

'Conceiving' maternal child healthscapes in rural
Uganda

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Abstract

This thesis examines the complexities of delivering high quality pro-poor maternal child healthcare. The research recognises that good maternal child health (MCH) is a fundamental development imperative in which initiatives are not achieving targets. There is a chronic deficit of well trained healthcare workers and increasing reports of abuse being suffered by poor patients. The research suggests that current mechanistic results orientated approaches to healthcare should be foregone in favour of an appreciation of the fundamentally fluid and social nature of health and healthcare delivery. It is also suggested that whilst current literature focus on either a patient or a healthcare provider perspective, examining the relationship between the two provides a complete picture of the healthcare transaction. This research aims to unpack the realities of delivering high quality, pro-poor MCH in the chronically poor district of Kibaale, mid-western rural Uganda.

Standing at a disjuncture between policy, conceptual theory and empirical research, this thesis presents the conceptual tool of 'healthscapes'. It is suggested that healthscapes are an effective approach to read the hegemonic social values of power, gender and care operating in place. Taking a relational view of space and place, it is suggested that individuals plot routes to achieve health aims through a 'terrain' constructed by their health knowledge embedded in place. This constructs a knowledge base for individuals which can become authoritative, potentially enabling them to construct informal spaces of health within the formal setting. In the informal spaces, individuals can adapt their behaviour to overcome barriers to the healthcare transaction and ultimately achieve their health goals. By contemplating the healthcare transaction from both the health-seekers' and the healthcare providers' perspectives, the post-structural approach challenges conventional understandings of power in health. This nuanced social insight into health-systems could thus be used to inform policy.

Based on 18 months of ethnographic fieldwork, the healthscape concept was used to unpack MCH transactions within Bunyoro as a whole, the Antenatal Clinic and the Maternity Ward of Kakindo HCIV. The research discovered that despite the prevailing negative perceptions of the government institution, over 60 women attended antenatal a week whilst only five delivered within the maternity ward. The research suggests that within the antenatal clinic, women were able to use their extensive place-based authoritative knowledge to construct informal spaces in which they could influence the healthcare transaction to achieve their antenatal aim. Due to cultural constructions of childbirth, if women presented at the maternity clinic, it was ordinarily for emergency reasons. Their lack of experience and need for care meant they had little place-based authoritative knowledge to influence the healthcare transaction and were subjected to the biomedical gaze. Suggestions are made as to how this approach could benefit policy.

Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other institute of learning.

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Abbreviations

AIDS	-	Acquired Immunodeficiency Syndrome
ANC	-	Antenatal Clinic
ART	-	Antiretroviral therapy
ARV	-	Antiretroviral drugs
CHD	-	Community Health Department
DDHS	-	District Director of Health Services
EmOC	-	Emergency Obstetric Care
FP	-	Family Planning
GW	-	General Ward
GoU	-	Government of Uganda
HCI	-	Health Centre I
HCII	-	Health Centre II
HCIII	-	Health Centre III
HCIV	-	Health Centre IV
HIV	-	Human Immunodeficiency virus
HSSP I	-	Health Sector Strategic Plan I
HSSP II	-	Health Sector Strategic Plan II
HSSP III	-	Health Sector Strategic Plan III
IMR	-	Infant Mortality Rate
MCH	-	Maternal Child Health
MDGs	-	Millennium Development Goals
MHCP	-	Minimum Health Care Package
MMR	-	Maternal Mortality Rate

MW	-	Maternity Ward
NHS	-	National Health System
NRM	-	National Resistance Movement
NRA	-	National Resistance Army
OPD	-	Out Patient Department
PAF	-	Poverty Action Fund
PEAP	-	Poverty Eradication Action Plan
PHC	-	Primary Health Care
PMA	-	Plan for the Modernisation of Agriculture
PMTCT	-	Prevention of Mother To Child Transmission
PNFP	-	Private Not for Profit
PPA	-	Participatory Poverty Assessment
PRSP	-	Poverty Reduction Strategy Paper
RRH	-	Regional Referral Hospital
SWAp	-	Sector Wide Approach
TBA	-	Traditional Birth Attendant
TCW	-	Trading Centre Woman
UPE	-	Universal Primary Education
UMoH	-	Ugandan Ministry of Health
UPC	-	Ugandan People's Congress
UN	-	United Nations
VCT	-	Voluntary Counselling and Testing
VHT	-	Village Health Team
VW	-	Village Woman
WHO	-	World Health Organisation
WHR	-	World Health (Organisation) Report
WVAR	-	World Vision Assessment Report

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Dedication

This thesis is dedicated to Melda and Florence.

Simultaneously the most wonderful women I have ever met and embodiment of everything
that's wrong.

Webale myono.

Chapter 1: Maternal Child Health, 'the greatest health divide in the world'

'The nurse calls two other nurses to help her hold the girl's legs. The nurse is yelling and warning the girl that she will use the measuring stick and slap her if she doesn't start to co-operate. She adds: "You are killing your baby".Finally it is time for the stitching. There is no local anaesthesia available, so the girl is sutured without and it is painful. The girl screams and keeps closing her legs. The nurse gets the measuring stick to make the girl obey'.

Moland (2006:147)

1.1 Introduction

Maternal child health (MCH) is intrinsically linked to the social, economic and political development of a country (World Health Organisation Report [WHR], 2002; WHR, 2005); the health needs of women and children cannot be left unmet without harming the whole of society (WHR, 2005). As the UN (2009) states, in the developed world childbirth is normally a time of joy and happiness. Representing 'the greatest health divide in the world' (WHR, 2005:6), in the developing world half a million poor women continue to die annually, either during pregnancy or childbirth (UN, 2005). Such worrying figures persist despite the high profile public recognition of the health imperative in 2000, when World Leaders made a united global commitment to improve MCH through the Millennium Development Goals.

It is well known that many of the health problems faced by pregnant women and infants are preventable, detectable, or treatable with access to well trained healthcare workers (WHR, 2005). In sub-Saharan Africa, where the majority of maternal and child deaths occur, less than 50% of the population receives adequate reproductive health services. Furthermore, more than half of all births take place without the assistance of trained healthcare workers (WHR, 2005). Globally, there is a chronic shortage of well trained healthcare workers with the deficit most acute in areas of greatest need, such as sub-Saharan Africa and Asia (WHR, 2006). Recent papers have also highlighted the maltreatment of patients

amongst poor communities by African healthcare workers (eg Moland, 2000; Jewkes *et al.*, 1998). Reports of maltreatment and abuse range from direct acts of physical violence, as shown in the opening quote by Moland (2002), (see also Zaman, 2004; Smith and Brown, 2001; Fonn *et al.*, 1998; Jewkes *et al.*, 1998 amongst others) to more subtle but no less damaging, psychological or emotional abuse (Penn-Kekana, 2004). This research suggests experiences of such abuse in healthcare delivery, be it in a formal or informal setting, can present barriers to mothers accessing healthcare for themselves and their children (Mulemi, 2008; Ager and Pepper, 2005). Perhaps unsurprisingly, nursing discourses have become increasingly defensive and blame poor conditions, insufficient pay, patient's attitudes and lack of consultation about major health reforms (Penn-Kekana and Blaauw, 2002). There is, however, significantly little empirical evidence that unpacks these emotive claims in a contextual setting and particularly takes into account the experiences of patients *and* healthcare providers in the healthcare transaction (Mulemi, 2008).

This research explores the reality of delivering high quality, pro-poor maternal child health (MCH) care in the Bunyoro Kingdom, rural Uganda from the viewpoint of the government hospital. The research presents the conceptual tool of a 'healthscape' which it suggests can be used to unpack how place-based authoritative knowledge might facilitate power in formal places of health to challenge the social order. By moving beyond the traditional negative discourse of healthcare and unpacking the emotive claims of poor care delivery, over time and in context, this research aims to present a more nuanced social approach to understanding healthcare practice in places which provides rich information that could benefit policy.

This introductory chapter is divided into three sections. Section 1.2 will discuss the imperative role of MCH on the global agenda, particularly in light of the Millennium Development Goals. The current health human resource deficit and claims of abuse will also be discussed. Section 1.3 will introduce the healthscape concept. The section will also explain how under a more social understanding of health, health geographers are in the ideal position to tease out the intersections between health, place and healthcare provision, particularly under a feminist ethics of care. The section will also introduce where and how this research was conducted. Section 1.4 will then conclude by highlighting the main aims of this research and the format of the thesis.

1.2 The 'greatest health divide in the world'

Each year more than half a million women die from causes related to pregnancy and childbirth and nearly four million newborns die within 28 days of birth (WHR, 2005). The reliability of statistics has to be questioned, particularly from the developing world where there are numerous problems in recording and reporting. Nonetheless the sheer scale and disparities within the statistics paint an illuminating picture. In 2008 in Sub Saharan Africa alone, for example, 265,000 mothers died due to complications of pregnancy and childbirth; 1,243,000 babies died before they reached the age of one month and 3,157,000 children, who survived the first month of life, died before the age of five (Academy of Science, 2009). Women and children are also particularly vulnerable to 'normal' risks of the developing world such as malaria, HIV, malnutrition, water borne diseases and respiratory tract infections. Furthermore, giving birth safely is still largely a privilege of the rich. The risk of a woman dying as a result of pregnancy or childbirth in Northern Europe is approximately one in 30,000; the same risk is one in six in the poorest parts of the world (Brazier *et al.* 2009; Ronsmans and Graham, 2006).

Apart from the fact that it is simply unacceptable that in the 21st Century poor women and children are dying unnecessarily during child birth and from largely preventable diseases, the continuously high infant and maternal mortality rates have significant implications. It is well recognised, for example, that women play a critical part in social, economic and political development. The 'triple burden of women' explains how women are responsible for reproductive work, productive work and community work, illustrating their care for the physical and economic health of their families (eg Graham, 1985, 1984; Blaxter, 1983; Carpenter, 1980; Litman, 1974). Moreover, poor maternal health, coupled with expensive, or inaccessible maternity services can generate intergenerational and often unbreakable, transmission links of poverty between mother and child (see DFID, 2005; Freedman *et al.*, 2005; Case and Ardington, 2004). As the Task Force for Maternal and Child Health, (2005: xi) stated, 'mothers, children and newborns reflect the well-being of society and inform future potential. They are the present and future workers in their economies, caregivers of their families, stewards of their environment and innovators of technology'. Improving women's health, therefore, benefits the whole of society at a host of scales.

Recently recognition of the imperative of this health issue shifted considerations of MCH away from the domestic realm of mothers and midwives and into the sphere of public health making it a political and moral imperative with corresponding implications for the state (WHR, 2006). With their adoption of the United Nations Millennium Declaration, world leaders partnered to reduce extreme poverty in a series of time-bound targets with set indicators (UN, 2009), now popularly known as the Millennium Development Goals (MDGs). Within the eight goals the imperative of MCH is identified specifically in two. Goal number four aims to reduce the under-five mortality rate by two thirds between 1990 and 2015. Goal number five, improving maternal health, has two specific targets. The first is to reduce the maternal mortality ratio by three quarters. The second is to achieve universal access to reproductive health. The roles of women and children are further recognised in the remaining six goals, to end poverty and hunger, achieve universal education, achieve gender equality (goals numbered 1 - 4), combat HIV/AIDS (goal number 6), achieve environmental sustainability and to achieve a global partnership (goals 7 and 8).

Whilst the united global commitment to the MDGs highlights a new solidarity to improve healthcare delivery to women and children, it is not without criticism. For the United Nations the MDGs offer the world an unprecedented opportunity to 'free a major portion of humanity from the shackles of extreme poverty, hunger, illiteracy and disease' (UN, 2009:3). They also imply the necessity for stake holders and governments to work effectively across policy spheres, forming new, potentially advantageous alliances. Others have received the goals with scrutiny and scepticism. Saith (2006:1167), for example, talks about them being 'a soft cloud of words and good intentions and moral comfort' that have dominated the funding and research agenda, despite having fundamental weakness in their theory, methods and scope. The world is, however, united in a set of agreed but challenging targets. As the UN put it, world leaders 'adopted a blueprint for a better world - and pledged to spare no effort in fulfilling that vision' (2009:5).

Whilst achieving that ambitious blueprint was never going to be easy, the challenge has further increased under the current global economic crisis. Whilst critics such as Saith (2009) argue that the economic crisis has provided a useful scapegoat for the otherwise slow progress towards achieving the goals, for the UN, the economic difficulties provide an opportunity to 'take some of the hard decisions needed to create a more equitable and

sustainable future' (2009:5). Unscheduled and revealing evaluation of progress towards the goals have thus provided an opportunity for the world to publically reaffirm its commitment to sustainability and more equitable development with a specific focus on MCH (UN, 2009:5).

The global commitment to improving MCH, however, is not matching the outcomes. Notwithstanding the problems with statistics, progress indicators show that whilst infant mortality has declined globally (from 90 deaths per 1,000 live births in 1990, to 67 deaths in 2007 [UN, 2009]), the unequal geographical distribution of this success has increased significantly. When combined with high fertility rates, the absolute number of under five deaths in sub-Saharan Africa has increased from 4.2 million in 1990 to 4.6 million in 2007 (WHR, 2009; UN, 2009). Measuring maternal mortality is particularly difficult. Illustrative of part of the MCH problem itself, in the developing world many women may die at home, either in childbirth, or through complications related to pregnancy and thus are not included in official statistics. Whilst figures can only be estimates within a level of certainty, they are unacceptably high. Figures for 2005, for example, suggested every minute a woman in the developing world died of complications related to pregnancy and childbirth. This adds up to more than 500,000 dying annually; 99% of these women live in developing countries (UN, 2009). The MDG Summit in 2010 suggested that whilst there has been some improvement in maternal mortality figures, progress is well short of the 5.5% annual decline needed to meet the MDG target (UN, 2009). The Summit also identified that whilst the figures had increased from 1990, globally only 63% of births were attended by skilled health workers in 2008. Large disparities still exist in providing pregnant women with antenatal care and skilled assistance during delivery, especially in remote areas. HIV is also continuing to curtail progress contributing significantly to maternal mortality in some countries.

Many of the conditions that account for maternal and neonatal deaths in the developing world could be prevented or treated with good quality healthcare; specifically, access to reproductive health services, antenatal care, skilled healthcare workers at birth and access to emergency obstetric care (WHR, 2009). Ideal locations of care are changing. In the developed world, as Chapter 2 will explain, the locus of care is shifting from formal institutions to the home. In the developing world, however, there are significant advantages in mothers accessing a formal continuum of care for childbirth. With

appropriate antenatal care, obstetric complications such as post-partum haemorrhage, infections, eclampsia and prolonged or obstructed labour can be avoided or treated. Malaria prophylaxis, tetanus vaccinations, de-worming tablets and folic acid can be administered and complications can be identified early (UN, 2009). Nutritional advice can be given and a mother can be tested for syphilis and HIV. HIV+ mothers can also be delivered in a manner to reduce the risk of mother to child transmission (Guay *et al.*, 1999; Marseille *et al.*, 1999) and receive follow up care.

Women who receive antenatal care and deliver with a skilled birth attendant are thought to be five times more likely to deliver a healthy baby than a woman delivering without (WHO, 2009). UNICEF and the WHO recommend a minimum of four antenatal visits during gestation. Whilst the proportion of pregnant women in the world who made one antenatal visit increased from 65% to 79% since the 1990s, a substantially lower proportion of women visited more than once (UN, 2009). In sub-Saharan Africa, less than 50% of women make four antenatal visits. Whilst one visit is better than none, less than four are insufficient for the administration of full courses of vaccines. Furthermore, whilst overall the proportion of births attended to by skilled health workers has increased (UN, 2009) in sub-Saharan Africa more than half of all births still take place at home without the assistance of trained personnel. Notwithstanding data critiques, it is interesting that 79% of women access antenatal services, albeit only once and yet just over half of women in sub-Saharan Africa deliver with skilled healthcare personnel.

It is widely acknowledged that healthcare workers are a critical element in both improving health outcomes and increasing the coverage of essential health interventions (WHR, 2006). The WHR (2006:4) *Working together for health* recognised that 'at the heart of each and every health system the workforce is essential to advancing health'. As the WHR (2006:16) put it, 'health service providers are the personification of a system's core values - they heal and care for people, ease pain and suffering, prevent disease and mitigate risk - the human link that connects knowledge to health action'.

Globally, however, there is a chronic shortage of well trained first level health care workers which poses a major constraint to achieving global health priorities and expanding health programmes (Dreesch *et al.*, 2005; Figueroa-Munoz *et al.*, 2005; Nullis-Kapp, 2005). The

shortage is also most acute in the areas of greatest need. The *Scaling up, Saving Lives* report (WHO, 2008), for example, estimates that Sub-Saharan Africa needs to train at least 1.5 million more health workers to reach the total of 3.2 million considered necessary to meet the growing demand. In Uganda, the current ratio is 1.5 staff per 1,000 people generating a deficit of one staff per 1,000 people (Kagolo, 2009). According to the Ministry of Health, Uganda will require more than 26,700 additional health workers for its current population. Moreover, existing healthcare workers are often maldistributed in relation to need. The situation has been further worsened by the HIV pandemic that has depleted systems capacity across sub-Saharan Africa (Matsiko and Kinwanuka, 2003). For a host of reasons countries are unable to educate - and uphold - a health workforce that is capable of sustaining and improving people's well being and chances of survival.

Furthermore, several recent papers have highlighted the maltreatment of patients by health workers, particularly in Africa. These reports tend to be most prolific amongst poor communities where there is a marked power gradient between patients and healthcare workers (eg Moland, 2002; Jewkes *et al.*, 1998). Some papers report direct acts of physical violence, such as the opening quote to this chapter by Moland (2002) (see also, Zaman, 2004; Smith and Brown, 2001; Fonn *et al.*, 1998; Jewkes *et al.*, 1998 amongst others). Others report more subtle expressions of power such as through the denial of information (Penn-Kekhana, 2006). Such treatment can dramatically affect health seeking behaviour. Terra de Souza *et al.*, (2000), for example, demonstrate that MCH care seeking behaviours were traditionally associated with several factors including socioeconomic conditions, mother's knowledge and beliefs of disease causations, severity, and expectations of the healthcare experience (Ricci *et al.*, 1996, Hudelson, 1993). A significant deciding factor in whether or not mothers would access MCH, were the beliefs about the health services available (Singh, 1993; DeClerque *et al.*, 1992).

Such reports, however, rarely embed the claims in a broader contextual setting. Patients tend to be referred to as passive, compliant, vulnerable actors in desperate need of help who thus have no authority in a biomedical setting. Healthcare workers, meanwhile, are portrayed as being permanently motivated to serve the public (Lindelov and Serneels, 2006). Taking a post-structural approach, it is argued here that there are occasions in which patients can use their place-based knowledge to influence the healthcare transaction.

Furthermore, it is suggested that healthcare delivery - both formal and informal - is difficult and stressful (Bégat *et al.*, 2005, Humpel & Caputi, 2001). Based predominately on literature from health-systems in the developed world (see, for example, Carrell, 2007 and Mulholland, 2007), it is also suggested that such stresses can lead to sensations of dissatisfaction, low motivation and 'burnout' (Demerouti *et al.*, 2000; Leiter *et al.*, 1998). These sensations are further compounded when healthcare workers operate in poor working environments (WHO, 2006; Marchal and De Brouwere, 2004; Narasimhan *et al.*, 2004; Chen, *et al.*, 2004; USAID, 2003). These conditions, in turn, compromise the healthcare workers' ability to provide competent and compassionate care (Bégat *et al.*, 2005).

Initiatives to improve health human resources, however, have focused on addressing macro-level strategies to improve the production of health workers with several African countries drawing up strategies supported by commitments from the international community (e.g. the Tokyo Framework, 2008). Whilst ambitious and admirable, much less policy attention has been paid to understand methods to improve the retention and performance of *current* staff (Hongoro and McPake, 2004), as they are embedded in the broader socio-economic health system. This follows Lindelow and Sernells (2006) suggestion that despite the attention of the role of healthcare workers in the advancement of health, until recently, healthcare workers themselves were a neglected component of health-system development (Hongoro and McPake, 2004; Travis, *et al.*, 2004). As a result, *The Kampala Declaration*, issued by the First Global Forum on Human Resources for Health in March 2008, requested governments to 'assure adequate incentives and an enabling and safe working environment for effective retention and equitable distribution of the health workforce'. Similarly, the G8 Communiqué in 2009 recognised the necessity to assure an enabling working environment for the effective retention of existing and newly trained health workers. Finally, the WHO resolutions on migration and rapid scaling up of health workers requested Member States to put in place mechanisms to address the issue of retention of health workers (WHO, 2002).

Policies to improve retention of health workers, however, were vague and not rooted in a solid understanding of the nature and source of performance problems amongst healthcare workers - and indeed, their patients - as embedded in the broader health context. As a

result, whilst rational and often commendable on paper, seldom do policies have the impact their makers intended, and health systems fail to deliver quality, accessible care (Hongoro and McPake, 2004). Meanwhile, as the Joint Learning Initiative (2004) explains, with mass labour migration and the HIV and AIDS infection, the resource crisis is escalating. A new approach is required.

1.3 Reconceptualising health and healthcare delivery

A functional and political economy approach views good health as the foundation of productivity; ill health renders an individual unproductive, unvalued and thus intrinsically 'other', or socially deviant as they did not conform to societal norms. Particularly in a colonial setting, the capacity to restore health, and thus productivity, represented significant social control which is seen as the basis of the supremacy of the medical professional of the 20th Century (Deacon, 2004; Crawford, 1994). Reflective of a number of disciplinary shifts, with the 'cultural turn' of the 1990s, the traditional logical or positivist, functionalist orientated philosophy to contemplate healthcare delivery had been replaced with a much more social understanding. With the rise of post-structuralism, third wave feminism and Foucauldian scholarship, space, place, health and illness have been increasingly recognised as fundamentally fluid, constructed phenomena that are situated and socially produced in particular contexts at a variety of scales (Smyth, 2005: 490). It was recognised that certain places have the potential for both healing and the promotion of general well being. Gesler (1996), for example, suggested that within *therapeutic landscapes*, the complex dynamics between place, wellbeing and healthcare can be analysed (see also Andrews, 2004). Spatial re-theorisation not only reconsidered the institute of the hospital as a place of health, but revealed a host of previously neglected places of healthcare delivery such as the home, the body, informal places and abstract places such as social spaces (Veenstra, 2007; Gattrell *et al.* 2004; Williams, 2002; Abel and Kearns, 1991).

The increasing policy and academic consideration of, and indeed necessity for, care in place also cast difficult question as to what 'care' actually is. In part this stems from disciplinary considerations and motivations. Geographers have been challenged to show whether or not they care enough to contribute to 'human good' through research (Lawson, 2009; Olsen and Sayer, 1997) to the benefit of the discipline and the wider world. As health geographers

are in an ideal position to tease out the intersections between health, healthcare, illness, therapy, gender, place and the body (Dorn and Laes, 1994; Kearns, 1994), we have great potential scope for nuanced social analysis that might alleviate inequality.

Within a constructivist understanding of the fluidity of health and place, post-structural theory challenged the existence of essential truths and logic and the suggestion that there is no single approach to knowledge development, and thus power (Doering, 1992). A post-structural feminist analysis in particular, focuses on explaining the complexity of the real world through a focus on the multiple scales and spaces of development that are intersecting and politically constructed (Lawson, 2007a). Being able to explain, at least some of the complexity, potentially enables the eradication of inequality based on issues of exclusion, gender, race sexuality, and power (Marchand and Parpart, 1995; Kabeer, 1994).

A Foucauldian analysis (1976) suggests that power, as intrinsically facilitated through knowledge, is asserted through a complex 'micro-physics' that is not only repressive but productive. Power, therefore, does not belong to an individual but is a force put into circulation or an apparatus of knowledge to maintain social hierarchy through the day-to-day activities in society. Echoing the functionalist perspective, therefore, a Foucauldian analysis recognises the need for control within a medical encounter. A post-structural, analysis, however, challenges the notion that the medical encounter is - or has to be - oppressive and recognised that there can be potential resistances to it. Bourdieu's (1990) notion of 'habitus', or 'authoritative knowledge', for example, allows for agency. The theory suggests that within any particular domain several knowledge systems exist based on previous place-based experience. In different settings, some of these knowledge systems as a result of experience, carry more weight than others and enable the holder to influence the healthcare transaction

A socially constructed understanding of health suggests that health, healthcare and interpretations thereof, are fluid and differ within a spatial-temporal contextual setting (Moll, 2004; 2002). Different health knowledges, therefore, emerge as hybrid, embodied and historically, technically and spatially contingent (Davies *et al.* 2004; Lorimer, 2003; Naylor, 2002). This research suggests that 'healthscapes' is a useful conceptual tool to understand the embedded power relations within a healthcare transaction. The healthscape

concept suggests that an individuals' place-based knowledge constructs a 'terrain' through which they have to travel to achieve their health aim. That terrain will be influenced by norms and expectation of care, formal and informal carers and barriers - tangible or otherwise - to healthcare. The route through the terrain constructs a knowledge base for individuals which, in some settings, can become authoritative. The authority of that knowledge potentially empowers the individual, enabling them to construct informal spaces of health within the formal setting. Whilst not refuting the role of institutional factors, within the constructed informal spaces individuals may be able to adapt their behaviour to challenge the social order and overcome barriers to ultimately achieve their health aim through the mobilisation of place-specific authoritative knowledge.

Crucially, the approach also factors in the aims, expectations and perspectives of carers, formal and informal, in a variety of places. It is suggested, therefore, that healthscapes could be a useful way to challenge conventional readings of power and action within healthcare delivery and understand the relationship between healthcare delivery and place. The nuanced social understanding of healthcare delivery embedded in context, could, in turn, be used to inform policy to improve healthcare and ultimately alleviate deprivation.

1.4 Research objectives and thesis outline

This research will use the healthscape concept to unpack the maternal child healthcare transactions within Kibaale District, the Bunyoro Kingdom, mid-western rural Uganda. The Bunyoro Kingdom is chronically poor and has a high infant and maternal mortality rate, a high HIV prevalence and a general low level of health. In part due to a lasting colonial legacy, the Bunyoro Kingdom has a very poor reputation and is locally known as 'the Black Hole of Uganda' due to its level of development, the 'lazy' Bunyoro tribe, prolific witchcraft and failed development initiatives. Despite some successes, the biomedical health-system is generally struggling with a chronic shortage of medical supplies and drugs which is not aided by the poor infrastructure. A greater problem, however, is the low level of morale amongst the staff. The district also has a number of alternative healing options such as herbalists, traditional birth attendants, bone setters and witchdoctors.

The overall objective of the research is to use the conceptual tool of 'healthscapes' to develop an understanding of the health-system in Bunyoro and thus the reality of delivering effective, pro-poor maternal child healthcare in context. It is hoped that this information could be used to inform delivery of a high quality level of health care for the poorest communities. Some policy suggestions will be made.

The specific research questions are:

- What are the different health places in Bunyoro that support or contribute to MCH? What does it mean to 'care' in these places?
- How do healthcare recipients conceive biomedical MCH in the Bunyoro Kingdom and can authoritative knowledge be used to affect the healthcare transactions?
- What are the healthcare workers' perspectives of the conceived biomedical healthscapes?
- What is the reality of delivering high quality, pro poor care, from user and provider perspectives and how could this understanding be used to inform policy?

In order to investigate these aims a total of 18 months was spent living in the Bunyoro Kingdom. Anthropologically informed ethnographic methodologies were used to understand healthcare delivery in its broadest sense. Unlike other research, this research considers the perspective of *both* the service users and the service providers to glean a more complete picture of the healthcare transaction. The healthscapes concept was used to understand the complexities of MCH care delivery in the Bunyoro Kingdom. Analysed data collected from Kakindo HCIV, locally known as 'the hospital', revealed three key places that informed MCH; the broader setting of the societal norms and expectations of women in Bunyoro in which there were a number of informal health spaces, the Antenatal Clinic and the Maternity Ward. The data was then coded up again to reveal distinct informal spaces within the formal places of health, in which place-based authoritative knowledge potentially empowered women to influence the healthcare transaction. These embedded informal spaces were analysed, first from the health-seekers' perspective and then from the point-of-view of the nurses.

The thesis is divided into seven subsequent chapters. To provide the conceptual framework for this research, **Chapter 2** will discuss how interpretations of health and healthcare delivery have developed and how health and place are now understood as fundamentally fluid phenomena that are situated and socially produced. It will be explained that within fluid interpretations of health and place, knowledges carry different weights or authority and can thus be used to influence the healthcare transactions and challenge the top-down supremacy of the biomedical model. It will also be explained how shifting disciplinary and political ideologies have begun to pay more attention to the significant overlaps between formal and informal healthcare delivery which has cast question as to what 'care' actually means in place. It will be argued that such discussions are ethically important to do 'human good' both for the discipline and the wider world, ideally through a feminist ethic of care. This chapter will also explain the healthscape conception fully and argue how it can be used to understand healthcare transactions in place.

Chapter 3 will anchor the empirical data collection through a contextual background by explaining the historical and contemporary history and geography of the Bunyoro Kingdom. The Chapter will critique the decentralisation policies that aimed to overhaul decades of turbulent dictatorship which decimated Uganda's professional base, particularly in health. It will be suggested that decentralisation politics did much to construct a homogenous 'poor' who seemingly failed to seize the benefits of development. The broad demographics of the field-site will also be set out looking particularly at the current tribal conflict and low standards of living in Bunyoro.

Chapter 4 explains how this research was conducted by discussing the methodological choices and philosophical underpinnings in relation to a broader disciplinary agenda. The interdisciplinary focus of the research lends a nuanced understanding to the complexity of healthcare delivery. The chapter will explain that the research was lengthy and bound in difficult questions of ethics that required a continuous (re)evaluation of the research in general, and the positionality of the researcher in particular. This chapter will explain and justify the methods used to conduct this research, namely action research through participant observation, focus groups and personal discussions. The chapter will also explain the data analysis through 'crystallisation' (Richards, 1994) and qualitative coding. Being so ethically bound, this chapter will specify how this research contributed to 'human

good'. It will also be discussed that data revealed that whilst women were willing to overcome significant social and tangible barriers to access antenatal care, a much lower percentage were willing to engage with maternity care.

To investigate this phenomenon, in the first of three empirical chapters, **Chapter 5** unpacks the broader societal norms and gendered expectations of health within Bunyoro set against the struggling health-system. These societal norms represented the terrain constructed by place-based knowledge through which woman had to travel to reach the formal place of health in which a number of informal spaces of health were constructed. The chapter focuses on three key characteristics that influenced health-seeking behaviour and, in turn, constructed informal spaces of health. Firstly, the broader expectations of women in relation to health are discussed. Answering the criticisms of the homogenous 'poor', distinctions are made between two key groups of health-seekers. The chapter argues that good health is not something that 'just happens' (Feierman and Janzen, 1992) but takes considerable organisation from a variety of health spaces which constructs a gendered norm. These cultured, gendered perspectives of women's role are discussed to argue that despite women's responsibility for health, in some places they were marginalised in their decision making capacity. The chapter suggests that as well as such societal barriers, women also had to overcome tangible barriers such as the low standing of living and poor infrastructure. The chapter argues, however, that there are numerous opportunities to develop place-based authoritative knowledge. The chapter will also discuss health-seeking behaviour in relation to the multiple of health options before discussing the services available at the formal place of health that is Kakindo HCIV.

The second empirical chapter, **Chapter 6**, narrows the focus to contemplate the formal place of health of the antenatal clinic. It is suggested that the high levels of attendance suggests women valued antenatal care. It is also argued, however, that in order to access this care, women had to use their place-based authoritative knowledge to construct informal spaces in which they were empowered to influence the healthcare transaction in effort to achieve their health aim of accessing antenatal care. Due to prevailing institutional norms of the formal health place, the women's influence on the healthcare transaction was not always positive. These constructed spaces of health are also considered from the nurses' perspectives. It is argued that due to their difficult working environments, the nurses felt

forced to adopt a number of 'legitimate' coping strategies which had a negative impact on their government work.

Following from antenatal, **Chapter 7** will contemplate the maternity ward. By discussing the local understandings of birth in Bunyoro, the chapter argues that health aims within the maternity ward were entirely different from those in antenatal. As childbirth was considered a normal part of a woman's role in Bunyoro, accessing formal maternity care often meant there was something complicated or emergency about the delivery. Subsequently the women needed medical care and thus were subjected to a biomedical gaze. Whilst women were able to construct informal spaces within the maternity ward, their lack of experience of the formal maternity place meant they had little authoritative knowledge to influence this transaction. Again both the women's and the nurses' perspectives are considered.

Chapter 8 will draw all the arguments to conclude the thesis in four sections. The first section addresses the empirical findings of the research by answering the specific research questions. The chapter then suggests the conceptual contribution of this research via the healthscape tool. Potential limitations of the research are contemplated before finally, the potential future research agenda will be explained.

Chapter 2: Ways of knowing healthcare.

'No object, no body, no disease, is singular. If it is not removed from the practices that sustain it, reality is multiple'

Moll (2002:6)

'Nursing is not primarily designed to contribute to the sum of human knowledge or the advancement of science. The great and principle duty of a nurse is to make a patient comfortable in bed, something not always attained by the most bookish of nurses. Any intelligent, not necessarily educated woman can in a short time acquire the skill to carry out with implicit obedience the physician's directions'

Thompson (1906:846)

'Care as a political concept requires that we recognize how care - especially the question, who cares for whom - marks relations of power in our society and marks the intersections of gender, race, and class with care-giving'

Tronto (1993:24)

2.1 Introduction

Improving maternal-child health (MCH) for women in the developing world will not only increase social, political and economic development, but will prevent the unnecessary deaths of more than half a million poor women annually (WHR, 2009: 6). As a myriad of failed development initiatives have shown; this is easier said than done. Furthermore, drawing on colonial understandings of the powerful biomedical model, a number of papers have suggested chronically poor patients are being suppressed by the hierarchical power of biomedical professionals (e.g. Zaman, 2004; Moland, 2002). This, in turn, affects their health-seeking behaviour. Recent evidence-based healthcare initiatives have highlighted

the necessity to move from a mechanistic, results-orientated approach to healthcare. Instead, as the opening quote by Moll (2002: 6) suggests, there is an increasing appreciation of the fundamentally fluid and social nature of health and thus the healthcare delivery required to sustain it (Dobrow *et al.* 2004; Sheaff *et al.* 2004; Ferlie and Shortell, 2001). Such an insight should facilitate an understanding of how to deliver healthcare that is efficient, appropriate and effective. Less consideration has been given, however, to the realities of implementing such an approach.

This investigation stands at a disjuncture between policy, conceptual theory and empirical research. Recent economic crisis has demanded unscheduled review of the progress towards the rapidly approaching MDGS. Moving away from Thompson's (1906: 846) above suggestion that caring is secondary to medical curing, this has re-highlighted the imperative role that women play as informal carers in the maintenance of health and the production of their communities (MacKian, 2008). In turn, it has been suggested that a more social understanding of health could positively influence the delivery of healthcare (Cummins *et al.* 1997) which thus demands a consideration of what 'appropriateness' and 'efficiency' mean in 'good' healthcare delivery which, as the Tronto (1993: 24) quote above suggests, poses difficult political questions. Bridging the policy, research and popular agendas, these concerns are reflective and reinforced by disciplinary shifts. Health geography has rejected a logical or positivist philosophy and suggested health might be more usefully understood as constructed, fluid and complex; as Moll (2006: 6) put it, health knowledges are multiple. It follows that appropriate healthcare delivery is similarly socially constructed. There has, therefore, been renewed policy and academic interest in the highly nuanced relationships of 'care' and healthcare delivery in place - both formal and informal - in the maintenance of health. Hereto neglected in the literature, however, are clear contemplations of what it is to 'care' and who delivers care. Furthermore, radical geographers have been forced to articulate how they 'care' or benefit 'human good' (Lawson, 2010; Olsen and Sayer, 2007, 2009:81). In interdisciplinary fields, therefore, scholars have endeavoured to carve a pathway of academic debate through policy and theory to investigate what 'care' means, how it can be delivered and who should care in a variety of contexts.

The overall aim of this research is to investigate the complexities of delivering high quality, appropriate healthcare, in context, particularly in light of recent claims of abuse of power by

healthcare workers (i.e. Zaman, 2004; Moland, 2002). It will be argued that to inform healthcare delivery the implicit mechanistic approach to health systems needs to be foregone in favour of an appreciation of the multiple ontologies of healthcare. In turn, such an understanding will highlight the multiple epistemologies of healthcare practice brought into being by different individuals and sustained through day-to-day, socio-material practices and knowledges, in a host of places (Moll, 2002). It will be suggested that theoretically, health geographers are well situated to examine such intricate relationships between space, health, illness and healthcare provision to the potential benefit of policy (Milligan and Wiles, 2010; Dyck, 1995). Such understandings could also be used to benefit 'human good'.

This chapter will provide the conceptual framework for the empirical investigation. It will explain the relationship between knowledge and flows of power in healthcare delivery in contexts, formal and informal. As this is a mutually constructive relationship, to borrow Nagar *et al.*'s (2002) expression, the organisation of the chapter reflects a matter of emphasis, not a strict partitioning. Section 2.2 contemplates the evolution of theoretical perspectives in health geography. The functional approach will be discussed in Section 2.2.1 which serves to understand the power of colonial medicine to cure 'deviance' and restore productivity. Section 2.2.2 considers the political economy perspective. Section 2.3 discusses a social constructionist approach to health which reconceptualised the fluidity of health in place. Section 2.3.1 will discuss the potential role of feminist post-structural theory in challenging conventional gendered hierarchical understandings of health. Section 2.3.2 will then look at how constructivist approaches re-theorised space, place and health in geography and discuss the role of power in health as constructed through health knowledges in place. Bourdieu's (1984) cultural-structuralist analysis of social space will be used to suggest 'habitus', as place-based authoritative knowledge, can facilitate power to challenge the social order. To situate this research on the disciplinary agenda and bridge the gulf between theory and practice, Section 2.4 will unpack the complexities of caring in formal and informal places. Section 2.5 will then draw all these discussions together and present the notion of 'healthscapes', a conceptual tool 'conceived' to unpack the complexities of healthcare transactions. Finally 2.6 will conclude this chapter by summarising the arguments made and explaining the specific research questions that underpin the thesis.

2.2 Different theoretical perspectives in health geography

Conceptualisations of health and illness within geography have diversified considerably in recent years. In line with theoretical 'turns' in the discipline as a whole, over the years these changes have prompted a shift from a positivist, epidemiological conceptualisation of disease and illness, to a more cultural and constructed understanding of both health and place as situated and socially produced fluid concepts. An increasing appreciation of the multiple understandings of space, and the specificity of place, has challenged previous understandings of concrete spaces of health and care, such as hospitals and clinics. It has also re-evaluated previously neglected places of health such as home spaces (Dyck, 1995). Challenging questions have been raised over what actually constitutes 'care' in a variety of settings, particularly as 'everyday' care and medical transactions blur. Such developments in thinking demonstrate that the taken-for-granted features of the present should be challenged, and explain the otherwise 'obvious' appearance of medicine today (Wright and Treacher, 1982:2). Without such a historical perspective, the beliefs and behaviours of people in relation to health knowledges often appear inexplicable, irrational, and self defeating (Lupton, 1995), especially in a pluralistic health-system. The next sections will, therefore, explain the evolution of theoretical perspectives informing scholarship and research. It is argued that a functionalist understanding is particularly useful to explain a colonial approach to health, and thus to ground the historical legacy of biomedical supremacy.

2.2.1 The functional approach and colonial healing

The traditional functionalist approach to health that was particularly popular in the 1950s, suggests that within consensual society an order is derived from individuals' actions within defined roles or functions. Under Parsonian thinking, the classic functionalist approach is to view illness as a 'social deviance' (Parsons, 1987). It is accepted that the sick are unable to work in the usual way, but instead require care. The patient may even need to absolve themselves from responsibility for the management of their illness (Mechanic, 1979:42), literally handing over all personal power to the doctor. The rationale is that if a patient rests, recovery is more likely and the risk of death is reduced. This then protects society's 'investment' into their schooling, training, *etcetera*, and thus the functioning of society. Whilst illness legitimately gave a person a right to withdraw from productive society, this

temporary state was a threat or failure to conform to societal expectations and norms. It was a sign of moral malfunction, and a source of blame (Lupton, 1995; Crawford, 1994; Greco, 1993). Later in the 1950s, the functional approach to health was undermined by sociologists, and is now seen as outdated. As Moll (2002) explains, Marxists highlighted how functionalism rejects antagonism, struggle and change. A functional approach does, however, explain the original colonial understandings of health in Africa through the quests for 'civilisation' and science, and the subsequent organisation and lasting powerful legacy of healthcare which was reified through practice.

With the development of the colonial biomedical model in the late nineteenth century, Africa captured the imaginations of explorers who sought to socially, culturally and *morally* reform the Dark Continent. The post-Enlightenment European mind viewed Africa as 'a unique space, as a repository of death, disease and degeneration, inscribed through a set of recurring and simple dualisms – black and white, good and evil, light and dark' (Vaughan, 1991: 2). Vaughan (1991) provides an account of Stannus, a Medical Officer in Zomba, Nyasaland in 1910, who, like many medics, kept a photographic 'catalogue of horrors', documenting alien ailments from elephantiasis of the scrotum to advanced cases of leprosy and yaws. Many photographic journals recorded 'tribal tattoos', lip plugs, or cases of albinism. Mission journals from the 1890s to 1940s commented on the curious bits of wood hanging on babies' hair and the dirty pockets on women's necks which were 'heathen charms worn to keep off the various diseases' (as quoted in Vaughan, 1991: 69). In MCH, the 'cruel, sin-disfigured' elder women or 'heathen grandmothers of Africa' who assisted in childbirth, came to symbolise the immensity of the 'evil' the missionaries were opposing in their work (Doulton, 1907). Women in particular were an enigma. Early colonial literature is dominated by descriptions of highly sexualised women who stood in sharp contrast to the idealised aristocratic middle-class imagination of European femininity. As British ambassadors were discouraged from befriending, employing or marrying African women, the only association they had with them were illicit sexual affairs. The casual approach that was so unlike the strict control of female sexual behaviour in middle-class European society at the time, generated simultaneous mystery and fear of these 'wild', different, African women (Vaughan, 1994). There was, therefore, a real intrigue and scientific objectification of the African subject, both through the representation of biological science, and the fascination with 'tribalism'.

Africa, therefore, was intrinsically 'other' and thus potentially posed a threat to the ordinary functioning of society. Goffman (1963) suggests that such difference between self and other, a 'difference' or 'deviance' from the norm, generates stigma. The 'otherness' had to be overcome and controlled to enable individuals to adhere to the norm and become productive members of society. A Foucauldian (1975) analysis takes this approach a step further in reference to the 'anatomical atlas', or the focal point for disciplinary power, that is the body. For Foucault, such a highly sexualised body represented the ultimate site of political and ideological control, surveillance, and regulation (Lupton, 1995). Overlapping into the political economy approach, the conceptualisation of what is 'normal' defines the limits of behaviour, and, in turn sanctions activities, generating this uncontrollable other. Foucault (1975) suggests that state apparatuses such as medicine, (but also education, psychiatry and law) had the power to establish these boundaries, thus rendering bodies productive through their political and economic use. Illich (1977:19) develops the argument further by suggesting that professionals assert 'secret knowledge about human nature' through which they 'claim a monopoly over the definition of deviance and the remedies needed'. Such powers, for example, utilise binary opposites to label bodies as deviant/normal, unhygienic/hygienic or controlled/wild with no comprehension of other conceptions of the body which differ from this approach. Gilman (1985) uses this argument to suggest that from the need for control of 'other', and the constant fear of the loss of control, comes the objectification of what is 'normal' and what, in turn, is not normal and therefore uncontrollable. As the 'not normal' poses a threat to the functioning of society, it becomes the ontological basis for the formation of stereotypes. According to Foucault therefore, in the late 19th century bodies were being constructed and regulated by institutions such as hospitals, prisons, schools *etcetera*. In turn, bodies were both being subjected to, and were reinforcing, the extension of institutional governance over the most intimate of personal behaviour and beliefs. In the hospital, for example, changes in the medical system such as the introduction of physical examination, microscopes and developments in anatomy, psychiatry and surgery demanded that an institutionally constructed body should reveal certain secrets to a questioning medical gaze. The owner of the body is supposed to surrender his or her jurisdiction over their body to a 'greater' power. This is clearly shown in colonial medicine.

Colonial medicine was administered through the control by the greater power of the African other. The medical gaze, however, was about more than just surveillance of the flesh. Vaughan (1991:56) explains how missionary medicine combined, sometimes uneasily, a belief in the powers of biomedicine, with a conviction that those 'called' to the medical profession were mere servants of the 'Great Healer' of souls (Vaughan, 1991:56). Throughout the colonial period missionaries provided more medical care for African communities than did colonial states (Leggett, 2002). In most African countries, it was not until at least the 1930s that secular medicine reached rural communities. In the late 19th century, therefore, for most Africans any encounter with biomedicine was likely to be with an explicitly religious version, as missionaries introduced 'western' midwifery and childcare practices (Vaughan, 1991). This not only explains the functional organisation of healthcare - which was literally to restore an individual's role in society - but also reinforced the image of the 'sick continent' in Britain, as churchgoers heard about the accounts of the valiant medical missionaries curing the physical and spiritual ills of 'the Africans', prompting what Mackenzie (1984) terms the 'collection-box' phenomenon.

Secular and missionary medicine, therefore, both relied on social pathological models of illness. Secular medicine saw modernity and the disintegration of 'traditional' societies as the fundamental causes of disease, whereas missionary medicine took the view that disease would only be conquered through the advancement of Christian morality, a sanitised modernity, and 'family life' (Vaughan, 1993). Consequently, whilst secular medicine tended towards an ethnic model of collective pathology, mission medicine concentrated on individual Africans and their responsibility for sin and disease. Under this understanding, illness was linked to the fundamentally evil nature of fallen man in creation; human beings were exhorted to strive against evil through a 'government of the body' (Turner, 1992; 2000). People became ill, not through a breach of hygiene regulations, but because they had transgressed a social norm or taboo that separated the sacred from the profane (Douglas, 1966). One example is HIV which was traditionally linked with immorality, punishment and death, largely due to its association with illicit or immoral behaviour, deviant practices and ethical failure (Mugamni, 2004; Herek, 1999). The other is the use of witchcraft or traditional healing which were traditionally seen as 'backward', anti scientific, and/or 'traditional' (Pels, 1998; Olivier de Sardan, 1992). Missionaries recognised, for example, that African midwifery practices were the locus of the reproduction of many

strongly-held beliefs, so that African 'midwives' exercised a huge amount of moral and social control which had to be broken for Christianity to succeed (Vaughan, 1993). The darkness of the African birthing hut was positioned against the candles and white sheets of the maternity ward in which 'mission babies' were born. The ideal 'mission baby' was one born in a missionary House of Birth, whose mother had attended the child welfare clinics so that the child would receive the appropriate moral and spiritual upbringing (Vaughan, 1993). Indeed in missionary medicine, the healing of the body always came second to the winning of the soul and the fight against the 'evils' of the African society (e.g. van der Geest and Finker, 2004; Iliffe, 1995; Curtin, 1992). The infamous missionary doctor Albert Cook, who worked in Uganda, was even accused of being distracted from evangelization by putting medical work before the conversion of souls (Vaughan, 1991).

This discussion highlights two key points. Firstly, it shows the evolution of power of the medical professional under a functional approach. Returning to Foucault's discussion, medicine was a powerful institution of control, setting up 'supreme authority in matters of hygienic necessity' (1979: 54). Under the functionalist approach a carer could restore an individual's productive capacity; (s)he could make somebody 'better', not only physically but also morally. This power enabled the individual to reintegrate into normal society and be a valued, productive member again. Carers, therefore, acted as guardians, not only of health, but also of moral societal order, using their power to distinguish between normality and 'deviance' (Lupton, 1995); the literal societal guardians of the potentially disruptive nature of illness. Secondly, this discussion shows the capacity of biomedical discourse to culturally construct illness and healthcare practice which then becomes a powerful tool of social control. Witchcraft is a good example here, not least due to the conflict over what 'witchcraft' actually means. Middleton and Winter (1963) and Harwood (1970), for example, endeavour to distinguish between witchcraft and sorcery, with the former being a mystical and innate power, the later an evil magic consciously practised against others and sometimes deploying objects, 'medicines' or 'tools'. Problems with the definition arose, however, through the French translation of the English term 'witchcraft', *sorcellerie* (Moore and Sanders, 2001). In many early texts, witchcraft referred to local belief about good, evil, causation, divination and healing that provided 'a coherent ideology for daily living' (Fortes, 1953; 18; Evans-Pritchard, 1937, Gluckman, 1944). Such a fluid understanding meant that the term 'witchcraft' could be used to construct anything from zombies, ritual murder, sale

and manipulation of body parts, to general occult powers and magic, (Moore and Sanders, 2001) and hence potentially 'demonised' a whole range of practices.

Whilst both these points illustrate the foundations of the supremacy of the medical model, critiques of this approach need to be noted. Specifically, it is debatable whether, from a colonial perspective, an African body had no meaning other than the necessity of surveillance and control and was just rendered an object to be prodded, tested and examined. Some critics have argued that a doctor-patient hierarchy which the patient is seeking verification - both abstract and physical - for their role in society, paints too simplistic a picture. The functionalist perspective does not, for example, allow for potential conflict as it typifies patients as compliant, passive and grateful in front of a universally beneficent, competent and altruistic doctor (Turner, 1988:46). There is no suggestion of a capacity to challenge the hierarchy of doctor over patient, or a consideration of the healthcare transaction within different health spaces. Critics further suggest that a functional approach pays too little attention to the power embedded in this encounter which is generated through conflicts of interest, whether explicit or implicit, between the patient and the doctor, and which require negotiation at every step (Gerson, 1976; Strong, 1979). As Lupton (1994) explains, a functional approach also does not consider that both doctor and patient have different, and indeed often conflicting, interests. Whilst curing the sick, a doctor is predominantly earning a living and endeavouring to progress his career. A patient is aiming to get well. Critics also suggest that a functionalist approach envisions a medical gaze that is too 'clinical', neutral and universal.

2.2.2 The political economy perspective

In part developed from a Parsonian understanding of health, the political economy perspective - also known as critical structuralism (Lupton, 2003) - arose in the 1970s and early 1980s, informed by Marxist critiques of the nature of the capitalist economic system. As Lupton (1994) explains, political economists see a symbiotic relationship between capitalism and healthcare: capitalism produces health needs which are treated in such a way as to obscure their origins and demands the consumption of commodities to secure the healing process, which in turn, supports the capitalist system of production (Renaud, 1978; Navarro, 1976;).

A political economy approach recognises an individual's capacity and obligation to contribute to the production of society through capitalism which remains the basic organising principle of economic life (Harvey and Scott, 1989). As good health is the manifestation of a person's productive capacity, the economic cost of ill health is regularly cited (see Ose, 2005). This is particularly poignant in the developing world where there is no welfare system to support ill individuals and their families, and where illness can push people into a poverty trap from which it is very difficult to escape (CPRC, 2006). The cost of malaria, for example, is frequently seen as both a condition, and cause, of poverty, and therefore a major constraint to economic development (see UN Roll Back Malaria, 2009). As Mitchell *et al.* (2003) suggest, in a capitalist system the reproduction of both the means of production and the forces of production (labour power) must be ensured, otherwise the circuit(s) will be broken, production will cease, and capitalism will ultimately flounder.

Good health as the fundamental root of an individual's productive capacity is thus a vital component in the complex circuit(s) of accumulation enabling commodity production. Furthermore, whilst health is a contested concept it holds a dual role as both product and producer. Recent discussion, for example, has witnessed an 'extraordinary efflorescence of interest' (Harvey, 2000:14) in 'the body' as a grounding for all sorts of theoretical enquiries. A political economy perspective contemplates the role of health in the body as a producer of profit through work, but also as an enabler of profit through health. The massive rise of popular interest in the concrete manifestation of good health through the body is undeniable. As Shilling (2003) suggests, newspapers, magazines and television are replete with features on body image, plastic surgery and how to keep the body looking sexy, young and beautiful. The business of weight loss and keep-fit is now a growing multimillion dollar industry. In 2003, Shilling estimated that in the UK alone, the gym and health club business was worth an estimated £1.5 billion per annum. In 2007 the gym industry was worth £3.7 billion (FIA, 2008).

For political economists, ill, ageing or physically disabled people are therefore marginalised by society because they do not contribute to the production and consumption of commodities (Lupton, 1995). Other groups such as women, people from non-English speaking backgrounds, black people, the unemployed, or members of the working class, are also marginalised. As a result, they may then live disadvantaged lives with restricted access

to healthcare services, and suffer poorer health than those from privileged groups (Lupton, 1993). Unlike functionalists, however, political economists object to the power held by the medical profession and question the values of biomedicine. Instead, political economists focus on the identification of the political, cultural and historic factors that shape health, disease, and healthcare issues (Lupton, 2003). Moving away from the narrow biomedical explanations of illnesses caused by single factors that can be treated using medicine or technology, political economists turn instead to the prevention of illness or the maintenance of good health (see Lupton, 2003 for a discussion of the state's failure to acknowledge the role of environmental toxins).

A political economy perspective also contemplates the role of 'non work' in the production of health. For example, Mitchell *et al.* (2004) open their article, *Life's Work*, with three vignettes of contemporary life to highlight diversity in productive power. They focus on the relationship between the production of value at work, and the social reproduction of labour power, along with the conditions that enable its employment. To use their third vignette, a woman sewing clothes at home whilst supervising her children's homework and talking to her husband hundreds of miles away about their harvest, is being directly productive (through the clothes), promoting future production by developing her children's productive capacity, and transcending global boundaries by maintaining the relationship and support network of the family. Only the production of the clothes is directly marketable in terms of monetary return, but is no more important than the contribution of 'non-work'. In the developed world, the role of non-work or informal caring became mainstream on the academic agenda with the rising neoliberal ideology of the 1980s, when health and social care provision for the elderly were restructured to avoid costly hospital care. With the move towards increased community respite, and particularly home care, the role of informal carers, which was previously neglected in the geography literature, came to the fore (Milligan, 2000; Harper and Laws, 1995).

Both a functionalist and a political economic approach view health as the root to an individual's personal productive capacity. Consequently, as introduced in the last section, the capacity to cure 'social deviance' and thus enable an individual to (re)become a valued, productive member of society, represents not only power over productivity, but a source of moral and societal order (Lupton, 1995). Developing Foucault's (1979) discussion Weisz

(1990: 6) suggests that under a political economy or functionalist approach, the institution of 'medicine has assumed a cultural importance that goes far beyond its ability to make people feel better'. Political economy writers comment on the 'cultural crisis of modern medicine' in which the high status of the medical profession, and the faith that is invested in its members' abilities to perform miracles, resulted in other social problems being inappropriately redefined as illness (see also Freidson, 1963). Zola (1972) saw medicine as a major institution of social control that superseded the influence of religion and law as a 'repository of truth' and which, rather than improving people's health, actually undermined it through the side effects of medical treatment and by diminishing lay people's capacity for autonomy in dealing with their own health care. Under this approach, any care delivery then becomes an institution of social control that could potentially reinforce racism and patriarchy (Ehrenreich, 1978). Illich (1977:9) further spoke of the power of professionals in general, but in medicine in particular, who have managed to gain a 'supreme ascendancy over our social aspirations and behaviour by tightly organizing and institutionalizing themselves'.

As an institution, the hospital is considered the 'premier institute of biomedicine cross culturally' (van der Geest and Finkler, 2003:6). Traditional understandings of hospitals view them as an isolated entity, a world apart, a culture all together separate from the 'real' world (see, for example, Salisbury, quoted in Foster and Anderson 1978; Coser, 1962; Goffman, 1961; Caudill, 1958). Into this separate world an 'inmate' enters and lives in a self contained community which reconstructs his identity and personal power (van der Geest and Finkler, 2004). Under a political economy perspective patients then, in theory, become vulnerable through their lack of knowledge and their reliance on doctors to recover and restore their productive power, and have little opportunity to challenge doctors' decisions (Lupton, 1995). This is particularly the case for socio-economically disadvantaged groups whose lack of power is further entrenched through their interactions with powerful doctors who seek to maintain the social status quo. The argument suggests that the hegemonic authority and the coercive hierarchical power that medical professionals possess is partially masked, and thus accepted, by their normative involvement in hospitals (Rothman, 1991; Reiser, 1984). Hospitals evolved therefore, from caring to curing; institutes of kindness (in the broadest sense) to professionalism, with technology enhancing disparities that cemented divisions between doctors, alternative practitioners and other medical

professionals such as nurses and midwives (Deacon, 2004; Starr, 1982; Rothman, 1991). Such an understanding laid the foundations for the centralised, urban biased, hospital orientated, largely white and male medical profession of the 20th century (Deacon, 2004; Hill, 1994). Using the Foucauldian (1974) understanding of power, it is suggested here,, however, that this presents a highly simplified portrayal of medicine, which focuses on the supposed crushing of helpless patients in the pursuit of professional advance, rather than the improvement of people's health. As Atkinson (1995:33) put it, in much of the literature, 'the asymmetry of the relationship is exaggerated to the point that the lay client becomes not the beneficiary but the victim of the consultation'.

Claims to 'truth' and the political neutrality of biomedical knowledge have been challenged, particularly in relation to the power held by various individuals as exercised within the healthcare transaction, and to new understandings of places of health and healthcare delivery. This new, and often quite radical thinking, was both reflective of, and reinforced by, disciplinary shifts in health geography which questioned long standing theorisations of place, power, the body, actors and indeed care in a healthcare transaction. The next section will discuss this socially constructed thinking, looking particularly at the changing approach to health delivered in place by a variety of actors.

2.3 Social constructions of health in space and place

Post-structural writings had been informing a new theoretical approach from as early as the 1970s. From the 1980s, however, social constructivist analysis received increased expression across a number of disciplines (Lupton, 2003). Social constructivists questioned the claims to the existence of essential truths and suggested that what was asserted to be 'truth' should be considered the product of power relations, and as such, was never neutral, but always acting in the interests of someone. The growing predominance of post-structuralist analysis of health received renewed vigour across the social sciences in the 1990s. The 'cultural turn' created a new health geography that, using a constructivist analysis, recognised the fundamentally fluid nature of health and the power-bound spaces and places in which it is delivered (Dyck, 1997). Kearns and Joseph (1993: 715), however, suggested that in health, the 'distinction between space and place is, at best, ambiguous and may well be more hindrance than assistance to the development of theory and

research'. Whilst the 'hindrance' of the concepts in research is challenged, it is agreed that a clarification of terminology is required. This section will, therefore, discuss the evolution of the post-structural approach to social organisation, particularly from a feminist perspective, and then discuss how the new constructivist approach re-theorised the key concepts of space, place and scale in health, and the inherent role of power in healthcare.

2.3.1 A post-structural approach to social organisation

A *structural* approach to understanding behaviour within a social domain discloses the underlying organisation of a culture's distinctive features and focuses on how meaning and action, or 'practice', interact in interdependent ways to inculcate and reinforce cultural knowledge and norms of social behaviour (Low and Lawrence-Zúñiga; 2003). *Post-structural* theory, however, questions claims to the existence of essential truths and logic, with the suggestion that there is no single approach to knowledge development, and thus power (Doering, 1992). Bourdieu (1977: 214), for example, argues that identifying rules that actors follow does little to explain how people use these conceptual schemes practically and discursively, to produce and reproduce social norms and culture. Post-structural theory, therefore, does not deny, but continues to engage with, structural processes as they work out in relation to concrete contexts, meanings, histories and cultural productions. As Bryson (1992: 225-26) explained:

'the search for a single all-encompassing theory is therefore rejected in principle as is the very possibility of objectivity. Western philosophy's quest for truth and certainty (described as logocentrism) is therefore abandoned and is seen as the product of a particular historical era that is becoming inappropriate in a post-modern society that is increasingly characterised by fragmentation, diversity and diffuseness in all spheres of life.'

As Lupton (1995) discussed, what is asserted to be 'truth', or the interpretation thereof, should be considered the product of power relations, and as such, is never neutral but always acting in the interests of somebody. A post-structural analysis, therefore, unmasks and explains power relations which can be used to 'reconstitute the world in less oppressive ways' (Davies *et al.* 2006: 89) which may then be used to alleviate social inequality (English and Irving, 2008; Francis, 2000; Druzec, 1989). A post-structural approach thus

contemplates the dynamic inter-linkages between power, space, language and time; at different spatial scales of the body, home, region, nation and globe (Lawson, 2008; McDowell and Sharp, 1999; Sim, 1998).

Under a traditional Foucauldian (1980) analysis, self is not a fixed, coherent personality as presented in positivist theory; it is positioned and positions in 'discourse'. Discourses are socially and culturally produced patterns of language which constitute power by constructing objects in particular ways. According to Foucault (1980), wherever there is discourse, knowledge provides the possibility of resistance, which is both a necessary component, and a creator, of power. Resistance to power can manifest itself subtly through silence or general noncompliance, as well as more visual or audible protests (English and Irving, 2008). Power then unfolds, not through large-scale events, or necessarily from the top down, but via capillary action or complex 'micro-physics' at the extremities (English and Irving, 2008; Foucault, 1981; 1976). Under this view, power becomes localised, dispersed, diffused and typically disguised through the social system, operating at a micro, local and covert level through sets of specific practices (Turner, 1997). Power is not, therefore, associated with particular institutions but with practices, techniques and procedures, in a variety of places. Moreover, discourses are not fixed, but change over time as the social institutions which produce them change (Francis, 2000). In turn places are represented, not as socially and politically neutral, but as the outcome of dynamic social relations and power struggles between groups in society (Harvey, 1996). Knowledges that are developed within those places are situated and socially produced in a historical, social and political context (Smyth, 2005), and can be potentially useful in certain settings. Stemming from a Foucauldian analysis of power (1972) to summarise the post-structuralist approach by using the works of Best and Kellner, (1991), Blunt and Wills, (2000) and Pratt, (2000); Gesler and Kearns (2002) present a five point strata of the principal ideas of post-structuralism that blur with a radical feminist approach. This is shown in table 2.1.

Such a constructivist approach became particularly useful in health geography, nursing studies and development geography (Lawson, 2007; Doering, 1992). Whilst the reality of disease states or bodily experiences is not in question, the constructivist approach suggests that these states and experiences are continuously constructed and reconstructed in place, and thus can only be understood through gendered, social and cultural analysis. Parr and

Butler (1999), for example, use Turner's (1984) theory (which critiques the biological reductionism of corporeal existence suggesting human beings are both 'bodies' and have 'a body') to discuss how the social construction of illness can have a greater impact on an individual's life than the manifestation of disease (Moll, 2002; Barton, 1996).

Table 2.1: The principle ideas of post-structuralism

	Principal idea	Explanation
1.	Language	Language does not reflect reality, rather it constitutes it. Language is 'the medium for defining and contesting social organisation and subjectivity' (Pratt, 2000:625). Through language, the human body becomes the location where social practices and organisations of power meet – the body is no longer purely biological, but invested with relations of power and domination (Dickson, 1990).
2.	Identity	Identities are historically produced. Rather than being naturally given, they are performed in the activities of one's daily live. Attention then focuses on multiple, interacting facets of the subject i.e. class, gender, sexuality, disability and ethnicity.
3.	Power	Focus lies on power, specifically its intimate connection with the formation of knowledge. There are multiple forms that control the actions of people which are contested through the politics of feminism, sexuality, class and ethnicity.
4.	Disputing binaries	A refutation of binary oppositions of Western philosophy such as subject/object, male/female, appearance/reality, reason/nature, which puts the inferior term in a negative light.
5.	Interpretations	The insistence that there are 'no facts, only interpretations, and no objective truths, only the constructs of various individuals or groups' (Best and Keller, 1991:22).

