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COMMUNITY BASED DEVELOPMENT: POTENTIAL AND OBSTACLES
TO IMPLEMENTATION IN WESTERN KENYA

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ABSTRACT

Primary Health Care (PHC) programmes attempt to put the responsibility for the design and implementation of rural development projects in the hands of local people. PHC programmes have been developed in acknowledgement of the failure of past top-down programme design.

This paper describes two examples of PHC programmes intended for implementation in Mbita Division, South Nyanza; community based Health Care (CBHC), and income generating projects for women's groups. I argue that such programmes need to incorporate an understanding of the local sociological, ecological, and infrastructural constraints in the programme design.

Implementing Community Based Health Care (CBHC) will necessitate enlisting active community discussion and participation at the outset, and ideally the local communities should bear some of the financial responsibility as well. Incorporating the traditional medical practitioners whose services are still valued will increase the efficacy of the programme.

Attempts to support income generation projects for women's groups must acknowledge the lack of cooperation between women, which is fostered by changes in marriage patterns which break down kin ties between women. The absence of business management skills, low educational levels, and conflicting labour demands on women represent additional serious constraints to the success of income generating ventures. To address these local constraints programmes should allow for more individualized participation rather than requiring cooperative ventures, and financial support would be better spent for conducting management training and study tours for women rather than allotments for project seed money.

INTRODUCTION

Over the past decade, social scientists concerned with economic development in the Third World have stressed the importance of including the participation of local people in planning and implementing development programmes. A similar approach is now being advocated by many agricultural scientists and health professionals working on the problems of rural development. The recent focus on "farming systems" research design and the emphasis on establishing Primary Health Care systems are attempts to make development more responsive to the needs of local people and results in part from an acknowledgement that past "top-down" development programmes have had limited success.

The Primary Health Care (PHC) approach is seen as responding to the identified needs of the rural population and being sustainable by local efforts. PHC has become a major goal of health and nutrition programmes in the Third World since the Alma Ata Conference of 1978, where it was recognized that the existing approach to health care with its reliance on high technology and centralized medical facilities did not represent an appropriate model for many developing countries.

The majority of pernicious health problems in the developing world could be most effectively managed by enhanced preventive measures rather than sophisticated curative medicine. It was recognized that debilitating childhood illnesses such as malnutrition, diarrhoeal diseases, measles, polio, and other immunizable diseases result from numerous interrelated problems at the village level. These problems include poverty, lack of

awareness of proper nutrition, poor sanitation facilities, absence of immunization programmes, overpopulation, inadequate child care, and overburdened mothers. Building more hospitals and importing expensive medical equipment is not the solution to such problems, rather they must be dealt with in the villages where they originate.

For these reasons, the World Health Organization, UNICEF, and other national and international health care programmes have for the last decade focused on Primary Health Care as the means of improving health and living standards in developing countries. While the emphasis differs from one country to another, the basic components of most PHC programmes include:

- 1) Community participation in planning and implementing programmes through community based health care (CBHC) to train and equip local health workers,
- 2) Parental education to increase awareness of the role of nutrition and preventive health care in determining well-being,
- 3) Adequate and safe water supplies and sanitation,
- 4) Improved nutrition,
- 5) Immunization against preventable diseases,
- 6) Maternal and child health care including immunizations and family planning services, and
- 7) Referral to health centres/hospitals for more serious ailments (after Ebrahim, 1985).

In Kenya, there is great potential for community based PHC programmes to make significant improvements in the quality of life. Various elements of primary health care have been introduced throughout the country by the Ministry of Health and by private or mission based health centres, often with the

support and cooperation of international and national NGO's (such as UNICEF, Catholic Relief Services, Bread for the World, the Aga Khan Foundation, Amref, and many others.) This paper discusses the efforts to introduce PHC programmes in Mbita Division, South Nyanza District.

