptoms persist
C Healer extracts false teeth
D Nurse, injection to prevent infection
E Home treatment continued
7C Sophia’s own illness

Treatment options
A Home treatment with herbs from neighbour; symptoms not serious
B Neighbour provides herbs and advises her to see a Trad. healer; symptoms persist
C Traditional healer; symptoms persist
D Hospital; symptoms very serious

Diagram 8 Resty’s treatment seeking behaviour
8A 1st illness episode : child

Treatment options
A Home; anti-malarial drugs and cold sponge; symptoms not serious
B Cold sponge, symptoms serious
C Clinic; symptoms very serious
8B 2nd illness episode child

Treatment options
A Home treatment anti-diarrhoea drugs; symptoms not serious
B Clinic; symptoms persist and serious
C Hospital admitted for 4 days; symptoms very serious

8C Resty’s illness episode

Treatment options
A Hospital; symptoms very serious
B Home traditional herbs; prevent further recurrence
Diagram 9  May's treatment seeking behaviour

9A  1st illness episode: child

Treatment options
A Home treatment; anti-malarial drugs; symptoms not serious
B Hospital; symptoms very serious

9B  2nd illness episode child

Treatment options
A Home treatment; anti-malaria drugs; symptoms serious
B Hospital(5 days); symptoms very serious (critical)
9C May’s illness episode

A Home continued working while sick; symptoms serious
B Clinic nurse friend; symptoms very serious

Diagram 10 Sarah’s treatment seeking behaviour
10 A 1st illness episode : child

A Home treatment; herbs, anti malarial drugs
B Symptoms serious; clinic
C Symptoms persist; back to clinic
D Home treatment continued with herbs
10 B  2nd illness episode: child

**Treatment options**
A Home treatment; with anti-malarial drugs; symptoms serious
B Hospital; symptoms very serious
C Home; herbal baths

10 C  Sarah’s illness episode

**Treatment option**
A Home treatment with herbs; symptoms not serious
Diagram 11  Maria's treatment seeking behaviour

11A  1st illness episode: child

Treatment options
A Clinic; symptoms serious
B Neighbour herbs; symptoms persist

11 B  2nd illness episode child

Treatment options
A Clinic; symptoms serious
B Hospital; symptoms persist and very serious
11 C  Maria's illness episode

Treatment options
A Clinic serious
B Hospital; symptoms persist and very serious

Diagram 12 A: Ana's treatment seeking behaviour
1st illness episode: child

Treatment options/locations
A Home treatment; symptoms serious
B Hospital (Mulago); symptoms very serious
Diagram 12 B: 2nd illness episode: child

Treatment options
A Home treatment with anti malarial drugs; symptoms serious
B Hospital (Mulago); symptoms very serious

Diagram 12 C
Ana's illness episode

Treatment option
A Home treatment with herbs
CHAPTER NINE

WOMEN’S PERCEPTIONS AND INTERPRETATIONS OF ILLNESS
SYMPTOMS: IMPLICATIONS FOR TREATMENT SEEKING

9.0 Introduction

Peoples’ perception of the gravity of the illness, their knowledge of the illness and its remedy have long been established as key factors in influencing treatment seeking behaviour [Young 1980; Kleinman 1980]. In seeking treatment people are guided by their social cultural beliefs, not only in interpreting the symptoms, but also in identifying the possible causes. The context and environment under which the illness occurs, greatly influences its perception and interpretation. In Kamwokya there was strong evidence that the women’s interpretation and definitions of illness symptoms were important in treatment seeking actions. This is clearly demonstrated in their general description of steps taken when they or their children under-five fall ill. The first step when signs of illness are noticed is to determine their nature, for example, whether they are clinical (western) or non-clinical (traditional). The next step was, in either case, to assess the severity of the symptoms - whether they are life threatening or not (see chapter5). The descriptions are conventional and give an impression that women primarily depend on their understanding of the symptoms when managing illnesses in their family.
9.1 Women’s definitions and interpretations of symptoms

Mildred (case 1), in her general description of illness behaviour or worries about illness, is explicit that what she does depends on the symptoms and how she interprets them. To quote her verbatim, "bwendaba ngo omwana tali bulungi, ngezako okumanya ki ekimuluma nga si namuwa ddgala" (when I see the child is not feeling well, I try to diagnose what he/she is suffering from before giving any medicine). She distinguishes between clinical and non-clinical (traditional) symptoms; the latter category, according to her, requires non-medical therapies. Whenever Mildred identifies or even suspects such symptoms, she consults her aunt in a neighbouring zone. This woman procures the required medications for her or introduces her to a traditional healer.

During the first illness episode when the child scalded his hand, the condition was defined not only as clinical but serious, warranting immediate first aid and later a visit to Muna clinic. During the second illness episode, Mildred again categorised the symptoms as clinical but "not" serious although they included high temperature and shivering. In this case she opted first for self treatment by administering anti-malarial tablets available at home.

An hour later, however, when the child developed a very high temperature and started convulsing, Mildred re-assessed the symptoms, found them now serious enough for an immediate visit to Muna clinic and later Mulago hospital, where the child was hospitalised. After discharge Mildred opted to
administer local medicinal herbs provided by friends who convinced her that this treatment was the genuine remedy for "yabwe" (convulsions). This is an example of a situation where traditional remedies are applied to cure an illness which is perceived as clinical (in this convulsions).

For her own illness symptoms, which were initially categorised as "clinical" and "not serious", Mildred opted for self treatment with tablets available at home. Later, however, when the symptoms became life threatening, she called in a nurse who treated her with injections. After recuperation she consulted a diviner to ascertain whether or not foul play (witchcraft) was the cause of the illness. This again points to uncertainties in the interpretations of the symptoms leading to the utilisation of combined options.

Like Mildred, Yatek's (case 2) choice of treatment options also depends on her interpretation of the symptoms. This was shown during the two courses of her children's illnesses. During the first episode the symptoms (recurrent convulsions) were perceived as non clinical and Yatek chose to consult healers who treated the child with traditional medicines.

Unlike Mildred, however, Yatek has a strong conviction that treatment for non clinical symptoms should not involve clinical remedies at all. According to her, a mixture of therapies may prove fatal or have other disastrous effects on the child. Thus when the child with non clinical symptoms was admitted to Mulago hospital (in Yatek's absence), she felt she had by all possible
means to get her from there to save her life and took her to a traditional healer where 'appropriate' therapies could be administered.

In spite of Yatek's confidence in these therapies, during the second illness episode of her child, she did not consult traditional healers/diviners at all. According to her these symptoms were clinical and only modern therapeutical treatment options should be taken. Thus, a nurse friend was consulted initially and, when the symptoms became life threatening, the child was taken to Mulago hospital.

Yatek interpreted her own symptoms (severe headache, fever and dizziness) as “non-clinical” and not serious. She thus did not consult any lay practitioner directly but claims to have indirectly benefited from her child's treatment with traditional therapies. Yatek's interpretation of her own illness symptoms as “non clinical” and not serious, though their nature indicates otherwise, suggests that other factors like who is ill, and the money available, are also at play.

Like her counterparts, Betty's (case 3) says her treatment seeking is influenced by perception of the nature and severity of the symptoms. According to Betty, symptoms like headache and mildly elevated temperature, though clinical are not serious and therefore do not warrant more than home treatment with over the counter pharmaceuticals. Unlike some of the other women, however, Betty seems not to have much confidence when interpreting non specific symptoms. She therefore consults her mother or
sister-in-law who with their greater knowledge and experience, can determine whether the symptoms are medical, and therefore whether to consult biomedical practitioners or lay healers/diviners.

The two illness episodes of Betty's children show this pattern. During the first episode Betty perceived the symptoms as clinical and not serious and chose self treatment with drugs available at home. Later, when the symptoms got serious, she sought treatment from Kisenyi valley clinic and the nurses' house clinic in turn.

During the second course of illness, Betty's perception of the symptoms was initially as above, but when the child did not respond to the therapies and even developed other symptoms, she suspected other "non clinical" causes and consulted her mother-in-law. The latter attributed the symptoms to evil eye and advised immediate consultation of a known traditional healer outside Kamwokya. Further advice included ceasing to administer pharmaceuticals so as to avoid the complications which result from combining modern traditional therapies.

In her own illness, there is also evidence of doubt and uncertainty in Betty's perceptions of the symptoms. This is reflected in her choice of treatment which puts a strong emphasis on traditional medicine. The option she took for a minor skin burn (rabbit fur dressing), getting immunised against AIDS by a traditional healer and using a self prepared herbal concoction for a probably
clinical 'localised pain' (kinsibye) all reflect the dilemmas women face in determining and interpreting their illness symptoms.

Aisa (case 4) says she also decides first on the nature and seriousness of the symptoms. Mild body temperature or a slight cough among her children are not considered serious enough to warrant any attention apart from watching over. On the other hand symptoms like high temperature, loss of appetite, diarrhoea, vomiting, incessant coughing and laboured breathing are always interpreted as serious and a number of treatment choices may be made. The options include consulting an aunt, self treatment with over the counter drugs, visiting Kisenyi valley clinic or Mulago hospital, and finally consulting traditional healers/diviners.

During the first illness episode of the child, though Aisa interpreted the symptoms as serious and tried a number of treatment options (home treatment, consulting a herbalists and visiting Mulago hospital), she appears to have been uncertain about the interpretation of the symptoms. This is indicated by the fact that even during the hospitalisation period, she sent her aunt to consult a diviner/healer outside Kamwokya. Aisa accepted the latter's diagnosis, that the child had been 'charmed', and felt that cure was effected through his distance healing therapy, rather than by the biomedical care at the hospital.