Source: Adapted from Gesler and Kearns (2002)

Post-structuralism, therefore, helps to complicate seemingly clear-cut and hierarchical structures. Notwithstanding critiques, such an approach can be useful to take a flexible, contextualised and *gendered* reading of power relationships (Ryan, 2001; see also Francis, 2000; Bulter, 1990). Post-structural feminists, for example, challenge the notion of one single theory or *grand narrative* being capable of explaining women's position throughout

time and across space. A post-structural feminist approach moves beyond the binaries of male and female and associated 'essentialising' practices (Davies *et al.* 2006: 88) and has re-thought 'gender' as a complex relational frame of reference (Kenny, 2007). Connell (2002; 1987), for example, suggested *gender regimes* corresponded to a set of wider social patterns, known as *gender order*, in which gender was dynamic, complex, constantly negotiable, powerfully constrained, or *practice*. Butler (1993; 1990) further challenged the assumption that binary sex/gender is a given or natural division and argued that bodies are constructed as male and female through the repeated 'performance' of certain discursive practices – *gender*. As Vasterling, (2003:209) explained, Butler's denaturalisation of the categories of sex and sexuality opens the ontological domain to 'questions of power', raising the political question as to whether there are hegemonic conventions which legitimise some bodies over others.

The understanding of gender as dynamic and fluid has contributed to the the feminist post-structuralism critiques of the ways in which medical discourses have historically constituted a site of sexual discrimination. Medico-scientific justification has been used to differentiate women from men on the basis of biology and anatomy, in turn, providing scientific evidence to prevent women from entering public life (Lupton, 1993; Bunting and Campbell, 1990; for critique, see Shorter, 1982). Entrenched male control was cited in the literature of the 1980s 'birthing movement' which critiqued the male dominated medicalisation of pregnancy, childbirth and the female body which produced female agency in a particular way (see Oakley, 1982 1979; Katz-Rothman, 1982). Birth serves as a microcosm in which the critical encounters between rapid technological progress and cultural values, expertise, normative behaviours, social organisation, gender relations and the political economy, can all be clearly viewed (Halfon, 2010; Viisainen, 2001; Zechmeister, 2001: see Mansfield, 2008, Thompson, 2005 for discussion of 'naturalness' of childbirth).

A feminist post-structural approach, therefore, permits analysis beyond liberal feminists' attention to individual women's rights, radical feminism's collective action for justice and the end of patriarchy (English and Irving, 2008). Critiques lie in the lack of inattention to patriarchy and structural exclusion of women which feminists see as a challenge to the gains in developing solidarity, mobilising against a common oppressor, and valorising the sovereignty of experience (Irving and English, 2008). In general, however, post-structuralist

studies of gender have offered alternative ways of seeing and theorising 'time, space, sexuality, regulation, control and power' (Bell and Valentine, 1995; Rojek and Urry, 1997; Valentine, 1999) which can be used to make social changes. As Nagar *et al.*, (2002:271) explain,

'[s]lowly but surely these feminist studies have reshaped the terrain - both at discursive and policy levels - by deeply politicising notions of work; by placing households, shop-floors, hospitals, schools, weekly markets and diasporic networks in direct relationships with corporations, markets, banks, and development institutions; engaging with people's lived experiences....in all their contradictions.'

A feminist, post-structural analysis is thus particularly useful to challenge entrenched ideologies about power. Before such an approach can be used to challenge conventional understandings about power in healthcare transactions, however, there is a necessity to discuss how health concepts are used in health geography and indeed, what they mean.

2.3.2 Constructed space, place and scale in health in geography

Whilst constructivist approaches as informed by post-structural writings gained popularity across the social sciences in the late 1980s and 1990s, they had particular resonance within the 'cultural turn' in geography. Within this turn, medical geography experienced a significant 'paradigm shift' (Kerans and Gesler, 1998:1). From the shadows of medicine emerged a new health geography that both engaged with social theory and addressed public health concerns, by re-theorising health and healing in place, often in an effort to alleviate inequality at some scale. Whilst medical geography continued to broadly study the physical *spatial orientation* and distribution of disease, health geography turned its attention to more nuanced, *social understandings* of health, disease and wellbeing. Constructivist work, therefore, teased out the intersections between health, healthcare, illness, therapy, gender, the body and place (Dorn and Laes, 1994; Kearns, 1993; Gesler, 1992), revealing previously masked power relations (Irving and English, 2008). By doing so, the new approach also provided new analyses and strategies for social justice that could, potentially, 'do human good' (Lawson, 2010).

Simultaneous to the emergence of health geography, geographical focus as a whole shifted away from crude utilitarian concepts of space as simple area descriptors to a more reflective understanding of the meaning and utility of space (Mackian, 2008; Gattrell, 2002; Williams, 1998). The re-theorisation of both place and health as complex material, sociological, experimental and philosophical phenomena became crucial to understanding the influence of the local in the making of and experience of health and healthcare (Parr and Butler, 1999; Parr and Philo, 1996). As a result, there was a necessity for geographers to engage with the 'recursive constitution of place and people, rather than conceptualising places and spaces as unchanging 'backdrops'' (Dyck, 1999:247). Amidst this 'fluidity', however, there is a need to contemplate what, exactly, 'space', 'place' and its related 'scale', mean in health.

Smyth (2005: 490) suggested that 'despite the vocabulary', with the cultural turn, public health interest moved away from therapeutic landscapes. Therapeutic landscapes are frequently described as where 'physical and built environments, social conditions and human perceptions combine to produce an atmosphere which is conducive to healing' (Gesler, 1996:96). The concept recognises that certain physical places have potential for physical, mental and spiritual health promotion and healing, such as Lourdes, France (Gesler, 1996), Bath, England (Gesler, 1998) and the Hot Springs, South Dakota (Georges, 1998). From that understanding, certain specific, physical, elements became associated with well being, such as the presence of wilderness, water, or open green space, which then have tangible policy implications, for example on urban planning (Maas *et al.*, 2006; Health Council of Netherlands, 2004; DoH, 2004).

According to Smyth (2005), however, recent attention has focused on broader therapeutic 'spaces' such as hospitals, gyms and prisons (Stoller, 2003). The most fundamental understanding of space is as an area or a physical distance. Space can be either the bounded area, or place, in which processes occur, or the definable distance that separates two places of processes (Kearns and Joseph, 1993). Gattrell's (2002), discussion of the 'distance' that separates health places, for example, echoes traditional understandings of geometric space in spatial analysis of health. Soja (1985) and Dear and Wolch (1989: 1987), however, used social theory to suggest that space can be seen as both the medium and outcome of social relations. Smyth (2005) further suggests that within spaces of health that provide therapeutic functions such as hospitals, or parks (i.e. that are not specific or unique

places but contribute to health and healing), the specific geographical location is of less significance in the therapeutic role than the physical, social and symbolic organisation of that space itself. Such spaces can vary in scale - as will be discussed. What is important are the practices and process *within* that health space and the role that they have in the production of place, rather than the particularities of specific place itself.

'Place', in contrast, relates to somewhere specific or particular, such as the place that is Lourdes (Smyth, 2005). A significant amount of empirical research has applied extensive quantitative methods and techniques for statistical modelling to investigate the impact of contextual factors within specific places on health (see Chaix *et al.*, 2005; Subramanian *et al.*, 2003 for reviews of this approach). Ordinarily the places investigated affected marginalised populations; Gatrell (2002), for example, discussed the spatial distribution of unhealthy places and the role they play in the production of health. Highlighting the role of scale in understanding place, Gatrell (2002) further suggests that 'Grandfather's favourite chair' positioned by the window also becomes a place of health because it is given personal meaning and contributes to his health just as the local hospital would. Indeed, Kearns and Joseph (1993) suggest that an appreciation of the human experience in understanding place adds a necessary and location-specific dimension to understanding the implication of relations in space. Gesler (1991: 165) suggests that whilst 'place is studied with an eye for its meaning for people, space is analysed in terms of its quantifiable attributes and patterns'. In this understanding, therefore, space is a necessary but insufficient ingredient of place and thus may involve a dispersed but ordered arrangement of differentiated places. Health action occurs *over* space, whilst it is *in* places that 'people become what they are' (Griffiths and Johnston, 1991: 185). That is not to say, however, that 'place' is only a specific geographic location, nor is it an empty environment or terrain which serves as the 'backdrop' for health interactions (Dyck, 1999: 247). A constructivist understanding of place and health suggests that neither can exist independently from the actions or factors that constitute and are contained within it. The specific place that is Lourdes is visited due to its therapeutic properties; the therapeutic properties attributed to Lourdes, however, were only embraced through visitation to the place. The actions are thus embedded in broader spatio-temporal social, historical, cultural, economic and political contexts (Smyth, 2005) which are informed by, and constitute, place.

To just say that place is specific and carved out of space, however, ignores both the mutually constitutive relationship between the two concepts, and the key role of scale in considerations of health. Teather (1999), for example, discusses how information technology, the space of flows (Castells, 1989; Lefebvre, 1991:354) and discursive spaces create specific place via the mental attitudes and conventions held by members of the public and the media. These places, however, are far from fixed and are continuously being constructed by changes to the broader space (see also Marcus' 1992 example of 'rape space'). The hospital is another good example. Under the re-conceptualisation of place and its role in health, far from being viewed as 'isolated islands' (Coser, 1962:3) or closed places, hospitals were reconsidered as spaces of medical flows of power and potentially places of life-and death-drama (Long *et al.*, 2008). It was DelVecchio-Good (1995) who first called for *cultural* studies of 'biomedicine' suggesting that biomedicine was not a monolithic entity, but an institution that was strongly affected by its local contexts (see also van Amstel and Van der Geest, 2004). Hospitals were thus seen to be spaces of health that were reflective and reinforcing of the dominant social and cultural practices of a society (Van der Geest and Finkler, 2004; Lock and Gordon, 1998). Subsequently, in his study of rural healthcare delivery in South India, Nichter (1986:14) concluded that the setting, with all its typical characteristics of competition, conflict and concerns about status and power, was 'a place for local politics'. Zaman (2004) noted how local tensions in Bangladesh were illustrated through the many hospital admissions with violent injuries, and Goopy (2005) discussed the influence of local culture within hospital environments in Italy.

Hospitals are thus now considered to be reflective and reinforcing of cultural and societal behaviours in which beliefs, practices and institutions of medicine will be reinterpreted and restructured by the receiving society (Van der Geest and Finkler, 2004). It needs to be acknowledged, however, that some of the processes constructing the more fluid spaces of health are still governed by the space itself. There is, for example, still an institutional framework governing the function of organisational space (Hero and Talbot, 2004); there is still a medicine round, a hierarchy of medical professionals, and institutional norms and practice that prevail within the institutional space, and inform the construction of fluid spaces of health.

Within those multiple fluid spaces of health there is a further necessity to factor in the scale at which those spaces are continuously (re)constructed. For a sick individual, for example, the socio-politics of health in the micro scale of a hospital bed continuously inform, and are informed by, the local setting of the hospital. This, in turn, informs the overall health of the individual (see Castree, 2004 for denominations of scale). Such an understanding then highlights how space and place are organised both in relation to each other and within the world, and thus, how they can be interpreted in relation to health. Traditionally, notions of 'scale' were seen to provide a language to investigate the various sized places that are carved out of space (Gatrell, 2002). The processes within each of these units could then be analysed from micro to global level. Such terminology, however, is immediately problematic as the appropriate scale has to be decided. It is unrepresentative, for example, to analyse the dynamics of HIV care access at a purely global level. Furthermore, focusing on one level of scale can underplay the role of contributing factors within, or between, that place and the world. Analysing the dynamics of global access to HIV care may not highlight the nuanced understandings of access at household scale. It must thus be understood that processes can occur in multiple scales simultaneously. Echoing Rainham *et al.*'s (2010) discussion, such pre-determined boundaries, whether scalar or geographical, ignore or compartmentalise how processes are affected by time. In healthcare, processes can be contemplated over time in relation to scale, such as the time spent involved in health at the local scale of the hospital. Health, however, is a constructed concept that requires the varying input of diverse formal and informal actors. Over the course of an individual's lifetime they will require care that needs to be contemplated at a micro to a global scale, at countless, and at times simultaneous, occasions.

To avoid such problems with representation Jonas (2006) suggests that rather than 'setting' a unit of scalar analysis, a more nuanced view is generated by considering the outcome of interrelated processes which may operate simultaneously at various spatial scales (see also Marston *et al.* 2005). Such an approach responds to Cummins *et al.* (2007) concern that all too often the role of people and place in health - or the compositional and contextual factors - are seen as too mutually exclusive in health research (see also Macintyre *et al.* 2002), and that this should be forgone in favour of a relational approach between place and space in health. As Cummins *et al.* (2007) suggest, some geographers, such as Castree (2004), Massey (1999) and Graham and Healy (1999), suggest that place might be more

usefully viewed as nodes in a network than as a discrete and autonomous bounded spatial unit. Space can then be seen as unstructured, unbounded and freely connected. Within that 'free' space, emphasis lies on human practice which forms 'constellations of connections' that extend beyond the traditional bounded notions of place, and thus move beyond conventional distinctions of context and composition. This relational view of place and space suggests that as area definitions are relatively dynamic, fluid and separated by socio-relational distance, networks of processes have a long or short 'reach', and varying levels of complexity, on both a daily basis, and over the life course. This approach suggests it is short sighted, therefore, to distinguish between the micro and the local scale, particularly in health (which is not necessarily synonymous with geographical proximity), because the processes in each place inform each other, and thus the overall space of health. As a result, particularly in light of the dynamic and changing characteristics of place, individuals often influence, and are influenced by, conditions in multiples places (Cummins *et al.* 2007).

This approach also draws on the earlier discussion of the significance of power in understanding healthcare delivery. Hudson (2004: 463 emphasis added) discusses how 'spaces, flows and circuits are socially constructed, and temporally stabilised in time/space by the social glue of norms and rules, and both *enable* and constrain different forms of behaviour'. It is suggested, therefore, that whilst power, as generated by knowledge, can only be exercised in relation to resistance change is possible because the balance between power and resistance is not fixed. Furthermore, we know that place is both constituted by, and constructed by, actions and social relations, formal or informal. As Cummins *et al.* (2007) suggest, those individuals can be conceived of in a variety of ways, from individuals and community organisations, to businesses, regional or national governments and institutions, peer-networks and families, even specific governing discursive frameworks such as policy or law. Whilst the role of these actors in health place might rely on specific access to tangible resources, it is also informed by social networks, knowledges, and expectations and anticipations of care, all of which are significant in the overall receipt and delivery of care.

Developing from the role of actors in the provision of care in place, Murdoch (1998) makes the distinction between 'spaces of prescription' - spaces that are relatively prescribed in

terms of formalised and standardised control of access to resources – and ‘spaces of negotiation’ – spaces that are, or have the potential to be, much more fluid in the way in which human activity and resources are organised, depending upon the fluid characteristics or spaces and people within them. Developing this idea, Bourdieu and Wacquant, (1992:16) suggest that within a social group as embedded in place, there are a ‘set of ...historical relations between positions anchored in...forms of power’ which thus shape identity, opportunity and propensity to risk taking (Bourdieu, 1984). According to Bourdieu and Wacquant (1992:17):

‘each field prescribes its...own regulative principles [that] delimit a socially structured space in which agents struggle, depending upon the position they occupy in that space, either to change or to preserve its boundaries and form.’

Understanding of that social field enables some understanding of health behaviours and material circumstances which differ by status level. From these fields ‘habitus’, or ‘authoritative knowledge’, is generated that guides individuals and groups in evaluating what to prefer, how to act, what to say, and how to say it (Bourdieu, 1990). Authoritative knowledge privileges one particular knowledge system at the expense of another. Jordan (1987; 1993: 152), for example, maintains that:

‘For any particular domain, several knowledge systems exist, some of which, by consensus, come to carry more weight than others, either because they explain the state of the world better for the purposes at hand (efficacy) or because they are associated with a stronger power base (structural superiority), and usually both’

The legitimisation of one kind of knowing as authoritative implies a devaluation of other kinds. Jordan, (1997) and Sargent and Bascope, (1997) suggest that consequently, participants come to see the current social order as the natural order of things. It is also suggested, however, that the power generated by knowledge in place can be used to challenge the conventional order. Notwithstanding the formal institutional aspects of a healthcare setting, in contrast to the Foucauldian analysis of power and knowledge, and drawing on Murdoch’s (1998) spaces of negotiation, Bourdieu’s theory allows for *agency* in

the healthcare transaction. It is suggested here that if space and place are considered relational and contemplated through networks of processes rather than discrete units of scale, place-based knowledge can become authoritative in certain health settings. Not only does this authoritative knowledge empower the holder(s) to challenge the perceived hierarchy or otherwise entrenched order of place, but it can create new informal spaces of health that are embedded within the particularities of formal place. Moving away from understandings of medicine being a dominant institute of social control, those spaces, in turn, *produce* knowledges which can influence the healthcare transaction. The capacity to create these health spaces within, rather than constituting, place, draws, therefore, on a host of different interactions between spatially contingent social networks, expectations and anticipations of care and knowledges (Cummins *et al.* 2007; Davies, *et al.*, 2004).

It is suggested here, therefore, that situated knowledge can be used in certain contexts to create informal spaces to take control of the healthcare transaction. It is also suggested that this approach can be used to provide a new approach to healthcare delivery. Before this can be done, however, as this research is all about care - both 'natural' and 'professional'-delivered in place - both formal and informal - there is a necessity to unpack the complex interpretations of the term 'care' in health, how its delivery can be conceptualised in changing places and the role of power through knowledge which constructs identity and informs the healthcare transaction. This discussion will also show how geographers could be useful in care, and how care could be useful to geographers.

2.4 The geographies of socially constructed care

Section 2.3 discussed the fluid conceptualisations of health in place and the associated creation and continuation of power through different knowledge(s) in different places and times which reconstructs identity within the healthcare transaction. It follows that the maintenance of such a fluid notion - that is the delivery of care - is highly complex and equally, if not more, variable in different places. The giving and receiving of care is so fundamentally imperative to human existence that we often do not appreciate it until it is threatened (Milligan and Wiles, 2010; Milligan, 2005). As a result, only recently has attention been paid to what 'care' actually means, and how it can be conceptualised, particularly on a day-to-day basis. Moreover, with changing ideologies and the interchangeable use of the terminology on popular and academic agendas, the boundaries

between health, politics, and questions of identity and responsibility have become blurred. Shifting neoliberal ideology from the 1980s, for example, restructured the locus of service provision for the elderly from institutional space to community or home based alternatives (Milligan, 2000), in turn transforming places, identities and power relations. In the developing world, as Chapter 1 explains, it is agreed that institutional care delivery is the most effective avenue of service provision, particularly for pregnant HIV+ mothers. A major critique of the literature, however, is that due to their complexity, notions of 'care' or 'carers', are rarely clearly explained defined adding an unnecessary layer of complication.

2.4.1 Geographies of care and caring geographies

Despite - or perhaps due to - the centrality of care in our lives, notions of care have occupied a curious position within the academic agenda. Notwithstanding some concern that geography should get 'back to basics' (Heynen, 2006:920) and contemplate the matters that are fundamental to survival, such as food, health, and housing, geography has a deep and sustained interest in using scholarship for positive change in the world (Connolly-Carmalt and Faubion, 2009). As Lawson (2007:2) put it, geography takes the substance of caring very seriously. Indeed Smith lamented that, as geographers, we have a 'special role' of helping to reveal the '*spatial* malfunctionings and injustices and contributing to the design of a spatial order of society in which....the rights of all are respected' (1973:121; 2000:1, emphasis in the original). Certainly, the diverse elements of geography, which range from development to globalisation and from liberalism to environmental change, traverse complex terrains of ethical and spatial justice (Connolly-Carmalt, 2010). This is where health geographers have the unique capacity to both contribute to critical normative geography and make some positive change in the world.

Motivations for more recent attention, however, are two-fold and yet highly interlinked. Firstly, partly in concern for the discipline's future (see Martin, 2002; Castree, 2002, 1999; Massey, 2000), geographers of late have re-contemplated how research can be produced that both uses ethical methodologies and can be translated into political action (Connolly-Carmalt, 2010). In their call to re-centre the normative basis of radical geography, Olsen and Sayer (2007, 2009:81) challenged geographers to articulate a concept of 'human good' or well being. Rising to this challenge, Lawson (2010) suggested that rather than a radical geography, the way in which geography could contribute to human good, and to the

discipline, is through a caring geography. Within caring, or 'care-ful geographies' (see Staeheli and Brown, 2003), feminist care ethics assert the absolute centrality of care to our human lives and suggest that we are all in need of care and an emotional connection to others. Such a feminist ethic of care also challenges conventional distinctions between public spaces as the realm of politics and justice, and private spaces as associated with emotion, care and welfare. Notwithstanding problematic definitions, the recognition of the absolute centrality of care to our lives immediately binds notions of care and care delivery in moral judgement and responsibility (Smith, 1997). This responsibility orientated approach, however, is far from new. Indeed, Morrill contemplated the 'responsibility of geography' over twenty years ago (cited in Lawson, 2007). Relating to the second motivation for the re-situation of care on the academic and indeed popular agenda, perhaps the more appropriate question, to borrow Lawson's (2007) phrase, is why (re)focus on care *now*?

In addition to disciplinary concerns, and reflective of considerations of care on the popular agenda, as Lawson (2007) explains, we now live in times defined by relentless right wing extension of market relations into all spheres of our existence. The more consumer - or client - related conceptualisations of health care, university education, care for the elderly, support for the working poor and environmental protection generated by the market-orientated approach, challenges how such services are both perceived and delivered and where they are delivered. The reduction in public provision of care and social support, for example, coupled with a neoliberal ideology based on individual over collective responsibility, has resulted in a changing typology of care through ageing in place (Cutchin, 2003). In many developed countries, from the latter half of the 20th Century, the implementation of policy focused on ageing and community care in place, re-centred the main space of care for vulnerable people from institutional place into domestic space, and by default into the realm of women (Milligan *et al.*, 2007, 2001; Milligan, 2000). The shifting location of care impacts its delivery and indeed the place of caring, as well as impacting upon the care givers and receivers. Academic inquiry has also, therefore, contemplated how the boundaries between a place of healthcare delivery and a domestic space of home can blur with the relocation of care. The blurring use of space, in turn, potentially challenges existing knowledge systems, enabling different authoritative knowledges to come to the fore, and (re)constructs the identity of the carers in relation to the care

recipient. Such challenges can alter relationships and perceptions of the meanings of home (see Milligan, 2006; 2001; Wiles 2003a,b, Twigg, 2000).

Whilst situating the role of care on the academic agenda, in all of these discussions a transparent consideration of the plural meanings of 'care' is significant by its absence. It is suggested here that this adds a further layer of complexity to an already intricate relationship. In effort to unpack some of that complexity, therefore, there is a necessity to ask a few questions, specifically, what we mean by 'care'.

2.4.2 *What is care?*

'Care' abounds on the popular and academic agendas. Whilst the proposed *healthcare* reform occupied a significant part of the recent UK election manifestos, several thousand people ran a gruelling 26.3 miles to show that they *care* for those less fortunate. Fashion tells us we should *care* for our image, whilst cereals tell us we should *care* for our hearts. We take *care* of bills in restaurants, wearing the shirt ironed with *care*, that is representative of somebody *caring* for us. The meanings of 'care' and, in turn carers, are clearly blurred. This section will, therefore, separate the spatial caring roles of 'medical professionals', 'domestic labourers' and 'home health carers'.

In their efforts to tackle the complex and spatial nature of care, Milligan and Wiles (2010:5), amongst other geographers, such as Grant *et al.*, (2004), Graham (1991), and Tronto (1989:282-3) make the distinction between *caring for* and *caring about*. *Caring for* implies a specific subject as the focus of caring, whilst *caring about* is characterised by a more general form of commitment that refers to less concrete objects. Whilst activities could be undertaken by formal paid workers or informal unpaid workers such as family, friends and volunteers, the most readily understood definition of people *caring for*, are the healthcare workers themselves who are based in a formal health facility. Referring to the opening quote by Thompson (1903), these care workers are generally considered to be female and employed to make people comfortable, rather than advance science. This highlights how medicine is traditionally seen as male, whilst nursing is considered naturally female. Webb (1996) suggests that this essentialism illustrates a critique of the medical model which appreciates the biomedical notion of 'cure' over the more humanistic notion of 'care'.

Within an African health system, such healthcare workers, or people who care *for*, can also extend to traditional birth attendants and traditional healers such as herbalists, witchdoctors, bone setters and spiritualists.

Most basically, caring *for* also refers to the undertaking of practical and often personal tasks such as washing or the administration of medicine, but can involve childminding or household chores (Milligan and Wiles, 2010). A recent strand of literature even discusses removing close proximity in care by collapsing the space-time continuum and caring *for* from a distance via paid care or through remote technologies such as telephone, webcam, video-link *etcetera* (Couclelis, 2009; Milligan, 2000). Caring *about* refers to the emotional aspects of care which might include the generalised relational and affective elements of *being caring*. The term 'care-ful' is also often used in the same manner in which, informed by interdisciplinary literatures, geographical work might be able to conceptualise 'care-ful geographies' through an ethics of care (see Milligan and Wiles, 2010). This is where the 'landscape' terminology discussed in Section 2.3 becomes particularly useful as it provides an analytical framework for connecting the literatures about the socio-spatial and contextual aspects of giving and receiving care.

In order to contemplate intricate relationships in places of care in health, however, it is suggested here that the definition of caring *for* needs to be broken down again. Whilst the WHO defines healthcare workers as 'all people primarily engaged in actions with the primary intent of enhancing health' (2006:16), a distinction needs to be made between everyday delivery of care that sustains health, the administration of care to restore health in an informal environment, and the formal delivery of healthcare within an institution. This is because whilst there are similarities in the actual delivery of care, be it in a formal or informal, day to day, or emergency capacity, difficult questions surround where care is delivered and how it (re)constructs the identities of the carer and the cared for, and thus entrenched power relations through knowledge. It is suggested that a distinction needs to be made between the everyday, and often taken for granted, care delivery through *domestic labouring*, and medical healthcare delivered in the home. Domestic labouring refers to the caring *for* that is delivered through everyday tasks to support or maintain health, such as providing food, maintaining hygiene at home, and emotional well being, to teaching about health through teeth brushing, assessing symptoms of illness, and seeking

treatment (McKie *et al.*, 2004; Graham, 1993); what McKie *et al.* (2004:602) term 'doing family'. Such domestic labouring needs to continue in *addition* to any practical informal caring. Informal caring within the home, hereby referred to as 'home health care', refers to people engaged in the formal administration of medical healthcare to family members within a home setting.

So what is care? The popular notion of caring is as an affect; a feeling of compassion or empathy, or the manifestation of a moral imperative which usually requires some form of self sacrifice (Morse *et al.*, 1990, 1991; Griffin, 1983). Whilst bound in responsibility (e.g. Massey, 2004), this is a useful foundation to define caring. Caring requires action and self sacrifice. Nobody knows you care about, or for, somebody, until you make some sacrifice, however small, to tangibly show that fact. The nature of that act depends on the broader context in which the care is being delivered. Furthermore, a feminist ethic of care challenges conventional distinctions between public and private space, suggesting that rather than separating the *about* and *for*, the acts and structures of caring stretch across public and private spheres, and seek to connect the individuals, communities and institutions that shape care (see also Milligan and Wiles, 2010). It is suggested here, therefore, that it is important to consider care in context.

2.4.3. *Who cares?*

Domestic labouring, home health caring, and professional administration of care by healthcare workers, are considered women's roles. Indeed, drawing on entrenched gender roles, nursing (or caring in some capacity) was, according to Florence Nightingale, the 'quintessential female profession' and 'to be a good nurse is to be a good woman' (Nightingale 1980; as quoted in Marks, 1994:32). Referring to Thompson's quote (1906:846), the role of nurses was to be obedient to doctors in order not to hinder and 'diminish' doctors' work (Nightingale; 1980). Main responsibilities for caring, therefore, ordinarily fall on women as wives, mothers, grandmothers, sisters and friends, particularly in the first five years of children's lives (McKie, 2004; Armstrong and Armstrong, 2002; Thomas, 1995; Ribbens, 1994; Graham, 1993). Such assumptions are reinforced by the political institutional landscapes built around employment legislation and social support, which underpin normative assumptions of women as the primary carers (Milligan and Wiles,

2010:7, Lewis, 2002; Graham, 1991). The traditional gender template furthermore infers that women, are, or should be, natural carers (McKie *et al.*, 2001), who provide (unpaid) care out of love and filial piety (Heaton, 1999). As McKie *et al.*, (2002:897) described, however, 'traditional assumptions about the relationship between femininity and caring remain relatively intact', despite economic and demographic factors that exert contradictory forces, such as the feminisation of the workforce, increased geographical mobility, changing family structures (see Nissel, 1980; Finch, 1987) and the changing role of men (see also McKie, 2001; Cancian and Oliker, 1999;). Whilst many men may deliver care, they are overlooked (Allan, 1999), as is the fact that women's experiences, expectations, and considerations of caring, vary dramatically (Dean and Thompson, 1996).

As Windebank, (1999: 1) explained, however, it cannot be denied that there are 'fundamental conceptions of the duties and responsibilities of caring with an associated moral expectation'. Brown (2003) and Milligan (2005) discuss the difficult 'moral' questions surrounding giving and receiving care in the appropriate caring space (Conradson, 2005; Dyck and Dossa, 2008), that should be delivered by a suitably caring person with fair levels of access and distribution (Meade, 1980). Milligan and Wiles (2010), further discuss how some carers see caring as 'work' whilst others see care more as 'something you just do' (Rose and Bruce, 1995:115) as part of a reciprocal or loving relationship. Such questions prompt a consideration of what is 'fair' or 'equal' and instinctively morally good within the context of a caring relationship (Pearce and Dorling, 2009, 2006; Dorling *et al.*, 2007; Shaw *et al.*, 2005). Changing care dynamics in both the developed and developing worlds have generated further difficult ontological questions of ethics, morals, identity, social justice and responsibility in care (see Milligan *et al.*, 2007; Massey, 2004; Silk, 2000). A recent Guardian article, for example, suggested that whilst parents are at work, within the 'hidden industry', 14 million grandparents in Britain alone are providing childcare worth £3.9 billion annually; 200,000 of whom do so alone with absolutely no support from the state (Robins, 2009). In the developing world Robson (2004) discusses the 'hidden workers', or carers, in Zimbabwe, in which due to the HIV pandemic, grandparents, men and often children, are forced to care for family members. Such caring roles conflict with long standing traditions and norms of kinship, in some cases reconfiguring the family dynamics. Heaton (1999) uses a Foucauldian analysis to show how traditional gazes of the informal carer engender, maintain, but particularly undermine particular figures and configurations of care. Indeed, Mackay (1998)

suggests that certain political and social systems obscure the central importance of care to the extent that some powerful groups and actors benefit from care whilst simultaneously devaluing it. McDowell (2004), for example, highlighted how the 'neoliberal condition', combined with current economic transformations, created a sense of unease about the balance of responsibilities with regard to the physical performance of care within the home and labour market in ways that disproportionately disadvantage women and men in low skilled employment. Increasingly, however, it is being recognised that carers have needs of their own (Milligan, 2005; Gallagher and Gerstel, 1993), and the importance of this care is being increasingly appreciated (see Olsen, 2002).

2.4.4 Where does caring take place?

In the developed world there has been a significant shift in the location of care to the home, which, ideologically, is seen as the 'gold standard' of care (Exley and Allen, 2007). This spatial shift has both impacted the places in which that care occurs, but also how care-recipients and care givers are affected by that relocation of the site of care (Milligan *et al.*, 2007). Aronson (2000), Corbin and Strauss, (1990), Gubrium and Sankar, (1990) and Rubenstein (1990), for example, discuss how, if the home becomes a site of caring, that landscape is then transformed through caring paraphernalia. The home, which originally - and with some idealism - was seen as a safe place 'with familiar and protective boundaries' (McDowell, 1997:13), then becomes a site of care. The home can become a place of marginalisation and oppression in which carers, particularly women caring for long term health needs, feel isolated and disconnected from the outside world (Yantzi *et al.*, 2006; Teeland, 1998). A number of sources contemplate the emotional impact on mothers who have to care for terminally ill children, older relatives or ill spouses within the home (see Salin *et al.*, 2009; Exley and Allen, 2007). In this situation, the only release from the emotional trauma is recovery or death, transforming the home to a final resting place. Care homes meanwhile make substantial profits by creating spaces for the growing elderly population which simulate homely caring *about* whilst not necessarily providing caring *for*; the conversion of the day-to-day care that is so taken for granted or is often lowly paid work into a commodity (McDowell, 2004). In the developing world, the benefits of healthcare in biomedical institutional places are being recognised such as in the prevention of mother to child transmission of HIV.

Drawing on the discussion in Section 2.3, as health and its maintenance are so fluid, places of healthcare exist within a host of contexts. As caring for health can range from supervising teeth brushing to an operation in hospital, caring can occur in any place at any time; arguably anywhere could become a site of caring. Within that place - at whatever scale - are certain situated or authoritative knowledges that can facilitate power to challenge, or maintain, social boundaries depending upon the interpretation in context. Drawing together all these strands of literature, this research suggests that 'healthscapes' are an insightful way to 'conceive' the complexity of healthcare transactions within social space from a feminist, post-structurally inferred approach.

2.5 Healthscapes

Since the 'cultural turn', health geography has increasingly recognised that place is not only relevant in health but that it *constitutes* as well as *contains* social relations and physical resources (Cummins *et al.*, 2007: 1825; Jones and Moon, 1993; Kearns, 1993). Both academic and policy concerns have led to further examination of not only the role that informal caring plays in the formal delivery of healthcare (Parr and Philo, 2003; Williams, 2002), but also how geography is central to care and the caring relationship (Barker, forthcoming; Power, 2008). Constructivist understandings presented a wider, more relevant view of health, care and gender that challenged previous entrenched hierarchies (McKie *et al.* 2004; Olesen, 2002). In the process, however, it also highlighted the disjuncture between theory and research as it showed how public health policy was still underpinned by many unchallenged presumptions, such as the shifting contexts of family and employment. In turn, academics and policy makers alike have endeavoured to generate conceptual approaches to unpack the nuanced dynamics of healthcare delivery in place, both for the benefit of social theory, and for broader healthcare policy.

McKie *et al.*, (2004), for example, present the notion of *carescapes* to contemplate the multi-layered aspects of the role of domestic relationships. The theoretical basis posits that to achieve particular care aims, people plot routes through a changing, but gendered, multi-dimensional terrain that comprises their experience and anticipation of care (McKie *et al.*, 2002: 594). The concept, therefore, incorporates the spatial and temporal into an analytical

framework using a terrain metaphor. McKie *et al.* (2002) suggest that carving the pathway may be restricted by tangible barriers such as the availability of caring resources, incomes or services or entrenched (ordinarily gendered) ideologies. In their 2004 work, McKie *et al.* developed the carescape concept to specifically examine the experience of health. They proposed the notion of *healthscapes* which endeavoured to contemplate the role of care in gendered experiences of health and was based on the template that assumes women, especially mothers, are natural carers who 'should' be responsible for care delivery (Lister, 1997). They suggest, for example, that contemplating the role of the nuanced experiences of caring takes into consideration the diverse ways of accounting for health, and locates explanations in the hegemonic social relations of power, gender and value operating in time-space.

Theoretically, this conceptual approach makes sense. McKie *et al.* (2004), for example, suggest that the healthscape concept highlights how Scottish healthcare policy fails to consider the contributions of gender divisions in domestic labour to health. Five points of critique, however, can be made. Firstly, there is no explanation of *how* the concept was used to reach these conclusions. Secondly, whilst the ordinarily gendered barriers in the pathway to access health were acknowledged, McKie *et al.* (2004) do not contemplate any potential resistance, adapted behaviour or coping strategies utilised to overcome those barriers to achieve the health aim which may, in turn, cause the health path to deviate. Thirdly and in relation, only lip service is paid to the role of power in the healthcare transaction; the social relations of power are acknowledged, but there is little specific discussion of the impact of power on the healthcare transaction and thus potential resistance. Caring is an activity in which subtle and not so subtle, relations of power can be expressed (Tronto, 1993). McKie *et al.* (2004) do not consider the hierarchy of dependency generated where the actions of one individual facilitate the being of the other (Koukkanen and Leiono-Kilpi, 2000). Without explicitly contemplating the role of power, and thus any dependency in health, it is further assumed that all actors in the healthcare transaction are both aiming to achieve the same health goal and have equal capacity to achieve that aim.

It is known that the nature of the care required in a healthcare transaction is both constructed by, and in turn constructs, expectations of that care and the individual delivering it (Milligan and Wiles, 2010). Even the 1950s critiques of the functionalist

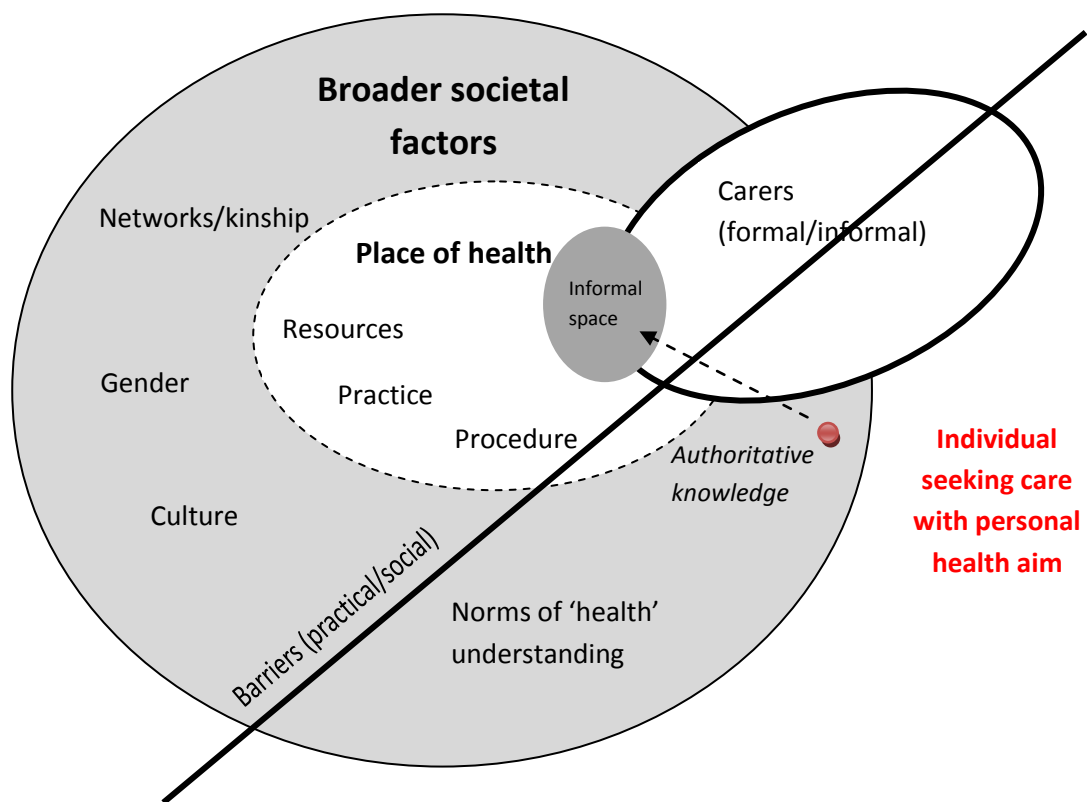
approach acknowledge that the aims and expectations of the care receiver differ dramatically from those of the care deliverer (Lupton, 1994). Using the example of picking children up from school, Barker (forthcoming) touches upon this by suggesting that care giving processes can become the site of struggle when, despite changing gender identities and roles, existing gendered configurations of care are mapped directly onto new spaces of care without contemplating differing health expectations. McKie *et al.* (2002: 594) do contemplate 'experience and anticipation of care' in their carescape concept which feeds into the healthscape approach. In the fourth critique, however, again by not explicitly analysing the power dynamics in healthcare transactions, McKie *et al.* (2002) do not contemplate the *specific* input of previous expectations of care in the healthcare transaction and thus, what happens if expectations are not met.

Finally, McKie *et al.* (2004) implicitly consider scale by focusing on care for under fives in a domestic setting, and the broader application to health policy at a regional setting in the life-course, or healthscape. They do not, however, acknowledge either the relationship between the two scales, or the different impacts they may have in care delivery. In the healthscape that is a child's life, the place of care delivery through the brushing of his teeth, for example, whilst relational, has very different expectations of care outcome than, say, being taken to hospital.

A socially constructed understanding of health suggests that health, healthcare and interpretations thereof, are fluid and differ within a spatial-temporal contextual setting (Moll, 2004; 2002). A (feminist) post-structural analysis questions essential truths, and thus entrenched hierarchies. It is suggested here that healthscapes could be a useful way to challenge conventional readings and understand the relationship between healthcare delivery and place. That understanding, in turn, could be used to promote well being in a variety of settings (Milligan *et al.*, 2004). It is also suggested, however, that there is a necessity to develop McKie *et al.*'s (2004) concept. Taking a relational view of space and place, this research suggests that within a specific time bound healthscape, individuals plot routes to achieve health aims that negotiate a 'terrain' constructed by their health knowledge embedded in place, the barriers - tangible or otherwise - to healthcare, healthcare resources, and other healthcare actors, formal and informal. The route through place-based knowledge constructs a knowledge base for individuals which, in some settings,

can become authoritative. The authority of that knowledge empowers the individual, enabling them to construct informal spaces of health within the formal setting. In the informal spaces, individuals, or groups of individuals, can adapt their behaviour to overcome barriers to the healthcare transaction and ultimately achieve their health goals through the mobilisation of place-specific authoritative knowledge. Figure 2.1 depicts the healthscape concept.

Figure 2.1: The healthscape concept



Developing from McKie *et al.*'s (2002) concept, the theoretical basis to this healthscape still posits that to achieve particular place-based care aims, people plot routes through a changing, but gendered, multi-dimensional terrain. That health aim, and thus the healthscape, could be contemplated as part of a spatially variable, interrelated scalar process (Jonas, 2006). Here analysis focuses on MCH but the concept could be used to contemplate achieving the health aim of brushing teeth, or purchasing medical treatment. In the journey to achieve aim it needs to be understood that scale will vary. Brushing teeth, for example, could be analysed at the micro level. Depending upon the reasons for analysing the healthcare transaction, however, it might be that the global networks

responsible for producing the toothpaste need to be considered, as does the local influence of what the children are taught at school. This also factors in the element of time. That time could, for example, be the point of healthcare access during pregnancy. It could be also be the time spent brushing teeth during an individual's life-course. Time could also be understood more broadly in relation to place, such as the reconstruction of place during times of crisis. The caring nexus is also important in influencing the healthscape route.

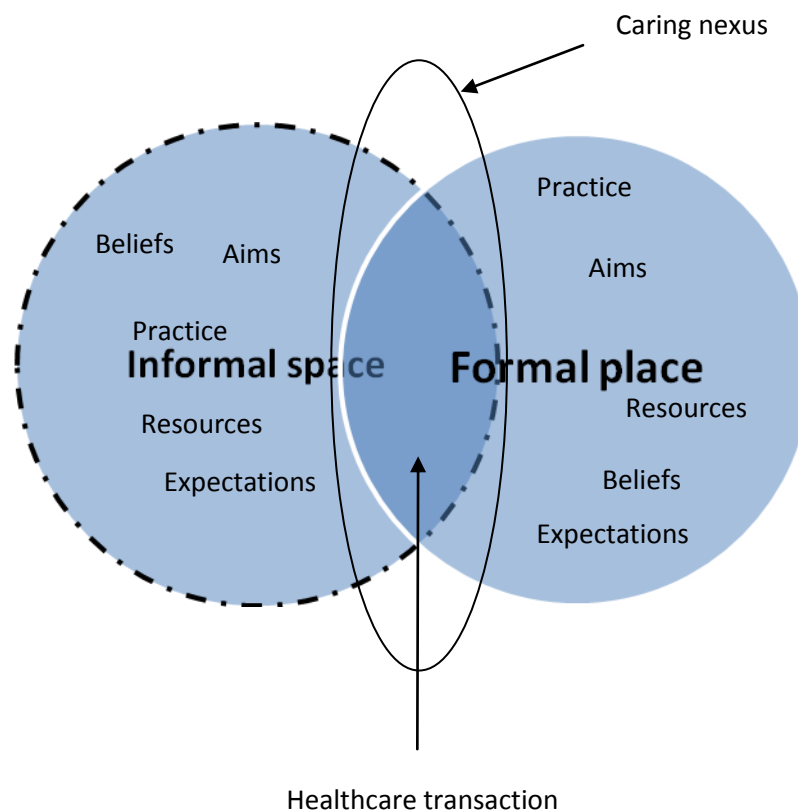
As the diagram shows, the formal place of health is embedded in broader socio-economic context. Within that broader societal 'space' there are local understandings of health which inform expectations of the treatment and care that health requires. Such understandings may differ from the health-seeker's perspective. These interpretations also construct the expected roles of carers, formal and informal in 'society' and in the place of health (Milligan and Wiles, 2010). As the diagram shows, carers might be embedded within the social space and thus potentially share the same expectations of care as the health-seeker. They may also, however, be influenced by factors beyond the immediate contextual setting. This relationship, in turn, infers a power hierarchy, or caring nexus, as the individual seeking health is dependent on the input of carers - formal and informal - in the overall health aim. The broader contextual factors influencing the access of appropriate healthcare also include the role of culture which is often inexplicably linked to the gendered dynamics of health (Mckie *et al.* 2007) and the influence of broader networks and kinship that inform healthcare understandings (and thus expectations of health). Along the route are 'barriers', both physical, such as lack of access to resources, and those presented by broader society, such as gender disempowerment.

Unlike McKie *et al.* (2007), however, this healthscape concept contemplates how place-based knowledge could be used to challenge those barriers. It is suggested that the broader context of the healthcare transactions equips an individual with place-based knowledge. Whilst the institutional practices of health places are recognised, the permeable 'boundary' of that place suggests the diffusion and potential utilisation of place-based authoritative knowledges. Through these knowledges individuals become empowered within the institutional place, generating potentially multiple informal spaces of health. Within those spaces of health the place-based authoritative knowledge may be sufficiently empowering

to enable the individual to control the healthcare transaction in effort to achieve their health goals.

Further attention is required, however, to the constructed informal space of health, as shown in Figure 2.2.

Figure 2.2: The space of the healthcare transaction



Whilst authoritative knowledge may permit the formation of informal spaces within the formal place of health, that space is still embedded within the formal space. The healthcare transaction, therefore, occurs within the overlap of the institutional norms of the place of health - such as the availability of resources, the effects of policy and practice - *and* the knowledges which constructed the informal space, which are informed by the broader social setting such as the influence of gender, culture *etcetera*. Carers within that health transaction may also be from the formal and/or the informal space, and thus the two may have very different expectations of what it is to deliver care, and indeed different aims

within the healthcare transaction. Potentially, therefore, within the healthcare transaction, an entirely new caring nexus is generated. It is suggested here, therefore, that the only way to truly understand the healthcare transaction which may, in turn, inform the healthcare outcome and future health-seeking behaviour, is to contemplate both of these perspectives.

2.6 Conclusion

The political economy approach to health suggested that, by virtue of their knowledge, and thus capability to cure social, moral and cultural 'deviance', colonial medical professionals had supreme power which laid the foundations for the centralised, urban biased, largely white and male dominated medical profession of the 20th century (Deacon, 2004). A feminist, post-structural approach challenges the impression that patients are compliant, grateful and passive individuals that are suppressed by biomedical hierarchies. As Smyth (2005:490) reminds us under a constructivist lens, neither health, nor place, are 'fixed realities', but are 'situated and socially produced in particular...contexts' and at a variety of scales. Within those fluid places of health, knowledge(s) are hybrid, embodied, and historically and spatially contingent (Davies *et al.*, 2004), and thus carry different weights, or authority, in different settings at different times (Bourdieu, 1984). It is suggested here that place-based authoritative knowledge can empower individuals to construct informal spaces of health within formal health institutions. Within those constructed spaces authoritative knowledges can be used to influence the healthcare transaction in effort to achieve the health aim. The role, however, of concrete actors or processes within places of health, and their influences on the informal constructed spaces, must be recognised. It must also be acknowledged that not all actors in the healthscape have the same aims or expectations of care and face the same barriers in efforts to achieve those aims. It is suggested here that a healthscape approach can be used as a tool to 'conceive' how different, situated, knowledge reconstructs space and thus identity in the healthcare transaction. This nuanced understanding that incorporates the perspective of both healthcare seeker and provider could potentially be used to improve healthcare delivery.

This research argues that to be effective, health systems need to move beyond the technical, results orientated, systems of healthcare to address the distribution of power,

knowledges and resources in the intimate spaces of bodies, families, households and communities (UN, 2005) and formal health care settings (Sheaff *et al.*, 2004). Conducted at Kakindo HCIV or, 'the hospital', the objective of this research is to unpack the realities of delivering high quality, *appropriate*, MCH care in the chronically poor district of Kibaale, in the Bunyoro Kingdom, mid western rural Uganda.

The healthscape concept will be used to 'conceive' the reality of delivering and seeking care within three places of the Bunyoro Kingdom, rural Uganda. Chapter 5 will critically discuss the broader societal factors and informal spaces of health within the Bunyoro Kingdom in which the formal place of health, in this case Kakindo HCIV, is embedded. This chapter will contemplate the entrenched norms and expectations of MCH focusing on the role of kinship, gender, culture and local understandings of health in Bunyoro. Chapter 6 will then discuss the place of health that is the antenatal ward at Kakindo HCIV. Focus lies on the expectations local women have of antenatal care, and how they may use their place-based authoritative knowledge to attend the clinic. Chapter 7 then considers the maternity ward. It is suggested that the nature of care delivered in this formal place differs from that of the antenatal ward which, in turn, affects health-seeking behaviour. To provide a complete picture and respond to criticism of current studies (e.g. Moland, 2002), the healthcare recipients', *and* the healthcare providers' perspectives and interpretations of care delivery in the antenatal and maternity wards will be considered. Before that can be done, however, Chapter 3 provides the contextual background of the Bunyoro Kingdom, rural Uganda.

Chapter 3: *'The Black Hole of Uganda'*.

3.1 Introduction

At Independence in 1962, with all its abundant natural resources and industrial potential, Uganda appeared poised for rapid economic growth. Within four years, however, Uganda had become a byword for economic mismanagement, incapable leadership, the abuse of human rights and devastating poverty. In 1986, after more than two successive decades of chronic political instability and civil war, Museveni's 'no party' democracy embraced ambitious and in part, successful economic and institutional reforms, particularly in health (Kasfir, 1998: 54). The 'no-party' state, however, was also accused of excessive presidentialism, corruption and neo-patrimonialism (Hickey, 2005) which both excluded the poorest groups and, through political discourse, shaped those 'left behind' by development (Hickey, 2005; 2003; Francis and James, 2003). Rather than booming in Independence, Uganda became one of the world's poorest and least developed countries with a reputation for corruption.

This chapter will anchor the empirical data collection that follows through a contextual national background. It is impossible to provide a detailed account of all of Uganda's history here which, whilst short, is dramatic. Much has been written, for example, about the civil conflict that raged in the North of Uganda for nearly 25 years and in which more than 20,000 children were conscripted and some 400,000 people displaced amidst horrific atrocities and heinous human rights violations (see Dagne, 2010; van Acker, 2004; de Temmerman, 2002; Doom and Vlassenroot, 1999, to name but a few). Such events have been so pinnacle to Uganda's identity that whilst they cannot be discussed in detail, they cannot be omitted entirely. A timeline (Table 3.2) is therefore presented to give a very broad overview of significant historical changes in Uganda.

Within this chapter, Section 3.2 will provide a contemporary country profile of Uganda. Section 3.3 will discuss the legacies of the past, specifically two historic events that it is suggested have shaped Uganda; firstly the invasion and decimation of Bunyoro by allied

Buganda-British forces which left a lasting perception of the district; secondly, the onset of Independence that greatly affected the country's economy and the health sector. Section 3.4 will contemplate how Uganda has endeavoured to restructure her economy over the last 40 years through decentralisation and market reform. It is suggested that such decentralisation politics did much to construct a homogenous 'poor' of Uganda which has had a lasting legacy, particularly in terms of dependence on international aid. This section also considers how the health sector was structured under the market-orientated reforms, including the brief trial of user fees and a number of healthcare policies. The broad demographics of the field-site of this research are discussed in Section 3.5, looking particularly at tribal conflict and the standard of living in Bunyoro.

3.2 Uganda in 2010: a contemporary country profile

As Figure 3.1 shows, Uganda is a small, landlocked country lying across the equator and wedged between Sudan, Kenya, Tanzania, Rwanda, and the Democratic Republic of Congo.

Figure 3.1: Map locating Uganda in Africa (and the field-site, Kibaale)



Source: Produced by Bostin (2010)

Uganda measures only 241,139 square kilometres (World Vision, 2006). Lakes comprise 20% of the country, 12% of the country is national park land and the remainder is forest, woodland and grassland (USDS, 2010). At the point of the fieldwork Uganda was split into 80 administrative districts, as shown in Figure 3.2.

Figure 3.2: The districts of Uganda highlighting Kibaale within the Bunyoro Kingdom.



Source: Produced by Bostin (2010)

The fieldwork was conducted in Kibaale District which, along with Hoima and Masindi comprises the Bunyoro Kingdom. The Bunyoro Kingdom is home predominately for the Runyoro speaking Munyoro tribe, but also to some resettled Mkaiga from the Mkaiga tribe of Kamwenge and Kyenjojo. The map also highlights the Buganda Kingdom, home of the

Luganda speaking Muganda which also includes the capital, Kampala. For clarity, Table 3.1 summarises the main features of these three tribes.

Table 3.1: The key characteristics of the three tribes specific to this research

Tribe	Single Tribesman	Language Spoken	General Location	Percentage of total pop~
Baganda	Muganda	Luganda	Kampala, Wakiso	18%
Bunyoro	Munyoro	Runyoro	Kibaale, Hoima, Masindi,	3%
Bkaiga	Mkaiga	Rkaiga	Kamwenge, Bunyoro	4%

Source: Adapted from Leggett (2002)

For its size, Uganda has remarkable physical and biological diversity. This is reflective of the humid equatorial location which is regulated by altitude, distance from the sea and the large water bodies. Below the equator landscapes are generally lush and green with up to 130cm of rainfall a year and two dry seasons (December - February and June - July). Travelling north, the vegetation thins to savannah, becomes semi arid rangelands after the River Nile and eventually becomes arid land in the north. This area experiences less than 50cm of rainfall a year and regular drought. Intersecting this vegetation gradient is the 'Fertile Crescent', which stretches between the Kenyan border to the east, Mount Elgon, the River Nile and Lake Kyoga to the west (Leggett, 2001).

Topography and climate affect land use. Uganda is known locally as the 'Food basket of Africa' due to the volume and diversity of its cash crops. The most southern districts, such as Kabaale and Rukungiri, are cool enough to produce cauliflowers, lettuces and apples. Around the River Nile cash crops such as coffee, tea, cotton, groundnuts, tobacco, sugarcane, flowers, cassava, potatoes, millet and pulses are produced. The 'cattle corridor', which runs from Rukungiri in the south west eastwards through Mbarara, and eventually to Kampala, produces much of the country's milk and beef. There is also high production of goat meat, tilapia and perch. In the arid lands to the very north, cash crop production is low. People mainly live a nomadic existence due to the climatic conditions, herding a hardy variety of cattle. More recently, Uganda has been greatly affected by climate change. It is

not unusual for the dry seasons to be very late, or to experience high levels of rainfall in the south. In the north, drought has increased in frequency and severity with 2009 being particularly dry and resulting in significant starvation (see Womakuyu, 2009). Rainfall also governs farming production. Soyabean, for example, is planted during the first rainfall. Late rainfall can delay planting and in turn jeopardise food supplies the following season.

Agriculture underpins Uganda's industry so the country boasts much heavy agricultural processing (particularly cotton ginning and coffee curing), but also the production of cement, light consumer goods and textiles. Uganda exports coffee, fish and fish products, tea, electricity, horticultural products, vanilla, and cut flowers which, in 2008, generated an estimated \$1.72 billion (USDS, 2010). Whilst rich in the natural resources of copper, cobalt, limestone, phosphate and most controversially oil, Uganda is heavily reliant on imports of petroleum, metals, cereals, vehicles, medical supplies, and capital equipment from the UAE, Kenya, India, South Africa and China. Such a dependence on external imports is risky. During the riots following Kenya's 2007 elections, for example, the price of petrol more than doubled in Uganda with many petrol stations being forced to close (see Pflanz (2007) for details of the election riots and Kauju (2008) for details of the impacts on Uganda's revenue).

The last census recorded a population of 30.9 million in 2007 (USDS, 2010) of which 1.2 million lived in the capital city, Kampala. Literacy is estimated at 70%, with a 54% primary school completion rate in 2008 (USDS, 2010). This relatively high rate, however, includes the government's Universal Primary Education (UPE) programme which entitles all children to free primary school education but does not contemplate its quality. English is Uganda's formal language but each of the 15 different tribes in Uganda has its own operational language. Swahili is spoken only by Tanzanian settlers or the military.

Healthy life expectancy at birth is 49 years for men and 51 years for women (World Vision, 2009). Whilst low and a country average this is actually a significant improvement on the 2003 rate of 42 years for men and 44 years for women (WHO, 2008). The under five mortality per 1,000 live births stood at 138 for both sexes (WHO, 2006). In contrast, neighbouring Kenya recorded 120/1000 under five mortality, Ghana recorded 112/1000 and Rwanda, 203. The same indicator for the UK shows six deaths per thousand live births in

2004 (WHO, 2006). In Uganda, under five mortality is a result of neo-natal causes (24%), malaria (23%), pneumonia (21%), diarrhoeal diseases (17%) and HIV and AIDS (8%) (WHO, 2006). The maternal mortality rate in 2000 was 880 per 100,000 live births (World Health Statistics, 2006). HIV and AIDS accounted for 25% of all deaths (male and female of all ages), followed by malaria (11%), lower respiratory infections (11%), and diarrhoeal diseases (8%).

3.3 Legacies of the past

As a former British colony, the history of Uganda is documented in a detail far beyond the scope of this research. Two particular events, however, one in colonial history, one in more contemporary history, have particular resonance (see Table 3.2). The first is the initial colonial struggle for control in the mid 1800s. This conflict was a major catalyst in Bunyoro's decline from being a powerful state that represented the greatest threat to colonial rule, to a Kingdom with a decimated social and economic system that today is referred to as the 'Black Hole of Uganda'. This period also saw the arrival and settlement of Christian missionaries in Uganda who, in the 'competition for souls' (Leggett, 2002: 13), set up a number of churches and hospitals. The second, and more contemporary event, is Uganda's dictatorship which, in the 1960s, was responsible for the decimation of a well developed health sector and the expulsion of the vast majority of the country's professionals.

3.3.1 Colonial conquest

The importance of the Bunyoro Kingdom in the colonial conquest of Uganda is illustrated by the spread of literature about Bunyoro's history. There are frequent references to Bunyoro in the writings of Victorian and later travellers and explorers such as Speke, Grant, Baker and Emin Pasha. The first explorers arrived in what is now known as Uganda in 1860, and in 1888, a royal charter assigned East Africa to the Imperial British East Africa Company.

Table 3.2: Timeline of Uganda's colonial and contemporary history

	Date	Event
Colonial History	1830	The first records of international discovery in Uganda when Arab traders moved inland along the Indian Ocean coast of East Africa
	1860	British explorers enter Uganda in search of the source of the Nile River
	1870	Buganda start attacks on Bunyoro
	1875	Muteesa I, the Kabaka (king) of Buganda invited European missionaries to bring Christianity to the country, rapidly followed by Catholic missionaries
	1888	Royal charter assigned East Africa to the Imperial British East Africa Company
	1890	Anglo-German agreement confirming British dominance over Kenya and Uganda
	1894	British to build a protectorate around the Buganda Kingdom
	1895	United Buganda-British forces conquer Bunyoro
Contemporary History	1960	Buganda declare unilateral independence
	1961	British granted self government to Uganda
	1962	Obote led Uganda to formal Independence
	1966	Obote assumed all governmental powers
	1967	Obote proclaimed Uganda a republic and became president – reign of terror
	1971	January 25 th Obote ousted by Idi Amin Dada. Most violent reign to date
	1972	Amin expelled non citizen Ugandan Asians. Collapse of professional sector, especially health
	1978	Ugandan exiles and Tanzanian armed forces wage war of liberation
	1979	Kampala captured, Amin fled
	1980	The Ugandan People's Congress (UPC) led by Obote elected (democratically or otherwise) into power
	1980-	UPC power challenged by National Resistance Army (NRA) led by Yoweri
	1985	Museveni. Bloody battles and worst human violations on record including Luwero genocide. Obote ruled until July 12 th 1985
	1985	Army forces led by Gen. Tito Okello seized Kampala. Fighting continued
	1986	January. Museveni became president over a government called the National Resistance Movement (NRM). Museveni still in power today.
	1987	Civil conflict breaks out in the North of Uganda between the Lord's Resistance Army (LRA) and the government. War continues for over 20 years with over 20,000 children abducted as soldiers and 1.5million people displaced.
	2006	First multi-party elections in Uganda. Museveni won over Besigye but support decreased.
2006-7	Government of Uganda involved in mediating peace talks to resolve conflict in the North	
2009	International peacekeeping forces drafted in to North to facilitate peace.	
2009	Member of Parliament presents a bill making homosexual activity illegal.	

Source: Adapted from Leggett (2002).

It was a natural move for the British to build a protectorate around the Buganda Kingdom in 1894 (USDS, 2009) as it was the most prosperous and sophisticated Kingdom, with a well equipped standing army and locally available resources (Leggett, 2001). Like the British system, Buganda was a hierarchical society headed by a monarch and so became the centre of colonial administration, education and other forms of 'modern development' (Leggett, 2001: 6). At the time, the principal threat to Buganda and thus British security was the Bunyoro Kingdom. This section, therefore, will explain the decline of the Bunyoro Kingdom under colonial conquest which, it is argued, has had a lasting legacy on how the Kingdom is perceived today.

Bunyoro's dramatic demographic and social transition is generally considered in four stages. In pre-colonial East Africa, Bunyoro was one of the oldest and most powerful kingdoms. Archival evidence suggests Bunyoro's power and influence developed in the regions of all four great lakes and even extended into modern day Sudan, Congo, Kenya, Rwanda and Tanzania (Nyakatura, 1973, 1970; Ingham, 1957). Before colonial conquest, Bunyoro boasted a varied environment, extensive trade networks, intricate ecological knowledge, skilled indigenous medical practitioners and a seemingly powerful ruling state. During the 18th Century, however, the Bunyoro Kingdom suffered immense political and demographic decline. Doyle (2000) attributes some of Bunyoro's decline to the violence and germs brought by the Arab traders in the 1830s in their quest for slaves and ivory. Bunyoro's cattle stocks, for example, were decimated through exposure to disease vectors on the rangelands (Doyle, 2006). Additionally, Bunyoro's ideological power rested on the assumption that royal government was necessary for social stability, public well being and the control of nature. From the late 18th century, princely rebels and rival kingdoms began to undermine the kingdom, challenging the monarchy's power. By 1860, Bunyoro was already in political decline with new environmental, medical and demographic problems escalating (Doyle, 2006). Literature shows, for example, that King Kumurasi begged for medicine from traders 'to prevent the offspring from dying shortly after birth' (Speke, 1863 as quoted in Roscoe, 1923). The Kingdom was facing what is generally considered to be Bunyoro's first demographic crisis (Doyle, 2000; General African Census, 1960; Uganda Protectorate, 1912).

