RURAL WOMEN'S SEXUALITY, REPRODUCTIVE HEALTH, AND ILLITERACY

A CRITICAL PERSPECTIVE ON DEVELOPMENT

Gisele Maynard-Tucker

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Preface

I started being interested in anthropology while I studied for my bachelor's degree at the University of California, Los Angeles (UCLA). I was an adult woman, married with a young son, when I decided to go back to school and earn an academic degree. After graduating with a Ph.D. in anthropology from UCLA, I worked for many years as a freelance international consultant in various developing countries, Africa, Latin America, the Caribbean, Asia, and India. My background in anthropology helped me understand the various cultures, and I was able to immerse myself in ethnic beliefs, customs, and practices. It also helped me to navigate between the policies of the ministries of health, the administrating agencies, and nongovernmental organizations (NGOs). I acquired expertise in my field evaluating various programs, among them family planning, reproductive health, maternal and child health, and HIV/AIDS prevention. The reason I decided to write this book is to illustrate the years spent in the field dealing with various health topics involving rural women.

I also want to share my experiences with students and those interested in development work. In order to do so, I describe the challenges of being an anthropologist living in foreign countries and dealing with ethnic customs, gender inequality, and the need for adaption to improbable situations. I illustrate the problems working for international and national organizations that were not always in harmony with their bureaucracy, policies, and sustainability procedures.

While evaluating the programs in the health facilities of the ministries of health in various countries, I always had to visit the rural communities that were the most challenging for the delivery of the programs. I became interested in rural communities, and my interest in rural women came from the time I spent living with the Quechua Indian women in Peru. I realized that

illiteracy was a major handicap for them, along with their lack of power to decide about their reproductive outcomes. In the book, I want to bring to light the numerous challenges rural women face when dealing with health, illiteracy, gender inequality, and cultural beliefs, and I describe their approach to modern medicine and their enduring use of traditional medicine and healers.

The book illustrates rural women living in different ethnic societies and provides insights into health-care delivery in rural parts of the world. It reveals the intimate life of the women who are subject to gender inequality, subservience to their partners, and their need to conform to cultural customs. In many cultures girls are not the valued gender and are dependent on their male partners or on their kin for economic survival unless they are educated or have mastered a skill. I write about their approaches to modern medicine and their pragmatic solutions to resolve their health problems based on their financial means and cultural beliefs. Traditional medicine is very much alive in rural communities because of traditional beliefs and the lack of health facilities, transportation, and cash. Healers and traditional midwives are the health-care alternatives to physicians and trained midwives. The high maternal mortality in most developing countries attests to this problem, which is known by international donors, ministries of health, and local NGOs but remains unsolved.

I also discuss my findings about women involved in sex work in Madagascar, Senegal, and India in order to show that women who are illiterate and have no skills have no alternative but to sell their bodies in order to survive. Clandestine sex work is a way for poor women to make fast money in order to take care of their children and to be independent from a partner. However, it is risky because of the HIV epidemic and also because of violence from clients.

Women's status and conditions are related to their education. In Morocco, there are educated modern women who are ministers in the government's offices, and there are women who live in the countryside and are veiled, wearing the burqa, and follow the cultural customs of subservience to their husbands. The latter are illiterate and have no skills. Women's status will remain unchanged until girls are educated and learn a professional skill, and until the mothers will change the girls' enculturation process; that is, raising girls not as their image but very much like they raise boys, independent and assured. Girls should be liberated from cultural oppression through the same enculturation as their male counterparts.

The book gives an inside look at the health systems in the rural areas of Peru, Africa, the Caribbean, and Asia. Everywhere, ministries of health depend on international funding to improve their national programs, but because of corruption and the constant migration of the trained medical staff, the outputs of the ministries are very limited. On the other hand, international

organizations do not supervise or monitor the improvement of their projects through surveys of beneficiaries' opinions of the quality of care of the services. There is a big gap between programmatic improvement that is the focus of the organizations and the satisfaction of the beneficiaries.

Finally, I hope that the book will enlighten the readers about the reach of globalization in traditional societies, and the ways of life of rural women in various cultures, their plight for survival, and their strategies when dealing with their sexuality and health problems. I try to show that illiteracy affects women's health behavior, and their comprehension of modern drugs and medical explanations. It is a barrier to modern medicine and health-care delivery in the context of international development.

For me, this work is a testimony of my involvement in years of research and evaluations. I wrote the book for students interested in anthropology and other humanity sciences, and I also hope to reach policy makers and the broader international community who are supporting women's progress in developing countries. The book suggests a change of perspective within the development community from a single focus on women's health to a broader perspective encompassing linkages to literacy, microcredit, and communication.

Acknowledgments

I want to first thank the men in my life, my late husband Edward Anthony Tucker, who supported my studies and my field trips and who took care of my son when I was in the field, my son Nicholas Tucker, who grew up learning about his mom's passion for anthropology, my brother Professor Roger Maynard, who thought that the writing of a book was a great achievement, and my dear friend Daniel Simmons, who supported me with clever advice and infinite love.

I am immensely grateful to Dr. Cyndi Frank for her help editing and commenting on the book. I have very many people to thank over the years for helping me with my career, such as my late friend and colleague Dr. Barbara Pillsbury and my great friend for many years and colleague Dr. John May. It has been a real pleasure to work and collaborate with each one.

Starting with my youngest years, I should thank my mother, who gave me a strong will and taught me to be disciplined and competitive for my piano exams. I am grateful to my professors at UCLA and at California State University Northridge (CSUN)—they believed in me and kept pushing me to the next academic degree. Thank you, Drs. Gregory Truex and David Hayano at CSUN and Drs. Jennie Jo, Carole Browner, Nicholas Blurton-Jones, George Sabah, and Susan Scrimshaw at UCLA—you shaped my background as an anthropologist.

I am infinitively grateful to be part of the Society for Applied Anthropology and to have had the opportunity to present my work every year at the Annual Meeting of the Society since I was a graduate student. I cherished those meetings with my colleagues and friends where we discussed our research and new ideas. In this very intimate group there are Drs. Pamela Erickson, Merrill Eisenberg, Kathryn Oths, Ruthbeth Finerman, and Suzanne Hanchett. I thank you for your support and interest in my work. I am also

thankful for Dr. Tom May's friendship over the years. Please forgive me if I did not mention all my colleagues and friends from the SFAA, because the list is exhausting.

I also want to thank the Center for the Study of Women at UCLA for my long affiliation with the Center, where I was able to meet wonderful colleagues involved in research on various women's topics. It has been a very beneficial and stimulating experience in my life. Thank you, Drs. Miriam Dexter, Rhonda Hammer, Denise Roman, Kathleen Sheldon, and Kathleen McHugh, our director from 2005 to 2014.

Finally, the book is dedicated to the women who opened their hearts to me and let me enter their lives; my comadres in Peru, Elena, Ingracia, Simiona, Paolina, and Maria; and the women who worked on the mysterious client in Haiti, Maria, Cathy, and Monique and all the women who were willing to be interviewed and trusted me in so many countries.

You are all in my heart forever.

List of Abbreviations

AIDS	acquired immune deficiency syndrome
ARI	acute respiratory infection
ART	antiretroviral therapy
CARE	Cooperative for Assistance and Relief Everywhere
CBS	community-based services
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CIA	Central Intelligence Agency
CNLS	Conseil National de la Lutte Contre le Sida
DHS	demographic health survey
DRC	Democratic Republic of the Congo
EHAP-IFH	Enhanced HIV/AIDS Prevention and Improved Family Health
EMONC	emergency obstetric neonatal care
FESP	Female Education Scholarship Program
FGM	female genital mutilation
GDP	gross domestic product

HIV	human immunodeficiency virus
ICPD	International Conference on Population and Development
ICT	information communication technologies
JSI	John Snow Research and Training Institute Inc.
KHPT	Karnataka Health Promotion Trust
MDG	Millennium Development Goal
MHTF	Maternal Health Thematic Fund
MOH	ministry of health
NGO	nongovernmental organization
ORT	oral rehydration therapy
OXFAM	Oxford Committee for Famine Relief
PRIM	Pour Renforcer les interventions en Sante Reproductrice
PVO	private voluntary organizations
STI	sexually transmitted infections
TBA	traditional birth attendant
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDF	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WRH	world rural health

Introduction

My Journey across Countries

The book illustrates my experiences as an anthropologist, both as an observer and a participant passionate for the fieldwork and the lessons learned from the various cultures and people I encountered during my years in the field. I invite the reader to join me in my journey across many regions of the world to observe rural women's health behavior as they struggle against illiteracy, gender inequalities, poverty, patriarchy, and repressive cultural norms.

I came to the United States from Nice, France, from a middle-class family with a background as a classical pianist. The journey to becoming an anthropologist took several years and two universities. I was an adult, married with one son, when I finished my studies. School and fieldwork were a bit problematic for my husband, but with his moral and financial support I was able to keep up with my grades and to go to Peru for fieldwork for several consecutive summers in order to collect data for my Ph.D. thesis. The obstacles that I encountered working with the Quechua Indians living in an Andean village near Cusco illustrated my lack of experience and the difficulties in studying this ethnic group because of their marginality. But the summers spent living with the Quechua Indians (1982–1986) in the village were rewarding because I acquired experience as an anthropologist, made many friends, and was enthusiastic about my work. In order to facilitate my contact with the women, I started learning their language. Quechua women carried on their traditions and would cling to their native language with only a basic command of Spanish. I knew that I had to learn their language in order to enter their world. At that time, UCLA was offering exotic language classes, and Quechua was one of them, headed by Professor Jaime Daza, a native of Bolivia. In addition, learning the Quechua language facilitated my understanding of

their culture, promoted communication with my informants, and helped me with the composition of questionnaires.

Living in the village was nothing like living in France or the United States; I discovered that I was quite flexible and adaptable! The village had no electricity or running water or bathrooms, and the climate was hard to endure because of the high altitudes and the frequent changes in temperatures. During the day it was quite warm, eighty-five degrees Fahrenheit, and at night it was freezing. But the sky was so blue and pure, and at night the stars seemed so close. However, the wind was my enemy, lifting clouds of dirt from the road and the mountains and bringing cold temperatures. I always wondered how I adapted to the climate, the high altitudes (10,500 feet), and the lack of commodities. I think that I was pushed by my curiosity and my great avidity for new adventures. After repeated stays in the village of Markita (a pseudonym) I was well known by everyone and became the comadre (fictive kinship, the godmother of several children). This role permitted me to enter their intimate life and to ask questions about it. My comadres appreciated the fact that I would try to speak their language, and I would listen to their daily stories, which usually involved complaints about their drunken husbands, their hard life, and having too many children. My Ph.D. thesis, "Reproductive Decision-Making and the Use of Modern Contraception in Rural Peru," was based on this fieldwork and was the culmination of several years working with the Quechua Indians, learning their culture, customs, and inquiring about their use and knowledge of family planning.

A year later, I answered an ad looking for a research and evaluation advisor from an international NGO (nongovernmental organization) working in Haiti on a family planning project in the private sector. I got the position having no idea about the state of the country and the political situation at that time, such as the turbulent election of Aristide. The time spent in Haiti taught me about development and its intricacies and gave me a taste of corruption, poverty, oppression, political lies, and violence. The time was difficult because of the loneliness. It was hard being away from my husband and my son and to make friends, because everyone was involved with family, friends, and fearing the political situation. I had to get used to the unbelievable level of poverty of the population and the constant begging for food and money.

In Peru I visited the barriadas (the slums) of Lima where migrants live in makeshift cardboard box dwellings, but the slums of La Cite Soleil in Port-au-Prince were worst (Maternowska 2006). The hopelessness of the people was exposed everywhere. Due to lack of employment, there were numerous men just hanging around doing nothing and looking so sad and hopeless. My position led me to evaluate the health facilities of the private sector, where corruption was always on the edge. But during my stay in Haiti I met some remarkable human beings who spent time devoting their lives to improving

Haitians' living conditions, such as Paul Farmer, Catherine Maternowska, John May, Jean Pierre Guengant, Michel Cayemites, Dr. Guy Theodore in Pignon, and Raoul Denis and his wife, the great pianist Micheline Laudun Denis.

When I came back to the United States, I began a career as an international consultant, and because of my experience in Haiti and Peru, the presentation of my work at conferences, and some publications, I was reaching the interest of development agencies. Since then, I have worked for the last twenty-five years as an international consultant in various parts of the world, including India, Indonesia, Africa, Latin America, and Asia. The projects and programs I evaluated were diversified. In Indonesia I examined the training of traditional midwives; in Nepal I evaluated a project about girls' education; in Guatemala I inquired about the reproductive behavior of homeless teenagers and the services of the health facilities in Bolivia. I explored the use of family planning and the prevention of HIV/AIDS in many countries of Africa, and the impact of sex work in Madagascar, Senegal, and India as it related to HIV prevention. This wide variety of projects gave me a larger perspective of the problems people and countries were facing about the concept of health and governments' responses through their national health systems. Those years working in development resulted in formidable lessons learned.

As an international consultant, I visited many countries, and some more than once over the twenty-five years. It has been always exciting to enter a new world and learn about a new culture and new customs and bring some improvements into people's lives. In each country while evaluating the services of the medical facilities, I found individuals who were very responsible and wanted to improve the life of the populations, while others did not care. They felt that they were not paid enough and worked too much or were depressed by the slow progress of the programs in the public health sector. These people were at the core of the problem of the weak health infrastructure and often could not be blamed for their attitude in view of the environment in which they had to work: lack of material, lack of transportation and up-to-date training, in addition to a low salary. In contrast, the private sector and NGOs were somewhat better organized. The personnel were better paid and trained, their reach was adequate for the communities, and they usually supervised their projects.

In most countries I worked with rural populations who lived far away from hospitals or clinics. Depending on the size of the populations, some communities had a health post with an assigned doctor and health workers and sometimes a trained midwife. The medical personnel usually commuted to their assigned post and because of lack of supervision, they were often absent. This reinforced the practice of traditional medicine, because the traditional healer was always there—ready to cure them of their illnesses. In various countries, I was asked during debriefing by the personnel working at

the ministry of health about the conditions of the communities I had visited. Often, the ministry of health of the country did not support frequent regional supervision and was ignorant of the need of the communities. They were also ignorant of the economic conditions of the populations because primary care and birth delivery services were always too expensive for the patients. Additionally, some health facilities were lacking basic commodities: running water, beds, and sanitation. Doctors and nurses would work without instruments and medical material. When I was reporting what I saw in the countryside to the ministry of health, they were surprised, because educated, urban doctors working in the offices of the ministry of health usually do not travel to the countryside.