During the second course of illness, the child's symptoms were perceived to be "non clinical" and serious by both Aisa and her landlord, the herbalists.
The 'appropriate' non clinical treatment options taken included oral administration of liquid traditional medicine and consulting a diviner/healer outside Kamwokya. When there was no improvement in the child's condition, Aisa wanted to consult another healer. But at this point her husband diagnosed the symptoms as clinical and urged her to seek help from Mulago hospital. It is not clear what influenced Aisa partner's perception of the illness symptoms; very likely it was trial and error, since the initial treatment choices had proved ineffective.

In most Aisa interprets her own symptoms, whatever their nature, as non clinical and if clinical as not serious. In the specific illness reported, however, the symptoms were perceived as both clinical and serious, and effective treatment was sought at Mulago hospital. But Aisa still consulted traditional healers during and after the hospitalisation period. This behaviour suggests psychological dissatisfaction with biomedical options, especially in the case of a woman's own illnesses. Apparently scapegoats (mostly co-wives and business rivals) have to be 'found' before the disease can be cured. This service is not available at modern health care premises.

Phina (case 5) provides a rather unique case due to her belief that her children had been "immunised" against most of the common non clinical illnesses, like evil eye and false teeth. Naturally therefore, most of the illness symptoms afflicting her children are perceived as clinical, requiring biomedical treatment if interpreted as 'serious enough'. This is shown in both the reported
illness episodes of her children. Phina’s perception of the symptoms and subsequent treatment of her own illness follow a similar trend, again probably to be attributed to her belief that she is also protected against most non clinical illnesses, courtesy of her childhood traditional immunisation.

Similarly, but for different reasons, Jemima (case 6) feels that most illness symptoms afflicting children are clinical in nature and hence require biomedical treatment and she acted accordingly during the two illness episodes of her child. For adult illnesses by contrast, Jemima is of the view that non clinical symptoms exist, hence requiring traditional treatment choices. She points out that such remedies are usually effective on a preventive basis. This probably explains her perception of symptoms (clinical) and choices of treatment (biomedical) when she actually fell ill, in spite of experiencing symptoms like dizziness and general fatigue which are usually perceived by most women as non clinical. Since Jemima is protected by traditional means against non clinical complaints, any illness she suffers must be of clinical origin.

Sophia (case 7) has a firm conviction that all misfortune must have supernatural non clinical causes. Her perception and interpretation of symptoms and the choices of treatment are influenced by this belief. During most of the illness episodes in her family (including her own) she initially sought treatment from traditional healers. It was only when these options failed that she sought biomedical care. This resort to biomedical choices,
however, is not indicative of a change in the perception of symptoms since, in every illness episode, Sophia utilise traditional and biomedical options concurrently.

Though Resty (case 8) has a tendency to categorise children's illness symptoms as clinical and therefore to seek appropriate care from clinics, drug shops, pharmacies and hospitals. She stresses the need to consult lay healers promptly if the symptoms are persistent or are non specific. She attributes the previous death of her child to delays in consulting traditional healers. Resty believes that symptoms like high temperature and stomach pains are clinical, whereas those like dizziness, restlessness, insomnia, bad dreams and nightmares are or might be non clinical.

In all the three children's illnesses reported, she perceived the symptoms as clinical, interpreted them as serious and sought modern care. It is only during the third illness episode that she supplemented the biomedical options with traditional medicine.

For her own illness (a miscarriage), despite undergoing a successful therapy at Mulago hospital, Resty did not leave anything to chance. She consulted a traditional healer who not only 'diagnosed' the cause of the miscarriage but also provided medicine to prevent any such misfortunes in future. This option, taken after recovery, may again be viewed as an attempt by Resty to gain psychological satisfaction. Though successful, the biomedical option appears
to have left her uneasy about the cause of the illness and the chance of a future recurrence.

May (case 9), on the contrary, has a strong bias against traditional healers and herbalists. She believes that most of them are frauds and consequently not eligible to handle her illnesses, let alone those of children. In all the cases of illness in her family (both children and self) her treatment choices are influenced by this attitude. She is one of the few who do not utilise traditional treatment options, always preferring biomedical ones if affordable.

On the other hand, Sarah (case 10) has a belief that professional medical options have limitations as remedies for both children and adult illnesses. She, like Resty, has a tendency to combine modern and traditional options in the process of treatment seeking. The two accounts of her children's illness provide evidence of this. In all cases, both modern professional and traditional options were utilised concurrently. For her own illness, whose symptoms were categorised as clinical and interpreted as serious, Sarah relied on a traditional option (oral administration of a strong herbal concoction) prepared by her aunt. This is another example where a known traditional cure was used to treat clinical symptoms.

Maria (case 11), unlike most of the other women (Betty is the exception) apparently has no confidence in her own diagnosis at all. This compels her always to consult a herbalist neighbour and friend. The latter does not stop at
diagnosis but often goes ahead to prescribe, procure and administer the 'appropriate' remedies.

Maria's friend is inconsistently aware of her own limitations. She may advise the former, as evidenced during the first illness episode of the child, to seek modern care promptly if she is out of her depth. But in the same illness episode she also recommended abrupt cessation of bio-medical therapies and started her own course of treatment.

This friend also influences Maria's choices of treatment when Maria herself falls ill. In the reported instance she took her friend's advice and sought professional care from Mulago hospital. After recovery and discharge from Mulago she continued with the traditional baths, massages and oral administration of liquid medicine recommended by her friend. These therapies were probably meant to supplement the bio-medical care, to provide psychological satisfaction and in the process to enhance recuperation.

Ana (case 12) is a desperate woman with a retarded and chronically ill child. She is aware that the child's symptoms are clinical in nature and whenever he falls ill she strives to utilise bio-medical options. Throughout the interview she did not mention ever consulting herbalists/traditional healers for her child's condition. However for her own illness symptoms (which to this observer appeared clinical), Ana relied exclusively on her herbalists neighbour's remedies and those cured her ailment.
9.2 **Traditional Medicine and illness management**

The use of traditional medicine and traditional healers is a salient feature in illness management in Kamwokya. An earlier study in the community revealed the presence of a number of traditional healers. Unlike the clinics and drug shops who advertised themselves with sign posts or placards outside the residences, the healers did not do so [Wallman 1996 pp 129]. It was pointed out this was due to the general stigma attached to traditional healers in particular their ways of operation and diagnosis. However discussions with the people revealed that many people, even the respectable members of society like the educated, church leaders do visit them [ibid.].

Further, there are a number of old people in the community who are said to have vast knowledge of traditional herbs and medicine, some even traditional healers not practising officially. These frequently gave advice and provided herbs and medicine to their neighbours and friends. A number of women in Kamwokya relied on them for illness diagnosis and treatment (see Ana, Maria, Aisa and Yatek).

Women pointed that some symptoms appear to them as traditional and those require non western (traditional) treatment. Whenever such symptoms were identified, appropriate treatment was sought. During illness episodes, the decision to use traditional healers or herbs was predominantly guided by interpretations and definitions of symptoms (see Yatek, Aisa, Betty). The decision to use traditional healers is embedded in indigenous cultural beliefs, about the causes of certain kinds of illnesses. The
belief that there some illnesses that are not western frequently forced women to use both traditional herbs and modern (bio medical) treatment concurrently, to ensure nothing is left to chance. This was enhanced by the fact that there was also uncertainty in symptom definition which could both be interpreted as both traditional and western. Symptoms like convulsions could fall either way.

There were marked differences between men and women in the acknowledgement and use of traditional healers. Men in most cases advised their wives to visit clinics or hospitals when the children or their wives were reported ill. On the contrary, women were ready to use traditional healers if they felt that was the best treatment for the symptoms. Because men seldom approved of traditional healers, women often sought treatment secretly without the men’s knowledge. However, some women used the traditional healers openly, even when their husbands disapproved of it (see Yatek).

One of reasons why women readily used traditional healers could be the fact that, health care is culturally part of their reproductive responsibilities and have the power to decide and use any means that is deemed fit for illness management. Men’s disapproval did not stop them from using them when the need arose, which is a further manifestation of women’s strong position in determining the health care of their family members. It also important to note that men’s open disapproval does not mean they do not visit traditional healers; they do visit but secretly as was revealed by the traditional healers interviewed in the community [Wallman 1996].
9.3 Conclusions

The above accounts show that women's perceptions and interpretations of illness symptoms play a role in their choice of treatment and that they vary according to women's own beliefs and knowledge about illness, and the availability of friends or neighbours who can confirm their own interpretations or assist in identifying and labelling the symptoms. However, there were often uncertainties in their assessments, leading to concurrent use of traditional and bio-medical treatment. As demonstrated by the cases, even when the right diagnosis was made, it was not always possible to utilise the presumed appropriate treatment due to the factors already discussed. For instance, although Resty defined the symptoms during the second illness of her child as serious, she could not seek appropriate treatment due to lack of money.

Similar procedures for the definition and interpretation of illness symptoms were identified in the wider study of children's illness in Kamwokya [Jitta 1996]. Unlike the use of facilities like clinic or drug shops by women, which was influenced by money and time; the use of both traditional medicines and healers was influenced more by beliefs and interpretations of symptoms than money or time.