Meanwhile, Bunyoro had been subjected to a number of raids by the Buganda. These attacks increased in intensity and frequency throughout the nineteenth century, particularly between the 1850s and 1870s whilst Bunyoro's political system was being weakened (Doyle,

2000). Fisher (1911), for example, recorded that in the reign of Nyamutukura (c. 1779-1835) Buganda made constant inroads into Bunyoro territory. Furthermore, in 1862, Speke observed Bugandan armies returning from Bunyoro with 'immense numbers of cows, women and children, but not men' because they were all killed in conflict (Doyle, 2000: 36). As Doyle (2006) explains, the classic interpretation of the weakening Bunyoro portrays an ancient, loosely organized, pastoralist-dominated empire challenged by a younger, compact, highly centralized agricultural neighbour; Buganda.

Albeit in dramatic decline the Bunyoro Kingdom still represented the greatest challenge to British conquest (Doyle, 2006). In part, this was due to Bunyoro's presence around the great lakes which fed into the River Nile, the search for which had brought the British to Uganda initially. In their effort to expand their territories, eliminate the greatest security threat and benefit from the remaining wealth of Bunyoro, allied forces invaded in a violent and prolonged offensive. The brutal and destructive war marked the second stage of Bunyoro's decline. By the end of 1899 Bunyoro's king, Kabaleega, had been captured and exiled. Bunyoro lost some of its richest, most heavily populated and historically significant territories such as Buyaga and Bugangaizi, which despite being later returned to the Bunyoro, are still referred to as the 'lost counties'. These lands contained most of the royal tombs and many sacred sites. As Doyle (2006:80) summarised, 'the lost counties, in sum, stood as a symbol to the Bunyoro of all the injustices of colonial rule'. A further two thirds of the Bunyoro territories were granted to Buganda and Tooro, including the finest cattle lands and the best banana producing regions, leaving Bunyoro's economy in ruins.

The after affects of the war were equally brutal. In addition to conflict, poverty, environmental and medical shocks such as smallpox and sexually transmitted diseases almost completely depopulated what remained of the Kingdom (Ugandan Protectorate, 1912). Displaced from their homes, many people took refuge in the bush, exposing themselves to a greater risk of malaria, dengue, sleeping sickness, river blindness and water borne infections from a lack of drinking water. Furthermore, many healers had been killed or had fled and medical treatment was expensive. As Doyle (2006) explained, there are also accounts weakening Bunyoro social values and institutions in the aftermath of war. In a letter to a friend, Fisher (see Doyle, 2006: 86) wrote that in 1899, '(t)he moral condition of the people was indescribable, gangs of poor women called *Balanga* went along the roads calling out and offering themselves to anyone in return for food'.

Doyle (2006: 80) describes how 'diplomatic policy towards Bunyoro was no less harsh than the nature of the conquest itself and played an equally important role in contributing to Bunyoro's colonial problems'. The period from the 1920s to the 1950s is generally viewed as the third transition, when British administration, famine and disease, delayed Bunyoro's population recovery. By 1925, despite over 25 years of British civil administration, Bunyoro was in a dire state. In the aftermath of conquest, the British ruled the kingdom with a system of administration entirely alien to Kabaleega's political, military and particularly, commercial expansionism. British rule was neglectful, oppressive and violent. The confidential notes of a meeting at Government House in 1925 (cited in Doyle, 2006), for example, noted that the administrative chiefs believed the threat of flogging was necessary to 'control' Bunyoro women. When this became illegal, the chiefs encouraged peasants to beat their own women. It is perhaps unsurprising that sustained development work was unusually difficult (Doyle, 2006). The curious anomaly was that due to British missionaries' efforts to cure the 'ills' of the 'socially deviant' Bunyoro (see Section 2.2.1), the Kingdom actually had one of the best rural and maternal health systems in the region after 1925 (Beattie, 1963). As Doyle (2006) explained, however, the nature of the war suggested an irrational British antipathy towards the Bunyoro and an unshakable bias towards the Buganda. Conquest also broke 'the spirit' of the Bunyoro (Beattie, 1971; Fisher, 1911). Population experts of the time, such as Schweinfurth *et al.* (1891), feared that the early 20th century might witness the extinction of the tribe. It is likely that nowhere else in east Africa was the introduction of colonial rule as painful; some ethno-historians even suggest that the rapid, damaging decline of one of pre-colonial East Africa's most populous states is of broad significance for not only Ugandan, but also African history (Doyle, 2006: 91).

Colonial literature furthermore paints a very unfortunate impression of the Bunyoro. In his diaries in 1895, for example, Fisher was 'truly amazed at the condition of this overrun, distracted, impoverished, unsettled, disunited, starving, sickly, cowed lot' and blamed their plight on poor leadership of Kabaleega (see Doyle, 2006: 93). Europeans concluded that whilst the Bunyoro suffered unusual disadvantages, this was their own fault (Doyle, 2006). Early ethnographies such as those by Roscoe (1922), Gorju (1920) and Fisher (1911), however, showed that prevailing views about Bunyoro in general, and those about the effects of colonial rule in particular, were normally derived from self-preserving or benefitting conviction, rather than empirical study. As Kiwanuka (1968a) suggested, these have received little correction, criticism or interpretation. Certainly there was much

covering up of British error. Doyle (2006), for example, notes how Captain Frederick Lugard, an agent of the Imperial British East Africa Company, bankrupted his employer by invading Bunyoro instead of trading with Buganda. It was only by portraying Kabaleega as a monster that he managed to save his career. Furthermore, there was clearly a hatred of the British by the Bunyoro. Through field-work in 1996, for example, Doyle found that the Bunyoro today felt their ancestors were given little choice other than to defend themselves against an uncompromising aggressor, and that Nyoro resistance condemned their country to decades of malign neglect by a colonial government. Indeed most Bunyoro today blame the lasting legacy of the demographic, economic and social problems during the colonial period, on the antipathy of British officials (Doyle, 2006). The legacy of the demographic, economic and social problems, particularly in reference to health, will be discussed further in Section 3.4.2.

3.3.2 Devastation in Independence

Structural reform under Independence also has relevance to this research. Leggett (2002) described how Uganda's politics were fragmented along tribal and religious lines in the run up to Independence. There was a further fundamental divide, not between the colonial authorities and a nationalist movement, but between different elements of the prospective ruling class. Affluent Buganda declared unilateral Independence in 1960. Their interests were so different from the new national government of an independent Uganda, that there were effectively two states within the country. Whilst the constitution negotiated at independence was described as federal, in reality, only Buganda had separate and significant powers. At the point of Independence therefore, Uganda was fundamentally split into two opposing states.

Britain granted internal self government to Uganda in 1961. At this time, despite its political factions, Uganda still had one of the most highly developed health service delivery systems in Africa (Kyaddondo and Whyte, 2003). There were numerous well-equipped referral hospitals, virtually every district had an efficiently functioning hospital and there were well-stocked dispensaries at county and sub-county levels (Deininger and Mpuga, 2005). Healthcare services were free of charge and of good quality. The fundamental political split in the country was loosely bridged by a marriage of convenience between the Uganda

People's Congress (UPC) led by Milton Obote, representing the national parliament, and the *Kabaka Yekka* (KY – King Only) representing the Buganda leadership. This unlikely partnership, however, was only to gain the benefits of initial rule and subsequently the coalition fell apart. Obote seized the opportunity to become Prime Minister and led Uganda to formal Independence on October 9th, 1962. Obote, however, led a violent dictatorship and ruled through harassment, terror and torture. By proclaiming Uganda a republic in 1967, Obote became president and abolished the traditional kingdoms sending the Kabaka into exile in Britain (Mutibwa, 1992).

Obote was ousted in a military coup led by armed forces commander Idi Amin Dada, on January 25th 1971. At this time, Uganda actually still had a strong health system. Dodge and Weibe (1985) explained how in 1972, whilst there was some neglect and mis-management, there was still a well organised referral system and follow-up care was routinely encouraged (see also Deininger and Mpuga, 2004). Uganda had a network of well staffed hospitals, health centres, dispensaries and maternity units. In 1972, few patients had to travel more than ten kilometres to their nearest health centre. The population of Kampala welcomed their new leader, Idi Amin Dada, as a liberator and a relief from Obote's reign of terror. Furthermore, as a former member of the King's African Rifles of the British Colonial Army, western powers saw him as a loyal ally who could be relied upon in the fight against communism (Sembuya, 2009; Leggett, 2002). The governing approach of Amin, however, is still commonly referred to by Ugandans as 'the politics of the gun', whereby concepts of democracy and constitutionalism were abandoned and the state's responsibility to uphold and protect the civil and political rights of its citizens were turned upside down (Leggett, 2002). Amin's eight year rule generated more economic decline, social disintegration, and human rights violations than during the whole of Uganda's history. The International Commission of Jurists estimated in 1978 that more than 300,000 Ugandans had been murdered during Amin's reign, including Obote's army (Sivard, 1993).

By the time of Amin's downfall, 'the economy was well on its way to ruin' (Jamal, 1991: 81). After a dream which told Amin all the Asians were plotting to overthrow him, in 1972, Amin issued a decree that all non-citizen Asians had to leave Uganda within three months. As much of Uganda's professional base was composed of Ugandan-Asians, their expulsion had a profound effect on the economy. From 1973 to 1980 incomes per capita in Africa fell by 0.6% per annum: in Uganda the decline was 10 times greater (Lateef, 1990). There was a

dramatic decline in real wages promoting the growth of the *magendo* economy, characterised by an informal economy in foreign exchange, overcharging and corruption. The *magendo* boom initiated a trend towards 'private sphere' activities, despite the continued existence of the public service (Wallman, 1996). The devastation of cash-crop production and chronic insecurity greatly reduced the tax base in the country to only 6% of GDP, in contrast with 20% in sub-Saharan Africa (Lateef, 1990). High military costs also reduced public sector expenditure (Macrae *et al.*, 1996). All sectors of the economy were dramatically affected, especially the health sector.

The expulsion of over 80,000 non-citizen Asians saw the loss of doctors, nurses, dentists, surgeons, pharmacists and health-sector middlemen. Health institutes were destroyed in rioting and looting. Hospital infrastructure was also destroyed, leaving formal health care mostly in the hands of NGOs, missionary and private practitioners. Furthermore, in 1974, with the economy deteriorating still further and security worsening, many Ugandan doctors and other professionals left to take up positions outside the country (Dodge and Weibe, 1985). Hansen (1995) suggests that during this period approximately 50% of doctors and 80% of pharmacists left Uganda. Poverty constrained recruiting practices and diminished professionals left a health sector in which half the staff employed were untrained (Macrae and Zwi, 1993). The situation of the health sector was bleak.

The levels of economic mismanagement, political instability and conflict, however, meant it was impossible to prevent further deterioration, let alone start rebuilding the health infrastructure. In October 1978, Ugandan exiles and Tanzanian armed forces (following trespass onto their land by Amin's troops) began the so called 'War of Liberation'. On April 11th 1979, Kampala was captured and Amin fled. Following a succession of both interim leaders and ministerial systems of administration, in December 1980, the Ugandan People's Congress (UPC) was elected - democratically or otherwise - into power under the rule of the previous President, Milton Obote. Rival powers claimed the election had been rigged which led to guerrilla rebellion from the opposing National Resistance Army (NRA), headed by Yoweri Museveni, and several other military groups against the UPC. Obote's regime was no less violent the second time around. In order to quash the NRA support, mass civil conflict raged until 1985, with some of the world's worst human rights violations on record, including mass genocide in Luwero, just north of Kampala (Leggett, 2002). Obote ruled for the second time until July 27th, 1985, when army forces, led by former defence force

commander General Tito Okello, seized Kampala and proclaimed a military government, forcing Obote to flee into exile in Zambia. Whilst agreeing to a ceasefire, the NRA continued fighting seizing control of Kampala in January 1986. Museveni's forces organised a government with himself as president, called the National Resistance Movement (NRM, or 'the movement'). The NRM took power in 1986 under a form of 'no party' democracy. It is probably more accurate to describe Uganda's political system as a 'hegemonic party system' whereby 'political supremacy [is] exercised by a single organisation, with smaller opposition groups not able, so far, to put up any significant resistance' (Carbone, 2003:487). Given Uganda's turbulent history, the NRM leadership held the notion that multi-partyism would revive ethnic and religious cleavages (Francis and James, 2003).

As Hickey (2005) explained, Museveni's 'no party' movement makes a particularly interesting case-study to analyse the impacts of politics on poverty reduction strategies (Kasfir, 1998). Museveni was concerned with 'getting the politics right' (Hickey, 2005:995) which, in health policy, witnessed some successes through decentralisation, the introduction of user fees and later market orientated reform. Critics argue, however, this was a political move that bolstered Museveni's career, particularly with the outbreak of the HIV pandemic. Such politics shaped 'the poor' and marginalised the most needy. This has particular resonance for this research in relation to the portrayal of the Bunyoro. The following section, therefore, will discuss contemporary changes to the health sector under Museveni's continuing rule, thereby situating the health sector of the Bunyoro field-site.

3.4 Economic reform over the last 40 years

Successive post-Independence regimes from 1962-1985 were characterised by high levels of political instability, heinous violence, authoritarian rule and ineffectual development policy (Mutibwa, 1992). The resulting decline of the national economy had a dramatic effect on the availability of resources for health. In the fiscal year 1986/7, for example, the value of the Ministry of Health budget was only 6.4% of its 1970 levels (UNICEF, 1989 cited in Macrae *et al.*, 1996). The NRM's 'no-party' democracy aimed to incorporate three key elements, namely parliamentary democracy, popular democracy and a decent standard of living (Kasfir, 1998:45). For the NRM, the priority was economic reform, not healthcare, as it was assumed that such social improvements would follow the wave of modernisation under a

decentralised system. As Hickey (2005) explained, this attempt to combine representative and participatory forms of democracy in order to reduce poverty has come under increasing scrutiny in recent years. Furthermore, it is questionable how beneficial such a market approach to health really was. There are two interrelated threads that need to be discussed; firstly the response of national and international policy-makers involved in broad sector rehabilitation, and secondly, how the poor benefited (or not) from those highly political, market-orientated reforms under a decentralised system, across all services but particularly, healthcare. This section, therefore, will consider the construction of 'the poor' under the process of decentralisation. It will then consider the specific health care policies introduced under the decentralised health system and how effective they were.

3.4.1 Decentralisation and the construction of 'the poor'

Museveni declared in one of his first speeches to Parliament in 1986, 'I do not want a country of peasants' (cited in Hickey, 2005: 998). This became clear in Uganda's Ten Point Program which aimed to rebuild national unity - particularly across party political lines - and to provide a strong economic foundation for development with a particular focus on 'modernization' (Macrae *et al.*, 1996). On its accession to power in 1986, the NRM saw decentralisation as a 'necessary condition for democratization' and hence central to the fulfilment of their goal of establishing a 'popular democracy' in Uganda (Kisakye, 1997).

Decentralisation is the transfer of administrative and political powers from central to regional or sub-national governments (see Nsibambi, 1998; Mamdani, 1996; Tidemand, 1994; Francis and James 2003 for critique of local level functioning). Decentralisation was promoted by the World Bank in the 1990s across most of Sub-Saharan Africa. In most cases decentralisation arose from dissatisfaction with the centralised systems of national planning and administration that were the by-products of former colonial systems (Murissa, 2008). The World Bank suggested decentralisation was a necessary part of the structural reform required to promote the efficient use of resources, particularly in light of the dramatic failure of African governments to effectively manage social services such as health, education, water and sanitation (World Bank, 2003). By virtue of quickening decision making processes and increasing participation by the local people, decisions would then - at least in theory - be tailored to people's needs, corruption associated with centralised

government would be reduced and service delivery would be improved (Murissa, 2008; Shah and Theresa, 2004).

Kayizzi-Mugerwa (1998:36) argues that the specific objectives of Uganda's 1987 decentralisation across all public sectors were: increased democracy, accountability and responsiveness; the improved capacity of the local people to participate in the decision making process, especially with regard to service delivery; and the promotion of local ownership of the programmes (Langseth, 1996a:15). There were three elements to Uganda's poverty reduction policy under a decentralised government: the Poverty Eradication Action Plan (PEAP), the Poverty Action Fund, and the Plan for the Modernisation of Agriculture. The PEAP was Uganda's 'home grown' version of a Poverty Reduction Strategy Paper (PRSP) which were being implemented throughout sub-Saharan Africa as prerequisites to qualify for the Highly Indebted Poor Country debt relief (Hickey, 2005). Uganda's PEAP had four central pillars to it: creating an enabling environment for economic growth, ensuring good governance and security, promoting the ability of the poor to raise their incomes and increasing their quality of life (GoU, 2010). As Hickey (2005) explained, this 'participatory' democracy was institutionalised through a devolved system of local government in a pyramidal structure of Local Councils (LCs) at village (LC), parish (LC2), sub-county (LC3), county (LC4) and district (LC5) levels. In rural Uganda, this system devolved functions, competency and resources to elect local government councils (Francis and James, 2003; Regan, 1998).

Uganda achieved significant levels of poverty reduction during the 1990s as a result of decentralisation, particularly through the international donor aid it facilitated. The Poverty Action Fund, for example, increased funding for social services at district level which extended health and water infrastructure (Ablo and Reinikka, 1998). Decentralisation in Bushenyi district was heralded as the reason for the district service coverage of immunisation increasing to 80% in 1996 (Nsibambi (1998). At country level, Francis and James (2003) cite the capacity of the primary school system doubling during 1996-7 from 3.6 million to 6.9 million as a result of Universal Primary Education (UNDP, 2004; McGee, 2000). According to general household surveys, the income poverty headcount fell from 56% in 1992 to 44% in 1997-8 (Appleton *et al.*, 1999) and then to 35% by 2000 (Deninger and Okidi, 2002, as cited in Hickey, 2005). Uganda also saw an impressive reduction in HIV and AIDS prevalence (Okidi *et al.*, 2002) to the extent it was once considered the model response to

the HIV epidemic (Green *et al.*, 2006; UNAIDS, 2004 - see Stoneburner and Low-Beer, 2004; Shelton *et al.* 2004; Hearst and Chen, 2004; Green, 2003; Wilson, 2004 for single partner/condom use argument; see Fenton, 2004; Halperin and Allen, 2000; Singh *et al.* 2003; Wawer *et al.*, 2005 and Shelton *et al.* 2005 for condom promotion and structural factors). Ten years of Museveni's rule saw Uganda rise in the UNDP's Human Development Index (HDI) to a position of 147 out of 173 (UNDP, 2003).

There is, however, an extricable link between poverty and politics. In Uganda, the legitimacy of the hegemonic party system rests heavily on the claim that participatory democracy serves the country better than the sectarian character of the previous multiparty system. Statistics suggest that the policies of the NRM were successful but some authors challenged whether this rapid growth was repeatable (Hickey, 2005) and indeed, truly participatory (Francis and James, 2003). Practical advantages, for example, facilitated improvements. During the early 1990s, a low Gini-coefficient allowed a high level of 'elasticity' in the relationship between growth and poverty reduction (Okidi *et al.*, 2002). Conditions for pro-poor growth were effectively met in this period due to the growth concentrated in the newly liberalised and labour intensive coffee sector (Hickey, 2005; Blake *et al.*, 2002; Hamner and Naschold, 2000). Critics also argue whether this growth was even; certainly there was an urban bias. During 1997-2000, the richest 10% of Uganda benefitted from the growth twice as much as the poorest exacerbating regional inequalities, particularly in the conflict-torn north (Okidi and Kempaka, 2002). Between 1999-2000 and 2002-3, for example, the percentage of the population living below the poverty line increased from 34% to 38% (Hickey, 2005), which is when Uganda rose on the HDI. Parkhurst and Lush (2004) even suggests HIV was a massive advantage to Uganda as Museveni was the first African leader to acknowledge the pandemic, in turn opening his arms to billions of dollars of international donor aid and boosting his reputation.

Decentralisation depends on the capacity of districts to raise their own revenue and use it effectively in the transparent provision of services to achieve their targets (Kayizzi-Mugerwa, 1999). There have been a number of problems with lack of transparency in the allocation of resources and weak budgetary procedures of record keeping and auditing. Francis and James (2003) explain there is scope for the tax burden to fall on the poor farmers through the PMA. Murrisa (2008) suggests that whilst through competitive tendering road maintenance improved, there were complaints that private bodies

underpaid the labourers resulting in poor workmanship and swift deterioration of constructed roads. Similarly, highlighting the gap between service provision and local need, a 1996 health survey noted a significant lack of drugs thought to be because most of the grants transferred to districts for health had been used for salaries (Nsibambi, 1998). Whilst Universal Primary Education had made education accessible for all children, improved access had not been matched by an increase in infrastructure and staffing (see UNDP, 2004). There were also concerns that decentralisation could lead to political unrest if local bodies become too powerful, or the 'wrong people' (Hutchinson, 1999), particularly 'sons of the soil' (i.e. through tribal nepotism, (see Francis and James, 2003)) gained control creating powerful mini governments - which was a problem in Bunyoro.

By far the greatest critique of decentralisation in Uganda, however, was effective representation. Hickey (2005) suggests that under a decentralised government, there should be the opportunity for specific interest groups to have representation at each level of the political system. Constitutional provision was made, for example, for local councils to have minimum female representation of one third, for there to be Council Secretaries for women and for People with Disabilities (PWD) throughout local government. The only influence the PWD has had in Parliament, however, is to ensure Parliament buildings have wheelchair access; a law yet to be extended to other Kampalan public buildings (Hickey, 2005). There was also concern that higher level government failed to include people at parish and district levels in decision-making processes in more than a token way. Parish level priorities were often not considered, for example, and communications to communities were poor, preventing them from holding their representatives accountable (Francis and James, 2003).

Most commentators agree, therefore, that the NRM's decentralisation generally began to reverse the decimation of 20 years of brutal conflict, but that the no-party system enabled the NRM to push through a reform agenda without opposition (Morrissey and Verschoor, 2003). The policy reform was pro-poor, in theory, enabling greater inclusion of marginal voices throughout the political system than is generally the case under multi-party representative democracy. This was illustrated through the successful immunisation policy in Bushenyi which gave poor women a voice in decision making. As Hickey (2005) argued, however, although the chronically poor were 'included', there is a sense that this is a politics of inclusion rather than 'influence' (Brock *et al.*, 2002) which in turn, constructs 'the poor'.

This construction is significant to this research. Chronic poverty is a multidimensional, temporal phenomenon that is experienced subjectively (CPRC, 2004; Hulme and Shepherd, 2003). In many policy discourses, however, there is still a tendency to group 'the poor' into one hegemonic entity with the same requirements. In Uganda, people who did not benefit from policies under decentralisation were generally constructed through a language of marginalisation as 'those left behind' (Hickey, 2005). This, in turn, had implications for the way the poor were included in poverty policy. Statements of civil servants and political elites, even presidential speeches, tended to categorise 'the poor' as 'unable' to benefit from economic growth or poverty problems. They implied the opportunities were there, but, especially in rural areas, individuals were failing to maximise them, often with reference to drinking or wasting chances (Woodhouse, 2003). Such an approach exonerates any 'failure' or lack of full participation under the no party approach. This is also particularly relevant to the Bunyoro, who were constructed as a lazy, backward tribe who do not seize the opportunity of development initiatives.

It is important to finally note that, in February 2006, Uganda held its first multiparty general elections (USDS, 2009). Whilst the opposition leader of the Forum for Democratic Change (FDC), Kizza Besigye, received 37.4% of the vote, President Museveni gained a third term in office with 59.3% of the vote, despite some serious irregularities in the voting procedure. Besigye is running for election again in 2010.

3.4.2 Decentralisation in the health sector and policy reform

As Major General (Rtd) Jim Muhwezi MP, the Minister of Health (until 2001) explained, the Government of Uganda has 'struggled to achieve better health for the people in Uganda and thereby contribute to the enhancement of the quality of life and productivity' (MoH, 2005:1). To improve the efficiency and effectiveness of service delivery Uganda decentralised its healthcare system and made a number of reforms based on market principles (Hutchinson, 1999). The decentralisation of health services to districts and further to Health Sub-Districts was, in theory, to abdicate service provision to local authorities and individuals, enabling personal responsibility for health through economic growth leading to better household incomes and thus allowing greater choice of health service.

The main reforms were based on the following four cardinal market principles (World Bank, 1994; as listed in Okunozi, 2005):

- Individuals, charities and private organisations should be made responsible for health care;
- Public funding of health care should be restricted to health promotion and prevention of disease;
- Central government's role should be restricted to policy formulation and technical guidance, with delivery of services left to the private sector and local authorities;
- The private sector and non-governmental organisations should be supported to become the key providers of health and social services.

The decentralised National Health System (NHS) in Uganda constitutes institutions, structures and actors which have the primary purpose of achieving and sustaining good health (MoH, 2010). This includes all government health facilities under the Ministry of Health including the services of the Ministries of Defence, Internal Affairs (Police and Prisons) and Ministry of Local Government. The NHS also includes private health providers (PHPs), private not for profit (PNFP) providers and traditional and complimentary medicine practitioners (TCMPs). This research suggests the NHS technically also includes informal structures such as 'assistants' in hospital. Under decentralisation, districts and health sub-districts play a key role in the delivery and management of health services at district and sub district levels respectively (MoH, 2010). Table 3.3 outlines both the health structure and the main services available at each facility.

The Health Sector Strategic Plan I (2000-2005) (HSSPI, 2000-2005) signified the expansion of implementation of major health reforms initiated in the late 1990s. The National Health Policy (NHP) provided strategic direction for implementation through a Sector Wide Approach (SWAp). The SWAp to health development aimed to provide an environment that would enable effective coordination of all partners in Uganda's national health development; increase efficiency in resource applications; and ensure effective access to essential health care (Syngellakis and Arudo, 2006). It particularly aimed to improve health status and services through a coordinated framework for better use of resources with a notable shift towards Primary Health Care (PHC) (MoH, 2005).

Table 3.3: Hierarchical structure and services available at each health facility

Type	Service Provision
Ministry of Health	Strategic planning, overseeing all health services
National Hospital	Referral Services offered by general hospitals and RRHs plus comprehensive specialist services, health research/teaching
Regional Hospital	Referral Services provided by general hospitals plus, specialist clinical services such as psychiatry, Ear, Nose and Throat (ENT), ophthalmology, higher level surgical and medical services, and clinical support services (laboratory, medical imaging, pathology). Also involved in teaching and research.
General (HCIV)	Hospital Preventive, promotive, curative maternity, in-patient health services, surgery, blood transfusion, laboratory and medical imaging services. In-service training, consultation and operational research in support of the community-based health care programmes
Health Centre III (HCIII)	Basic preventive, promotive and curative care and support supervision of the community and HC II under its jurisdiction. There are provisions for laboratory services for diagnosis, maternity care and first referral cover for the sub-county
Health Centre II (HCII)	First level between formal health sector and communities. Out- patient care and community outreach services
Health Centre I (HCI- Voluntary Health Team)	Facilitating health promotion, service delivery, community participation and empowerment in access to and utilization of health services. The VHTs are responsible for: Identifying the community's health needs and taking appropriate measures; Mobilizing community resources and monitoring utilisation of all resources for their health; Mobilizing communities for health interventions such as immunisation, malaria control; sanitation and promoting health seeking behaviour; Maintaining a register of members of households and their health status; Maintaining birth and death registration; Serving as the first link between the community and formal health providers; Community based management of common childhood illnesses including malaria, diarrhoea, and pneumonia.

Source: Adapted from the HSSPIII (2010)

The Health Sector Strategic Plan I (2000-2005) (HSSPI, 2000-2005) signified the expansion of implementation of major health reforms initiated in the late 1990s. The National Health Policy (NHP) provided strategic direction for implementation through a Sector Wide Approach (SWAp). The SWAp to health development aimed to provide an environment that would enable effective coordination of all partners in Uganda's national health development; increase efficiency in resource applications; and ensure effective access to essential health care (Syngellakis and Arudo, 2006). It particularly aimed to improve health status and services through a coordinated framework for better use of resources with a notable shift towards Primary Health Care (PHC) (MoH, 2005).

The HSSPI also included the Minimum Health Care Package (MHCP) which stated the policy approach to the burden of disease and management of public funds. During the HSSP I many bottlenecks in implementation of the MHCP were identified. These prompted policy shifts in the HSSPII (2005/6-2009/2010) to concentrate resources on a limited set of evidence-based, cost effective interventions under each element of the MHCP (MoH, 2005). Significantly focus also shifted towards primary healthcare with a marked reallocation of resources in favour of lower levels of care (MoH, 2005). Such a move served to highlight the link between ill health and poverty and thus, Uganda's commitment to achieving the MDGs (MOH, 2005).

The HSSPII suggests many of the HSSP I targets were achieved, and in some cases, surpassed under the decentralised health system. This was highlighted by the dramatic rise in the utilisation of public sector and private not for profit (PNFP) services which was attributed to a combination of improved physical access, improved quality of care and the removal of user fees in 2001. Other achievements were registered in many of the priority programmes, according to the MoH, notably the Expanded Programme on Immunization, in which coverage for DPT (combined diphtheria, tetanus and whooping cough vaccine) rose from 55% in 1999 to 89% in 2004/5 (MoH, 2005). Significant improvements were also seen in the polio campaign with no new cases being reported during the period of HSSP I, and only four deaths from measles (registered) in 2004 (MoH, 2004). There was significant expansion of PMTCT, VCT, ARV and malarial programmes. The MoH recognised that these achievements were made despite the severe constraints of underfunding, continuing inadequacies in the production, recruitment and deployment of trained personnel, essential medicines being frequently out of stock and lack of equipment for making the new health centres

operational. Health Centre IIs (HCII), in particular were constructed much more quickly than resources were available which severely limited the planned reduction of inequality targets (MoH, 2004).

It is particularly illustrative that the HSSPII views the 2001 abolishment of user fees in all government facilities (except for private wings in hospitals) as an achievement of the HSSPI. User fees at the point of healthcare access were introduced as one of the key methods to finance health reforms (see Deininger and Mpuga; 2005; Gwatkin, 2000; McPake, 1993 for theory behind user fees). User fees were first introduced in Uganda in 1990 and were met with massive opposition motivated by fears that such fees would preclude access to health services by the poor, especially in a subsistence economy. Such charges, however, were considered a vital tool for the decentralised districts to improve delivery of health services. Initially fees were charged of 500/= (Ugandan shillings) for adults and 300/= for children in rural areas and up to 1,000/= and 500/= in urban areas. Today 500 shillings is equivalent to approximately 30 UK pence and would buy a kilogram of sugar; to a poor family it is not an insignificant sum of money. Whilst set at district level, however, the fees varied dramatically between health units although were always lower than the prices at private facilities (Lindelov *et al.*, 2003). Msweigye's (2002) research found that most of these fees were being used to supplement staff salaries, rather than improving the health infrastructure. Nabyonga (2005) also found that user fees presented a barrier to access services, particularly amongst the poor. To combat this, the government suggested fees could be used to subsidise those least able to afford care (Shaw and Griffin, 1995), or to provide exemption schemes for the chronically poor, but there were problems of accountability and transparency.

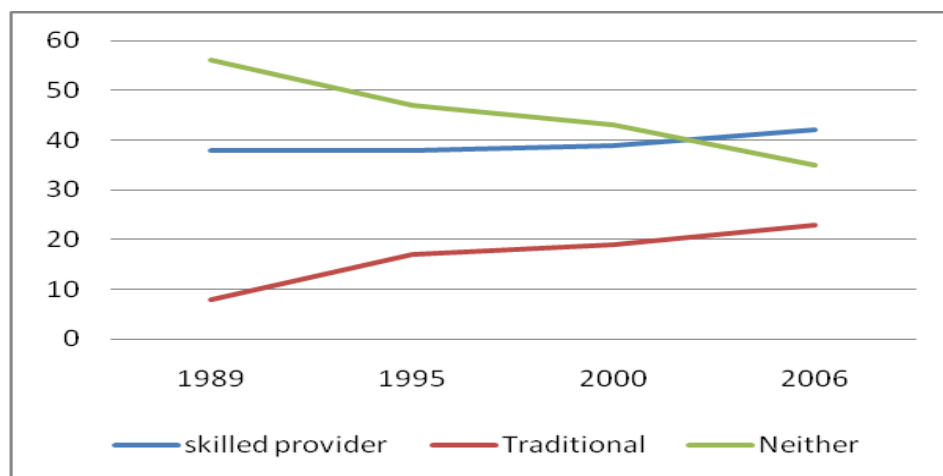
Particularly in poor areas of Uganda the monetary cost of treatment posed a barrier that prevented the poor from obtaining socially optimal healthcare (Deninger and Mpuga, 2005; Nabyonga *et al.*, 2005). There were also concerns revenues were not being used appropriately to improve the health sector. All fees at first-level government health facilities in Uganda were removed in March 2001, largely as a response to the findings of the World Bank's first Participatory Poverty Assessment Report (1999) (Government of Uganda, 2004). The funds generated were typically 5% of the total expenditure needed for most hospitals and they had little, or no, impact on the quality of efficiency of services (Okuonzi, 2004). Xu *et al.* (forthcoming) show that the utilisation of health services by the poorest

increased after the abolition of fees. The MoH (2005) suggest attendance at Out Patient Departments (OPD) increased from 0.4 visits per person per year in 2000 to 0.9 in 2004/05. Deninger and Mpuga (2005) also argue that the fact there was little change in aggregate health spending suggests that the more affluent may have opted out of the public system, in favour of more expensive, but perceived better, private practitioners. Deninger and Mpuga (2005) also note a reduction in the incidence of morbidity and the elimination of asset-bias in access to treatment that had characterised the system before the abolition of user fees.

There was, therefore, split opinion about the success of the HSSPI under the SWAp of a decentralised government. The HSSPII represented a consolidation and extension of the perceived achievements of the HSSPI and was developed through intensive processes involving all key stakeholders in health development in Uganda. The priority of the HSSP II was to fulfil the health sector's contribution to the PEAP and MDG goals through a reduction in fertility, malnutrition, HIV and AIDS, tuberculosis and malaria and specifically, a reduction in maternal and child mortality.

The policy recommendations for the National Development Plan (2008) recognise that the presence of a skilled birth attendant has a major impact on the ability to deal with complications. The statistics, as reproduced in Figure 3.3, show that whilst the number of women delivering without any assistance has decreased, the overall rate of biomedical support is still very low.

Figure 3.3: The prevalence of attendance at birth from 1989 to 2006



Source: Adapted from the National Development Plan (2008)

Priority of the HSSPIII is given, therefore, to sexual and reproductive health in effort to protect women during pregnancy and childbirth, whilst addressing the need for family planning (MoH, 2010).

Decentralisation brought new policy frameworks that instigated dramatic health sector reform, but not all in a positive manner. Critics of the decentralised health system echoed the critics of the decentralisation process as a whole, particularly in terms of appropriate use of resources and equality of participation. A main critique, for example, was that funds allocated to districts were 'earmarked' by donors and the Ministry of Health for specific purposes and thus, contrary to the principles of decentralisation, could not necessarily be used to serve the district in the most appropriate manner (Okunonzi, 2004). During the fieldwork the hospital had not had tetanus vaccine for months and yet took endless deliveries of boxes of condoms (see Figure 3.4).

Figure 3.4: Consultation room of Kakindo showing the stacked (orange) boxes of condoms.



Source: Personal fieldwork photograph

Although access to health services is said to have increased as a result of the growth in private clinics, socioeconomic inequality within Uganda has grown and the poor have been increasingly marginalised (Okunonzi, 2004; Government of Uganda 2004a, 2004b). Despite the suggested improvements to the health sector under the HSSPI, key health statistics from

the Uganda Bureau of Statistics from 1990-1995 to 2000-2004 presented in Table 3.4, have actually worsened. In PPAs conducted by the World Bank in 1999, 2002 and 2004, public opinion also suggested the health services had declined.

Table 3.4: Ugandan health status outcomes

	1990-1995	2000-2004
Nutrition (% of children with wasting)	6.2	8
Access to safe water (%)	39.4	53.8
Access to proper sanitation (%)	34	51
Infant mortality (deaths/1000)	81	88
Neonatal mortality (deaths/1000)	27	33.2
Malaria mortality (%)	25	37
Diarrhoea (%)	17.7	17.8
Maternal mortality ratio (deaths/100,000 births)	506	505
Child mortality (deaths/1000)	147	151
Life expectancy (years)	50	47
% of deliveries in health facilities	38	38
Fertility rate (no of children)	7.4	6.9

Source: Ugandan Bureau of Statistics, 2001

It is against this contextual health policy framework and mixed impressions of the success of health reform, that the fieldsite in general and its health system in particular, can be discussed.

3.5 Introducing the Bunyoro Kingdom

As Section 3.3.1 outlined, the Bunyoro Kingdom has played a significant role in the history of Uganda. In turn, the Kingdom was constructed as backward and lazy; 'Nyoro', the abbreviation for Bunyoro, for example, is still used in Buganda to refer to anything low quality, dirty or locally produced (Doyle, 2006). This section goes on to discuss the 'Black

Hole of Uganda' in greater detail, which, in turn provides justification for its use as a fieldsite. It will discuss the demographics and basic living conditions of Bunyoro whereas Chapter 5 will contemplate the Bunyoro healthscape more specifically.

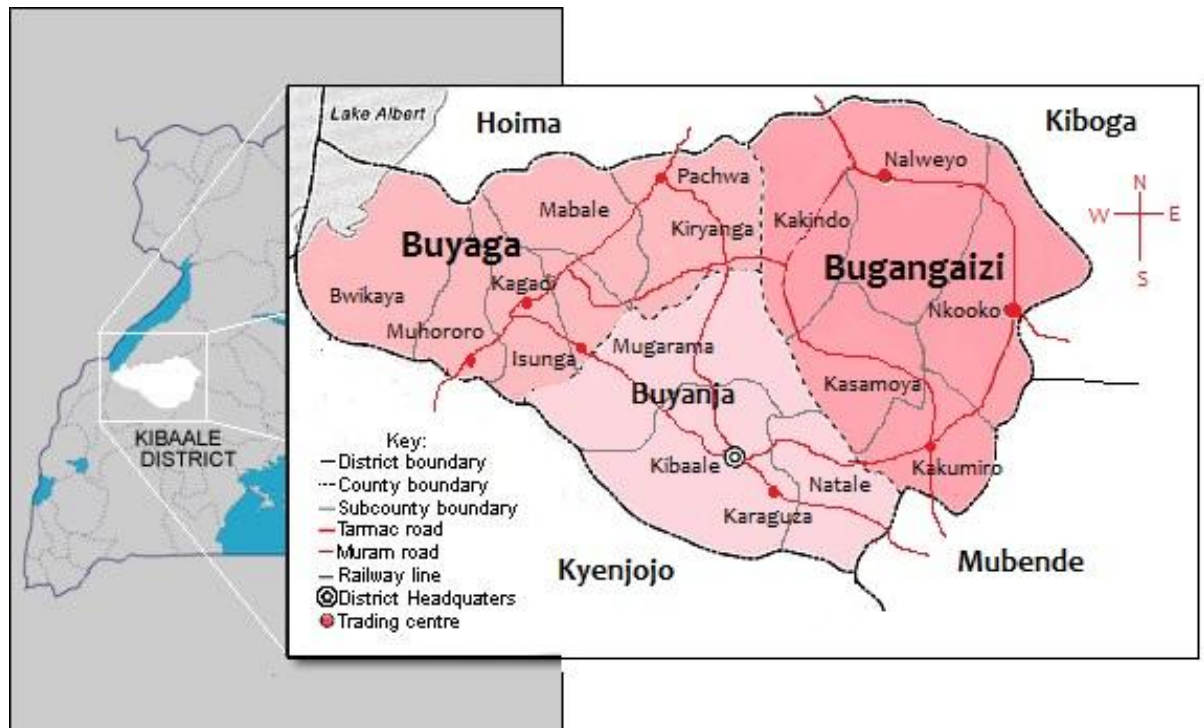
3.5.1 Overview of the Kingdom

European contact with Bunyoro from 1862 and subsequent missionary administration resulted in a good spread of literature about Bunyoro's colonial history. The history does not fit with either of the dominant demographic change models, the standard explanation for which is that Bunyoro was 'backward, reactionary and intractable' (Doyle, 2006: 5). Perhaps due to this, few subsequent ethnographies of the district exist. Roscoe's 1923 book is an indispensable source, but as Beattie (1964) criticises, methodologically it is old fashioned and superficial, largely because it is based on a relatively brief visit and on set questions posed to informants by interpreters. Beattie's anthropological writings were considered by Doyle (2006) to form the most valuable body of research in Bunyoro society providing useful case studies of social change in the 1950s. Beattie (1964) is not immune from criticism however. Doyle (2006) indicated he relied on Roscoe's writings (despite Beattie's personal criticisms) for much of his analysis of the pre-colonial state, interpreted myth and ritual in a rather literal manner and wrongly assumed, particularly in his 1971 text *The Nyoro State*, that many of the colonial state's characteristics had evolved directly from the pre-colonial situation. Beattie's writing was arrogant and disrespectful of the Kingdom in which he chose to reside. Since the early 1970s, however, with the exception of Doyle's (2006) text and occasional reconsiderations of colonial or pre-colonial histories such as Willis' (2002) work on alcohol, Bunyoro's history has been neglected.

The Bunyoro Kingdom lies in mid-western Uganda (see Figure 3.2). It is composed of three districts, Kibaale, Masindi, and Hoima which run in an L-shape against the Ugandan boarder of Lake Albert with Kibaale as the 'foot'. The fieldwork was conducted in the hospital of Kakindo sub county, which is in Bugangaizi county, Kibaale District, part of the Bunyoro Kingdom (see Figure 3.5). The Kingdom has a total area of 21,376 sq km, one third of which is covered by water. The population is approximately 800,000 people, but is sparsely distributed with a population density of 37 people per square km. Three percent of people live in urban centres (Uganda Connect, 2008).

In contemporary Bunyoro the standard of living was generally poor. The administrative centre of Kibaale, where the District Director offices were (e.g. of health, education, *etcetera*), had power, water and (slow) internet connection. Houses were of a good standard, often with sanitation and piped water. The rest of the district was generally poor.

Figure 3.5: Map of the Bunyoro Kingdom



Source: Reproduced with kind permission from Tugengayne

People in trading-centres lived in small one-roomed homes, approximately 6 feet by 4 feet, built of brick with corrugated iron roofs, some behind a small general shop. It is not unusual to find families of four or five sharing this space (see figure 3.6).

Figure 3.6: Varieties of trading-centre housing

Source: Personal fieldwork photograph

Trading-centres were small collections of wholesale and retail shops selling a variety of wares from sugar and soap to paraffin and bicycle parts and the ubiquitous Coca Cola. There was normally a primary school (government), occasionally a secondary school, a police post, a government health facility and private health facilities such as drug shops and clinics. There was often a bar, a tailors and a hair salon. In the remote villages, people lived in traditional mud houses with thatched or occasionally corrugated iron roofs (see Figure 3.7). These homesteads were sparsely distributed and often deep in the bush, so, illustrative of chronic poverty, were difficult to access. There was no piped water (see Figure 3.8), limited sanitation and only a few households in the trading-centres had access to power through solar panels. The physical infrastructure was weak with only murrum roads which became impassable in the rainy seasons (see Figure 3.9). Subsistence agriculture was the main occupation, particularly in the villages. There was a growing base of large scale commercial farming in tobacco, sugarcane, tea, maize, rice and cattle but this was dominated by a few, usually external, individuals in part because access to markets was difficult physically due to the poor infrastructure. At the time of the fieldwork there were no means of communication.

Figure 3.7: Typical 'village' housing



Source: Personal fieldwork photograph

Figure 3.8: Drawing water from the borehole



Source: Personal fieldwork photograph

Figure 3.9: Local road conditions in Bugangaizi



Source: Personal fieldwork photographs

3.5.2 Tribal conflict

Bugangaizi faced problems generated by ethnic tensions. Before reaching Bugangaizi the road from Hoima passed through Katikara, a booming Bakiga trading-centre which hosted a Monday market serving wholesale traders from Hoima. Just over six years ago, however, Katikara was dense bush, home to wild animals and insects. In 2001, the government turned a forest in Kamwengwe district into Kibaale National Park evicting the indigenous Bkaiga. The Bkaiga migrated to nearby areas, largely into Bunyoro territory, causing clashes over land which resulted in the displacement and death of hundreds (Tumusiime, 2008). Through local councillors, the government intervened, offering compensation to the resettled Bakiga if some agreement could be made with the Bunyoro. In reality, however, this compensation rarely materialised. In consultation, the Bunyoro allowed the Bakiga into their kingdom but only to undeveloped, dangerous bush lying in a conveniently protective ring around Bunyoro settlements. The Bakiga, however, were a notoriously hardworking tribe who quickly cleared the land and in less than five years surpassed the Bunyoro in standard of living. The situation was aggravated when Fred Ruremera, a Mukiga won the LC5 seat (the highest position of local council) in 2001, but was rejected by the Bunyoro leading to bloody clashes to the extent that the President had to intervene. After negotiations

George Namyaka, a Munyoro, was appointed chairperson (Businge, 2008). This instilled a deep sense of rivalry between the two tribes and further land clashes erupted in 2004 (Tumusiime, 2008). In the 2006 local elections Namyaka stood unopposed preventing further conflict (Businge, 2008). He was in power for the duration of the fieldwork.

Further conflict has recently arisen, in part as a legacy of colonial rule in Bunyoro (as discussed in Section 4.2). The historically disputed land was administered directly during the colonial period, but at Independence in 1962 its management shifted to the Buganda Land Board under the Buganda government. Many Bunyoro are, therefore, technically squatting on Buganda land. In March 2008, Museveni reached an agreement with the British Prime Minister to establish a joint intergovernmental committee to set up a land fund to enable tenants to buy back their plots from the landlords. Unsurprisingly, the land bill has met with opposition. The Buganda Kingdom suggested the bill is tantamount to grabbing from landlords (Maseruka, 2008). In contrast, the Prime Minister of the Bunyoro Kingdom, Emmanuel Aliba Kiiza, challenged the bill saying paying off the landlords was unfair because the Baganda owned the land illegally. Reimbursing the Baganda would therefore be like 'rewarding a thief...The Government should heal the wounds inflicted on us by the colonial masters rather than worsening our problems' (Kwesiga, 2008: online). The conflict is still not resolved and has become more significant recently since oil has been found in Bunyoro making the land much more valuable.

3.6 Conclusion

Despite being poised for rapid economic growth in 1962, within four years of Independence Uganda had become a byword for corruption, economic mismanagement, abuse of human rights and devastating poverty. Original colonial conquest decimated the Bunyoro Kingdom leaving a demographic crisis from which it is surprising Bunyoro was able to recover. The conquest also marked the first construction of the Bunyoro being a backward, lazy tribe and sewed the seed of a culture of violence. In the country as a whole, successive dictatorships after Independence devastated both the economy and the health sector.

Under the new rule of the National Resistance Movement led by President Museveni, the 'no-party' state initiated a number of development policies originating from the Ten Point

Program that focused to rebuild national unity and to provide a strong economic foundation for development with a particular focus on 'modernisation' (Macrae *et al.*, 1996). It was assumed social development would naturally follow. The Poverty Eradication Action Plan, the Poverty Action Fund and the Plan for the Modernisation of Agriculture were implemented under the new decentralised framework that, in theory, abdicated decision making to grass roots, participatory levels. There was an inextricable link between poverty and politics. Global circumstances enabled some of the growth and there was a significant lack of transparency. At the same time, 'the poor' were both marginalised and constructed as 'left behind' because they were unable to seize the benefits. The Ugandan health-sector was decentralised and restructured under market principles highlighting a marked shift towards primary healthcare in line with the MDGs. Whilst the user fees introduced in 1990 and abolished in 2001 were seen as a failure, opinion is mixed about the success of other healthcare reform; certainly the poor were marginalised.

This chapter also introduced the Bunyoro Kingdom. It was suggested that colonial conquest and market orientated reform policies aided to construct the Bunyoro as a lazy, backward tribe. Certainly the standard of living was low and the district was struggling with on-going tribal conflict. Chapter 5 will discuss how such living conditions represented societal and pragmatic barrier to health. Before that can be done, however, Chapter 4 will explain the methodological approach to this research and how the research was conducted.

Chapter 4: Researching maternal child health

A 23 year old woman presented at clinic with severe abdominal pain and a high fever. Her medical card said she had two children but two people lived in her household; it was probably a clerical error. The doctor, a visiting American missionary, diagnosed a urinary tract infection (UTI) and prescribed her high dose antibiotics.

Something was not quite right. After I asked a few questions it transpired that she had left her husband and children to be with another man, who was 20 years her senior and had seven other wives. She broke down as she explained she had 'failed' to produce him a child and was terrified he might leave her. She explained that, fearing she had been charmed by the other wives she had sought advice from a herbalist and collected plants from the forest to cure her predicament. Clinical tests suggested she had picked the wrong herbs which had poisoned her. Tests also showed she had Chlamydia and acute pelvic inflammatory disease as a result. It was unsurprising she could not get pregnant.

As the American doctor scribbled out his UTI diagnosis, he looked at me and said "I'm a scientist, you're a human, I'd never think to ask those questions, we make a good team"

(Dr. David Elliot M.D., pers. comm. July, 2009)

4.1 Introduction

In a series of disciplinary 'turns' over the last forty years, the objects, subjects and means of research have been overhauled. The 'hows' and 'whys' of human geography research, however, at least until very recently, have been conspicuous in their absence. As Barnes *et al.* (2007:31) put it, within human geography, 'for the most part, the discipline operates a 'don't ask, don't tell' policy with respect to methods'. But methods matter. A critical discussion of the philosophical underpinnings of research, the choice of field study site, the

constructed 'research reality' through positionality and indeed, the actual way in which the data was collected, is essential in all research (Hemming, 2008; Barnes *et al.*, 2007; Crang 2002). Arguably, however, a transparent consideration of the methodological approach is more critical *still* in research that is potentially sensitive or has particular ethical issues (Valentine, 2003) – which is exactly the nature of this research.

To say this research was challenging is an understatement. This research was lengthy, difficult, sensitive, at times distressing, but always entirely encompassing. Embracing the post-structural approach, this research sits at an interdisciplinary cross section. It thus gleans a rich insight into healthcare delivery by utilising literature and methods from health geography and medical anthropology and related disciplines such as sociology, nursing and medicine. This research endeavoured to capture the complexity and diversity of values, perceptions and experiences (Langevang, 2007; Rawlins, 2006; Leyshon, 2002) in an effort to explain social inequality. Using such a mixed-methods approach not only generated a nuanced, 'thick description' (Geertz, 1973) but raised ethical issues that, answering to criticism, demanded a transparent discussion about the methodological approach. Within the field, difficult questions of justification, ethics and approach arose on a daily basis demanding continuous reflection of both the research in general and the situatedness of the researcher in particular. Within the discipline, meanwhile, in part motivated by a critical, self-reflective concern for the future, Lawson (2009) highlighted the necessity to both question the critical in critical geography and to re-conceptualise ethics, to not just not harm, but to actively contribute to 'human good' (Olson and Sayer, 2007).

Chapters 1 and 2 provided the rationale for *why* this research was conducted and Chapter 3 justified *where* this research was conducted. This chapter will contemplate *how* this research was conducted and by whom - it will not only ask, but tell (Barnes *et al.*, 2007) - by discussing the methodological choices and philosophical underpinnings of this research and the situatedness of the researcher. To borrow Nagar *et al.*'s (2002) expression for a second time, because these topics are closely intertwined, the organisation of the chapter reflects a matter of emphasis, not a strict partitioning. Indeed arguably, the choice of fieldsite, ethical issues, logistics, methods used, *etcetera*, stem from, and are interwoven with, the methodological or philosophical approach to the research. Section 4.2 explains the ways in which the research fits on the broader disciplinary agenda which is increasingly becoming

aware of the necessity to ‘do something’ and ideally something to benefit human good. It will also discuss how this can be put in practice through ethnographic approaches, specifically ethical action research. Such an approach demands a consideration of the positionality of the researcher which was significant in this research (and is discussed in Section 4.3), and how boundaries between researcher and researched can blur as that positionality changes. The actual methodological techniques and logistics are then discussed in Section 4.4. First the pre-fieldwork preparations in the UK and initial work in Uganda are considered. Then the specific methods of hospital ethnography (using participant observation), focus groups and triangulation - or more aptly crystallisation – are contemplated. Using this discussion, Section 4.5 contemplates the coding process through which the three healthscapes were conceived and the data analysed.

4.2 Methodological approach

“primarily a series of aesthetic constructs, a set of ego-trips into the exotic”

(Firth, 1984: ix)

As Chapter 2 explained, this research uses a post-structural feminist lens to view the MCH processes and practices within Kakindo HCIV in effort to tease out the intersections between health, illness, healthcare and place (Dorn and Laes, 1994; Kearns, 1994, 1993; Gesler, 1992) through the concept of healthscapes. It was discussed that a post-structural approach does not refuse structural processes but continues to engage with them as they work out in relation to concrete contexts, meanings, histories and cultural productions (Lawson, 2008; McDowell and Sharp, 1999). The application of a feminist analysis within the post-structural frame enables a critical examination of how inequality is produced through difference in order to engage with it more effectively (Lawson, 2008). It is thus well understood that in social constructivist research the researcher must recognise that the way in which we know the world is positioned, partial and constructed (see Desmond, 2004; McDowell, 1992); data are not just ‘out there’ to collect (Hammersley and Atkinson, 1995). As Rose (1997) put it, in research, we should not try to offer an all-seeing, all knowing ‘view from nowhere’.

Nearly two years of working in a rural African hospital tells an interesting tale. With mud huts, witch doctors and proclamations to ‘make a difference’, the field-site once, to use

Firth's (1984; ix) line, represented the ultimate ego trip into the exotic. In actuality, the collection of the empirical data was simultaneously tough, challenging, wonderful, sensitive - and a working reality. Within a few months, the exotic became routine and even mundane. Consequently, epistemological moorings frequently shifted during the fieldwork creating new methodological quandaries, challenging ethical dilemmas and continuous self-reflection. These methodological and ethical developments were also reflective and reinforcing of broader disciplinary shifts. Whilst Geography as a discipline questioned its identity and future, Lawson (2009) challenged the 'criticalness' of human geography and called to re-conceptualise ethics, not just in terms of not doing harm, but in terms of *actively* contributing to 'human good' (Olson and Sayer, 2007) - and indeed, to contemplate what that actually means. This section, therefore, will discuss the philosophical underpinnings of this research and begin to unpack the complex ramifications of the ontological framework and the epistemological approach. It will first discuss how this research fits within a changing discipline and then introduce ethnography as a constructivist methodological approach. As Gesler and Kearns (2002:21) put it, in research, it is useful to know 'where we are coming from'.

4.2.1 Disciplinary agendas and the necessity to be useful

The mid 1990s saw parallel methodological crisis and stark self evaluation in a number of social sciences relevant to this research. In nursing, for example, reminiscent of the opening vignette, researchers began to recognise the polarisation of methodologies between an objective scientific approach and a human subjective approach (Walters, 1996). Only ten years earlier, philosophy had questioned the fundamental assumptions of both the objectivism inherent in positivist methodologies and the subjectivism predominating in interpretative methodologies (see Bernstein, 1983). Criticisms lay not just in the fact that a positivist tradition underpins most scientific research, but that little critical attention was being paid to methodology at all, rendering, as Hekman (1986:1) put it 'the social sciences (are) cast adrift without a theoretical anchor'. Hekman further argued that an analysis of the methodological crisis in social science research in general, and nursing in particular, should be the starting point for all contemporary social and political theory. This gave rise to the questioning of the polarised nature of nursing research that focused too heavily on either the positivist stance and the masculine supremacy and power to cure a patient, or the feminist subjectivism of caring. Contrary to literature that undervalues the role of caring -

both formal and informal - in the healing process, the positivist value of curing and the humanist value of caring were both recognised, but as independent entities. Also significant to these epistemological developments was the increasing conceptualisation and understanding of the role of care in the nursing process, and the resultant impacts on care delivery and the carer (see Gardulf *et al.*, 2008; Ihan *et al.*, 2007; Begat, 2005).

Similarly in anthropology, Hemmings (2005) lamented the distinction between anthropology *in* medicine and medical anthropology suggesting that anthropologists do not engage with medicine enough and vice versa. This stemmed from a criticism that anthropology needed to be more relevant to doctors and patients (Hemmings, 2005) and indeed to broader stakeholders in general such as nurses, health managers, allied health clinicians and patients' friends, families, advocates and support groups (Long *et al.*, 2008) particularly as societal public health needs rose on the global agenda (see Kickbusch, 2009). Long *et al.*, (2008) use the example of Zaman's (2004) ethnographic study of a Bangladeshi hospital ward where Zaman was repeatedly asked by medical students *how* the information would be practically used. This argument is, however, not without criticism. Shand (2005), for example, suggests there has been significant growth of anthropology *in* medicine where anthropologists have worked alongside clinical professionals and have been of direct clinical importance. Long *et al.* (2005) take this argument a step further by suggesting that, largely due to the methods used, anthropologists' contribution to medicine is not always recognised (see, for example, Bardram and Bossen's (2005) work in video ethnography, Rapp's (1999) work with amniocentesis and its social and clinical implications and Warin's (2003) contributions to understandings of anorexia and its treatment).

Within Geography, in response to the 'cultural turn', health geographers endeavoured to emerge from the shadow of medicine and epidemiology and establish themselves as Health Geographers. The incorporation of social theory reformulated and re-orientated the previously narrow, epidemiological focus on illness and disease into a much broader interest in the way cultural beliefs and practices structure the place of health experience and healthcare provision within health geography (Kearns and Moon, 2001; Kearns, 1993). New avenues of cultural inquiry enabled nuanced health knowledges which focused increased attention on sensitive topics such as the spatial marginalisation of certain disadvantaged groups (Valentine, 2003) and the potential to work with different disciplinary audiences. In

2003, for example, whilst seemingly introducing the sub discipline of health geography to a nursing audience, to his surprise, Andrews (2006; 2004; 2003a,b; 2002) found more than twenty published papers in journals in which nurses had explicitly employed geographical conceptual frameworks and perspectives. At more or less the same time the 'caring strand' hit the geographic agenda initially with Parr's papers in *Progress in Human Geography* (2004, 2003, 2002) which was largely situated in place as caring shifted from institutions to homes. Kearns and Moon (2002) made the connection with caring and the broader health research agenda. No connection was made, however, between the 'geographical strand' and the 'nursing strand' (Andrews, 2004). The cultural turn highlighted how health geographers are in the ideal position to make this connection, particularly as they use a wide range of theoretical frameworks and nuanced concepts to interpret the subject matter, ordinarily utilising qualitative, or mixed methods research design (Cutchin, 2008). This was advantageous to both the 'real world' and the discipline as it gave health geographers the opportunity to critically engage and 'establish its relevance to our present and future world' (Castree, 1999: 764).

A crucial element of this research is the need to 'to do something'; to offer solutions, or at least provide evidence on which solutions could be deduced. Agreeing with Martin (2001) and Castree (2002) this is what geography is *supposed* to do. First and foremost doing 'something' should be an effort to alleviate deprivation, but it is also of benefit to the discipline. The 'policy relevance debate' born from the 1970s 'critical turn' is beyond the scope of this discussion. It has to be highlighted, however, that it has long been recognised that Geographers have a disturbing habit of not only missing important intellectual and politically significant debates, even when they play a major role (Dicken, 2004), but they have a tendency to 'abdicate powerful ideas developed or nurtured within its ranks (to) other fields of inquiry' (Turner, 2002: 428 – see also, Thrift, 2002; Castree, 2002; Storper, 2001; Banks and Mackian, 2000). Similar to the critiques of the impact of medicine *in* anthropology and medical anthropology within Geography, the overriding ethos of the policy debate was the necessity to be useful, to do something, be it via policy or in the advancement of knowledge – to take action. As Martin (2002: 190) put it, 'as geographers we should be striving to inform and shape the process and improve the outcomes' which is our 'moral duty'. For many researchers such as Gleeson, (2000), Dyck, (2000), Kitchin, (1999), Chouinard, (1997), geographers have a moral responsibility to contribute to the actual struggles of marginalised or vulnerable groups. There is a danger, however, of resting

on a romanticised ideal. The production of current research practice is representative of the power/knowledge agenda of academia and the necessity to 'hit targets', specifically for the Research Assessment Exercise (Kesby, 2000b) but arguably also reflecting the increasing market orientated principles of the academy. Kitchin and Hubbard, (1999), for example, highlight how physically difficult it can be to marry research practice with political action. Furthermore, there is an inherent ethical dilemma in advancing a personal academic career by engaging with the challenging, difficult lives of those less fortunate and then walking away to write up the research in an office several thousand miles away. It will be discussed in Section 4.3 that the same social position facilitated by an academic career that permitted entry into the fieldsite also made it very difficult.

In any research, ethical concerns should be first of all to protect the participants, the research (James *et al.*, 1999; Catania *et al.*, 1990), and the researcher (Skinner, 1998; Etherington, 1996; Lee, 1993). This becomes more significant still if the research is of a sensitive nature, or it involves vulnerable participants (see Delor and Hubert, 2000). There is a growing area of debate, for example, about the ethics of conducting anthropological research on the effects of AIDS in sub-Saharan Africa (Nyambedha, 2008; Meskells and Pels, 2005; Herzfeld, 2002) which has also highlighted the difficulty in defining and using the term 'vulnerable' in real life settings (Delor and Hubert, 2000). Certainly in our efforts to alleviate deprivation with the cultural turn in geography greater attention was paid to the necessity to protect research subjects and particularly if they were marginalised, disabled or vulnerable (Valentine, 2003). Greater consideration was also given to how the participants, or 'knowers', benefitted from either the research itself or via a development of their skills, knowledge and capacities through the research itself (Kesby, 2000b). In terms of research, however, this was not always easy. Nyambedha (2008), for example, highlighted the ethical challenge to researchers, and particularly ethnographers, who are expected to find better practical solutions to the problems of the people they study, vulnerable or otherwise.

The ethical necessity - yet methodological difficulty - in taking action and being useful in geography has received new attention via a debate that arose in *Antipode* during the course of the research. In 2007, Olsen and Sayer once again challenged critical geographers to contemplate who we are and what we do. In their call to re-centre the normative base of radical geography they highlighted the necessity to consider, not only what human good

may be, but the notion that this may not be entirely at odds with the descriptive and explanatory aims of social science. Lawson (2009) took this argument a step further and suggested that, instead of a radical geography we should be contemplating a caring geography which, informed by feminist care ethics, highlights the centrality of care to human well-being and survival and engages moral philosophy with empirical studies of labour and life (see also Lawson, 2007b; Kittay, 1999; Sevenhuijsen, 1998). Lawson (2009) also highlights how the dialogue between geography, the content of care and care ethics is underway (Smith, 2005; McDowell, 2004; Staeheli, 2003). Feminist political economy for example, has paid great attention to care. To provide but a few examples, Brown (2003) and Milligan (2000) contemplate how the home hospice is reshaping home and gender relations; Mckie *et al.*, (2002) examines the role of informal carers in the production of the individual; Jarosz (1996) and Freidburg (2004) trace labour abuses in global food commodity chains and Milligan *et al.*, (2007), amongst many others, contemplate the questions of ethics, social justice, morality and responsibility bound in a woman's 'duty' to care.

This new argument has a particular resonance in this research which was ultimately bound in shifting methodological questions and ethical challenges and yet endeavoured to actively 'do some human good'. There was an inherent necessity 'to be useful' both at a conceptual level through the research output, but also on a daily basis within the communities from which the researcher personally benefits. The research, however, highlighted a major critique to the philosophical approach that 'good' human geography research should be both ethical and actively beneficial. Perhaps indulging in Olsen and Sayer's (2007) challenge that benefiting human good is potentially at odds with the descriptive and explanatory aims of social science, once again, frank discussions about *how* social science can benefit human good and yet still be 'good' social science, are conspicuous in their absence. Despite being informed by the post-structural movement, which recognises that research is partial, positioned and constructed (Desmond, 2004; Robertson, 2002; England, 1994; McDowell, 1992) there was also considerably little contemplation about the fluid role of the researcher in the construction and reconstruction of research. To respond to these critiques, therefore, it is essential to be transparent about the role of the researcher in the research, and indeed the methodological approach and to know 'where we are coming from' in terms of this research (Gesler and Kearns, 2002:21).