During my work in the countryside I found that in most countries there was a clear division between the head office of the ministry of health and the regional country offices. However, loads of papers were exchanged between the two entities like a bureaucratic tug-of-war. The lack of communication and supervision along with the minimal funds invested in health services and facilities outside urban towns and cities were major constraints for the medical staff and patients. The poor communication between the ministry of health and the communities was illustrated by the weak infrastructure of the health services and affected the success of the programs and the health of the populations.

I particularly focused my interest on rural women, because they were most in need of help—they had no schooling for the majority and were subjected to partners' authority and to the customs of the various cultures. They were sedentary (compared to their partners, who were migrating for wage labor), and their role was to reproduce, raise children, and work the fields or resell produce at markets. Rural women's sexuality has been hidden, tabooed, and subjected to cultural and religious norms. However, since the promotion of modern contraception and the prevention of HIV, women's sexuality has become more public and an inevitable topic.

It was difficult for women who were nonliterate to understand the implications of modern contraception and modern medicine (for HIV treatment) with its discipline, treatment, and timing. When they failed the treatment, they went back to the traditional healer. However, if the healer could not cure them after many months, they would try again to see a physician. For most, they use both medical systems, depending on the results and their financial means. Poverty has a female face (World Bank 2009); women who were very poor and had no skills and no education often used their bodies to generate cash.

Everywhere, I found some women involved in formal and informal prostitution because they needed to feed their children or their partners were unemployed or they were single mothers. Clandestine sex (informal/clandestine/survival sex) is practiced when women are desperate and in need of cash.

It is a survival behavior in poor countries because the majority of women have no opportunities to find jobs or cannot access formal credit. Women usually resell produce at markets or in the streets, but those fragile entrepreneurial ventures are not enough to feed a family, especially if they are widows or single mothers or have been abandoned by partners. For the many who practice "survival sex," they have had to refute their cultural values about sexuality and face avoidance by their family, discrimination by society, and violence from partners and clients.

These women are caught between traditions and modernity, but most have no basic tools (education and or skills) to help them decide their future. Along with a loss of self-esteem, sex work provides some economic independence and a break with family ties. Sex work is usually fast and relatively well paid compared to other menial jobs, but it is often associated with violence from clients and partners and is difficult to abandon. It is also stigmatized everywhere by societies and religions and is usually performed secretly or in special quarters and brothels. Due to a stressful global economy, clandestine sex is practiced everywhere that governments do not give any opportunities for women to better themselves through girls' mandatory education and the learning of skills.

Since 1979 the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) was adopted by the United Nations General Assembly and became a bill of rights for women. At the Beijing conference in 1995, the Platform for Action emphasized women's empowerment, health, men and women with equal power in decision making, legal rights, and education—since then, progress has been uneven, and there has been a lack of development in rural regions (United Nations 2010). The Millennium Development Goals (MDGs)[1] were established following the Millennium Summit of the United Nations in 2000, during which world leaders agreed to eight specific and measurable development goals to be achieved by 2015.[2] Recent statistics show that progress is lagging. Maternal mortality is still very high in South Africa at 510 per 100,000 live births, and women's fertility is also high with an average of 6.89 children per woman (WHO 2012; World Factbook 2014). The literature has reported an unmet need for family planning (20 percent to 30 percent) (Guengant and May 2011: 316). Furthermore, children's mortality in developing countries is still high (79 for 1,000 live births) related to acute respiratory infections (ARIs), diarrhea, malaria, measles, HIV, and malnutrition (WHO 2012). In sub-Saharan Africa only 10 percent to 30 percent of school-aged children reach the secondary level (Guengant and May 2011: 314). In addition, more women (60 percent) than men are infected with HIV in sub-Saharan countries (UNAIDS 2009).

Many international development agencies have emphasized women's empowerment through education, because even a few years of schooling make a difference in a woman's understanding of illnesses and seeking treatment for

herself and her family (UNAIDS 2010; UNESCO 2010; USAID 2002; World Bank 1998).

As new goals are elaborated every decade, the goals developed thirty-two years ago by CEDAW in 1979 have not been reached. Governments have not eliminated all forms of discrimination against women (i.e., male land inheritance, violence against women, gender inequalities globally, and many countries adhere to customary law).[3] In addition poverty is found wherever governments offer no job opportunities for their citizens. Somalia, Ethiopia, and Sudan have frequent famine periods, and children and maternal mortality rates are high in sub-Saharan countries.

This book discusses women's health in relation to sexuality, gender inequities, the commonalities found in behavior, and challenges imposed by poverty, illiteracy, lack of skills, and unemployment in many cultures. At the level of the governance, for most developing countries, there is corruption and a lack of civic and social services for women along with a lack of legal protection against violence. Women's role and status are subject to cultural traditions, religious tenets, and males' authority. Although modernity is encroaching everywhere, in various rural regions of the world, illiteracy rates for women are higher than for men. Statistics show that there are a total of 20.8 percent illiterate women for 11.7 percent illiterate men (CIA 2011). In rural areas, girls are assumed to continue the traditions and embrace their mothers' role, while boys are educated, more free of customs, and are raised for an authoritative role within the family and the society.

"Health literacy has been defined as the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health" (WHO 2012: Track 2). Therefore, health literacy is related to the individual's years of schooling in order to understand and use information.

The ICPD 1994 (International Conference on Population and Development) Program of Action stated, "Everyone has the right to education, which shall be directed to the full development of human resources and human dignity and potential, with particular attention to women and the girl child" (Principle 10). In addition, international development organizations are increasingly aware of the relationship between illiteracy and women's reproductive health. For that reason the MDG5 target has set a goal to "achieve universal access to reproductive health" because the use of contraception is lowest among the poorest women and those with no education.

The goal of this book is to illustrate the life and behavior of rural women, their hidden sexuality, and the impact of illiteracy when they are asked to understand medical personnel's jargon and medication information, which can be difficult to comprehend and operationalize in their daily routine. The lack of literacy skills impacts the ability to make effective decisions about

prescribed medication and treatment and often results in a preference for traditional medicine and healers, which are known and trusted entities.

This book will give a new perspective on women's reproductive health and the struggle for survival while using their fertility and sexuality in order to feed and care for their children. The goals of the book are to reach the general public and the international and civil societies with information that can be used for improving the delivery of health programs. Globalization places an enormous stress on women, especially if they are not equipped for the modern world and cannot read or write. By relating my experiences, I hope to interest the readers about the women living in developing countries, their beliefs, customs, and the way they deal with health as they are using both traditional and modern health systems depending on their financial means and their cultural beliefs. The following pages give an overview of each chapter that composes this book.

CHAPTER 1: INTERNATIONAL DEVELOPMENT AND RURAL HEALTH

The chapter describes the roles of donors, consulting agencies, and NGOS as well as the consultant who acts as a mediator between donors, local governance, and consulting agencies (Justice 1987; Maynard-Tucker 2008; Sridhar 2012). Given that the maternal mortality statistics are highest in rural regions of the world, the author assesses the progress made regarding health delivery in rural communities as it relates to the Durban Declaration of 1997. Adopted by the Second World Rural Health Congress, the declaration stated, "Since the great majority of poor people of the world live in rural areas, we pledge ourselves to this global initiation to achieve health for all rural people by the year 2020." Harmonious collaboration between donors, consulting agencies, and governance are primary elements for a successful program delivery. This does not always happen because of the complexities of the bureaucracies involved. Easterly has written about the lack of accountability of agencies and their grandiose projects poorly designed and "unworkable goals of sustainable projects" (Easterly 2006, 190; Calderisi 2006; Ditcher 2005).

The health infrastructure in rural areas is weak and lacks quality of care. The medical personnel are poorly paid, and the living conditions are difficult. Decentralization of the health services has been challenging for many countries, especially among sub-Saharan countries. At the level of the governance, the rural areas are forgotten because they are isolated and do not create economic inputs. For the major part rural communities lack strategies and development for agriculture production because men migrate for wage labor and women work the fields.

CHAPTER 2: PERU: FIRST EXPERIENCE IN THE FIELD

This chapter describes my experiences as a graduate student doing fieldwork for the first time in a foreign country, including my first contact with the Quechua Indians[4] and the difficulties in choosing the fieldwork location and developing trust with the women. The period of adaptation was difficult because of lack of comfort, sanitation, and privacy that characterized the life among the Quechuas. Over the many summers spent with the Quechuas a deep friendship flourished and evolved into a fictive kinship. I became the godmother (*comadre*) to some of their children. I describe a period of slow adaptation to the rhythm of their lives, their culture, and beliefs. I examine women's responsibility and intimacy along with the role of interpersonal violence that was commonplace in relationships. The impact of males' labor migration on women's routine life gives an insight on their personal thoughts. This chapter also illustrates women's view and innate perspective on gender, reproduction, and raising children. In addition, women expressed their thoughts about sexual relations and their concept of maleness.

Finally, I discuss women's concept of fertility and their use of contraception with its failure. Quechua women's struggle between traditional and modern medicine and the anecdotes reported illustrate their conflict and their way of adapting to new behaviors (Oths 1994; Finerman 1989).

CHAPTER 3: HAITI: THE CHALLENGE

This chapter focuses on the difficulties that one can encounter working in development. In Haiti I lived through Aristide's election campaigns (1990s) that were based on a promise for a better life for Haitians with dynamic speeches on the local television. Everyone hoped that it would happen! It was a country in turmoil, and there were safety issues in doing fieldwork or walking the streets. During Aristide's election it was dangerous walking the streets because of gunfights from the political opposition and several *dechoukaj*[5] against the houses of the elite.

Haiti's political instability, the resulting corruption, and challenges of conducting research and evaluation of family planning services in the private sector will be discussed along with the delivery of family planning services. Gender inequities and the medical personnel's attitudes and behaviors toward patients in health facilities were also reported (Maternowska 2006).

Women wanted to control their fertility but were afraid of side effects of the methods, did not understand the information given by the medical staff, and could not establish any friendly ties with the personnel. Although Haitian women were more sexual than the Quechua Indian women, they also wanted to keep their partners monogamous, but this was difficult to achieve because

many men were involved in multiple unions and also visiting prostitutes. Finally, I describe the impact of the U.S. embargo in a rural community where the population was starving at the time of the research.

The next chapter reports on women's conditions when confronted by cultural customs, beliefs, and HIV discrimination in some selected countries of Africa.

CHAPTER 4: AFRICA: WOMEN'S CONDITIONS

This chapter uses vignettes to illustrate women's conditions in various countries of Africa. The situations described happened during the evaluation process of various development projects that involved women participants. The chapter reports on cultural customs, beliefs, religion, laws, and work in which women are ill-treated compared to men. Women are subject to the authority of their husbands/partners, and they are confronted with violence and discrimination in case of HIV. It also shows how the need for cash impacted women and how little resources they had to survive economically independent from their partners, sometimes being obliged to choose sex work as an option. Although the UNAIDS is aware of the women's situation, they have not yet produced any efforts to empower rural women and improve the health delivery.

The next chapter discusses the problem of introducing change in a traditional society and how mothers' lack of economic means and literacy affect the treatment of children's sicknesses.

CHAPTER 5: INDONESIA AND MOROCCO: BIRTHING HUTS AND SELF-MEDICATION

Chapter 5 reports on consultations conducted in Indonesia and Morocco. In Indonesia women refused to change their cultural customs because they did not get any benefit from the newly implemented birthing huts. The project was not well designed and did not improve the life of the women at the time of the evaluation. In Morocco mothers used self-medication and visited traditional healers in order to cure their infants' and children's illnesses because they could not afford to visit doctors (Oshikoya et al. 2009). The purpose is to show that "change" was not introduced within the context of the culture and that mothers' illiteracy also impeded decision making in seeking care, and ultimately their children's health. In rural communities women were constrained by cultural norms and beliefs and relied on healers and midwives to keep the family healthy. However, modern medicine was available in pharmacies, markets, fairs, and through street vendors. Some mothers during the phase of illnesses also experimented with modern drugs because the cure

was more rapid than with traditional medicine. Some traditional healers and midwives used a combination of modern drugs, potions, and rituals to cure children's illnesses. Mothers who were living in rural communities where there was no transportation to health posts self-medicated infants and children with teas and a haphazard use of modern medicine. Over the years, studies (Levine 2012; Hough 2012) have shown that the health of the family rests upon the women's shoulders and that there is a strong correlation between the women's literacy level and the decisions taken in self-medicating and seeking care.

The global economic stress in developing countries has affected women more than men, and the following section reports on women's sex work in Senegal, Madagascar, and India.

CHAPTER 6: MADAGASCAR, SENEGAL, AND INDIA: SEX WORK

This chapter examines issues related to sex work and HIV prevention in Madagascar, Senegal, and India and is based on field visits and research. The discussion includes behavioral commonalities, gender inequalities, violence, men's behavior, and NGOs' strategies for empowering sex workers by using as a model Sonagachi's and Ashodaya's interventions in India (Dowla and Barua 2006; O'Brien 2009). There are behavioral commonalities between the three countries with some cultural differences. In Madagascar and Senegal women practiced clandestine sex work, covertly from their partners, their relatives, or friends. Most of the women were in a relationship, a few had partners who knew about their extra activities, but the majority did not know. In the time of HIV, clandestine prostitution is an invisible challenge to HIV/AIDS prevention because these women did not use medical facilities for medical checkups and testing due to stigmatization.

In India, the Devadasis interviewed in the state of Karnataka were the sex slaves of the Goddess Yellamma. Dedicated by their parents to the temple, young girls entered the world of prostitution at the age of menarche. Parents hoped for good fortune from the Goddess and financial support from the girls. The money that the girls made from sex work was divided between the temple and the support of their parents. Sex work was institutionalized, accepted by most, and linked to the economic stress, superstition, and religion that characterized the rural communities of Karnataka. In India the women interviewed were nonliterate and had no skills to access jobs, and in Madagascar a third of the women were literate but could not find jobs. In Senegal less than a third of the women were literate and most were single women with children who had been abandoned by partners and were without a source of income.

Sex work is a survival behavior found everywhere when women do not have skills or schooling. Governments are aware of the huge influx of prostitution because of the high rates of unemployment, but they have not taken any steps to develop social programs for women or mandate education for girls.

The next chapter gives a microview of donors' impact and in doing so will debate the role of donors and some very important issues related to the structure of international health programs and projects.

CHAPTER 7: NEPAL AND MADAGASCAR: BROADENING THE REACH OF HEALTH

Can donors broaden their perspective about health? This chapter presents two examples based on the author's fieldwork in Nepal 1994 and in Madagascar in 2011. Data showed that donors could make some positive changes if the research was well designed and not too ambitious. The first example presented is the Female Education Scholarship Program FESP (USAID/Asia Foundation), which was implemented in the district of Banke (Nepal) in 1991, and attempted to show that change could be integrated into the rural communities. The program emphasized girls' education and promoted late marriage through a mentoring process by educated Nepalese women and money incentives given to parents.