Also entangled in women's perceptions and interpretation of illness symptoms are the social support networks which seem to play a contributory role in the choice of treatment options. These are examined in the next chapter.
CHAPTER TEN:

SOCIAL SUPPORT NETWORKS AND TREATMENT OPTIONS

10.0 Introduction

Social networks have long been recognised as important channels of support and link among people, especially in urban areas [Mitchell 1969, Barnes 1972, Epstein 1969]. They have been described as "the configuration of cross-cutting interpersonal bonds in some unspecified way, casually connected with the actions of these persons and with the social institutions of their society" [Barnes 1972 pp: 2]. And the characteristics of these linkages as a whole may be used to interpret the social behaviour of the persons involved [Mitchell 1969 pp: 2]. Three broad categories of social relationships have been identified: [i] the structural type, this is when the behaviour of people is interpreted in terms of actions appropriate to the position they occupy in an ordered set of options such as a family or a factory; [ii] the categorical type, where the behaviour of people in unstructured situations may be interpreted in terms of social stereotypes such as class or race; [iii] the personal type, where by the behaviour of people in their structure or unstructured situations may be interpreted in terms of the personal links individuals have with a set of people and the links people have in turn among themselves [Mitchell 1969 pp: 10]. Mitchell, however, cautioned that the three are not different types of actual behaviour, but rather different ways of interpretations of the same
actual behaviour to achieve different types of understanding and explanation [ibid.].

In this chapter, the focus is on personal type of networks with specific reference to treatment seeking when the woman herself or her children under-five are sick. In her study of social life in Zambia, Epstein further distinguishes the personal networks as either effective or extended. The effective are ones in which the members interact frequently in the neighbourhood and where ties are forged solely on the basis of physical contiguity and proximity; The extended ones are relatively open and transcend neighbourhood spreading to the locality and beyond [Epstein 1969]. In Kamwokya the existence and the importance of similar social networks in all aspects of life was acknowledged by most people talked to. In a community like Kamwokya, houses are cramped next to one another, toilets and other facilities are shared, there is overcrowding and a high population density and a very dynamic and competitive economy [see Wallman 1996 chapter 2]; it was stressed that all people need and have these networks to get by. Women's descriptions of their treatment seeking behaviour always indicated other players in the process of illness management. Consultations with friends, neighbours, and relatives are constantly made when women themselves or their children are ill. The extent to which these networks influence women's treatment seeking behaviour is examined below.
10.1 Networks and treatment seeking in Kamwokya

In Yatek's case(2), when illness symptoms persist in spite of self treatment, she consults a doctor (*musawo*) at a nearby clinic. This doctor is known to Yatek's family and often treats the children on credit. She was introduced to the doctor by her husband in 1990 and has patronised the clinic ever since. For persistent, non specific (non clinical) illness symptoms afflicting her children, Yatek consults a traditional healer with whom she is also well acquainted. She was introduced to this healer by a friend.

In other words, when Yatek or her children fall ill, she does not seek treatment just from any care provider, but from those well known to her. Such care providers often extend credit for treatment when cash is not readily available and, in return, Yatek makes sure that she patronises their premises; in the process therefore supporting or increasing their volume of business. Yatek has other friends and neighbours whom she relies on for other things like child care. When her sister is not around, the children are left with a neighbour; it is the same neighbour who took Yatek's child to hospital in her absence. Yatek's other personal networks are at the place of work where she has established friendly relationships with the families for whom she does household chores. She can approach them for credit when the need arises. Indeed Yatek relied on these good friends during Liz's illness for support.
For Betty (case 3), the relationship between herself and the nurse from whose house (clinic) she often seeks treatment both, for own and children's illness, is quite clear. The nurse is not only Betty's friend but has children attending her nursery school. Further, Betty not only gets, treatment from the nurse, but does so at reduced rates. Betty has many other personal networks. Her good relations with the church leaders in Kamwokya, enabled her to get credit which she used for setting up a poultry unit.

Aisa (case 4), consults her neighbour and landlord Jaja whenever her child or herself fall ill. The relationship between Aisa and Jaja is not of a mere landlord/tenant nature; Jaja not only treats Aisa like a daughter but is also a traditional health care provides for Aisa and her children. In return Aisa and family remain Jaja's permanent tenants, in Jaja's squalid quarter, although they can afford to rent better accommodation elsewhere. Aisa's other personal networks are in the market. She has two friends who stand in for her during her absence, or who can advance her some money when she has run out. Aisa reciprocates in the same way. Aisa has very close relationships with her aunt, who is always consulted on various matters including health care.

When Phina's children fall ill (case 5) she always visits a drug shop / clinic owned by her deceased husband's friend and kinsman. In return, the owner of this facility is a regular and special customer at Phina's business premises. Further, at this health care facility, not only are Phina's children
treated on credit when treatment money is not available, but the doctor's wife also provides emotional support to her. And when the illness cannot be managed at this facility, the doctor advises Phina to visit Mulago hospital where he 'connects' her to specific health workers to ensure she gets a good and respectful service. Phina has other women with whom she collaborates in brewing Ajon. These stand in for her when the need arises and can also advance credit to her.

Likewise, Jemima (case 6) does not visit just any health-care facility when her child falls ill. She visits St Catherine's clinic downtown where, over the years, she has become closely acquainted with the paediatrician and owner. Jemima or her child may be treated on credit when cash is not available and, in reciprocation, Jemima occasionally gives the doctor beautiful wax prints as gifts. Jemima's other networks are in her place of work. She uses another woman's licence to buy the merchandise she sells and, in Jemima's absence, the friend helps her out.

Likewise Sophia, (case 7) consults not just anybody during any illness episodes but those care providers she is closely acquainted with. These include a woman neighbour/herbalists, her own sister, a friend who is a nursing aid and a traditional healer outside Kamwokya. Sophia has close relationships with the people who supply the beer she sells. They frequently supply on credit and she pays them after selling off the beer.
For child care, the neighbours take care of her children in her absence and she does the same for them.

Resty (case 8) usually visits Kisenyi Valley clinic when her child is sick. She was introduced to this facility by a neighbour’s wife who is a tribesmate of the clinic’s owner. Alternatively she seeks treatment from another clinic in the market area, which is owned by her husband’s friend. In both places treatment may be given on credit, if necessary. When she fell ill and had to be taken to Mulago hospital her husband’s relative, who is an employee of the hospital, not only escorted Resty to Mulago but used his position to ensure that she got proper treatment. Resty is very close to Betty (case 3), and the latter cannot send Resty’s child out of school. She also collaborates with other women like May for child care purposes.

When May (case 9) falls ill she consults a nurse at a nearby drug shop. The nurse/owner of this facility and May are close friends and, in the past, the latter used to sell cassava tubers to the nurse on credit. May is at home most of the time, so many neighbours leave their children with her and when she is hard up they help out with food and other things.

Similarly Sarah (Case 10), does not visit just any health facility when her child falls ill but Muna clinic in the market area, Sarah’s husband having been friends with doctor owner of this clinic for a long time. Sarah frequently supports other women by giving them charcoal on credit and collaborates with aunt Peggy who stands in for her when she is absent.
Maria, when she or her children are ill (case 11) normally consults her neighbour, a herbalist and traditional birth attendant. The two are close friends, their relationship dating a year back when the latter assisted Maria in childbirth at home. If the illness requires bio-medical attention, Maria visits Kisenyi Valley clinic where she is well known and always treated satisfactorily, often on credit.

Ana, (case 12) relies almost entirely on relationships forged with friends in the past to meet her health care needs. Otherwise, it is evident that she would not cope. One such friendship involves a senior nursing officer at Mulago hospital whom Ana used to assist in the past. This health worker rescues Ana from desperate situations, especially when her mentally retarded child is ill. Ana also consults her neighbour and landlord Jaja. The latter treats Ana like a daughter and is always available when needed, often just to provide emotional support.

All women had networks they used in all aspects of urban survival. They were very important for rich and poor alike when there was an illness in the family as demonstrated by the cases. It is evident that social support relationships exist between women and the health-care providers and are a significant factor in influencing women's treatment seeking choices. These relationships, usually reciprocal in nature, are useful in counteracting some of the constraints which women encounter in seeking health care. Inevitably, one such constraint is lack of cash for treatment, since
provision of treatment on credit features prominently in most of the network relations examined.

On the other hand, however, the fact that even well off women like Betty and Jemima are involved in such relationships suggests that money constraints are not the sole incentive for forging them. Other factors like time, convenience and pure sociability could also be at play. Similar networks in the Caribbean constituted the basis for much of the socio economic activity in the informal economy [Mohanty et al 1991]. In Nairobi, a study of women beer brewers of Mathare Valley showed how women relied on a network of connections between them to buy and sell beer wholesale, to gain extended credit, to put up bail and help collect money for fines and to provide help in case of emergencies [Nelson 1988]. In Tanzania, women's networks were used to pool resources, labour, for help in finding jobs, for providing advice, information, for exchange of services and emotional support [Tungaraza 1995].

Mitchell points out that, the most important aspect of social networks is the content of the link which may be economic assistance, kinship obligation etc. Women in Kamwokya used their effective networks for child care, attending to their business when absent, defining symptoms and provision of herbs and identifying the appropriate treatment option. The extended part of women's networks included friends, health-care providers [nurses, doctors, traditional healers] and relatives who helped out
in matters related to illness management. The instrumental content of these links included, obtaining treatment on credit, money for business after or before an illness crisis, exchange of herbs, identifying appropriate healers and defining the symptoms. The networks were very instrumental when illness symptoms became serious, leading to disruption of business operations and hospital admission. In Kenya a similar situation was observed. Women manipulated their networks, both effective and extended, to assist them in brewing and selling Buzaa in an insecure environment [Nelson 1988].

10.2 Kinship- Family networks and illness management

Studies have highlighted the importance of kin in supporting the family when the mother cannot provide full time care to the children and family [Graham 1994]. Women kinship networks (the mother’s mother, mother in law, sisters, cousins and nephews) are particularly important and are generally rated as more useful than friendship networks [ibid.].