DESCRIPTION OF RESEARCH AREA

A 1983 report entitled "Third Rural Child Nutrition Survey" published by the Central Bureau of Statistics (CBS, 1983) examined conditions of health and mortality and standards of living in many parts of Kenya. The results of this study indicated that South Nyanza District has the highest rate of early childhood mortality in Kenya (216/1000 births), as well as very high rates of malnutrition and malaria. The standard of living is lower in South Nyanza than many other agricultural areas of Kenya as measured by such indicators as the access to piped water, sewage facilities, and the low rate of female literacy. For these reasons, South Nyanza was selected as one of three districts in Kenya for concentration of UNICEF's Child Survival and Development Programme. This programme aimed at reducing these high rates of mortality and morbidity and to generally improve the standard of living in the District.

As part of this programme, in September 1984 a socioeconomic and nutritional survey of Mbita Division in South Nyanza was initiated. The programme was sponsored by UNICEF in collaboration with the District Development Council and was intended to provide a baseline of data on the existing socioeconomic conditions which influence nutritional status and the welfare of children. The

objective was to learn more about the factors that affect health and child welfare in order to isolate entry points for intervention programmes, to determine which problems should have highest priority, and to identify target populations for intervention efforts.

In other work I have described the socioeconomic composition of the area (Chaiken, 1985) and the range of programmes which would be feasible and appropriate for PHC interventions in Mbita Division (Chaiken, 1985; 1986). The recommended interventions include both long-term and short-term programmes which address the following critical problems:

- 1) poor nutritional status of children - between 20% and 35% of children tested in each community showed evidence of malnutrition (stunting), which contributes to high childhood mortality, frequent illnesses, and impaired mental and physical development.
- 2) Poor immunization coverage - which results in many children dying or suffering permanent impairment from preventable diseases causing an additional strain on local health care facilities.
- 3) Poor sanitation and water resources - as the majority of homes have no latrine and draw water from unprotected sources, which contributes to frequent diarrhoeal diseases.
- 4) Community isolation - which impedes the effective dissemination of health care and educational services.
- 5) Low levels of women's incomes and education - which contributes to local women's difficulty in providing adequate food and appropriate care for their children.

This paper discusses two proposed areas of programme intervention in Mbita Division which are based on active community participation in planning and implementation. First, I consider the introduction of community based health care (CBHC), which is a comprehensive programme designed to reach people in

rural communities with educational and motivational campaigns, to increase public awareness of preventive health measures, and to provide basic front-line medical services. Second, I discuss programmes intended to provide opportunities for women to increase incomes through participation in women's groups. The objective of this paper is to increase the awareness of development planners of the sociological constraints facing such programmes, in order to illustrate means of avoiding likely obstacles to programme implementation.

COMMUNITY BASED HEALTH CARE (CBHC): IDEALS AND REALITIES

Community based health care has been implemented successfully in a number of countries, and is now being introduced in several areas of Kenya. The approach of CBHC is to train individuals who are selected by their communities to serve as volunteer community health workers (CHWs). The CHW is then responsible for educating and motivating his/her neighbours to adopt improved health practices. Emphasis is placed on improved sanitation, nutrition, and water supplies, and the importance of immunizations, breast feeding, simple treatment for common ailments (such as use of oral rehydration fluids in treatment of childhood diarrhoea), and family planning.

In South Nyanza District the training of CHW's is only in its infancy. The District health staff ¹ in collaboration with supporting NGOs (e.g. UNICEF) have begun to train a team from each Division on the role and potential of CBHC and ways of introducing a CBHC programme in their area. For the most part the team from each Division is composed of civil servants such as

local clinical officers, community nurses, Field Health Educators, nutrition workers, plus some personnel from the agriculture and educational sectors. A few representatives of NGO's have also been included in the divisional teams, such as women's group chairpersons and staff from mission health centres.

Each divisional training team is expected to call community barazas to introduce the notion of CBHC and to motivate the community to select CHWs for future training. Once the CHWs are selected, the divisional team is responsible for developing a training curriculum and agenda. This is generally not expected to be formal classroom type training, but rather to take the form of discussions and practicums, where the CHWs learn by doing or by working with trainers.

When the training is complete, the CHWs are hopefully motivated to begin educating their neighbours through home visits, demonstrations and role plays with organized groups such as women's groups, and through setting an example to their own communities. In theory and in design, CBHC is intended to bring information to people at the local level, on an individual and non-formal basis, and to provide opportunities for people to learn by observing and by doing, rather than relying on more orthodox teaching techniques which in the past have failed to make a demonstrable change.