Conversely, the project Maternal Health Thematic Fund (MHTF) sponsored by the United Nations Populations Fund (UNFPA) in several countries in order to decrease maternal mortality revealed weaknesses and a lack of in-depth research. The author participated in the evaluation of the UNFPA MHTF in 2011 in Madagascar, where the maternal mortality is high due to home delivery (440/100,000 live births), which is consistent with many rural areas globally. This chapter argues that donors can make an impact if the project or program is well designed and well structured with the beneficiaries in mind and within a selected geographical area. In Nepal, the girls changed their behavior and benefited from the project, but in Madagascar women's mortality due to home delivery was not reduced.

The chapter also reports on several issues that affected the lives of the beneficiaries, such as cancellation of programs/projects, the local governance's dependence on international aid, and the lack of program sustainability by the ministry of health or local organizations once international aid is terminated (Easterly 2006; Kimaro and Nhampossa 2007).

CONCLUSION: LESSONS LEARNED?

Are lessons learned? In this section I recapitulated the lessons learned about myself and about being an anthropologist working in development. I talked about my passion for fieldwork and its challenges and discipline. I also make suggestions for improving the delivery and the quality of care of the health systems. The gap between urban and rural health delivery still exists, and illiteracy promotes a strong barrier to understanding the context of health, prevention, and the application of treatment in rural communities. Because of the global reach of modernity in every region of the world, girls and women who are nonliterate suffer from marginality and lack of job opportunities. Gender inequality persists, and men are in control of women's sexuality and fertility. Women raise the children, and in doing so transmit their submissive role to their daughters and shape the boys' character in paternalistic societies.

Poor women are using their fertility and sexuality to keep a man close and hope to be compensated with economic security. However, because of the search for cash, men migrate and often abandon women and children. This sexual conundrum is the result of a rapid modernization process in which unschooled women are trying to adapt and survive and are caught between traditions and modernization.

Health alone cannot be improved if the patient's environment lacks the basic elements for survival, such as access to clean water, sanitation, and hygiene. Women's empowerment has to be accompanied by educational, economic, social, and political changes—as such, this is a complex problem that governments and donors have not shown the aptitude or capacity to address. Until we develop a multilateral response to this issue, we will not be able to remedy the problems.

The next chapter gives a glance at the complexities of "working in development" and comments on the lagging decentralization process of the health systems and the long-lasting dependence of the governances for international aid.

NOTES

1. MDGs were established following the Millennium Summit of the United Nations in 2000. Following the adoption of the United Nations Millennium Declaration, 193 United Nations and 23 international organizations are committed to the MDGs by 2015.

2. The eight specific and measurable goals are: eradicate extreme hunger and poverty; achieve universal primary education; promote gender equality and empower women; reduce child mortality; improve maternal health; combat HIV/AIDS, malaria, and other diseases; ensure environmental sustainability; and develop global partnership for development.

3. Customary laws are indigenous laws; they are discriminatory toward women and often are in violation of women's rights (Muna 2011).

4. Quechua Indians in this study lived in a village thirty kilometers from Cuzco in the Andes at 10,500 feet of altitude.

5. *Dechoukaj* is a colloquial word for the uprooting and burning of the houses of the elite by the populace.

Chapter One

International Development and Rural Health

The purpose of this chapter is to give the reader some notions of the mechanisms of international development in general and the various organizations involved and dealing with the implementation of health programs in developing countries. The description of rural health infrastructure illustrates the problems related to the need for decentralization of health services in many countries and the governments' long-lasting dependence on donors for supporting the health systems through international aid.

International development evolved from a U.S. plan to rebuild Europe's infrastructure and economy after World War II. This was followed by the Marshall Plan (the Recovery Act of 1947) to foster stabilization of Europe. Supported by President Truman, in 1950 the Act for International Development was designed with goals of creating market for the United States by reducing poverty and increasing production in developing countries, helping countries to prosper under capitalism, and diminishing the dread of communism. From 1952 to 1961 programs supporting technical assistance and capital-intensive projects continued as the primary form of U.S. aid. In 1961, President Kennedy established USAID (U.S. Agency for International Development), which over the years developed directives and programs based on the basic needs of the poorest countries.

International development includes foreign aid, governance, health care, education, poverty reduction, gender equality, disaster preparedness, infrastructure, economics, human rights, and environmental issues with a focus on alleviating poverty and improving living conditions in developing countries. It is related to the concept of international aid and as such it is also related to disaster relief and humanitarian aid. The latter were usually short-term relief projects. Long-term aid solutions aimed at improving necessary capacities

for human resources in order to create sustainability in a project that would be carried on with no further support of international aid, financial or otherwise. Usually, selected projects involved problem solving that reflected the traditions, culture, customs, politics, geography, and economy of the region. Other projects were related to empowering women, building local economies, human rights, and protecting the environment.

The U.S. Congress determines the amount of money the projects will receive each fiscal year. This unpredictable type of funding affects projects susceptible to significant budget changes year to year. Donors' funding for health in developing countries has quadrupled over the past two decades, increasing from $5.6 billion (US) in 1990 to $22.1 billion (US) in 2007 (Kaiser Family 2009). Governments have implemented funding mechanisms and partnerships such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and philanthropic organizations such as the Gates Foundation. All are working toward solving the health problems of poor countries. Although the budget has increased over the years, the Gates Foundation (2009) stated that it would not be enough to meet the predictions of the UN's Millennium Development Goals (MDGs) by 2015.

FUNDING MECHANISMS

Development aid may be 70 percent bilateral[1] given from one country to another, or it may be 30 percent multilateral[2] given by donor countries to international organizations such as United Nations Agency, UNICEF, or UNAIDS, which then distribute it to developing countries via implementing agencies. Implementing a project is a long process and is usually costly. About 40 percent to 60 percent of the grant is usually spent for implementation, sometimes in addition to indirect costs that are estimated at 10 percent to 15 percent. Lately, funding is becoming more complex. Large donors usually influence the priorities of grants (HIV has been a priority for the last two decades); likewise, 80 percent of the World Health Organization's (WHO) budget is classified as multi-bi (unilateral and multilateral donors) financed and also accounts for voluntary contributions (Sridhar 2012; DeCapua 2012).

DONORS' ROLE

In 2009, the Group of Eight composed of France, United States, Britain, Russia, Germany, Japan, Italy, and Canada made sure that global health would be on the agenda of donor governments such as the United States, Britain, Japan, and the European Commission, in addition to the Bill and Melinda Gates Foundation. How these donor organizations choose their pri-

orities is more complex. For instance, the World Health Assembly decided collaboratively through deliberation what the priorities should be for the organization. The United Nations Population Fund (UNFPA) Executive Board decided to invest their efforts in reducing maternal mortality across assisted countries by implementing the Maternal Health Thematic Fund (MHTF) in 2008. The latter was based on the high rate of maternal mortality associated with home delivery and complications of birth and reflected the UN's MDGs. Once donors have chosen their priorities, they usually put the project up for public bid among consulting firms. The firms interested in the project write a proposal about the project that includes methodology, logistics, implementation, training of staff, instruments and material, communication with stakeholders, partners, ministry of health's budget, and also a budget for offices overseas. The competition among firms is fierce, and the winner is usually evaluated based on the donors' goals and preference. The budget is a determining factor for the contract.

The partnership with the ministry of health determines how the project will be implemented, that is, vertical (stand-alone) or horizontal. Depending on the nature of the project, some donors prefer their program vertical. Usually the program aims at specific conditions such as HIV prevention and care, or family planning, or malaria prevention and care. Conversely some donors want their program horizontal—that is, integrated into the health systems that provide prevention and care in the general health services (Elzings 2005; Rifat et al. 2008).

Donors' vertical programs usually employ local medical personnel and use resources from the public sector. Human and material resources linked to the public health systems are generally very weak, creating major challenges for the quality of care of the services of the programs. Donors and administrative agencies are often losing precious time during implementation because of the weak public health infrastructure and the need to train medical personnel. Governments are aware of the problems, but the very low gross domestic product (GDP[3]) allotted for health does not permit them to renovate the health systems. Everywhere, there is inertia from the local governments about health, social, and civic needs of the populations along with a disregard about women's social conditions. At this point, governments must rethink along with donors the delivery of health, not as a vertical curative element, but as a social need that should be delivered in tandem with basic education and social improvements.

CONSULTING FIRMS

Consulting firms[4] provide technical and managerial assistance to public health programs worldwide. They are involved in public health research in

the United States and overseas, and some agencies have offices in foreign countries. For instance, one of them is John Snow Research and Training Institute Inc. (JSI) in Boston. It is a firm that offers technical and managerial assistance to public health programs around the world. JSI utilizes the Internet to advertise its expertise in capacity building, information system development, management, monitoring, evaluation research, program development, quality assurance and improvement, strategic planning, technical assistance, and training. The firm has been in business for thirty years and has offices in seventy-five countries. Their major donors are U.S. federal government agencies, country government international organizations, private foundations, and universities. JSI is a popular consulting firm among many others that are very competitive, bidding for federal grants and making a decent living on development aid.

I worked with numerous consulting firms as a consultant; the majority of them were logistically helpful, with some being more diligent than others (e.g., finding the right connection for long flights [twenty-four hours] from Los Angeles to Madagascar), and some were more or less helpful when I had important questions in the field. For instance, the personnel's lack of background knowledge of the country-project would create additional burden when trying to make decisions in the field. Generally, these consulting firms were helpful with the final editing of the report.

NONGOVERNMENTAL ORGANIZATIONS (NGOS)

There are several types of NGOs. Some are funded by government grants as well as donors such as CARE and OXFAM. Others are funded from private donations, foundations, and governments (May 2012: 43). Some are international in scope, while others are national or very small and locally focused. The latter usually work privately and are independent from the public health sector. Some NGOs work for profit, charging patients who visit the health facilities, while others who are sponsored by private foundations work with communities and do not charge for their services. Local NGOs dealing with health issues are small organizations that must follow the regulations of the ministry of health. They work with communities and are usually very efficient, especially in rural areas.

Faith-based organizations became very popular during the George W. Bush era because they were getting a lot of funding for preaching abstinence and the negative effect of abortion. Faith-based organizations are now getting some federal grants, along with local government funding and donations. I have witnessed the work of one faith-based organization in Malawi that impressed me. The congregation was offering schooling for children five to fifteen years old along with furniture-making classes for the community's

teenagers. The pastor of the Protestant faith talked about family planning and HIV/AIDS prevention during his church sermon and was open to counseling his parishioners about HIV/AIDS prevention. Community-based organizations also work at the grassroots level and provide development in rural areas along with women's empowerment through self-help associations and microcredit groups.

ROLE OF THE CONSULTANT

Doing research or evaluating projects and programs in various countries is challenging and intimidating. Each culture is different, and one has to adapt and learn to understand the life of the people and their constraints: economic, social, political, and cultural. In a foreign country, the consultant navigates between the various layers of the society; the minister of health and his entourage; the medical personnel working in hospitals and clinics (physicians, pharmacists, nurses, promoters, and community health workers); and the medical staff assigned to health posts in rural communities, usually composed of a doctor, a nurse, a promoter, and a midwife. Obviously the social scale is hierarchical, and the salary is reflected in their position. In developing countries doctors working in hospitals and clinics do not make the same type of salary as in the United States, and as a consequence many migrate to Europe or the United States. This has resulted in a huge shortage of medical staff in many African countries; for example, in Mozambique there are 548 doctors for more than 22 million people, and in Malawi there are two doctors for 100,000 people, compared to the United States, where one can find one doctor for 416 people (McAllester 2012).

The role of a consultant[5] implies being a mediator among the donor, the administrative agency, the local government, and the informants. In the field, the consultant focuses on the people he/she was asked to study and on improving their lives through better health delivery and program amelioration. In doing so the consultant has to evaluate the constraints and the benefits of the program. At the same time the consultant must follow the donor's terms of reference and examine the feasibility of the project based on human and material resources of the local authorities. The problem is that the regional office and the office of the ministry of health are not always harmonized in implementing new ways of health delivery. The consultant during debriefing becomes the advocate of the people.

Basically the role of the consultant is to mediate between three entities that are bureaucratic and linked to each other but not united for the same cause. There are (1) the donor organization(s), (2) the administrative office in charge of the project administration, and (3) the local government offices. Each one has different goals. Donors are investing money into programs that

improve the life of the people, the administrative office has the responsibility for the project in the field, and the government offices are interested in using the funds for their own perspectives. The consultant's advice through his/her recommendations represent informants' needs. The consultant's skills must include an understanding of the role and positions of the donor who has invested funding in a project with a concrete schedule and anticipated results. The administrative agency most of the time works closely with the consultant in order to present a good report that would please the donor, and the local government officials usually promise to follow the recommendations and make some change in their programs in order to get additional international aid (Maynard-Tucker 2008).

It is a complex game, because each entity is focusing on their gain, and often the beneficiaries[6] are the least part of the operational problem. It is very difficult to convince local ministry officials to promote changes in their programs. Ministries of health are usually characterized by a large bureaucracy mostly centralized in cities, and officials have very little field experience in rural communities and must deal with a shortage of human, material, and financial resources. Most disconcerting is the fact that there is a lack of supervision in health facilities in the rural regions and poor communication between rural communities and central offices. Lately, however, I have seen some improvement with the use of computers in small communities; communications with marginal villages is only by cell phone, if they are lucky to have electricity and a receiving post nearby.

CONSULTANTS' CHALLENGES

Most overseas work is challenging because it takes place in countries facing political turmoil. In my particular experiences (Bolivia, Haiti, Guatemala, Guinea, Peru, Madagascar, and Nigeria, to name a few) foreigners are usually targets because they are frequently associated with the international personnel working for companies that exploit the resources of these countries. For instance, in Nigeria it was not possible to leave the hotel after work for fear of being kidnapped, molested, robbed, or killed. International oil companies exploit the Nigerian oil resources without giving compensation to the fishing communities contaminated by petroleum waste after oil extraction. Everywhere in the Third World the road conditions are very difficult, even with an SUV. Except for a few countries, most roads outside urban centers are dirt, not well kept, and are dangerous for night driving. Another more mundane problem is to avoid a number of serious diseases that are common in many of the countries where development work takes place, such as malaria, tuberculosis, hepatitis, poliomyelitis, diphtheria, and many others. Hy-

giene and sanitation are nonexistent in many rural parts of the world, and water carries bacteria that are deadly to foreigners.

HEALTH INFRASTRUCTURE IN RURAL COMMUNITIES

In general rural communities are farming cooperatives operated by families, or are communities/villages where people practice agriculture and raise animals. They are isolated, and many do not have access to roads and have no commodities such as running water, electricity, or sanitation. They are usually located near a river or a stream. People speak a dialect or an ethnic language and practice traditional customs and beliefs. Schools and health facilities are located far away by foot, sometimes two to five kilometers. People are very poor, and most are nonliterate. Since the 1970s there has been an interest among the international community about the need to include rural communities into the global perspective of health.