The extended family and kin members were very important in the lives of Kamwokya women. Frequently relatives like sisters, aunts, mother assisted in all sorts of things ranging from advancing credit, help with child care and household chores, help with business. A number of women came to Kamwokya through relatives like sister and aunts whom they have kept close contact with. In terms of health care these close kinship networks were very instrumental in advice regarding to traditional healers and use of herbs. Some
women often went to their home villages to consult relatives like mothers and mother in laws (see Betty). This again reinforces the nature of the belief system in traditional healing dealt with in a covert manner and with trusted close relatives and friends. Even non relatives who were trusted and relied upon were referred to using terms like *Jaja*, normally used for relatives thus indicating the closeness of the relationships.

Women use these relations and kinship ties to make various decisions affecting illness management; a factor well embedded in many African cultures and families, is again not taken into account by decision making theories.
10.3 Men's role and treatment seeking behaviour

Men's involvement in illness management has been neglected by many researchers and little is known of their role in this important arena.

The women of Kamwokya pointed out that traditionally men are expected to contribute financial support towards seeking treatment for their members of households. A number of women, like Betty, Mildred and Sarah pointed that, their husbands used to provide money to their families some of which was used for seeking treatment. However, it was revealed that increasingly men are contributing less and less towards treatment seeking costs when the children or women are ill. With women having access to money, they are taking over the men's role of providing for healthcare costs. The first reason noted by the women is that, because they(women) were earning, men did not feel obliged to pay. The second reason is that a number of men are unemployed (See May, Resty and Sarah), and some are engaged in casual jobs which do not generate enough funds. As a result men's contribution towards treatment seeking was reported to be inconsistent and irregular. A number of men often contributed towards treatment seeking costs when the symptoms became critical, in most cases requiring hospitalisation for a number of days. The reason for this pattern of behaviour was that when there is hospitalisation, then the women are not earning at that particular time. Second is that, the symptoms are life threatening and need to be addressed urgently using all
the resources available. Men’s reluctance to contribute towards the costs of treatment caused a lot of conflict between the spouses as regards what treatment option to use. In many instances men were not informed where treatment was sought and the costs involved.

In actual illness episodes there is evidence that men do play a role in illness management in their families but in a covert manner because illness management remains primarily a woman’s responsibility in the family. In the general description of women’s treatment seeking behaviour, all the married women pointed out that, the first step they take when the children fall ill is to inform their husbands. However, for the women’s own illness, the husbands only came to know of it when the illnesses were at an advanced stage. It was important for the husbands to know in the case of children because, in patrilineal societies like Uganda, children belong to a man’s clan. The women constantly referred to their children as “someone’s child” (mwana wabandi). If anything happens to the child, the mother may be blamed not only by her husband and his clan, but also by the whole community or even nation. As for the women’s own illness, they only have themselves to blame. Further, according to tradition for a woman to adopt the sick role it must be clearly visible to others that she is very ill, otherwise "omukazi talwala" (a woman does not fall ill)” (See Bantebya and Ogden 1996). The extent to which men influence women’s treatment seeking behaviour is examined below-
Mildred (Case 1) says when her child falls ill, she normally consults her husband as a first step, though she does not expect him to provide any money for treatment. When the illness symptoms become critical, however, he advises her what to do and where to go, which is usually to seek modern professional care at Mulago hospital.

Mildred does not consult her husband for own illness, unless the situation is critical, her view being that "proper wives" (omukyala mutufu) should not bother their husbands with minor ailments.

However, when the symptoms become critical, she then feels obliged to consult her partner. When she fell seriously ill with pneumonia and self treatment with home remedies had proved ineffective, her husband brought in a nurse to treat her.

When Yatek's (case 2) child falls ill she also initially informs her husband before proceeding with her own medications. Yatek and her partner have conflicting perceptions of the illness symptoms among children, and many times Yatek does not comply with his advice regarding treatment. During the first illness episode, for instance, she refused to take the child to hospital or a clinic as her husband advised, preferring a traditional healer of her own instead. In response, Yatek's husband refused to contribute to treatment costs at the traditional healers, because he did not believe in the diagnosis made.
Betty (Case 3) too, consults her husband whenever a child falls ill and in most cases the latter advises her to seek bio-medical help. As shown in the two illness episodes, however, Betty’s subsequent choice of treatment depends on her own perception of the illness symptoms on her paramedical training background. She ignores her husband’s advice and proceeds with her own medications.

For non-specific, non-clinical symptoms afflicting either herself or a child, Betty delays in consulting her husband, preferring her mother-in-law and aunt instead. Her belief, and that of most women, is that men generally do not understand such symptoms and are therefore incapable of giving any useful advice about treatment. Often, treatment is taken surreptitiously, without the husband’s knowledge.

During the second illness episode of Aisa’s child (case 4), her husband insisted on seeking treatment from Mulago hospital, instead of consulting another traditional healer, allegedly more powerful than the previous one, outside Kamwokya. Even when Aisa herself suffered an ectopic pregnancy, it was her husband who chose to seek urgent professional help at Mulago hospital.

Resty (case 8) also first informs her partner when she or her child falls ill. When she suspects non-clinical symptoms, however, her husband is not consulted. Other people (aunt, sister and friend) are preferred instead. Like Betty, Resty does not have much confidence in her husband’s
understanding of such symptoms and would not take his advice seriously.

When Resty fell seriously ill and had a miscarriage however, her husband promptly arranged to take her to Mulago hospital.

May (case 9) does not mention her partner in relation to her illness behaviour. Since her partner abandoned her for seven years and is not the father of the under five child, May does not feel obliged to consult him.

Even for own illness May prefers to consult her mother.

When Sarah's child is ill and fails to respond to home treatment (case 10), she consults her partner who then decides whether to seek professional help from a clinic or hospital. Again however, when she suspects non clinical symptoms her husband is not consulted, aunt Peggy being preferred instead. For own illness, especially if is non-clinical, Sarah also relies more on her aunt's advice than her husband's.

Maria's husband (case 11) does not believe in the potency of traditional remedies and whenever he is consulted about treatment he always opts for modern professional help at private clinics or Mulago hospital. The traditional health-care choices which Maria resorts to are kept secret, from him except when the child suffered from measles, when she knew he would be compelled by the gravity of the condition to comply with the elaborate rituals involved in the traditional cure of the disease.

In her description of illness behaviour, Ana (case 12) hardly refers to her partner for her own illness. The only mentioned time was when he advised
Ana to visit the hospital when ill, an advice which she rejected. This may be due to the fact that, though married, Ana is more or less a deserted woman, a situation which compels her either to make independent health care decisions or to consult one of the few people close to her like her neighbour/landlord Jaja. However, when the child is ill he is informed and sometimes provides money, which is most of the time insufficient.

Most husbands had reservations about the traditional health care options, rarely recommending them at all and certainly not for children's illnesses. This is contrary to their wives who are always willing to try these options, at least concurrently with the biomedical ones in attempts to seek rapid cures for their children. This paradoxical behaviour between spouses as indicated (in Yatek's story) may culminate in conflicts regarding health care choices which may be to the detriment of the sick child. Men's preference of bio-medical may due to a number of factors, a] they are ignorant about the costs involved in seeking treatment, such as time and money . b] do not understand the conflicts and compromises women make to fulfil their roles, including seeking treatment or c] they are possibly better informed and educated about the different ailments affecting their families than women. Men asserted that, it is women who believe in witchcraft all the time and they argued, that most ailments such as malaria, diarrhoea prevalent in Kamwokya are clinical. They noted that, men who openly support the use of traditional herbs and believe in
witchcraft are not respected in the community. However as already pointed in (chapter 9), the ideal is not to go, but in reality people visit traditional healers secretly.

For their own illness, most wives do not find it necessary to consult their husbands unless the situation is critical. Many prefer to consult other people like neighbours, friends or relatives of the same sex even in cases of serious illness. The explanation for this is probably twofold, viz. -the traditional belief that a proper woman should not complain of minor ailments, least of all to her husband and second, the attitude among women that men generally do not understand women's illnesses and are therefore neither eligible nor capable of giving rational and relevant advice about treatment options.

Another factor is the reluctance of husbands to swap domestic role responsibilities with their wives. Though such support would go a long way in mitigating the time and money constraints on women seeking treatment for their children or themselves while engaged in business, it does not go down well with husbands who feel it undermines their status as family heads. There is urgent need for men to acknowledge the changing gender division of labour, given the realities of work opportunities in the informal sector and changing family structures.

In effect, the constraints which women face or the hardships they endure as they seek health care for family members are to some extent culturally
sanctioned by norms pertaining to the domestic division of labour where certain roles e.g. seeking treatment for children are ascribed on the basis of sex.

10.4 Conclusions

In general women in Kamwokya used their networks, kinship, effective and extended, to assist them with illness management for themselves and their children under-five both to meet the demands of their participation in income generation activities and to meet their reproductive responsibilities. Most of these networks were Kamwokya based, with a few out of Kamwokya further stressing the extent to which women's activities and relations are locally based. These networks can be called upon at any time when the need arises.

One significant importance of the networks was the credit facilities frequently given to women. Almost all the women at one or another had their children treated on credit. This is a service not available at government facilities and may be a contributing factor as to why many women are reluctant to visit the hospitals. For the very poor, who cannot afford to have credit at health facilities, they have no option but to visit the hospitals.

Credit facilities were enhanced by the fact that these women were regular attenders of these facilities, also the owners are members who reside within the communities and know each other. In hospitals it is a different picture, many if not all the health care workers are strangers to women and sometimes
even speak in a language [English] often not understood by women, adding to their misery of waiting long hours, lack of privacy and no socialisation. Women's credit worthiness was enhanced by the fact that they were engaged in some sort of business whether viable or not.