The potential contributions of CBHC programmes to the quality of life in the area is great, but major obstacles to the introduction of CBHC exist. The factors that may impede the effectiveness of CBHC programmes need to be isolated and discussed, so that means of averting the problems can be

incorporated into the programme design. The initial work conducted in 1984-5 in Mbita Division has identified a number of potential problems with CBHC introduction, but also suggests possible solutions.

One constraint may be the availability and participation of the divisional CBHC team members who are intended to train the CHWs. Most of the team are civil servants working for the Ministries of Health, Agriculture, or Education. The remaining trainers are on the staff of mission health centre, or are women's group leaders. All of these people are already employed in full time jobs and their work as trainers must be added to their existing job responsibilities. This conflict of responsibilities may impinge upon the trainers freedom and willingness to allot time for training CHWs.

The second problem concerns the constraints placed on the community health worker. While either men or women may be selected as community health workers, in practice it is more often women who are chosen to serve as the CHW. Much has been written about the heavy labour demands placed on African women (Boserup, 1970; Hafkin and Bay, 1976; Fortmann, 1982; Bay 1982; Hay and Stichter, 1984), and the women of South Nyanza are no exception to this generalization. Mbita women are responsible for a large portion of the agricultural labour as well as providing labour for a variety of time consuming domestic tasks such as child care, fuelwood and water collection, grain processing, marketing, cleaning, and cooking. Despite their hard work, the productivity of the area is low (most women report that their

annual harvests of grain last for only 4-6 months of the year), and most families do not produce enough food for the entire year.

As a result, the majority of women engage in off-farm labour, such as making charcoal, selling vegetables or grain in the market, or processing and marketing fish, in order to earn needed cash for domestic expenses (for detailed discussion see Chaiken, 1985). Thus most women have little free time; to expect local women with so many other demands on their time and energy to volunteer to serve the community without pay as a CHW may be unrealistic.

Complicating this situation is the fact that the trainers of CHW's are by and large salaried workers, who are participating in CHW training exercises as part of their employment responsibilities. In contrast they are asking the local CHW to participate without any form of remuneration, either from the government or from the community itself. From the point of view of the CHW, it seems that everyone profits from CBHC except the CHW; the regular Ministry of Health and mission employees all receive salaries and their work loads may be reduced by the CHWs, and the community receives a valuable service, at no cost. In contrast the incentives for effective and enthusiastic participation of the CHW are low.

Finally there is the question of where the CBHC programme originates. Although the notion of community initiative and responsibility are the essence of the programme, it may not be perceived this way by the local people. CBHC, like many previous development programmes is introduced to the community through the district and divisional administration. To convince local people

that the CBHC programme is really initiated by their own efforts, rather than a government controlled programme may be difficult.

For the people of Mbita Division it seems to make little difference whether the new programme originates with the central government or at the district level. In either case, their perception remains the same, that this is a government programme for which the government should take management responsibility. The long history of a pronounced "dependency mentality" in the area will be difficult to overcome and the implementation of CBHC in Mbita Division will require intensive efforts to foster a true sense of community participation at the outset. A real danger exists that serious community discussion and involvement in planning will be minimized in order to expedite the implementation of the programme. This could well result in a community attitude that the programme is the work of District officials for which the community bears no responsibility.

CBHC RECOMMENDATIONS FOR PROGRAMME IMPLEMENTATION

Several solutions can be suggested for avoiding the potential problems facing the implementation of CBHC in South Nyanza. The first step concerns the initiation of the CBHC programme, when the community is introduced to the concept and when the CHWs are selected. It is essential that this step proceed slowly to allow local people to discuss the possible benefits they will receive from the hard work of their CHW, and determine a value for that service. If they are sincerely interested in having a trained CHW in their community and are willing to contribute to the support of her efforts, then this

bodes well for the chances of continued support for the CHW. It will also help reinforce the notion that the community is in fact responsible for the initiation and maintenance of the programme.