4.2.2 *Where this research comes from – ethical action research*

This research comes from the approach that is echoed across anthropology and geography in general, and medical anthropology and health geography in particular. The research suggests that developing the interdisciplinary positivist objective gaze with a humanist subjective understanding – which would then contemplate the curing and the caring – could generate a rich description and nuanced understanding of holistic health in place. A post-structural qualitative analysis recognises and embraces the complexity of human beings - which applies to both the researched and the researcher. In this research, the main methodological approach used was ethnography of which the research tool is participant observation. Participant observation will be discussed as a research tool in Section 4.4.3. It is important here, however, to understand the methodological approach of ethnography. Brewer (2000:6) defines ethnography as:

‘the study of people in naturally occurring settings or ‘fields’ by methods of data collection which capture their social meanings and ordinary activities, involving the researcher participating directly in the setting, if not also the activities, in order to collect data in a systematic manner but without being imposed on them externally.’

It was Malinowski (1922) who set the gold standard for ‘doing ethnography’ in which the common understanding of participant observation in ethnographic research has been living in a community for a substantial period of time and participating in the daily lives of people. In Brewer’s definition above, however, it is inherently contradictory to say it is possible to capture social meaning by participating directly and yet not imposing on participants. An ethnographic methodology certainly involves the researcher immersing themselves in the social setting. Hemming’s (2008) valid point, however, must be recognised as the approach, methodologically speaking, is internally diverse and its various versions have been influenced by positivism, humanism, realism and post-modernism. This highlights the difference between a humanistic ethnographic approach which seeks to accurately reproduce the views of the ‘insider’ or the ‘other’ (Brewer, 2000) and the contrasting constructivist approach - as adopted here - that recognises that reality is constructed through the process of participation and research, rather than merely being ‘out there’ to collect (Hemming, 2008: 153; Hammersley and Atkinson, 1995). Central to that interaction, therefore, is the

development of the relationships between the researched and the researcher through everyday events and interactions (Burgess, 1984; Van Maanen, 1988). For some researchers, a critical geography that is bound in issues of *doing something*, and thus ethical concerns, has constructed a simultaneously more nuanced yet directed ethnography which stems from the far from new notion of 'action research'. Action research informs the methodological approach of this research.

Many researchers suggest that designing action research or interventions can help prevent the researched community from feeling they are being exploited by researchers (e.g. Akeroyd, 1984). The situation is made worse if life circumstances of those being studied remains the same (Geissler, 2005; Hoeyer, 2005) - or potentially even worse (Nyambedha, 2008). Action researchers are committed to conducting research which not only does no harm through research, but challenges unjust and undemocratic economic, social, and political systems and practices. The goal is not necessarily to change the inequality, but *explain* it (Payne and Payne, 2004) and specifically to develop the skills, knowledge and capacities of the participants to use the results themselves. Whilst a work in progress with a complex history (Brydon-Miller *et al.*, 2003), the general understanding of action research, or what Gleeson (2000: 65) has termed 'enabling geography', is captured in Reason and Bradbury's (2001: 1) definition as:

'a participatory, democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes, grounded in a participatory worldview which we believe is emerging at this historical moment. It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and their communities'.

It is suggested here that in action research there is a necessity to respect the knowledge or participants and to further their skills through the process of research. Stemming from Oakley's (1981) focus on equality and sisterhood, it is considered unjust that in the realm of research, the 'subjects' of research are treated as external objects which can be examined and then excluded after relevant information had been extracted from them (see also Kesby's (2000b: 424). Developing Oakley's (1981) point, Valentine (2003) explains how

feminist geographers in particular, have been at the vanguard of questioning how knowledge is produced ethically which has promoted a move for researchers to work with, rather than on, research participants (for example, Moss, 2002; Rose, 1997; England, 1994). This research is feminist and post-structurally informed. Consequently, concerns for ethics provide the foundations of both an action research approach and of this research. It is reflective that there is not a separate 'ethics section' in this chapter, but a continuous reflection about the ethical implications of the methodological approach and the methods used. All formal ethical approval was obtained, both within the UK and Uganda. Paying continuous attention to the ethics of what was being done, and how it was being done, however, was a governing research tool of the action research in itself. Action research, however, challenges the claims of a positivistic view of knowledge which holds that in order to be credible, research must remain objective and value-free. Instead it takes the idea that knowledge is socially constructed and embedded within a system of values and promotes some model of human interaction (Brydon-Miller *et al.*, 2003). This then requires some contemplation and thus reflexivity of 'our place' in the world (Chouinard, 2000), how we approach a situation, and in turn, what we can do to alleviate it.

Yeung (2003:446) describes reflexivity as the 'capacity of the research practice to allow the researcher to reflect upon his/her own situatedness in the research process'. I was aware of the necessity to recognise that research is partial, positioned and constructed and a process in which, as researchers, we are positioned in relation to the data (Robertson, 2002; Rose, 1997; McDowell, 1992). Conducting feminist research, I was, however, situated as a female that could potentially dismantle prior knowledge that failed to take account of gender differences (Payne and Payne, 2004). I was also acutely aware of the necessity to reflect and respond to my changing positionality and blurring boundaries across the 18 months of fieldwork. Any reference to positionality further immediately invokes cultural assumptions about the potentially fluid hierarchy, power, competence and vulnerability in society (Christensen and Prout, 2002; Morrow and Richards, 1996). This not only create difficult ethical dilemmas, but ethical quandaries which change continually under the shifting power relations which are part of any research (Hemming, 2008) but particularly, when it is lengthy.

In summary, the methodological approach to this research is one of feminist, post-structural ethnographic investigation which both recognises and embraces the complexity of human beings in terms of both researcher and researched. There is a necessity to be ethical, produce sound research and to actively benefit human good, no matter how small. It is recognised that data are partial, positioned and constructed. Following Rose's (1997) point, there is also a necessity to continuously position ourselves in relation to the 'data' and research process in general. Due to the prolonged and 'embedded' nature of this research, that positionality changed frequently and thus requires careful consideration, as is explained in the next section.

4.3 Positionality in ethnographic research

The role of the positionality of the researcher needs to be considered in any research but particularly in research that is sensitive, prolonged and takes an ethnographic approach. The process of ethnography necessitates prolonged face-to-face contact between the ethnographer and the community of study through deep participant observation; it is a method that watches the community in action, listens to what they say, and participates in their lives (Schensul *et al.*, 1999). Whilst this approach relies on the assumption that it is actually possible to participate fully in the lives of the people being studied - which in itself is open to debate - without critical reflection there can be an inherent romanticism, or naivety about ethnographic research. The one ethnographic study that exists about the Bunyoro Kingdom written by Beattie in 1960, for example, is both colonial and highly idealised. As an ethnographic research tool, without some critical awareness, participant observation makes no sense; it is inherently contradictory. Participatory observation expects the researcher to perform the dual purpose of being both inside - that is the participation - and outside - that is the observation - of the social world of their host community (Wind, 2008). A researcher is supposed to totally emerge themselves in a different community to truly understand what is happening. They are also supposed to remain a researcher who maintains analytical and intellectual objectivity through distance. As Spradley (1980) explains, the ethnographer is then expected to simultaneously be an insider and an outsider. The very presence and subjectivity of the researcher can generate bias, not due to who she is, but by the very virtue of being there (Wind, 1998; see also Landstrom *et al.*, 2006; Wilkstron and Larsson, 2003; Costello, 2001). Furthermore, some researchers suggest ethnographic data is a creative exchange which is socially constructed as it mostly relies on complex interactions

between 'self' and 'other' both of which are spatially and temporally bound in a personal set of idioms (eg Dwyer, 1977; Crapanzano, 1977). It then follows that the personal background of the researcher becomes vital in both the ethnographic methods that collect data through participant observation, and the subsequent interpretation and use of that data and indeed the ethical capacity to do something about it (Valentine, 2003).

My personal background is as a health geographer. This, in itself, often caused question as many health officials asked me to justify how I was theoretically equipped to conduct this research. As Ward (2007) noted, publically describing oneself as a geographer is often a difficult task and being labelled as one is often open to crude lay understandings of what geography is about (see also McDowell, 1998). Indeed, at the presentation to the Ethics Board of the Institute of Public Health at Makerere University, despite applications for research permits for controlled trials of malarial drugs, research based on children's behaviours and restrictive sanctions of consumption in alcohol abuse, it was 'the geography presentation', as it became known, that attracted the most attention. I was able to explain the advantages of my nuanced viewpoint, as shown in section 4.3.1, but I was forced to consider my role within the research, particularly because I was the only white and female person within the room.

In the field, I was the only resident white person for a two hour drive in any direction. The main road through Nalweyo was occasionally used as a short cut in the rainy season towards Kyenjojo and then Kibaale National Park. The local people were used, therefore, to seeing *bzungu* or white people in huge 'overlander' vehicles or air conditioned 4x4s but had never really had the opportunity for engage. Unsurprisingly, when I first arrived, I attracted a lot of attention. As almost the local 'celebrity', or novelty (see Hughes, 1999), I was invited to people's homes, to parties, to weddings and to church, at which, as the white person I was expected to give a sizeable donation to proceedings. From the outset I endeavoured to learn community life. Puwar (1997) makes the point, that chatting is important for creating rapport and for gaining an insight. In Nalweyo I chatted, I carried, I cooked, I washed and I child minded. With bemusement, the community watched me struggle at the borehole for water every morning, cook (badly) over charcoal, endeavour to hand-wash my clothes and, in short, live a local life within the community. Whilst I worked hard to earn a position within the community, it is naive to say I could ever truly have 'a place' when I was so very

different. It was ethically important, however, to show I had some commitment to the community, to understand the toils of daily life and to offset the image of the white tourist sweeping through the village.

Soon the high profile invitations to formal weddings and parties were joined by invitations to the local market in Katekara on a Monday, and to do my washing (and gossip) with the ladies at the weekend. Within only a few weeks, I was invited to sit on the floor and eat supper from plastic dishes with my fingers rather than being given the fork saved for special guests. I became known as the '*mzungu musawo*' (white nurse) and was given my Munyoro *empaako* or 'pet name' of '*Abwooli*'. I found myself gossiping with the women about their 'men trouble' and local scandal whilst washing in the swamp, the same way in which I would with a girlfriend over coffee in *Starbucks*. I was particularly thrilled when I arrived for an important meeting as late as the DDHS indicating that we were both running on 'African time'. By virtue of being ethnographic, as much data was gleaned 'at home' as it was in the hospital ergo my neighbours were participants in the research as much as the nurses were. In terms of the 'ego trip into the exotic' (Frith 1984: xi), however, this romantic, idealised - and indeed, arrogant - picture requires a more critical discussion in terms of 'doing human good' and producing ethical yet useful research.

Feminist anthropology stresses the necessity to be acutely aware of the personal background of the fieldworker and the differences gender, age, looks and former experience may make when the fieldworker tries to find a suitable place and role in the field (Moore, 1988). My age and sex were simultaneously useful and a barrier (see also Skelton, 2001; Madge *et al.*, 1997; Staeheli and Lawson, 1994; Nast, 1994; McDowell, 1992). I was acutely aware of the fact that the very reasons for my 'fame' within the community and indeed initial access to it - the fact I was white, female, young, educated and relatively affluent - were the very same reasons that both alienated from the community and yet enabled my immersion within it. Hemming (2008) highlights the shifting power relations between researcher and research subject; arguably for the first month of the research I was the one being researched within the community. I was 23 when I arrived in the field which, by Munyoro standards is very old to not be married and to not have children; I was regularly asked 'what was wrong' with me. I was, however, young and clearly, to use McDowell's (1998:2138) expression, 'ignoramus' enough, for the local women's intrigue to develop into

what can probably only be described as pity. Lloyd, as cited in Scott *et al.*, (2006:36) echoes this point stating that being a 'young female student was often a barrier' yet enabled rapport with females who were an important part of the research network. My neighbours, Eva and Mamma Joshua, for example, bemusedly watched me struggle to light a *cegil* until they showed me the trick with a *caverra* (a plastic bag). As I brewed *chai* (tea) and chatted with my new friends it occurred that a Kampalan researcher may have found it harder to integrate within the community without the social distance, or 'ignoramity'. Indeed a frequent criticism of development workers was that whilst the young Kampalan men and women could speak the language, they did not understand rural life, and made no real attempt to. In this situation, as Herod, (1999:317) put it, 'my positionality as an 'outsider' was important in conducting the research', or at least enabling it to begin with.

In contrast, when I first met the District Director of Health Services (DDHS) I had to travel for two hours across the bush on the back of a motorbike. Windswept and bedraggled the DDHS looked me up and down and asked if I was the 'PhD researcher's assistant'. When I explained I *was* the PhD researcher, with a doubtful expression he took my research proposal and told me to return the following week. As I faced the two hour journey back and the first drops of rain fell, I was again reminded of my 'young, white femaleness' that was first highlighted at the ethics presentation to the IPH. Certainly being female enabled this research and provided access, not only to the formal, female space of the maternity ward, but to the female spaces of production, reproduction and community work (eg Graham, 1985; 1984; Blaxter, 1983) at home which was so vital to inform the data collection. It was the pity, same sex and similar age that endeared Mama Joshua and Eva to help me when I first reach Nalweyo and generated a friendship that in many ways 'validated' me within the community.

Finch's (1981) suggests that women researchers can work better with women because they share similar experiences. Whilst I was the same sex as the women both in Nalweyo and in the hospital which made me an 'insider' (Oakley, 1981), other similarities of our social identity were highly debatable. Bowes and Meehan Domoros (1996), for example, suggest the social identities of the researcher and how they relate to their subjects, should be of primary concern in terms of both the quality of the research and ethical considerations of it. Echoing this, Oakley (1982) gathered that interview rapport and minimal social distance was

more likely to develop when both the researched and the researcher shared the same ethnicity or some other identity aspect which allowed for identification and empathy between the interviewer and interviewee. Furthermore, Rhodes (1994) raises the issue of 'matching' researcher and researched in terms of categories of social position suggesting that shared experience makes for better research. It was even questionable whether we shared gendered attributes. In a mundane, yet highly representative example, whilst I wore traditional dress or a skirt around the village, outreach work with the hospital on motorbikes necessitated the wearing of trousers - which totally horrified Mama Joshua and Eva.

In the past such concerns about social distance have led to feminist researchers endeavouring to minimise differences in order to address ethical questions of privilege and power (Oakley, 1981). Rhodes (1994) and Bowes and Meehan Domoros (1996), however, argue that researchers can become too preoccupied with matching researcher and researched which runs the risk of marginalising certain types of research, making, for example, racism only a concern for racialised groups. Similarly, along with Gelsthorpe (1993), Bowes and Meehan Domoros (1996), suggest there is not an 'ideal' position to which researchers can aspire; they have to maintain a reflexive, critical evaluation of those circumstances and the way they influence their work. Valentine, (2003) develops these criticisms by suggesting that trying to minimise social difference echoes an essentialist approach because it uncritically attributes particular connections to physical attributes such as sex or race which obscures the diversity of experiences and viewpoints between and within particular social groups, and conflates 'difference' with power (Chouinard, 1997; Kobayashi, 1994). As Valentine (2003) goes on to explain, Rose (1997:313) points out that if power relations in the research relationship are conceptualised in this way, it means that the...

'...relationship between researcher and researched can only be mapped out in one of two ways: either as a relationship of difference, articulated through an objectifying distance; or as a relationship of sameness, understood the researcher and researched being in the same position'.

Whilst researchers can understand across 'differences' they can equally fail to connect across 'sameness' (Valentine, 2003). This then suggests that our positionings as researchers

and informants are never *a priori* apparent or defined, they are always mutually constituted through the relational context of the research process (Valentine, 2003; 2002).

4.3.1 *Blurring boundaries*

My concern, however, was not just about the relational context, *per se*, but how that relational context changed with the 'informants' - who, in some cases, were my friends and neighbours - across the many months of fieldwork. It is suggested here that the changing relationships of researchers and participants is neglected in academic research and that there is a necessity to ethically protect the researched, the research, and indeed, the researcher. There is a danger when using participant observation, for example, that by living and working so closely with participants the researcher becomes so embedded that the boundaries between 'research' and 'life' became blurred (see Yamba, 2005; Hastrup and Elsass, 1990). Not only is there a necessity to be aware of positionality as a researcher, but also how that positionality can change over time, potentially requiring a change in analytical distance and also demanding continual ethical reflection to protect both the researched, and the researcher.

I was very aware of the general necessity for reflexivity and particularly how, once I had 'found my feet' in Nalweyo, I had removed a barrier and potentially renegotiated my power within the research environment (see Christensen, 2004). For example, once I was no longer dependent on assistance to draw water, light the cegil *etcetera*, to a great extent I once again became a white, educated, relatively affluent, young woman, but one who could live a Nalweyo lifestyle. Half way through the research I was also aware that the permit I held from the Ugandan National Council for Science and Technology was for a somewhat different piece of research. Arguably, however, overcoming the hurdle of my 'differentness' had integrated me sufficiently into the community as a person in my own right. It was only on return to the UK in December 2006 for a brief period to upgrade my PhD, for example, that I was aware how close I had become to the research as the examiners made a bemused point that I spoke about 'we', and 'us', both in reference to the hospital and my home.

The irony, however, was that as I had become closer to the research and more comfortable within a field space that had become my home, my behaviour changed in a manner that, without critical reflection, was not necessarily beneficial to the research. I found, for

example, that my mindset had shifted from 'staying' within a community to 'living' with a community. Just before I left for the PhD upgrade, for example, I had invested in my 'home' and bought a paraffin lamp because I was struggling to write the notes, which were part of my daily (research) life, by candlelight. By local standard this was an extravagant expense which, ironically in my efforts to be more 'at home', actually reminded the community about a social distance they had become familiar with enough to forget (ignoring momentarily, the flight to the UK which, rather than divulging, I said I would be in Kampala, for exactly this fear). Hemming (2008) discusses the continually shifting power relations between research and research subject; at this point, as the researcher, I felt I had lost some 'power' in the research process as a whole by reasserting my potential power over the community who, vice versa, felt I was reminding them of my power through my disposable income. This stark self reflection of my positionality within the fieldsite demanded some critical contemplation of my field-notes. Notes from my first day at the hospital, for example, commented on the shabby paint work and that the patients were forced to drink out of old drugs containers to wash down *fancida* (malaria prophylaxis) at the antenatal clinic. Six months later 'we' could not buy paraffin to boil water for mothers to take tablets with. The drinking vessels and shabby paintwork became somewhat arbitrary.

As the boundaries blurred, I also had to be very careful to distinguish between 'gossip' and research. I learnt a lot about life in Kibaale from the perspective of a poor woman, for example, over a cup of tea or whilst doing washing in the swamp. If anybody ever suggested information should stay confidential it - of course - did, but invariably the conversation that stated with '*you mustn't tell anybody, but.....*' gleaned the most interesting information that could not be used in the research. At times the blurred boundaries also generated difficult medical situations. Many people saw me as the '*Mzungu Masow*' (White Nurse) and would come to my home asking for medical treatment, particularly about sensitive issues. The simple response was that I was not qualified medical personnel and could not assist. Highlighting the necessity 'to do something' in an ethical capacity, anthropologists have debated at length whether or not a researcher should intervene if they witness actions they consider violent, unfair or just wrong in any setting (see Parker, 2001; Goodwin *et al.*, 2003). Seeking advice, the Ethics Board at the Institute of Public Health told me to 'use my judgement' in these situations. 'My judgement' again, depended hugely on my changing positionality, particularly as I began to understand the community better. There were a number of times, however, when I intervened in haste, not as a researcher, but as a human

being. I was fortunate that these situations had no real repercussions but they highlighted the intensity of the fieldsite. There were times when I felt I needed to ethically protect myself from a difficult world in which I was totally immersed both 'at work' and 'at home'.

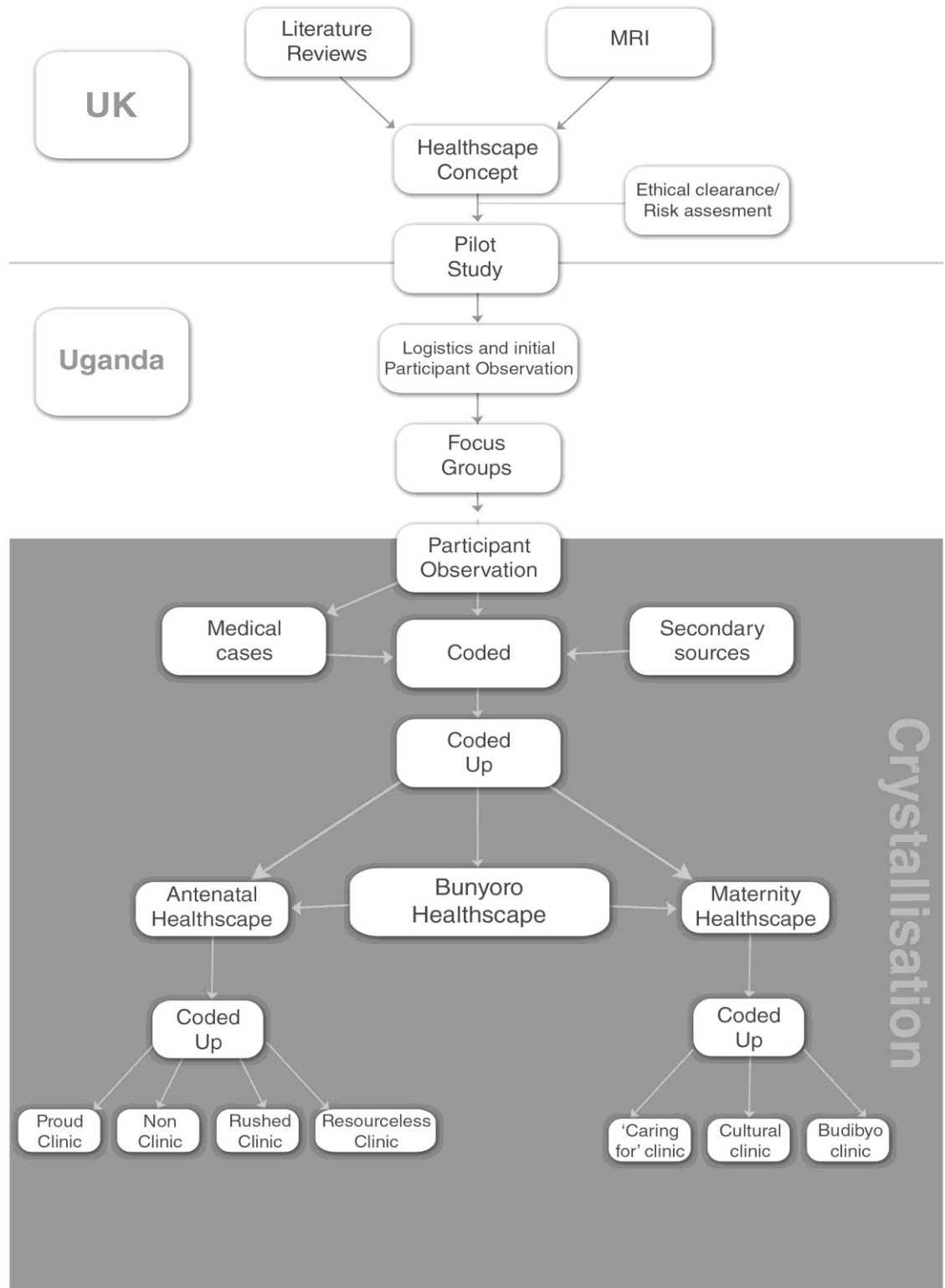
Aware of my changing positionality and the necessity to protect the research, the researched and the researcher, I endeavoured to instil some distance where possible; as Fuller (1999:221) put it, to 'go academic'. I deliberately travelled to Kampala one weekend every six weeks to discuss my notes with either my Ugandan supervisor, Dr. Freddie Ssenkooba or a good friend, Byaruhanga Michael. Both were useful 'grounding' sources of advice being Ugandan with a good working knowledge of the Ugandan health system but not the specificities of Bunyoro. I would also write summaries of research notes that I emailed to myself as Jennifer the researcher, not as *Abwooli* who lived in Nalweyo. It also helped me personally to have an occasional 'break' from the fieldsite. Far from ideal, the physical distance and change of scene helped, to some extent, to generate an analytical distance between home and hospital spaces and myself as a member of the community or *mzungu masaow* and researcher. The use of 'triangulation' – or more aptly 'crystallisation' which recognises that there are more than three sides to the constructed reality in which we live (Richardson, 1994 as discussed in Section 4.5.5) and encoding the results (see Section 4.6) also assisted to ensure the narrative remained as critical, plausible, reliable and accurate as possible. This is where, however, the continuously constructed relationships between researcher and participants perhaps has to be accepted as both inevitable and unavoidable (James, 2001) but also a crucial part of the research process.

Having discussed the methodological approach the next section will outline the methodological tools used to investigate the research aims outlined in Chapter 2.

4.4 Logistics and methodological techniques

Having considered the methodology and the approach of this research, the actual logistics and methodological techniques can now be discussed. A diagrammatical representation of the multi methods used in this research is presented in Figure 4.1.

Figure 4.1: The methods used in this research



4.4.1 *Preparations in the UK*

Whilst often seen as a 'tick box' exercise, the pre-fieldwork preparations in the UK were important methods in this research. At the beginning of the research I had little experience in a medical environment. In the first year of my PhD, therefore, whilst undergoing the appropriate research training and literature reviews I also voluntarily worked from 6am to 12.30 at the Manchester Royal Infirmary, four days a week, for six months, as a Domestic Assistant (DA). The role of a DA is to deliver breakfast, lunch and regular tea and coffee to patients and visitors. DAs are also responsible for the cleanliness of the wards, the ward kitchens, treatment rooms, bathrooms and toilet facilities and to dispose of any clinical waste. Technically DAs are glorified cleaners but arguably a vital part of the hospital system. This experience was the first introduction to the role informal medical staff play in healthcare transactions.

The purpose of working at the MRI was to become acclimatised to a hospital environment; to get use to the sounds, smells and the way institutions worked (see Pink, 2009), it was not to make a comparison between the two health systems. Referring back to the methodological approach of benefitting human good, or at least not hampering the situation, McIntosh (1977) and James (1984) discuss the inevitable feeling of awkwardness felt by a non-clinical researcher in a clinical setting and the possible risk of hampering medical procedures. This initial exposure to a medical environment indicated that a certain sense of awkwardness was both inevitable and acceptable. By disposing of contaminated clinical waste, cleaning the wards, cleaning up bodily fluids and cleaning MRSA infected rooms, I learnt the importance of following institutional procedure. Suggesting that acclimatising to a hospital was beneficial for the research is potentially contrary to points made in Chapter 2 about hospitals being reflective and reinforcing of broader social cultural norms and practices (e.g. Zaman, 2004). This suggests there is little I could learn from an inner city Manchester hospital that would be relevant to a rural Ugandan hospital. Again, the point was not to make a comparison between the health-systems. There are, however, institutional norms and practices, such as patient/healthcare provider hierarchies, the sick role of the patient, *etcetera*, that are indicative to institutions. As Hero and Talbot (2004) suggest, 'institutions shape the context in which actors make policy choices' so some initial

exposure to show how organisations influence structures, politics, values, to name but a few, was highly useful.

Experiencing dead bodies, injuries, blood and grief was also good personal preparation for the field. In any research, ethical concerns should be foremost of the agenda to protect the participants, the research (Dunne *et al.*, 1997; Fenton, *et al.*, 2001b) - but also the researcher (Skinner, 1998; Brannan, 1988). Protecting the researcher also protects the research and the resultant contribution to knowledge. As Long, *et al.*, (2008; 72) explain, hospitals are 'places of intensity, of life and death drama' which affect all concerned. Das (1985: 5-6) contemplates traumatic moments in field work and how sometimes, from an ethical perspective, 'society seems to take control of the researcher' and that some situations are so intense that they result in 'abdicating...the responsibility to provide an intellectual understanding of it'. Initial fieldwork preparations in the MRI - albeit only making tea and cleaning toilets – provided early exposure to ethical dilemmas.

4.4.2 Preparations in Uganda

My links with Uganda stem from being part of a (now defunct) DFID funded research group, Health Systems Development (HSD), through which I met Dr. Freddie Ssenooba who became my Ugandan supervisor. It was Freddie who 'introduced' me formally to the IPH which permitted me to just apply to present to the Ethics Board. I travelled to the Bunyoro Kingdom in March 2006, actually to visit an NGO I had become aware of through a colleague at University, unrelated to the research. The potential of the fieldsite became immediately apparent (see Chapter 3 for the history and background) as it was part of a decentralised health system in a chronically poor area that had a high HIV rate and a struggling local health infrastructure. Kibaale also had a high level of tribal conflict and a prolific local or traditional healing system. Undeniably there was an element of opportunistic 'luck' but, as McDowell (1998:2135) described it:

'Somehow you have to get out there, and although we often, in writing up our results, talk blandly of our samples or our case studies, letting the reader assume that the particular industry, location, site and respondents were the optimal or ideal for investigating the particular issue in which we were interested, we all know that the 'reality – if I can use that old modernist term – is a lot messier. A great deal depends in

luck and chance, connections and networks, and the particular circumstances at the time.'

Being part of the NGO also meant I had some connections on the local area in an otherwise very alien environment; it was a member of NGO, for example who both found me somewhere to live and negotiated a long term rent that was not based on *mzungu price* (the usual inflation for a white person). During what became the pilot study I was able to meet key individuals such as Samuel Enock, the In Charge of Kakindo HCIV and Dr. Dan Kwamywe, the DDHS.

In April 2006, I moved to Uganda and spent the first few weeks setting up the research. I applied for ethical clearance from the Institute of Public Health which enabled me to apply for a researcher's permit from the Ugandan National Council of Science and Technology and then a researcher's visa. I then travelled up to Nalweyo where I commuted daily to Kakindo HCIV, on foot, for a further 17 months. The decision to live in Nalweyo was, in part, due to availability of housing. It was also influenced by a preference to commute and at least have some distance between 'home' and 'hospital'. There was a public transport system which was sporadic and unreliable which I used whenever possible; useful discussions could often be instigated when crammed into vehicles. The daily commute on foot actually proved invaluable time to think through the happenings of the day, particularly if they had been distressing, and to reassert the 'researcher's approach'. Being on foot and thus able to stop and talk to people also broke down the barriers - social and physical - that driving would have generated. Beattie (1960) laments the value of having a vehicle to integrate into society in his ethnographic study of Bunyoro but in this setting it was more advantageous to engage with local means of transportation.

I also spent a week setting up the research itself. I travelled to the administrative centre to meet 'Dr. Dan' the DDHS who, as explained, told me to return in a week. Having read the proposal he recognised the research's potential to benefit the District and was subsequently forthcoming with his assistance. Based on advice from the Ethics Boards, the DDHS and I agreed that the nurses should know the purpose of the research. During my first visit to the hospital the In Charge called all the nurses to meet me, I explained the purpose of the research and gave them each a paper copy of the research proposal. The DDHS felt it was

unnecessary to obtain written permission from the nurses to engage in the research but it was the nurses should be given the opportunity to leave the research at any time they wished; none of the nurses opted out. Landstrom *et al.*, (2006) and Wilkstrom and Larsson, (2003) amongst many others, highlight how the presence of the researcher can dramatically affect the fieldsite by altering the behaviour of the people involved. As in Nalweyo, initially I was a novelty visitor in the hospital and a source of intrigue for the nurses. I worked hard within the hospital and for long enough for the nurses to get used to me. In the interest of ethics, I continuously reminded them that I was conducting research. I also ensured the nurses that I would protect their identities 'as far as possible'. Whilst in the research I refer to them by the generic term 'nurses', in such a small hospital it was difficult to protect their identity. Due to the working dynamics of the hospital in which there were no clear demarcations of roles, it was rare that any 'coded' results would pinpoint an individual.

4.4.3 Hospital ethnography

As earlier explained, an ethnographic approach necessitates prolonged face-to-face contact between the ethnographer and the community of study; it is a methodology that watches the community in action, listens to what they say and participates in their lives (Schensul *et al.*, 1999). Fieldwork and participant observation are the hallmark, or tools of ethnographic research (Wind, 2008; see also Shweder, 1996). Ethnographic participant observation is also a tool with which to understand the links between what happens locally and regional, national, and global events, policies and political and economic structures. As Den Hollander (1967), and Clifford (1980), put it, ethnographic data is far from 'mere' description. Notwithstanding the criticisms outlined in Section 4.3, Kaplan (1964) suggests ethnographers can use research in local settings to generate local substantive or mid range theories of culture (Maerton, 1967; Pelto and Pelto, 1878; Trotter and Schensul, 1998) that can be tested through research and intervention in other local sites or in other locations globally.

As has been discussed, in general, hospitals are 'places of intensity, of life and death drama' (Long, *et al.*, 2008; 72); no less so when they are the fieldsite. The previous shortage of literature about life in hospitals is blamed on their inaccessibility, in itself highlighting a difficulty. Long *et al.*, (2008) describe anthropological investigation as a relationship

between researcher and site of interest. Any relationship needs to be of mutual interest, and indeed benefit, in order to succeed. As highly structured and exclusive/excluding institutional spaces (Foucault, 1975), hospitals were initially inaccessible to ethnographic enquiry. Long *et al.*, (2008: 71) explain how barriers arise when an anthropologist attempts to access a hospital or clinic space to the extent that access cannot be taken for granted, and that the relationship often 'requires much sensitive nurturing' (Long *et al.*, 2008; 71). Van der Geest and Finkler (2004) furthermore suggest that in effort to stay 'natural' in a hospital a researcher basically has three choices: joining the staff, the patients or the visitors. Generally, researchers choose the role of the doctor or nurse and may put on a white coat and be regarded by patients as 'one of them' (e.g. Kuckert, 2001; Pool, 2000; The 1999; Frisby, 1998). Caudill (1958) took this a step further and investigated a hospital with true participant observation, as a 'disguised' mental patient and Rosenham (1973) described the accounts of eight researchers admitted for false insanity. Most famously Sarkodie became a fake patient in a Ghanaian hospital (Van der Geest and Sarkodie, 1998). The role of a visitor is limited due to restricted visiting hours. A more feasible role is that of a researcher. Whilst in the necessity 'to do something', I endeavoured to help as much as possible. Despite being known as the *mzungu masaow*, I endeavoured to maintain the role of 'a researcher'. There were numerous times, however, when this led to feelings of awkwardness and of sheer inadequacy, when I felt I did little more than get in the way, ask dumb questions and 'hang around' (McIntosh, 1997; James; 1984; van Maanen, 1982).

Despite the inevitable feeling of getting in the way, I maintained the role of a researcher and used MCH as a probe to understand the health system. This research is based on the premise that improving MCH is an international priority and one that reflects mass inequality and is thus detrimental to development. In theory, MCH services are dependent on many different aspects of the health system functioning. Consequently, using MCH as a probe is useful to understand how the health systems as a whole are functioning and serving the interests of the poor (Parkhurst *et al.*, 2005). As will be discussed in subsequent chapters, it quickly became apparent that MCH at Kakindo HCIV was largely composed of antenatal and to a much lesser extent, maternity services. Antenatal was certainly the busiest clinic and was ordinarily short-staffed; it was also where I could be 'useful' through record keeping. A total of ten Out Patients' Clinics were observed in total, particularly if that clinic was short staffed and required additional records assistance. I less regularly entered

the General Ward largely because it was rare for patients to be admitted. Chapter 6 and 7 will explain *why* this was.

Days in the hospital were long. I had to leave Nalweyo by 6.30am in effort to catch a vehicle or in time to walk the 8Km to arrive before clinic was scheduled to start. Ordinarily I arrived much earlier than the nurses. The wait provided a good opportunity to jot down observations about the hospital and the arriving clients. We then worked until 2pm regularly, as Chapters 6 and 7 will explain, under rushed and stressful conditions. I often then discussed with the nurses and greeted friends in Kakindo trading centre before starting the 8Km walk home to then light the cegil to prepare food. As Welch *et al.*, (2002) note, often the most interesting events or conversations happened when I had no mechanism to record them. I learnt to keep a scrap of paper on my person at all times on which I jotted down words to act as an *aid memoir*. This also served to record direct quotes. It became important, however, no matter how tired I was by the end of the day, to write up findings, thoughts and observations as soon as possible (see McDowell, 1998; Richards, 1996). For the 'fee' of a soda, a friendly Kakindo shop keeper used to let me write up my notes in his shop before walking home.

I spent approximately 18 months in Uganda (excluding the two weeks spent in the UK upgrading the PhD). I felt it would require at least 12 to begin to understand the fieldsite (see Hammersley, 1998); indeed a personal criticism of ethnography amongst current researchers is that of the time spent 'in the field' little is spent actually within the community of study. I made return trips to Kakindo in June 2008 and June 2009, each time only for two to three weeks. As the analysis developed, agreeing with McDowell (1998:2138), I 'longed to be able to ask some of the early questions again' and indeed, add a few additions. After the final trip, however, it became apparent that I needed to stop the data collection, which as Evans-Pritchard (1973) suggests, is always a difficult decision in anthropologically informed research.

4.4.4 Focus groups

Many researchers investigating sensitive issues have utilised focus group methodologies. A focus group is a small group discussion on a particular topic facilitated by the researcher. As Barber and Kitzinger, (1999) suggest, focus groups are not just a means to interview several

people at one time. Focus groups are a group discussion aiming to explore the formation and negotiation of accounts within a group context. They have proven particularly effective when one on one interviews are difficult, for example, due to a significant social distance between the researcher and the researched. Focus groups might seem an usual methodological choice for eliciting information about such sensitive, or potentially private behaviours (Wellings *et al.*, 2000) but they have proved successful in the past. Kitzinger (1990), for example, successfully utilised focus groups to study the role of the media in audience understandings of 'African AIDS' (Britten *et al.*, 1995; see also Branigan *et al.*, 1997; Mitchell and Wellings, 1998). Focus groups can create a milieu in which social relations are forged - based on the position of the researcher - and processes of discussion can be initiated which are similar to those experienced in everyday settings (Graham, 1983). It is important that they are not nominal groups in which participants are technically interviewed individually (see Stewart and Shamdasani, 1990). Often a group dynamic enables the research to establish whether there is a consensus view and to gently direct the conversation on the basis of reactions and interpretations, especially if discussing sensitive or contentious issues.

In this research a total of nine focus groups were conducted, one in each of the parishes which fell within the direct hinterland of Kakindo HCIV as shown in Table 4.1.

Table 4.1: Details of the nine formal focus groups conducted

No.	Location	Month (2006)	Size of group	Code
1.	Kirimasasa	April	8	FG1
2.	Nalweyo	April	7	FG2
3.	Katekara	May	10	FG3
4.	Kikoko	June	8	FG4
5.	Mukono	April	8	FG5
6.	Burroko	May	6	FG6
7.	Kakindo	April	9	FG7
8.	Igayaza	May	8	FG8
9.	Kikwaya	May	3	FG9

The focus groups were conducted after some preliminary observations at the hospital so I had some idea of the services available, but within the first three months of the fieldwork. These focus groups were deliberately conducted early in the research in order to ascertain a general picture of the women's perceptions and expectations of both Kakindo HCIV and their health seeking behaviour. Women spoke about accessing maternity and antenatal services at Kakindo HCIV but also discussed their health in general such as their efforts to maintain their families' health and the different health options available. Technically 'informal focus groups' were also conducted in the maternity ward through steered discussions as shown in Figure 4.2 below. Ethically the purpose of the discussion was always made clear to the participants. Note the assembled crowd included women who had gathered for photographic purposes.

Figure 4.2: An informal focus group in the maternity ward



Source: Personal fieldwork photos, kindly taken by Ankwanasa Gadi.

As the formal focus groups were conducted early within the research, an 'interpreter' (rather than a translator, see Temple, 2002) was used. Whilst there are many pitfalls in using translators in research (see, for example, Temple, 1997, 1998; Edwards, 1998) I had little option at this stage of the research when I was so unfamiliar with the language. A large body of literature discusses the influence of the researcher's gender and social class, as well as other social characteristics, on the research process (Temple, 2002; Alibhai-Brown, 2000; Mahoney and Zmroczek, 1997). My 'interpreter' was a local man who worked for the NGO. Whilst it is perhaps unusual to choose a man to act in this role, reflective of the gendered nature of development, I was unable to find a woman who spoke both Runyoro and Rkaiga and fluent English. The NGO worker, however, was a key member of

the community who had grown up locally. He knew the difficulties the women faced and had a good general grounding in development issues. In each focus group some women knew him which put the others at ease. We also had a good rapport and I had briefed him thoroughly about the nature of the research and the healthscape concept. I had to rely on him to facilitate the discussion but asked him to translate regularly and run questions past me. I did not record these discussions but, with the participants consent, at times made scribbled and as unobtrusive as possible notes that I elaborated on after the focus groups. My interpreter and I also sat together for at least an hour after each focus group and an hour again after I had written up the notes to ensure there were no misunderstandings on my part and to begin to tease out analytical themes. Rather than being analysed directly these notes were used as a foundation to the observations within the hospital and to unpack the broader societal context in which the hospital was set (see Fig. 4.1). The NGO worker also served as a really helpful 'sounding board' and source of encouragement throughout the research.

The NGO worker was also instrumental in recruiting participants by spreading the word amongst local leaders including local preachers who announced the focus groups, in the vernacular language, after church. The focus groups took place in the respective trading centres, ordinarily in the community hall. I compensated the women for their time with sugar and soap. Such gifts seemed more appropriate than giving money (see Scott *et al.*, 2006: 39) and were highly appreciated. The NGO worker was paid directly for his time.

The NGO worker also gave me formal instruction in *Runyoro*. Undoubtedly language plays an important part in research practice (Hunt and Bhopal, 2003). It was not possible to learn Runyoro before I left for the field. By the end of the fieldwork, however, whilst I was far from fluent in the complex Bantu language, I had a good spoken vocabulary and could translate the majority of what was being said. A few of my neighbours spoke English and would assist with translation and I received formal lessons from an elder community member. The nurses were fluent in English and hoped the research would improve their working lives so were happy to discuss or translate anything I could not understand; their literal translations were often startlingly frank. The NGO workers also aided as a 'cultural guide' (Hennings *et al.*, 1996) ensuring that I was 'on track' with my interpretations.

4.4.5 Triangulation and 'Crystallisation'

Triangulation - or using several methods to offer complementary measures of concepts to yield a more rounded and accurate set of results (Payne and Payne, 2004: 230) - arose in response to criticism of qualitative approaches from positivist researchers, particularly the charge that such approaches lack appropriate validity (Hemming, 2008; Blaikie, 2000). Within this research 'triangulation' was used, not in the traditional primary qualitative and quantitative approach, but by cross referencing findings with appropriate statistics, policy documents, media sources, theory and indeed by talking to people. Drawing on a number of sources, therefore, endeavoured to ensure that the narrative remained as critical, plausible, reliable and accurate as possible (see May, 2006; Valentine, 2001; Crang, 2002; Hughes, 1999; Sporton, 1999). It is important to recognise, however, that as a constructivist perspective embraces the constructed nature of reality, any employment of mixed methods can only ever produce a partial view of the research topic (Hemming, 2008). Moving beyond just three views of the world, Richardson (1994) suggests the use of the term 'crystallisation' to recognise the multi faceted nature of the world. As Darbyshire *et al.*, (2005) agreed that mixing methods produces a deeper and more complex view of the issue under investigation. Certainly the combination of participant observation, focus groups, discussions, statistics, policy documents and media sources used in this research produced a very rich set of data.

4.4.6 Data preparation and analysis

In preparing the data for analysis, key governing principles of a grounded theory approach were used. These included the necessity to step back and critically analyse the situation, to think abstractly, to recognise the tendency towards bias and to display sensitivity to the words and actions of respondents. The research sought to build systematic theoretical statements inductively from coding and analysing observational data and to develop and refine conceptual categories, (Payne and Payne, 2004: 98; Strauss and Corbin, 1998: 12). Whilst the analysis was grounded in post-structural feminist theory, the method of analysis was not a grounded theory approach, *per se*.

All data was typed up from the original hand written sources. Painstakingly, every single piece of data was given a code that was unique but identifiable. Codes differed, therefore,

for general fieldnotes, personal communications, focus groups and clinical cases. These codes were listed in a code book, examples of which are shown in Tables 4.2a and 4.2b. Details of the field-notes, personal communications and medical cases used in this research are available in Appendix 1-4. Appendix 5 shows a page of ‘fieldnotes’ which also included personal communications and details from policy documents. The lengthy annotations show the first part of the data preparation.

Table 4.2a: Example of the unique codes given to antenatal cases

No.	Code	Date	Place	Description
1	ANCCASE 1	March 06	Kakindo HCIV	Patient with kidney infection diagnosed as UTI
2	ANCCASE 2	June 06	Kakindo HCIV	Patient not disclosing she had taken quinine
3	ANCCASE 3	July 06	Kakindo HCIV	N forcing woman to hold sample that wasn't hers

Table 4.2b: Example of the coding given to general fieldnotes.

Tally	Code	Date	Place	Description
7	FN7	April 06	Kakindo HCIV	Banging through medical cases
8	FN8	April 06	Kakindo HCIV	No drugs at dispensary
9	FN9	April 06	Kakindo HCIV	No staff
10	FN10	April 06	Kakindo HCIV	Routine care delivery, boring
11	FN11	April 06	Kakindo HCIV	Couldn't open door to lab

At this stage the data were also ‘cleaned’ (Kumar, 2005) to discard or double check any missing, incorrect or incomplete data. There were opportunities for clarification on the subsequent trips to Uganda (June 2008, July 2009) but data had to be discarded. There were some maternity cases, for example, that I did not see from admission to delivery. Ordinarily this was because labour is a long, unpredictable process and either my shift ended or I was busy in the antenatal clinic at the time. As these data were incomplete, they were discarded.

Each of the data collected from the antenatal ward, the maternity ward and life in Bunyoro in general were taken in turn and the content analysed. Meaningful words, sentences and phrases were listed under the data's unique code in an Excel spreadsheet. This was done ‘by hand’ rather than using an analytical computer package. Despite being very time consuming, this was mainly because with such a huge volume of data stretching over nearly

two years it served as a useful re-familiarisation exercise and ensured the analysis was theory driven. Through this process I also became familiar with the code book and could tease out more subtle cross-cutting themes. Potential bias has to be acknowledged. Whilst some of the bias may have been counteracted by the time spent in the field and the coding process was conducted on a number of occasions over several days (Fielding, 2001), some bias is inevitable in any research (McDowell and Sharp, 1999). Each new meaningful phrase was added as a new 'column' to the code book. If the phrase was repeated by new data, the data's code was recorded under the established column (see Kumar, 2005). Once all the content of all the data had been sorted through, these were grouped together, or coded up, into broad MCH themes in relation to healthcare delivery. Firstly a coding frame was developed based on the data that described the broader Bunyoro setting (see Fielding, 2001). Much data, for example, explicitly discussed matters of gender or kinship. These broader societal factors composed the space of Bunyoro through which the women had to charter a path to achieve the goal of accessing MCH from Kakindo HCIV.

As Table 4.3 shows, the original coding frame was then coded up again within the Bunyoro frame to analyse the two different health places of the maternity and antenatal wards. Within these places the data collected generated quite clear informal spaces that were constructed through the women's behaviour, discourse, opinions and coping strategies. As Figure 4.1 shows, in the antenatal ward the informal spaces of the *proud clinic*, the *non-clinic*, the *rushed clinic* and the *resource-less clinic* were constructed via place-based authoritative knowledge in the institutional space. The data also showed that whilst place-based authoritative knowledge enabled the construction of the informal spaces the knowledge did not always influence the health transaction in a positive manner.

In the maternity ward the double coded-up data revealed informal spaces based on issues of *culture*, *caring for*, and *'budibyo'*. A slight difference in data, however, has to be explained. As a result of the nature of childbirth, deliveries could not be predicted and happened at sporadic times, often at night. Furthermore, highlighting the necessity of the research, few women presented to deliver at Kakindo HCIV. Whilst a total of 32 deliveries were witnessed during the course of the fieldwork, eight were seen in full from the point of admission to the point of inoculation of the neonate. Therefore, the places of maternal health constructed within the maternity healthscape are based on these eight cases plus

broader observations, focus groups and personal communications. The eight cases were extreme but illustrative of some important issues. They were also reflective of the broader socio-cultural aspects of childbirth in Bunyoro, as the subsequent chapters will explain. This additionally adds further justification to this research.

Table 4.3: Extract from the coding frame illustrating the double – coded themes

Theme	Codes		
The Cultural healthscape			
Patient's lack of medical understanding	MC3/P	MC2/IA	MC6/SB
Inability to share information/communication	MC1/CP	MC8/BB	MC9/MaI
Difficulty in referral	MC1/CP	MC2/IA	MC8/BB
Normalness of death	MC3/P	MC8/BB	MC6/SB
Normalness of medical issues (rep of culture)	MC1/CP	MC2/IA	MC3/P
Woman's duty to reproduce	MC2/IA	MC3/P	MC6/SB
Local healing	MC4/LH	MC5/STI	MC6/SB
Home treatment/ownership over health	MC2/IA	MC4/LH	MC5/STI
Gender dynamics	MC5/STI	MC6/SB	MC8/BB
Vulnerability	FN16	MC6/SB	MC5/STI
The Caring for healthscape			
Lack of questions by doc	MC1/CP	MC12/VCT	MC14/BW
Appropriate roles	MC3/P	MC6/SB	MC8/BB
Lack of privacy/performance of medical marvel	MC3/P	MC6/SB	MC8/BB
Difficult patients	MC1/CP	MC3/P	MC4/LH
Delaying to present to clinic	MC1/CP	MC4/LH	MC9/MaI
Speed of consultation	MC2/IA	FN17	Per. com3
Lack of kit at hospital	MC3/P	MC6/SB	MC7/lab
Not bringing right kit to hospital	MC3/P	MC6/SB	Per.com4
Purpose of vehicle	MC3/P	MC8/BB	Per.com9

Potential bias also has to be recognised through the use of ethnographic methodology which, as discussed, requires immersion in the field. This analysis was, however, conducted back in the UK, in part due to limitations of time and power in the field, but also to 'step back' and critically analyse the field-notes. The two subsequent visits to the field in June 2008 and June 2009 were used to discuss the analysis with my Ugandan supervisor and the nurses in effort to test or 'validate' the ideas.

4.5 Contribution to the field

Having lamenting the ethical necessity for a researcher to not only do harm, but tangibly benefit the communities in which they work, it is only right to explicitly outline my contribution. The In Charge of Kakindo HCIV asked me to advise the nurses about their medical practice during the research. As I was not a qualified practitioner, I was not equipped to do this. Arrangements will be made, however, to share the results of this research to the nurses via the DDHS. Since the fieldwork, the Health Sector Strategic Plan III (2010) has been released which calls, explicitly, for an analysis of health and healthcare practice from a more social perspective highlighting the potential value of this research. I have also offered to share the results of the research to the participants of the focus groups and clients and patients at the hospital via the LC system (see Chapter 3) and community meetings. Possible policy recommendations are made in Chapter 8.

By virtue of the ethnographic nature of the research, I went out of my way to assist friends and neighbours to develop their personal skills, knowledges and capabilities and respected their position as 'knowers' (Kesby, 2000b), not least in their assistance to my research. I helped women with advice about family planning, we wrote HIV educational packages for International HIV and AIDS day (2006) and I taught skills in book keeping, English and functional adult literacy. I also worked with the NGO to strategically develop their capacity through tangible skills and coordinating relief fieldwork.

4.6 Conclusion

The methodological approach of this research was one of post-structural feminist investigation which both recognises and embraces the intricacy of human beings - both the researched and researcher. Such complexity required contemplation of the 'hows' and 'whys' of research. In the challenge of the existence of essential truths, it is suggested that being both a scientist and a human, and appreciating the caring and the curing, produces a nuanced insight to the complexity of appropriate healthcare delivery.

This research was lengthy and ethically bound. It also recognised the necessity to actively 'do human good' via a feminist ethic of care to inequality (Lawson, 2009). Such an approach requires that ethically, research not only does not harm, but actively benefits its participants

by increasing their skills, knowledges and capabilities through the process of research. Whilst it was more difficult to increase the skills of the nurses in the data collection, by virtue of the ethnographic methodology, every effort was made to develop the skills and knowledges of the community through this research. Some possible policy suggestions are made in Chapter 8. The formal results will also be shared with both the appropriate professionals and the participating community, particularly in light of the new HSSP III's (2010) focus on the social orientation of health-systems.

Being so ethically bound this research also required considerable and *continuous* reflection of positionality. It was highly appreciated that the same, potentially unethical positionality of being a white, relatively affluent academic permitted access to a community in which I became both celebrity and, to use McDowell's (1999) phrase, 'ignoramus'. Whilst being ignorant inspired initial pity that broke down some of the social distance as the local women showed me how to survive in Nalweyo, once I found my feet by virtue of my very comfort through embedded participation, my social distance was once again highlighted. In turn, it could be argued that such immersion (at least as far as possible) into a community - which was the objective of ethnographic research - actually reduced the analytical distance which could question the validity of some of the data. In effort to overcome this, frequent critical self reflection was enforced over both the researcher and the data.

Some potential bias will have been overcome in the analysis process which, whilst not adopting a grounded theory approach, *per se*, did use the same principles of stepping back and identifying potential for bias (Payne and Payne, 2004). After all the 'crystallised' (Richardson, 1994) data sources were given a unique code, the data was coded and then coded up into the three healthscapes of Bunyoro, Antenatal and Maternity. The antenatal and maternity data was then coded again to reveal the conceived informal spaces within each hospital environment in which the women altered their behaviour in order to potentially utilise their authoritative knowledge to mitigate the healthcare transaction.

Having revealed the *hows* and the *whys* of the research, the *whats* can now be contemplated. From the perspective of Kakindo HCIV there were three clear places of MCH health that were coded up from the data. These were the maternity ward, the antenatal ward and the broader contextual setting of Bunyoro Chapter 5 will explain the broader

societal factors through which women chartered their health-seeking path to reach the formal place of health but in which were constructed a number of informal spaces of health. Chapter 6 and Chapter 7 will then explain this curious MCH health-seeking anomaly using the healthscape concept.

Chapter 5: Spaces of health in Bunyoro

'The cultural definition of the individual's place in society, and of the human body and its parts is inseparable from healing practices. To define dangerous behaviour and to define evil is to define some causes of illness. As the definition of evil changes, so does the interpretation of illness. To understand change in healing, we must understand what it is that leads people to alter the definition of dangerous social behaviour'

Feierman and Janzen, (1992: 1)

'Biomedicine, and the hospital as its foremost institution, is a domain where the core values and beliefs of a culture come into view'

Van der Geest and Finkler, (2004: 1996)

5.1 Introduction

This research suggests the healthscape concept, as shown in Figure 2.1, could be used as a conceptual tool to understand how place-based authoritative knowledge could be used to influence healthcare transactions. Agreeing with Van der Geest and Finkler's (2004: 1996) quote above, the hospital serves as a good site through which to view the core values and beliefs of a culture. Using data collected within Kakindo HCIV, this research will address the specific research questions outlined in Section 2.6 and use the healthscape concept to unpack the realities of delivering high quality, pro-poor MCH care in the chronically poor rural district of Kibaale, mid-western Uganda.

The coded data revealed three key places of MCH; the Antenatal Ward (ANC), the Maternity Ward (MW) and the broader societal context of Bugangaizi itself which contained the formal place of health and in which were constructed numerous informal spaces of health. Chapter 1 outlines the benefits to mother and baby of a woman accessing a continuum of maternal child healthcare from a formal medical facility. Whilst approximately 65 women a week registered for antenatal treatment in contrast, on average only 10 women a week delivered

their babies in the maternity ward of Kakindo HCIV. As Figure 2.1 depicts, the broader societal factors of the Bunyoro Kingdom constructed a difficult health 'terrain' that women of Bugangaizi had to negotiate to achieve their health aims. The data suggested that women were willing to traverse this terrain to access antenatal care but the data suggested that fewer women were prepared to access maternal care. In order to unpack the reality of delivering highly quality, pro-poor health in Bugangaizi, the difference in this health-seeking behaviour needs to be understood.

In the first of three empirical chapters, this chapter will unpack the broader societal factors that informed a Bunyoro woman's health path. These societal factors also generated the terrain through which a woman had to carve a route to access MCH from Kakindo HCIV. Within that terrain a number of informal places of health were constructed in spaces such as the borehole and the market-place which informed individuals' health understanding and thus health seeking behaviour. Section 5.2 will discuss the broader demographics of health in Bugangaizi in relation to the rest of Uganda to highlight the overall pressures on the strained health-system. Section 5.3 will answer critiques from Hickey (2005) about policy considerations of the 'homogenous poor' and discuss the broad differences between two key groups of health-seekers in Bugangaizi. Section 5.4 will examine the interlinked societal factors in turn. The anticipated norms of health in Bugangaizi for both groups of women will be discussed. Then the impacts and influences of the broader societal expectations of gender, culture and kinship in relation to accessing healthcare from the biomedical facility will be unpacked. It will also be considered how these societal factors could present barriers - physical and social - to accessing formal healthcare. Section 5.5 will consider the healthcare seeking behaviour in Bugangaizi.

As Chapters 1 and 2 explained, the ideal continuum of care is for a woman to receive antenatal, maternity and postnatal care from a formal biomedical facility. As Chapter 5 discussed, however, whilst women were willing to make the considerable effort to access antenatal care from Kakindo HCIV, they were clearly receiving maternity care from other places. The health-seeking path thus deviated from the ideal institutional route after accessing antenatal care. Whilst Chapter 7 will unpack the rationale behind this behaviour, Section 5.5 will consider the other health facilities available to women such as traditional birth attendants, witch doctors and bone setters. Section 5.6 will then contemplate the

formal place of health that is Kakindo HCIV and the MCH services that were available there before Chapter 6 focuses on the antenatal ward.

There is also the need for a brief re-clarification of geography. As Chapter 3 explained, the Bunyoro Kingdom is composed of three districts, Hoima, Masindi and Kibaale. Within Kibaale, Bugangaizi encompassed the counties of Nalweyo, Kakindo, Kasamoya, Nkooko and Kukimiro. In theory, Kakindo HCIV served all of these counties but due to distance, patients largely originated from Kakindo and Nalweyo sub-counties. 'Bugangaizi', therefore, will be used throughout this Chapter to refer to people largely from Kakindo and Nalweyo which are part of the Bunyoro Kingdom.

5.2 Health in Bugangaizi

Following the launch of National Health Sector Strategic Plan I (HSSP I), Uganda witnessed some overall improvement in healthcare services (WVAR, 2006). As Chapter 3 explained however, whilst health statistics suggested that overall Uganda's health had improved development was far from uniform across all the districts of Uganda. Despite the efforts of the health sector and marked improvement at a national level, the delivery of the Minimum Health Care Package at the *community* level remained limited. Whilst demands on the health sector increased, inequalities were exacerbated across and within districts of Uganda, particularly in rural areas.

As one of the many dimensions of chronic poverty, poor health was omnipresent in the villages of the Bunyoro Kingdom. Along with discussions about crops and the weather, almost every conversation discussed who had died, or who was 'sick'. One local councillor was famous for booking meetings, often months in advance, with the caveat of 'if he was well enough, God willing' (pers. comm. 154, February 07). Whilst some of the negative accolade of 'The Black Hole of Uganda' can be attributed to a colonial legacy at the point of fieldwork the Bunyoro Kingdom had a low standard of living. There was limited sanitation and water, poor quality infrastructure, low standards of education and, as will be discussed, a struggling health-system. Numerous development workers spoke of their frustration about failed initiatives in the Bunyoro Kingdom (pers. comm. 79 June 06; pers. comm. 128 September 06). The World Vision Assessment Report for Nalweyo-Kiisita (WVAR) (2006:38), for example, discussed the 'threats' to development initiatives in Bugangaizi which referred

directly to specific characteristics of the tribes, such as 'selfishness and egocentrism of members', 'mismanagement of funds' and 'women subordination'. These threats were enhanced under the decentralised system which was controlled by an elite few.

The District Director of Health Services (DDHS) for Kibaale recognised the serious challenges the district faced in delivering a high quality health service, not least due to the severe lack of medical supplies and drugs which was not aided by the road infrastructure. Over 60% of the population of Kibaale had to walk a minimum of five kilometres to the health centre, compared to the Ugandan average of 52% (MoH, 2006). The DDHS suggested, however, that a greater problem was the shortage of trained staff which had led to poor service delivery. The high volume of patients heightened this situation with the long hours and difficult circumstances resulting in low staff morale. This was further compounded by meagre and irregular pay (pers. comm. 56 April, 06). Despite some achievements in Kibaale such as immunisation, the district was greatly affected by diseases such as malaria, HIV and AIDS, pneumonia, skin infection and tuberculosis. Malaria was the leading cause of mortality (38.5%), followed by acute respiratory tract infections (23%), intestinal worms (12%) and diarrhoea (4.9%) (DDHS, 2006). The prevalence of HIV in Kibaale district as a whole was 6.4% in 2006 (WVAR, 2006). Whilst lower than the national average of 6.8%, it has to be noted that both figures are formal percentages based on hospital treatment and do not include undiagnosed individuals.

Whilst this research is not about HIV, *per se*, due to Uganda's association with the pandemic (see Chapter 3) it proved almost impossible to talk about health in Uganda without at least referring to HIV. The legal age of consent in Uganda was 18; sexual debut for most was early at around 16 years; in Bugangaizi it tended to be 12-14 (WVAR, 2006). By the age of 15, 30% of women will have had sexual intercourse. By age 18 this proportion increases to 72% (Nahabwe, 2004). In Kibaale, like most rural areas, the HIV pandemic disproportionately affected young people and the most vulnerable, particularly women and girls. The WVAR (2006) also suggested that the burden of caring for entire families fell increasingly on the shoulders of women (see also Nelms, 2005; Sowell *et al.*, 1999; Scoble *et al.*, 1995). The vast majority of the population were also extremely vulnerable to health risks due to lack of safe water and poor sanitation practices.

District statistics, as shown in Table 5.1, show that Kibaale has worse indicators than the national average. The only exception is life expectancy which is often lower for country figures due to the perils of urban life such as traffic accidents.

Table 5.1: Comparison of health indicators between Uganda and Kibaale

Parameters	Uganda	Kibaale
Infant mortality (/1000LB*)	88-100	122
Child mortality (/1000LB*)	152	205
Maternal mortality (/100,000 LB*)	505	550
Fertility rate (%)	7.1	7.8
Population growth (%)	3.7	5.4
Life expectancy (yrs)	45.7	49.1

**live births*

Source: UNDP and UBOS (2004)

Table 5.2 highlights trends of the ten top diseases from 2003-2005 in Nalweyo and Kisiita. Caution has to be urged with the statistics as these are based on sketchy patient records. Despite some improvements, Table 5.2 shows an increase in malaria, acute respiratory infections, intestinal worms, diarrhoea and sexually transmitted infections (STIs). It is worth noting that the rise in indicators could be reflective of a growing population and an increase in the use of government health services after the abolition of user fees in 2001 (see Chapter 3).

Table 5.2: Increase in cases of the top ten illnesses in Nalweyo and Kisiita 2002-2005

Type of illness	2002/03	2003/04	2004/05
Malaria	6894	6881	7431
Acute Respiratory infection	5001	4835	8112
Intestinal Worms	2990	2774	3452
STIs	873	923	1037
Acute Diarrhoea	343	264	821
Eye Infections	462	352	537
UTI	234	275	333
Skin Infections	619	316	529
Anaemia	521	345	360
Ear Infections	246	239	227

Source: Health Centre III records, Nalweyo and Kisiita (via WVAR, 2006)

The WVAR (2006: 50) also made the link between access to healthcare and education suggesting:

'the low retention rates in primary schools communicates a cycle of illiteracy and ignorance, lack of basic skills and knowledge hence making them more vulnerable to poverty, disease infection and becoming entrenched among the poor in the community'.