It is evident that, among those women who are married and cohabiting with their husbands, the latter do influence their health-care choices, particularly when the symptoms do not improve with treatment already offered. For a number of reasons, but mainly by virtue of their being household heads or as an attempt by wives to ask for treatment money, they are usually the first to be consulted about illness symptoms in children, regardless of the nature of illness symptoms. Their response in such cases is mostly to advise their wives to seek professional care from modern health care facilities. However because health care is an integral part of women's reproductive responsibility, women have the powers to accept or reject the men's advice. Frequently women followed their own decisions on where and when to seek treatment for themselves or their children.

Men's financial contributions towards treatment seeking costs are increasingly becoming less forcing the women to pay and manage their own illnesses and that of children.
CHAPTER ELEVEN
EXTENDED CASE ANALYSIS: YATEK'S STORY

11.0 Introduction

This chapter presents Yatek's story as an extended case analysis to demonstrated the context under which illness management takes place in the family. The case shows that illness in the family is not managed in isolation from what is happening both within and outside the family. Illness management both affects and is affected by social and economic relations in the family. The focus here is an extended analysis of the specific illness episode of Yatek's child (for the details of Yatek see Chapter 5 pp105-110). Yatek's case shows how treatment seeking for a child, got both affected by and affected the family relations leading to violence and separation.

11.1 Liz's illness episode

Three year old Liz had recurrent convulsions and loss of consciousness which left her very weak. In between attacks of convulsions, the child would be perfectly healthy. With each attack, Liz was taking longer to regain consciousness.

Faced with such symptoms, Yatek the mother, defined them as non clinical and not requiring bio-medical attention. Her husband believed otherwise and recommended that the child be taken to a hospital or clinic. Yatek instead
opted to put the child on a course of traditional medicines including herbal concoctions taken orally or mixed with bathing water as treatment for "yabwe" [sudden convulsions]. After two weeks, however, the situation worsened and Yatek gave up this treatment. She then consulted numerous healers/diviners who provided a wide variety of medicines, but to no avail. Finally, Liz’s illness was diagnosed to be the result of malevolent spirits originating from Yatek’s co-wife. This confirmed Yatek’s suspicions. The healer who diagnosed the illness asked for Shs 50,000 ($50) to exorcise the evil spirit from Liz. Yatek could not raise the money and her husband refused to contribute anything since he did not believe that his second wife in Kisoro was a witch.

One evening, in the absence of both Yatek and her husband, Liz had a severe attack of convulsions. A neighbour rushed the child to Mulago hospital in the Acute Care Unit. When Yatek learnt about the situation on returning home, she panicked thinking her child was dead. To quote her verbatim she said “namanya omwana wange affudde kubanga obwo obulwadde si bwa dwaliro” (I knew that my child would die, because such illness is not for the hospital).

Yatek hurried to Mulago with the intention of getting Liz before any treatment could be given. But Liz had already been admitted to the paediatric ward and was on treatment. Yatek waited till late in the night when the nurses on duty were asleep and sneaked off with the child. She headed straight
to a powerful healer/diviner, four kilometres away from the hospital, where a similar diagnosis as the previous one was made.

Liz was kept at the healer's for three days. During that time attempts were made to exorcise the evil spirits from her. The healer warned of a likelihood of the spirits returning since the co-wife in Kisoro had not stopped 'sending them'. For this treatment, the healer charged Shs 25000 ($25). Yatek paid Shs 5000 ($5) leaving a debt of Shs 20000 ($20). The healer again asked for Shs 5000 ($5) to 'uproot the evil' spirits, but Yatek could not raise the money. The child temporarily improved, i.e. the convulsions got less frequent. Two weeks later, Liz was still having convulsions and Yatek was worried and feeling insecure as she thought the evil spirits from the co-wife were still on the rampage.

Another healer/diviner was consulted and diagnosed a similar problem but only asked Yatek to prepare a big feast involving a large variety of local dishes to feed all his people including relatives and apprentices. After the feast, the healer performed numerous rituals and managed to 'bind' the Kisoro evil spirits.

Treatment costs for Liz's illness amounted to a lot of money, the total of which Yatek could not remember as the illness lasted over five months. She knew, however, that it was not less than Shs 100,000 [$100]. Her partner did not contribute anything for the reasons mentioned earlier. Yatek still owed money to friends and relatives as debts incurred during Liz's long illness.
During Liz's illness all Yatek's small businesses suffered and she would even have lost her job if it was not for her considerate boss.

To Yatek's disappointment, Liz's illness did recur three months later. It was now apparent the therapy had not worked as similar symptoms resurfaced.

After much contemplation, coupled with advice from friends and relatives, Yatek decided to consult another traditional healer. She was assured by friends that the healer was renowned and experienced in his work. Thus Yatek and Liz moved to the traditional healer's premises which is not only a health facility but also his home. The healer insisted on keeping the child under constant observations day and night. As before, Yatek was compelled to shift from her home and took up residence at the traditional healer's. This greatly displeased her husband as he never believed the diagnosis of the illness.

For the period they stayed at the healer's life became unbearably hard. All Yatek's cash resources were depleted and she had to rely on money borrowed from friends, sympathiser and relatives. Her income seeking activities were again adversely affected and some of them such as preparing snacks and casual labour ceased completely. Yatek would come to work at the university from the healer's place in the morning and return in the evening. The healer's wife and other women with patients around kept Liz. For this favour she normally returned with something for the healer's wife and the other women.
Occasionally she checked in at home during her lunch break, but most of the time her sister who lives nearby would brief her on the situation at home. Yatek's husband, who all along abhorred his wife's residence at the healer's, accused her of infidelity, and of using the child's illness as a cover-up. After all efforts to woo her back, including divorce and separation threats, had proved futile, Yatek's husband responded by selling off a cow and pig, two of the most important family assets. He refused to contribute part of the money to meet Liz's treatment expenses.

In retaliation, Yatek seized and hid the only remaining treasured family asset, the land title deed for the plot where their house is located, registered as is customary in the husband's name. On discovering what had happened, Yatek's husband responded by calling in the police, accusing Yatek of being a common thief, even denying her as his wife. Yatek was detained at the police station, and released after surrendering the title deed.

After undergoing several therapies at the healer's, the child gradually improved and was declared cured after a period of three months. Yatek then took the child to her husband and later moved to another suburb to be with a friend, leaving all the children behind.

The separation from her family turned out to be a blessing in disguise for Yatek. For instance, as a consequence of ridding herself of the arduous burden of domestic responsibility she had sufficient time to resume her former businesses activities and even ventured into new ones. This
diversification enabled her to make sufficient money to pay off Liz’s
treatment bills and also to cater for school fees and other scholastic materials
for her children who had dropped out of school. Further more she continued to
contribute foodstuffs and other household basics to her children through her
sister.

Yatek’s assiduousness and dramatic progress however did not impress her
husband. He remained oblivious of everything and insisted that Yatek should
return home. Yatek, however, did not budge. After exhausting all channels
including outright intimidation and coercion, Yatek’s partner ironically
approached FIDA (a non governmental legal clinic providing free legal
services to disadvantaged women) for advice. He accused Yatek of
neglecting the family and the children, denying them motherly attention.
Yatek was summoned to FIDA and during the hearing she hit back by
declaring that their relationship was not legally binding thus making
cohabitation with him, at most, merely optional. This is a classic case
because normally it is women who seek support from the organisation.
Yatek, however, indicated she would reconsider her decision if her partner
was ready to forfeit the title deed in favour of one of the children. The partner
agreed to hand over the deed; and Yatek insisted that the lawyers had to be
present and sign.
11.2 Conclusion

Yatek's case demonstrates how illness management affects and is affected by family relations. Illness management is inextricably entangled in a complex web of intra family personal relationships and activities. Without spousal or other consensus illness may irreversibly upset the fragile equilibrium of inter-spousal relationships in the family. In this case, the child's illness was not only bad in itself, but sparked off a series of events which threatened the core survival of the family as a domestic social unit. It led to separation of Yatek and her husband. The illness diagnosis was at the core of the problem as the co-wife was being accused of bewitching the child, which the husband categorically refused to believe. Consequently, the illness of the child was being indirectly blamed on the father. He refused to contribute anything towards treatment costs and thus severed relations further. The illness did not affect the husband only but also the other children. Some dropped out of school due to the loss of Yatek's income which was eaten up by the illness.

Yatek's case demonstrates the interplay of various factors in decision-making within the household. The child's illness is entangled in more than one household, all of which are headed by one man. Because health care is part of Yatek's responsibility as a woman, she makes her own decision completely ignoring the husband advice and his protest against the diagnosis. Yatek's powerful position is strengthened by her economic position and the man's weak economic position in the family. Despite Yatek's refusal to
adhere to his authority, he wants her back to the extent of taking her to a
women's organisation; which actually strengthens Yatek's position. The
illness of a child led to changes in power relations with Yatek using her
position as a mother to ensure that her children's property[land and house]
are protected.
The separation, though bad for the family did in some ways give Yatek the
time to search for much needed money and later it placed her in a strong
bargaining position vis-à-vis her partner. She continued to support her
children even when she was not living at home, so rendering the partner
powerless. His appeal to an organisation predominantly for women showed
his desperate attempt to have Yatek under his control again. This case clearly
demonstrates the complexity of illness management and the inter play of
various factors within and outside the household and the power yielded by as
gate keepers of health care in their families. Once more, the inadequacies
of decision making theories in African context is evident as demonstrated
by this case.