The barriers to health delivery in rural communities are the responsibility of local governments. Access to a health facility is difficult because of the lack of roads and transportation. Usually the health post, if there is one in the community, has no electricity or running water. The midwife or promoter in charge is underpaid and he/she lacks the training and resources to treat patients. There is no supervision of their work or of their absences, and the medical personnel sometimes overcharge the patients for the visit or sell injections not prescribed in order to make additional money. Their knowledge of medicine is limited, and they misdiagnose illnesses, confounding malaria with respiratory infections, and often patients are not referred to the hospital in a timely manner. There is a shortage of doctors in Africa, and doctors do not want to live in rural communities. Too often, I witnessed the strategy used by sick individuals; they waited to get medical help until they had explored the last resort. At first, they would try to cure themselves with teas and visit shamans, and if after a few days they felt worse, they would then go to the hospital—usually it was too late.

Modern medicine is costly, and hospitals are usually located far away from communities and villages. In addition, people do not trust doctors who do not speak their language or give incomprehensible explanations of their condition in a medical jargon. It is easier to visit a shaman whom they trust, who speaks their language, and who explains the sickness within the cultural context and gives remedies that are a divine combination of herbs and the blessings from the Gods.

THE NEED FOR DECENTRALIZATION

In developing countries, the ministry of health located in urban centers has centralized their offices in cities. This has created a real problem, because directives to regional offices are sometimes delayed or too bureaucratic, to the detriment of field inputs. Since the 1990s, many countries such as Malawi, Senegal, Guinea, Uganda, Ghana, Botswana, and South Africa have attempted to decentralize health-care delivery. It has been a challenge, because the medical personnel resented living in rural areas with few commodities and very few resources in terms of transportation, roads, hospitals, clinics, and health posts, as well as the lack of medical supplies, laboratories, beds for patients, running water, and working sanitation. The improvement of rural areas represented a huge financial investment for governments, and health is not the primary preoccupation, based on the low GDP allotted for health. For example, in 2010 in Senegal, health expenditure was 11.56 percent of the GDP (public government expenditure), and per capita expenditure was $58.50 US, compared to the U.S. health expenditure at 17.7 percent of the GDP, and per capita at $8,508 US (World Bank 2012).

In general, at the level of the rural hospitals, I often witnessed a lack of ambulances to fetch patients and a shortage of paramedics. Also, many rural hospitals did not have an intensive care unit, and many did not have adequate medical resources, laboratories, and medical apparatus to perform tests. In Cameroon the rural hospital had toilets built outside the building. Another important gap was the absence of an efficient curriculum of supervision from the central offices of the ministries of health, because usually regional offices were poorly administered (see also Taylor 2012).

Rural populations have the highest ratio of mortality for children under five years of age, but we do not have any current statistics. In 2011, WHO reported that there has been an improvement of the overall child-under-five mortality, which dropped from eighty-seven deaths per one thousand live births in 1990 to fifty-one in 2011. However, it is still insufficient to reach the MDG5 target of two-thirds reduction levels by the year 2015 (WHO Fact Sheet No. 178: 2013).

Likewise, maternal deaths due to home birth delivery were not documented statistically in rural areas. Maternal mortality was reported between 385 and 500 deaths per 100,000 women, and 99 percent were happening in sub-Saharan Africa. Most surveys conducted by WHO and UNAIDS in the past decades mentioned that in rural areas there was more maternal death than in urban areas, but there are no recent statistics about rural areas. Taylor (2012) writes, “South Africa health minister Dr. Motsoaledi has won praise for acknowledging the chaotic state of the public health sector and is pledging to do his best to remedy the situation.” WHO reported that between 1990 and 2010 the global maternal mortality declined by only 3.15 percent per

year. This is far from the 5.5 percent required to achieve MDG5. The main causes for maternal mortality were/are hemorrhage, sepsis, hypertension, obstructed labor, obstetric fistula, and unsafe abortions.

DEPENDENCE ON DONORS

Swaziland's 1.2 million people face the worst HIV/AIDS epidemic; it is estimated that 26 percent of adults (fifteen to forty-nine) are infected, reported the National Emergency Response Council on HIV and AIDS (NERCHA) (UNAIDS 2010). Swaziland is a kingdom in which the majority of the population lives below the poverty level (World Bank 2000). Swaziland is heavily dependent on international donors (80 percent) for HIV treatment and care and the treatment of malaria, tuberculosis, and other diseases. In the case of cancellation from donors and because of low governance capacity, the country's health systems cannot function without international donors (Daku 2012).

In 2004, India was allocated $140 million for HIV/AIDS treatment, yet over a year the grant received was unsigned and no money was distributed for the program. It was estimated that about eighty thousand infected patients would have died because they could not afford the treatment out of pocket and were waiting for the donor's treatment program (Stern 2005).

In Malawi the external funding comes from the Global Fund that is responsible for procuring the country's HIV test kits and drugs; including the treatment of HIV/AIDS, the government funds represent only 1 percent of the country's programming.

Conversely, in 2011 the Global Fund was also victim to lack of money and donations and had to cancel Round 11.[7] Because of bureaucratic complexities, no new program could be introduced (Daku 2012). In order to break the dependency on donors, Zimbabwe has instituted some innovative financing to keep up with HIV treatment for infected patients. The government has a policy of 3 percent "sin taxes" on the buying of cigarettes and alcohol (Kardas-Nelson 2012; IRIN 2013), while in Kenya health-care financing depends heavily (52 percent) on out-of-pocket payments for services.

Some of the reasons the public health sector's health-care delivery is deficient can be traced back to the average expenditures spent by governments in the health sector. For example, in sub-Saharan Africa the GDP rarely exceeds 5 percent, and most African countries spent less than $10 US per person per year on health care, when a minimum should be $27 per person. Along with the lack of health care, 50 percent of the populations do not have access to modern health facilities and 40 percent do not have access to safe drinking water and sanitation (Daku 2012).

Local governments' great neglect of rural communities is reflected by the high rate of maternal and child mortality along with the low rate of immunizations (Kaseje 2006).

The following chapter reports on several fieldworks conducted among the Quechua Indians living in a small village in the vicinity of Cuzco, Peru. For a few years I was able to befriend Quechua women and recorded their reproductive and sexual behavior associated with the introduction of modern contraceptives at the health post.

NOTES

1. Bilateral/unilateral aid means aid from a single donor country to a single recipient country.
2. Multilateral aid represents groups of countries or an institution representing a group of countries such as the World Bank that provide aid to one or more recipient countries.
3. Gross domestic product (GDP) is the monetary value of all the finished goods and services produced within a country (Investopedia).
4. Consulting/administrative firms provide professional advice to an organization for a fee. If they successfully get the bid, they will administer the finances, the logistics, and the management of the project. They keep a roster of consultants' curricula vitae and will contact consultants based on their experience and knowledge of the country and language for missions overseas.
5. This section contains some extracts from the article "Becoming an International Consultant," G. Maynard-Tucker, *NAPA Bulletin* 29: 181–95 (2008).
6. Persons who benefit from the project/program.
7. Round 11 was a call for proposals from countries that needed financial aid from the Global Fund for their health services such as AIDS, tuberculosis, and malaria.

Chapter Two

Peru

First Experience in the Field

This reports my first experiences in the field and describes the life of women in a small rural community of the Peruvian Andes called Markita (a pseudonym). While taking a class about Peruvian ancient civilizations and artifacts as an undergraduate at UCLA, I fell in love with the country and convinced my husband to take us to Peru for vacations. My son was ten years old and excited about finding gold left over by the Spaniards in archeological sites. We went to Cuzco and marveled at the Inca ruins. It is in Cuzco that I decided I was going to study the Quechua Indians. The Quechua Indians mingled with the mestizo[1] population but seem more reserved, and the women were fascinated by my son's blond hair; they could not help touching his head. We came back from Peru without gold, full of stories, and with me dreaming to return for some exciting study among the Quechua Indians. Meanwhile, I started my master's degree at the California State University, Northridge, and decided to study the enculturation process of the children in the region of Cuzco for my M.A. thesis.

FINDING THE SITE

Two years later I was back in Cuzco, looking for a village where I could contact the women and start my interviews. The clerk of my hotel in Cuzco gave me the name of two villages nearby. I took the bus and went to one village, but I could not establish any contact. Very few women spoke Spanish, and they thought that I was a lost tourist. However, when I reached the second village, I saw a woman selling fruits from her house. I approached her

and started speaking to her. She could speak Spanish! I bought some fruits and asked her if she had some friends; she said yes, and then came Elena, who became one of my best informants. I explained to them that I wanted to interview women for a study about their traditions and culture. They were willing but also apprehensive of my study. I learned later on that they often had bad experiences with people that came from "outside." For instance, traveling salesmen took advantage of their marginality and their semiliteracy[2] and would sell them books such as the Britannica Encyclopedia series for a fortune on credit. Often they could not keep up with the payments, and the salesmen would take the books back after a few months. The irony was that they could not read the books because of their infrequent schooling, and only the children who were sent to school, mostly the boys, could have attempted to read the books. However, possessing the *Britannica Encyclopedia* in Spanish was more a status symbol for the ones who could afford it than an investment for the education of the children. Among my female informants less than a third had formal schooling up to six years but not continuously.[3]

The following is a description of the village, women's conditions, their use and beliefs in traditional medicine, women's reproductive health, and the village's health post[4] at the time of my fieldwork research that lasted several summers.[5]

MARKITA

Markita[6] was an agricultural community of 3,500 inhabitants in the 1980s, situated at 10,500 feet in the Peruvian southern sierra and located in the region of Cuzco. Because of its location within the sacred Valley of the Incas, villagers would find pottery shards dating from the Inca period in their fields, indicating that the location had been occupied for many centuries. The village was divided into two sections joined by a steep cobblestone road that dated from Inca times. The higher section of the village, built on the top of a hill, had the church, the plaza, and the city hall, while the lower section, situated at the foot of the hill, included a covered market, a few trade stores, several ministry offices, a bank, and the Consejo (the municipality, where I obtained the authorization to interview the women). It was also the location of the offices of the subprefect and the mayor. Political regional offices in Cuzco appointed local authorities in the communities, the subprefect and the mayor. Rather than being locally elected, both were unsalaried appointments. The regional office of the ministry of health in Cuzco administered the health post, located about two blocks from the municipality. About 700 inhabitants lived in the top section of the village and 2,800 in the lower part. On a clear day Markita offered a breathtaking view of the beauty of the Andes, built

Figure 2.1. Living Quarters, Markita, 1984

within a high plateau encircled by the snow-capped mountains of the Andean Cordillera.

In Markita the main street, the only paved road about three blocks long, was lined on each side by houses constructed of whitewashed adobe. Each house had a courtyard with a faucet, electric outlet, and primitive bathroom facilities (people who lived in adobe houses were usually better off economically than people who lived in huts). Away from the main street there were huts built here and there. Huts were small living quarters about nine by fifteen feet. They were built from adobe bricks with an A-frame straw or corrugated roof. Corrugated roofs were preferred because people had lost the skill of making traditional straw roofs. Corrugated roofs were noisy when it rained, they kept the heat in, and when women cooked inside the hut, the smoke blackened the walls, so the door was left open for ventilation. The huts were dark, cool, and smoky. On the dirt floor guinea pigs, ducks, chickens, pigs, cats, and dogs ran freely. At night the hut sheltered animals and humans against the freezing cold. There were no electricity, water, or bathroom facilities. Women fetched water daily for domestic purposes, cooking, and washing clothes. A large field across from the main street served as a communal toilet. Going to the toilet was done in groups, because women talked and gossiped during that time. I was invited many times to join them

but refused because of my clothing (I wore jeans), and they wore large skirts that covered their whole body when they were squatting.

The learning of the Quechua language was an asset for entering their intimate life, asking questions, and being part of the community. Although the women said that they had some schooling, their knowledge of the Spanish language was marginal because of their lack of schooling. In addition they enjoyed hearing me speak Quechua with a French accent and stumbling on their guttural explosives. I was "la senorita" who drank beer because the water was polluted, and boiling water at 10,500 feet of altitude took forever. I was educated and spoke a few languages and lived so far away—France and/or the United States were the same distance as the moon for them. I traveled alone, without the protection of a man, but I was married and was able to leave my husband to come to their village for several months on end to befriend them. All of which put me in a specific category that did not exist in their culture, but I had to fit somehow; therefore, they thought of me as half male doctor and half female schoolteacher. Once they accepted me, they trusted me and always wanted to give me one of their children when I was going back home.

After finishing my M.A. thesis about the enculturation process between parents and children, I decided to go on with my Ph.D. studies at UCLA and started research that might improve their lives. Each year the women had a new baby or a new pregnancy, and they always complained about it, saying that they were poor, had no money, and could not feed their family,[7] I thought that inquiring about the use of contraception and decision making within the couples would give some clues to developing programs better suited for their lifestyle. The women wanted to control their pregnancies, but they had cultural and economic barriers along with a poor delivery of care at the health post. In addition, the oral contraceptive methods were not appropriate for their lifestyle, especially the Pill. The IUD was the method preferred by the medical staff at the health post, but women were scared of it and did not understand how it worked. On the other hand the Pill had to be taken daily, and women would often forget to take their pills regularly. At that time the failure from the Pill was so high that women became afraid of it. In addition there was much gossip about the side effects of the Pill circulating in the village by the women who had experienced failure of the Pill and became pregnant. Furthermore, the medical personnel who were commuting from Cuzco were often absent when they were needed. And when they were present at the health post, the quality of the health-care services was inadequate. Now, looking back at this situation, I realized that good counseling would have helped, along with a better attitude from the medical personnel.

MODERNIZATION IN MARKITA

Modernization was slowly invading the village in the 1980s (Bourque and Warren 1979). The main street was paved, and the bus travel to Cuzco lasted thirty minutes instead of two and half hours. Schooling was mandatory for children, and the classes were taught in Spanish. Consequently children who were only Quechua speakers were handicapped. Children learned basic writing and reading along with some mathematics. Schoolteachers were mestizos, were not well paid, and they lacked books and materials to teach adequately. Because of the proximity of Cuzco, villagers would travel often to the city in order to buy produce, clothing, and material for the household. In Cuzco, villagers were in contact with modern life: television, refrigerators, blenders, radio, hi-fi, and tourism. They could also find theaters, markets, and health care. In the village the wealthy families would buy a television and watch it at night, although many times the reception was not good because of the winds and the lack of antennas. Men were more mobile than women and traveled often to Cuzco for work or for pleasure. In doing so, they were transmitting new modern values and a new lifestyle to their female partners. Because of modernity, most villagers did not chew coca any longer, and when I tried to chew coca, they were very opposed to it, telling me "coca chewing is for the peones" (peasants). Families consisted of parents and children. They did not live with extended families any longer, having left behind older parents in their native communities. Although most couples practiced sirvanakuy (common law marriage), this process became legal after ten years. Divorce existed, but no one could afford a lawyer. Divorce was characterized by abandonment by the male partner, and although he was supposed to give monetary support for the children, in general once men abandoned the family, they did not support their children.