Despite some increase in enrolment at primary school level, particularly for females, as a result of Universal Primary Education (UPE) educational levels in Bugangaizi were generally low with a large proportion of children still being denied access. The WVAR (2006) found a decrease in retention across the school years and a significant decline in female attendance with increasing age. This was attributed to young women being married or expected to work at home. The quality of UPE was also questionable. World Vision calculated a (qualified) teacher-pupil ratio of 1:84 in Bugangaizi (2006:51). The son of a secretary who had moved to the district for work, for example, found that students in his Primary 7 class were studying material he had covered in Primary 4 (pers. comms. 148, January 07). Teachers were also regularly absent from their posts or sent the children to dig in their 'gardens' (farms) rather than studying.

As the WVAR (2006:16) stated, 'the health status of the sub counties of... [Bugangaizi] is generally appalling with major hindrances in accessibility of the population to quality health services'. As Chapter 3 outlined, the Sector Wide Approaches (SWAps) as part of decentralisation were designed to increase 'gender mainstreaming' as the central approach to improving equity through the development of a gender-sensitive health and education sector. As Booth and Bennett (2002) suggested, however, 'gender mainstreaming', particularly in rural Uganda, remains a 'fuzzy concept'. In order to be effective, the approach to gender requires 'extraordinary changes in the organizational mentalities of both domestic and international actors' (Hafner-Burton and Pollack, 2002: 340). In other words, to improve conditions for women issues concerning gender need to be considered at every stage of healthcare planning and provision as part of an interlinked methodological approach. Such gender concerns cannot just be considered as an afterthought or in separate 'woman-centred projects' (Theobald *et al.*, 2005).

Answering to this criticism, there is a necessity to contemplate the role and effects of 'gender' in Bugangaizi in relation to carving a path to access MCH, which Section 5.4.2 will discuss. There is requirement necessity to answer Hickey's (2005) criticism and discuss the broad differences in women's health-seeking behaviour in Bugangaizi.

5.3 Unpacking 'the poor': Women in Bugangaizi

At a personal level, poverty in Uganda is defined as an inability to meet the basic necessities of life, poor access and quality of social services and inadequate infrastructure (Kiguli *et al.*, 2009). Hickey (2005), however, criticised the consideration of the homogenous 'poor' that all live in the same socio-economic circumstances. This research suggests that no population should, or can be homogenised as a whole. Within any seemingly similar population subtle divisions exist through axis of gender, ethnicity, access to resources, knowledge based on previous experience, to name but a few. Certain differences, such as marital status, can dramatically alter the socio-economic status of an otherwise 'poor' woman. These issues notwithstanding, this research identified key, but broad, socio-geographical differences between two sets of women that accessed healthcare from Kakindo HCIV; those who lived in the trading centres and those who lived in the rural villages. Whilst a broad generalisation, the gendered norms and expectations of these two groups of women were very different which in turn affected their MCH seeking paths. The distinction between the two groups will be made throughout the chapter.

The women of Bugangaizi - and thus patients of Kakindo HCIV - could be broadly split into two socio-geographic categories, 'Trading-Centre women' (hereby TCW) and 'Village Women' (VW). The majority of TCW had received rudimentary schooling so could speak fair English and had basic literacy skills. Most were small-scale business women, normally shop keepers, tailors (see Figure 5.1), or hairdressers. Alternatively they might have small enterprises such as selling *chapatti* (see Figure 5.2) or second hand clothes. As Figures 5.1 and 5.2 illustrate, the women had some disposable income. Note that in both of these photographs the women are smartly dressed in traditional *Gomez*. Mama Beatrice has her hair 'woven' (braided with extensions) and Florence has chemically straightened her longer hair, indicating that both women had the time, resources and inclination to attend to their personal image. For the majority of women their disposable income was such that they

could afford basic private healthcare and certainly access a consultation at a trading-centre dispensary. TCW women were generally able to access family planning.

In addition, there were some women living in both Nalweyo and Kakindo trading-centres who were (relatively) highly educated professionals such as teachers, development workers, secretaries, and healthcare workers. Ordinarily they had been drafted to Bugangaizi by their employers and saw their residency as a part time stop gap away from 'home'. If they required healthcare services they would access them from the private clinics in Hoima, or go 'home'. With the exception of healthcare workers themselves, this sector of the population of the trading-centre was not included in the analysis.

Figure 5.1 Florence's tailoring business in Kakindo



Figure 5.2: Mama Beatrice making chapatti in Nalweyo.



Sources: Personal fieldwork photographs

In contrast, 'Village Women' (VW) is used in reference to women who lived in the remote traditional housing deep in the bush. VW were chronically poor and thus had a low standard of living surviving on subsistence farming with some small surplus trade that produced little disposable income. The identity of VW was very much constructed by their capacity to reproduce. VW were expected to have at least five, at times up to eight or nine children to their husband. 'Marriages' were recognised locally but were rarely overseen in a formal church setting. A VW was often one of a number of wives to her husband. A husband was supposed to pay dowry to his wife's family but in a chronically poor community alleviating the family of another mouth to feed was often considered sufficient whilst payment was delivered gradually.

VW spoke of the larger trading-centres with their motley collection of shops and services as 'town' (pers. comms. 145, December 06). A journey to 'town' was a significant trip in both distance and cost. Literacy levels amongst VW were generally low but there were a number of small education schemes. Figure 5.3 shows a Functional Adult Literacy (FAL) group. It also highlights the differences in dress of VW compared to TCW; note the women are barefoot.

Figure 5.3: A local village Functional Adult Literacy (FAL) group



Source: Personal fieldwork photograph

Table 5.3, adapted from Kiguli *et al.* (2000), outlines the broad distinctions between TCW and VW. These are not binary opposites as this would jar with the post-structural approach and suggest too broad a distinction. The two groups did, for example, intermingle at market places, when VW travelled to trading centres and of course, within the hospital. VW could also become TCW during their life course through marriage or other family changes. The broad distinctions, however, serve to show the differences between the two sets of women.

Table 5.3: Broad differences between Village Women and Trading-Centre Women

Trading-Centre Women	Village Women
Owns some property e.g. land	Lack assets
Bicycle/car/radio	Eat one meal a day
Can afford to go to town/city	Lack clothing/soap
Primary, possibly some secondary education	Children cannot go to school/do not complete
Can afford private, distant medical care	Cannot afford drugs or medical treatment
Brick housing, corrugated iron roof	Poor housing
Access to sanitation	No sanitation
Facilities to access drinking water	No safe drinking water
Less often ill	Often ill
Has some regular income	No cash money

Source: Adapted from Kiguli *et al.*, (2009)

The next section will discuss the different societal norms that both influenced the health path and represented the terrain through which the two groups chartered their route to access MCH from Kakindo HCIV. The coded up data that revealed this terrain also highlighted a number of constructed informal spaces of health.

5.4 Broader societal factors

As Figure 2.1 showed, in order to access MCH from the formal biomedical institution of Kakindo HCIV, women had to plot a route through a 'terrain' constructed by their health knowledge embedded in the broader place of Bugangaizi. Bugangaizi was constructed by a number of societal factors, specifically gender, culture and kinship. These factors presented

societal barriers and served to inform place based knowledge. Other more tangible barriers were also presented. The route through these factors was determined by local understandings of health. These understandings included what was 'wrong' with the body, the care it required, who should deliver that care, where it should be delivered and the power hierarchy that generated. The route is also affected by healthcare actors, formal and informal. The route through place-based knowledge can then construct a knowledge base for individuals which, in some settings, can become authoritative. This section will unpack the key factors of the norms of health expectations of and for women in Bugangaizi, the interlinked factors of gender and culture and the role of kinship and broader family networks which all impacted the health 'journey'.

5.4.1 Norms of health in Bugangaizi

The Runyoro word for health - *obulamu* - means life, which, in a broader sense, comprises the blessings of well-being, tranquillity and freedom from worry (Field Note [FN] 47; see also Reynolds-Whyte, 1997). Any threat or uncertainty to that well being was considered ill health. This was illustrated when one woman said she was sick. It transpired her 'sickness' was because her soya crop was failing (pers. comm. 98, September 06). As Ogden and Kyomuhendo (1996:143) note 'maintaining good health entails more than the management of disease and illness'. Taken literally, the maintenance of health requires effective organisation, adequate nutrition, water, housing and sanitation and continued collective defence against disease; in other words, health is not something that 'just happens' (Feierman and Janzen, 1992: xvii).

Ogden and Kyomuhendo (1996) further explain that in Uganda, most household chores such as cooking, washing clothes and keeping the home clean - what Chapter 2 would refer to as domestic labouring - contribute to household health management and thus fall within the responsibility of women (see also Harrison, 2008; Wallman, 2006). Bernan *et al.*, (1994:206) define the action of maintaining or producing health within a Ugandan household as:

'a dynamic behavioural process through which households combine their (internal) knowledge, resources and behavioural norms and patterns with available (external) technologies, services, information and skills to restore, maintain, and promote the health of their members'

In addition to the maintenance of health through domestic labouring, it was also often the responsibility of women to deliver home healthcare to treat illnesses (Ogden and Kyomuhendo, 1996 – see Chapter 2 for terminology). There are a number of possible explanations for this. Firstly, home treatment could be explained by the need for privacy in stigmatised illness such as those that are sexually transmitted or due to witchcraft. Secondly, some home treatment could be motivated by low perceptions of government healthcare. Thirdly, VW had less disposable income than TCW to travel to the trading-centre to access more formal treatment. VW, therefore, were much more likely to seek alternative sources of medicine and health promotion or treat at home. As Section 2.4 discussed, the space of home then becomes transformed through the actions of caring to become a place of care.

For both TCW and VW in Bunyoro having a healthy family reflected a woman's fitness as a wife and mother and enhanced her status as an *omukyala omutufu*, or a 'proper woman' (pers. comm. 63, April 06; see also Ogden and Kyomuhendo, 1996). Whilst in general a very poor woman would be excused and pitied if her family was sickly, if a woman was unpopular within the neighbourhood and she, or particularly her children were sick, her perceived inability to care would reflect badly on her moral grounding as a woman and would be sharply criticized (Wallman, 1996).

Furthermore, as the responsibility for health fell within the domestic realm, the extent of that realm, and thus potential sources of place-based knowledge, must be recognised. For VW, and to a lesser extent TCW, the domestic realm extended to spaces that included, for example, the borehole, the market, church on a Sunday and the trading-centres. As health was such a dominant issue in the chronically poor district, it was one that was discussed at great length. Subsequently such informal spaces could easily be transformed into potential informal spaces of health discussion or places of care through discourse. On the whole, TCW had a greater disposable income and thus could more readily access resources from drug shops in the trading-centres. Arguably, however, VW were equally, if not better equipped through the time they spent discussing ideas and sharing knowledges that could potentially become authoritative.

Maintaining the family's health also extended to women maintaining their own health to be able to meet the significant demands placed on them as reproductive females. It was

reiterated on a number of occasions, particularly in the ANC and the MW, that it was the role of a 'good' Bunyoro woman to 'produce' (pers.comm.182, July 07) and a woman who aborted was a failed woman (MC2/IA; see also Kyomuhendo and McIntosh, 2006; Kyomuhendo, 2003). Such an approach to pregnancy was reflected within the hospital where, as the In Charge explained, women who presented at the ANC were 'clients', not patients. The 'client' title was because women were '*simply doing what they are supposed to do*' socially and culturally, by reproducing (pers.comms.86, July 2006). They were not ill unless significant complications arose; then they became 'patients'.

This approach lies in sharp contrast with literature from the developed world discussed in Chapter 2, which critiques the 'medicalisation' of the birthing process (Williams and Umberson, 1999). It was considered not only unnecessary, but unlucky, for example, to ever inquire how a pregnant woman was feeling, '*until she had her baby in her arms*' (pers. comm. 172, May 07). In part, this was in recognition of the vulnerability of pregnancy, but it was also because she was only fulfilling what was expected of her. Kamatenesi-Mugisha and Oryem-Origa (2007:1) further suggests that sickness and death of an expecting mother is considered a normal and natural phenomenon; they explain that 'culturally, the woman who has died during childbirth is equated to a soldier dying during a war'. This will be discussed further in Chapter 7. Indeed, Moland (2002) suggested that matters of reproduction and birth are not just about care, but control, and a field in which many actors have a vested interest. The politics of reproduction in Bunyoro for VW constructed a norm of health in which a good woman was supposed to have a number of healthy children to highlight the prowess of her husband. Multiple children also provided the woman with greater assistance in the home and insurance against recessive hereditary diseases such as sickle cell anaemia. It was the norm for women, therefore, to maintain both their productive role in health within the home, and their reproductive role. This was exemplified when a 32 year old pregnant woman presented at the Out Patient's Department at Kakindo HCIV (MC16/M). She was pregnant for the eighth time, but this was the first time she had ever sought medical care during a pregnancy. Despite being late in her pregnancy it transpired that she was not seeking antenatal care, but treatment for the migraines she was suffering which were preventing her from working. Highlighting the productive and reproductive pressures she faced, she explained that she needed to get well to finish harvesting her maize crop before the end of the week when her husband was coming to collect the crop to sell at market.

It is important to note, however, that particularly for TCW, norms of health were slowly beginning to change. Bugangaizi has undergone some transitional development via NGO health, education and finance initiatives. As a result, some women, mainly TCW but also VW, had both an increased disposable income and were more empowered which challenged traditional gender roles. Some sources, for example, highlighted the increase in 'moral decay' (World Vision, 2006: 37) or 'Lifeism' (pers. comm. 74, April 06; pers. comm.75, May 06) in Bugangaizi. This was attributed to a hedonistic lifestyle of alcohol consumption as a result of increased income which was linked to casual sex amongst a growing sample of the population (Silberschmidt, 1991). At a similar time, Kyomuhendo and McIntosh (2006:235) associated the increase of women drinking with a 'worrying tendency' for Ugandan newspapers to portray women as 'sex objects' (Turyakira, 2010). It was feared that such developments in behaviour would lead to an increase in the transmission of HIV, sexually transmitted infections (STIs) and unplanned pregnancy (see Koenig *et al.*, 2003). Whilst TCW could partake in Lifeism, prevailing gender roles (as will be discussed), meant they still had limited capacity to insist on the use of barrier contraceptives (Nyanzi *et al.*, 2005; Nyanzi *et al.* 2000). There was, however, a notable increase in TCW accessing *Depo Prova*, the contraceptive injection from Kakindo HCIV (FN 96) due to radio delivered health campaigns.

As Kaye *et al.*'s (2005: 630) research suggested, in African cultures women are brought up to be submissive to men. Silberschmidt, (1991), however, suggested that women's increased empowerment through development made them seem 'disobedient and provocative' and a challenge to their husbands' status. At times men felt the necessity to reassert their authority through violence or demanding sex by force. Such shifts in norms of behaviour in relation to health were represented in medical cases that presented at the hospital. In MC14/Bar, for example, a woman who had borrowed money to set up her own bar had been ferociously beaten by her husband. He felt that in the eyes of his male counterparts she had undermined his status. Furthermore, in MC17/micro, a woman presented at hospital with bad burns. She had been part of a microfinance scheme run by a local NGO which were often aimed at women due to their natural ability to manage money (Willis, 2005). The woman had successfully managed to set up her own small-scale tailoring business and had generated sufficient income to repay the loan. In refusing to give her husband the loan money to buy alcohol, he had punished her disobedience by pouring boiling water over her.

The next section will discuss the interlinked societal factors of gender and culture and thus will contemplate the changing dynamics in greater detail. It is important to highlight that the norm of MCH in Bugangaizi was that women were *expected* to produce many children. As reproduction was their role in society, they were not sick by being pregnant and thus were not looking for care to 'make them better' but to sustain their pregnancy. In turn, a woman who could not produce failed to meet the expected health norms. Women were also expected to maintain their health and the health of their families through production in the home. As the next section will explain, many barriers were presented, tangible and social, to prevent MCH access.

5.4.2 Gender and Culture

In this research, culture is understood to be the 'learned, shared and transmitted values, beliefs and norms and life way practices of a particular group that guides their thinking, decision and actions in patterned ways' (Leininger, 1985:209). In relation, as Nii-Amoo Doodoo and Frost (2008:432) put it, 'that pervasive gender inequality is intimately intertwined in the fabric of sub-Saharan African society is hardly disputable', or indeed requires much explaining. Chapter 4 outlined how, despite 'gender mainstreaming', many policies of decentralisation only paid lip service to the gendered dynamics in which sectors were embedded (Booth and Bennett, 2002). As Hafner-Burton and Pollack (2002: 340, cited in Theobald *et al.*, 2005) suggested, for gendered policies to be effective in Uganda, 'extraordinary changes in the organizational mentalities of both domestic and international actors' would be required.

In Bugangaizi it was expected that a bride price would be paid for TCW and VW. Kaye *et al.* (2005) discussed the impact of bride price in different socio-cultural contexts in Wakiso District, central Uganda. They discovered a direct correlation between the bride price which 'bought' the woman into the man's household and women's lack of independence, especially in relation to health-seeking behaviour. Through a bride price, a woman is 'bought' and the 'buyer' controls all financial and social resources (Kaye *et al.*, 2005:302). This, in turn, reduces women's decision-making capacity, enhances power imbalances and is often related to domestic violence (Wolff *et al.*, 2000; Heise, 1998). The law protects the man as, whilst a woman can leave, she (or her family) is expected to repay her bride price. Kaye *et al.* (2005) also suggested that bride price was a reason why women were married

early as 'selling' younger females brought bride price income which would enable the unmarried men of the family to buy their brides. Both TCW and VW expected some sort of payment on commitment to a relationship. In the village 'marriages' were often not pronounced in church but were recognised within local law. The bride's family would expect to receive some payment for their daughter, if not monetary, in land, crops, animals, and recently, shares in small businesses. Some research views dowry in a positive light suggesting it is an appreciation to the bride's family of the 'asset' the man was receiving, particularly if she was educated or skilled (Tebajjuikira, 2010; Tibatemwa-Ekirikubinza, 1999). Recently, however, the Constitutional Court rejected a petition presented by the NGO *Mifumi*, based in Tororo District, to abolish bride price (Tebajjuikira, 2010). In personal discussions, women often spoke of the injustice of husbands who were suspicious about their behaviour with other men despite having many wives (pers. comm. 81, July 06; see also Heise, 1998).

VW were often, therefore, disadvantaged by lack of decision making capacity to seek healthcare when required, despite their responsibility for health. In MC3/P, for example, the mother saw her young child suddenly convulse violently and knew she was gravely ill. She was, however, unable to take the child to the hospital without permission from her husband who was in the trading-centre, five kilometres in the opposite direction. The one year old child died en route to the hospital of cerebral malaria. In this case the child was so ill that it was highly unlikely those few minutes would have made much difference. The speed at which treatment is accessed, however, can be vital in such cases, particularly in vulnerable patients such as young children or the elderly (Källander *et al.*, 2008; Jones *et al.*, 2003). Similarly, in case MC9/Mal, a young woman presented at Clinic with her six month old, desperately malnourished baby. The neonate was acutely anaemic and covered with small wounds as a result of tape worm and general damage to a poorly body. The woman's husband followed *Owobusobozi Bisaka* (the Almighty Bisaka) a man who said he was Jesus reincarnate and led the cult like *Abaikiriza* religion (see Munaabi, 2006). Bisaka's followers believed in the power of prayer above all else, even to heal, and thus did not believe in biomedical medicine. The woman explained she had been forced to 'escape' from her husband to seek treatment for her baby. Within the place of her home she was subordinate to her husband's demands. She explained that through discussions with other women whilst washing, she realised her baby was dying but that the hospital could help. The women assisted her with money for transport to the hospital whilst her husband was

visiting one of his other wives. The knowledge constructed within the place of washing, therefore, constructed a space in which the woman was empowered, through knowledge and assistance, to access help.

Bugangaizi, for VW, was a polygamous society. Bove and Valeggia (2009) suggest that polygyny across sub-Saharan Africa, but in Uganda in particular, represents an excellent example of a 'co-operative conflict' paradigm in which women's access to resources essential for their own health and that of their children, is structured by their polygamous lifestyle (see also van de Walle, 2005; Timæus and Reynar, 1998; Lesthaeghe *et al.*, 1989). Social relationships in Uganda were not structured by cooperation amongst co-wives. They knew about each other through gossip (FN61), but did not associate with each other as a matter of course. There were, however, regular examples of physical conflict in response to revoke of resources, as the man took a younger wife. A fight broke out in Nalweyo trading-centre, for example, between united wives against their husband as he had abandoned all seven of them and his collective 48 children to establish a shop in the trading-centre for his latest wife, who was 20 years his junior (FN200; see also Madhaven, 2002; Dorjahn, 1988). Whilst it was unusual in Uganda for co-wives to unite in such a manner (see Adams, 1998; Bledsoe, 1993; Caldwell *et al.*, 1992 for potential advantages) the incident did highlight the women's collective power, not least through how their husband was ridiculed in the trading-centre for several weeks (see Dorjahn, 1988 and Clignet, 1970 for theory of 'divide and conquer' tactics to avoid such unity). There was much competition between wives for attention from their husband, but also to maintain the support owing to their families (FN62). Some research, for example, suggests polygamous families are hindered in their healthcare access because limited resources have to be shared amongst many families. It is also suggested that the father may not have the same commitment to thirty children to different wives as he would to just a few children from one woman (Dudgeon and Inhorn, 2004; Brahmbhatt *et al.*, 2002).

The polygamous society also had a direct impact on women's sexual health. Bove and Valeggia (2009) discuss the influences of polygyny on menopause and mental health, both of which have been under-theorised in Uganda. There are obvious links, however, between vulnerability to STIs and fertility outcomes (see Blanc and Gage, 2000; Adoekun and Nalwadda, 1997). Some research actually suggests sexual health is good *within* polygamous relationships that are faithful to those committed to the arrangement (see Pattern and

Ward, 1993) and as a result, transmission rates of HIV and other STIs are reduced (Malungo, 2001; Mukiza-Gapere and Ntotzi, 1995). At the hospital, however, there were regular cases of patients requiring treatment for STIs. Having visited a local healer with pelvic pain and an unusual vaginal discharge MC5/STI had been told that her 'fallopian tubes were loosened'. She clearly had an STI, for which her medical records showed she had been prescribed antibiotics. She said she had completed the course and had recovered. Since then she had sexual intercourse with her husband and the symptoms had returned. When the medical officer asked whether a condom had been used the 33 year old woman blushed and giggled like a schoolgirl (FN123). She was one of six wives and clearly had no understanding that her ailment was sexually transmitted, or how it could be controlled. It was explained to her that she needed to abstain from sex while she completed the prescribed drugs. It was also suggested that her husband and, ideally the other wives, should be tested. The patient became very flustered saying that would not be possible, and that she had to be a 'good wife'; in this case to the detriment of her health (see also Kasooaha, 2008a; Pattman, 2005).

VW thus had limited personal control over their reproduction in an environment in which men were culturally responsible for sexual decisions. As the WVAR (2006:20) states: 'women are supposed to be obedient and submissive to all advances from men'. Ssekinboobo (1992) argued that both men and women across Uganda are taught that wives should defer to husbands in sexual encounters and may be socialised to give priority to male pleasure and control in sexual partnerships. Amongst the Baganda and Sebei of Uganda, Obbo (1993:215) further found that traditional premarital education given to girls stresses never to deny their husband's demands for sex. Whilst, of course, there were exceptions to these beliefs, and natural caution has to be raised about idealised models of sexual behaviour particularly from a Western context (see Kesby, 2000a), these viewpoints highlight the general subordination of VW in sexual relationships.

As discussed in Section 5.4.1 there had also been a recent rise in 'Lifeism' which put women in polygamous relationships at greater risk, especially as women had limited power to negotiate the sexual relationship and insist on the use of barrier contraceptives (see Bhana *et al.* 2007; Gibson and Hardon, 2005). In Bugangaizi, suggesting the use of contraception was often associated with promiscuity (pers. comm. 142, December 06; see also Nyanzi *et al.*, 2005; Nyanzi *et al.* 2000; Kisekka, 1976) or myth that they made a woman barren in the long term (pers. comm. 144, December 06; see also Kaye *et al.*, 2005). Certainly in trading-

centres, despite availability, there was a low rate of condom use. World Vision (2006)'s focus groups, discovered that young men who represented the most at risk group, tended not to use condoms due to a lack of knowledge and perceptions of cost and reduced sexual satisfaction. The In Charge of Kakindo HCIV made the comment that men felt 'cheated' by condoms (pers. comm. 61, April 06). As discussed earlier, it was notable that of the few women who obtained family planning from Kakindo HCIV they were all TCWs who accessed *Depo Prova* the non-barrier contraceptive injection (FN96). Whilst the injection could be used secretly to prevent pregnancy it did not protect against STIs. The WVAR (2006) report acknowledges that whilst the community were aware of the presence of HIV and AIDS, they were 'not comfortable talking about it' (2006:32). The report also suggests that local beliefs prevail, such as that HIV is caused by witchcraft, is a curse to sinners and can be spread by latrines or sharing food with an infected individual or is transmitted by mosquitoes. In critique of this finding, this research suggests that with the proliferation of HIV campaigns across Bugangaizi via the radio, the health centres, numerous NGOs and indeed through personal experience, women, particularly in trading-centres, were well informed about HIV (FN120). They were less familiar, however, with other STIs such as gonorrhoea and genital warts from which they were at great risk.

The increase in Lifeism was also associated with an increase in domestic violence with which there is a notable link between pregnancy and domestic violence (UBS, 2001; Ballard, *et al.*, 1998; Gazmararian *et al.*, 1996). Kaye *et al.*, (2005), for example, found that of new attendees at an antenatal clinic, 57% of women reported a history of domestic violence during pregnancy, most of which were moderate to severe. Statistics from the Uganda Law Reform Commission report (2007) suggested that over 78% of women experience domestic violence annually and yet, according to the Uganda household Survey 2000-2001, as many as 77% of women in Uganda believe that being beaten by their husbands is acceptable (as quoted in Kiwawulo, 2010). It has to be further considered that the majority of domestic violence cases go unreported. Whilst little is known about the context in which domestic violence occurs, or men's and women's perceptions of its consequences (Kaye *et al.*, 2005), domestic violence has recently gained much attention in Uganda. This is largely due to the dramatic increase in cases and numbers of women being admitted to hospital (Ssendendo, 2010; Kiirya, 2010). During the fieldwork there were no cases of complicated pregnancy as a result of domestic violence. As shown in cases MC14/Bar and MC17/Micro, however, domestic violence was prolific in Bugangaizi. Until recently the law has done little to protect

women who were subjected to domestic abuse. In March 2010, however, President Museveni passed the Domestic Violence Act 2010 which aims to punish perpetrators of domestic violence (Tebajjuikira, 2010). A convicted individual is liable to a fine of up to 960,000/- (about £320) or two years imprisonment (Tebajjuikira, 2010; Turyakira, 2010). It will, however, take many years before this law is enforced in rural areas. It must also be noted, that many men were also subjected to domestic violence. Largely TCW, but to a much lesser extent, VW spoke about 'fighting' amongst couples particularly when the woman had some disposable income (FN106). 'Fighting' implied that both men and women were perpetrators of violence within the home, often in relation to consumption of alcohol by both parties (see also Tamale, 1999; Tibatemwa-Ekirikubinza, 1997; Kasozi, 1994).

Gender inequalities have thus been linked to a plethora of outcomes such as poor general sexual health (Lary *et al.* 2004), the transmission of HIV (DeRose *et al.*, 2002), mortality, impaired broad wellbeing (Shen and Williamson, 1999; Caldwell, 1990b) and indeed, domestic violence. In Bugangaizi, the WVAR (2006:63) found that women were considered as 'a weaker vessel, ignorant about issues around them and hence subordinates while the men are strong and knowledgeable'. Despite being seen as 'weak', in Bunyoro, like most African societies, women had the gendered responsibility for the multiple activities that were critical to maintaining health, such as fetching water and firewood, cooking and washing, looking after animals as well as raising children and tending the 'gardens' or farms. Such labour was considered part of the gendered expectations of a woman; it also took up huge amounts of time. Whilst all women were engaged in the three gender roles - productive, reproductive and community roles - men had only productive responsibility. World Vision's focus groups (2006) approximated that women in Bugangaizi worked for 18 hours in a 24 hour period in a very different capacity to men. Table 5.4 is a representation of their findings adapted to allow for the differences between TCW and VW's activities. VW would conduct all this work personally. Many TCW, however, had paid house-girls who conducted most domestic chores, often whilst the TCW was engaged in her small industry.

Taking time out of such a busy schedule to, for example, access healthcare, had serious knock on effects on the day's tasks. Most VW also had to consider either finding childcare or more likely, would take the children with them. Despite their massive work load, women rarely had any disposable income and would have to ask their husband for money when

required (FN88). Whilst VW were socially disadvantaged in their lack of decision making capacity about sexual matters, they were also limited in their power within the home, despite being responsible its production.

Table 5.4 Roles for women and men in a 24 hour clock

Time	VW and their activities	TCW and their activities	Men and their activities
6:00-10:00	Waking up Preparation of breakfast Preparing children for school Garden work	Waking up Bathing Organising work to be done at home Going to work	Waking up Digging
10:00- 13:00	Looking for food to cook Fetching firewood Fetching water Cooking lunch Serving the husband	Working in small industry Serving/Being served lunch	Bathing Resting
13:00-18:00	Going to garden Looking for supper Cooking supper	Continuing work in the shop/business	Going for leisure (drinking)
19:00-20:00	Bathing children Serving supper Preparing the bed	Checking on children for bathing and supper Late shift in shop/evening work	Coming back from leisure Eating supper Sleeping
21:00-6:00	Sleeping	Sleeping	Sleeping

Source: Kisiita Sub county Development Plan 2005-2008

VW also faced practical health barriers. Whilst maintaining a healthy family was considered part of the role of an *omukyala omutufu* (proper woman), many women commented upon the pragmatic difficulties of Bunyoro (FN73). As the World Vision report (2006) corroborated, in Bunyoro, particularly for VW but also for TCW, sanitation facilities and clean water were in limited supply. Access to clean water was a problem throughout Bugangaizi, due to its topography. With the exception of the hilly administrative centre, Bugangaizi was predominately flat so there were no natural water sources (pers. comm. 174 May 07). The low water table also meant drilling bore holes was expensive. The Nalweyo-Kisiita Development Plan (2005-2008) suggested that the borehole to people ratio was 1:513.

Furthermore, VWs often had to move approximately 12 kilometres to access clean water, even in the rainy season (WVAR, 2006). In the dry season particularly due to the naturally low water table, the water supply was regularly exhausted. There was also a lack of ownership, or community mobilization for maintenance so boreholes often stood damaged for months (pers. comm. 82, June 06). Tension was then generated with neighbouring villages if increased pressures were put on their limited supplies. There were also concerns that women and girls were vulnerable to sexual advances when walking long distances at night to draw water. Many families, therefore, had to rely on the River Mpongo or the swamps for water. Some TCW had tanks to collect rain water, or could afford to pay the local entrepreneurs. These were young men who had set up businesses cycling out to distant boreholes and delivering 20 litre jerry cans of water for 300/= (approximately 7 UK pence).

Sanitation provision was also limited, particularly in villages where either up to 20 households shared one centrally located pit latrine, or, as was more likely, used the bush. Due to the water shortages, even in schools and health institutions there were rarely hand washing facilities, either at the latrines or for before eating (pers. comm. 77, Sept 06). The headmaster of a school explained he had invested in cutlery for his teachers. Whilst most of them had grown up eating with their fingers, to use cutlery both befitted their status and prevented some absenteeism due to ill health, possibly as a result of not being able to wash their hands before eating (pers. comm. 107, September 06). It was a common complaint of schools and hospitals that latrines were make-shift so were dangerous, particularly during the rainy season and in light of the 50 foot drop below. Latrines were often filthy and riddled with maggots. The problems with sanitation and lack of clean water clearly contributed to the death rate as a result of dysentery, diarrhoea, schistosomiasis and increasingly cholera (Jjuuko, 2008; Edyegu, 2008).

Adequate nutrition was also a problem. Diets in Bugangaizi were based on the surplus crops that were in demand at market, particularly in Hoima. Most meals, therefore, were based on starchy staples such as matooke (small green plantain), cassava, maize and *lumondi* (a white sweet potato) with a stew like 'sauce' ordinarily made from *onebwa* (ground nuts) or beans. Despite the lush soils and heavy rainfall, there was a significant shortage of other fruits and vegetables. If a village family could grow tomatoes, pineapples or mangoes, for example, these were good bartering currency for other produce such as soap or salt. It was

also difficult to store food which, in the equatorial climate, easily fermented, increasing the prominent cases of kwashiorkor. Kwashiorkor is a protein energy malnutrition that limits the rate of nutrient absorption in children's bodies resulting in significant wasting and making children sickly, as represented by their distended bellies (see Figure 5.4).

Figure 5.4 Example of kwashiorkor; a common health problem in Bugangaizi



Source: Personal field photographs

Particularly in light of their physical workloads it was very difficult for pregnant women to maintain an appropriate nutritional intake especially when hookworm was so prolific as a result of walking barefoot. There was also a shortage of cow's milk. HIV+ mothers are encouraged not to breast feed their babies after six months due to the risk of mother-to-child transmission (UN, 2009) but there were no affordable alternatives. Goat's milk was not culturally acceptable.

The WVAR (2006) also suggested that environmental sanitation at household and community level was poor within the villages. They found that mosquito and snake harbouring bushes surrounded most homes, there were no rubbish pits and often children's excreta was scattered all over the compounds (the land surrounding homesteads) which were generally dirty and uncared for. Coupled with poor housing, these conditions meant that women and children were regularly exposed to coughs, flu and jiggers. Jiggers are tiny sand fleas which live in stagnant, dirty soil. They burrow under the skin and lay their eggs

causing much localised infection which, whilst easily both cured and prevented, if left untreated, can make the suffer lame affecting their future productive capacity, but also very ill with the infection. Children were particularly vulnerable because they tended to move barefoot and sleep on the ground and their bodies were easily overwhelmed by infection.

In critique of World Vision's (2006) findings, however, ordinarily it was only the most chronically poor families that lived in such conditions. Personal research found that people in general in Bunyoro, took great care and pride over their possessions and living environment. There were even running jokes about how the local water collector spent longer polishing his bicycle than he did riding it and that the LCI's too big, second hand *Marks and Spencer* blazer had been ironed until it was shiny. Children would scavenge for old scraps of newspaper to pin on the walls of mud huts and many people would painstakingly decorate the outside of their homes (FN75). Homesteads were generally kept clean. Often, therefore, a poorly kept compound was the sign that something greater was wrong with the family, ordinarily illness or general struggle. In the next Section the vignette of Florence will be used to discuss the changing caring nexus of families as a result of HIV. Such 're-constructed' families tended to struggle initially or living conditions would slip when the main carers, often grandparents, literally became too old to cope.

In focus groups and personal communications, therefore, many VW spoke in exasperation about their efforts to be 'good women' and to have a healthy family but it was difficult when they faced such pragmatic difficulties such as the lack of water and the vulnerability of their children (FG [focus groups] 2,7,8; pers. comm. 76, June 06). VW also lamented the physical difficulties of reaching the clinic. The Hospital I/C explained that the hospital served the villages within a 15 kilometres radius (pers. comm. 52 April, 06). To access the hospital VW had the choice of either utilising public transport, or 'footing' (as walking was locally known) to the hospital.

Public transport was difficult. Whilst sporadic, there was a 'public' transport system that was monopolised by a few entrepreneurs who had the means to buy vehicles; either cars, or third-hand, twelve seat mini buses. For a villager, the prices of fares fluctuated from expensive to very expensive. In 2006, to travel eight kilometres cost 3,000/= (Ugandan Shillings, approximately one pound), which was a considerable expense for a chronically

poor villager. The vehicles were also always overloaded, with at least 20 people, and often jerry cans of fuel, crates of soda, goats and sacks of produce. They careered down the potholed murrum (local clay and gravel) roads at a tremendous speed. Highlighting the 'normality' of a woman being pregnant in the village, there was never any thought that a pregnant woman should have a seat or be offered any more space than anybody else; she was not sick, she was fulfilling her duty as a woman (Kyomuhendo and McIntosh, 2006). Public transport was also unreliable. It did not follow a particular time-table and required the traveller to wait by the side of the road, potentially for hours, in the hope a vehicle might pass. As it was not womanly to ride a bicycle (pers.comms. 132, October, 06), other than hitching a lift, the only other alternative was to walk.

It is well recognised that women are the primary health givers at family and household level (Neema, 1999: iv) and yet are often disadvantaged by a lack of economic and jural authority at community and household level (Wallman, 1996). Gendered cultural norms in Bugangaizi meant that women had a difficult terrain through which to plot their health routes to Kakindo HCIV. They were reliant on men for permission to leave the home which could add vital time to the long health journey. They also faced pragmatic barriers such as lack of water and sanitation which increased the health risks to them and their children challenging the cultural definition of their place in society as 'good women' (see Feierman and Janzen, 1992 opening quote). It also important to note that due to traditional cultured gendered norms and the slow rate of development there were few options for women. Drawing on Shrestha's (2002) notion of 'becoming a development category' and failed decentralisation policies, these frustrations were personified by a 14 year old young woman who said she was deliberately '*trying to become HIV+*'. She had been withdrawn from school before she had completed Primary 5 and since then had been assisting at home and in the gardens. In her own words, she was '*only ordinarily poor*'. Her rationale was that if she was HIV+, orphaned, a victim of domestic abuse or even pregnant underage, there were NGOs and charities she could approach for assistance to improve her future. As it was, she was '*only ordinarily poor*' which she felt resigned her to being one of a man's multiple wives (pers. comms. 90, August 06).

5.4.3 Kinship

There was a local saying in Bunyoro that 'kinship is like your buttocks....you can't cut it off' (Whyte and Whyte, 2004: 77). Every Munyoro belonged to 150 exogamous, totemic clans,

membership of which was acquired patrilineally (Beattie, 1975). Highlighting the input of informal care into a formal setting, when a woman went into hospital it was expected that a member of her family, normally her mother, sister or oldest child, would accompany her and be her assistant. This involved performing tasks such as preparing food, assisting with bathing, running errands *etcetera*. Whilst seemingly mundane day-to-day caring, such input was a vital part of accessing healthcare as without an assistant, a women literally would not be able to access over night treatment such as maternity care. Such involvement of the broader family also helped to develop place-based knowledges as everybody had some experience of healthcare and women were quick to offer advice. *Muzei*, or older wise women, were often consulted, for example, if the ailment was considered to be spiritual or caused by witchcraft (FN113). There was also much family knowledge about which herbs to use to cure simple problems of pregnancy such as cramps. It was also unspoken that family, no matter how distant, should be helped in times of need.

Notions of 'family' in Bugangaizi, however, were changing which has affected traditional caring dynamics. Whyte and Whyte (2004) and Robson (2004) review old themes in the study of African kinship that have fresh relevance in a time of HIV, poverty and gender consciousness; those are the lineality and relationships within families that (re)construct dynamics. As Table 5.1 showed, Bugangaizi had a high mortality rate which was locally suspected to be a result of the poor standards of living and particularly HIV (pers. comm. 77, April 06). Bugangaizi subsequently had a high number of '*efakazi*', or widows, orphans, and vulnerable children (WVAR, 2006) who were particularly marginalised in terms of empowerment to access resources and make health decisions. There was an entrenched expectation, therefore, that 'somebody' within the family would offer support to a widow or care for orphaned children; institutional care was seen as a very last resort. Nonetheless the HIV pandemic was causing strain and restructuring caring dynamics.

Florence was over 75 years old when one of her sons and two of her daughters died of HIV. As their respective partners were also very sick, Florence took custody of her eight grandchildren, one of which was less than a year old. Whilst Florence worked incredibly hard to care for 'her' new children, she was an elderly woman who struggled just to feed them all. This role of 'informal' carers in the upbringing of children orphaned by HIV is being increasingly recognised (see also Ssengonzi, 2007; Foster, 2000; Foster *et al.*, 1995).

Monetary support was available from charities and NGOs for widows bringing up children but was not necessarily available for informal carers (Seeley, *et al.*, 1993). Florence did receive some support from a local NGO which, whilst better than nothing, was small and unreliable. Highlighting the persisting stigma of HIV, even when transmitted from mother-to-child, Florence refused to have the children tested saying she would rather not 'live under that cloud' (FN93).

Robson (2004) also discusses the 'un-childlike', 'hidden child workers' of Zimbabwe. In Bugangaizi there were increasing numbers of young children responsible for caring, either for ill adults, or orphaned siblings or even becoming heads of households. 'Childhood' is a particularly difficult construct in Uganda due to the civil conflict in Northern Uganda in which thousands of children were abducted and trained as child soldiers under the Lord's Resistance Army. Whilst the conflict has now officially been resolved, one of the greatest tasks of rebuilding an area wracked by conflict for over twenty five years, is the rehabilitation of these 'soldiers' that had been subjected to horrific atrocities and forced to perform them (De Temmerman, 2001). Furthermore, due to the high death rates in Bugangaizi, children regularly experienced death which, whilst traumatic, was also part of everyday existence to the extent they appeared to adopt the active problem-focused coping strategy approach (see Dageid and Duckert, 2008); this literally involved 'getting on with life' as best as possible and often restructured family responsibility.

This has a dramatic effect on the health-seeking path to Kakindo HCIV. Fausta was ten when she became a commercial sex worker to support her orphaned siblings who were six, four and three years old. In Uganda, a child is officially classified as an orphan if one parent had died. Fausta's mother had died, and her father was abusive. Abuse is common amongst orphaned families (Amazia, 2010) through child labour, torture and neglect (WVAR, 2006) and increasingly, sexual abuse, or defilement (Emurut, 2010). It is traditionally believed, however, that boys cannot be defiled (WVAR, 2006) and as Uganda continues to support a proposed bill to make homosexuality punishable by death (see Kagolo, 2010), it is highly unlikely that such misconceptions will be overcome in a short period of time. Fearing further abuse from the extended family, Fausta decided to care for 'her' children alone. She faced difficulties, however, as she was both a commercial sex worker and was young and thus was breaking the constructions of a 'good' Bunyoro. Fausta openly said that she

'would never approach the hospital for treatment for fear of how (she) would be treated in that place' (pers. comm.162, March 07).

Furthermore, whilst there was a notable rate of underage pregnancy in Bugangaizi, few cases presented to the hospital for either maternity or antenatal care. Such behaviour was regularly the topic of conversation amongst the staff at Kakindo HCIV. One member of staff commented on how many young women, particularly orphans, leave school early often enticed, or 'groomed' by men with money and the promises of a better life that rarely materialise. Relaying the story of a woman from Kakindo, one healthcare worker explained it was not long until the women 'get caught' and become mothers. She relayed a tale about a woman who left her family and became pregnant by a man who then refused to support her. *'It's not uncommon'*, the healthcare worker said, *'to find a woman with four children, FOUR (gesturing with fingers in my face), to different men, can you imagine?! And is it surprising that before long HIV comes in?'* (pers. comm. 124, Sept, 06). Drawing on Fausta's comment, it is perhaps unsurprising that the 'breaking' of cultural, gendered norms, whilst common occurrences in Bugangaizi, can generate barriers to women accessing healthcare.

Additionally, whilst some families were supportive of orphaned headed households there were occasional 'clashes' with 'normal' families which served to isolate orphan headed households; as of yet, however, a full discussion of these dynamics are absent in the literature. There were a number of cases in Bugangaizi, for example, in which mothers said they disliked their children playing with orphans, not due to a fear of HIV transmission, but because they were 'picking up bad habits' from the children who were receiving little or no formal parental guidance. Mothers commented that orphans had little respect for adults; a trait they did not want their children to inherit (pers. comm. 194, August, 07). In MC18/play, an eight year old boy was admitted to the hospital having being badly beaten. A father had come home to find the boy and his daughter 'playing at sex'. The children were both fully clothed and whilst the age of sexual debut in Bugangaizi is twelve, it is probable that the children were merely copying what, by virtue of the living conditions, they had seen their parents do. The father, however, had blamed the 'orphaned boy' entirely, and in his shock had severely beaten him. Furthermore, it was not unusual for very young children to come to the hospital for treatment alone, or for children to bring the siblings for whom they cared. In MC11/GA, for example, a six year old girl had walked ten kilometres from her

home, alone, for treatment for malaria. In MC19/ble a fifteen year old brought his eleven year old sister and 'charge' to hospital with 'bleeding'. Following a dispute with a neighbour he feared his sister had been poisoned. She had actually started menstruating. Whilst she was young anyway, without any formal 'care' from a family, neither of the 'children' had experience to come to this natural conclusion.

Kinship, therefore, played a vital role in the support of health-seeking from Kakindo HCIV through the informal caring of assistants. Kinship also supplied a host of knowledges about health including the benefit of experience of accessing care from the hospital. These place-based knowledges could potentially become useful within the formal place of health. The changing kinship or familial dynamics, however, could also generate barriers within the health-seeking path to the formal place of health. The break of cultured, gendered norms stigmatised families could also reduce place-based authoritative knowledge which may affect formal healthcare access. Having discussed potential barriers in the health seeking path, that actual path in terms of women's health-seeking behaviour, can now be considered.

5.5 Health seeking behaviour in Bunyoro

Due to the very broad understandings of health, or *obulamu* (blessing), health-seeking behaviour could realistically include accessing fertiliser to treat a failing harvest. In Bunyoro, like parts of most African countries, healing systems were pluralistic and included indigenous, religious and allopathic theories and practices (Ovuga *et al.*, 1999; Ensink and Robertson, 1999). When discussing curative care or personal healthcare in a Bunyoro setting, however, there is a necessity to remove at least some of the romanticism of the exotic African 'other'. Bunyoro women, both TCW and VW, responded to ill health, particularly in relation to pregnancy, in the same manner as people the world over; they first waited for a couple of days to see if they would recover (Green, 2000). Like anybody, the time for a gradual recovery was restricted by the limitations ill health imposed on a productive lifestyle. On many occasions, VW would discuss how they '*couldn't afford to be ill*' (pers. comm. 46, April 06) in relation to how illness hampered, or took time away from their productive and reproductive responsibilities. If they did not recover quickly, the decision about the next step depended upon a number of factors such as the interpretation of the infliction and its origin. Bunyoro women distinguished between the ultimate cause of

a disease, which accounted for the victim status of the afflicted individual, and its physical manifestations (Green, 2000; Caplan, 1997; Feierman, 1985) which, in turn, determined which source of healthcare to charter a path to. As the next section will explain, the potential sources were many.

5.5.1 Traditional models of health

Due to the very holistic interpretations of wellness, the restoration of good health could require a variety of treatments. To cure a simple cold, for example, after waiting a day or two to recover naturally, TCW and VW might buy biomedical treatment (pharmaceuticals) from the drug store. Accessing the drugstore was much more 'costly' for the VW than the TCW in terms of time to reach the trading-centres and fears that they might be given substandard or expired drugs (F68). VW were, therefore, more likely to rely on either their familial handed down knowledge of plants, or to consult the local herbalist (FN60) and administer treatment within the home. Regularly VW, but also some TCW, would access healing from a herbalist instead, or as well as buying biomedical drugs. It was not uncommon to see patients wash down antibiotic capsules with a green herbal tincture from the local witch doctor (also see, Davis-Roberts' (1992) account of treating a child in Zaire with traditional and biomedical methods). Whilst accessing a witchdoctor was considered 'backward' and thus behaviour more fitting to a poor VW than a TCW, both VW and TCW recognised the value in traditional knowledge about herbs. If the ill individual felt the cause of their ill health was spiritual or witchcraft related, they might seek treatment from a diviner who could interpret how the 'charm' (or curse) could be lifted or the spirits appeased (Teuton, *et al.* 2007a; Teuton *et al.* 2007b; van Duijl *et al.* 2005).

Across Uganda the informal health sector, including both indigenous and religious healing, represented the largest section of the health system (Teuton, *et al.*, 2007; WHO, 2001; Ensink and Robertson, 1999). Whilst there are no formal statistics for Bunyoro, the HSP III (2010) suggests that approximately 60% of the population of Uganda visit traditional healers at some point within a particular illness. The traditional healers within the informal health sector of Bunyoro had a number of different skills and knowledges designed to cure different ailments and conditions. In addition to herbalists, these also included witchdoctors, bone setters and traditional birth attendants (TBAs).

Traditionally the Bunyoro believed in supernatural agents which were propitiated by sacrifice and prayer and made use of by certain magical techniques. In pre-European times, illness was common and often fatal, but there was little or no understanding of the physical causes of these events. To some degree, supernatural beliefs and practices provided understanding for the otherwise inexplicable and thus relieved ignorance and doubt (Beattie, 1960). With some adaptation, these beliefs survived into times very different from those with which they were traditionally associated. People sought 'magical' help in times of misfortune, be that illness of self or charge (such as a child), the failure of crops, lack of rain etc. It was widely but 'quietly' accepted that witchcraft and traditional healing still took place in Bunyoro. In 1911, a European law made it an offence to claim to be a possessor of any kind of supernatural power (Beattie, 1966; Roscoe, 1922) so the government repression has left a lasting association of witchcraft - or charming as it is locally known - with an untamed, primitive culture yet it is still widely practiced (Namboze, 1983). Herbalists were more public with many advertising on local radio and in the newspapers. Some herbal centres claimed to be able to cure HIV; regularly charlatan 'doctors' captured the attention of enticed audiences in local markets with the magical healing capacity of their secret herbs (see Figure 5.5). One 'herbalist' told an audience in Katikara market that his herbs, if taken in regular doses by a 'believer', would guarantee that person a wish. Many people plunged themselves into long term debt to buy the wish granting herbs; which was marijuana.

Figure 5.5 The local herbalists 'stall' at the market



Source: Personal fieldwork photographs

Witchcraft and the power of herbal medicine could also be used for deviant means which often then overlapped with the biomedical system as people required treatment. The Runyoro translation of 'sorcery' means to injure another person by the secret use of harmful medicines or techniques (Beattie, 1960). The most common method was literally to poison somebody with a deadly medicine. I was advised to never accept food or drink from a Munyoro for this reason. 'Medicine' could also be blown at an intended victim or laid on the floor surrounding their home so as they stepped over it they activated the powers. Figure 5.6 shows a witchdoctor's home and clinic.

Figure 5.6: A witchdoctor's home and 'clinic'



Source: Personal fieldwork photographs

Children were said to be particularly vulnerable, largely because they are both accessible and less resilient and thus useful targets to indirectly attack a parent. The nurses would often say that their children had been charmed by the Bunyoro when they were persistently ill, normally with a fever and a cough but did not respond to biomedical treatment. Curiously, whilst the nurses would recognise that their child had been cursed or charmed, they would not access a witchdoctor in effort to cure the predicament as this would suggest they believed in the primitive ideal and thus, would betray their status as pioneers of biomedicine. Instead, they would persist with the biomedical treatment and pray at their church. Other spells involved a symbolic or 'expressive' quality and some sort of magical or

non-empirical element. Medicines are usually made therefore, from bits of hair, nail parings and other parts of a certain person's body. This medicine was then usually put inside an animal horn in the roof of that person's house with intent to injure him.

Such skulduggery was common. In Nalweyo, a young, educated and attractive woman came to the trading-centre to work for an NGO. She soon attracted the attention of local men and thus quickly felt the wrath of the men's wives. She became pregnant by her boyfriend but the villagers were convinced that one of the local, married men was the father. The girl presented for delivery at one of the larger hospitals in her home district and had a horrendous labour which lasted for over 90 hours. Eventually her parents called in a diviner as they sensed there was something more than medically wrong. The diviner identified that the young woman had been cursed by a spell from which she was intended to die during childbirth. The women responsible had taken sand from the place where the young woman urinated, had a medicine made from it and had suspended it in a bag in one of their homes (see also Reynolds Whyte, 1997). The young woman would suffer until the bag was cut down, a diviner intervened or she died. The diviner invited to the hospital managed to identify this curse and remove it, so the young woman was strong enough to go for a Caesarean section at the hospital. Both mother and baby survived but, in the mind of the mother, only due to the intervention of the diviner, not the surgery (FN189). Drawing on the holistic understanding of health, diviners or spiritualists may also be consulted for other 'health' curative reasons. During the fieldwork, for example, a woman told me that one of her husband's other and older wives had 'cursed' her through a diviner. The curse meant that every time the younger woman entered the man's home he smelt the overwhelming stench of faeces and would consequently send her away (FN173).

The skills of bone setters were also recognised. Originating from Native American cultures, bone setters are traditionally thought to have gained their powers from a lightning strike. They then received teaching to learn how to manipulate broken bones back into the position to promote the quickest natural healing (Hatipoglu & Tatar, 1995; Parsons, 1939; Benedict, 1935). There were many local tales of bone setters being able to fix shattered limbs that had been referred for surgery at Molago, the largest government hospital. Following a colossal motorbike accident that shattered his pelvis, for example, one man was told he would never walk again. As he could not afford the treatment at Molago to stabilise

the injury, he invested in the treatment of a bone setter. Within three months he was able to stand with the support of crutches (FN198).

Due to such success stories, the social standing and role of traditional medical practitioners and birth attendants was recognised by world health bodies (Nyanzi *et al.*, 2007; Sibley and Sipe, 2006; Lech and Mugadi, 2005; WHO, 1992). In 2005, TBAs were trained in safer delivery practices to protect them as well as the mother and baby. In theory, they were also integrated into the mainstream health-system, so for example, were entitled to basic medical equipment and were supervised by the District Medical Officer (Amooti-Kaguna and Nuwaha, 2000). Whilst TBAs in Bugangaizi received some training, they did not receive any benefits and were frequently turned away from Government health centres when they requested items such as cotton wool and gloves (see also Amooti-Kaguna and Nuwaha, 2000:204).

In Bunyoro, however, many women still chose to deliver with a traditional birth attendant (TBA). Melda was the main TBA who served the hinterland of Kakindo HCIV. Her ward was deep in the bush, accessible only by motorbike, bicycle, or on foot with some local knowledge. Everybody, however, knew where Melda's place was; such was her role in the community. Melda inherited her skills from her mother and, at 77, had been a TBA for over 60 years. It was not unusual for her to, single-handedly, deliver over ten mothers a week. She also delivered a number of TCW who could afford to arrive at the ward on *boda-boda*, the private hire motorbike taxis. This indicated that TCW had disposable income and could afford private biomedical healthcare, and yet they *chose* to deliver in the bush with a TBA. Whilst Melda had limited equipment and no pharmaceutical drugs, she had traditional knowledge of special herbs to soften the younger women's pelvis to ease the delivery (see Tabuti *et al.*, 2003 for botanical details) and to induce labour if needs be (see Kamatenesi-Mugisha and Oryem-Origa, 2007). Figure 5.7 shows Melda with her two main natural medicines and Figures 5.8 and 5.9 respectively, her ward and delivery room.

Figure 5.7: Melda and her herbs



Source: Personal fieldwork photographs

Figure 5.8: Melda's maternity ward



Source: Personal fieldwork photographs

Figure 5.9: The delivery room

Source: Personal fieldwork photographs

Melda had received formal, certificated government training but was always turned away from health units when she asked for basic equipment such as gauze, gloves or sterile string to tie the umbilical cord. Melda thus ordinarily delivered the mothers with her bare hands which carried a risk of HIV transmission. She did, however, recognise the advantages of biomedical antenatal care which she always promoted to her mothers. She was also adamant that she knew her limitations and would refer mothers to hospital if they were at risk. Melda provided a vital service to the community that was acknowledged through ‘payment’ via foodstuffs. She explained, however, that she felt trapped and unable to leave her home. One of her sons lived in Fort Portal and as she was getting old and tired, she wanted to live with him in the traditional Bunyoro manner. The community were refusing to let her leave because she was so needed. She was also worried that she had no daughter who could assist her, or continue her trade.

Regularly the traditional model of healing (but not charming or cursing) would overlap with the biomedical model. It was mentioned earlier that antibiotic tablets were often swallowed with green herbal tinctures. As discussed many women accessed Kakindo HCIV for antenatal care but then opted to deliver with a TBA. The bone setter regularly operated in the hospital compound. The two models, however, were not always compatible. In

MC4/LH the midwife found a series of about ten-twelve small darkly coloured scars, each about half a centimetre, on a woman's chest. She explained that she had had breathing problems so a local healer had made these incisions in her chest using a razor blade and had rubbed the wounds with herbs (see Accorsi *et al.*, 2003; Chindia, 1995). Two weeks on she still had breathing problems but she could not understand why she had such horrific chest pain. It was very obvious from the weeping wounds that they were highly infected but because the woman viewed those incisions as medical treatment, she had made no connection between the wounds and her pain. In the biomedical place of health, traditional medicine is generally frowned upon. Ordinarily in the formal place of health, when the traditional and biomedical models met, it is usually because the traditional knowledge has caused harm. Under a Goffmanian (1963) understanding, those wounds were a physical stigma representing deviance or dangerous social behaviour and a lack of medical understanding. Drawing on Feierman and Janzen's (1992) opening quote, this discussion highlights how healing practices are inseparable from the cultural definition of the individual's place in society, and of the human body and its parts. In turn, the definition of dangerous or inappropriate social behaviour constructs the type and nature of care or treatment accessed.

As Chapters 6 and 7 will explain, it was reiterated on a number of occasion that both TCW, but particularly VW, saw biomedicine as a last resort for MCH (pers. comm. 15, April 07). Before reasons for this viewpoint can be discussed, however, there is a necessity to discuss the services available at the hospital as part of the broader biomedical model.

5.5.2 Biomedical health in Bunyoro

Within Bunyoro there is a mix of private and public health facilities including clinics, drug stores and pharmacies. Government health facilities are available from HCI up to HCIV. Table 3.2 (Chapter 3) outlines the different services available at these facilities. Kakindo HCIV, shown in Figure 5.10, was locally referred to as 'the hospital' and was the main health facility that served the sub counties of Bugangaizi.

Figure 5.10: Kakindo HCIV



Source: Personal fieldwork photograph

On average, 15 people would present at the Out Patients Department (OPD) of Kakindo HCIV daily. This number would almost double on Thursdays which was Kakindo market day so when patients would combine the lengthy trip to the hospital with a visit to the market. Highlighting the gendered nature of health space (Mackian, 2008; Nanda, 2002; Wallman, 1996) patients were overwhelmingly women and children; it was very rare to see a man queuing on the veranda of OPD, unless his complaint was an injury such as a snake bite or as a result of violent conflict. It was also notable how women and children would present at the clinic in their 'Sunday best', either the traditional Gomez or their smartest clothes. Figure 5.11 shows women and children queuing up, very early, waiting to see the medical officer who had not yet arrived. The young girl seated and wearing white is holding the green budget exercise books that all patients were expected to bring which served as their medical records. Figures 5.11 shows the consultation space of OPD.

Figure 5.11: The veranda where patients waited to be seen



Source: Personal fieldwork photograph

Figure 5.12: The consultation space

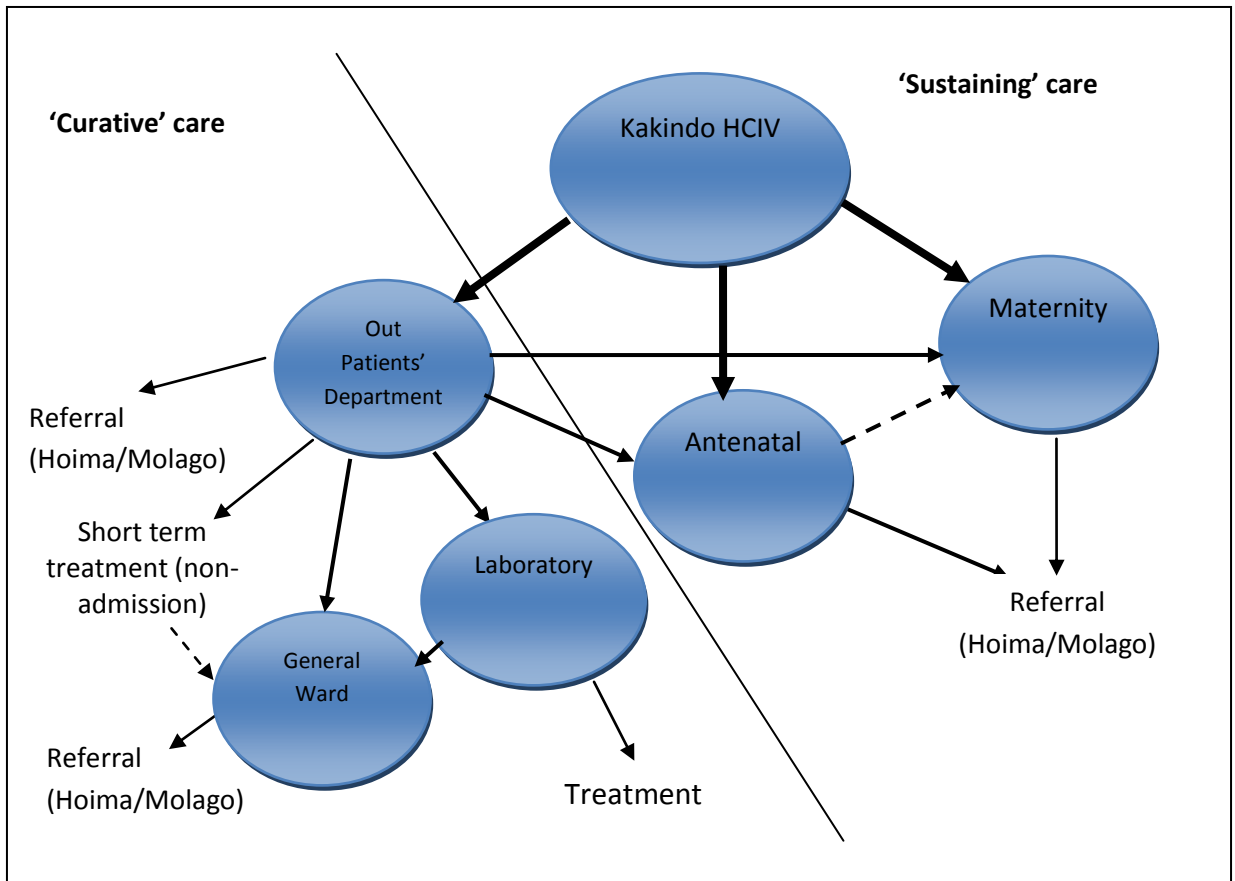


Source: Personal fieldwork photograph

The care available at Kakindo Health Centre IV (HCIV) could be split into two broad areas. Firstly, what will be termed 'curative care' which was the delivery of medicine or treatment to make people better. Curative care was delivered in the OPD, the General Ward and

through testing in the Laboratory and subsequent treatment. Secondly, preventative, or what in this setting will be termed ‘sustaining’ care, was delivered to prevent illness or to support a condition such as pregnancy which was not a medical emergency. Figure 5.13 shows the possible referral processes in the seeking of medical care from Kakindo HCIV which started at the OPD.

Figure 5.13: The processes of care seeking at Kakindo HCIV



Source: Fieldnotes

Consultation at OPD was the entry point into the healthcare transactions. Patients would present with a self diagnosis which the medical officer would confirm and prescribe appropriate drugs. If the drugs were in stock they were available free of charge (FN31). The details of the complaint and the diagnosis then had to be copied into the hospital records. Rarely was a physical examination conducted. Alternatively, a patient could be admitted to the GW of Kakindo HCIV, or referred to Hoima hospital or even the Molago hospital in

Kampala. If the patient was admitted to the GW, however, by virtue of the admission they received much longer, hands on care.