1. In patrilineal cultures, children belong to the father and when divorce happens the children
are supposed to be left with the father unless they are breast feeding

2 FIDA Uganda is an affiliate of the Federation International de Abogadas(International
Federation of Women Lawyers) It runs legal clinics to champion the legal interests of
victimised women and push for legal reform. Women are given legal advice and those who
cannot afford the fees are assisted with free service.
CHAPTER TWELVE

ILLNESS MANAGEMENT: A GENDER CONSTRUCT

12.0 Introduction

The last four chapters have examined the factors that affect treatment seeking behaviour for women's own illness and that of their children under-five. It has been shown that treatment seeking behaviour cannot be explained by single factors. It is a process that involves many actors and depends greatly on the situation both within and outside the family. Women in Kamwokya are responsible for illness management in their households and have considerable power to define and decide where and when treatment is sought. At the same time, conflict among members of the household regarding illness management were not uncommon and solutions were sought both within and outside the household unit. In this chapter, I discuss the extent to which a factor influences illness management and its limitations in treatment seeking is discussed. Furthermore, the role of the gender division of labour and the multiple roles of women in illness management is discussed. The constraints arising from the gendered division of labour leaving women overburdened and hence without enough time to seek proper treatment are highlighted. Recommendations for a way forward for illness management in poor urban situations are discussed along with any limitations, and areas for further research.
12.1 Gender division of labour: implications for illness management

It is evident from the women’s descriptions and patterns of treatment seeking that illness management is primarily a woman’s responsibility. Women are the key decision makers, determining and defining the symptoms, what actions to take, who to consult and where treatment is sought.

In the general description of illness management all women with partners pointed out that, when illness symptoms are observed, particularly among children, their partners are informed as heads of household and also, for some women, to solicit money for treatment. However in actual illness episodes, though partners were informed of the illness, the women seldom adhered to their partners advice. Even those not working, like Maria and Ana, decided when and where the treatment was sought.

Decision making theories do not give us much insight into this dimension of decision making powers within households. In managing illnesses, women draw their source of power, first of all, from the culturally constructed gender division of labour, that allocates health care, among other things to the women’s domain. Decision making theories, both resource and the normative, (see Blood and Wolfe 1960 and Rodman 1972) neglected the role of the division of labour as a factor in decision making.

Dwyer and Bruce[1988], pointed out that gender based responsibilities are most explicit in Africa. In some societies husbands are responsible for
paying for lodgings, children's tuition and other educational costs. Almost universally women in Africa are viewed as ultimately responsible for fulfilling children’s food needs. However, in some situations, food and clothing for the children may be female/male joint obligation. The overall gender division of labour at household level in Kamwokya is unequal with women taking on a greater share of both productive and reproductive tasks. As has been observed elsewhere in Africa (see Dwyer and Bruce 1988), as women’s economic power increases, so does their workload, and the tendency for men to ignore some of their household responsibilities.

In Kamwokya all women, whether poor or rich, as evidenced by the case histories went to great length to fulfil their role with or without men’s support. Women out of necessity are increasingly paying for treatment for their own illnesses and those of their children. Even when men had money, they were frequently reluctant to pay, particularly when the symptoms were not seen as serious, because their wives were earning. Despite this, women showed greater determination in managing and controlling their health and that of children and they have constituted a wide range of social networks for mutual support.
12.2 Resources in illness management

At the onset of the study it was hypothesised that income constraints would be more important than those of time. However, the case studies suggest that the opposite is true. Below all the factors that were found to influence women’s decision on treatment seeking are discussed along with their limitations.

12.2.1 Income vis-à-vis treatment seeking

Economic factors have been found to play a major role in influencing women's illness behaviour, particularly over what they choose as 'appropriate' treatment for specific illness symptoms for themselves and their children. A number of income options which Kamwokya women rely on to enhance their capacity to raise money and pay for treatment have been identified (see chapter 6). The most popular among these options is participation in numerous, informal income generating activities. One marked feature of the Kamwokya women, as they struggle to survive and search for better health, is their resilience as reflected by the income options or combinations they create, find or engage in. Women's participation in various business activities aim at generating sufficient money to maintain family well-being including affording to pay for treatment during illness episodes. The need for money, as demonstrated by the Kamwokya women, is greater than ever before, given Uganda's history of two decades of political and economic mismanagement, leading to poor and heavily commercialised social services.
By virtue of having different income options and social resources the women inevitably have disparities in their incomes, with some having more money at their disposal than others. These disparities are reflected in the different patterns of treatment seeking behaviour among women.

Some women relied on their spouses for financial support. For these women the husband's level of income greatly influenced their treatment seeking behaviour. For instance Maria, whose husband had a stable income, often sought treatment from the clinic. On the other hand, Ana rarely used cash options, due to the poor economic status of her husband. Her husband was not always around when illnesses occurred, and even when present there was no guarantee that he would provide the funds. Further, the economic status of the spouse determined the credit worthiness of women when treatment on credit was being sought. Maria (case 11) could get treatment on credit while it was difficult for Ana (case 12) who had a poor and less caring husband.

The working married women consulted their husbands to inform them as heads of households and not necessarily to solicit treatment money. However some husbands, on a number of occasions, assisted in the settlement of the treatment bills, especially hospitalisation fees.

Liquidation of belongings was another source of income for Kamwokya women. However, it has limitations in so far as getting treatment, especially at government facilities i.e. hospital and clinics, is concerned. These facilities cannot barter treatment in exchange for material possessions and insist on
cash. Possessions could, however, be used with a local clinic or drug shop, as a deposit pending payment, and traditional healers, diviners and herbalists, are said to accept such possessions as direct payment for treatment. This may partly explain why such treatment sources are commonly used by the poor and cash strapped women.

As for formal employment as a source of income for women, the absence from home and limited autonomy characteristic of this option have dire consequences for the women. In times of crisis, illness episodes for instance, permission would have to be granted at the woman’s place of work for her to take off time to seek treatment. Prolonged periods of absence may result in dismissal as was the case with Yatek (case 2) when she was absent from her job for a fortnight, nursing her sick child. Jemima (case 6) gave up her job as it was not raising enough money for her family.

Participation in income generating activities was the main source of income for women in Kamwokya (cases 1 up to 10). The limitations of this option in relation to treatment seeking manifest themselves in two ways: one, the failure to generate enough income to meet treatment expenditures; two, the time constraints of having to manage a business and seek health care accordingly. The first constraint is apparent among many of the poorer women; frequently treatment was sought on credit (see Resty case 8, Sophia case 5, Phina case 7, May case 9) While their businesses keep their families from starving, they cannot cope with additional treatment expenditures. However, businesses
could be used as "security" to get them credit from the health providers in case of an illness.

The effects of money on treatment seeking were reflected in women’s treatment seeking options. The majority of the women relied on home treatment with drugs available at home or bought from drug shops. This meant they could save on the consultation fees normally charged by the clinics. Furthermore, treatment was frequently received on credit from facilities which women were well aquatinted with. For the very poor women like May this option was not always available and her last resort was always Mulago hospital. Other women like Resty, due to lack of money could not seek treatment from the clinic and had to resort to Mulago hospital when the symptoms became critical.

It was evident that due to women's income options, and disparities notwithstanding, women were generally faced with a dilemma as regards raising and ensuring that money is always available for treatment during crises. In spite of their hard work, stamina and resilience, due to financial bottlenecks, many of them have not succeeded in the struggle for better health for themselves and their children. Consequently they are often out of poverty and desperation rather than ignorance or backwardness, compelled to utilise treatment options which are not only ineffective but could be dangerous.
It can be argued that if all women had ready access to and control over 'ample' monetary resources, the disparities in their treatment choices would not be so marked as has been the case in this study. Despite the limitations, the importance of money invested in business, and dividends from it, however small, cannot be underestimated, especially in regard to meeting crisis expenditures needed to treat serious illness or maintain family survival.

In conclusion, money as a major resource in decision making about treatment seeking, has been found to be important in illness management. However, the study has shown that, it is not only the physical presence of money that affected women's decision but also the potential to earn money which women frequently used to receive treatment on credit. The fact that they were engaged in some sort of business, whether viable or not made the women credit worthy. Women went to great length to protect this status. The nature of illness management as described earlier in the chapter, which ensured minimum disruption of their enterprises is a clear manifestation of this fact.

12.2.2 Time vis-à-vis treatment seeking

Women's time use has been found to be a critical resource for women's access to health care. The different categories of women in this study had different time use patterns, which were a product of the nature of their work, and particularly of the business activities they were engage in. This variation
in income options meant that some women suffered more time constraints than others (see chapter 7).

Most of the women in Kamwokya work for over 14 hours a day. There were variations in time schedules, with some very busy early in the morning e.g. May (case 9); others busy from dawn to dusk e.g. Mildred (case 1), Yatek (case 2) and Jemima (case 6). Others are busy at night e.g. Phina (case 7) and Sophia (case 5). Similar situations have been reported elsewhere [see Popkin and Adoan 1993, Folbre 1988]. For these women the time sacrifices involved in seeking even the minimal treatment for their children or themselves during crisis illness symptoms are high. The opportunity costs of such time sacrifices may mean the entire collapse of their business with disastrous consequences not only for themselves but also those under their support. The need to concentrate on earning a living in or outside the home detracts time from child care (including treatment seeking) even while it provides monetary income essential to it.

Women were also constrained in terms of child care and household chores. While it was easy to combine business with child care and household responsibilities; it was very difficult to combine treatment seeking with the latter. Consequently, treatment was sought in a manner that would not keep the women away from home for long hours or days. Apart from Betty and Jemima, most of the women could not afford to hire housekeepers and, in their absence, they relied on relatives and the goodwill of neighbours.
Because of these multiple responsibilities, time has become a major constraint to all women and has consequently affected the nature and patterns of illness management.

There are variations in time constraints experienced by women depending on the activities engaged in and resources available to them. The time constraints for the better off are of a different nature and are mainly reflected when the women themselves are ill.