GENDER DIFFERENCES

Boys were sent to school for a longer period of time than girls. Boys averaged about eight years of schooling while girls only attended for six years. Young girls were sent to school intermittently. When the mother needed help, girls were kept home to help with the children and household duties; meanwhile, boys were sent to school regularly and had very few chores and responsibilities. They were mostly on their own after school or playing soccer. From an early age girls and boys lived in different spheres with different chores and responsibilities, and this gap between the sexes continued to adulthood. As such, the workload of women and the responsibilities for their families were amplified, while men migrated in search of cash or when partners abandoned the family.

Figure 2.2. Selling Food on the Road, Markita, 1984

Quechua women wore the traditional clothing,[8] while men did not. Men migrated regularly in search of jobs and spoke better Spanish than their wives and were more acculturated to modern ways of life (Bourque and Warren 1979; Babb 1980). Men were usually the breadwinners, though women also worked selling cooked dishes on the road or reselling produce at the market. One woman was a successful retailer and fully supported her children and her husband. When migrating for several months for work, men often established a second family elsewhere, and women left in the village had to find ways to make some cash during the absence of their partners. They usually found out about the other woman and second family, and when the husband would come back, they would argue over money spent for the other family. Women, too, had love affairs when their husband was away, which sometimes ended up in unwanted pregnancies and abortions. Marriage was rarely legal; they practiced common law marriage and serial monogamy. Love between the sexes was nothing like the Western version; men's and women's attractions were based on pragmatism, such as "a good man is a man who does not drink, does not chase women, and supports his family, and a good woman had to be faithful, fertile, and should take care of her children." Women had difficulties living without a man because of economics, protection, and cultural norms. For instance, when abandoned by her partner, a woman would quickly try to find another man, and in order to bind her new

partner to her, she would become pregnant. This was easy to do, as they did not use any modern contraceptives and practiced sexual abstinence during the menses, which they call the rhythm method. On the other hand, women always complained about having too many children, and they knew that these temporary relationships would not last.

WOMEN'S ROLES

The women trusted me, and I became their confidant. I found out that they were not "in love" with their husbands/partners, but they needed them for survival. Their life was very insecure, living without their kin, with husbands/partners who migrated for work daily or monthly without communication. Women were in charge of raising the children, looking for firewood for the cooking, carrying water from the public faucet in large containers for washing clothes in addition to preparing food for the family. They had to prepare the children for school early in the morning and take care of the babies and feed the small animals (guinea pigs and chicken) that lived in the huts. In addition, some women would cook large pots of soup and sell it by the roadside in order to supplement their need for cash. Their life was a long list of chores, and they were busy from early morning until nighttime. They had no electricity in the huts, and children would do their homework by

Figure 2.3. Helping Mother, Markita, 1984

candlelight. When the husband would return for a few days, he would spend some time at the local tavern drinking with his friends and would go home and expect to have food ready and sexual services. The majority of the women called their sexual life "el trabajo" (the work), which they described as being only an action to satisfy the man and which left them sexually aroused. Lack of privacy and sleeping with small children in small quarters was also not conducive to sexual relations.

In Markita, men were excused for their immoderation and had more freedom to do what they wanted compared to women. It was also culturally accepted that men expressed their frustrations by drinking to excess, by using violence on their wives, by having extramarital affairs, and by supporting a second wife and family elsewhere. The women would say that men have "urges" that cannot be controlled.

VIOLENCE

Gossiping was always a problem, because it led to violence. For instance, one day my friend Matilda, who was in her twenties with three children, accepted a soft drink from a man who was not part of her kinship at the popular main store in the village. This was later related to her husband. As soon as he returned from work, he confronted her with the story. She agreed that it was true, and he beat her in front of the children. He punched and kicked her and made a hole in her leg with his pointed boot. She showed it to me, and I asked her if I could talk to him about it; being the comadre, I could not let him go without a sermon (I really wanted to punch him). We had a long talk, and he explained to me that he was jealous, lost his temper, and was sorry for his violence. I pointed out to him that his two sons were present and probably would replicate his behavior in the future, and I begged him to take a walk as soon as he felt violent toward his wife. I do not know if he followed my advice, because shortly after this incident they moved out of the village.

Men were violent most of the time, and women could also be violent (Harvey and Gow 1994; Alcalde 2010). Especially when they were drinking, they would throw objects around (whatever was close to them, pots or dishes). Men's violence occurred almost daily and could be seen on the faces of their wives (they had blackened eyes from their partners' blows). Men would come back from work, stop at the local bar, drink, and then go home. If the dinner was not ready and warm (cooked on wooden fire), or if the women did not do the chores ordered by the men, they would get beaten. Women would deny their beating and would say that they fell and hurt themselves. Women would excuse their partners' violence, telling me, "If a

man does not beat his wife once in a while, it means that he does not care for her."

Abuse of alcohol was a big problem among the sexes. One day my comadre Elena was very upset; she told me that her husband had a second wife and fathered two children. She resented the money he spent with the other family because she had five children with him. That day, he came back from labor migration drunk and demanded food and sexual services. She had also been drinking and was furious about his behavior. She threw a clay pot at him, and he then ran after her with a knife. She ended up in the mountain at night, walking for hours, and then went to spend the rest of the night with a friend. When she returned home, he had left without leaving any money for the support of the children. Gossip about others was used frequently as a means to control the social life of the village.

TRADITIONAL HEALING IN THE VILLAGE

Traditional medicine[9] was very popular and was the way the villagers treated their illnesses. They would go to visit a physician in Cuzco only if they did not get any result from the healers. In Markita, there were four healers in the village: a curandero (male healer), a spiritualist, and two curanderas (female healers). Each one had a specialty and used herbal teas to cure their clients. The curandero was the most popular, about forty years old, married with seven children. He attended births, treated chronic illnesses, and healed bone and muscular injuries. During delivery, he used herbal teas, incantations, and prayers. He also used a belt around the abdomen of the woman during delivery and tied it each time she pushed to help with the expulsion of the baby. He read coca leaves and predicted the future and cured mal de ojo (evil eye), susto (bad fright), and empacho (stomach disorder). The spiritualist treated chronic illnesses with modern medication, prayers, and incantations and rituals of white and black sorceries. He had an office in the village and was the most expensive of the healers; he demanded a dinner in addition to fees for rituals.

The well-known curandera in the village was a nurse who used to sell drugs from her house-store. She was single, in her forties, and treated everyone with injections of penicillin. During one of my stays in the village, she gave an injection of penicillin to a woman who went to her for "nervios," a psychosomatic condition that does not require penicillin (see also Oths 1999). The woman was allergic to the drug and died. Her death left three children, her husband, and the whole village in tears. The curandera left the village quickly after learning that her patient had died, because villagers wanted to punish her for her malpractice. She came back two months later and resumed her normal life offering her services to the villagers. She was

charging less than the health post and was treating people for primary care, infections, injuries, and pulmonary ailments.

The other curandera specialized in preventing pregnancy and causing infertility with the prescription of herbal teas. She was illiterate and monolingual in Quechua. She had ten children and was a widow. She believed in hygiene, washed often, and always looked clean and neat compared to the villagers. She treated patients with herbal teas, incantations, prayers, and massages. She read coca leaves and tarot cards for divination. She believed in the hot and cold theory (Logan 1977) and applied it to her treatments; for example, she would use herbs that have the property to "cool the uterus" so that during intercourse the "hot blood" (semen) could not survive.[10] She also taught women to wash their private parts with a rag dipped in an herbal brew. Hygiene was a serious problem, and rare was the person who could wash daily. Because of the lack of hygiene, the whole village was contaminated by skin diseases. One of them was "la grata," a colloquial name for a virulent virus transmitted by shaking hands that left me sleepless because of the constant itching of my hands. The pharmacist told me to avoid touching other parts of my body, because the virus would spread everywhere. He sold me a cream, which I used to apply on my hands, but I had to wrap my hands in toilet paper at night for the fear of touching my face. I was not cured of the virus until I returned home.

INGRACIA

When I arrived, I did not know much about the customs, norms, traditions, and language. It took several weeks to win the women's trust and to be accepted. I rented a room from Ingracia, who had a fruit stand in front of her adobe house. She furnished my room with her son's little bed and a table and I bought a camping stove, a chamber pot, and a coffeemaker in Cuzco. I used two sleeping bags at night because it was freezing. The room had a broken window, and the wind and cold would come in at night along with some huge spiders that would cling to the walls until the morning sun would appear. Ingracia had twelve children: four died in infancy and eight survived. They ranged from six to eighteen years old. The six-year-old who lent me his bed would give me advice about the poisonous spiders in the room. "Do not touch them!" Ingracia's house also had a toilet in the courtyard and a faucet. The toilet consisted of a hole in the ground and two pieces of wood to squat on. When she had money she would buy chemicals, which she used to throw in the hole. The water from the faucet was used for domestic purposes, cooking and washing (the water looked like milk because of chemicals). Ingracia was in her forties (she looked much older) and could not read or write; her husband was living apart on their land with their two oldest sons.

They produced coffee, fruits and vegetables, potatoes, and maize that she was reselling from her home store. The six smaller children were living with her and attending school; however, she was always sickly because of her "bad blood."

THE RITUAL

One day Ingracia told me that she invited the traditional healer for a ritual in order to regain her health. She had previously gone to Cuzco to see a doctor for her ailments and had surgery for uterine myofibroma, but since the surgery she had felt dizzy, had pains in her lower abdomen, and was vomiting frequently. She was given medication, but after a few days did not feel any better, so she threw the pills away. She told me that the doctors left some "bad blood" during the surgery, and this was the cause of her pains. At that time, I had kidney stones and was also in pain. I had seen a doctor in Cuzco who wanted to perform a difficult surgery on me by removing a second kidney that I did not know I had, along with the stones. I was willing to get treated by the curandero. Ingracia assured me that the curandero would heal both of us during the ritual. She proceeded to send me to the pharmacy to buy peroxide, mercurochrome, cotton, gauze, bandages, and a little bottle labeled agua de Florida (water from Florida) for her "surgery." I was nervous and scared because I did not know about the technique of "magic surgery" performed by healers. She reassured me, telling me that he would put her to sleep and during that time he would remove her "bad blood." Having had surgery in Cuzco at the hospital, she knew that the curandero was not going to do a normal surgery on her.

The night of the ritual, she cooked guinea pigs and chicken for the curandero and his assistant and they drank chicha (the traditional drink made out of maize). By the time they arrived in my room, which was the largest in the house, they had prepared a table for the healer and brought some chairs and benches for the children and her husband, who came for the occasion. I was sitting on my bed, pushed in one corner of the room facing the healer.

The candlelight was blown out and the room became dark because they nailed a blanket over the broken window. Juan, the healer, was in his forties, modern, and semiliterate. He used chanting, prayers, potions, and modern medicine for curing illnesses. He worked with an assistant in charge of the props. He received his divine call at the age of nine and also learned his curing trade from his father. After some small talk about the village people, he started the ritual chanting and praying to the Quechua gods (the Apus) and the Catholic saints who were supposed to come accompanied by ten angels. He would change his voice depending on the Gods'/Saints' answers (higher or lower), and with his assistant he would make noise with a paper as if the

angels would fly in the room. I was spooked! Finally after a long discussion with the Gods, Ingracia was asked to lie down on the floor and to answer their questions. The Gods reassured her about her condition through a dialogue in Quechua. At the end of the ritual the curandero told her that the Gods suggested performing the surgery next time. Throughout the ritual, there were interruptions. Ingracia's husband asked for advice about his land and they would make some small talk, then there was silence—and the prayers would start again along with the chanting (Bussman and Sharon 2006).

At the end of the ritual, one of the deities, through the intermediary of the healer, spoke to the children, telling each one of them to study well at school and to be good and obey their mother. The children were respectful and agreed, answering "si Papacito." Finally, it was my turn, and in Spanish the healer told Ingracia to make a tea for me from the skin of a pink potato. She did it, I drank the potion, and I passed the stones in the afternoon. My condition did improve; however, hers was more complex. She was better for a few days after the ritual, and then her pain returned along with her complaints about her ailments until the next ritual. The cost of the ritual was $10, an enormous sum for her to pay in addition to the expensive dinner. However, the ritual was beneficial because it distracted her from her health problems and gave the whole family a night of entertainment and the feeling that they were in close communication with the Gods. The curandero postponed her surgery at each ritual, and this lasted for a few months. During my subsequent stay in the village, Ingracia told me that one of her friends recommended a physician in Cuzco; she went to see him, and she was relieved from her pains. He treated her with injections of hormones and vitamins (Mathez-Stiefel et al. 2012). But confidentially she said that she was still calling the curandero for the children's sicknesses and for advice about her husband, their land, and also because it was important to keep in touch with the deities.

PRIVATE DOCTORS

Villagers had a choice of traditional healers in addition to the not-very-dependable health post staff. Those who could afford it also visited private doctors in Cuzco, as we have seen with Ingracia's story. Villagers went to private doctors when all the recourses of traditional medicine had failed and when the patient had saved enough money, because private doctors were very expensive for their budget (Finerman 1989). Many private doctors were not fluent in Quechua, and the nurses criticized the Quechua women's traditional clothing and their lack of hygiene. Quechua women who were illiterate could not read the medical forms and sign their name. There was a lack of

communication between doctor and patient based on language barrier and health literacy; patients did not understand the doctor's explanations of their ailments. The majority of the villagers praised injections as a magic cure, which is why the curandera-nurse was so popular: her treatment focused on injections of penicillin, as did the doctors who used injections for their treatment.

Home birth delivery was popular, but much less among the young women, who preferred to go to the hospital in Cuzco to have their babies. Overall, villagers would choose the medical services based on seriousness of the illness and their availability of cash. They often self-medicated and combined traditional herbal teas with modern drugs to cure an ailment. The pharmacist was also a source of health care; he would diagnose ailments from his book and would sell the appropriate drug treatment. I used his skills many times. However, if the sickness was serious, such as acute respiratory infections (ARIs) or acute diarrhea for children, mothers would wait a long time before making the decision to visit a doctor or to go to the hospital. The problems were associated with a lack of cash, lack of transportation (Oths 1994: 245), and the way they were treated at the health facilities.