Community support need not come in the form of cash payments and should be left up to the individual communities to decide during informal discussions. Other types of compensation, such as paying for the training costs of the CHW, or volunteering a day of farm labour from each family to help the CHW will clearly demonstrate the community's respect for and support of the CHW. At the same time it will foster a sense that the community is making a real commitment to the implementation of the programme.

A second way to improve the effectiveness of CBHC programmes would be to select the traditional healers already working in the community as CHWs. Many people continue to consult the various traditional health practitioners and the value of their knowledge is already well established in the community. As illustrated in Table I., the percent of families who consult traditional healers is comparable with the percent who turn to western, allopathic practitioners at government or mission based health centres, indicating continued acceptance of traditional medicine.

Table I.

Utilization of Health Services in Mbita Division

Consultations for Medical Care
During Previous Six Months

	Have Visited		No Visits Made		Total	
	#	%	#	%	#	%
government health centres	16	29.1	39	70.9	55	100.0
mission health centres	23	40.4	34	59.6	57	100.0
traditional midwives/herbalists	20	35.1	37	64.9	57	100.0

By offering the traditional health workers an opportunity for additional training their own status in the community will be enhanced. At the same time the programme builds on strength by relying on a person who is already respected and trusted to disseminate information on preventive health care (see Ebrahim, 1985: 159ff; Pillsbury, 1979; Werner and Bower, 1983: 28ff). The traditional healers are likely to receive a better following than other community members. An additional advantage is that the traditional healers have already worked out their own "fee" structure and the community members recognize the need to compensate them for their services. Thus if the traditional healer and the CHW were one and the same, the problem of enlisting community support for the CHW might be reduced as the

precedent for supporting this person's services has already been well established.

PROGRAMMES FOR WOMENS' GROUP INCOME GENERATION

Poverty and poor food security are important problems in Mbita Division. Few people are able to produce enough food on their farms to meet their subsistence needs for the entire year. The standards of living are quite low, with only about 4% of sample households living in houses constructed of permanent materials and the large majority (over 60%) living in mud houses with thatch roofs. Women bear the primary responsibility for providing food for the family, and as their farms are not sufficiently productive they often spend a great deal of their time seeking income from alternative sources in order to feed their families. Many husbands are employed away from the farm (either in wage labour or in fishing) but only 30% of the women reported receiving remittances from the husband to help with routine household expenses. The majority of women are solely responsible for day-to-day acquisition of food for their families.³

The poor nutritional status of children is in part attributable to the low incomes and marginal farm productivity. In order to improve health and welfare, or at least have the potential for improvement, the economic conditions of women must be improved. One Primary Health Care package for Mbita Division includes programmes aimed at increasing the income generating capabilities of women. Specifically income generation projects for women's groups are being introduced and include projects such

as cooperative poultry raising, beekeeping, vegetable gardening, and running maize mill businesses.

The concern for strengthening cooperative efforts among women and for concentrating on groups in order to reach the greatest number of women is a valid one, but local factors may impair the efficacy of such well intended programmes. The interest in starting women's group projects is something which has filtered in from other regions of Kenya and is not necessarily the most appropriate approach for Mbita Division.

There are several factors that may hamper efforts to introduce cooperative projects in Mbita Division:

- 1) unlike other areas of Kenya, there is little precedent or experience with cooperative efforts involving large groups of women,
- 2) most women lack the management skills necessary for successfully conducting business activities,
- 3) considerable support and cooperation from the husbands of participating women is essential so as to avoid the problem of men taking over women's group activities, and
- 4) the women who are most in need of assistance in the form of new, viable economic enterprises are often the ones who have the least time to participate in such activities.

To elaborate the first point, most women's group projects require high levels of cooperation between the members. In cases of vegetable farming, poultry keeping, and other agricultural projects, the lack of participation of even a few members can threaten the entire project with collapse. In any type of project the group must agree how the funds generated are to be used (divided among members, used for social welfare projects, reinvested in the business, etc), and there must be similar accord in the everyday management of the project.