In relation to treatment seeking, the interplay between time and money is different for the very poor women like May or Ana than for the best off women like Betty and Jemima. For May, her business is small, very marginal and operates for a few hours along the road side, consequently, money is more of a constraint in relation to treatment seeking for her than time. On the other hand, Betty runs a number of enterprises i.e. nursery school, poultry unit, pig and cow in the backyard, and is busy throughout the day. Her activities generate enough money to support her family's needs including health care. In terms of treatment seeking, she is more constrained by time than money.

The women who were heavily constrained by time stressed that they needed to be present in person to operate their business activities. In case of an illness they were therefore reluctant to use options like visiting hospitals, because it takes at least an hour to receive treatment there. Instead, other options like visiting clinics and drug shops where time costs are much lower, are preferred. In general, women try as much as possible to limit the time they
spend on treatment seeking. As a result many of them end up with serious conditions which require professional attention and often hospitalisation. Consequently, for most illness episodes, women underplayed the severity of the symptoms so as to continue operating their businesses.

12.2.3 Social support networks vis-à-vis treatment seeking

Apart from money and time costs, there were other factors/resources that influenced Kamwokya women's capacity to get treatment when they or their children fall ill. Wallman and Baker[1996] point out that money values have not been ascribed to such elements and the majority are, in any case, not tangible or amenable to quantitative pricing. Though not quantifiable, however, these resources do have an economic value and have implications in the health seeking context.

The women of Kamwokya frequently made decisions on health care in consultation with other actors like neighbours, friends, relatives outside their households. This is another dimension which theories of decision making do not take into account.

Social status

The women in this study were selected to reflect differences in socio economic status. Some are poor and lack things which confer status, like a house, education, skills, a job or a good reputation and others are better off in these respects. It is evident that women in the latter category [Betty, Jemima
and Maria] find it easy to secure credit, especially in instances where money for treatment is not readily available. This is not true for most of the other cases. In other words, it can be argued that in certain situations, social status or prestige is readily, though indirectly, converted into financial or social support.

In the context of treatment seeking by the poorer women, the shortfalls of status are quite apparent as demonstrated by this statement from May (case 9):

"If you are poor, no one will give you credit, because they are not sure of how you will pay back". Resty (case 8) had this to say: "if you are poor, no one wants to associate with you, for you have nothing to give back"

Networks

If social status is not available as a means of accessing treatment for the poor Kamwokya women, the same cannot be said about the local network relationship. As noted earlier (Chapter 10) such relationships, forged out of mutual need, exist among all cadres of Kamwokya residents, irrespective of social or economic rank. These networks are not in any way formalised. They have developed out of necessity and can be severed at any time and others can be established, depending on the situation. In this community total independence is almost impossible, even for the well off, with houses crammed next to each other people, sharing toilets, children playing together, buyers and sellers all moving in and out of the parish. If for instance, one member of the community owns a clinic, she needs customers (patients) for
her business to survive, and possibly the first ones are the neighbours and friends. Hence the dire need for good neighbourliness.

These networks take different forms depending on situation and social status; Resty and May always take care of each other’s children. Sometimes Resty keeps Betty’s children in her absence, in exchange Betty normally finds it difficult to dismiss Resty’s child from her school for lack of school fees. It is also common for Sarah to give charcoal on credit to women like Resty, Ana and May; and May occasionally assists the nurse friend, who normally treats her on credit, with housework.

Further, as demonstrated by the case material, Kamwokya women do not seek treatment just from anywhere that suits their time and money constraints but from those premises or people where they are known. The importance of these networks to the poor, especially in times of stress, should not be underestimated. Examples where women have been assisted during difficult situations during illnesses are abundant (see Chapter eight).

However some disadvantages may also be associated with these relationships. For instance out of ‘commitment’ to the networks, the women may continue to receive wrong advice or utilise inappropriate treatments from those involved in the networks. Genuine health care providers (doctors and nurses) may ignorantly or deliberately be sidelined in favour of quacks who have close network connections with the women.
These disadvantages, however, should not be exaggerated as they appear to be grossly outweighed by the benefits. What is important are the financial and social support gains that these relations confer on those involved in them in times of crisis, where no alternatives for management of the illness may exist.

12.2.4 Perceptions and interpretations of symptoms vis-à-vis treatment seeking

Perceptions and definitions were also found to play a role in influencing women's decisions on where and when to seek treatment. All the women indicated that symptoms and their severity determine the actions they take. However, in the specific illness episode, the steps taken sometimes do not necessarily tally with the nature of symptoms observed. Women's definitions and interpretation of symptoms follow three stages of illness progression, with each demanding a particular kind of attention and choice of treatment. The first stage includes symptoms that are known for a given illness, either clinical or non-clinical, which are regarded as not serious and which can be dealt with at home or with the over-the-counter drugs. These symptoms may include headache, mild fever, cough, or intermittent diarrhoea. The second stage of illness progression is "serious". These involve symptoms that require outside treatment, either at the clinic, or by traditional healer. The symptoms at this stage may include high temperature, vomiting, laboured breathing. The third stage is the "severe" (critical or life-threatening). This a stage where there is utmost urgency to seek immediate treatment from qualified providers in
hospitals or traditional healers. The symptoms may include very high temperature, laboured breathing, delirium, convulsions (See Chapters 5 and 10).

In the first two stages, women pointed out, they can manage the illness in a manner that is not unduly damaging to their other activities. Treatment is carried out either at home or within Kamwokya, not far from their homes and businesses. The last stage is different and requires the immediate attention of the specialist which is the hospital or traditional healer, services mostly outside Kamwokya.

This kind of illness progression analysis by women was not developed consciously but as a result of experience and the need to balance and fulfil all their responsibilities, including health care. However, it could be very dangerous and may lead to loss of life. In many of the cases, children were rushed to hospital in a critical condition (see May, Resty, Mildred).

Further, the use of both traditional medicine and healers was influenced more by beliefs and interpretations of symptoms than money or time. Women believed that there some illnesses that are not western which can be dealt with by use of traditional herbs or medicine or consulting traditional healers.

12.3 CONCLUSIONS

The background to this thesis lay in two situations in Uganda that seemed to be interrelated. The first was the increase in women's involvement in the
labour market, particularly in the informal economy, during the last two decades (see Chapter 1 and 2). The second is the persistent poor social indicators which have existed for over two decades; the infant mortality rate [IMR] was 122 infant death per 1000 live births; the under five mortality rate, 203 death per 1000 live births [NCC 1994 World Bank 1993a]. A new born Ugandan baby has only 80% probability of reaching the age of five years. Maternal mortality is estimated to be at least 600-1000 maternal deaths per 100,000 live births[Kadama 1993; Kasolo 1992, NCC 1994, UDHS 1995](See chapters 1 and 2). As more women enter the labour market, available evidence shows that health conditions are progressively deteriorating. Uganda's social indicators are reported to be deplorably low, with health indicators being among the world's worst[World Bank 1993a; NCC 1994].

In trying to understand the interrelationship between these situations, this thesis sought to examine the effects of women's access to money and time use on their treatment seeking behaviour for their own illnesses and that of their children under-five. The assumption made was that treatment seeking behaviour will be more influenced by women's access to and availability of money than by their time use.

Evidence from the study has proved the assumption wrong. It has been demonstrated that illness management is not context free, and that no one factor can explain the whole process; it both affects and is affected by other
things happening in the family. In Kamwokya, time was found to be the major
organising factor and a critical resource in illness management. The family
context for many of the women changed all the time, particularly the
economic situation, with some women's spouses losing their jobs, women
changing their businesses, businesses collapsing for one reason or another, as
is shown by the case histories. This greatly affected women's capacity to seek
"appropriate" treatment when either themselves or their children were ill.

Due to the multiple roles that women had to fulfil, they frequently sought
treatment around and within Kamwokya for their own and their children, with
the exception of Jemima (case 6). It is the choices of treatment sources within
Kamwokya that differ, and that is when the money becomes important. Even
then, this applies to children, but not to the women themselves. For women,
money was not found to play any significant role at all. Their treatment
choices were similar for all the women, rich or poor. This is because even for
the best off women, the responsibility for managing businesses has not in any
way reduced other responsibilities like child care and household chores.

Hence, many women choose to combine the two responsibilities. However,
it is very difficult to combine treatment seeking, especially at the third stage
of illness symptoms with child care, household chores and business. Time
spent on the latter activities is 'lost' to the former. Consequently time has
become one of the major constraints on women in seeking health care. And
because time is a major constraint, treatment seeking has to be fitted in with
all other things happening in the family. It is only when symptoms are life threatening that they are given priority over the other responsibilities. Women's worries of being away from home and their business are genuine and, as demonstrated by the cases, when women are not around the consequences are quite telling. The re-negotiations are all centred on time use to ensure that the woman fulfils all her multiple responsibilities, including treatment seeking, as a "proper mother" [Ogden 1995]. Similar findings have been reported elsewhere in Africa [Dwyer and Bruce 1988]. Time use data suggested that decision-making about these trade-offs is an exclusive concern of the women who balance the conflict between market work and child care by reducing sleep and leisure.

It has also been shown that there are differences in illness management between women's own illness and that of their children. The dire need for women to both financially support their families and take care of children and household chores leaves them with little time for themselves. Women are decision makers in their families, ensuring their survival. While spouses contribute and support their families, evidence shows a decreasing financial contribution when their wives are earning. Some spouses do not contribute anything at all to their families.