Technically, Kakindo HCIV had one doctor, one Medical In Charge (I/C), one registered comprehensive nurse, one enrolled comprehensive nurse, one registered comprehensive midwife and two enrolled midwives. 'Enrolled' means they were still training on a government programme whereas 'registered' meant the nurse had graduated. This was also distinguishable through their uniform. Registered nurses and midwives 'put on white', they wore the distinctive white government uniforms which were quite a status symbol, whereas registered staff wore simple pink dresses. 'Comprehensive' refers to a higher qualification. The hospital also employed one psychiatric nurse (male and never attended clinic), one nursing assistant, one laboratory technician, one records keeper and occasional student nurses on placement. There were also two 'sweepers' (cleaners) and a woman who ran a small kiosk shop in the hospital compound. A dentist visited every third Thursday of the month. There was however a high staff turnover so this skills base fluctuated somewhat. Of the hospital staff, four were from Bunyoro (FN32). The rest were Muganda by tribe all from Kampala or Jinja, Uganda's second largest city.

The hospital staff all owned some type of private drug shops or clinics. These ranged from very small dispensaries up to sizable health facilities offering maternity services and basic laboratory testing. It is actually illegal for Ugandan government staff to own a health facility or to be engaged in healthcare practice other than the government facility in which they are formally employed (pers.comm. 48, April 06). All of the staff, even the locally born Bunyoro, were use to a higher standard of living than Kakindo could offer. Many had trained in Kampala or Jinja where the standard of living was significantly higher. Many also had experience of working in private clinics (for other people) and much bigger hospitals, usually at Molago Hospital in Kampala, or in Hoima. Hoima was the neighbouring district which actually served as the referral hospital for Kakindo as it was much closer than Kibaale's referral hospital at Kagadi (see Figure 3.7).

5.6 Conclusion

This chapter discussed how Kakindo HCIV was under considerable pressure from a chronically poor district that had significant health problems. It also explained how women faced societal and, at times, very practical barriers that both affected and informed their chartered path to access MCH at Kakindo HCIV. What was overwhelming was that childbirth was just something that women were supposed to do as *omukyala omutufu*, or good woman. Pregnancy was not a medical condition, ergo required healthcare to sustain, rather than cure. The chapter also explained how despite the awesome responsibilities VW had to be 'good women' and produce the home and reproduce a number of children, they were highly subordinate in society. VW were reliant on their husbands to provide permission and money to access the health centre. They also faced many tangible barriers in the maintenance of health such as a lack of water, which had knock on effects on their health seeking behaviour. There was a notable increase in domestic violence, particularly for TCW, in relation to an increase in alcohol consumption which some associated with changing gendered norms and a rise in sexual promiscuity. In the polygamous society women also felt competition from co-wives to obtain support and resources from their husbands for the family. Whilst providing vital hospital 'assistants', kinship played a vital role in the sharing of place-based authoritative knowledges that could potentially empower. A lack of kinship within the many re-structured families left them at a considerable health-seeking disadvantage. Some re-structured families also lacked the vital support from the local community.

The chapter also explained that with broad understandings of health, particularly in a pluralistic health-system the decision of which healthcare model to access depended upon the identification of what was causing the illness or what healthcare was required. Potential MCH options included traditional healers, witch doctors, herbalists and TBA. The chapter also outlined the services available at Kakindo HCIV.

It is highly significant that despite all these societal and practical barriers and forces, both VW and TCW were willing, and able, to overcome them in effort to access antenatal care from Kakindo HCIV. It is further significant that, as the statistics suggested, VW and indeed TCW, were not prepared to overcome the same barriers to access maternity care with the

majority choosing to deliver with Melda, the TBA. Chapter 6 will look at the dynamics in the Antenatal Ward and Chapter 7 at the Maternity Ward in effort to explain why this might be. As Figure 2.1 illustrated, in order to provide a complete picture, the Chapters also acknowledge the role and impacts of carers, formal and informal, on the healthcare transaction.

Chapter 6: The Antenatal Clinic

'Abasaho basemereirwe. Tibakufaayo. Nkutiina'

('The nurses are proud. They don't care. I fear')

(Focus Group [FG] 3 – Village Woman)

'How am I to treat these clients when I don't even have paradol? They will
blame me but what am I to do'

(Nurse Pers.comm. 161, March 07)

6.1 Introduction

Chapter 5 explained that the government health-system in the chronically poor Bunyoro Kingdom, mid western rural Uganda, is facing serious challenges to the delivery of high quality care, particularly a lack of medical supplies, low staff morale and poor infrastructure. The chapter also discussed the broader societal norms and practical barriers through which the women had to charter a path to access MCH from Kakindo HCIV. This Chapter will discuss healthcare transactions within the Antenatal Clinic. As Chapter 1 explained, antenatal care represents a unique opportunity to improve the health of women and infants and ultimately improve infant and maternal mortality rates. Focus groups, however, painted an overwhelmingly negative impression of Kakindo HCIV in general and the antenatal care in particular. It also suggested, in line with Kiguli *et al.* (2009), that there had been a drastic decline in services over recent years (Focus Group [FG] 2, 4-5).

It is particularly strange, therefore, that despite the barriers women faced and the negative perceptions they had of the antenatal care delivered, the rate of attendance showed that clients were willing to attend the antenatal clinic (ANC). The coded-up data revealed a number of ways in which the women adapted their behaviour, utilised help and presented themselves differently in order to access the healthcare. As Figure 2.1 illustrated, it is suggested that their place-based knowledge allowed them to construct informal health spaces. Within those spaces, the place-based knowledge was sufficiently empowering to enable women to influence the healthcare transactions in effort to achieve their health

goals. As Figure 2.2 showed, however, that constructed informal health space was still embedded within the broader health place and thus was impacted by institutional norms. As a result, the influence over healthcare transaction was not in a positive manner.

In this Chapter, Section 6.2 outlines the services available at the ANC. Section 6.3 explains the clients' perceptions of the hospital in general and the ANC in particular. Four key constructed informal spaces will then be considered in turn. Section 6.3 will consider the constructed '*proud clinic*', 6.4 the '*non-clinic*', 6.5 the '*rushed clinic*' and 6.6 the '*resource less clinic*'. It has been acknowledged that within each constructed space, or clinic, there were still institutional practices and actors who had potentially different health aims. In order to understand the healthcare transaction in its entity, and to answer critiques of purely client based studies (e.g. Ndyomugenyi and Katamanywa, forthcoming; Kiguli *et al.* 2009; Kiwuwa and Mufubenga, 2008), the clinics will be considered from the clients' and nurses' perspective.

6.2 The Antenatal Clinic

The Antenatal Clinic (ANC) used to run only on a Monday and Thursday. At the beginning of 2006, the In Charge made it a 9am-2pm daily clinic, in theory, to make accessing antenatal more flexible but it also alleviated some pressure on the hospital and its staff. Thursday, was Kakindo market day so ANC was often particularly busy because the VW would combine the long journey with a trip to the market. The Immunisation Clinic also ran on a Thursday. Reflective of the high reproductive rate of the local area, some women would combine a visit to the Immunisation Clinic with a neonate with the first antenatal visit of their next pregnancy (see Figure 6.1). On average ten women a day would come to Kakindo hospital to be 'booked' (registered) for antenatal with the number easily reaching 40 on Thursdays.

Figure 6.1: Immunisation clinic on a busy Thursday

Source: Personal fieldwork photograph

Different nurses and midwives ran the clinics in their own way using various physical spaces of the hospital. The ANC, however, largely had three, occasionally overlapping sections to it. Firstly, clients were ‘booked’ or registered during a brief consultation with the nurse or midwife to explain any ailments. If the client was attending the ANC for the first time, details such as their home address, pregnancy history, estimated stage of gestation *etcetera*, had to be recorded in the ANC register. First time clients, therefore, made the initial consultation lengthy, particularly on busy Thursdays when there was an influx of new clients. Very occasionally, a client might be weighed, measured and have their blood pressure taken. When they were available, details were recorded on pink medical cards, but women were expected to come to clinic with an exercise book, to serve as their medical records. These were readily available locally at a cost of 200 Ugandan Shillings (200/=) which is approximately three UK pence. Whilst this was affordable, it was not unusual for a client to reuse her, or a friend’s, exercise book. All the clients were registered at the same time, and always in front of each other (see Figure 6.2).

Figure 6.2: The open air antenatal space where registration took place

Source: Personal fieldwork photographs

The clients were then called individually - or in twos if clinic was very busy - to a treatment room where they were palpated by the nurse to determine the stage of gestation, feel the foetal lie and listen to the foetal heartbeat. At this stage, drugs would be administered such as malarial prophylaxis, de-worming tablets, folic acid, iron tablets, and treatment for other ailments - if resources were available. Technically, drugs should have been dispensed from the hospital pharmacy. By dispensing drugs as part of the consultation, the midwife's hands would be covered in powdered residue from the tablets. Often as she then went to palpate the next client, she would leave her fingerprints of white powder on the mother's stomach. One midwife commented that she '*feared for contamination*' (pers. comm. 91, August 06). She explained, however, that clients were highly unlikely to go up to the dispensary after the clinic to collect drugs but also that using a spoon, or 'cutting' the medicine with paper, took too long on busy clinic days. Having a separate set of drugs in the ANC, however, made it difficult to keep records of drug use, and thus, stock. According to Government health care policy, such as the Health Sector Strategic Plan II (HSSPII) (2005) any single dose preventative medicine such as *Fancida* (malarial prophylaxis) and *Mebendazole* (de worming tablets), should be taken in front of the nurses at ANC. The midwife explained, however, this could not happen because '*there was never any paraffin*' (pers. comm. 89, August 06) to boil water to make it safe to swallow tablets with. *Mebendazole* could be (unpleasantly)

chewed, but Fancida was not swallowable without water. The nurses feared that because the 'women aren't use to swallowing proper medicine' (pers. comm. 60, August 06), they were either discarding or selling the tablets. Some nurses also administered the tetanus vaccine as part of the consultation.

The nurses all had different approaches to clinics, but most separated out a third stage which involved giving the results of testing such as for HIV, syphilis or checking Haemoglobin levels. Having explained how the ANC clinic ran, the next section will discuss the women's general perceptions of the clinic which led to their use of place-based authoritative knowledge to construct informal clinics in which they could influence the healthcare transaction in effort to achieve their health aim.

6.3 Perceptions of the hospital

VW had an overwhelmingly negative impression of the health services at Kakindo HCIV. They spoke of the social difference between them and the young, educated, professional and English speaking Buganda healthcare workers. The village women believed the nurses were 'proud' and 'rude' (as supported by the findings of Ndyomugenyi and Katamanywa, forthcoming) and viewed them as dirty, smelly, poor villagers who did not have the 'right' clothes or shoes to come to hospital (also found by Kiguli *et al.*, 2009; Kiwuwa and Mufubenga, 2008; Kaye, 2000). The women said the nurses were physically intimidating, in part due to their uniform, but also because of their smart 'town' clothes, high heels, jewellery and elaborate hair weaves. Banyoro VW particularly felt they were conceptualised as a backward, lazy tribe that were associated with witchcraft.

According to Kaye (2000), good quality maternal health services are those that are readily accessible, safe, effective and acceptable to potential users and are staffed by technically competent people who are helpful, respectful and non-judgemental. VW had had very different experiences of the maternal health services available at Kakindo HCIV. Supporting much current research, VW said the hospital was disorganised, unsanitary, that there were animals everywhere (see Figure 6.3) and that there were never any drugs available (see also Kiguli *et al.*, 2009). The nurses were lazy, late and often entirely absent from clinic (an opinion that was also found by Ndyomugenyi and Katamanywa, forthcoming). VW felt the hospital was a very public place where there was little privacy, even from male members of

staff (FG2, 5, 6). They said the nurses deliberately prescribed brand name drugs which were only available in their private clinics and they did not trust the dosage or expiry dates. They also blamed the lack of drugs in hospital on nurses stocking their private clinics (FG1-5) (see also Jitta *et al.*, 2003).

Figure 6.3: One of the antenatal treatment rooms



Source: Personal fieldwork photographs

VW were worried they might be referred to Hoima hospital for a caesarean section or if complications were discovered (FG3) (Kiwuwa and Mufubenga, 2008). Some women were terrified they might be tested for HIV against their will (FG1-2, 4-8) (also see Harling Salyer *et al.*, 2008; Dahl, 2008). VW also said that the antenatal clinic (ANC) could be generally confusing. It was unclear where to go within the hospital, especially for first time clients (FG2, 3, 6, 7). Other clients were more concerned about general etiquette. There were not sure, for example, when to stand in front of a nurse and when to stay seated. In focus groups many clients joked about how their nerves made them clumsy and awkward which made them “*seem more like villagers*” (FG2) as they knocked things over, bumped into each other or tripped up.

TCW, on the other hand, had a much more pragmatic view of the hospital. One client said:

'yes, the nurses are proud, but you can learn how to handle them. Ok, you have to be careful they don't refuse to treat you but me, I don't worry about them, I know them, so they treat me somehow ok. I wouldn't deliver from there [the government hospital], but antenatal is free and drugs are normally there. It's different for the villagers though.' (pers. comm. 87, July 06)

It is indicative that throughout the eighteen months of fieldwork, a client never returned for a subsequent, normal delivery. There were occasions in which a client had to return due to an obstetric emergency and there were many *prime gravida* (PG, first baby) normal deliveries, but no repeat normal deliveries. As explained, on average, 65 clients a week were registered for antenatal care. In contrast, however, only approximately ten women a week would deliver in Kakindo HCIV. Furthermore, it was not unusual for a woman to present to the ANC for the first time whilst in labour, but refuse to be admitted to hospital. On examination, one woman had a cervix dilation of eight centimetres (i.e. she was in the final stages of labour) and yet she preferred to walk the eight kilometres back to her village to deliver from home (Field Notes – FN98). Her obstetric history listed her as gravida 7, para 2, abortus 1 – of her seven pregnancies she had only two living children and yet, in highly advanced stages of labour, she chose to walk the 8km back to her village, rather than delivering in the government institution.

In contrast to what some studies suggest, Kakindo clients clearly recognised the advantages of attending ANC. In Kyenjojo District (South Western Uganda), Ndyomugenyi and Katamanywa (forthcoming) found that the reason for over half their sample of village women not attending ANC was because, adhering to the Ugandan gendered norms of health, they did not perceive themselves to be sick and therefore felt they did not require treatment. In Kakindo, however, the women recognised the advantages of ANC to support their pregnancy, particularly when the reproductive rate was so high and their lives were so physically taxing. Their actual medical knowledge was limited; they did not know, for example, the specific advantages of certain drugs, or what the tetanus vaccine did, but they recognised that going to ANC was advantageous for their health and that of their baby. This was largely due to the bombardment of health messages broadcast on a community radio station, set up by a large NGO in early 2006. As the only form of entertainment, most local

people had access to a radio, either personally or within the community. These were cheap, battery operated, plastic copies of well known brands, mass produced in China and bought from local markets via Kampala (FN39). The effectiveness of mass media in promoting health behaviours has been debated (for example see, Harling Salyer; 2008, in contrast to Flora and Wallack, 1990). As Chapter 5 discussed, however, due to women's lifestyles they spent a lot of time together discussing health matters. All women in Bugangaizi, but particularly VW, therefore, were able to access - and share - healthcare information and experiences. As a result, women knew both the benefits to their pregnancy of antenatal services, but also, and crucially, what they were entitled to as part of the government antenatal care.

In contrast with Kaye (2000), but in line with Amooi-Kagunau and Nuwaha (2000) and Neema (1994), many VW quoted the importance of having an ANC number. This was literally the number they were given when they registered at antenatal clinic, composed of the year's running tally, and the number of that year; so the 48th client in 2007 would be 48⁰⁷. It represented a whole lot more. The women were very pragmatic about the risks they faced if they chose to deliver with a traditional birth attendant (TBA), or in the village. Most VW had experience of a friend or family member dying in the village due to complications associated with childbirth. They recognised that if complications arose, they would need to go to hospital. As Chapter 5 discussed, the VW also recognised the pragmatic difficulties associated with physical access and transport within the rural landscape, and thus, realistic potential delays in access at the most critical time (see also Kiguli *et al.* 2009; Parkhurst and Sengooba, 2005). A dominant belief was that presenting at hospital as an emergency obstetric case would be much easier with an antenatal number. A recent example was often quoted of a mother who presented as an emergency case, but the nurses refused to treat her because she had no antenatal number. According to the tale, she subsequently died (FG 1-4). There was no record of this incident in the maternity register and the nurses dismissed it as rural myth. Whilst they could rationalise their behaviour in relation to antenatal numbers, which will be discussed, having an antenatal number clearly influenced the client's behaviour.

In light of these overwhelmingly negative perceptions, it is perhaps surprising that over 60 women a week would attend the antenatal clinic. During focus group discussions the VW's

negative discourse about how they had altered their actions to cope, or influence, healthcare transactions constructed a number of informal clinics within the antenatal clinic. The next section will discuss each of these constructed clinics in turn from the clients' perspective but crucially, also from the nurses' perspectives.

6.4 The proud clinic

Clients would often refer to nurses as being 'rude' and 'proud' (*basemereirwe*). A number of previous studies, such as Kiguli *et al.* (2009) and Harling Salyer *et al.* (2008), have suggested that these perceptions act as barriers to poor people accessing healthcare. In the ANC, clients constructed an informal clinic in which they adapted their behaviour in effort to minimise the social distance between themselves and the nurses. In some healthcare transactions, this proved successful and the clients were able to achieve their health aim. In others, the efforts made the situation much worse. The following sections will outline first the clients' construction of the 'proud clinic' through their behaviour and then the nurses' perspective.

6.4.1 The clients' 'proud clinic'

The vast social distance between the educated, professional, English speaking nurses and the poor VW was mentioned in every focus group (FG 1-8). The VW described the nurses as rude, impatient and highly intimidating, as also found by Kiguli *et al.* (2009). This was particularly explained through their physical appearance, which was seen as an expression of power. The majority of the nurses actually rarely wore their uniforms, unless they were comprehensive nurses and thus the most qualified. These women were said to 'put on white', which was the colour of their uniform but also a real statement of success and power (Rosch, 1978; Tajfel, 1978). Sparrow (1991) noted the fear and respect the nurses' uniform instilled in patients compared to those wearing less formal attire. This is why, in the developed world more healthcare providers now wear 'street clothes', particularly if they are delivering long term care, (Shakespeare, 1994; Finklestein, 1993; Rafaelo and Pratt, 1993). Uniform is a phenomenon that reflects important processes and induces various outcomes and can be a useful window to view multiple and competing social identities within an organisation (Rafaeli and Pratt, 1993). The nurses' smart street clothes, therefore, were actually an informal uniform and a statement of social power over the clients (see, for

example, Barnes and Eicher, 1997). It was also illustrative of their rebellion against the institution as they refused to wear their uniform.

It would follow that in front of the smart nurses, the clients' social distance through poverty was emphasised. A post-structural analysis, however, challenges this structural process in context and identifies the informal clinics the clients created for themselves which contested and negotiated this identity in place. The VW's pre-clinic preparations, for example, often became a subject of discussion at focus groups. They spoke about cutting their, or each other's, hair especially to go to clinic (FG1, 2, 4), and taking special care to apply lotion to their skin (FG1, 4). The day before a woman went to the ANC was often concerned with washing and ironing clothes (pers. comm. 140, December 06). It was clear that at clinic the VW wore their 'Sunday best'; if they could, the full traditional *Gomez*, if not their least tatty clothes. Walking barefoot, or wearing 'slippers' made locally from recycled car tyres or cheap plastic, were well recognised symbols of poverty (see for example Mascie-Taylor *et al.*, 2003). In effort to disguise this, VW often borrowed shoes. In one particular clinic three women shared the same pair of shoes and a handbag, each passing them to the next woman waiting as they left the treatment room (ANCCASE 4). Some VW often wore or borrowed cheap, plastic bead necklaces or bracelets. Many women said they would seek advice from family and friends about what time to arrive, where to sit, what to bring and how to behave. Ideally they went to clinic with a friend from their village.

That sense of unity within the almost domestic space challenged the traditional hegemonic social power relations and ways of knowing. It enabled the women to take control of the healthcare transaction to their benefit, at least to some extent. By renegotiating the 'poor' identity which VW viewed as a potential hindrance to their healthcare experience, they were empowered sufficiently to increase their propensity to risk taking (Bourdieu, 1984). Coupled with the authoritative knowledge of the collective group of VW seeking antenatal care, they created a space in which they reduced some of the social distance (Jordan, 1993) which increased confidence and capacity to influence the health outcome. Their identities were closer to who they felt they should be to assist the healthcare transaction (Moss and Dyck, 1999). As will be explained in the *rushed-clinic* this shared sense of unity benefitted the women as, at times, they assisted each other in difficult clinics.

The efforts to minimise social distance, at times, however, backfired on the clients. Many of them were not used to wearing more formal dress, or had to improvise with safety pins or rope where buttons and sashes were missing. They often, therefore, struggled to undress for consultation which delayed and angered the nurses. The buckles or laces on shoes were practically difficult. Many women would struggle for a good fifteen minutes to fasten buckles only to walk four feet to have to remove the shoes to get on the consultation bed. One VW lost her place in the queue because she took so long to get her shoes on, but insisted on waiting until the end of the clinic just so that she could walk in wearing shoes - and then struggle to take them off. Many VW were also just not used to wearing shoes - especially high heels - and would struggle to physically stand and walk (see Stilgoe, (2001) for discussion about the tactile advantages of walking barefoot in difficult terrain and Mascie-Taylor *et al.* (2003), for health problems associated with walking barefoot and poverty). As will be explained, many VW walked for several kilometres to reach the clinics, so when they arrived they were hot, sweaty and dirty. Additionally, beneath their formal dress VW usually were not wearing underwear or wore the traditional red, black and gold cloth underskirt of a VW. This did not go unnoticed by the nurses.

Many women also spoke of being 'betrayed' by their villager bodies. A post-structuralist theoretical perspective of the body suggests there is no such thing as a 'natural' body that can be separated from society and culture (Lupton, 2000). Meanwhile using the theory of disability and impairment, Hughes and Paterson (1997) and Hall (2000) suggest that the actual, material entity of the body, the blood and bones, has been neglected under constructionist theory. Moreover, Hall (2000) and Longhurst (1995) suggest the importance of the in-between, the geographical 'other' in which the body is seen as social and social processes are part of the body or embodiment. Skin complaints, such as scabies, for example, are common in poor areas, as are the scars of tape worm. Both present physical marks on bodies that are synonymous with poverty. Women also regularly bore the scars of receiving treatment from a traditional healer or herbalist and had what the nurses called 'villager's breasts', a product of bearing up to 14 children. It was Connell (1983) who suggested that social practices can change the biology, or form of the body. Connell argues these changes have lasting effects on the body, not just in creating muscles and shape, but actually transforming posture, bone structure *etcetera*. Most of the VWs had physically laboured for all of their lives which was clear from their aching limbs and joints and their muscular arms and calloused hands. On numerous occasions in Prevention of Mother To

Child Transmission (PMTCT), for example, a hypodermic needle had to be used to draw a drop of blood because the point of a lancet was not deep enough to penetrate the thick skin of labouring fingers. These socio-cultural processes and practices became part of the person; they were 'embodied' (Hall, 2000).

Over time, therefore, the history of the body builds up which not only provides context for present and future interactions and body shapes, but allows bodies to be physically 'read' (Rose, 1997). As Rose (1993:32) put it, 'far from being natural, bodies are maps of the relation between power and identity' on which social practices are marked or embodied. VW's bodies, therefore, could be read as villager bodies, constructed through the social practices that dictate their lives, including alternative forms of caring such as herbalism. Some marks, therefore, physically carved poverty on to the women's bodies. Shilling (1993) adds to this discussion by suggesting that embodiment is not just restricted to physical changes but also incorporates changes to the mind and a less tangible embodiment, for example the presence of power or sexuality. Shilling (1993) does not, however, factor in place. As contested bodies are produced and consumed in particular places and localities, the same body that is so betraying in the constructed 'proud clinic' is also a vital element of survival in a rural poor village. Poor women have to be physically strong to work, but, as Nast and Pile (1998) suggest, location and context are key to how bodies are experienced, read, constructed, produced and reproduced. Within the ANC therefore, no matter how smart the outer clothing, the body beneath was the physical embodiment of the lifestyle of a villager who was socially distant from the nurse. Regardless of being smartly dressed, the poor body also served as a tangible reminder to the nurses of how 'difficult' these clients were; as will be discussed. Within the 'proud clinic', therefore, bodies were socially and culturally inscribed within a moral and institutional regime (Valentine, 2001). The cultural inscription, and indeed efforts to hide it, immediately categorised women in a certain social field.

6.4.2 The nurses' 'proud clinic'

The nurses knew that the VW, and to a lesser extent, the TCW perceived them to be proud. The nurses were frank that they felt their professional status and identity required fitting behaviour and through this justification openly admitted that their behaviour could be perceived as proud. This was reflective of how their personal construction of self informed

their approach and care in a formal and informal setting. The nurses saw themselves as educated professionals who were worthy of a much better life and recognition than they received within Kakindo. A pursuit of this recognition often led to their absenteeism from clinic. They did not stigmatise against poor people, *per se*, although they did expect a certain level of behaviour that was respectful of their status as professionals. They would chastise women who were dirty and smelly. Their rationale for this was that it was unhealthy, particularly in relation to the women maintaining sufficient levels of hygiene to properly care for a baby. It also put them at risk. Scabies, for example, is highly infectious on skin contact.

Nurses often justified what could be considered their 'proud' behaviour, as being in the clients' best interest. Their potentially harsh behaviour towards underage pregnant mothers, they said, was in deliberate effort to instil some sense of responsibility and family planning. They saw this broader education informed by their proud behaviour as part of their duty of care to the poor women. They also explained how difficult clients could make the clinic when they withheld information which was vital to treatment. A dispute broke out during one clinic, for example, where a mother in labour refused to reveal her HIV status (ANCCASE 7). The nurses did not negatively stigmatise HIV+ mothers indeed, they often went out of their way to assist them. The nurses would argue with mothers, however, when they withheld their HIV status.

There was very little pragmatic difference between the antenatal treatment of an HIV+ mother, apart from the dispensing of anti-retro viral drugs and some occasional advice about nutrition and delivery. The process of delivery was the same, except the nurses would take greater precautions such as bandaging small wounds and wearing two pairs of gloves. The nurses knew, however, to seek emergency help if, for example, she received a needle stick injury. The nurses also delivered babies in a manner to reduce the risk of HIV transmission via exposure to bodily fluids. There was no reason why the same precautions could not be utilised for all deliveries with the exception of the speedy administration of *nevirapine*. The nurses felt, however, that the mothers' were deliberately withholding information which was a challenge to their professional status (FN6).

Similarly one VW registering for antenatal said she had no previous obstetric history. It was only on palpation that the nurse discovered a caesarean section scar. Kakindo HCIV is not equipped to deliver women with caesarean section history so all cases have to be referred to Hoima. The nurses' rationale for her anger was that vital time had been lost; if the woman had said she had a caesarean scar, she would have been consulted first (ANCCASE 6). Clients would also withhold information about other treatment, perhaps bought from a drug store, which risked wastage of hospital resources and potential overdose (ANCCASE 2). The nurses explained that they would be blamed for poor healthcare practice if there were negative repercussions and yet they were dependent on the clients to divulge vital information.

Working in the clients' best interest was also the nurses' rationale for stressing the importance of an ANC number. In one discussion a nurse dismissed claims that she would refuse to deliver a client who did not have an ANC number. She believed vehemently in the advantages of ANC to a successful delivery and the mother's long term health and explained she wanted to instil the same belief in the clients (pers. comm. 147, Dec. 06). Nurses also spoke of the potential damaging effects of traditional healing. Like many Muganda, the nurses were Born Again Christians, so did not believe in the powers of supernatural forces, or at least in theory. They often spoke, however, of how vulnerable their children were to the local Bunyoro. A major problem in the hospital was the local belief that if somebody had been cursed and then engaged with 'white man's medicine', particularly an injection, this acted as a catalyst to speed up the effects of the curse, ensuring a prolonged and horrible death (see also Langwick, 2007). The Local Councillor for Health explained that if a mother had been forced to go to the hospital after being cursed or visiting a witch doctor, she was doing so as *'a last resort and probably did not expect to come out alive'* (pers. comm. 164, April 07). There had also been many informal discussions about the high death rate at Kakindo HCIV. This was because people delayed presenting at clinic until they were in a critical state. The nurses feared, therefore, that patients would delay presenting at clinic due to traditional healing, or would present with complications that they were unable to treat. With the limited resources of Kakindo HCIV there was little that could be done to save them but the high death rate reflected badly on the nurses' practice. At a staff meeting it was also reported that Hoima hospital had complained that Kakindo healthcare workers were referring patients who were too sick, often as a result of delayed presentation after traditional healing. Few VW had the means or resources to make the journey to Hoima but

of those that did, many either died en route or at Hoima hospital. At the time, Hoima was attempting to deflect much media attention due to its poor facilities, to the extent it had become known as 'a centre of pain, disappointment and frustration' (Kato and Kayizii, 2006:4). The increased death statistics as a result of Kakindo referrals was a further unnecessary negative reflection on Hoima's healthcare practice. The nurses at Kakindo thus saw their vocal prejudice against traditional forms of knowledge that conflicted with the biomedical system as a way of educating women against this danger.

Whilst the nurses' acknowledged that they could be perceived as 'proud', they justified this as either being motivated by concern for the women's long term health, or as a legitimate response to behaviour that questioned their status. Their status in society, and recognition thereof, became a running theme and explanation for their approach to a number of clinics. The best example is within the non-clinic.

6.5 The 'non-clinic'

Whilst antenatal clinics were supposed to run daily, Monday to Saturday, they regularly did not happen. Clients would talk about 'bouncing' from clinics which meant they arrived, '*found nothing and left empty handed*' (FG1). Absenteeism from clinics has regularly been cited as a reason why clients do not use antenatal services the world over (see for example, Lindelow and Sernells, 2006; Dreesch *et al.*, 2005; Figuero-Munoz *et al.*, 2005; Kober and Van Damme 2004). The next sections, however, will unpack this situation from both a client and healthcare workers' perspective and discuss the informal healthscapes generated.

6.5.1 The clients' 'non clinic'

In focus groups and informal discussions, both TCW and VW, lamented the number of times they had 'bounced' from ANCs due to a lack of nurses. If TCW reached the hospital and bounced, they would just leave. They lived within a short walking distance of the ANC or along the main road and for them a taxi fare was not a considerable expense. It was also much easier for them to return to the clinic on another occasion. As Chapter 5 explained, by virtue of VW living so deep in the bush, travelling to reach the clinic took considerable time and effort. Furthermore, there were significant implications if having reached the clinic, they bounced.

As Chapter 5 explained, VW were reliant on permission from men to attend the ANC and indeed, money for transport (Mugisa, 2005). Access to the hospital was difficult. As Chapter 5 explained, public transport was expensive and unreliable so most women walked. VW would leave their homes very early in the morning to reach the hospital before it became too hot, or, particularly on market days, the road became too busy and dusty (FG2-4). VW often walked vast distances to the ANC anywhere up to full term. The women's concern, however, was less about the physical exertion. Many VW were still actively digging in the fields well into their third trimester so walking twelve kilometres was not over strenuous (see Longhurst, 1995 for a critique of the discourse surrounding physical exertion in the late stages of pregnancy). They were more concerned, however, about the time this took away from their productive and reproductive responsibilities at home. Many VW also spoke of how, when they reached the clinic and bounced, they feared returning home to explain to their husbands that the time and money had been wasted. It could take weeks for a family to save sufficient money for antenatal care again, by which time, relatively minor complications such as anaemia may have increased, or it might be too late in their third trimester to take drugs such as *fancida*.

Some studies suggest many women in the developing world have little or no time to avail themselves of health services due to their productive and reproductive commitments (e.g. Kyomuhendo, 1997). In the context of the ANC healthscape, a common complaint was that clinics were never formally cancelled. It was common knowledge that the nurses were usually three or four hours late for clinic, so the clients had the difficult decision of whether to wait just in case the nurse appeared, or to leave the clinic and not waste the day, especially during the harvest season.

It was not unusual, therefore, to find hot, tired, hungry women sitting dejected on the floor of the ANC clinic. Many had had to bring breastfeeding children who quickly became restless. Geographers have recently called for greater attention to be paid to the 'everyday experience' of health in place (Baer and Gesler, 2004; Tonnellier and Curtis, 2005); it is suggested here, that in their disappointment of the non-clinic, an informal health space was constructed through the sharing of everyday experience of health in place. This, in turn, shared some potentially useful authoritative knowledge. All the clients had experience of childbirth and the majority had some experience of the government health facility. They all

had time to kill, and, in their frustration, they were all willing to speculate on why the clinic was not happening. Mulemi (2008), Baer *et al.*, (2003) and Cleary (2003) suggest that although patients' perspectives and experiential responses are subjective, they constitute an important level for understanding healthcare issues in a health-system, particularly when rumour spreads quickly. As discussed, in rural villages women spend a lot of time together, furthermore, the 'bush telegraph' is an immensely powerful tool of communication. Walking home from the hospital one evening, for example, I tripped on a pothole. Despite there being no mobile phone network, within ten minutes, a neighbour cycled out to assist me; this incident highlights how just by word of mouth, general information spreads incredibly quickly, especially if it is of an emotive or emergency nature. It is well recognised that patient satisfaction is one of the factors that influences whether a person seeks medical care, complies with treatments and maintains a relationship with the provider/health facility (Brawley, 2000). In turn, it follows that perceptions or assumptions about healthcare shape expectations of delivery, both positive and negative (Kiguli *et al.*, 2009; Ager and Pepper, 2006; Radley and Taylor, 2003) and thus the likelihood of healthcare access.

Within this constructed space of dejection, a different social order, or caring nexus arose. The knowledge of the most experienced women - usually a client who was older and had a number of children - constructed her identity as the informer and gave her power to lead the conversation (Mckie *et al.*, 2002). After a couple of hours clients, who were otherwise strangers, would engage with each other. This was often through impromptu discussion about whether or not to wait for the nurses, or in conversation about babies they had brought to the clinic; it was not unusual for women to offer nursing mothers water, or food, for example. A common sense of unity and shared belonging was then created within the constructed space. The women would never sit on the antenatal benches but instead sat on the floor of the clinic on their *lessu* (the piece of cloth that VW always wore tied around their waists), or under the shade of the large molinga tree in the compound. The identity and power of 'the lead' woman was constructed through her advice to the less experienced women, particularly PGs. She would guide the caring conversation within this newly created informal space. The women *cared about* (to use Milligan and Wiles', (2010) analogy) each other enough to convey practical advice such as which drug shops were most reliable in relation to price and which TBAs offered the best service. 'Old wives' tales were discussed concerning herbal remedies for ailments and the ways to ease normal symptoms of pregnancy that were affecting their work such as backache.

Within the constructed space, knowledge was also exchanged as the VW conveyed 'tips' as to how to mitigate the healthcare transaction. One VW, for example, spoke about bringing 'her sister' to clinic. The term derives from bring 'an assister' which is colloquial terminology for a bribe. You would never enter a police station without 'assistance', for example, either money or a crate of soda or beer. The sister of this VW was her surplus mango crop. She knew most nurses did not have their own land and thus were reliant on the rare and expensive wares of the trading centre (FN2). Mangoes became her currency to buy a good service. Other conversations noted the differences between what clients were entitled to from government care and what they received at the clinic. Often this was related to drugs, or lack thereof. Amongst this caring 'chit chat' of shared health behaviour conversation would develop into highly exaggerated horror stories of complicated or emergency deliveries in the hospital. Speculation was rife about why the nurses were so regularly absent, and why they delivered the (perceived) poor quality care. The perception that the nurses were rude and proud was routinely confirmed. It is suggested, therefore, that this informal space, ironically generated due to the lack of clinic, empowered women with information to affect the healthcare transaction to potentially achieve their health goals. It also served however, to perpetuate misunderstandings of why the nurses were absent.

6.5.2 *The nurses' 'non clinic'*

Unlike the difficulties McPake *et al.* (1999) encountered, the nurses at Kakindo HCIV were very transparent about their absenteeism from clinic. This highlights their level of despondence with the healthcare system that employed them and thus their necessity for self protection. The nurses hated their lives in Kakindo. They felt they were under appreciated, undervalued and had few opportunities. Nursing and healthcare staff at Kakindo HCIV would frequently say they were 'struggling', 'suffering' and 'neglected'. They would regularly comment that their 'status' or identity as educated professionals, and their vital role within the community was 'unrecognised'. The nurses had particular expectations and beliefs about how they and their social status should be perceived, as informed by the social, political and institutional constructions of healthcare workers (Simmons and Bennett-Jones, 1989). Beyond the respect they felt they should be shown in the hospital as care givers and restorers of productivity (see Chapter 2), the nurses felt they should be able to tangibly display their status. They often spoke, for example, of how, by virtue of their profession, they '*had to send.... children to the best schools in Kampala*' (pers. comms. 105,

June 06), or been seen buying new clothes, or be able to entertain. In Uganda, it is considered rude to not invite people to share food, or at least *chai* and *bugoya* (tea and ripe yellow bananas), should they visit. Even the most poor of families will offer a small token in welcome. In Uganda in general, public perception and particularly recognition of people's social status, was highly important.

The nurses also had the monopoly of the health-system breaking down the patriarchal family arrangement in which the nurses (as mother) were part of an ideological resonance of power and thus were subordinate to the male doctors (see also Mark (1994) and Gamarnikow (1978)). There were no doctors at the hospital so the nurses had supremacy, even over the In Charge. For the nurses, however, the ANC personified a low recognition of their authority. As pregnancy was so 'everyday', antenatal clinics embodied routine, mundane care delivery. Furthermore, the clients were often dirty, uncooperative and generally more effort than the nurses felt their professional time was worth. Similarities can be drawn here with Milligan and Wiles' (2010) discussion of informal spaces of care in which domestic labouring is undervalued, creating resentment. Roenen *et al.* (1997:127) discussed how nurses adopt 'strategies to cope with the often extreme discrepancies between social, economic and professional expectations and real-life situations'. When the nurses were absent from the ANC they were frank about their absenteeism. Ordinarily they were at their private clinics or drug shops or in the administrative centre of Kibaale accessing their salary or discussing potential training. Both of these activities were in an effort to honour their professional identity through status and direct payment. The nurses' recognised the disruption their absence caused to the clinic, and, by virtue of their contribution to a multidisciplinary team (see Baxter, 2002), to the hospital in general. They saw their absences, however, as legitimate coping strategies for dealing with the difficult conditions in which they were forced to live and work.

For the nurses, their government pay, or lack thereof, was a particular issue. A survey of African health workers who had migrated, or were intending to migrate, showed that issues of salary and living conditions dominated their decision. In Uganda, 72% of health workers cited salary as their main reason for intending to leave the country (Hongoro and McPake, 2004; Vujici *et al.*, 2004). Illustrative of the motivating capacity of salary, it is well recognised, and unsurprising, that poor remuneration is a significant factor that pushes

workers out of the public health sector or even the country (Hongoro and McPake, 2004; Mueller and Price, 1990). As the fieldwork commenced, the staff had not received their pay for nearly three months. The DDHS explained that this was due to the nationwide and well publicised ‘technical error’ in which, due to a computer glitch, hundreds of public sector workers nationwide had disappeared from the payroll. Teachers and healthcare workers in rural areas were particularly affected. In reality however, this accounted for a month’s salary and the nurses had not been paid for two months prior to the incident. The ‘technical error’ was responsible for a short term delay in payments but this particular incident was quickly and very publically rectified as civil servants were reregistered. For the nurses at Kakindo, however, pay continued to be unreliable and, until September 2007 (the end of the fieldwork), the nurses still had not received the back pay owing to them. Furthermore, the Human Resource Inventory (HRI) which was conducted as part of the Government’s Health Sector Strategic Plan II (2005/6-2009/10) to generate information about the staffing situation in the health sector, found major discrepancies between the actual payroll and the staff claiming payment. There were indications of double counting of staff and retired or deceased staff still being paid. Yet the nurses were not being paid. Whilst waiting for a nurse to arrive for clinic, the voluntary HIV counsellor said he had not seen her for several days which he said was because she, like healthcare workers in general had, ‘*no money so no enthusiasm*’ (pers. comm. 133, October 06). The nurses spent many days when they should have been at clinic trying to retrieve missing payments.

The nurses’ lack of enthusiasm extended further when staff felt their pay - when they received it - was not representative of their training. For the individual employee, pay is viewed as an important reward or outcome (Lum *et al.*, 1998) which should be reflective of their (perceived) level of work. One member of staff, for example, was an enrolled, comprehensive nurse; she was far more qualified than any of the other nursing staff and was often called upon for help in emergency situations. Her position was only created by the government in 2000 as part of a move to cut costs by promoting specialist training which would bridge the work of a number of health professionals (HSSPII 2005). Part of this initiative established a cadre of comprehensive nurses who are qualified as both nurses and midwives, thus reducing staff requirements especially in quieter rural areas (Hongoro and McPake, 2004; Sengooba *et al.*, 2003). For this member of staff, her qualification was so new it was not fully recognised. Her official uniform was that of a registered nurse and nurses far less qualified than her were receiving greater pay. As she put it, “*why should I*

struggle when I'm not even recognised?" (pers. comm. 85, July 06). It is also significant to note that despite her higher level of training, which in theory was a cost reducing exercise, she worked in addition to, rather than instead of, the other staff so was largely surplus to requirements unless in emergency circumstances.

Chaudhury *et al.*'s (2006) study on the absence of teacher and health workers in developing countries, noted that the wages of national civil-service systems are typically not fully responsive to local labour market conditions, nor to individual characteristics and are often compressed relative to those in the private sector. The nurses at Kakindo spoke about *'struggling to make it (their salary) last'* (pers. comm. 83, June 06), especially when they had to pay school fees. Nurses would often also complain that, as part of their salary, they did not receive a subsidy for working in the rural area which nurses employed in the private sector generally received to offset the recognised difficult working conditions. The majority of their resentment stemmed from a government drive to recruit more nursing staff to the rural areas by offering a significant financial incentive (Balagadde, 2006; Nabusoba, 2009). Hongoro and McPake (2004), recognise the advantages of such incentives in a broad range of settings. Eichler *et al.* (2001), for example, show that indicators of achievements improved when a bonus system was introduced in Haiti. Rodrigues (1989) shows a similar outcome in Brazil, Mooney (1994) in Denmark, van Damme (2001) in Cambodia to cite but a few examples. The new scheme in Uganda, however, would not compensate nurses already employed in the rural areas. Clearly such incentives work and it follows that a direct denial of incentives to some could cause bitter resentment. After the initial unveiling of the scheme in the national media, it was the sole topic of conversation at Kakindo for many days, with the nurses angrily suggesting this was one of many examples of how they are neglected and underappreciated in the government healthcare system.

To supplement poor salaries to a level they felt representative of their status, therefore, many of the nurses engaged in dual working practices, or 'informal' economic activities (McPake *et al.*, 1999). These were normally private clinics or drug stores, but occasionally involved other sources of income such as a shop, restaurant and in one case, a small garage. The scale of these businesses was reflective of the nurses' qualifications and age (see McPake *et al.*'s 1999 discussion of the three sets of factors – local economy, health worker's characteristics and national and district health policy - likely to determining health workers'

choice of additional economic activities). One enrolled comprehensive nurse, for example, had a clinic in Katekara that rivalled some of the services available in Hoima. Time spent within these businesses resulted in their absenteeism from the government ANC. Whilst it was common knowledge that the healthcare workers all had their own health facilities, it was illegal under government law. This was illustrative of the flexibility the nurses enjoyed and their lack of managerial supervision. At the time, however, the news was dominated by reports that the Health Minister, Jim Muhwezi, had been charged with the gross misuse of \$4.3 million intended for children's vaccines as part of the Global Alliance for Vaccines and Immunisation. With two other ministers he was also accused of the mismanagement of money granted to Uganda by the Global Fund to Fight Aids, Tuberculosis and Malaria (Grainger, 2007). More recently, in May, 2010, three Ministry of Health senior officials were accused of diverting government drugs worth over \$4.4 million to a private company (Mugeni, 2010). In light of this high level of corruption within the health-system, a government healthcare worker owning their own health facility ranked lowly on the government health priorities. In Bunyoro, however, the government could also not risk losing the nurses from already understaffed rural areas.

In such a poor area, coupled with the salary from government employment (albeit unreliable), the additional income from a private clinic could actually lead to a good standard of living. Arguably, as much as the nurses complained about living in Bunyoro, the freedom to earn an additional income and achieve a decent standard of living, acted as a disincentive to leave the government health-system. Whilst the private sector was better paid and there were more training opportunities, it was much more regulated and monitored and higher standards were expected. As one nurse explained that in private facilities *'you are actually expected to work. And if you don't turn up for work, they are ever raising (telephoning) you, checking what is what, there is no freedom'* (pers. comm. 80, June, 06). Such coping strategies, therefore, provoke difficult moral and ethical questions as they are viewed as both 'survival strategies' that enable healthcare delivery (e.g. Roenen *et al.* 1997) but at the same time they can be viewed as actions that 'work against the efficiency of the health-system' (Ssenkooba *et al.*, 2003). Roenen *et al.* (1997) develop this further, using the argument that, with the exception of some recent empirical work about economic regulation (Bennett *et al.*, 1994), the literature tends to address such nurses' attitudes and behaviour by generic and normative statements (WHO, 1989) or in moralistic terms, from 'lack of motivation' to 'corruption'. When contemplating the health-system as a whole,

however, these actions need to be considered in terms of their functional aspects and their actual consequences (Cartier-Bresson, 1992). Indeed, Mintzberg (1994) terms these 'emergent strategies' which, taken together, are as important in shaping the healthcare system as are planned structures and actions and must, therefore, be considered when contemplating the health sector.

In summary, therefore, VW constructed the 'non-clinic' as a space that, whilst did not fulfil their healthcare requirements, actually generated an informal space which empowered their approach to health through the sharing of information, albeit partly speculation. In contrast, the nurses, saw the non-clinic as the result of necessary and legitimate coping strategies for their poor working conditions which were not befitting of their status in society.

6.6 The rushed clinic

As well as often being absent from the ANC, nurses were regularly very late for clinic. Clients would often have to wait for hours. Long standing hospital policy stated that the ANC had to be finished and locked up by 2pm. Hospital policy also stated that it started at 9am. It was only the time of closure, however, that was adhered to. When nurses eventually arrived for clinic they then had to rush to consult all the clients by 2pm. On a busy Thursday (market day) clinic, there could easily be 40 clients waiting for antenatal. If a nurse did not arrive until 11.30am, there were only 2.5 hours to register, consult, palpate, dispense drugs and test 40 women. Technically, that was an average contact time between client and nurse of 2.25 minutes. It is unsurprising therefore, that in focus groups clients constructed the 'the rushed clinic'.

6.6.1 The clients' 'rushed clinic'

The previous section explained the difficulties clients faced in physically accessing the ANC and the resultant despondence if they bounced. The same concept can be applied to clinics where the clients endured the journey only to wait, for hours. This also generated an informal space of shared everyday experience, enabling clients to discuss their views. Most clients were prepared to wait; they had had a long and expensive journey and recognised

the value of antenatal, if only for the ANC number. In focus groups, the VW would comment, however, that once the nurse arrived, the clinic was 'dreadful', 'uncomfortable', 'embarrassing' and above all else, 'rushed' (FG 1-8).

In the nurses' haste to complete the clinic before 2pm, antenatal clinics usually felt out of control. VW commented that they were never given enough time to discuss their true problems with the nurse, especially if they were first time clients and thus needed more time to complete the registration. The lack of time to explain regularly led to compromised and, at times, dangerous healthcare practice. There was a case, for example, where a woman was told on two separate ANC visits that she had a simple urinary tract infection. Having completed the course of the medication she tried to explain to the ANC nurse that the symptoms had not improved. Without listening to the client, the nurse prescribed more of the same medication. It was only on her third visit when during a quiet clinic, she broke down in tears due to the pain that the nurse took the time to diagnose that she had a raging kidney infection for which she was immediately put on intravenous antibiotics and close foetal monitoring (ANCCASE 1). In another consultation, when asked if she was taking any medication - literally as the nurse was closing the medical notes and gesturing for the next client - a mother quickly said no. It later transpired she had malaria. As the nurse stood with the full syringe of quinine, she noticed a receipt tucked in the back of the medical book saying the mother had already received a dose at a local drug store. To overdose could have been very harmful to both the mother and her baby (ANCCASE 2).

Working at this speed, the nurses inevitably made mistakes. At one very busy PMTCT clinic for example, a nurse drew a blood sample from a client to test for HIV. She was already flustered due to an earlier incident in her private clinic that had made her very late for Kakindo HCIV. As her mobile phone rang, she put the unlabelled vial of blood on the table and left to take the call. On her return, and preoccupied with grumbling about the incident at her clinic, she labelled the vial and went to hand it to the client sat in front of her. The client protested and refused to take the vial saying it was not her sample. The nurse shouted at her aggressively (locally known as 'blasting') and cursed her for not taking the vial because she was slowing the clinic and wasting time. The client said it could not possibly be her sample because she had not yet had blood drawn (ANCCASE 3). Such mistakes were common as a result of the nurses' distraction or lack of concentration in the

rush to complete clinic on time. On a number of occasions the HIV register did not tally with the individual medical records requiring a second check and finding that, in haste, it had been wrongly recorded in the mother’s ANC book that she was HIV+ when she was not (see Figure 6.4).

Figure 6.4: Errors in the HIV register

Client Name	Status	Test 1	Test 2	Test 3	Test 4
Kabwido	P	976	NEG		NEG
Kabwido	P	977	NEG		NEG
Kabwido	P	978	NEG		NEG
Kabwido	P	589	POS	POS	POS
Kabwido	P	977	NEG		NEG
Kabwido	P	950	NEG		NEG
Kabwido	P	930	NEG		NEG
Kabwido	P	981	NEG		NEG
Kabwido	P	817	NEG		NEG
Kabwido	P	983	NEG		NEG
Kabwido	P	665	NEG		NEG
Kabwido	P	984	NEG		NEG
Kabwido	P	985	POS	NEG	POS
Kabwido	P	986	NEG		NEG
Kabwido	P	987	NEG		NEG
Kabwido	P	988	NEG		NEG
Kabwido	P	989	NEG		NEG
Kabwido	P	990	NEG		NEG
Kabwido	P	599	NEG		NEG
Kabwido	P	954	NEG		NEG
Kabwido	P	788	NEG		NEG
Kabwido	P	584	NEG		NEG
Kabwido	P	786	NEG		NEG

Furthermore, twice during the fieldwork, clients came to be tested for HIV who already had a ‘TP’ status recorded in their book. This means they had Tested and proven Positive. A TPRR status means Tested, Positive, Results Received and appropriate treatment given. This record is made at the point of treatment. By virtue of re-presenting for testing, these patients did not know they were HIV+. They had not, therefore, been counselled, or received any treatment. Effective management of HIV requires swift response to early testing but it is particularly documented that treatment with anti-retroviral therapy during the period of primary infection may significantly alter the course of HIV infection (Kinloch-de-Loes *et al.*, 1995). This is clearly difficult if the patient has not been told their status post testing.

For the busy Thursday clinics a volunteer HIV counsellor assisted with the HIV testing. Ordinarily, however, in the rush of the clinic, testing was a way in which the nurses could save time so it often did not happen. In focus groups VW commented on this with mixed views. Some said they did not want to know their status so actually embraced the fact there was no testing and for this reason would avoid Thursday clinics (pers. comm. 104, Sept. 06).

For others, the categorical fear of being tested for HIV, even against their will, was their rationale for avoiding the ANC. In the ANC clients' blood was regularly tested for HIV without women's consent and thus, without them receiving the results. Normally this blood sample had been collected to test for syphilis or to run haemoglobin tests but the nurses' insisted that HIV tests should be conducted. Each mothers' medical notes also said she had been told comprehensive nutritional information. Bunyoro diets' were particularly poor, and yet so easily improved with some nutritional information particularly about food preparation which could be particularly important for a person living with HIV and thus a low immune system. In the nurses' speed, however, this teaching rarely occurred.

The nurses' speed also made them impatient and irritable. Anything that slowed down the process of the busy ANC added to their stressed response. Their body language and demeanour reflected their irritation making VW uncomfortable, nervous and thus awkward. Often a nurse would ask a question so quickly that it was difficult for the VW to hear. If she asked the nurse to repeat herself, the nurse often became impatient and angry. In one particular consultation the nurse threw down her pen and slammed her hands on the desk to push herself up from the chair and lean over and shout the same question in the VWs personal space, inches from her face. Whilst not physical, this was actually a highly violent act which could constitute psychological abuse. Whilst recognising that what is considered abuse varies culturally (Krauss, 2006), the WHO defines abuse as 'any act or omission that damages self esteem, identity or the development of the individual' (Ellsberg and Heise, 2005: 93). Such abuse can easily include yelling or degrading as well as physical violence (Mason *et al.*, 2008; Saltzman *et al.*, 1999). Similarly, one particular nurse had the habit of reiterating the question in a mocking 'sing song' voice. Referring back to Pratt's (2000:625) point, if language is 'the medium for defining and contesting social organisation', the client was entirely embarrassed and her 'lowly' identity as a poor villager was re-constructed as the nurse exclaimed she '*couldn't* even understand her own language' (FN69). In both cases, therefore, the nurse was delivering the tangible care. She was *caring for* (Milligan and Wiles, 2010) by administering drugs and palpating, but she was not *caring about* the poor women. The power of language was also expressed when the nurses complained about the patients to each other in English. Whilst ordinarily the VWs could not understand what was being said, they knew by virtue of it being English, it was derogatory. If the nurse was really irate, she would tell the client to either leave, or to go to the back of the line and wait for the end of the clinic.

Clients also commented that many of the nurses used the open air ANC space to 'book' women (see Figure 6.2). The VW felt was too exposed, particularly on a Thursday when there were often men waiting in close vicinity for Voluntary Counselling and Testing (VCT). Clients were unlikely to discuss ailments of a personal nature in front of other women and particularly in front of strange men. The most obvious example is that a woman may not wish to disclose her HIV status. The lack of privacy also extended to VW being ushered out of the consultation room very quickly to minimise the time between clients. It was very common, particularly on a Thursday, to see women half naked and desperately struggling to cover themselves with their elaborate traditional dress in the waiting room of the clinic. The hospital's solar battery was also in the consultation room. The healthcare workers had discovered how to charge their mobile phones from the solar battery and the consultation room was also one of the few places in the hospital where mobile phone signal could be found. This resulted in an endless stream of people, including male staff, wandering into the consultation room to check their phone for messages or that it was charging. Significantly, one of the UNDP's Millennium Village Projects, Ruhira in south east Uganda, has noted a significant increase in the number of women attending antenatal clinics, purely through the increase in privacy (UNDP, 2008).

A number of curious informal spaces developed in this setting. In some cases a caring nexus developed in which, through their shared identity, older and more experienced women would care about other clients enough to assist them. Older VW, for example, would often advise other, ordinarily younger, less experienced VW where to sit, or when to stand. They might repeat or interpret questions which had been misunderstood or not heard. In a group setting, they would support each other if, for example, the nurse claimed a vial of blood belonged to client who had not yet been tested. The constructed, but shared identity within the 'rushed clinic' enabled clients to rally together to, for example, force the nurse to collect the tetanus vaccine. Within the informal spaces 'rushed clinic' there were many acts of kindness such as women lending their lessu to clients who may have forgotten them, holding other women's children whilst they went for their consultation and holding women's place in line.

Other constructed spaces were much less positive. TCW, for example, had power, certainly over the VW and to some extent, the nurses. They would regularly arrive late and walk

straight to the front of the queue to be seen by the nurse first. The nurse would consult the TCW first, unquestioningly, and in English. The nurse would also conduct the consultation in a way to minimise time. For example, the nurse would immediately test the sample of a TCW rather than making her wait until the end of clinic when all the samples were tested together. The nurses lived, or had private clinics and drug stores within the local trading centres so more often than not they knew the TCW presenting for consultation. Due to their connections, it was mutually beneficial for the nurses to respect the TCW in the ANC. The nurses were often reliant on TCW neighbours, for example, to save them rare produce such as pineapples, or to watch over the staff in their drug stores. The links also extended to the husbands of the TCW who were often the small scale traders or the taxi drivers who might deliver drugs to the nurses' clinics or provide subsidised transport.

Interestingly, however, cultural and institutional norms, particularly about what constituted a 'good woman', prevailed over the shared sense of identity within the constructed space. The village had a particularly high rate of underage pregnancies and at times young women of 16 or 17 would come for consultation. The legal age of consent is 18 and generally women are expected to be married before becoming pregnant. Therefore, despite the high rate of underage pregnancy, as Chapter 5 explained, these women were going against what was perceived to be the role of a 'good woman'. In this situation, spaces were constructed that could be highly unsupportive of the underage women. They received no assistance from the older women and were often subject to comment and giggles. This was illustrated by a case in which a young woman who, despite insisting she was 18 to the nurses, was clearly much younger and had learning disabilities. She was wearing the simple traditional dress of an unmarried woman but struggled to unfasten the zip at the back. Far from offering assistance, the other VW just laughed, one even making a non too subtle comment about how this 'girl' expected to care for a child if she '*could not even dress herself*' (FN117). Contrary to the clients' claims that the nurses had little patience for them, within some constructed spaces, traditional norms perpetuated to the disadvantage of women who were pregnant underage.

6.6.2 The nurses' 'rushed clinic'

The nurses were as pragmatic about the *necessity* of being late for clinics, which subsequently became rushed, as they were about their absenteeism. Again this was

because they felt their professional status was unrecognised. Packing a busy clinic into a couple of hours due to their lateness was highly stressful and exhausting. This created a vicious cycle in which the nurses' sense that they were undervalued was perpetuated due to their coping strategies, which in turn, made them stressed and impatient at clinic. The following section, therefore, will consider the clients' construction of the 'rushed clinic', from the nurses' perspective.

When nurses were late for clinic, making it rushed, they were pragmatic about their time keeping. Their power as medical professionals meant nobody would question their lateness. They also believed they had to compensate for their difficult lives in manners which made them late for work. A regular complaint was that on the sporadic and lowly wage, the nurses could not afford a 'housegirl' to conduct the domestic chores that were ill fitting to their status. A nurse would often arrive late to a clinic with the simple explanation that she had had to prepare food (which is a particularly lengthy process), finish washing or go to the market. Drawing water was also a regular rationale that caused problems within the hospital. As Chapter 5 explained, it was well known that Kakindo sub-county had a water shortage (World Vision, 2006). Whilst the hospital did not have running water it did have huge locked storage tanks which contained water for hospital use, particularly cleaning. The medical staff would spend several hours each morning filling jerry cans and taking the water home. One nurse would arrive in a car with six or seven 20 litre jerry cans which had to be filled and delivered to her extended family before she would start clinic. Arguments would break out on a daily basis, not because of the use of water - because this was considered acceptable - but about people's fair share of water, especially during the dry season when supplies ran low. This often led to clashes and questions of roles and responsibilities. It was the sweeper, for example, who had the key to the faucet. She regularly complained that her professional work was being questioned as clients felt the hospital was dirty because she had no water with which to clean. She also could not refuse the nurses the key, but equally had no managerial structure to turn to for support.

Conflict over water use was an almost daily catalyst for sparking arguments reflective of the broader lack of monitoring, management, or teamwork within the hospital as a whole. The nurses felt stressed, over-worked and undervalued. There was a general low morale amongst the staff and a lack of support for each other. The nurses would often say there

was not enough staff for the workload, in part, due to a high staff turnover but also due to their lack of mutual support. A disproportionate amount of work, for example, fell on the nurses who lived on site, especially for emergencies during the night or covering staff who had not reported for duty. Not only did they not receive any recognition for this, monetary or otherwise, they also felt they were unsupported. If a nurse had had to attend a night delivery, that served as an explanation for being late for clinic the next day. Following a particularly difficult, delivery one nurse declared she was too tired and needed to rest saying she had '*earned her little pay*' for that day. With no other staff available, she cancelled clinic, dismissed the waiting clients then went home (FN102). In this particular situation, a pregnant woman was sent away from the ANC who subsequently died. It later transpired that she had come to the hospital with vaginal bleeding which is indicative of abortion. Having bounced from ANC she had had an incomplete abortion which caused a fatal infection. The next day the dead woman's husband stormed the clinic with an assembly of armed local men who began to destroy the hospital. The nurse explained that it was not her fault because the VW had not told her she had complications and if she had, the nurse, of course, would have treated her. Whilst little could have been done to prevent the abortion, the subsequent infection could probably have been controlled. The nurse's argument, however, was that none of the other nurses supported her. They all knew she had been working hard throughout the night but nobody was willing to cover her day shift, forcing her to cancel it. There were also complaints that the opportunities within the hospital, such as well paid training, were always offered to the same midwife who was related to the I/C. The nurses had no avenue through which to vent these concerns and frustrations, other than subconsciously through their healthcare practice.

It is instructive that despite all the complaints about the poor quality of health-systems in Africa, very little literature addresses the effects of the working conditions on healthcare deliverers. Much has been written about how healthcare providers, especially nurses in the developed world, are generally considered to be at high risk of work-related stress and burnout. This theoretical consideration is also applicable to the developing world. Various studies have demonstrated that nursing is stressful in general (e.g. Humpel and Caputi, 2001; Tai *et al.* 1998). A review of the literature by Hillhouse and Adler (1997) suggests that the primary sources of nursing stress include work overload, death and separation experiences, poor communication and social support, the emotional demands of patients and families and a constantly changing work environment (Guppy and Gutteridge, 1991;

Hipwell *et al.*, 1989; Ogus, 1992). The stress levels can be further increased through contributory factors such as professional isolation, long working hours especially at night and lack of resources which happened regularly at Kakindo HCIV (Kigiri *et al.* 2009; Ilhan *et al.*, 2007). Many staff spoke about being ‘burnt out’ (pers. comm. 64, April 06). Cherniss (1980:5) described burnout as a “process in which the professional’s attitudes and behaviour change in negative ways in response to job strain” (see also Olupot, 2009; O’Brien-Pallas, 2006) reporting on the necessity to increase nursing staff in Uganda). Burnout can particularly result from the gap between individual’s expectations to fulfil their professional roles, and the extent to which the structure of the organisation permit that (Leiter, 1991; 1992b). This was clearly the case at Kakindo HCIV which, in turn, had knock on effects on healthcare delivery. Maslach *et al.*, (1996) state that whilst individuals experiencing burnout may still feel concern, they can no longer give themselves as they had formally and are less able to provide service in a consistent, caring manner (Cavanagh, 1992; Leiter *et al.*, 1998). A negative feedback mechanism develops whereby dissatisfaction with the job leads to burnout, often caused by stress generated by staff shortages or absenteeism, which results in a low level of care, more staff absenteeism and increasing the stress on other members of staff as the work force is diminished (Strachota, *et al.* 2003; Davidson *et al.* 1997; Cameron *et al.*, 1994).

Nurses in Kakindo HCIV were frank that, at times, their healthcare delivery was not ideal. There is a link between moral distress and burnout in nurses. Moral distress is defined as ‘the painful psychological disequilibrium that results from recognizing the ethically appropriate action, yet not taking it, because of such obstacles as lack of time, supervisory reluctance, an inhibiting medical power structure, institutional policy, or legal considerations’ (Rice *et al.* 2007:46, see also Espeland, 2006; Maslach *et al.* 2001; Corley *et al.* 2001; Jameton, 1993). The nurses, however, took no responsibility for their poor healthcare delivery as they attributed it as part of the necessary coping strategies to mitigate the difficult conditions in which they were expected to work.

6.7 The ‘resource-less’ clinic

It was regularly cited in focus groups that the antenatal clinic was old, unsanitary, poorly designed and was seriously lacking in basic equipment and resources. In many cases clients constructed informal spaces that generally accepted the resource constrained reality of the

chronically poor rural area. By virtue of their means, TCW were able to adapt to the shortage of key resources. The poorly equipped clinic served, however, to reinforce the hierarchy of the nurses over the VW.