While I would not characterize relationships between women in Mbita as especially competitive, neither would I say that they exhibit strong cooperation. Part of the explanation for this comes from changing marriage patterns and kinship relationships. In Mbita Division, as in much of Kenya, a woman moves to the clan area of her husband upon marriage and takes up residence in his family's compound. Marriage is prohibited to anyone of your own clan or from a group of interrelated clans, generally resulting in people finding their marriage partners from a fairly distant location (Ayot, 1979).

Traditionally, a man would usually take his wife from among a few specific clans that had long been a source of wives for men of his clan, creating an alliance or a reciprocal relationship between clans. For example, the men of the clan residing in Salu, Mfangano Island very often married women from the Kaksingri clan on the mainland around Sindo town, and the men of Rusinga Island very often married women from Uyoma, Siaya District. As a result of this pattern, in traditional times when a woman arrived at her husband's home, she would find other women already living there to whom she was related, and with whom she might have worked in her natal home.

In recent decades, given the tendency for young men to migrate out of their home area for education and for work, it has become more common for them to marry women whom they have met while living away from home. The traditional patterns of marrying women from one chosen clan have broken down and wives can and do come from many different clans and locations (Ayot, 1979; Hay, 1976). The result is that when these women come to live in their

husbands' homes, they come as strangers with few prior acquaintances and kinship linkages between them.

This fact, I think, is central to the explanation of why it has been difficult to foster strong cooperative relationships between women. In traditional times, there would have been greater likelihood of achieving this end, as the ties between women were not only affinal ties of being married into the same clan, but were often reinforced by consanguineal relationships. Today these important kinship ties are usually absent, which results in less basis for cooperative relationships between women.

The second reason there may be difficulties in fostering successful women's group projects is the lack of managerial skills and experience among most group members. As illustrated in Table II., more than one third of Mbita women surveyed have never attended school, and less than ten percent have received any secondary schooling, which suggests that effective business management which necessitates some reading and record keeping may be difficult for many Mbita women.

Table II.

Educational Status of Adults in Sample Households

	No Schooling	At least Some Primary	At least some Secondary
Men	3 (5.2%)	37 (63.8%)	18 (31.0%)
Women	28 (34.6%)	45 (55.6%)	8 (9.9%)

Women do engage in very small scale business activities, such as processing and trading in smoked fish, but only seven percent of women surveyed reported that business provided their primary source of income, and 25% reported fish dealing as their main economic activity. This compares with 61% who indicated farming as their most important economic activity (Chaiken, 1985).

There is a history of women's groups in Mbita Division initiating income generating projects after receiving money or materiel from a sponsoring agency, yet there is little evidence that any of these projects have produced significant benefits for the group members (Chaiken, 1985). A typical example follows:

"a group received a large donation over two years ago to establish a poultry keeping project. The poultry shed has been completed, but there has yet to be a chicken placed in the coop. Problems which this group has encountered include concern about access to and funds for chicken feed, difficulty in accounting for the money to the sponsoring organization, internal conflicts between members, and interference from local administrators unhappy with the women's actions and decisions." (Chaiken, 1985: 29-30)

This group is generally representative of the problems encountered among women's groups in Mbita, the only difference is that their project was more ambitious, the amount of money involved greater, and so their failure was more visible.

Most of the women in the women's groups have little education, and even fewer have any experience as a successful entrepreneurs. The fundamental requirements of running any type of business, such as computing costs, ascertaining availability of necessary inputs or raw materials, determining a price and marketing structure, and keeping basic records are all foreign notions to these women. Even the better educated women may not

know how to accomplish these tasks, as they have no previous experience with such responsibilities.

Additionally, Mbita Division is quite isolated, and most women have had little opportunity to travel outside their area. As a result, they have little exposure to the work of other women's groups and other development projects. They may have heard that women in other areas are earning income from knitting sweaters, but their view of this activity is distorted and second hand. They are likely to attempt to follow such an example without considering whether it is appropriate for their situation.

The third problem which has commonly affected the chances for success of a women's group project is the lack of support from local men. Traditionally, the more valuable economic resources in most families were controlled by the husbands (Hakansson, 1985; 1986; Hay, 1976; Pala Okeyo, 1978; 1979) While economic patterns have changed somewhat in recent generations, the notion that women should not be responsible for any substantial wealth has persisted.