The findings of this study show that the decision-making theories (the Resource and the Normative Resource) which this study used as a framework to explain women's treatment seeking behaviour in Kamwokya are
inadequate. These theories do not take into account various factors found to be very vital in health care decisions in Kamwokya. They do not take into account the gender division of labour which gives women enormous power to manage their own illnesses and that of their children. Moreover, decision making theories do not take into account the role of other actors both within and outside the household. Decisions to seek treatment were often influenced by friends, neighbours and relatives. Further, cultural beliefs were also found to influence health care decisions especially those regarding the use of traditional healers.

In relation to other responsibilities like paying rent, food, and education of children, women were found to play a key role in decision-making within their households. However, the secrecy surrounding the source and amount of money husbands earned, made it impossible for women to transform their actions into strong power bargaining positions. At most, their decisions were seen as part of their bid to fulfil their reproductive and productive roles. Furthermore, the withholding of money earned by men from their families, when their wives begin earning, meant that women spent most of their money, leaving them with little savings if any. Decision-making theories, do not take into account such situations which can be manipulated, to reduce the power held by the individuals with more resources. However, though decision making related to the fulfilment of women’s reproductive roles has not been taken into account by the theories,
it was a source of power and pride for the women of Kamwokya and has altered household gender relations (see Yatek, Betty). This poses a threat to male supremacy and male ego.

This change has both positive and negative implications. On one hand it has facilitated women's access to money enabling them to support their families; on the other hand, too much work and too little rest has an adverse effect on the health of women themselves and that of their household members.

Health care theories, on the other hand, can to some extent explain women's treatment seeking behaviour in Kamwokya, because they cover a wider perspective which includes most of the determinant or explanatory variables. Variables such as money, time, perceptions, faith in healers, and networks, were identified in this study as factors that influence women's behaviour. The re-negotiations of when to seek treatment and where by women, indicate that illness management is a process beginning with symptom definition and progressing to seeking treatment. However, unlike what has been suggested by the Path models and Determinant or explanatory models, this study has revealed that illness management is a process whose steps are influenced by various factors [determinants] and which is part of the gendered responsibilities allocated to women. Consequently, illness management cannot be isolated from what is happening in the household.
Compromise, which was emphasised by Blackburn[1991], in her study of “Poverty and health: working with families in UK”, is a major theme in the lives of Kamwokya women too. Blackburn pointed out that caring for children’s health in poverty involves compromises, as parents have other obligations [Blackburn 1991 pp 137]. A similar situation exists in Kamwokya, where women have enormous obligations of providing for their families. Thus, illness management involves either compromising the needs of the family for the sake of women’s health or that of children; or compromising the health of the children or the woman herself for the sake of other family needs.

Similar to what Blackburn [1991] found in London among low income families, while poverty reduces the amount of power and choice women have, they go to great lengths to take control over those parts of their lives which they could control. This, they do by making compromises. The Kamwokya women made many compromises as shown by the case histories. Prominent among these, was compromising their own health for the sake of the children and other family needs. Similar observations were made by Graham [1984]. She found that while a mother was quick to identify and respond to symptoms of illness and disability on others, women cared less for their own health. In this regard, Graham argued that a mother’s role in caring for others blunts women’s sensitivity to their own needs.
"Being ill makes it difficult for individuals to maintain their normal roles and responsibilities. Since mothers' roles and responsibilities are particularly indispensable, mothers are reluctant to be ill" [Graham 1984 pp 159].

The women of Kamwokya found it extremely difficult to be ill and went to great length to deny being ill. Even when ill, they carried on as normal until the symptoms became very serious. "Stickiness (rigidity) of intra-household division of labour" to some extent explains why women deny being ill in order to fulfil their responsibilities as "good" mothers and wives. Women are the "centre" of the family survival and well-being, and thus they strive to make ends meet, including denying being ill. These coping strategies and compromises highlight what Graham has referred to as "a paradox of successful caring: the responsibility of irresponsible behaviour" [Graham 1984 pp 185]. From a professional view Kamwokya women ought to have themselves treated rather than continuing to work while they are sick.

Similarly to what Graham observed, in the context of conflicting pressures and shortages of resources, the pursuit of family welfare and the survival of family by Kamwokya women, take priority [ibid.]. Behaviour considered irresponsible by outsiders is the means by which responsibilities are met by Kamwokya women. In essence, such a paradox can only be understood in the context of the family which shapes the meaning and range of choice available to women.
Finally, it could be argued that the two situations, poor social indicators and women’s entry in the labour market, are interrelated. Women’s entry in the labour market has meant an increased workload leaving them with little time for treatment-seeking when women themselves or their children are ill. A number of the women spend most of their time away from their homes and children. Furthermore, all women reported no time for leisure; it is work, work, work all through. This, among other factors, has led to the grim situation reported above. In the long run, due to poor health, fewer and fewer women will be able to manage income generating activities and the consequences to the nation at large and their families in particular can only be imagined.

12.4 Illness management in urban poor areas: which way forward?

To address the grim health situation in Uganda, it is important to recognise that treatment seeking behaviour cannot be explained by single factors and is a process that involves many actors and depends greatly on the situation both within and outside the family. Women are predominantly responsible for illness management in their households and have the power to define and decide where and when treatment is sought. Consequently, there is a need to take into account the routines of families, which to a great extent determine the choice of treatment when an illness occurs, as demonstrated by this study. Policy makers, health care providers and professionals need to confront and understand that women’s choice of treatment seeking occurs within and is
affected by the routines of everyday life. Further the issue of men relegating their responsibilities to women has to be challenged to address the grim situation reported above.

The recent women’s conferences in Cairo and Beijing have underscored the importance of mainstreaming gender and the need to focus on men through recasting the concept of “male participation” and focusing on “male responsibilities”. The long term goal is recognition of equal rights and responsibilities of women and men in the family and society as stated in the Beijing Declaration...

“No 15 p 6) [Arrow 1996].

Men’s responsibilities is a stronger term which implies that men are obligated to carry out certain activities and can therefore be held responsible. Educational programmes encouraging men to embrace their responsibilities are recommended. Information and education process has to include discussions of the roles and responsibilities of men and women in the family. The changing gender division of labour and relations ought to be highlighted for the benefit of both men and women and their families. Further, the presence of private health care providers, whether qualified or not has facilitated women's modes of treatment seeking. It is evident that they are used for almost 90% of all illnesses in the community. They are very close to
the people and can easily be accessed. Time spent at these facilities is reported to be minimal (less than an hour). Given the economic situation in Uganda (see chapter 3), more and more people are and will continue to enter the market to either supplement their income or earn income to support families.

This kind of illness management, as demonstrated by the cases, is bound to have grave effects. For instance, there is evidence that anti-malaria drugs are being used excessively. Almost all the women (see chapter five) first treated their children with anti-malaria drugs. The majority do not even know the correct dosage and frequently the children do not complete the courses. Some women rely on nurses to administer drugs which they are not supposed to give and who are practising illegally. These nurses are said to administer very strong drugs to patients for a quick recovery which is, of course, the women's desire. Reports on health conditions in Uganda indicate that, increasingly, malaria parasites are becoming resistant to most of the anti-malaria drugs on the market [NCC 1994] and malaria is now one of the top causes of mortality in Uganda [UDHS 1995, NCC 1994].

The way forward is for governments to take private providers on board, and to train them and monitor their services. They could be used as intermediaries to educate and pass on information to women on various health issues including symptoms and danger signs and the importance of women's own health.
Basic education programmes on health and illness management are recommended for both men and women to reduce the abuse of drugs, some of which has led to malaria parasites becoming resistant to most of the anti-malaria drugs.

Government hospitals and centres who have well trained and qualified staff are not often the priority when women want to seek health care, due to the delays and long waiting hours at these facilities. To alleviate the problem, priority should be given to women with children as a way of cutting down the waiting time.

12.5 Limitations of the study and areas for further investigation

This thesis primarily focused on women as health care providers in families. Men were not systematically interviewed except on a few subjects. Many of the men talked to, lost interest once I mentioned treatment seeking as the main subject of investigation, and immediately referred me to their wives. Given that women have taken over what was traditionally a man's role (financier of the family, including paying for illness) there is a need to investigate men's role in illness management and perception of the changes under way.

Further evidence from this research shows that women are earning money and have the power to treat themselves and yet do not give priority to their own health needs. This is quite alarming and there is great need to investigate this phenomenon further.
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APPENDIX 1: Aide Memoir for Life History

1] PERSONAL BACKGROUND

Date of birth and age of respondent

Place of birth

When and where at school

Where living at each age

Occupation of parents

2] LIVING SITUATION AT EACH AGE INTERVAL

Who living with in the household? Who else

3] REPRODUCTIVE HISTORY

Pregnancies, when and where, live births / miscarriages.

4] OCCUPATION/ECONOMIC ACTIVITY/EMPLOYMENT FINANCIAL CONTRIBUTION

Income generating strategies or jobs, when and where

Place of work /operation

Who else contributed/ contribute to the household living [financially]

5] HOUSEHOLD EXPENDITURE ITEMS

What are household's expenditure items

who pays for what item and when

6] TIME USE

How do you spend your day, doing what and where

who else helps you
APPENDIX 2: Aide Memoir for Treatment Seeking

1] GENERAL TREATMENT SEEKING [including advice and help]

In times of sickness for what do you do, go for advice, diagnosis, help and or treatment. is it the same for mother and children? what determines your actions

Are they specialist or non specialist [friends, kin. neighbours]

What is your relationship with the health provider, how did you get to know him

2] SPECIFIC ILLNESS EPISODE[S]

FOR EACH EPISODE

who was sick age and sex

what were the symptoms and what was the illness

how did you define the symptoms

what treatment was given and why

Who did you go to for advice, diagnosis, support, treatment

how much time did this involve [for every option used]

how much did the episode cost [roughly] and who paid, credit

did the treatment work