6.7.1 The clients' 'resource-less clinic'

It was discussed, and accepted, within all focus groups that there was a significant lack of resources within the hospital. Several recent studies have pointed to the central role of drug availability in community perceptions of quality of care in African settings (Jitta *et al.* 2003; Haddad *et al.* 1998; Gilson *et al.* 1993). As explained in Chapter 3, Uganda abolished user fees so clients and patients of government facilities had a right to expect to receive free drugs. In Kakindo HCIV, there was a regular shortage of even the most basic of drugs such as Paracetamol and iron tablets. Furthermore, the 'bush telegraph' was instrumental in informing clients when there had been drug deliveries and thus when it was more likely that the ANC had drugs. As there were often no drugs in the hospital immediately after a drugs delivery, however, it was locally believed that the Kakindo nurses stole drugs from the hospital, to sell, or use within their private clinics and drug stores. This was not aided by a number of high profile court cases in which health officials were prosecuted for the same crime (Businge, 2010; Kagiri, 2009; Grainger, 2007). It was suggested that by changing the packaging to disguise drugs stolen from the government it was difficult to tell the dosage or expiry date of drugs (FG3). Many people believed nurses bought or 'acquired' older drugs that were cheaper or destined for destruction so questioned their effectiveness. It was also believed that nurses deliberately prescribed expensive brand name drugs that they stocked in their clinic when a cheaper more generic option was available in the hospital (FG 2, 4; also see Businge, 2010).

In addition to there being a lack of resources, VW would also suggest that some of the resources available were substandard. Kiguli *et al.*, (2009) cite the lack of decent equipment as a reason why patients would either seek treatment from private facilities, or not seek medical treatment at all. The treatment for syphilis highlights this well. Due to a general outbreak of syphilis across Uganda, but particularly in Kibaale, the DDHS had made it mandatory that all clients had an RPR (rapid plasma reagin) test for syphilis. The treatment required powdered penicillin to be dissolved and administered, via injection, into the lower right quartile of the buttock. This, in itself, is a painful injection. It was made worse,

however, due to the quality of the limited resources available. A disposable needle was used to pierce the foil top of the solution and draw it; the same needle was then used to pierce the foil top of the powder and inject the solution into the powder. The same needle was then used to draw the suspension and inject the client. Disposable needles are only supposed to be used once. With the repeat use, the needle often failed entirely but by the time of injection was certainly very blunt making an uncomfortable treatment even worse. At a number of focus groups this treatment was cited as a reason for avoiding testing clinics (FG 2,3,4). Unlike Jitta *et al.*'s (2003) findings in south eastern Uganda, 'public' needles were not used; they were always disposable and never reused between different patients. Additionally, with the exception of dental needles that had to be bought, there were always needles at the clinic, albeit in rationed supply.

Focus group discussions also drew on VW's constructions of informal spaces in which their authoritative knowledge enabled them to influence the healthcare transaction. Respondents regularly suggested that the women felt they had to support each other in their request for tetanus vaccines when they knew that it was in the dispensary. Again, this draws on the fact that women had endured great 'expense' to travel to clinic, they knew the drugs were available, but they also knew they needed to control the healthcare transaction and challenge the traditional flows of power. This was only possible, however, when a number of clients required tetanus and thus had shared knowledge to move beyond their social field (Veenstra, 2007) and challenge the traditional knowledge system (Jordan, 1987). Generally it was accepted that drugs were rarely at clinic. Apart from trying to attend after a delivery, the clients' viewed the expense of buying drugs at a local drug store as part of going to the ANC. With the abolition of user fees, this actually highlights how by referring clients to local drug shops (which happened to be their own), nurses were still perpetuating a fee paying system, but had moved it from within to outside the health facility (see also Jitta *et al.*, 2003). In effect, therefore, payment was being made to private providers of drugs and essential medical supplies – who in this case, were the nurses themselves.

The actual physical environment, or built space of the hospital greatly affected the healthcare transaction. In focus groups, VW regularly commented on how unsanitary and dirty the hospital was. It was certainly dark and dingy and there was often medical paraphernalia such as discarded blood stained cotton wool from VCT or empty drugs

packets strewn over the compound. The walls were adorned with dated, tattered posters and broken or unused equipment lay everywhere. There were regularly chickens and goats in both the compound and the wards (see Figure 6.3). As was a regular complaint about Ugandan hospitals, the pit latrine toilets in Kakindo HCIV were disgusting (Mugeni, 2010; Kagili, 2009) to the extent that VW feared to allow their children to use them for fear of infection (pers. comm. 88, July 06).

The actual hospital space was not fit for purpose and regularly served to highlight the nurses' power. If two nurses were registering clients at the same time there were not enough chairs forcing clients to kneel at the nurses' feet for consultation. When kneeling, however, it was difficult for the nurse to draw blood to conduct an HIV test; she would often require a couple of attempts to find the vein due to the awkward angle and poor light (FN172). In Uganda, certainly in the village and to a lesser extent amongst poorer communities in the cities, women and children still genuflect to recognise individuals with status, or positions of authority. This could even be in respect for age. When receiving drugs therefore, including anti-retro viral drugs, heavily pregnant or sick women would kneel on the floor before the seated nurses. Respect for profession was much greater than age as even '*muzei*' (old wise women) would kneel before the young nurses.

The physical design of the space could also become disabling and oppressive to clients (for example, Imrie, 1996; Vujakovic and Matthews, 1994; Golledeg, 1993). Marcus (1992) and Gibson-Graham (1997) suggest that how one acts in space is dependent on how it is conceptualised in relation to self. A theme of this research is that certain authoritative knowledge operating created informal spaces in which VW were empowered to influence the healthcare transaction. That power tended to break down, however, in the consultation space, particularly of a rushed clinic. Here in a one-to-one setting with the nurse, VW did not have the support of their peers. In focus groups VW often mentioned that the space was small yet intimidating (FG 2,4-5). It could easily accommodate a client and their attending nurse, but when clinics were busy clinic often two consultation beds would be used to palpate two clients. This then would require the presence of two nurses, myself to keep records, plus any medical staff passing to charge their mobile phones from the solar battery. The physical space then became very difficult to negotiate. Mothers often banged limbs against the door handle or the corner of the chair as they collided as one client tried

to leave as another entered the small space. The consultation beds themselves were also very high and a significant struggle for women, particularly if they were heavily pregnant and/or physically small, to clamber on to for the palpation. Regularly a woman would scramble up and then realise she had left her lessu - which she needed to spread over the bed to lie on - on the floor. It was below the status of the nurse to pick up the lessu and pass it to the VW so she would watch her struggle back down, pick it up and then struggle back up again. The torn plastic upholstery of the bed meant the lessu often slipped and it was physically difficult for the VW to coordinate holding it in place whilst scrabbling up to the bed. Vujakovia and Matthews (1994: 361) echo the socio-spatial view of Golledge's 'distorted spaces' (1993: 64) in which disabled people create their own space and actively transform the landscape from their perspective. Certainly the physicality of the built space was made more difficult due to the nerves created by social understandings of the space, such as the nurses' authority. In contrast, the space was not a problem for TCW. The bed was still too high but the TCW were not nervous, and would make the nurses wait if needs be.

6.7.2 The nurses' 'resource-less' clinic

The nurses' approach to their lack of resources was interesting. They berated the shortage hugely, largely blaming it on the decentralised healthcare system and saw the lack of resources as a major barrier to healthcare delivery, but one that was beyond their control.

The nurses acknowledged the shortage and substandard resources they were forced to use which they felt negatively affected their healthcare. They suggested the poor administration and tiered level of decentralisation proliferated corruption and as a result, resources rarely filtered down to the lower health units, particularly the HCIIIs and HCIIIIs. There was an incident in March 2008, for example, where drugs worth 60 million Ugandan shillings (approximately £20,000) meant for various health centres in Kibaale district were found in the stores of Kibaale referral hospital (Kasooha, 2008b). Amidst various mismanagement claims including that unscrupulous workers were hoarding the drugs to sell, the hospital explained the drugs had not been distributed because the institution did not have a vehicle to deliver them due to mismanagement of maintenance funds. Furthermore, in 2009, the National Medical Stores discovered over 100 non-existent Health Centre IIIs that for years had been receiving drugs and funding from the government. The

New Vision newspaper (2009) calculated that as HCIII's should have a minimum of five staff that meant there were 500 salaried ghost workers a year which translated to a total loss of earnings of approximately US \$ 45,000 a month. The nurses were adamant that they did their best with the few resources they received due to this level of corruption.

The nurses were also, however, pragmatic about the fact that they used government drugs. Again in necessity to compensate for their low recognition, they saw this as one of the few 'perks' of the job. The 'leaking of drugs' at district and health unit levels has been linked to the previously discussed coping mechanisms of health workers in the poor system (see also Jitta *et al.*, 2003; Jitta *et al.*, 1993; McPake *et al.*, 1999). This was never obvious at Kakindo HCIV. The nurses would take generous doses of medicine home for family and friends but there was nothing to suggest they were stealing on a bigger scale. They did complain, however, about the problems of transparency when there were a number of different sources of drugs. For example, there was a box of mixed drugs in the ANC, a box in the general ward, occasionally a box in the laboratory, often a box in maternity in addition to the main dispensary. It was interesting that whilst taking drugs for personal use was a compensatory perk of the job, this would often escalate the low collegiality amongst the nurses. Regularly the antenatal nurses would accuse the maternity nurses of using their drug stocks. Not only could this result in there not being drugs in antenatal for the clients, but it implicated the stock keeping. Kakindo HCIV acted as a satellite centre to collate information from all the smaller health units to send to the Health headquarters in Kibaale. Keeping records, therefore, consumed an inordinate amount of time in. *Nevirapine* and anti-retro viral drugs were very closely monitored, for example, so if there was a discrepancy with stock, the headquarters would want to know why. Ordinarily this was because maternity had 'borrowed' supplies from antenatal but not recorded that fact.

The nurses were also personally affected by the ill equipped hospital. There were not enough residential quarters, for example, so some nurses had to rent a home in the local trading centre. As the government did not cover such costs it was a great expense. Fortunately, these nurses were able to walk the short distance to work whereas in other districts, the lack of accommodation for medical staff can result in high transportation costs (Kagili *et al.* 2009). They also commented on the lack of water for hospital use. Not only did this impact on the patients, such as there not being water to swallow tablets, but the nurses

also felt they were at risk because there was little water to regularly wash their hands (pers.comm. 46, April 06). They also had to be inventive with equipment which, whilst highlighting their ingenuity, slowed down the clinics. There were never enough pipettes, for example, to test for HIV using whole blood. The nurses had designed a system in which they rinsed the pipettes in a solution of JIK (a locally available bleach) between clients.

The nurses' also felt their professional status could be questioned due to the ill equipped hospital. One TCW, for example, complained about how much the injection of syphilis hurt. The nurse lamented about the lack of support from the District Headquarters who generated policies but did not provide the appropriate equipment with which to implement them; she said *'they sit in their offices eating and implementing impossible policies then get angry if you complain or make a mistake'* (pers. comm. 163, March 07). 'Eating' is a term regularly used in Uganda which refers not to the literal consumption, but the using or wasting of official funds for personal gain.

6.8 Conclusion

Due to the construction of pregnancy as an everyday occurrence that a woman was expected to experience in her lifetime, the ANC delivered routine, mundane care. The clients, however, recognised the value of this care for their health and that of the pregnancy to the extent they were will to engage with the 'rude', 'proud' nurses. To engage with the difficult healthcare delivery, however, the clients used their authoritative knowledge to adapt their behaviour in hope of influencing the healthcare transaction in a positive manner. This created informal spaces of health. In some settings, these mitigating strategies proved successful. The creation of an informal health space when a nurse was very late for clinic, not only highlighted their place-based authoritative knowledge, but ironically generated a space in which potentially authoritative knowledge could be shared. In other situations, however, efforts to influence the healthcare transaction were less positive. Wearing shoes, for example, was an effort by VW to disguise their 'villageness'. It served, however, only to heighten the social distance between them and the nurses as they struggled with buckles to remove them. Under their best clothes and borrowed jewellery, VW were still the physical embodiment of poverty through their tape worm and witchcraft scars. Overall the VW, and to a lesser extent the TCW, had a prevailingly negative impression of the antenatal clinic believing that the nurses were rude and proud and yet. The clients were willing, however,

to traverse the difficulties, social and practical, discussed in Chapter 5 to get to the ANC. Within the ANC the clients could use their place-based authoritative knowledge to construct informal spaces of health in which they were empowered to influence the healthcare transaction – how ever successful it transpired to be – in effort to achieve their health goal.

The nurses, in turn, were aware of the VW's impression of their healthcare delivery. Their frank explanation, however, was that they were stressed and burnt out. A vicious circle perpetuated their stress. The nurses felt their professional status was not being sufficiently recognised. In turn they were strict with patients and engaged in activities that would enable them to live in a way that was befitting to their status. This made them absent, or late for work, which then made them more stressed and irritable. The working conditions were far from ideal, even in terms of pragmatic shortages of basic equipment. Whilst arguably *caring for* costs nothing, it can be expensive when the nurses already feel they are making huge sacrifices by working under such difficult conditions.

Despite the barriers, clients were willing to charter a path through difficult terrain to access antenatal care from Kakindo HCIV. More than 60 women per week registered. In contrast, however, only approximately ten babies delivered their babies at Kakindo HCIV. Chapter 7 will investigate why.

Chapter 7: The Maternity Ward

‘Becoming a mother is not an illness, it is a normal process which occurs during the lives of the majority of women and can indeed be seen as a manifestation of health...it is physically very demanding, and a time when women are very vulnerable....and in need of professional help, but capable of being participants in the birth process’

(London House of Commons, 1992)

7.1 Introduction

In order to stop women and children dying unnecessarily and to increase socio-economic development, MCH care has to improve. Despite concerted efforts to improve delivery of maternity services in Uganda, inequalities in the use of maternal health services mirror those of maternal health outcomes (Brazier *et al.*, 2009; Chowdhury *et al.*, 2006; Kunst and Houweling, 2001). Less than 32% of women deliver with the assistance of trained personnel (HSSPIII, 2010; Stanton *et al.*, 2007). It has long been recognised that home deliveries contribute to the ‘immense human tragedy’ in Uganda (Amooti-Kaguna and Nuwaha, 2000:203). Considerable effort has been made, therefore, to re-locate deliveries, ideally into institutional space, or to at least assert some level of regulation via skilled maternity care (Waiswa *et al.*, 2010; Brazier *et al.*, 2009; Tann *et al.*, 2007) the advantages of which are explained in Chapter 1. Furthermore, the quality of care has been questioned. As Kaye (2000) suggests, antenatal care has little impact on the reduction of maternal morbidity and mortality if it cannot detect problems during pregnancy, or services to manage them are non-existent (see also Rooney, 1992). In other words, getting women to maternity services is one thing; being able to deliver appropriate, effective care, is entirely different.

As Chapters 5 and 6 discussed, it is well recognised that perceptions of healthcare shape expectations of healthcare delivery, both positive and negative (Katz and Algeria, 2009; Kiguli *et al.*, 2009) and thus, the likelihood of healthcare access. Many of those perceptions of healthcare are also bound up in broader knowledges and understandings of what, culturally, pregnancy and childbirth mean. These perceptions, in turn, inform

considerations of the appropriate roles of professionals and women giving birth within bounded spaces, both formal and informal (see Dyck, 2001; Jones and Moon, 1993; Kearns, 1993). As the opening quote suggests, whilst giving birth is physically demanding, it is a normal, natural thing for a woman to do; especially in Bunyoro (Kyomuhendo and McIntosh, 2006) where, as Chapter 6 explained, it was considered a woman's duty. Whilst she is vulnerable and in need of care, a delivering woman should be able to choose where and how she receives that care according to her construction of childbirth. As Mutabazi (2005: 27) put it 'caring and treating patients requires much more than knowledge of disease processes and prescribing medication. It involves showing love and care to the patient'.

The construction of birth in Bunyoro suggests that medical care should be accessed in childbirth in only emergency situations. As a result, the nature of cases presenting at the Maternity Ward (MW) shaped the expectations and requirements of care in a very different manner from the Antenatal Clinic (ANC). The healthscape concept revealed how authoritative knowledge constructed three informal spaces of health in the MW. In order to explain how these spaces informed the healthcare transaction, Section 7.2 will explain the recent shift towards a more human rights orientated approach to birth in Uganda to provide a contextual background. Section 7.3 will unpack develop cultural constructions of the *lutalo lwabakyala*, or the 'woman's battle' that was childbirth in place in Bunyoro. Section 7.4 will explain the local perceptions of the maternity care delivered at Kakindo HCIV. Section 7.4.1 will explain how the informal spaces were 'conceived' from data. Section 7.5 will unpack the 'caring for' space. Section 7.6 will consider the cultural space and Section 7.7 will contemplate the '*budibyo*' or 'what to do' space. Each of the constructed spaces will also be explained from the nurses' perspective. Finally, Section 7.8 concludes this chapter.

7.2 Changing approaches to birth in Uganda

As Chapter 4 explained, in the past, Uganda's maternal morbidity and mortality have been attributed to the country's socio-economic and political instability which was characterised by the destruction of health infrastructure, chronic shortages of staff and resources, problems of physical access and the low priority of healthcare planning within an economically orientated new government. Despite a 'favourable and enabling policy environment' (Kyomuhendo, 2003:22), which includes in-depth policy consideration about education, gender, reproductive services and decentralisation, there has not been an

increase in utilisation of emergency obstetric services within biomedical health facilities. This is reflected in the persistently high maternal death rate (HSSPII, 2005). Part of the policy failure is attributed to the inability to implement policies due to a lack of resources, skilled staff and health infrastructure (WHO, 2002).

More recently, however, the discursive space surrounding childbirth has begun to shift from the broad discussion of lack of resources, to a narrow, perhaps more individualistic, consideration of the delivery of care in context (see Mackian, 2008 for a methodological approach to reading Ugandan therapeutic landscapes through newspapers). Media sources during the fieldwork, and in the immediate subsequent period, increasingly used a vocabulary of human rights in relation to childbirth. Mutabazi (2005:27), for example, suggested that the 'enjoyment of the highest attainable standard of health is a fundamental right of every human being.....this right, however, remains one of the most abused rights in developing countries including Uganda.' Whilst suggesting that nurses need better 'customer care skills', Mutabazi (2005:27) goes on to suggest that 'rude behaviour by some health workers constitutes a gross violation of people's rights to dignity and health'. In his call for a health probe into Mityana Hospital (central Uganda), Kagiri (2009:36) spoke about the 'spontaneous expression of the bitterness and frustration of poor people' after the death of a mother in labour and her baby whom the nurses refused to treat. Highlighting the high status of nurses, however, at the first graduation ceremony of Jinja School of Nursing and Midwifery, the Higher Education State Minister, Mwesigwa Rukutana, warned medical personnel that they must not be identified as 'rude, arrogant and negligent'. To the nurses he said: 'You are next to God, so your role is to protect life. God gives life and you assist to sustain it. If you don't do that, you will go to hell' (Musingo, 2009: on line). Writing for *The New Vision*, Uganda's leading daily newspaper, Kobusingye (2008:13), a registered comprehensive nurse commented that:

'the mistreatment of women and infants is among the factors that lead pregnant women into the hands of untrained traditional birth attendants or unskilled relatives, especially for women in the rural areas. There is a tendency to think women and infants only die under the care of unskilled people. We seldom think about those who die as a result of negligence or mistreatment by midwives.....It would, therefore, be right to say nurses and

midwives who ill treat expectant women are deliberate contributors to maternal mortality in Uganda.'

With this new discourse there has been a growing appreciation of the inherently social and fluid nature of childbirth which, in turn, informs expected norms of healthcare delivery, actors, and indeed, spaces of birth. It is being increasingly recognised, for example, that maternal and infant mortality has been influenced by socio-cultural beliefs such as ideologies of gender and the resultant entrenched power relations, as explained in Chapter 5 (e.g. Davis-Floyd and Sargent, 1997; Vlassoff and Bonilla, 1994; Caldwell, 1990a). As of yet, however, whilst much has been written about the clinical cause of maternal deaths in Uganda in relation to the healthcare system, surprisingly little has been written about the effects of socio-cultural beliefs, particularly set against the biomedical framework. Exceptions include the Save the Mothers Initiative needs assessment in Kiboga District (conducted in 1998 but unpublished) and Kyomuhendo's (2003) work based in Hoima. Kyomuhendo's (2003) work will be relied on heavily here, in part due to the shortage of literature, but also because Hoima is within the Bunyoro Kingdom, the neighbouring district to Kibaale, and Hoima's main hospital was the referral hospital for Kakindo HCIV.

From a policy perspective, therefore, birth is being understood as less of a medical event and more of a social occurrence. There is thus an increasing focus on the necessity to deliver efficient, effective, appropriate care, in context. In order to understand what that appropriate care might require, there is a need to understand the construction of birth in Bunyoro.

7.3 Birth in Bunyoro and the *lutalo lwabakyala* (woman's battle)

Within Bunyoro culture, whilst posing a physical burden, childbirth is an essential rite of passage for women. As Chapter 5 and 6 discussed, in most ethnic or traditional Ugandan societies where continuation of the lineage is a central dynamic, the importance of a woman still lies in her ability to produce children (pers. comm. 86, July 06; FG 2,3,5; see also Kyomuhendo and McIntosh, 2006; Kyomuhendo, 2003). Whilst fraught with dangers, in the main, childbirth and pregnancy are the major areas where women are able to enhance their status within the household and community. Childbirth also marks the crucial transformation from a girl to a woman with a first pregnancy or the enhancement of a

woman's status in society as she matures and becomes a more responsible member with subsequent babies. This can be a significant, life changing process as women contemplate their new identities as mothers which at times can require a reconsideration of their relationship with others - including their unborn child (Messias and DeJoseph, 2007).

The construction of birth, particularly for first time mothers, however, depends hugely on their positioning, or re-positioning in relation to their experiences of existing models of motherhood. Such model(s) naturally incorporate competing familial or societal expectations about childbirth and caring. In the villages, for instance, women with children were generally referred to by the name of their middle child. In Nalweyo, my neighbour and mother of Hilary, Joshua and Presse, was Mamma Joshua. Nearly every day Hilary, Joshua, Presse, 'their mum' and I ate breakfast together. It was only on my last evening in Nalweyo after 18 months of fieldwork when Mamma Joshua and I shared supper without the children, that she told me her personal name was Paulina. Until then, her role in Bunyoro, and thus constructed identity, was as Joshua's mother, not as her own person. The repositioning of self within a place of birth, therefore, is highly significant for some women. It would follow, however, that as the repositioning of self within a place of birth or motherhood varies between individual and surrounding circumstances (Messias and DeJoseph, 2007), it may not always be positive. As Chapters 5 and 6 established, in Bugangaizi there was a high rate of underage pregnancy (FN174). Despite the prevalence of this situation, however, to be pregnant underage - and to a lesser extent, out of wedlock - was highly stigmatised in the village. Often the association was made between young women being 'groomed' by older men whilst walking to school through the promises of a better life (see, Kinsman *et al.* 2000). Underage pregnancy was also associated with the high rate of illegal abortions with witch doctors (Kinoti, 1995; Singh, 2005).

Under traditional Bunyoro custom, childbirth was equated with 'walking down a hazardous thorn-strewn path' where death and survival are the only two possible outcomes (Kyomuhendo, 2003:19). A woman who goes through childbirth, therefore, was seen to have bravely endured the dangers, particularly if she had delivered alone without any assistance, biomedical or otherwise (FG4). Her resilience was proudly recognised with the traditional praise *garukayo* (which translates to 'dare to go back'), to which she responds *amahwa* ('there are thorns'). A woman who dies in childbirth is considered to have fallen

victim to the thorns. Those who require hospitalisation, an episiotomy or caesarean section are said to display weakness (Kyomuhendo, 2003). Having stumbled on the thorny path by seeking medical help, if they survive, not only are mothers not entitled to the revered *garukayo* accolade, but they are referred to as *omugara* (lazy), despite the fact the circumstances were beyond their control. As the *garukayo* expression suggests, a woman was also expected, dangers notwithstanding, to keep treading that path, i.e., to 'go back' to being pregnant. There is also an implicit vulnerability; the path is always thorny, no matter how many times it is walked and no matter what precautions - such as a full course of tetanus vaccine - are taken.

Within the woman's battle that is childbirth, therefore, the woman is supposed to win, with stoicism and without showing signs of fear. Furthermore, according to Kyomuhendo (2003; 1998), death was considered the woman's failing, even when external factors such as a lack of transport or funds prevented her from seeking medical help. She suggested that prevailing belief can, at least in part, be used to explain why women either left it so late, or did not present for medical help. Focus group responses and general conversations within this research did show slight variations from this conceptualisation. Certainly, pregnancy was considered part of a woman's 'duty' or 'role' (FG 2, 3). There was a very pragmatic approach that women were supposed to have children to continue the lineage. This was also supported in conversation with men who rationalised their 'need' for a number of wives within the polygamous society through the necessity to have at least one healthy son to continue the clan name and to inherit any assets. With such a high prevalence of HIV and sickle cell anaemia, it was important to have 'back up' (pers. comm. 134, October, 06) wives and children. Women also spoke of the necessity to 'recover' quickly from childbirth (pers. comm. 166, October 06). Drawing on Chapter 5's discussion, in the maternity ward, one woman expressed how important it was for her to move on from her pregnancy to be strong enough to work again. This, she explained, was because she was the youngest of seven wives. She was 'fearing' that her husband might find a younger, more attractive wife, unless she 'proved herself' by having a baby, thus fulfilling her role as a good woman, but also by recovering swiftly to be able to tend the shop she ran for him as quickly as possible (pers. comm. 166, April 07). It was also recognised that a woman without children, or suddenly becoming unable to have children, was a 'failed' woman (FG 4, 5, 8).

All the VW, however, were frank about the risks they faced delivering alone in the village. In Kyomuhendo's (2003:21) study, for example, 60% of the 808 women surveyed knew of someone who had died of a maternal cause in the previous year. Statistics were not gathered from the focus groups but most of the woman had had some recent experience of maternal and infant mortality. It was overwhelming, and somewhat distressing, how frank VW were about the risk of death or serious complications during childbirth. Kyomuhendo (2003:16) found that in Bunyoro, pregnancy is 'a test of endurance and maternal death is a sad, but normal event'. It was even more disconcerting that mothers only went to the hospital as a last resort in an emergency case. Even then, some VWs said they would rather weigh up the options of 'their battle' and potentially die at home than risk the long difficult journey to face the 'rude' nurses (FG7), particularly if they had not been to antenatal.

Focus groups corroborated that it is the role of a good Bunyoro to reproduce. Whilst the dangers associated with giving birth in the village are well recognised, traditionally, a woman is supposed to 'battle' alone. Today accessing biomedical care is not seen as a weakness, *per se*, but the fact that only ten women a week delivered at Kakindo HCIV in comparison to the weekly average of 60 women presenting for antenatal, suggests that the hospital was not the women's first choice as a place of childbirth. In light of the benefits of formal MCH to a successful pregnancy, there was a clear necessity to ascertain why this might be.

7.4 Local perceptions of the maternity ward

Drawing on the local understandings of childbirth, the VW's perceptions of the biomedical maternity care were startling. Understanding these perceptions also explains how women used their place-based authoritative knowledge in effort to influence the healthcare transaction, in turn creating informal spaces within the MW. This section will also discuss how these spaces were conceived from the focus group discussions and maternity cases.

The VW explained that childbirth was a natural, normal event that in most cases should not require medical intervention. The women recognised, however, the frank limitations and dangers of delivering from the village. For example they understood that, in an entirely medical capacity (such as the necessity to stop bleeding or the requirement of suturing), Kakindo HCIV was the best place to deliver from. Every woman within the focus group that

had experience of the services at Kakindo HCIV, however, said she would prefer to deliver with a TBA. Echoing some of the negative perceptions of antenatal, the VW said the MW was an uncomfortable, dirty, dingy space which was lacking in basic amenities (see Figures 7.1 and 7.2). Some women spoke about how difficult it was to deprive their home of equipment they would need in maternity such as jerry cans to carry water or blankets (FG 3, 5, 6). They said the nurses were proud, rude and ignorant of local culture (FG1 - 9). VW also said that whilst the nurses gave out drugs, little 'care' was shown in the maternity ward (FG2).

Figure 7.1: The maternity ward



Source: Personal fieldwork photograph

Maternity was also viewed as expensive, not because of user fees, but due to the informal payments required for the nurses and what clients were expected to bring. A number of women spoke about how disrespectful the nurses were of their things such as using their gloves for unnecessary examinations so that they had to buy more. Opportunistic costs also had to be taken into consideration such as having to take an attendant and taking time out of the responsibilities of the home, especially if this included young children. As Kyomuhendo (2003) found, women feared 'surgery' (an episiotomy) or a caesarean.

Another complaint was the way in which nurses tried to turn the clients into passive, dependent individuals who had no say in the birthing process despite the fact, as one VW said, *'it is our body that is producing'* (FG, 2). It was also discussed that the nurses would not listen to medical complaints or the client's views about what was best for their bodies such as previous negative responses to drugs and treatment. As previously discussed, the clients were fearful of presenting at the maternity clinic without an antenatal number. The preferred space of delivery, overall, was with a traditional birth attendant (TBA).

Figure 7.2: The delivery suite



Source: Personal fieldwork photograph

7.4.1 Conceiving the maternity spaces

The maternity spaces were conceived slightly differently from the antenatal or general spaces and therefore need to be explained. As Figure 4.1 showed, data from participant observation, medical cases, personal communication and secondary sources such as policy documents and newspaper reports were all given a unique code. This data was then 'cleaned' to eradicate or, where possible, to verify any data that was wrong, incomplete or could potentially be misinterpreted. This data was then coded up to reveal the three key health places of Bugangaizi, the Antenatal Clinic and the Maternity Ward. The data for

Antenatal and Maternity were then coded up again to reveal the informal spaces of health constructed by the clients behaviour as guided by their authoritative knowledge. During the cleaning process, however, it became apparent that of the 32 maternity cases observed, there were few records of maternity cases from start to finish. This was due to the unpredictable nature of childbirth; deliveries often occurred randomly or at night or whilst I was otherwise engaged at the antenatal clinic. Additionally, and as a further justification for this research, few clients reported to deliver at the maternity ward particularly in relation to the 65 clients that reported to the antenatal clinic. Eight cases were observed from the point of admission to the point of inoculation. Whilst extreme, these cases are representative of the 32 observed, randomly, in the 18 months of fieldwork and, which it can be inferred, are reflective of the maternity cases in general. The coding up of the maternity data was, therefore, based on these eight cases as shown in Table 7.1. As a result the analysis for the maternity healthscape is smaller scale than the antenatal or Bunyoro healthscape. In part, this is useful as it avoids generalisation and enables the in-depth, case-by-case reflection which Kleinman (2006) suggests is crucial for navigating different cultures.

The nature of these medical cases, whilst illustrative of some important issues, was also significant and may have a more general applicability. All the medical cases were either emergency obstetric cases (EmOCs) or they had something unusual about them such as being premature, high risk, multiple, or last minute deliveries, an emergency repair, or a failed traditional delivery (see Table 7.1). The emergency nature of these cases is both reflective and reinforcing of the local cultural constructions of childbirth in Bunyoro, which in turn informed health seeking behaviour. That is, that the hospital is not the place for a 'normal', uncomplicated delivery (see Chapter 2 for the discussion that suggests a 'normal' delivery is an entirely socially constructed phenomenon). This understanding was even reflected in the language used. Women presenting for an uncomplicated delivery were still 'clients'; they still were not sick. The expected complications of pregnancy such as abortion or breech presentations were still normal enough for the woman to be referred to as a client. It was only the moment they became physically ill that they became 'patients'. Generally, therefore, the nurses and midwives referred to women who were presenting at maternity as 'mothers'.

Table 7.1: The cases used to code up the maternity spaces

Case No.	'Type' of case	The 'caring for' space	The 'cultural' space	The 'budibyo' space
		Description		
1.	Delivery	Older woman, multi para, big baby, tried to deliver with TBA, big episiotomy, significant pain		
2.	Delivery	Horrendous delivery, small mother, massive baby, failed with TBA, 18hrs into labour father called to 'force her to push'.		
3.	Breach referral	Mother told at antenatal baby was breech and referred to Hoima. Did not go; presented in labour following failed delivery in village. Referred to Hoima, died en route.		
4.	Episiotomy repair	Young woman pregnant as result of rape, now HIV+, repair to slipped, infected episiotomy		
5.	Twin delivery	Stress induced labour of premature twins. Shared placenta. One very undeveloped, other died after few hours.		
6.	Abortion	Repeat abortion, young woman.		
7.	Compound delivery	Mother left it far too late to present, delivered as she ran across compound		
8.	Premature delivery	Baby very premature, kept for a few weeks in incubator, taken home too early, subsequently died.		

It will be argued here that as childbirth was considered a normal phenomenon, having to access maternity care meant that the cases were of an emergency nature. In turn, the clients had different health aims and needs within the MW than they did within the ANC. It

is suggested that these aims informed clients' expectations of the care. As within the ANC, clients endeavoured to use their place-based authoritative knowledge to construct informal spaces in which they were empowered to influence the healthcare transaction. Due to the nature of the care required, however, this was easier said than done. The clients were able to construct informal spaces but, as it will be shown, due to the emergency nature of the care required and the women's relative lack of experience of a biomedical institution, it was difficult to influence the healthcare transaction in a positive manner.

7.5 The 'caring for' maternity space

Milligan and Wiles (2010) make the important distinction between *caring for* and *caring about* (see discussion in Section 2.4.2). As Chapter 2 explained, care is the provision of practical or emotional support and thus is fundamental to our very existence (Lawson, 2009). *Caring for* is seen to encompass the performance of care-giving, including the activities undertaken by formal paid workers or informal, unpaid workers such as family, friends and volunteers. As Twigg and Atkin (1994) explain, it goes beyond the norms of reciprocity commonly practiced between adults. *Caring about* refers to the emotional aspects of care including the generalised relational and affective elements of *being caring*. It was therefore illuminating that a 'lack of care' was cited in a number of the focus groups as a reason why women did not like to attend Kakindo HCIV's maternity ward. This manifested itself in two ways; firstly a 'neutrality' in which the nurses *cared for*, through the practical administration of treatment, but did not seem to *care about* the woman they were caring for. Secondly, an active absence of *caring about* manifested through harsh, degrading treatment.

The next sections, therefore, will unpack the 'caring for' maternity space from the perspective of the clients using the eight cases shown in Table 7.1. The midwives perspectives of the same maternity space will also be discussed.

7.5.1 The clients' 'caring for' maternity space

Whilst in Bunyoro giving birth was something that women were expected to do to fulfil their duty as 'good women', a successful birth was still a thing to be marvelled at and celebrated. In the village, a newborn would be welcomed with a great party, a goat would be roasted

and dancing would continue until dawn (pers. comm. 92, October 06). In fact, it was locally believed that this was why so many women died during childbirth in the village - because everybody was busy partying to celebrate the baby and forgot about the mother. In contrast, it was believed that in resource-limited hospital the vulnerable newborn most likely to die (pers. comm. 93 July, 06). Whilst pregnancy was normalised, birth was still a joyous occasion. In the hospital, however, it was a procedure that was ordinarily conducted in silence, without a single word of encouragement, support, or congratulation.

Communication between healthcare deliverers and their patients is one aspect of the power laden relationship that has attracted much attention over the last 20 years (Blanquicett *et al.*, 2006; Chaitchik *et al.*, 1992). Research findings, largely based on oncology studies, indicate that effective healthcare deliverer-patient communication is related to patient satisfaction, healthcare deliverer satisfaction, compliance and medical outcomes (Thorne *et al.*, 2005; Goldman-Sher *et al.*, 1997). Communication represents, therefore, a valuable tool in any healthcare transaction (Veronesi *et al.*, 1999; van der Kam *et al.*, 1998; Chan and Woodruff, 1997). Communication, however, was highly significant in its absence in the maternity ward of Kakindo HCIV. The lack of communication was highlighted by the nature of the EmOCs. As explained, cultural understandings of birth suggested that normal deliveries should be conducted at home, therefore, the majority of the cases at Kakindo HCIV were extreme or emergency cases in which some communication would have aided the process. In Case 2, for example, the mother was an 18 year old *prime gravida* who was naturally nervous about her impending delivery. Her attendant was her 15 year old sister. She had reported for delivery early because she was in agony. She was screaming in pain, sweating profusely and could hardly stand. Having been admitted to the delivery room, on a number of occasions the client sent her assistant for the midwife who was conducting the antenatal clinic at the time. When the nurse finally went over, the mother was only two centimetres dilated so had many hours of labour ahead of her. This was illustrative of the lack of knowledge of the woman and her young attendant. Ordinarily a woman presenting to deliver would bring her mother, a sister, or an elder child. Through experience, this attendant would know that the labour had only just started and that it was unwise to repeatedly disturb the midwife.

After the antenatal clinic the midwife went back to maternity. The young woman was still lying on her back in agony, screaming '*moway*', the traditional Bunyoro call of distress. The midwife demanded to see the woman's antenatal book. The woman had presented at antenatal a week earlier for the first time. She was told on palpation that there was a large swelling on her baby's head. She was subsequently advised to deliver from the hospital and not with a TBA. The mother knew, therefore, that there was something abnormal about her pregnancy which undoubtedly added to her distress. Without saying a word, the midwife pushed down hard on the woman's stomach making her cry out in pain. Taking the woman's remaining pair of surgical gloves, without saying a word the midwife conducted an internal examination. '*Bah*' she cried, '*she is only three centimetres*' (dilated) (FN105). Leaning over the woman's 'bump' the midwife lowered herself so she was a matter of inches away from the woman's face who, lying on her back, was trapped against the bed. In a quiet and controlled manner, the midwife told the woman to stop her screaming because she was making an unnecessary fuss. Finally she threatened that if the mother did not stop disturbing her, the midwife would '*send her to push from Hoima*' (FN105). The midwife then left the room without saying a word about the pregnancy, any suggestion about how long the labour would last, or even whether the mother should stay in the delivery room or return to the maternity ward.

Similarly, after delivering a very large, almost five kilogram baby, an older, *multi gravida*, was clearly exhausted and in a lot of pain (Case 1). A pair of blood stained scissors indicated that she had to have an episiotomy. The nurse was lolled against the equipment trolley checking a text message on her mobile phone. Lying still amidst blood and the after birth the mother groaned. Clutching her sides she endeavoured to sit up. The midwife cried out in exasperation. Without another word she pushed the mother back down on the bed and seizing both of the woman's ankles, the nurse crossed them roughly. The woman screamed in pain. The midwife went back to her phone. The negative impacts of a lack of communication on a healthcare transaction have been well documented, including heightened anxiety on the part of the patient (Thorne *et al.* 2005) and insufficient information on which to base decisions (Liang *et al.*, 2002; Gafni, *et al.*, 1998; Silliman, 1997). In both of these medical cases it would have cost the nurse nothing, even in time, to share a word with the patients which could have dramatically improved their care experience (Tasaki *et al.*, 2000; Proctor *et al.*, 1996; Morse, 1992).

In addition to a lack of communication, there was also a lack of general assistance. In Case 3, for example, the mother presented in a very distressed state; she clearly knew there was something wrong with her baby. It transpired it was a breech presentation in which the baby's buttocks or feet were about to enter the birth canal first rather than the head (the latter is a cephalic presentation) (Hofmeyr and Kulier, 1996). Whilst a lateral presentation - where the baby is lying horizontally across the mother's stomach - will ordinarily naturally turn before delivery (FN194), a breech baby could not be delivered at Kakindo HCIV once labour had started. The woman was physically small and had a massive, distended and oddly shaped stomach which made it very difficult to clamber up onto the rickety delivery bed. In her haste, she scrambled up fully dressed and then struggled to hitch up her dress. The midwife bellowed at her, ordering her to strip. Clearly embarrassed, the woman tried to get back down to take her dress off; her attendant had left to buy examination gloves so the client struggled alone to get down from the table to undress. The midwife just watched. Removing what was clearly her best dress and leaving only her petticoat, the woman looked round for somewhere to hang her clothes. She made a couple of moves but kept faltering and changing her mind. In the already stressed situation this suddenly all became too much; the woman was clearly on the verge of tears, at which point I moved forward and took the dress from her and helped her back up on the bed. The midwife palpated the woman's stomach and then reprimanded her for calling her before the head was fully engaged; she added '*you are not ready*'.

As if on cue, the woman's 'waters' (the sack containing amniotic fluid) broke. The waters were blood stained and had a slight green tinge suggestive of a potential meconium aspiration. Meconium is the baby's first bowel movement which can occur within the womb if the baby is, or has been, in distress. There is a significant danger that a baby can then inhale the meconium requiring immediate suction. With a breech presentation, and thus difficult labour, there is a significant risk of asphyxiation. '*Look*', the midwife said to me '*you see the water*'. Pulling on an examination glove the midwife examined the woman internally to confirm the baby was breech. '*Ahhh....*' the midwife cried, '*she's finished*'. Writing a referral note in the woman's exercise book that served as her medical notes, the midwife shouted at the mother in *Runyoro* to turn over. The woman scrambled to turn, her feet flailing against the wet plastic and getting tangled in the rumpled lessu. She shuddered in the cold, her white petticoat stark under the glare of the halogen lamp in the dank delivery room. She lodged her hands under her cheeks in effort to hide her tears. '*Come*'

the midwife said to me *'with only a miracle is she (the mother) going to make it'*. Leaving the maternity ward, the midwife muttered a few words in *Runyoro* to the woman's husband who was waiting outside the maternity block and handed him the exercise book. Then she went home for *chai* (tea). As Chapter 5 explained, culturally, the husband was in charge of that situation: he was the one who needed to find fare and transport for him, his wife and their attendant to Hoima, plus replace the *caverra* and examination gloves and find money for the treatment in Hoima. The lack of information and general *caring about* the mother, however, was staggering. She never reached Hoima.

A further significant element of the midwives' lack of communication, which highlights the *caring for* healthscape, was their lack of physical contact with the mother, other than through invasive medical examination. In Case 3, for example, all the mother needed was somebody to steady her arm whilst she clambered down from the table. Similarly in Case 4, the young woman had undergone a particularly traumatic procedure but because her attendant was out getting an *'asante'* - literally a 'thank-you' of a soda for the midwife - the woman had to walk herself back to her bed in the maternity ward. She was unsteady and had to use the wall to guide her, dripping blood as she went. There was no reason why the mother needed to move so quickly; the delivery bed was not needed. The link between 'good' care and touch is so well established that most literature dates back from the 1980s. McCann and McKenna (1993), for example, opened their article on an examination of touch between nurses and elderly patients by stating that caring is said to be at the heart of nursing (Griffin, 1980) and that as touch is caring behaviour the act of nursing relies on the use of touch (McCann and McKenna, 1993). Similarly, Morse (1983) proposed that comfort may be the instrument of care and that touch is integral to comfort. Whilst touch may not always be therapeutic to the patient (Weiss, 1986), it is generally cited as an intervention of positive value (Lorenson, 1983; Knable, 1981; Witcher and Fisher, 1979; Indeed Montagu (1988) referred to touch as the mother of all senses and yet it is often the most neglected or assaulted sense of the hospitalised client (White, 1988). Certainly touch is recognised as a potent factor in the nurse-patient relationship (Hargie, 1981; LaMonica, 1979; Henderson, 1964; Gregg, 1963). Touch, or lack thereof, was not discussed explicitly in focus groups so it cannot be stated that it represented a reason why women preferred not to deliver from Kakindo HCIV. In two cases where I physically assisted clients (MC3/P; MatCase 4), however, the women seemed to respond to the physical touch but it cannot be said that these are representative of Bunyoro women as a whole. It can be assumed, however, that

in advanced stages of labour to be helped down off a maternity bed can only be beneficial to the healthcare experience.

In addition to the nurses' general lack of care, it was also suggested in focus groups that they could deliberately express their power through abusive behaviour. Many women spoke about being shouted at and scolded, particularly if they had not brought enough clothes to the maternity ward or they did not have money for examination gloves. On a ward round, the midwife found the baby of Case 8, left alone whilst her mother bathed. She was no longer in the make shift incubator but was wrapped in swaddling under the mother's blanket. The baby had been prescribed a sugar based medicine that was supposed to be administered with a syringe. Pulling back the swaddling to check the baby, the midwife found ants running all over the baby's body and face, including up her nose. In a rural African setting there are ants everywhere and they are particularly attracted to sugar. When the mother came back, the midwife 'blasted' her, shouting at her aggressively in front of all the other women and accusing her of being an unfit mother who clearly did not love her baby. The mother was desperately embarrassed and maintained she had only just bathed the baby but then had given her the medicine which had attracted the ants.

It was also suggested in focus groups that nurses expressed their power and lack of *caring about* through unnecessary surgery or procedures. Kyomuhendo (2003) found that women felt they were forced to have a caesarean section or an episiotomy to speed up the delivery process to either make space for another woman or to finish work early. An episiotomy is the deliberate, surgical cutting (with scissors) of the perineum between the vaginal and anal opening to widen the vaginal outlet to facilitate birth (Kettle *et al.*, 2007). It can also prevent spontaneous vaginal tears during childbirth (Fernando *et al.*, 2006). The procedure is performed if, for some reason, the baby has to be delivered quickly, for example, if the mother is too tired from labour or the baby is distressed. Whilst there has always been debate about its effectiveness (Lede, 1996), routine episiotomy is no longer performed in the developed world due to problems associated with healing and infection (Carroli and Mignini, 2008; Paul and Miller, 1995; Harrison *et al.*, 1984). In Bunyoro, it was locally believed that the nurses were quick to perform episiotomies, without permission, to hasten the birth process because they need to be somewhere else (such as their private clinics), or to attend to other patients. It was also implied that the nurses used this procedure as a way

of applying more direct and brutal control. An episiotomy is supposed to be performed at the peak of a contraction (Hartmann, *et al.*, 2005) so the pain of cutting is masked by the general pain of labour. In three focus groups it was mentioned that the nurses would just cut with either little regard for the client's welfare, or worse, as a form of punishment (FG3, 5-7).

What became very apparent was that the VW's lack of knowledge of the formal place that was the MW put them at great disadvantage. They had no power to construct informal spaces of health which could influence the healthcare transaction. Within the biomedical model, in which clients had to surrender to the medical gaze and the power of the nurses, particularly in the emergency setting, the historical relations between the position of the poor villager and the educated midwife were strongly anchored with little opportunity for the VW to contest the model. Whilst several different knowledge systems existed, within the space of the 'caring for healthscape', it was the biomedical knowledge that had the strong power base which was clearly shown through the lack of 'care'. Within that caring nexus, therefore, the biomedical knowledge was dominant, and indeed persuasive, because it seemed natural, reasonable and due to the women's inability to counter act it, consensually constructed (Jordan, 1999:57). It was not, however, a very *caring about* (Milligan and Wiles, 2010) experience for the mothers; arguably the nurses did their job but the fact remains women were not returning to Kakindo HCIV for subsequent deliveries. There is a necessity, therefore to also unpack the midwives' behaviour in this setting.

7.5.2 The midwives 'caring for healthscape'

It needs to be reiterated here that, as Chapter 6 suggested, the nurses saw themselves as educated professionals who were frustrated in their jobs and despised their living conditions. As the antenatal clinic embodied the routine, mundane nature of the care they had to provide, it would follow that deliveries - particularly emergency obstetric cases - would provide more of a stimulating working environment for them. With some exceptions, however, this was rarely the case. As Chapter 6 explained, the nurses felt over worked, underpaid and definitely under appreciated. Morale was low but the nurses and midwives were particular about their professional practice and how they were perceived within the community.

One of the ways in which this perception of professional self most tangibly personified itself within the *caring for* healthscape was through the clear demarcation of roles. I asked a midwife once why she had chosen her profession. She said she '*had it in her heart to care for patients and fight disease*' (pers.comm.46, April 06). On the same day, however, she also told me that mothers presenting to deliver brought an attendant whose job it was to '*do the caring*' (pers.comm.29, April 06). The midwife attributed 'caring' to washing, cooking, generally assisting to move the mother, help her to dress *etcetera*. Clearly, therefore, the midwife saw her role in the caring as the practical administration of drugs and medical procedure. Moland (2002:137) suggests the hospital 'symbolises the social power of the medical profession and represents the institutionalisation of specialised medical knowledge'. The specialised medical knowledge was the authoritative knowledge in the 'caring for healthscape' asserting the authority of midwife who was delivering her care through her professional medical approach. Such a medicalised view draws on the Foucauldian gaze in which the body was seen as a site that of disease or medical ailment that could be identified through a medical approach or with medical apparel (Foucault, 1989 [1973]). The gaze, however, objectifies the mother about to give birth into a patient with an ill body that is under the regulation of the powerful medical professional. This is exemplified by the notion of not being asked, or even told, that the midwife was about to examine a mother internally, which was a clear demonstration of the nurses' power over the subordinate patient. The woman's body became an object. As Young (1990:160) claims, in this setting 'pregnancy does not belong to the woman herself. It is a state of the developing foetus, for which the woman is a container'. The subordination of the physical self perfectly highlights Bordo's (1993) and Davis' (1995) point that the body became the object of process of domination and control as well as a site for self-determination and empowerment, or, on the delivering mothers' part, a lack thereof.

Through the clear demarcation of roles and the midwives' superiority through the medical gaze, some tasks were not fitting for that superior positionality. A midwife felt it was not appropriate, for example, to take a woman's clothes or to physically help her. Some midwives also spoke about potential dangers; as Chapter 5 mentioned, for example, scabies is particularly contagious through skin contact and in many emergency cases, the mothers had not been tested or had no record of their HIV status. In Case 5, the midwives were unprepared to put themselves at risk when the mother was so physically dirty (pers. comm. 122, September 06). The midwife's would regularly remind me that they were also

struggling and had dependent children so were *'not prepared to risk their lives, particularly when they were so underappreciated'* (pers. comm. 101, September 06).

The midwives also justified their lacking of *caring about* through the necessity to maintain their professionalism for the benefit of the medical transaction. The lack of 'unnecessary' communication, as one nurse put it, (pers. comm. 190, August 07) maintained a clear path of communication so that when specific instructions were delivered, they were clear and not 'clouded' by sentiment. The midwives understood that first time mothers were frightened. In actual fact, many of the midwives themselves had had difficult deliveries and upon questioning agreed that it had *'changed their nursing approach towards the patients'* (pers. comms. 176 April, 06). Their translation into practice, however, was through a more direct approach. In Case 2, for example, the midwife said that telling the mother she would have to push from Hoima was 'just a threat' (pers.comms.191, August 07) because *prime gravidas 'can be troublesome'* and that *'for the sake of the baby, they have to be managed carefully. Sometimes that requires being harsh to the mother because, in her fear, she is making the situation worse'* (*ibid*). The midwife's use of the term *'managing'* the birthing case again highlights the dominant, hegemonic medical gaze over the subordinate patient.

The midwives were also exasperated with 'difficult' patients. In Case 8, for example, the mother was clearly embarrassed after the nurse 'blasted' her when ants were found running all over the premature baby. The nurse explained that she had been *'fighting to save this baby and the mother doesn't even care enough to keep her clean. You see what we are struggling against?'* (pers.comm. 165, April 07). Arguably the nurse over reacted in this situation, it was unfair to embarrass the mother so much and was, in part, a reflection of the nurse being short tempered and tired having just dealt with another difficult case. Practically it is incredibly difficult to keep ants at bay in Bugangaizi and the baby was otherwise clean. It was, however, representative of a greater situation in which the medical staff felt the local people did not take enough responsibility for their health, particularly when it came to reproduction. The nurses would often comment, for example, that they felt sorry for women who reproduced so frequently. Similarly, in Case 4, the wound had become infected because the mother had not cared for it properly. The nurses did recognise that women in Bugangaizi had a general lack of empowerment but they felt

reproduction and the health of their children was a space in which they should take more active responsibility.

It also needs to be remembered that due to absenteeism and late arrivals of staff within the hospital, often there was only one nurse responsible for the whole hospital. This included running antenatal, delivering any mothers and running ward rounds in the General Ward. In Case 2, the nurse was amidst a busy Thursday antenatal clinic and had been repeatedly disturbed by the mother's attendant. The nurse commented that this was '*typical of PGs (prime gravidas – first baby); they panic*' (pers. comm. 192, August 07). A more experienced woman probably would not have presented for delivery that early anyway, but would certainly have known not to disturb the nurse unnecessarily. In this situation, perhaps ironically, the nurse argued that her antenatal clients were suffering because she had to leave them due to her 'difficult' delivery. She also commented that this was '*typical of the others*' (pers. comm 194, August 07) which draws on the argument presented in Section 6.6 that the nurses and midwives felt they had no support from their colleagues.

Clearly, therefore, the medical knowledge was authoritative in the *caring for* healthscape in which the nurses and midwives has a clear perception of their professional role. That role was about administering care in a medical capacity, it was *caring for*, rather than *caring about*. In many medical cases the midwives explained their behaviour as being in the patients' best interest for the benefit of their long term health. This was rarely 'brutal' or abusive behaviour, *per se*, but it certainly did not have any level of 'care' (caring about) or choice.

7.6 The cultural maternity space

In her study of women's choice to utilise biomedical maternity services in Hoima, Kyomuhendo (2003:22) found that, overall, rural women felt the delivery of maternity services 'was not perceived as culturally appropriate'. Focus group discussions generated a number of similar ideas which, when coded up, generated the analytical theme of the 'cultural healthscape'. The theme of an 'oppressing healthscape' was also created through the coding framework but the two are so inextricably linked that they are presented here simultaneously. As explained in Chapter 5, culture is understood to be the 'learned, shared and transmitted values, beliefs and norms and life way practices of a particular group that

guides their thinking, decision and actions in patterned ways' (Leininger, 1985:209). As Van der Geest and Finkler (2004) suggest, far from being the isolated islands that traditional Goffmanian thinking suggested, hospitals are both reflective and reinforcing of local social and cultural processes. Hospitals, therefore, can be considered as both an important part of the 'real world' and a revealing mirror to read the conditions in which it is situated, such as gender relations and chronic poverty (Anderson, 2004; Zaman, 2004). A significant element of the 'culture' of Bugangaizi VW, for example, was that women were largely subordinate to their husbands and their main role in life was to produce and reproduce. In contrast, the culture of the nurses and midwives was that they were successful, professional women, most of whom had children out of wedlock and disliked their rural working environment.

7.6.1 The client's cultural maternity space

For VW, production and reproduction were not always complimentary. During the summer of 2006, for example, there was a particularly long dry spell that lasted for a number of weeks. Soyabean is a staple crop of Bugangaizi but can only be planted with the first rains of the season. For those weeks conversation across the districts was dominated by concern for the lack of rain which could mean food shortages the following season. When the rains did finally come, everybody ran out into the fields, eager to maximise the growing season – including women who were up to 36 weeks pregnant. Overnight Kakindo HCIV was inundated with clients at both antenatal and maternity clinics because the heavy physical labour had induced complications or premature labour. On a very busy day, a woman was rushed in who had gone into labour at 32 weeks (Case 5). She had gone into premature labour whilst working in the fields and had been rushed literally straight into the hospital, therefore, she was physically dirty; she had mud up her legs, her arms and hands were dirty and she was sweaty. The midwife on duty refused to treat her whilst she was so dirty. As the woman lay on the delivery table it became apparent there was a further complication; she was delivering placenta first. The woman's attendant rushed in to wash her and the midwife agreed to treat her. The woman delivered a very under formed dead foetus which was clearly one of two babies that had been sharing the placenta. Moments later, she delivered a child that was also not fully formed. An APGAR score is used to determine the health of a newborn; this baby had an APGAR score of 2 meaning he was dangerously ill.

As usual, not a single word was said to the woman who was helped by her attendant back to the maternity ward. The *caverra*, *lessu* and the products of the delivery - including the dead under formed foetus - were scooped into a basin. The basin was then handed to the attendant to deal with. Meanwhile the other baby was left on the scale, naked and without attention. I asked the midwife why this was. She commented that there was little they could do for the baby and it was probably going to die. I suggested that whilst that probably was the case, the child was currently alive and the mother had never seen him. The baby was taken over to the mother and wrapped up with her; it died moments later. The attendant meanwhile came back with the empty basin.

A massive row broke out between one of the other mothers, the mother who had just delivered, the midwife and the attendant. The attendant did not know that the body of the smaller baby had been amongst the debris of the birth and had disposed of it. She was furious with the nurse, particularly when it suddenly became apparent that the mother was unaware she had delivered twins. Under Bunyoro custom, twins are called *barongo* (sing. *murongo*) (Beattie, 1962:1). They are a source of joy and celebration but they are also thought to bring about a state of grave ritual danger (*mahano*) and therefore are regarded very differently from other children and certain ceremonies have to be conducted. Traditionally, when the twins are born, the owner of the household - either the woman's father or her husband - is not allowed to see the mother or the children. They are either sent to another relative's home or a make shift shelter is erected adjacent to the house (note, it is not the male who is asked to leave). The man has to pay the local neighbours to come and care for the woman and the newborns until the ceremony can be conducted. Beattie (1962) describes the full traditional detail of this complex ritual which, over the years, has been modified. It is still an occasion, however, that has to be recognised, especially if the twins have died, otherwise it is believed the entire extended family will be cursed by the *Cwezi* spirits. Initially patches of red or white will appear on her body and people say she has been '*okya*' or burnt; she will fall sick and eventually die. The rest of the family will also suffer negative effects such as their crops failing, their animals dying and illness amongst children (Beattie, 1962:2; FN197). The modern day ceremony involves a big, expensive party but has to be conducted to pacify the *Cwezi* spirits (Beattie, 1962:2). If the twins die, however, both of their bodies have to be present at the ceremony. In Case 5, the mother would have been unable to conduct the ceremony as not only did she not have both bodies of her babies, but the midwife had neglected to tell her she had delivered twins.

In addition to Bunyoro women's delivery being affected by the seasons, there were other clear cultural elements affecting the point at which women presented to the maternity ward to deliver their baby. In Case 7, for example, a full term pregnant mother was busy working at home. She knew she was in labour but could not leave her young family until she had her husband's permission. She then did not have the time to reach the TBA with whom she had intended to deliver. Forcing her way through the hedge at the back of the hospital compound, she began to run to the maternity ward. She fell to the floor midway across the compound shouting for help. Fortunately, the nurse was administering the antenatal clinic at the time. She sent me to the maternity ward to gather the steel bowl (for the afterbirth), some examination gloves, sterile cord to tie the umbilical cord, scissors and the sheets from the nurses' bed in the small adjacent room to the ward. By the time I reached; the baby had been born. The nurse tied off the umbilical cord, wrapped the baby, and handing her to me, used the steel bowl to deliver the placenta. For the rest of the day there were running jokes that the mother should call the baby '*Ente*', which is Runyoro for cow, because she was born in a field.

Leaving the presentation at clinic so late due to 'cultural' reasons, however, did not always have such a successful outcome. In Case 3, the mother had been told at antenatal the week before that her baby was breech and that she should deliver from Hoima hospital. For many VW, Hoima is two hours and a metaphorical million miles away and represented a great expense. Whilst it cost 4,000/= to physically travel to Hoima, plus 1,000/= for her luggage, each way, she would also need to bring with her an attendant (another taxi fare) and arrange for somebody to care for her home, children and land. Finding the money, as well as the money for treatment in Hoima, was culturally the man's responsibility. This is why, in Case 3, the nurse spoke directly to the man and never told the woman what was happening. Culturally, he could not be the attendant, but he would be expected to travel with the woman to represent her at the hospital – this would then incur another fare as well as the cost of accommodation and food in Hoima. It would take time for the man to find this money and for the woman to make the appropriate arrangements. In this case it had taken too long to actually reach the hospital in time and the woman was forced to present to Kakindo HCIV, where nothing could be done.

Kyomuhendo (2003) also found that the lowly way in which women were treated in the maternity ward in Hoima, was a reason why the women chose not to deliver from there.

Focus groups identified that women recognised they were dependent on their husbands for money to go to the maternity ward but that there they were often turned into passive and dependent patients who had no power to influence the medical procedure. Unlike the antenatal clinic, the sporadic and very individual nature of the maternity cases meant it was often difficult for women to support each other and utilise their authoritative knowledge and thus they felt objectified and oppressed by the nurses. This complaint was regularly made in relation to the nurses refusing to allow women to deliver in a traditional kneeling or squatting position, instead compelling them to adopt the supine position (lying on their back) (FG 2,4). Similar to Kyomuhendo (2003), VW also mentioned at focus groups that they feared disturbing the midwives which included making noise during the delivery. In many countries there is a strong association between culture and pain response, beliefs, and behaviours (Weber, 1996). Moland (2002), for example, witnessed clients in Tanzania being scolded by nurses for crying out in pain during childbirth, as did Davis-Floyd and Sargent (1997); crying out was considered an 'un-African' thing for a woman to do during childbirth as it was associated with weakness. Similarly, Sargent (1984) found that amongst the Bariba of Benin, stoicism was idealised in response to pain and that an appropriate response to pain, including childbirth, is considered intrinsic to Bariba identity. Callister (1995) found that in China, crying out is believed to deplete the body of energy stores needed for the final stages of birth. Crying out, groaning, and moaning are considered childish and inappropriate responses that imply a future inability to care for the newborn (York *et al.*, 1999). In Kyomuhendo's (2003) study, however, a major complaint about the maternity services at Hoima was that whilst 'women giving birth consider the free expression of pain as part and parcel of childbearing' (2003:22), they were unable to express themselves within a hospital setting. By suppressing this pain, not only was the meaning and value that women attached to the childbirth experience undermined, but also made them feel that the sensations taking place within their bodies were being disparaged, detaching them from the birthing practice.

Overlapping with the *caring for* healthscape, 'culture' also affected how emergency obstetric cases were viewed by both the nurses and the other women, which, in turn, affected the nature of care they received. Case 4, for example, was not a simple episiotomy repair. The 15 year old girl had become pregnant and HIV+ as a result of being raped by a policeman as she walked to school. She had delivered at Nalweyo HCIII, a government health facility, but because she was so young, she needed a significant episiotomy to be able to deliver the baby. Some of the stitching had come undone and the wound had become

infected leaving a raw, gaping hole that was causing considerable pain. As she was sutured without anaesthetic, the nurse asked the woman's attendant (her mother), to physically restrain the patient to prevent her from interfering with the process. Prominent beads of perspiration were scattered across the woman's upper lip and forehead and she was mumbling and grunting like an animal, occasionally screaming that she should not receive an injection. It later transpired that the girl had been to see a witchdoctor in effort to abort the pregnancy but it had failed. She was then terrified that if she received an injection of 'white man's medicine' it would kill her (see Langwick, 2009). She was a young woman who had been raped and had subsequently become both pregnant and HIV+ and yet, not only was not a single word of support, explanation, or encouragement offered, but she was physically held to the bed whilst she was sutured without pain relief. After the midwife had completed the sutures - which highlighting her skill, had done neatly and quickly - in order to disinfect the wound, she dripped pure spirit all over it. The woman screamed and began shaking, her whole body vibrating as she moaned, her hands hovering on her hips, instinctively going to protect the wound. The midwife knocked her hands away. The attendant asked if it was spirit, the midwife concurred and they both laughed. Personal communication later explained that rape was a very common occurrence in Bugangaizi and drawing on local constructions of what a 'good' woman should be, it was culturally accepted as something that happened unless young women were married early or took great care. In this situation the approach of the attendant, who was the young woman's mother, was perhaps more surprising than the nurses'. She later told me she knew her daughter had been '*cavorting*' with the officer and that if '*she wanted to play women's games, she should behave like a woman*' (pers. comm. 94, August 06), meaning she should not cry out in pain.

Culture, particularly the expectations placed on a woman's role in the community, also generally defined where the women should deliver. On top of their physically stressful lifestyles, older women who had a number of children were often physically exhausted when they presented to deliver. In Case 1, for example, the mother was probably in her late forties and already had nine children. She had attempted to deliver with a TBA who had recognised that the mother needed to deliver in hospital where she could be referred if required. Similarly in Case 6, it was suspected that the woman had aborted for a third time, in part, due to her physical labouring. In Case 5, the stress of physically labouring after the sudden rains had prompted the premature delivery of the twins. Through the emergency

nature of all of these cases, culture dictated that the woman needed to deliver from the biomedical facility, rather than with a TBA therefore taking away their choice.