THE HEALTH POST

The health post was located at the end of the main street across from the town hall in a modest building. Poorly furnished, the facility was composed of four rooms: doctor's office, examination room, a gynecological room, and a dentistry room. However, the village had not had a dentist since 1982; the shoemaker used to pull teeth when the pain was unbearable. The health post was open Monday through Friday from 8:00 a.m. to 2:00 p.m. The services offered were children's immunizations, vaccinations and general medicine, gynecological examination, Pap-smear testing, and the distribution of contraceptive methods free of charge, sponsored by the government. Family planning services delivered at the health post were not advertised and were known only by word of mouth. The contraceptive methods were the IUD (Lippe's loop), the Pill, and condoms. The medical staff was composed of a doctor, a medical student in his first year of residency (he had to donate one year of medical services in the countryside in order to graduate), a midwife in training, and four female nurses. All were mestizos and did not speak Quechua. They lived in Cuzco and commuted daily for their appointments, which was imposed by the ministry of health. Early morning patients waited for the medical staff, who arrived usually late from Cuzco, and patients sometimes had to wait three hours for a visit with the doctor.

Couples who wished to use a contraceptive method had to register and sign a booklet. Women were not given contraceptives without their hus-

band's authorization. After an examination and a mandatory Pap-smear test that cost $3 at that time and took three weeks for results, the woman could ask for a contraceptive method. However, the midwife, who seemed to prefer the IUD, determined the choice. The problems with the IUDs were that the medical staff had only one size (large), and patients did not come back for the checkups. The Pills were given with minimal explanation, so that women really did not understand the procedures. Most women were nonliterate or semiliterate and had no knowledge of physiology. While condoms were given free of charge to men, men generally did not come back for a new supply. The reason was that men thought condoms were defective. Men and women were afraid of the village gossips about going to the health post for family planning. In addition to the poor service delivery there was lots of gossip about side effects of the methods from dissatisfied users. The Pill was not fitted for their lifestyle, they would forget to take it daily, they would skip the Pill for a week or two, and then would resume their regimen. Obviously, they got pregnant and blamed the Pill. Culturally, it was too difficult to understand the discipline of taking drugs regularly in a society that did not use watches or clocks and knew the time of the day by looking at the sun's position. Women did not acquire any discipline at school, since they were always absent. Besides doing the routine chores of the daily life, they did not have an organized Western lifestyle and could not bring themselves to take the Pill correctly on a daily basis. It was also the result of poor counseling because of the lack of communication between the women and the nurses, who did not emphasize the negative problems associated with skipping the Pill.

ABORTIONS

Among the Quechuas virginity was not enforced by cultural norms, so young people experienced sexual relations in their teens—boys and girls around sixteen to eighteen years old. Sexual education was not provided at school, so they had a vague knowledge of physiology and were ignorant about contraceptive methods. Usually girls got pregnant and kept the baby, who was raised by their parents. A girl could start a common law union with her boyfriend or could decide to live with her parents. Young girls did not use abortive methods because they did not have the knowledge or the cash to do it. Conversely, women living in a common union who had love affairs and got pregnant when their partners migrated for wage labor used induced abortion as the solution to their dilemma. In addition, abortion was also the most popular method to control the family size[11] in case of failure of contraceptive methods (Delicia 2002). There were different options to get abortions in town at various prices. Women would usually take several steps in their

decision-making process. When a woman was late with her period, she would wait for it for about two weeks before taking action. In order to bajar la regla (bring down the period) she would drink a daily herbal potion of ruda (Ruta graveolens) that acts as a strong contractor and a laxative. If her situation did not change, she would get an injection of oxytocin, or an injection called "period regulator" at the health post. Other methods of abortion involved a third person manually poking the uterus and medical abortions.

While some women used to take one remedy at a time, others would combine all at once in addition to jumping with heavy loads. Obviously, this was kept secret except from good, trusted friends, because gossip about a woman's abortion would destroy her reputation as a mother and a wife.

The following was told to me by one of my comadres who got an abortion from a curandera (traditional healer). She went to the curandera with a note from her husband (she wrote the note herself) giving the authorization for the abortion. She did not want her husband to know that she was pregnant again, as she already had three children and knew that her husband had another family elsewhere. Describing the procedure, she told me that while she was down on a bed the curandera put some gloves on and proceeded to poke the uterus with a long, narrow instrument. She was then asked to stay on the bed until she would expel the fetus. After six hours she expelled it and she was sent home bleeding with a supply of six antibiotic pills. She paid $26 for the procedure. The bleeding went on for weeks, and she later developed an intrauterine infection and had to see a doctor. In Cuzco, nurses and doctors were available for more sophisticated abortions at prices ranging from $20 to $55 (by vacuum suction). Some women had a history of two abortions, while others had multiple abortions.[12] The reasons to get abortions included the husband's adulterous life, the husband not working and having to support the family with roadside sales of cooked food, and abusive or alcoholic husbands. Other instances included women who had lovers during the absence of their partners, women whose husbands were sentenced to jail and had to support the children, and women who got pregnant while using a contraceptive method because of fear of giving birth to a "monster" or deformed child. Many rumors circulated in the village about birth control Pill users who gave birth to "monsters" without hands or with the mouth placed sideways. Any birth defects were blamed on the Pill and the IUD. As I was getting deeper into their lives, I realized women were using abortions instead of contraception not because of ignorance of modern methods but because they feared the side effects of the methods.

MEN'S AND WOMEN'S DECISIONS TOWARD CONTRACEPTION

In Markita men were the decision makers[13] about the practice and use of contraception. Various studies (Beckman 1983; Hollerbach 1980, 1983; Shedlin and Hollerbach 1981) showed that men were in control of their wives' fertility. Rhythm was the preferred method, however, because of traditional beliefs about menstrual blood. The majority of men and women had only a folk understanding of human physiology. They thought that during menstruation women would get pregnant more easily because the womb (uterus) was "opened." Some also thought that contact with menstrual blood was sucia (impure) and infectious (Snowden and Christian 1983). Men reported learning about the rhythm method while talking with friends at the local tavern. They knew that the mechanisms involve a period of abstention during ovulation, but because of their misunderstanding of physiology, they believed that ovulation occurred during the menses. Consequently, they practiced abstention during the menses and resumed as soon as the bleeding stopped (Laing 1987). The fact that men were in control of the rhythm method showed that they were checking on the dates of the menses, and by regulating the period of abstention, men also protected themselves against contact with menstrual blood, which is believed to be dangerous to their sexual organs. They said that if menstrual blood would enter and infect the urethra, this would lead to impotency.[14] Statistics taken at that time show that most women were not aware of men's methods of withdrawal, rhythm, or condoms. Condoms were rarely used with their wives because men used to say that condoms were for prostitutes only, and their wives were clean women (Stokes 1980). The majority of the women informants (90 percent) reported that they couldn't make decisions about using modern contraceptives because they might be accused of being unfaithful. Usually the husband's approval was sought. Also, women did not oppose men's decisions because they felt that men knew best: they were more educated, spoke better Spanish, and were accustomed to modern life.

FOLK BELIEFS ABOUT PHYSIOLOGY

Men and women believed that conception took place in the uterus, called la madre (mother) or la matriz (the womb). However, they believed that the uterus was not associated with the process of ovulation, which was thought to be vaginal only. For them, the uterus was an organ, round or oval, floating in the middle of the pelvic area. During conception the "impure" menstrual blood stopped and the baby was conceived from the blood women had in the uterus (different from the impure blood), and the husband's semen, also called "blood." Men believed that once a woman was pregnant, she must

have sexual intercourse repeatedly so that the baby's development is aided with needed additional semen. Women said that during delivery they get rid of the impure blood that they have accumulated during pregnancy. After delivery, the midwife physically manipulates la madre to lift it back to its normal position, and a belt is wrapped tightly around the woman's abdomen for a few weeks. It is believed that if the uterus is not put back to its normal position, it might fall out and the woman would die.

HEALTH LITERACY AND CULTURAL BARRIERS

As I was entering into the depth of the Quechua culture, I realized that the delivery of family planning services at the health post was not adequate for the villagers. The services did not help the women and did not suit the lifestyle of the villagers and their concept of conception and prevention. Designed for an urban population, the family planning program created barriers of inconvenience because of limited office hours restricted to five days a week. The frequent absence of the medical staff and the discourteous treatment was not conducive to establishing trust and open communication with the patients. In addition, the women were faced with a lack of communication due to the staff's monolinguism in Spanish along with their prejudices because of the lack of hygiene. Furthermore, if the contraceptive was free, the services were not, and the women had to pay a mandatory fee for the doctor's examination as well as for the mandatory Pap-smear test. The high rate of failure of the Pill brought gossip and fear of the method because the women did not understand the regimen and because it was not well explained in their language. Not being used to taking medication on time and experiencing the side effects of the hormonal methods, women blamed any type of illness on the practice of the Pill and would stop their regimen.

Users of contraceptive methods kept their practices secret from their best friends and relatives because they felt embarrassed using contraception in spite of the negative rumors. Many women also thought that drinking herbal teas and a long period of lactation would prevent pregnancy. Men wanted to limit their family size because of financial responsibilities for their numerous children; however, they did not do much about it. They were not using condoms with their wives and really were not interested in the women's methods. "It is a woman's responsibility to take care of her fertility," they used to say. Overall, both sexes did not understand the mechanisms of the various methods because of a lack of knowledge of physiology that clashed with their cultural concept of the body (Shedlin 1979; Shedlin and Hollerbach 1981). Often I would hear that the IUD was dangerous because it could travel inside the body and could lodge itself in the brain and kill the patient. The Pill produced monsters sin manos, con la boca al lado (without hands

with the mouth placed sideways). The condom produced impotency or mancha la cara de la mujer (spots on the woman's face). I asked them how the Pill, the injection, and the IUD in the body prevent pregnancy, and this is what they conceptualized: "la pildora y la injeccion cortan a la sangre en la vagina, y el espiral se coloca en la trompas" (the Pill and the injection cut the blood in the vagina, and the IUD is inserted in the tubes). One woman, a user of Depo-Provera, for six years, explained, "The injection goes to the head, the legs, and the stomach." Women thought that the best methods were the IUD, followed by tubal ligation, injection, and the Pill.[15] Most informants, both males and females, believed that conception happened during the menses, probably based on the observed period of estrus among animals.

LESSONS LEARNED?

My work among the Quechuas has been a formidable experience because I learned to understand the Quechua Indians, their behavior, and their culture. It was not easy. I had to get their trust, become their friend, and each day they taught me a lesson. I just had to open my eyes and listen. Anthropology demands flexibility and patience; I had both. We would celebrate children's birthdays together, and I would often be asked to make decisions in case of problems. For instance, they would say, "Where can I hide from the encyclopedia salesman who is coming to get my monthly payment?" "How should I confront my drunk husband about his spending at the tavern?" "Where do I go for an abortion?" Because I was the godmother, I was supposed to come up with answers and support. This role was more exhausting than collecting or analyzing data.

I had a hard time understanding women's behavior about fertility. They were always complaining about their large families or their new pregnancy, but if they were abandoned, they would look for a new partner, and if they would find a new partner, they would try to get pregnant in order to tie the man to them. This cycle repeated itself. Some men did not feel any responsibilities toward their children and would abandon the family. Women would say we "suffer," but men do not.

The use of contraceptives was new, and the program was not suitable for illiterate or semiliterate women who were using traditional herbal contraception and did not understand the side effects of hormonal methods or the impact of modern medicine along with its discipline. The IUD (large size) offered by the health post did not fit all women, and some women were experiencing expulsion of the IUD. This was difficult to understand, and gossip about the IUD roaming around inside the body was numerous. Gossip would destroy any effort to use contraception because it was based on fear of dying from an IUD that would pierce their heart.

CURRENT CONTRACEPTIVE PREVALENCE

In Peru there has been some general improvement in the use of contraception; the contraceptive prevalence for 2000–2009 shows 62 percent of modern users and 23 percent of traditional users. However, in rural areas only 33 percent of the women use modern contraception, and the average number of children per woman dropped from 5.6 to 3.6. Nevertheless, illegal abortion rates are high; about 41,993 abortions were performed from 2002 to 2003 (IPPF/WHR 2011). Stiff abortion laws oblige women to use illegal procedures that are dangerous for the life of the women, making Peru the country with the second highest maternal mortality in South America. Planned Parenthood Federation (2009) reported that public health facilities in rural areas are underfunded, they lack human and material resources, and the services are not adequate. Patients have to buy they own medicine, they must wait hours to see a doctor, and promoters are not well trained. Furthermore, only 20 percent of the pregnant women use a skilled attendant for birth delivery. The high maternal mortality denounces the fact that the problems in rural Peru are unchanged; women living in marginal communities have no access to health services in case of emergency because of geographical location, lack of transport, and lack of health facilities and human resources.

The lesson learned from my first experience with the delivery of a family planning program in the rural community of Markita was that it must be comprehensible to the target populations or it is a waste of money, effort, and lives, because women would rather choose abortions over contraception. Also, decision makers must know the culture before implementing programs. Quechua women would have wanted to control their fertility and to understand the modes of action of the contraceptives in the body if it had been explained within their concepts of human physiology. But the reality was that in Markita, because of the poor delivery of family planning services, they did not trust the methods or the drug regimen and were facing failure of the methods with new pregnancies and abortions. Based on my long experience working with illiterate rural populations in various regions of the world, the programmatic approach for delivery in rural regions should be different, because people are tied to their cultural traditions and concepts of hot and cold elements, and they have their own understanding of the body, sicknesses, and treatments.

Once I finished writing my doctoral thesis and presented some of my work at conferences, I made the decision to work in development improving family planning programs. Very soon, I was on my way to Haiti for a long-term consultation with a well-known agency as a research and evaluation advisor.