The notion of a group of women initiating a successful income generation project and controlling the money involved is viewed as a threat by some men, who become tempted to try to gain control over the women's wealth. Women, either singly or in groups, are vulnerable to outside interference if there does not appear to be a man behind them supporting their participation in economic ventures (Hakansson, 1985: 24; Muzaale and Leonard, 1982) In other cases, men have become involved in a women's group

projects, such as when a man is hired to tend the group's livestock or to work as a tailor using a machine owned by the group. The temptation to gain control over the group's resources is substantial, and if the women lack the managerial skills to prevent this from happening, they can lose control of their own project (Muzaale and Leonard, 1982; Wipper, 1984).

The final obstacle to the establishment of successful women's group projects is the availability of women's labour, especially among the younger and stronger women. As mentioned earlier, inconsistent participation by any given member can threaten the success of a cooperative based project. The participation of young women is especially important, as they tend to be stronger and better educated than the older women, and thus can contribute disproportionately to their numbers. These women also need the additional income that group projects can yield, as they often have small children at home, and little assistance with the household labour or with providing daily subsistence.

The problem is that all women, and especially the younger mothers, are already heavily burdened by the demands on their time. For income generating projects which are labour and time intensive, this may signal failure, as the needs of providing daily subsistence compete with the time needed to participate in group activities.

In summary, there are a number of factors that may inhibit the success of women's group enterprises. These include the socio-cultural basis for cooperation among women, the lack of educational and business experience among group members, and the

many, often conflicting demands on women's time. These factors must be taken into consideration when planning women's group activities, as failure to do so has resulted in the collapse of many well-intentioned projects.

FACILITATING SUCCESS IN WOMEN'S GROUP PROJECTS

Further failures of women's group enterprises will have serious consequences, beyond just the failure of an individual project. Unsuccessful women's group projects result in the members feeling incapable of helping themselves, it can foster feelings of dependency, it can provide sources of conflict between women making future cooperation impossible, it makes the members less likely to experiment in new economic avenues, and it reinforces the perception held by men that women are not competent.

Bearing in mind the constraints facing women's group projects, several steps can be taken to facilitate future programmes. First, instead of or at least prior to awarding small grants for initiating income generating projects, NGO's would be well advised to determine the levels of managerial and business expertise among group members, and to rectify any short comings. Aggressive programmes for training women and women's group leaders in the fundamentals of business, accounting, and planning may ultimately contribute more towards the future successes of the group than would outright cash grants to fund projects.⁴ Acquisition of the necessary managerial skills will give trained women insight into how to mobilize labour and capital necessary for running a competitive business, it will give the means to

find their own solutions to problems.

Second, projects should be designed to reward individual effort and require a minimum of group cooperation. The group can provide opportunity for each of its individual members, and still function as a group, without risking the entire enterprise collapsing from the lack of support of a few members. For example, in a vegetable growing project, the land could be divided into individual plots with resources such as watering cans, insecticides, and fertilizer purchased and managed by the group. Each individual member would be free to manage her plot as she saw fit and would have complete control over the vegetables produced on her plot (i.e. she could use them for home consumption, or market them). Group membership fees or implementation of a "tax" or "tithe" on amount produced would contribute towards the groups' expenses, but the income would accrue to the individuals. This eliminates the difficulties of enforcing cooperation between women who have little prior experience cooperating, and it also makes it less likely that outside interference or misappropriation of funds would occur, threatening collapse of the project.

If the women's groups are initially successful in implementing projects that rely primarily on individual efforts, then future projects that require more cooperation would be warranted. Achieving individual success and learning how to best manage one's own economic resources will provide each individual with experience which would be useful in the more complicated task of managing a cooperative venture of a group.

Third, useful support for women's groups could take the form of organizing and financing study tours for group members. Field trips where women see how other women's groups projects operate, give group members the opportunity for face to face discussions about the experiences and problems encountered by successful groups. This would help overcome the isolation and lack of outside experience that has hampered many Mbita women's groups. The opportunity to learn by doing is the most appropriate pedagogical device for women with little formal education or experience. If they have the opportunity to see another group's project, ask serious questions, and observe the advantages of a given project, then they are challenged to attempt the same for their own lives. They see that their aspirations can become a reality.