Culture was, therefore, a dominant authoritative knowledge within the biomedical healthscape. From a very foundational perspective, culture informed the client's perspective of childbirth and thus that receiving medical care in the biomedical facility was not the ideal healthscape in which to produce. Culture also informed when and where the mother's could 'push' from and the type of *caring for* she could expect.

7.6.2 The midwives' cultural healthscape

It needs to be reiterated here that the nurses and midwives at Kakindo HCIV were largely not Bunyoro women. The majority of the nurses were born in the Buganda Kingdom and had trained in Kampala or Jinja. The two nurses who were Munyoro had also completed their training in Kampala and Jinja and, by virtue of being educated, professional women, did not openly admit to having any knowledge of traditional healing or witchcraft.

Developing from the fact that the nurses had little experience or understanding of traditional practice, in Case 5, the midwife's explanation for her practice in which the underdeveloped foetus was disposed off before the *morongo* ceremony could take place, was frank; she did not know about the *morongo* ceremony. This is questionable as *morongo* ceremonies happened relatively frequently - I was invited to two during the fieldwork - and it was common knowledge in the trading centres what the celebrations were for. There is a greater question that the midwife should not have disposed of human matter in such a manner anyway regardless of the fact it was one of twins. The particular midwife explained that, in her (medical) eyes, it was not a baby but a collection of cells the same as the placenta which, therefore, did not require any special treatment (pers. comm. 99, September 06). She was livid, however, that her professional practice had been challenged. Her response was similar in relation to why the baby was left on the scales. She said, frankly, that the child was going to die anyway and that the mother would '*soon have another one to replace it*' (pers. comm. 97, September 06). The rate of reproduction did mean that birth and death became a regular occurrence. A mother who had just lost her neonate, for example, once said that this was God helping her because he knew she would not be able to support another child (FN149).

The nurses also lamented about the impact this cultural approach to childbirth had on their professional reputation. They complained, for example, that clients left it so late to present for a delivery that often there was little they could do. If a mother presented with a breech delivery early, for example, the baby could be manipulated into a better delivery position. As one midwife said '*we get blamed when they die but they leave it so late they are too sick, and there is nothing we can do for them*' (pers.comm.147, December 06). As was explained in Chapter 5, the nurses were also receiving negative reports from the referral hospital at Hoima that they were referring too many women who were dying either en route or within the hospital, affecting their death rates. They viewed this as a slur on their professional practice but there was little they could do when the mothers presented so late and in such an ill condition. The midwives also lamented the use of witchcraft, such as in Case 4, which often put the mothers in greater danger if there were complications or they refused treatment. The midwives also explained that the stricter approach to their care delivery was deliberate to instil some level of responsibility for the women's benefit. This included chastising the mothers for presenting late and encouraging them to engage with the Family Planning Clinic. The nurses also followed the cultural norms in the respect that they spoke with the clients' husbands and did not explain to the clients themselves (Case 1,3). This, they explained, saved time in an emergency situation as it was the husband who would need to make all the necessary arrangements.

The midwives, therefore, were as certain about the cultural roles of the women they were delivering as they were about their own professional roles. They saw their job as delivering medical care to these women in effort to benefit their health and, in some cases, to save their lives. Whilst they recognised that cultural elements made both their working lives and the lives of the women presenting to deliver more difficult, they endeavoured to work with this situation and improve it where possible.

7.7 The 'budibyo' maternity space

In Uganda *budibyo* means 'what to do'. It is a term often used, not in exasperation, but in frank realisation that this is the situation, nothing can be done about that situation, so you just have to cope with it. This theme was less dominant than the caring for or the cultural healthscape but it was a significant reason why the women preferred not to deliver at Kakindo HCIV. It also highlights the crucial role of the informal carers, or attendants and

how their authoritative knowledge in the caring nexus affected the healthcare transaction. As before, the budibyo healthscape will be unpacked from both the client's and midwives' perspectives. It will also be suggested here that, in some cases, there were things that could have been done about the situation.

7.7.1 The client's 'budibyo' maternity space

In a number of focus groups the physical space of the maternity ward was discussed. Often this related to the fact that the wards were dirty and dingy. If an attendant was staying with a client over night, for example, they would often sleep on a mat on the floor. Sleeping on the floor is nothing new for VW, in actual fact it is less alien than sleeping in a bed. As Chapter 5 explained, however, VW ordinarily keep their homes immaculately. Even the most poor of homes was always swept daily and well kept. It was often commented that the ward was a dirty place where there were too many rats that ate the women's food and kept them awake at night. The women also commented that it was difficult to live in darkness, especially during the rainy season when daylight hours are reduced. Due to a fire which totally destroyed Nalweyo HCIII, candles were prohibited and paraffin for the ward's lamp was beyond the means of most women. Such living conditions have to be contrasted with the 'home-like' environment of Melda's ward, as explained in Chapter 5.

The VWs also commented that the costs of coming to clinic were high. This was directly attributed to the cost of buying drugs that should have been supplied by the hospital but were rarely in stock. It was also attributed to the informal payments demanded by the midwives. Formal user fees were abolished in Uganda's health system in 2001 (Deininger and Mpuga, 2005). It was not unusual, however, for the nurse to ask for some type of 'asante' or thank you for her work. The 'asante' varied from sodas to produce such as mangoes, or informal assistance such as free transport if the woman's husband was a taxi driver. Other times, the nurses and midwives demanded money. In Case 8, the woman had delivered her baby very prematurely at 32 weeks. For over a week, the baby was cared for in a make shift incubator; a cardboard box with a paraffin lamp and a number of blankets. The neonate required intensive care such as regular feeding as it was too young to suckle, but was actually making good progress. After about ten days, however, the mother removed the baby from the maternity ward. It later transpired that for that level of care, the nurses had been demanding a payment of between 2,000/= and 5,000/= per day. This was a huge

expense for the mother to the extent that she had to leave the hospital; the baby subsequently died.

The costs of delivering in the maternity ward also extended to bringing the items they needed to the clinic. In Parkhurst *et al.* (2006), Kyomuhendo (2003), Moland (2000), Amooti-Kaguna and Nuwaha (2000), not having 'the right things', was cited as a reason for not delivering in the government maternity ward. As explained, the clients were expected to come to hospital with everything they needed, such as blankets, sheets, clothes, jerry cans for water and all their food, cooking utensils and charcoal. Personal communication suggested that many felt they could not deprive their family of the one blanket they owned yet they feared to present at maternity without one. Similarly a woman would need to use a jerry can in maternity to draw water to bathe with and to boil to drink. Families ordinarily only had one jerry can that could not be spared.

The women also needed an attendant to assist with all these chores, especially the lengthy processes of drawing water and cooking, to help during delivery and to buy drugs from the trading centre. Ordinarily this was the delivering mother's eldest female child, a neighbour or, in some cases, her mother. It needed to be a person who could donate considerable time and live within the birthscape. Informal care is very common across Africa; in 2004, for example, UNAIDS estimated that around 90% of all care for HIV+ people in Africa was provided by family members (Iliffe, 2006:102: see also Zaman, 2004). Informal caring also draws on the cultural model that Ugandans care for each other in difficult circumstances (Wallman, 1996). As Iliffe (2006:102) put it, 'everywhere in the continent, it appears, families had a unique and morally inescapable obligation to care for their own'. Focus group discussions often suggested that without a 'live-in' attendant, a client could not eat or would not be able to bathe. In actual fact, a real sense of community developed through the attendants and it was not unusual to find them helping other mothers, for example caring for their newborns whilst they bathed or sharing the cooking responsibilities. The cooking 'pit' was a little way away from the maternity ward in the hospital compound. The attendants would need to spend many hours there boiling water or cooking. Similar to within the informal spaces of the antenatal ward, the attendants were a vital source of useful authoritative knowledge that helped to empower the client within the healthcare transaction. They would often, for example, lend other mothers blankets or extra lessu at opportune moments when the midwives were present to prevent them blasting the women

for not having the right items. As well as practical care in some cases, the attendant would assist with informal *caring about* so might, for example, remind the nurse that their charge needed more drugs. The cooking pit also represented an informal health space in which information could be shared amongst the attendants for the benefit of the delivering mothers, such as how to 'deal' with the midwives, when the labour was advanced enough to call the midwives to come and deliver the baby and which drug shops sold the most reliable medicine.

Focus group discussions also suggested that the midwives were not respectful of the women's limited belongings. One woman explained that she had brought enough clothes to the maternity ward but that the midwife had used every item to mop up blood (FG5). Curiously, many VW also commented that they were worried about the lack of mosquito nets in the maternity ward. Due to a number of charitable NGO health campaigns, all the villages were aware of the perils of malaria and the majority of homes saw a mosquito net as an important investment (FN34). They would not take the mosquito net from home but, because most of the window panes were broken, the women did say in focus groups that they feared catching malaria whilst staying in the maternity ward (FG3,5).

It also became apparent that the space was not used as efficiently as it could be. As explained, there were ten beds in the maternity ward - eight of which were operational - but it was generally a space of delivery, not of maternity. Because women presented to deliver in advanced stages of labour, they often went straight into the delivery room. It was rare, therefore, to find women in the maternity ward waiting to produce. Occasionally this generated difficult situations. In Case 6, for example, the woman had suffered her third abortion in a relatively short space of time. It was a particularly difficult case anyway, in which the midwife on duty had had to attend a delivery during the night so she was tired and irritable and had little patience for this woman in distress. As I entered the midwife shouted down the length of the ward, *'Oh Jennifer, I am exhausted, all these mothers are disturbing me. I have been up all night and now this one (gesturing with her hand) has just aborted'* (FN99). As discussed, it is a 'good woman' who fulfils her role by having a baby; a 'failed' woman is unable to. This woman was clearly desperately embarrassed about her failure being shared in the unusually busy ward. Having just aborted, however, she also had to share a very public space with four mothers and their babies. Surrounded by babies, the 'failed' woman curled herself into a ball, in part in an effort to disguise her tears. It seemed

particularly unfair that she had been ushered out of the delivery room so quickly when it was not needed and the general ward was entirely empty.

It was also discussed in focus groups how equipment was misused in the maternity ward. A particular issue was the hospital vehicle which should have been on hand every day, with a driver, to take referred patients to Hoima. It was also used to take corpses home and to bring medical supplies from the District Headquarters. It spent most of its time, however, carrying charcoal, beer and produce for the nurses and taking them to and from the administrative centre at Kibaale. The VW complaint, however, was less about the vehicle's misuse *per se*, but about the fact that the nurses never paid for the fuel. It cost 25,000/= to fuel the vehicle sufficiently to reach Hoima which was far too expensive for a referred patient. The VW resented that they were expected to pay this bill and yet the nurses were using the vehicle, not only frivolously, but without paying for it, especially when the public transport route to Hoima was so difficult.

Whilst a less dominant theme, the budibyo healthscape clearly informed the client's perceptions of the biomedical healthscape and, in turn, affected their health seeking behaviour. Some of these complaints could have been easily rectified, for example, the woman who had aborted in Case 6, could have used the side room or been moved to the out patient's department, rather than having to be surrounded by mothers and their babies. Others reflected the broader Bunyoro healthscape, as explained in Chapter 5. The fact the ward was dirty, for example, was in part reflective of the water shortages particularly during the dry season but it was exacerbated by the nurses' personal use of it.

7.7.2 The midwives 'budibyo' maternity space

The nurses were actually more adamant about the difficulties of their budibyo clinic than the clients were. The lack of equipment in the maternity ward that, in some cases, was vital to a mother's and baby's survival, added to the midwives' general frustration about their working conditions. There was a shortage of bulb syringes, for example, to clear a baby's nose and mouth immediately after delivery and it was particularly dangerous to attempt this manually due to the risk of HIV infection. A number of nurses had attended training about how to use *Misoprostal*, a drug the Ugandan Ministry of Health wanted all health facilities, particularly in more remote rural areas, to have which controlled bleeding in pregnancy (Womakuyu,

2009). The drug was not available at Kakindo HCIV. Similarly, one nurse had been away on a six month training program learning how to use an ultrasound and foetal heart monitoring machine. She lamented the fact that her training was wasted as, not only did they not have the equipment, but the hospital never had any power (FN195). Not only were the nurses frustrated, they also felt this reflected badly on their practice as professionals if they did not have even the most basic of equipment. The nurse who trained to use the ultrasound, for example, feared that she would forget her training without the practice. Again reflective of the midwives perceived position within society, they felt it only fitting that they should have use of the hospital vehicle which was one of the few 'perks' in their otherwise difficult jobs.

The midwives were, however, quite ingenious in their adaptive approach. The exposed window frames where the glass had been broken became the perfect place to tie intravenous drug bags due to the lack of stands. Because they did not have the paraffin to sterilise instruments, the midwives devised a special concoction of Nomi, a local brand of washing powder and JIK, a local bleach which was used to scrub down all the equipment. They also became adept at utilising the emergency solar powered halogen lamp sparingly. At times, the midwives also adapted to assist the clients in the budibyo healthscape. In Case 7, for example, the midwife used the bed linen from the nurses' bed to wrap the baby in and very occasionally nurses who lived on site would lend cups and thermos flasks to women in the maternity ward. One nurse mentioned, however, that this could be a slippery slope. The nurses wanted to help but they were limited in resources and money themselves. In relation to their lack of personal resources, the nurses and midwives were very frank and surprisingly open about their demands for informal payments. They felt it only right that their hard work and dedication to the clients should be recognised but especially in light of their poor pay. The baby in Case 8, for example, required intensive and time consuming care which the nurses felt they should be remunerated for.

The midwives did, however, regularly complain about the 'disturbing attendants'. As explained, at times the attendants could be the client's mothers who were very experienced in all matter of childbirth. They had the authoritative knowledge, therefore, to wield some power over the healthcare transaction and, for example, question the midwives treatment and behaviour. In Case 1 the woman's attendant was her mother who had delivered nine babies herself. Whilst she was absent for the actual birth, she had the confidence and experience to quarrel with the nurse who had not immunised the newborn. In the nurses'

haste, she stuck the hypodermic needle into the baby's arm at an awkward angle going straight through the flesh and out the other side. This created a huge bruise on the newborn's arm and caused him much distress. Due to her knowledge and experience, the client's attendant had the power to demand that another nurse administered the vaccine. A prime gravida VW would not have had the confidence to do this. As the nurse was not used to her practice being challenged so confrontationally, she refused to deliver any further treatment to the client or her baby.

7.8 Conclusion

In Bunyoro childbirth is the *lutalo lwabakyaala*; the woman's battle. It is not, however, an illness. The Bunyoro approach to childbirth conceptualised it as a ritual that should not ordinarily require medical treatment and thus situated it firmly within the home or the ward of a TBA. In turn, this conceptualisation informed the nature of care that should be expected with a normal birth. Childbirth from a biomedical lens, however, constructed the maternity ward of Kakindo HCIV as a female space but one of emergency in which traditional and oppressive roles were asserted. Authoritative knowledge constructed three informal spaces. As the formal and informal spaces met, however, (see Figure 2.2), due to the emergency nature of the care required, the midwives and nurses dominated and asserted historical relations between positions which were anchored in forms of traditional power (Bourdieu and Wacquant, 1992:16). With the slight exception of the informal caring of the attendants, the dominant authoritative knowledge across all eight cases was the hegemonic, biomedical model which in many medical transactions reduced the fluid act of birth into an objectifying medical gaze (Foucault, 1989 [1973]). The medical gaze, therefore, required cure and not care; the nurses and midwives needed to *care for*, but not *care about* (Milligan and Wiles, 2010) the women delivering within the biomedical birthscape. *Caring for* clients was also fitting to the nurses' status, as was commanding the hospital vehicle, being uninformed of local culture and custom, and demanding informal payment from poor women. As a result, within the caring nexus, biomedical knowledge became persuasive because it seemed natural and reasonable. In addition, by virtue of the emergency nature of the cases, the women had very little ability to counter it and thus, the biomedical knowledge, became consensually constructed (Jordan, 1993).

The hegemonic biomedical approach to birth generated an overwhelming negative impression of the maternity care delivered within Kakindo HCIV. Contemplating the *caring about* approach of the TBA it is perhaps unsurprising that so many women chose to deliver with Melda than they do within the biomedical facility. The hospital is both reflective and reinforcing of local social culture (van der Geest, 2004) and these three health spaces highlighted entrenched gender dynamics that were oppressing reproducing women in Bunyoro, in turn, posing a barrier to their healthcare delivery. What is significant, however, is that some of the barriers to biomedical healthcare access such as the lack of cultural knowledge and the dirty wards, could be rectified easily and would improve access to MCH care.

Chapter 8: Conclusion

8.1 Introduction

The overall objective of this research was to unpack the reality of delivering maternal child health (MCH) care in the chronically poor district of Kibaale, Bunyoro Kingdom, rural Uganda. In order to address this objective, the thesis presented the conceptual tool of 'healthscapes'. It is suggested that place-knowledge can become authoritative within formal places of health thus constructed informal health spaces in which the individual is sufficiently empowered to influence the healthcare transaction in an effort to achieve their health aim. The tool was used to understand the pursuit of MCH for Bunyoro women.

It was shown that childbirth was what was expected of a Bunyoro woman. As a result, it was suggested that a pregnant woman in Bunyoro had very different health aims and expectations from the ANC than she did from the MW. This affected both the nature of care delivery and the women's capacity to use authoritative knowledge to influence the healthcare transaction. This research was not intended to be a policy document but it does suggest that such a nuanced social analysis facilitates an understanding of health which could be useful to inform healthcare policy. This approach became more poignant still when, towards the end of the research, the Health Sector Strategic Plan III (HSSP III, June 2010) was released. The HSSP III explicitly recognises that every Ugandan citizen should be able to access the highest attainable level of health as a fundamental human right (MoH, 2010: 38). It also suggests that healthcare delivery has to be *appropriate*, which can only be deduced through *social analysis* - the exact focus of this research.

To conclude this thesis, it will be argued that as health is understood as entirely fluid and constructed in place, understandings of the care - formal and informal - that maintain that fluidity are equally as complex. It will be suggested that the healthscape concept is an effective way to unpack the authoritative knowledges which could potentially empower MCH transactions and provide a new insight to healthcare provision.

This final chapter is delivered in four subsequent sections. Section 8.2 will contemplate the empirical findings of this research in relation to the conceptual framework outlined in

Chapter 2. It will also individually address the chapter's research questions. Section 8.3 will evaluate the healthscape concept and its potential contribution to healthcare analysis. Section 8.4 will contemplate potential limitations to this research. Section 8.5 explains the potential future research agenda and, answering both the disciplinary and empirical ethical concerns to 'do human good', will briefly highlight the contributions of this research in this regard and give some policy recommendations.

8.2 Empirical findings

This section will summarise the empirical findings of this research by addressing each individual research question, as posed in Chapter 2, in relation to the conceptual framework.

- *What are the different health places in Bunyoro that support or contribute to MCH? What does it mean to 'care' in these places?*

The two components of this question need to be considered separately. Coded up data from Kakindo HCIV, focus groups, personal communication and policy documents collected over 18 months of fieldwork revealed three distinct places of health; the ANC, the MW and the broader Bunyoro setting. The three places will be considered here in turn, starting with the broader health setting of Bunyoro.

Drawing on Sanders (1985:20) point that 'struggles for health are tied to a society's central struggles', the holistic Bunyoro understanding of health, or *obulamu*, was set against a pluralistic health-system of traditional and biomedical healthcare and incredible hard work. Good health for women and children in Bugangaizi required highly effective organisation, despite the social and pragmatic difficulties of the chronically poor district. Women, particularly VW, were responsible for the 'triple burden' of production, reproduction and community production which were considered part of the role of an *omukyala omutufu*, or a 'proper woman'. Despite their input into health, women were limited by their decision making capacity at household and community level. VW also faced pragmatic health barriers such as poor water and sanitation and physical difficulties travelling to the hospital due to poor infrastructure.

MCH was obviously delivered in the more formal places of health of the ANC and MW of Kakindo HCIV. The biomedical health services in Bugangaizi, however, were known to be 'generally appalling' (WVAR,2006:16). It was highly revealing, therefore, that women were willing to overcome the societal and pragmatic difficulties, outlined in Chapter 5, to access the ANC. Over 60 women a week - both TCW and VW - received antenatal care from the ANC. In contrast, only approximately ten, predominately VW, would deliver from Kakindo HCIV.

The fieldwork discovered that the formal places of health supporting MCH were not only biomedical. If only ten women delivered at Kakindo HCIV weekly, women had to be accessing maternity care from elsewhere. Women - both VW and TCW - recognised the dangers of delivering unaided in the villages and preferred to deliver babies with the support of a traditional birth attendant (TBA). In light of their disposable income, TCW *chose* to deliver with a TBA. Other alternative health places in Bunyoro that 'supported' MCH included witchdoctors and herbalists. Problems then arose when the traditional and biomedical models collided but there was little the hospital could do.

The second half of this research question rises to Dyck's (1995) challenge about what actually constitutes 'care' in different places. In Bunyoro, the giving and receiving of care was so fundamentally imperative to human existence that it was not appreciated, or even acknowledged, on a day-to-day basis. The majority of the triple burden within the broader Bunyoro setting was tantamount to 'domestic labouring' and 'just' part of the gendered expectations of Bunyoro women. Furthermore, drawing on Goffman's (1973) theory, an inability to meet this norm conjured questions of moral judgement and responsibility, resulting in stigma that constructed a 'bad' woman. This judgement also extended to re-structured families. An individual that was unable to care for their family could even be ostracised by the community for their failure.

'Care' in relation to MCH within the broader society of Bunyoro was more about maintenance rather than curing an ailment. Pregnancy was not only an everyday occurrence, but what was expected of a woman who was fulfilling her 'proper' role. Caring for that pregnancy, therefore, required general maintenance rather than special treatment. The value of formal antenatal care from the hospital to sustain the pregnancy

and benefit the mother was recognised. It was accessed, however, as sustaining care by women who were fulfilling their duties; it was pragmatic, basic and mundane. In accessing antenatal care, therefore, the VW and TCW's aim was to support their pregnancy; it was not an emergency situation.

The mundane construction of care also extended to the nurses' care delivery. The nurses also felt antenatal care was vital to sustain a pregnancy, but was not emergency care. This meant they could afford to be late, absent, or rushed for clinics as it was not a matter of life or death. To the nurses the care delivery within the ANC was boring, basic and compounded their sense of frustration, burn-out and general despondence with the professional and personal life that they felt was unbecoming to their status. Arguably the nurses delivered *caring for* (see Milligan and Wiles, 2010) in the sense that they did conduct 'some' antenatal clinics. In light of the HSSP III (2010), however, it is arguable how appropriate or effective these clinics really were. Regardless of being resource constrained, the nurses' despondence with their working lives was performed through their rushed clinics, their disregard for local tradition, or in some cases lack of basic *caring about* that would have made the transactions much more efficient and effective in improving MCH.

The nature of 'care' in the MW, however, was very different. By virtue of childbirth being such a regular occurrence and thus not a medical matter, women did not expect to deliver within a hospital. The negative perceptions of the hospital also meant the majority of women did not *want* to deliver from Kakindo HCIV. If women did present for delivery - ordinarily they were VW - the cases were unusual or emergencies. The client was then in *need* of care, or even medical cure, and was thus dependent on the nurses. They also had much less experience of the setting to inform authoritative knowledge as they had in the ANC. Within this setting, under the hegemonic dominant medical model, the mothers were supposed to subject their bodies to a questioning medical gaze and surrender jurisdiction to the greater medical power. The nurses, in turn, justified their considerable lack of *caring about*, as a deliberate move to keep the medical transaction swift and clear due to the emergency situation. Care in the MW became the pragmatic administration of emergency care that had little consideration of the broader context.

Informal care was also a vital, but overlooked, component of care delivery within the formal setting. Within the formal place of the ANC, women informally cared for each other, by, for example, giving advice or lending lessus. The importance of this care was highlighted when it was denied. A woman who was pregnant underage, conflicted gendered expectations and thus received no informal care from the other women. Without this input, the healthcare transaction for these women was all together much more difficult. The blurring between informal and formal care within the hospital was also embodied by the nurses' practice. The nurses considered any care, other than the formal administration of medical care, as below their status. Within the MW, the input of informal carers was essential. It was the informal carers that performed domestic labouring tasks within the formal health space such as cooking, washing, boiling drinking water and running errands. Without that input, women literally could not present at the MW.

Care delivery within the space of birth that was the TBA's ward was also entirely different from the biomedical place. Melda's maternity services were so revered within the community that they were refusing to allow her to retire. Technically Melda could not deliver complicated deliveries *per se*, in the sense that she could not administer drugs or perform an episiotomy. She did, however, have generations of handed down knowledge which enabled her to treat all women, regardless of tribe, age or circumstances, with the same care. That knowledge also enabled her to deal with many deliveries that were beyond the limitations of the hospital. Melda could, for example, turn a breech presentation and soften the pelvis of an underage mother. She also recognised her limitations and referred women to hospital when necessary. Some of the romanticism of the care that Melda delivered has to be removed. Undoubtedly she too was stressed and whilst valued within the community was not numerated for her demanding service. The fact that she, single handed, delivered up to ten babies a week, however, was testimony to her care delivery.

It became apparent across the three different places of health, therefore, that as the plurality of health places were socially and culturally situated, in each there were different understandings of what was 'wrong' with the body. These interpretations informed expectations of the nature of the care required.

- *How do healthcare recipients conceive biomedical MCH in the Bunyoro Kingdom and can authoritative knowledge be used to affect the healthcare transaction?*

It was overwhelming how negatively healthcare recipients conceived the biomedical MCH delivered within the Bunyoro Kingdom. As Chapter 6 and 7 explained, focus group discourse constructed the ANC and the MW as formal places of health in which the healthcare professionals were rude, 'proud', arrogant, ignorant of local culture and generally unapproachable. The fact that one client with a complicated obstetric history presented to the ANC in advanced stages of labour and yet preferred to walk the 8km back to her village to deliver with a TBA, is testimony to the perceptions of the MCH care delivered at Kakindo HCIV.

Chapter 5, however, explained, that whilst the triple burden of women often posed barriers to accessing healthcare, it also generated numerous informal spaces of health in which women were able to share their health knowledges as they washed clothes *etcetera*. As information spread so quickly, the negative perceptions and 'horror' stories about the healthcare delivery were equally shared. From a client's perspective only - the nurses' perspective will be considered momentarily - the origins of these beliefs were understandable. Chapter 5 outlined the social and pragmatic difficulties VW had to overcome to access antenatal care. To reach clinic and bounce unsurprisingly made women question the care delivery of Kakindo HCIV.

If the VW managed to reach a running clinic they still had to achieve their health aims. VW would use their place-based authoritative knowledge, gleaned from previous experiences, perceptions of the care that was required and numerous discussions in informal spaces of health, to moderate their behaviour and conduct. This in turn constructed informal spaces in which the women were sufficiently empowered to influence the healthcare transaction in an effort to achieve their health aim. The influence was not always positive. Wearing shoes to minimise the social distance between themselves and the nurses, for example, proved to be little more than a hindrance to the swift running of the clinic. At other times the efforts were successful. On a very pragmatic level, if a number of women required the tetanus vaccine and they knew it was in the dispensary, that shared authoritative knowledge constructed a space

in which the collective of women were able to persuade the nurse to get it and thus achieve the health aim. Informal health spaces constructed within the formal place of health through the nurses' absence also ironically represented an opportunity to further share authoritative knowledge. TCW's knowledge could be considered more authoritative still. By virtue of living in the trading centres, they had more ready access to transport and generally knew when the nurses would be late or absent. They also had sufficient social power to walk to the front of the queue in clinic. For both sets of women, therefore, formal places of health could be challenged, re-interpreted and contested due to knowledge that was authoritative, embodied, gendered and embedded in place (Duncan, 1996).

In contrast, the maternity clinic echoed more the classic political economy approach to health. Due to the emergency nature of the care required and the women's lack of experience, or authoritative knowledge, they had to depend on the midwives to deliver their babies safely. Suppression by the biomedical model not only subjected women's bodies to scientific regulation, regardless of local custom, but also served to enhance the gendered ideology of subordination to men. Despite otherwise having little or no responsibility for the production of health, in the biomedical place the men were very much in charge and, for example, were informed about *their wives'* conditions before the women were. The nurses explained their brisk care delivery as fitting and effective within the emergency setting. On a case-by-case basis, notwithstanding the resource constraints of the MW, this approach was largely understandable; the nurses successfully delivered some difficult maternity cases and thus achieved their health aim. During the course of the 18 months of fieldwork, however, not a single woman presented for a second delivery that was not an emergency; other women specifically said they would never deliver in Kakindo HCIV again. In light of the HSSP III (2010) and the recognition of the necessity to deliver a continuum of care throughout a woman's reproductive life, it is arguable how much this case-by-case approach positively contributes to the broader MCH picture.

Van der Geest and Finkler's (2004:1996) suggest that 'biomedicine, and the hospital as its foremost institution, is a domain where the core values and beliefs of a culture come into view'. In critique of this approach, the care that was delivered within the MW was

reflective of the nurses' core values and beliefs, but not necessarily of broader Bunyoro understandings. Whilst childbirth was a regular occurrence, it was still one to be celebrated and *caring about* was still required. It is illustrative, for example, that Melda who delivered both *caring for* and *caring about*, was so very busy. Literally voting with their feet, the number of women who opted to deliver with Melda suggested hers was the *preferred* cultural model of childbirth.

It has to be acknowledged that in Bunyoro, the biomedical model was an important institution of social control, particularly in the MW. The feminist post-structural analysis presented here, however, moves away from examining medical power as oppressive, highly visible and sovereign-based, with health-seekers entirely subordinate. In contrast it suggests that within the formal place, authoritative knowledge enabled the construction of informal spaces in which, at times, the health-seekers were empowered to influence the healthcare transaction. These spaces also produced knowledges which could be authoritative in future medical transactions to challenge the hegemonic model in an effort to achieve the health aim.

- *What is the healthcare workers' perspective of the biomedical conceived healthscapes?*

From initial fieldwork it was easy to see how reports of abuse inflicted on chronically poor patients by healthcare workers, such as those by Zaman (2004) and Moland (2002), reached the academic agenda. Certainly there was a prevailing negative impression of healthcare delivery which, at times, showed a significant lack of *caring about*. It is vitally important, however, to unpack these claims in context and contemplate the healthcare worker's perspective of the place-based healthcare delivery. In the 18 months of fieldwork, direct acts of violence against women were not witnessed. At times, however, aggressive healthcare was delivered which, due to the lack of *caring about*, made the healthcare transaction unnecessarily difficult. The notion of not telling, let alone asking a woman before conducting an internal examination, could be interpreted in some contexts as abuse. Whilst entirely surrendering to the medical gaze, for women who were subordinate in society anyway, this was just part of the healthcare transaction. With communication, however, the healthcare transaction would have been much less

traumatic and thus it was more likely that women would access maternity care for subsequent pregnancies.

It was significant that, in a community in which women were naturally subordinate to men, the nurses had such control in both the hospital and the broader community. This draws on the colonial understandings of the foundation of the supremacy of the biomedical model that could restore productivity (Turner, 2000, 1992; Lupton, 1994). The nurses were adamant, however, about how difficult their personal and professional lives were. The nurses also felt neglected by efforts towards new staff (Hongoro and McPake, 2004). The nurses were frank that many of the client's complaints, such as their absenteeism or tardiness, were knock-on effects of the legitimate coping strategies required for their difficult lives. The nurses were also generally bored, challenged by difficult patients and yet, in their minds, professionally stressed and burnt out. The research suggested that these feelings generated a viscous circle where their lateness made work stressful but was caused by the coping strategies they felt legitimate and necessary to compensate for their stressful jobs. The nurses also felt limited in their professional capacity by the lack of resources at the hospital, some of which they attributed to ill conceived decentralisation policies.

The nurses also lamented how they were 'at risk' from dangers such as scabies. Nurses would become angry if a patient refused to disclose their HIV status, but due to the challenge to their status rather than in fear for their safety. There were many rumours, however, about which nurses were 'sick' (had HIV) and whilst assumptions cannot be made, it is significant that two healthcare professionals from Kakindo HCIV died during the course of this research.

- *What is the reality of delivering high quality, pro poor care, from user and provider perspectives and how could this understanding be used to inform policy?*

This research sought to challenge the existence of essential truths and understand the peculiarities and specificities of action in place. It was not, therefore, intended to be a policy document. The healthscape concept, however, highlighted that delivering high quality, pro-poor care in the resource constrained, chronically poor district of Kibaale, was incredibly difficult. The concept challenged some traditional understandings of the

subjection of passive, uninformed health-seekers by the power of the hegemonic biomedical model. Equally, whilst current human resource policies tend to be premised on the notion that health workers are passive actors that are permanently motivated to serve the public (Lindelow and Serneels, 2006), it must be recognised that healthcare workers are human beings with personal aspirations and families to support. This analysis exposed the viscous cycle of how the nurses' feelings of dejection and stress perpetuated the prevailing negative beliefs of their healthcare delivery through their coping mechanisms such as their private clinics.

The healthscape concept used over an extended period of time, highlighted the highly complex social dynamics of healthcare delivery, particularly when embedded in the dynamics of a chronically poor context. It became clear that this nuanced understanding of the realities of delivering appropriate healthcare immediately unveils avenues for cost-effective policy intervention that could improve healthcare delivery. These will be discussed further in Section 8.5.

8.3 The healthscape concept

The healthscape concept represents this research's major contribution to theory. Health and place have been increasingly understood as both inseparable (Gesler, 2003:1) and situated and socially produced in particular contexts (Smyth, 2004). As Moll (2002) put it, multiple ontologies of healthcare practice are brought into being by different individuals and sustained through day-to-day, socio-material practices and knowledges in a host of places; consequently health knowledges are multiple and not always suited to an empiricist philosophy. Developing from this theory, McKie *et al.*'s (1994) concept and using Bourdieu's (1984) structural-cultural approach, the healthscape is a conceptual tool which can be used to read the hegemonic social relations of gender, power and values within a healthcare transaction. As shown in Figure 2.1, the concept suggests that place-based authoritative knowledge can be used within certain health places to sufficiently empower the individual to construct informal spaces of health. Within those informal spaces of health, authoritative knowledge could be used to influence the healthcare transaction.

To unpack the definition further, taking a relational view of place and space, the concept suggests that within specific time bound healthscapes, individuals plot routes to achieve their health aims. That health aim could vary in scale from brushing teeth to, in this case, accessing MCH to support a pregnancy. That 'aim' will be informed by the norms of health understanding. This is the 'local' understanding of what is wrong with the body and thus, what it requires in terms of care. Such understandings rely on socio-cultural constructions of the caring nexus, ergo what is the 'matter' with the body, the care it needs, who should deliver that care, where it should be delivered and the power hierarchy that caring generates. Interpretations of the health norm and thus what is wrong with the body will also affect the place from which health is sought. In Bunyoro, for example, if the health-seeking person had been cursed, the norms of health understanding would dictate they needed to access care from a witch doctor.

To achieve their health aim, health-seekers then have to negotiate a 'terrain' that is constructed by their health knowledge embedded in place. That place will contain endless informal spaces of health. For example, place-based health knowledge is contributed to by broader societal factors such as gender, culture and kinship. Gender, for example, can both facilitate and potentially constrain an individual. In this setting, gendered responsibilities generated informal spaces of health in which women were able to share their health knowledges through experienced based discourse. This place-based knowledge could then become authoritative in different settings. Gender, however, also represented a societal barrier that women had to negotiate as they were marginalised by their lack of decision making capacity. Barriers may also present themselves in a more tangible manner such as via a lack of resources. Drawing on and gathering place-based knowledge, the health-seeker charts a route through this terrain and into the place of health.

In that place of health, place-based knowledge could potentially become authoritative. The individual could then be sufficiently empowered to construct informal spaces of health within the formal places. Within the informal space of health, the place-based knowledge informs health-seeker's actions, behaviour or practice. It could become empowering, enabling the individual to construct an informal space in which they could challenge the traditional social order in an effort to achieve their health aim.

It needs to be understood, however, that that formal space is still constructed within the formal healthcare place. As Figure 2.2 showed, the space is thus still, at least in part, affected by institutional factors. For example within that constructed informal space will still be formal healthcare workers. The healthcare workers may have different expectations or aims within the healthcare transaction which, in turn, potentially present a barrier to the health-seeker achieving their aim. That space is also governed by institutional norms such as practice and the availability of resources. It also needs to be understood that that space could be continuously constructed and reconstructed with the addition of new place-based knowledges.

This approach challenges the impression that patients are compliant, grateful and passive individuals within the healthcare transaction. The healthscape approach can be used as a tool, therefore, to unpack how different, situated, health knowledges can reconstruct identity and thus (re)produce contextual social relations of power within the formal place of health as it is embedded in legacy of biomedical supremacy. It could be applied to any health situation at a variety of scales. The concept could also be suspended in time to analyse a number of healthcare transactions within the person's life course. The concept shows how, in some situations, the restructuring of power relations within the formal place of health may be advantageous to influencing the healthcare transaction. It also highlights how in any healthcare transaction there are multiple, and potentially conflicting knowledge systems. The conceptual tool may thus explain the adaptive or coping strategies adopted by health-seeking individuals to access formal, place based healthcare. Understanding the nature and necessity for these coping strategies could highlight required improvements within the health system.

8.4 Methodological lessons and research limitations

Any good piece of research contemplates potential bias and limitations to its findings and contemplates how lessons learnt could benefit the future application of the methodology. Chapter 4 contemplated the methodological approach and methods used to conduct this research in detail. It highlighted how this research was bound in difficult questions of ethics, which required a continuous, critical (re)evaluation of the positionality of the researcher throughout the research process. Perhaps as a result, a number of methodological lessons were learnt that could be applied to future research.

This research very much benefited by being conducted by a white female. The similarities in gender enabled confidence and the sufficiently 'alien' whiteness initiated enough 'ignoramus' induced pity (McDowell, 1998: 2138) to inspire intrigue that enabled early rapport. It is suggested that similar gendered based research would benefit from the same researcher. A potential limitation of this research, however, was that as the researcher, I was too 'close' to the fieldsite in which I was living and working. Whilst notwithstanding the benefits of an embedded ethnographic methodology, a lesson learnt was that the tool of participant observation works better if observation is permitted as well as the participation. Great efforts were made to ensure the research was scientific rigorously, such as 'cleaning' the data (Kumar, 2005), using 'crystallisation' (Richardson, 1994) and coding it and coding it up (Fielding, 2001). Efforts were also made to step away from the fieldsite when possible, such as visiting my Kampalan supervisor every six weeks. In research as encompassing as this, however, it is questionable how much analytical distance that time, space and methodological effort truly generated. Anthropologists since the 1960s have problematised the positivist belief that the 'underlying truth' is accessible if enough time is spent and a sufficiently good rapport is generated with informants (Wood, 2002: 34). The post-structural approach jars with the notion of discovering 'truth' anyway. Arguably, therefore, the longer I spent in the fieldsite, the more challenges to that truth were discovered, and indeed the more it seemed that further challenges were discoverable.

Ultimately, however, I could not relax into a post-structural reflexive uncertainty because, like most researchers, I had data to collect, a PhD to write and a District Director of Health Services to inform. With hindsight, spending 18 months in the field was perhaps not an appropriate - or an appropriately considered - period of time. It was long enough to become sufficiently embedded within 'the field' that was my home to lose some analytical distance. It was not, however, long enough to stop thinking 'something different might happen tomorrow'. It would refute with the ontological approach to health to suggest a community could ever be truly understood to the extent the events of tomorrow could not be surprising. It is recommended for similar research, however, that whilst a long period of time needs to be spent in effort to gain a basic understand of the health-system, it could be advisable to conduct fieldwork in two periods of perhaps nine to twelve months. Arguably, this recommendation is still contextually embedded as it is based on the premise that health is fundamentally tied to a society's struggles, and thus as those struggles change over the course of a year, so too will the society's health needs and beliefs. A limitation of this

research, which future research should consider, for example, is that whilst I spent 18 months in the field, I only saw the health effects of one Ugandan 'winter', which could have been anomalous. It is also recommended that similar research takes a gap of a few months after the first block of fieldwork to conduct some initial analysis to guide the second period of fieldwork.

A vital part of this fieldwork was living amongst the community. This research has argued that the emotive reports of abuse suffered by chronically poor patients at the hands of healthcare workers were not understood in context. This research does not exonerate the maltreatment of patients, but it does suggest that in any research practice considered 'abusive' needs to be understood within the broader socio-cultural context of the norms of society. It would have been impossible to even have scratched the surface of life in Bunyoro without experiencing it firsthand. As Chapter 4 explained, much of the data was collected whilst conducting day-to-day activities which simply would not have happened if I had not been living within the community. Whilst endeavouring to not add too much romanticism, the participatory approach to this research also, perhaps naively, aimed to 'give back' to the community that was technically assisting me in the pursuit of a qualification. Continuous efforts were made to not only not cause harm to the participants, or 'knowers' (Kesby, 2000), but to actively benefit them via the development of their skills, knowledge and capacities. It is recommended that such an ethical approach should be important in any research.

It cannot be denied, however, that living amongst the community was hard work, practically and in relation to the research. A major limitation, for example, was that with the lack of power only so much could be done by hand. Returning to the UK with 18 months worth of handwritten data to 'analyse' in the shiny chrome of the geography department, was a highly daunting task. A recommendation, therefore, is that if similar fieldwork is conducted in two parts, if possible, the researcher should live away from the actual fieldsite for the second part. Whilst acknowledging the colonial overtones of a slightly higher standard of living, as Fuller (1999: 221) put it, there is a necessity, at times, to 'go academic'. Living away from the fieldsite would provide a space in which to both find distance and start a more piecemeal analysis.

It has already been stressed that as a piece of post-structural research, this was not supposed to be a policy document. It suggested, however, that the healthscape concept can be used to read how place-based authoritative knowledges could be used in different places to both construct informal spaces of health and thus to challenge the traditional place-based assumptions of power. Understanding how these knowledges were used, however, i.e. the coping strategies that women adopted to access antenatal care, does highlight areas of the health-system that require attention. Improving these areas and, for example, understanding why women preferred not to deliver in the MW could be used in policy making that could ultimately alleviate inequality. A major limitation of this research, however, is that to gain, even the start of a nuanced understanding of the social system, requires sensitivity, dedication and above all else time. Time is a significant investment in any research that particularly does not lend itself well to policy.

8.5 Potential future contributions to the research and policy agenda

Towards the end of this research, the latest Ugandan healthcare strategic planning and policy document, the HSSP III (2010), was released. The HSSP III recognised the necessity to re-orientate healthcare delivery around a notion of human rights in effort to deliver effective, *appropriate* care that is accessible to all. The HSSP III explicitly recognises that every Ugandan citizen has the right to the highest attainable level of health as a fundamental human right (MoH, 2010: 38). The health plan highlights the necessity to show respect for cultures and traditions of the peoples of Uganda, but only if they are advantageous to health and all other practices must be discouraged. It also explicitly states that both public and private health providers should behave in a *professional* manner and ensure patients are fully informed and have provided consent before any treatment. It is also interesting that the policy recognises the necessity to address the resource crisis and to redefine the institutional framework for training health workers (2010: 43). The policy also suggests that prevailing cultural beliefs constitute one of the major determinants of health seeking behaviour in Uganda, with 60% of people seeking care from TCMPs, before, or as well as, presenting at 'modern' health facilities (HSSP III 2010: 50). The HSSP III also recognises that the current figure of 32% of women delivering with a skilled provider is far too low and that more social insight into MCH health-seeking is required.

Whilst not a policy document *per se*, it is suggested that this research can contribute to the broader academic agenda both conceptually and empirically. Notwithstanding the limitations outlined in Section 8.4, conceptually, the healthscape tool proved effective to generate a greater understanding of the health-system of Bugangaizi through analysing place-based authoritative knowledge. The concept highlighted, for example, how health-seeking behaviour is ultimately linked to local cultural understandings of health and thus, as childbirth was a natural part of a Bunyoro woman's role, there was no reason for her to deliver within a hospital, unless there were medical problems.

Empirically, this research suggests that, in line with the HSSP III's (2010) social approach to health, there are four key areas of future research and theoretical consideration that could benefit policy as follows:

Firstly, it is suggested that results-based policy, particularly within a decentralised system, focuses too much on practical constraints such as resources. Perhaps due to the legacy of Museveni's response to the HIV epidemic (see Chapter 3), Uganda has 'the Dutch Disease' and depends on international support to finance nearly half its total government expenditures (Antingi-Ego, 2005). The current financial climate, coupled with Uganda's controversial bill to make homosexuality punishable by death (see Mmali, 2009), has already resulted in a considerable decline in international donor aid to Uganda; Mugerwa (2009) suggests that the financial budget for 2010-2011 had been cut by 35% compared to the 2009-2010 figures. In the unlikelihood of an increased resource base, this research suggests there is a necessity to utilise current resources more efficiently, particularly human health resources. Agreeing with Hongoro and McPake (2004), whilst many countries have drawn up ambitious strategies to increase the human resource base, much less policy attention has focused on the retention and performance of *current* staff as they are embedded in the health-system. This research suggests that healthcare workers are undervalued and ill-considered and that their working lives could easily be improved by, for example, better management structures that ensure even workloads and opportunities through monitoring.

Secondly, and again in line with the HSSP III, the empirical data generated through this research highlights the necessity to know the local context in which the health-system is embedded. Chapter 7 gave the example of the nurses not knowing about the '*solongo*'

ceremony following the birth of twins. Healthcare practice that conflicts with local beliefs and customs is simply not going to be accessed. This knowledge could be easily accessed through the Village Health Teams (see Chapter 3). This research also suggests that the health dynamics of both polygamous marriages and re-structured families are currently under-theorised in the literature. Some theorists, such as Timæus and Reynar (1998) and Locoh (1988), have looked at how polygamous relationships shape family life. Less attention focuses on how sexual relationships or access to resources are negotiated within polygamous arrangements in a chronically poor setting. Analysis needs to move beyond the scope of HIV transmission and consider other STIs which impact reproduction such as Chlamydia and syphilis. Such considerations could be developed in line with Silberschmidt's (1991) suggestion that with new development initiatives, women's identities are changing as they have an increased disposable income through small-scale business. Furthermore, there are increasing numbers of re-structured families in Bunyoro and undoubtedly across Africa. The dynamics, and particularly health requirements of these families are, as of yet, under theorised in the literature particularly with a long term, i.e. life span, perspective.

Thirdly, both empirically and theoretically, this research highlights the necessity to understand healthcare transactions in their entirety. Certainly previous research tends to focus on either the healthcare provider *or* the healthcare receiver's perspective. This research recommends that a much more realistic picture is generated of the healthcare transaction, and thus the health-system, by contemplating both perspectives. Furthermore, it also suggested that the input of both informal carers and informal spaces of care must be considered as a vital part of the overall healthcare transaction. Even working at the MRI highlighted the necessity to care for the informal carers, even just to bring them, as well as the patient, a cup of tea. As far as possible, provision needs to be made to protect and appreciate the input of informal carers.

Fourthly, this research suggests that with the exception of Whyte (1997) and Green (2000), surprisingly little research contemplates healthcare delivery within a pluralistic system in which the traditional models of healing overlap with the biomedical model. Even in matters of MCH, it obvious that women were accessing both health models, sometimes simultaneously. The research also identified just how readily Melda's ward was used in conjunction with accessing biomedical antenatal care. This point has become particularly

poignant since the government of Uganda started to discuss whether or not to make TBAs illegal due to the suggestion - and emotive academic reports - that they are operating dangerous practices (see Mugiri and Ford, 2010; Kobusingye, 2008). This is a turnaround from the policy approach of the late 1990s in which TBAs were identified and trained in safer delivery practices, and generally brought under the mainstream health-system (see Nyanzi *et al.*, 2007; Sibley and Sipe, 2006; Amooti-Kaguna and Nuhawa, 2000). Certainly this research found that the services of TBAs were most definitely used and appreciated. Whilst it has to be considered that some of the TBA's popularity is in response to the prevailing negative perceptions of the biomedical health facility, not only will it take time for that model to improve but delivering with a responsible TBA is still preferable to mothers delivering in the villages unaided. It is suggested, therefore, that further research needs to be conducted to fully investigate the role that TBAs play in the provision of MCH, before a decision is made whether or not to make them illegal.

A full list of policy recommendations will be discussed with the District Director of Health Services of Kibaale.

Finally, in answer to the severe questioning I received at the Ethical Board of the Institute of Public Health, this research also suggests that human geographers in general, and post-structural feminist health geographers in particular, are in an ideal place to tease out the intersections between health, healthcare, gender, the body and place (Dorn and Laes, 1994; Gesler, 1992) perhaps much more so than healthcare workers themselves. This also highlights how human geographers can actively benefit 'human good'.

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Appendix 1: Copy of 'fieldnotes' showing data preparation

here, I reassure him— what does that suggest?? Is he already aware that there is a problem?? I did reassure him that I wouldn't and, after all, I was only there because there was a difference that needed addressing. – what sort of a researcher would I be otherwise??

Midwife arrives, young woman, perhaps mid 20s (Jen you know nothing!!!), pale skin because later learn she is actually a Muganda from Jinja. Looks wane and tired. She walks in without knocking and goes straight to the sink – with hindsight this is much more significant than it first appeared, she didn't knock for her in charge highlighting her level of authority and control over the situation, she has no respect for authority and neither did her question her at all or, in fact, react in any way at all. I try to engage her as much as I can.

Her name is ~~██████~~. She is trained in Kibaale ????. No she's not, unless she did her comprehensive training whilst working in Hoima but she graduated from Jinja. She says life in Kakindo is "somehow fair".

Later at her home she went on to say life here is hard. She commented on the lack of food stuffs. She has a daughter who is nearly two, father is in Kampala but no suggestion in all the time that I have known her (15 months on) that they are together. Always struck me as odd that as a single parent, Juliet didn't have more empathy with her patients, perhaps because she never identified with them as she saw them so different and below her. She did once relate to me how difficult the birth had been and, surprise surprise, she hadn't delivered in a government hospital but in a World Vision private clinic by a mzungu. She has, in her words 'almost died'. I asked her if that gave her more empathy towards her mothers, especially if they were young and alone – 'of course' was her response, but you could have totaled me. Juliet is a particularly hard done by individual; she always behaves as though the world is against her.

Juliet lives in a small rented accommodation which is not provided by the hospital. For a large majority of the time her sister is also resident there who acts as a house girl and attends her daughter, cooks food etc etc. That was often an issue when her sister was away, perhaps at school or before she

data response

Authority of female nurse over only male in charge

Rainy season from tank
Agency of the nurse one male present

FN 15

TO MA TRAMBO

life is hard - FN 16
difficult personal life

Construction of a portrait that doesn't really follow own behaviors

to pers. comm. - 17 June to Juliet

delivered privately

FN 19

empathy towards comm

FN 20

Issue of resident's unappreciated

not when she can she afford to pay? Role of women in the country.

FN 21

Appendix 2: Details of field notes directly referred to in the analysis

Code	Date	Place	Description
FN24	April 06	Kakindo HCIV	Young children bringing younger siblings
FN25	April 06	Kakindo HCIV	Banging through medical cases
FN31	April 06	Kakindo HCIV	No drugs at dispensary
FN32	April 06	Kakindo HCIV	Staff overview
FN34	April 06	Nalweyo	Poor homes have mossie nets
FN36	April 06	Kakindo HCIV	No staff
FN38	April 06	Kakindo HCIV	Routine care delivery, boring
FN39	April 06	Nalweyo	Everybody had radio
FN43	April 06	Kakindo HCIV	Couldn't open door to lab
FN60	April 06	Nalweyo TC	Local people picking herbs as well as buying medicine
FN61	April 06	Kirissa	Wives knew of each other
FN62	April 06	Kirissa	Competition for attention/resources from husband
FN68	May 06	Nalweyo TC	VW fear drug store drugs have expired
FN69	May 06	Kakindo HCIV	Client couldn't understand her own language
FN73	May 06	Kirissa	Pragmatic difficulties of village
FN75	May 06	Nalweyo	Decorated homes despite being desperately poor
FN87	June 06	Kakindo HCIV	Men only come to Kakindo with 'manly' ailments like snake bites
FN88	June 06	Kakindo	Woman asking for money from husbands
FN93	June 06	Katekara	Florence
FN96	July 06	Kakindo HCIV	Depo prova
FN98	August, 06	Kakindo HCIV	Mother 8cm dilated, walking back home to deliver
FN99	August 06	Kakindo	Woman aborted but nurse stressed
FN102	August 06	Kakindo HCIV	Too tired from night delivery, sent mothers home from ANC
FN105	August 06	Kakindo HCIV	Harsh communication to PG
FN106	September 06	Nalweyo	Women quarrelling with men
FN111	September 06	Kakindo HCIV	Bring fruits to appease nurses
FN113	September 06	Kirimasasa	Learning herbal knowledge from elders
FN117	September 06	Kakindo HCIV	Could not dress herself (underage mother)
FN119	September 06	Kakindo HCIV	Professional identity challenged by women refusing to reveal HIV status
FN120	September 06	Nalweyo	No. Of HIV education programmes on radio
FN123	September 06	Kakindo HCIV	Mature women giggling at condoms
FN147	November 06	Kakindo	Threatening to send to Hoima
FN149	December 06	Kakindo	God helping by taking the child
FN172	March 07	Kakindo HCIV	Difficulty drawing blood when clients kneeling
FN173	March 07	Kiryamassasa	Cursing younger wife
FN174	March 07	General	High rate of underage pregnancy
FN179	March 07	Nalweyo	Fausta
FN182	March 07	Kakindo HCIV	Woman pregnant 8 th time wanting migraine treatment
FN188	April 07	Kakindo HCIV-	Dirty/smelly/not conducive to healing

		General	
FN189	April 07	Nalweyo	Catherine's pregnancy being cursed
FN190	April 07	Kakindo HCIV	No mossie nets
FN193	April 07	Kakindo HCIV	Only one type of testing kit
FN194	April 07	Kakindo HCIV	Breech turning
FN195	May07	Kakindo	No power let alone ultrasound

Appendix 3: Details of the antenatal cases specifically referred to in the analysis

Identification	Date	Description
ANCCASE 1	March 06	Patient with kidney infection wrongly diagnosed as UTI 4 times
ANCCASE 2	June 06	Patient not disclosing she had taken quinine
ANCCASE 3	July 06	Nurse trying to force a woman to hold a blood sample that was not hers
ANCCASE 4	August 07	Two mothers sharing shoes
ANCCASE 5	March 07	Row re mother refusing to reveal her HIV status
ANCCASE 6	June 06	C section scar woman not telling nurses; delaying potential referral

Appendix 4: Details of medical cases specifically referred to in the analysis

No	Title	Code	Description
1	Cleft palette	MC1/CP	~1 week old baby, with cleft palette; mother also sick
2	Incomp. Abt.	MC2/IA	32 yr old woman, 8 th pregnancy, 8th (incomplete) abortion
3	Lady in purple	MC3/P	Woman with 1.5yr old baby, died of cerebral malaria
4	Local Healer	MC4/LH	Young female, infected cuts from herbal cure for pneumonia
5	STI	MC5/STI	Woman with 'loosened fallopian tubes'
6	Scalded baby	MC6/SB	Very badly scalded baby 25% thickness burns
7	Mzee lab	MC7/Lab	Mzee bouncing for forth time from TB check
8	Brewers	MC8/BB	Two boys badly burnt from brewing Wa. Later died;1 malaria
9	Malnutrition	MC9/Mal	Mzee with younger wife, dying baby
10	Sickle Cell	MC10/SC	17 year old with sickle cell, looked 7
11	Girl alone	MC11/GA	Young girl, 5/6 coming to clinic alone
12	VCT confusion	MC12/VCT	Woman presented for VCT but lost book; wanted results again
13	Rabies	MC12/Rab	17 year old man with rabies
14	Bar woman	MC14/BW	Woman beaten half to death by man in bar she works in
15	Dead baby	MC15/DB	Woman saw baby dying as 'blessing from God'
16	Migraine	MC16/M	Women seeking medical help for migraine in 8 th pregnancy
17	Microfinance	MC17/micro	Woman being beaten due to income from microfinance
18	Playing at sex	MC18/play	8 year old boy beaten for 'playing at sex'
19	'Bleeding'	MC19/ble	13 year old with bleeding (menstruation)

Appendix 5: Details of personal communication

Unique identification codes	Person	Date	Place	Description
Pers. comm. 40 April 06	Nurse	April 06	Kakindo	Attendants 'do the caring'
Pers. comm. 46 April 06	Nurse	April 06	Kakindo	Had it in her heart to care for patients
Pers. comm. 48, April 06	DDHS	April 06	Kibaale	Nurses' alternative incomes
Pers. comm. 49, April 06	Nurse	April 06	Kakindo	Not enough water to wash hands
Pers. comm. 52, April 06	Hospital In Charge	April 06	Kakindo	Hospital serves 15km radius
Pers. comm. 56, April 06	DDHS	April 06	Kibaale Admin	Stats re hospital, low morale etc
Pers. comm. 57, April 06	DDHs	April 06	Kibaale Admin	High maternal and child morbidity
Pers. comm. 60, April 06	Comprehensive midwife	April 06	Kakindo HCIV	Women aren't use to swallowing proper medicines
Pers. comm. 61, April 06	Kakindo HCIV I/C	April 06	Kakindo	Men feel 'cheated' by condoms
Pers. comm. 63, April 06	VW	April 06	Nalweyo	Role of woman to keep clean home and family
Pers. comm. 64 April 06	Nurse	April 06	Kakindo	Being 'burnt out'
Pers. comm. 74, April 06	Paul	April 06	Kakindo	'Lifeism'
Pers. comm. 75, April 06	Phina	May 06	Kakindo	'Lifeism'
Pers. comm. 76, June 06	VW	June 06	Kikwaya	Difficult to keep family healthy when no water
Pers. comm. 77, June 06	Headmaster of School	June 06	Igayaza	No water for the children to wash their hands after the toilet
Pers. comm. 79, June 06	World Vision worker	June 06	Kakindo TC	Despairing at development in Bunyoro
Pers. comm. 80 June 06	Local Lady	Sept 06	Nalweyo	Did not go to ANC as did not want to be tested
Pers. comm. 81, June 06	M. Joshua	June 06	Nalweyo	Jealous husbands aggressive
Pers. comm. 82, June 06	VW	June 06	Kirimassasa	Damaged borehole
Pers. comm. 83, June 06	Nurse	July 06	Kakindo	Struggling to make salary last
Pers. comm. 85, July 06	Nurse	July 06	Kakindo	Why should she struggle when not even recognised?
Pers. comm. 86, July 06	In Charge	July 06	Kakindo HCIV	Cultural role to reproduce
Pers. comm. 87, July 06	Teacher 1	July 06	Nalweyo	'how to handle' nurses;' difficult for villagers'.
Pers. comm. 88 July 06	Local Lady post client	July 06	Kakindo T/C	Hospital pit latrines too dangerous for her children to use
Pers. comm. 89, August 06	Comprehensive midwife	August 06	Kakindo HCIV	Never had paraffin for clients to take medicine
Pers. comm. 90 August 06	14 year old	October 06	Kiirissa	Trying to get HIV+

Pers. comm. 91, August 06	Comprehensive midwife	August 06	Kakindo HCIV	Feared for contamination of drugs by dispensing at ANC
Pers. comm. 92 August 06	Local woman	August 06	Nalweyo	Celebrating birth of baby
Pers. comm. 93 August 06	Local woman	August 06	Nalweyo	Mothers dying in hospital
Pers. comm. 94 August 06	Mother of raped girl	Sept 06	Nalweyo	If plays women's games, needs to follow rules
Pers. comm. 97 September 06	Nurse	Sept 06	Kakindo HCIV	Cultural clash re delivery
Pers. comm. 99 September 06	Nurse	Sept 06	Kakindo HCIV	Cultural clash re twins
Pers. comm. 98, September 06	Local Woman	Sept 06	Nalweyo	Sick because her crop had failed
Pers. comm. 101, September 06	Midwife	Sept 06	Kakindo	Not prepared to risk her life when so underappreciated
Pers. comm. 104 September	VW	Sept 06	Kakindo	Dodged clinic to not be tested
Pers. comm. 105, September 06	Nurse	June 06	Kakindo	HAD to send children to best schools
Pers. comm. 107, September 06	Headmaster of School	Sept 06	Igayaza	Cutlery to prevent teachers getting ill from dirty hands
Pers. comm. 122 September 06	Nurse	Sept 06	Kakindo	Nurses at risk from dirty patients
Pers. comm. 124 September 06	Healthcare worker	Sept 06	Kakindo HCIV	Lifestyle of TCW
Pers. comm. 128, September 06	Malaria Consortium	Sept 06	Kakindo HCIV	Problems of development in Bunyoro
Pers. comm. 132 September 06	Mamma Joshua	October 06	Nalweyo	A 'good woman' doesn't ride a bike. Pre clinic prep
Pers. comm. 133 September 06	Voluntary HIV counsellor	October 06	Kakindo HCIV	'no money, no enthusiasm'
Pers. comm. 134 October 06	Bagonza	October 06	Nalweyo	Having 'insurance' children against sickle cell
Pers. comm. 140, December 06	Teacher 1	December 06	Nalweyo	Could deal with nurses
Pers. comm. 142, December 06	Local woman	December 06	Kilimassasa	Condoms associated with promiscuity
Pers. comm. 144, December 06	Local woman	December 06	Kilimassasa	Condoms associated with being barren
Pers. comm. 145, December 06	Melda	December 06	Kikwaya	TCs are 'town'
Pers. comm. 147, December 06	Midwife	December 06	Kakindo	Culture makes their lives difficult
Pers. comm. 147, December 06	Nurse	December 06	Kakindo HCIV	Would never deny a mother without an ANC no.
Pers. comm. 148, January 07	Catherine	January 07	Nalweyo	Innocent reading materials at P7 he covered in P4
Pers. comm. 152, January 07	Melda	January 07	Kassambya	Melds had 'seen it all'
Pers. comm. 154, February 07	LCIV	February 07	Nalweyo	Would go to meeting 'if well enough'
Pers. comm. 160, March 07	Nurse	March 07	Kakindo HCIV	How can she treat patients without kit
Pers. comm. 162, March 07	Fausta	March 07	Nalweyo	Won't go to hospital due to treatment
Pers. comm. 163 March 07	M. Joshua	April 06	Nalweyo	Mothers die in village because everybody celebrating
Pers. comm.. 164, April 07	Local councillor for health	April 07	Nalweyo	If a mother had been cursed/seen witch doctor, then went

				to hospital, expected to die.
Pers. comm. 165, April 07	Nurse	April 07	Kakindo HCIV	Difficult mother
Pers. comm. 166, April 07	One of many wives	April 07	Kakindo HCIV mat	Wanting to be a good woman and have a baby but recover quickly
Pers. comm. 172, May 07	NASECO lady	May 07	Burruko	Never ask how a pregnant woman is.
Pers. comm. 174, May 07	Water Minister for Kibaale	May 07	Hoima	Low water table makes boreholes expensive
Pers. comm. 176, June 07	Nurse	June 07	Kakindo HCIV	Personal difficult labour made her view nursing differently
Pers. comm. 182, July 07	Lady in Mat	July 07	Kakindo HCIV mat	Needed to get back to work
Pers. comm. 183, July 07	Lady in Mat	July 07	Kakindo HCIV mat	Needed to 'prove' herself to husband, post baby
Pers. comm. 190, August 07	Midwife	August 07	Kakindo	'Short' conversation in emergency care
Pers. comm. 191, August 07	Midwife	August 07	Kakindo HCIV	Threatening to refer to Hoima
Pers. comm. 192 August 07	Midwife	August 07	Kakindo HCIV	PGs panic
Pers. comm. 193 August 07	Midwife	August 07	Kakindo HCIV	Unsupported at clinic
Pers. comm. 194, August 07	Mamma Joshua	August 07	Nalweyo	Doesn't like orphaned households