NOTES

1. Mestizos are people of mixed Spanish and Indian inheritage.
2. About a third of the women I interviewed were semiliterate (six years of school intermittently and they could barely read or write), while the others were illiterate (no schooling).
3. According to UNESCO, in 1993 the global literacy rate was 87.2 percent, and in rural areas 24 percent of the females had no formal schooling.
4. A health post is a small building equipped with medical instruments and material and operated by a doctor or a nurse or a promoter and a midwife.
5. This chapter is based on fieldworks conducted in a Peruvian village in the Andes (Markita) near Cusco. Three fieldworks were conducted in 1981, 1984, and 1986, during the summer months. In 1986 $N = 276$ informants were interviewed, in 1984 $N = 54$ couples were interviewed, and in 1981 $N = 30$ women. The questionnaires were composed in Spanish and Quechua. A student from the University of San Antonio de Abad in Cusco interviewed the husbands/partners.
6. The description of the village presents some extracts from my doctoral thesis "Reproductive Decision-Making and the Use of Modern Contraceptives in Rural Peru," UCLA Department of Anthropology, 1988.
7. In Markita women average 5.0 live births at thirty-one years of age, and the total fertility rate for women in rural areas was 7.0 children per woman. G. Maynard-Tucker, "Barriers to Modern Contraceptive Use in Rural Peru," *Studies in Family Planning* 17, no. 6 (1986): 307–16. (See also L. Tam, 1994.)
8. Women wore large skirts made out of *bayeta*, a black, heavy woven cloth; sweaters; a shawl; and a hat. The costumes dated from the conquest, and the hats were different in each region.
9. Traditional medicine was the most popular way to treat illnesses. Healers and midwives used plants, concoctions, massages, and incantations and divinations for most ailments physical and mental. Some healers and midwives introduced modern drugs to their treatment (injections) and referrals to health facilities.
10. The hot and cold theory is practiced in many regions of the world. Beliefs and practices in hot and cold theory are transmitted through enculturation and are associated with traditional medicine. The theory is based on the Greek humoral medicine of the four humors: black bile, yellow bile, phlegm, and blood. Over the centuries it has been modified to the hot and cold theory that also pertains to foods, herbs, medicines, and mental states. To be healthy one must maintain the balance between the opposite powers of hot and cold (Logan 1977).
11. In Markita during interviews women eighteen to fifty-four reported induced abortions, and some women had had multiple abortions.
12. Abortion was very popular; about one in every three pregnancies in the country was terminated through induced abortion (*Washington Post* 11/10/95: A24).
13. This study is based on the interviews of fifty-four couples; twelve couples were not using any type of contraception, twenty-seven were using unreliable or traditional methods, and fifteen were using modern methods (Maynard-Tucker 1986).
14. The belief that menstrual blood is dangerous to men's reproductive organs is also found in Africa, Asia, and Middle Eastern countries. In Africa some ethnic tribes such as the Lele, the Mbuti, and the Dogon have specific huts for women to live in during their period in order to avoid sexual contact with men.
15. This section and the following sections reproduce, with some modifications, material originally published in G. Maynard-Tucker, "Knowledge of Reproductive Physiology and Modern Contraceptives in Rural Peru," *Studies in Family Planning* 20, no. 4 (1989): 21–24. Permission to reprint has been granted by the Population Council and Wiley-Blackwell. The study is based on the interviews of seventy-five informants, thirty-six men and thirty-nine women who were asked to draw the female reproductive organs.

Chapter Three

Haiti

The Challenge

After completing my dissertation, I answered an ad from an international NGO looking for a research and evaluation advisor to work in Haiti on a family planning project sponsored by USAID. I got the position and lived in Haiti from 1989 to mid-1991. I took the position having no idea about the political situation of the country. It was the troubled years of Aristide's presidential election.

Haiti is located in the western part of the island of Hispaniola in the Caribbean. Its population in the 1990s was estimated at 6.5 million. The population growth was 2.1 percent annually, and about 70 percent of the Haitians lived in rural areas. The rate of illiteracy was about 85 percent, and in 1991 capita income was less than $400 US annually. Life expectancy at birth was fifty-five years, and women averaged 6.4 live births. The use of contraception was reported to be 6.6 percent among women and 8.5 percent among men (Cayemites et al. 1991: 20).

My position as research and evaluation advisor for an international NGO working in Haiti was my first step in development. I had some background on family planning programs delivery in Peru in the public sector, but I had no previous experience working in the private sector. The difference between the public and private sectors was that in the private sector patients had to pay a fee for the medical visit and the registration card given to patients. In Haiti this international NGO sponsored by USAID[1] was responsible for the family planning services implemented in hospitals, clinics, health posts, and CBS (community-based services), and my job was to evaluate the quality of the services and to improve them if possible.

THE BACKGROUND

When I first arrived in Port-au-Prince, I had to find a place to live, and I was surprised to see houses with heavy chain-link fencing over their balconies or terraces to discourage thieves. Port-au-Prince was a big, vibrant city divided into two parts: poor people living in slums like La Cite Soleil and rich people living in Pieton Ville far away from the center. I rented an apartment on the top floor of a house with a terrace that did not have any chain link so that I could enjoy looking at the view of the mountains on one side and the ocean on the other. The owners of the house, a middle-class Haitian family, lived downstairs with their three children. The husband was not working but practiced karate with his friends and was supported by his wife, who worked as a secretary. The house was encircled by iron gates and was located in Pieton Ville next to a slum. My office at the NGO was located several blocks from my apartment, and after many discussions with the office staff, the U.S. director of the project ordered the local staff to let me use one of their vehicles. The director of the project in Haiti was a doctor hired by the NGO because of his credentials as a gynecologist.

As I was getting used to my new work and the constant begging from adults and children in the streets, a murder was committed in front of the office. The NGO's offices were located in a house once owned by an elite family in a nice neighborhood of Pieton Ville. At that time Jean-Bertrand Aristide (a priest from the Salesian order) was running for the presidential elections. His political opponents, including the ex-president Baby Doc Duvalier's followers called the Tonton Macoutes, were fighting in the streets for their political goals. The victim was a well-dressed man in his late fifties who was killed by a bullet in the head. He lay bleeding outside the front door of the office. We called the police; however, they came hours later on a truck to verify the crime and to take away the victim. We were frightened to leave the office, thinking that the murderer was still around. That day I realized that in Haiti, there was no response from the Haitian police in case of emergency. The Haitian police force was small, had no cars except for an old truck, and public hospitals did not have any ambulance to respond to emergency calls. This incident obliged me to consider the safety problems associated with the conditions of living in a very troubled country.

FAMILY PLANNING SERVICES IN THE PRIVATE SECTOR

My work consisted of evaluating the delivery and quality of care of the family planning services in about fifty health facilities in Port-au-Prince and the countryside, and to give technical assistance to the Child Health Institute (CHI) for research projects. I reported to the director of the project in Haiti,

the director of the project in the United States, and also to the USAID Foreign Service officer in charge of the family planning program in Haiti. I started working in the Port-au-Prince health facilities and examined the interaction between doctors and patients,[2] the cleanliness of the facilities, medical staff's ways of handling the patients, the privacy of the patient during examination, and who made the choice of the contraceptives—promoters, doctors, or clients. I also checked doctors' medical material and stock of contraceptives. In the countryside I had a list of several clinics and health posts that I attempted to visit. Some of the clinics were getting between $30,000 and $50,000 US a year, a small fortune for Haiti. However, when I went to evaluate the services, some of the clinics were closed, and the inhabitants would tell me "the doctor moved and nobody is in charge." In one clinic, I found the place in complete abandonment with dog paw prints on the examination table. When I confronted the local director of the project with what I had discovered, he smiled and said that I was a fool to go to these facilities because most of them were closed, despite the fact that their names and locations were printed on the list of facilities getting paid for delivering the family planning program in the rural regions.

In some of the rural clinics, doctors did not have a table on which to put their instruments, and there were no beds for women to rest after a tubal ligation surgery. At that time, tubal ligation involved a small surgery and was dangerous because the women would travel by trucks to their villages on bumpy roads a few hours after the surgery. I was so upset knowing that the person in charge had received enough money to buy supplies for the clinics that I requested to look at the accounting book of one of the clinics. I found that the medical supplies were mentioned on paper as being ordered, but it wasn't clear if they had ever arrived at the facility. Obviously, the USAID officer was aware of my inquiries and my discoveries, but nothing changed. In addition, the director of the project who worked in his own gynecological clinic used to come to the office a few hours in the morning and would leave just in time to be at his clinic at 2 p.m. to see his patients (he was supposed to work until 5:00 p.m.). USAID was aware of it—they paid a person to spy on him, but they never confronted him or tried to replace him because the project would have to be stopped. If the project were to be stopped at its inception, the staff would become unemployed and the project would have to be put up for bid once more in Washington. Answering my inquiries as to why USAID would not take action, the officer replied, "This is impossible, it never happened."

THE GOOD AND THE BAD ABOUT FAMILY PLANNING

I had a contract for two years and was ready to learn and work in spite of the problems that I encountered in the office and during my stay. One success story was the hospital de Bienfaisance located in Pignon, which was owned by Dr. Guy Theodore and was sponsored by U.S. faith-based organizations. Pignon is situated north of Port-au-Prince sixty kilometers from Cap-Haïtien. Pignon is a rural community of about 33,000 inhabitants who are fortunate because they have good quality medical care and a working hospital. Dr. Theodore, a native of Pignon, went into the United States armed forces for a few years when he was younger and then returned to his native Pignon to help the people. He was always open to new ideas, and I could trust him because he was honest and was devoted to his patients. He knew how to talk to them and to treat them. He was offering family planning services in the hospital and was doing a great job. It was always a treat to visit him. His thirty years of dedication to his community was recognized by the international community when he got the 2008 Surgical Humanitarian Award given by the American College of Surgeons.

Rarely were the directors of the facilities involved in trying to help their patients, and the number of contraceptive users was a confirmation of their attitudes. For instance, one modest clinic located in the heart of Port-au-Prince received $150,000 US a year for the family planning program sponsored by USAID, and each time I visited the clinic it was empty of clients. The statistics reported that in 1990 the clinic had only ninety-eight users of modern contraceptives. At another clinic in La Cite Soleil, which had no clients, the promoter[3] would lie each time I asked how many clients she served. She would say one hundred women daily; however, during my random visits to the clinic, I never met a client. Some facilities that offered primary care were full of patients, but rare were the women who knew about family planning services, although the average children per woman was five in rural areas and four in urban areas. The attitude of the personnel at the health facilities was not friendly and did not encourage women to ask questions about the methods or to return to the clinic. The medical personnel usually did not greet the clients and would say nothing about the long wait to see the doctor. The surveys showed that the majority of men and women knew about contraception; however, very few were using it. The Demographic Health Survery (DHS) (1990) reported 13 percent contraceptive prevalence for the whole country.

CHILD HEALTH INSTITUTE

I also worked with the Institute de L'Enfance, or the CHI, which was a research center in charge of conducting surveys in various parts of Haiti about different topics, in particular the KAP survey of Knowledge, Attitudes and Practices of Contraception. My work as a technical advisor at the CHI comprised collaboration with Dr. Michel Cayemites, who was in charge of the research, and Dr. Augustin, who was the director. Together, we developed questionnaires in French and Kreol in order to evaluate the progress of the project. I would write the questions, and together we would discuss the goals of the questions. I also learned to speak and write Kreol so that I could write questions in that language. During data collection, Michel and I supervised the facilitators doing the interviews. The facilitators would then enter the data into a statistical program, and I would get the final data for analysis. I loved this part of my work, because it dealt with research and fieldwork, working with students and analyzing the results of the surveys. I have great memories of working with Michel Cayemites, Dr. Augustin, and the staff at the CHI.

The surveys were used to monitor the program and its impact on the use of contraceptive methods in rural and urban parts of Haiti. In some clinics and hospitals, the medical staff were trained to insert IUDs and Norplant, give injections of Depo-Provera, and perform tubal ligations and vasectomies. In rural areas, promoters distributed pills, condoms, and vaginal tablets. Depending on the institution, clients had to pay a small fee for a registration card, doctor's examination, and lab tests. Although the fees were minimal, it was always too expensive for their means. Men were not ready for the vasectomy, they did not understand the surgery, and were scared, but they wanted condoms. The program was giving twenty-five condoms per month to each male client who came to the facilities, and many would come back before the end of the month asking for more. They would say, "I have a wife and girlfriends and also I visit prostitutes, I need more condoms." In 1990, the USAID program distributed nine million condoms, and the results of the survey a year later showed that less than 4 percent of the men were using condoms. Where did the condoms go? A few months after the survey, there were rumors that the condoms were collected by a local gang and were shipped to other Caribbean islands, to be sold for profit.

QUALITY OF CARE OF THE SERVICES

Women would use contraceptives for a while, then would discontinue, usually after six months.[4] Major reasons for discontinuation were side effects, wanting another child, method failure, or refusing to switch to temporary

methods when a shortage of hormonal injections occurred. Long waits to see the doctor, in addition to the deficiencies in the quality of care of the services, caused many Haitians who wanted to control their family size to ignore, discontinue, and turn away from modern contraception. The delivery of family planning services was plagued by the medical staffs' rude attitude toward the clients during counseling; promoters' attitudes were detached, bored, authoritarian, hasty, and sometimes nasty (Maternowska 2006: 83; Maynard-Tucker 1994). Information given about the methods was not adequate. Promoters would not offer the whole range of methods and would forget to mention side effects or contraindications of the methods. Often the promoters would give their own negative opinions of the methods. Usually, the choice of the methods was made by the doctors or the promoters, and when women would come out of the services, they were not sure how the methods work and what side effects to expect (Maternowska 2006: 85; Maynard-Tucker 1994). When I confronted the doctors about choosing the methods for the clients, they replied that they knew best because the women were mostly nonliterate and could not understand the modes of action of contraceptives nor the side effects. This is the reason they recommended the use of tubal ligation for women with five or more children.

It took me a few months to find out that the women were willing to use contraception, but one main problem was the behavior of the medical staff (doctors, nurses, and promoters), which was not conducive to trust and/or establishing friendly ties with the client. Many times, I observed the rude behavior of the medical staff while I was accompanying potential clients to the facilities. Many women were nonliterate and came from rural areas; the medical staff was educated and did not like to deal with the rural population. Here again, there was a problem of communication between promoters and clients. It was very difficult for the women/clients to understand how the methods worked or why they would get side effects of the methods. A major problem with hormonal contraception was the infrequency and altered flow of their menstrual period (Maternowska 2006: 91; Maynard-Tucker 1994). The majority of the rural women had no schooling and were shy. They did not understand the medical staff's explanations about side effects, and because the staff was not friendly, they would not dare ask questions, feeling that they might be mocked. Many women used illegal abortions by doctors and traditional healers or midwives to end unwanted pregnancies, despite Haiti's tough laws on abortions. About 7 percent of pregnancies are ended by abortion (Population Research Institute 2003).

THE MYSTERY CLIENT

This unmet need for contraception led me to develop a process called "the mystery client" in order to monitor and improve the quality of the services. It was mainly based on the story of Marie, a rural woman whom I met during an excursion with some friends in the mountains near Port-au-Prince. Marie was thirty-eight years old; she had four years of schooling and was married with nine children, ranging from three to eighteen years old. She had ten pregnancies, but one child died in infancy. Her husband left her for a younger woman and did not support the children; however, he would come back irregularly and asked for "*Kontact*" (sexual relations). She was afraid to get pregnant again, so she decided to use the injection of Depo-Provera, but at every clinic we visited the medical staff wanted her to be sterilized, because she was too old to safely take the Depo-Provera. When we visited the health facilities and she requested a contraceptive method, the doctor would say, "You had ten children, that is too many children, the only method for you is the tubal ligation." She did not want the tubal ligation because she was afraid of the surgery and not being able to take care of the children after the surgery. At that time Depo-Provera was only given to women under the age of thirty-five years old because promoters would say "after thirty-five years of age women have high blood pressure; therefore, Depo-Provera would be harmful." She was disappointed because she could not get the method she wanted, so I decided to accompany her to the facilities and observed the interaction between medical staff and Marie. Upon my return to the office, I would comment about the rudeness and the lack of interest of the medical staff toward Marie to my coworkers, and they would say, "You must do something about it; why not use Marie as a simulated client?"