Finally, every effort should be made to support traditional women's groups, who generally have a longer history of success than recently established groups. In Mbita Division, as elsewhere, there are different types of women's groups. Some groups draw their membership from women who have all married into the same residential clan (affinally based), others are composed of women all originating from the same home area (consanguineally based), such as the Uyoma Girls group on Rusinga Island. In contrast, many groups are composed of women with no particular relationship between them, but which may be affiliated with a national or local level organizations such as Maendeleo ya Wanawake, KANU, or the Dorcus Society of the Seventh Day Adventist Church.

A few women belong to more than one group at the same time. Our interviews with women suggest that the clan based women's groups may have a higher potential for successful cooperation and project implementation. Although the sample is small (N=12), of women who belonged to more than one kind of group, when asked which group they thought would help them the most and which was working the most smoothly, all but one replied that they preferred the clan-based group (either post-marital or natal clan). The one dissenting voice said she preferred her church based women's group. Perhaps significantly, no women said they preferred the group of unrelated women, which suggests that the women themselves view the possibilities of working well together as greater in kinship based groups. Additionally, the kin-based groups generally have a longer history, as they were established earlier and have functioned longer than the other groups. This situation is similar to many other experiences found throughout the world in which cooperation was based on kinship relationships (Chaiken, 1983; Erasmus, 1977).

CONCLUSION

Primary Health Care programmes hope to improve the quality of life for rural people by putting the responsibility for development in local hands. PHC programmes seek to eliminate the causes of problems of underdevelopment rather than only attempting to ameliorate them--PHC is the equivalent of "preventive medicine" rather than the "curative" approach of many traditional development efforts. In the examples presented, CBHC attempts to facilitate public health education and modifications

in health seeking behaviour through the actions of community health workers. Programmes to promote income generating projects for women's groups address the identified problem of inadequate subsistence and poverty which contributes to malnutrition, low rates of education and literacy, and a host of other problems. The PHC approach is an attempt to address the past failures of development programmes.

Though the fundamental orientation of Primary Health Care programmes is more appropriate these programmes will also fail if local sociological, environmental, historical, and infrastructural constraints are not addressed in the programme design. Attempts to introduce generalized programmes (such as CBHC) intended for application anywhere in the Third World, are no more likely to succeed than the traditional "top-down" development programmes which were the standard in the past. Effective PHC programmes will need to be tailored to local conditions and will require substantial commitments of time and labour on the part of the implementing agencies to properly lay the groundwork and to ensure active local participation. Effective Third World development, like Third World agriculture, must be time and labour intensive, rather than relying on greater capital inputs.

NOTES

1

The district health staff are led by the Medical Officer of Health and include such personnel as the District Clinical Officer, District Public Health Nurse, District Public Health Education Officer. These people are responsible for coordinating and directing the staff placed in health centres and dispensaries at the Divisional level to carry out Primary Health Care programmes in the local communities.

2

The "fees" charged by traditional healers vary from gifts in kind (fresh fish, eggs, a chicken, a goat) to cash payments, generally of less than Shs. 50. One doctor working at a local mission health centre reported an incident when one of the traditional healers came to the clinic seeking medical treatment, leading a goat on a tether. He said, "when people come to see me for treatment, I charge them a goat, so I will give you a goat for my treatment."

3

For a more detailed discussion of household economies in Mbita, see Chaiken, 1985.

4

An example of the type of programme which might meet this need is the International Labour Organization's Project "Improve Your Business" (IYB). The IYB Project has designed a curriculum on basic business management principles intended for training entrepreneurs with limited formal education. The package includes an instruction course in bookkeeping, costing and pricing, marketing, and long term financial planning. After attending a course, each participant receives follow-up visits from business extension personnel to assist them in implementing the IYB approach. The IYB Project has recently targeted women's groups and women entrepreneurs for more intensive training efforts.

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