This led me to develop and organize a procedure to monitor the interaction between the medical staff and the clients for the USAID program, based on Haitian women's perceptions of the quality of care. I trained three women to be mystery clients and to visit the facilities. After their visits and during a subsequent debriefing I recorded their observations. I also developed a quantitative ranking scale for the purpose of evaluating the services in hospitals, clinics, and health posts. Directors of the facilities received a letter from the director of the project telling them that simulated clients will observe their services and will report to the office of the NGO. Many directors of the facilities did not believe the letter and were surprised when confronted by reports of the poor quality of care of their services at the next meeting. After an initial training with women who would act as simulated clients, I sent them alone to various facilities to play the role of client and observe the attitudes of the medical staff. One "mystery client" had nine children, the other had two children, and the third was a single woman. All of them were in their thirties, wanted to use modern contraceptives, and also wanted to

help improve the services. Results of their inquiries[5] pointed at three major determinants to the quality of care: (1) the environment related to the cleanliness, comfort, convenience, and access to the facilities; (2) the interaction between medical staff and clients related to staff attitudes, information provided, and the way it was delivered; and (3) competence of the staff related to explanations provided to clients, knowledge, and training. The major barriers were in order of priorities; the long wait in all the facilities, the promoter-client interaction, quality of information given to client, technical competence, promoter's training (comfort, cleanliness, requirements, imposed choice, convenience), accessibility, cost, and limited service delivery (Maynard-Tucker 1994). These findings were important along with the observations of the lack of greeting when the client arrived and the lack of privacy when explanations were given. In general, the health facilities were not clean, the floors and walls were dirty, the benches in the waiting rooms were broken, and the person who registered the clients was not friendly. In addition, during the visit women often did not have any privacy because there were no curtains or private space for patients to be seen.

These deficiencies were reported to the directors of the facilities during private meetings. At first they were on the defensive, blaming everyone for the lack of quality of care; however, they agreed that there were problems with promoter-client interaction and the training of promoters. Finally, they found that the detailed information provided by the mystery clients was helpful for better supervision of the staff and monitoring of their services.

Some of the advantages of the method were that it was replicable;[6] it did not disturb the work routine of the medical staff; and it allowed the native women and men to give their opinions of the services. Direct observations yielded rapid results and permitted frequent recommendations and follow-up. Moreover, the method did not require a large number of personnel (one person in charge and three or four mystery clients), extensive training of personnel, nor financial investment. In addition, because different women observed the same institution during a period of five weeks, data reliability was assessed. Also, observations were based on the women's perspective of quality of care and not imposed by Western notions of acceptability. I would retrain the mystery clients every five weeks with role-playing, and they became quite good at their jobs. They were paid $6 US for each visit.

EVALUATING THE CONDITIONS OF THE CLINICS IN RURAL AREAS

While I was working on the development of the "mystery client" procedure, I also visited the rural facilities in order to evaluate the impact of the program.

One day in June, I left with the chauffeur and Marie to evaluate the services in four clinics in the north of Haiti. During the first visit in the community of Arcahaie we found a little house that was supposed to be the clinic, but we could see no one inside and found only some clothes and a table that was used as the doctor's desk. The doctor was only working at the clinic on Saturday from 9:30 a.m. to 1:00 p.m. In the room reserved for family planning there was an old gynecological table against the wall, covered with dust, while another table held two boxes full of patients' files. In the hall there was a sewing machine and pieces of cloth everywhere. Marie was disgusted and said coming out of the clinic, "It is impossible that a doctor comes to such a dirty place."

We went then to the Montrouis clinic, where the facility was very busy. Patients were waiting to be seen by the doctor, but we did not know who was there for family planning because the services were integrated with primary care. Nevertheless, the registration fee of 2.50 *gourdes* (Haitian money) in order to see the doctor was quite high for a rural community. We then drove to a community in the vicinity of Gonaïves looking for the clinic in Gran Mont. The trip was horrific on a cobblestone road with a violent rain beating down on the car. In Gran Mont we looked for the clinic but could not find it. Apparently, it had been relocated somewhere on the road to Gonaïves. As we left Gran Mont under a relentless rain, the right front tire of the SUV blew out and the car went into a spill down in a field, hit an electrical pole that fell on the roof of the car, and finally stopped on the road. At the same time children were coming out of school and the car brushed against three children during its crazy course. During this ordeal the driver lost control of the car and did not even try to use his brakes. I saw that he was stunned and I tried to reach the brakes but could not because I had the security belt on that saved my life. When the car finally stopped in the middle of the village, everyone came out ready to kill us with machetes and threw stones at the car. Marie was sitting in the backseat and was calling on all the Catholic saints and the Voodoo *Loas* (deities) for divine intervention with loud prayers (Metraux 1989). I knew that if the children were injured, we would be killed. Villagers screamed, "La blanche come out," showing me the machetes. After a while, the chauffeur decided to get out and change the tire. They assaulted him, but he was able to change the tire. I was locked in the car with Marie and also praying for divine intervention. About one hour after the accident, the schoolteacher came to talk to me and asked me to take one of the children to the hospital because she had a bruise on her arm; the other two children were okay. We agreed and took the girl, about twelve years old, accompanied by the schoolteacher to the hospital for X-rays.

However, our ordeal was not finished. Coming out of the hospital, the judge, his secretary, and the doctor asked us for $170 US, and the judge told me that if I did not have the money he would throw me in prison. The normal

price for an X-ray was between $10 and $15. I only had $20 US and the chauffeur $10 US. I asked the local doctor for help. We were lucky that his clinic was part of the project sponsored by USAID. He quickly lent us the money. I had visited the prison in Port-au-Prince and it was horrific: people were piled in small rooms with no food unless their family brought the food daily. There was no sanitation, and people were treated worse than cattle. Back at the office, I was confronted by the local director of the project, who wanted me to stop my visits to the rural communities, and the USAID officer, who did not want to get involved. I did not stop going to the rural communities because it was my job to evaluate the program in these facilities, but I learned that these experiences were invaluable to understand the infrastructure of development and the role of the actors.

VOODOO RITUAL

What was very obvious when I arrived in Haiti was that Haitians were open about their sexuality and were not ashamed to talk about it. Women would talk openly about their sexual relations, and men were always talking about their wives, girlfriends, and the prostitutes they visited. I had a friend who was the owner of a factory, educated and well off, who was also married with children and confided to me that he visited a brothel in Port-au-Prince weekly. I asked him if he was practicing "safe sex" and he said no, because he would always go to the same woman and therefore trusted her.

One day, he took me to a Voodoo temple for a ceremony. He made his way to several temples until he found one located on a hill in a poor section of Port-au-Prince. It was a stadium with a roof that contained about five hundred to seven hundred people. In the center of the arena there was a pole with flags, and on the walls there were designs of the *Loas* (spirits that mediate with *Bondye* [God]). On the right side of the arena the drummers, dancers, and the *hougan* (priest) and *mambo* (priestess) were standing, balancing themselves on one foot with the rhythm of the drums. My friend requested two chairs in the front row. He paid for each of his requests. We were close to the actors, and I could observe their behaviors. The first part of the ritual was to call on the *Loas* (spirits), and for that purpose they used the drums and the dancers. Twelve women were dancing dressed in white with white sandals and their hair covered with a white scarf. They were drinking *klaret* (rum) and getting drunk while singing, and every so often voicing a sharp scream in the middle of their song. They moved their hips in a circle, and they were very sensual about their dancing. The crowd was moving like a wave with the drum, waiting for a dancer to become possessed by a *Loa.* The *mambo* was a woman in her fifties; she was drinking and dancing but was wearing a white outfit with a black scarf on her head to differentiate her

from the dancers. The *hougan*, a young man in his twenties, had a bottle full of a white liquid that he sprayed on the crowd (like a benediction). He then grabbed a bottle of *klaret* to drink and spilled some on the ground at various locations east, west, south, and north where the *Loas* were supposed to be. The women interrupted their dances and kissed the ground where the *klare*t was spilled. Very soon, one woman became possessed and started to tremble, moaning, and was contorting her body. The *mambo* started playing a type of maracas over her head in order to help her fall into a possessed state. She fell to the ground, her eyes closed, and started to walk barefoot but could not do so. She fell into the arms of the women who were around her, who watched over her so that she would not hurt herself during this ordeal. Several other women became possessed and fell into the arms of the dancers. The show went on for a long time until the *hougan* went around with a red scarf and put it on the shoulders of the possessed women, who quickly returned to their normal state and sat down calmly. I was puzzled by the ceremony, because I was not sure if the possession by the *Loas* was real or if they were playing an expected role in order to entertain the crowd. Nevertheless, women were the main actors and were the ones that received the *Loas* with the help of the *hougan.* The crowd loved it and became excited as the ceremony went on. I suspected that the spectators were drinking *klaret* too. The Voodoo religion is an amalgamation of West African practices by several tribes, the Fon and Ewe, the Yoruba, Bakongo, and Taino, and Catholicism along with some elements of Freemasonry. *Hougans* are very popular, and they serve all levels of the society. I had some affluent and educated friends who were Catholic, went to mass on Sunday, but also visited *hougans* for small ailments and good fortune and assisted at Voodoo rituals.[7] In Haiti, Voodoo is integrated in the society and the culture much more than Catholicism.

MALES' DOUBLE STANDARD

In comparison to the Quechuas, the Haitian women's status revealed that they had more sexual and physical independence than the Quechuas, although both cultures were patriarchal and men were often violent with their partners. Haitian women are very strong and are more independent than the Quechua women. They are not tied to the children because they live with the extended family, or have their older children taking care of the young ones. The young girls are well dressed, sometimes better than the boys. Girls are not brought up servile like in the Quechua culture, and some of them become Madam Sarahs, a colloquialism for independent women who travel within Haiti and sometimes outside of the country to buy produce and resell it for profit. Madam Sarah can be a large-scale business or a small one, depending on the woman's investment at the inception.

In both cultures, women thought they had too many children and men were not always responsible for the children because of labor migration and the loose type of monogamous commitments. Marie's ex-husband characterized the looseness of the unions in Haiti. He married (in a type of union called *Plasaj*, a common-law marital relationship)[8] Marie when she was sixteen years old and pregnant with his first child; she then had nine children. He was not always faithful and had many sexual relationships in addition to Marie. He left her for good after her tenth child was born, for a younger woman with whom he fathered one child. In addition he fathered seven other children with three other women during casual encounters. In total, by the age of thirty-five, he had produced eighteen children by five different women. He was supporting only the last woman and their daughter.

In Haiti, the person who helped me clean the apartment was a man in his late forties called Meridian. He was highly recommended by the owners of the apartment and was in marital union with seven wives. Each time I needed him because I was experiencing an attempted robbery at night, he was absent. Because my terrace did not have any chain links, robbers would climb the terrace in the middle of the night. I would hear them and I would call Meridian for help because he had a room in the basement of the house. But Meridian was nowhere to be found. During those robbery attempts that happened monthly, the owner of the house would usually use his gun and shoot in the air to scare the robbers. Months later, we learned that it was a gang in the nearby slum areas who were robbing everybody. The gang was eventually caught and beaten to death by the people living in the slums because they were robbed as well.

After one of those dreadful nights, I asked Meridian where he had been and why he did not answer my distress calls. He explained that at night he was usually visiting one of his seven wives and children. He had fathered twenty children.

WOMEN IN PERDITION

Haitians say "*ti moun se riches*" (children are wealth). Haitian women who have difficulty getting pregnant, or who have only one or two children, can claim that they are in *pedisyon* (perdition). The state of perdition means losing blood from the uterus. Women say that they are pregnant, but the child does not want to be born (Coreil et al. 1996). This condition can last for months or years and is an explanation for involuntary infertility. Women explain that they bleed every month because the uterus does not want to feed the child (although the bleeding is usually longer than menstruation). Being in *pedisyon* is a strategy women use to excuse their low fecundity: data show that most women who claimed to be in perdition had a below-average num-

ber of children, and it can happen to any woman. For a Haitian woman there is almost nothing worse than being sterile. It is said that sterile women are cursed by black magic. Having a low reproductive capacity is also a curse. *Pedisyon* is often a diagnosis attributed by a woman and her relatives and permits women to claim that they are pregnant and also gives them the freedom to attribute the paternity to past or recent partners (Murray 1976). This culture-bound syndrome shows that in the Haitian society being fertile was an important asset for a woman.

SOCIAL AND ECONOMIC INEQUITIES

In both Peruvian and Haitian societies the gap between the elite and the poor was enormous. In Lima my rich friends could not understand why I wanted to live with the Quechua Indians. They did not know anything about their ancestral culture and were part of the jet set, going to Paris on the weekend for shopping. They lived in a mansion with several Indian domestics. In Haiti, the elite usually lived in mansions surrounded by high walls and a guard at the gate with a rifle. However, depending on the whims of the political situation, the elite's mansions could be uprooted (*dechoukaj*) at any time. This type of violence was popular in Haiti when the populace wanted to take revenge on their oppressors characterized by the political elite, political opponents, and the Tonton Macoutes (Duvalier's followers). During *dechoukaj* the angry crowd took over the property by stealing furniture, appliances, doors, windows, electric outlets, tiles, and so on. Once the *dechoukaj* is finished, there are only the walls standing if the house is not burned. Art objects are sold for a few *gourdes* (lower denomination of Haitian money) because people do not know the value of the art objects and need instant cash. Obviously, the police never interfered in those situations. The owner of my apartment told me that he made some good deals hanging around houses that were going through a *dechoukaj* and buying the stolen goods for a few *gourdes*.

In Haiti, the elite spoke perfect French and also were part of the jet set; they traveled to Paris, New York, and Miami, where they owned houses. Most of the doctors I encountered attended the Faculté de Medicine in Paris and traveled widely. The elite were a solid group and were united in their goals of exploiting the resources of the island. They usually owned land and/or manufactured/assembled goods to export to the United States or other developed countries. Those factories used the labor of the Haitians but paid them very little. I remember doing a KAP survey in one of those factories where women assembled clothes all day long with sewing machines a few inches apart. This slave work only permitted the women to survive day by day. Although many wanted to control their pregnancies, they did not have

any money to buy contraceptives or to register at the health facilities. The money produced in those firms was not reinvested in Haiti, but was deposited in Europe or in U.S. banks. Low taxes for the elite and major corruption are the reasons Haiti cannot shake its poverty spell.

POLITICAL TURMOIL

I was in Haiti during the election of Jean-Bertrand Aristide in 1991 that promoted so much hope for the people living on the edge of survival. However, his political opponents did not give him time to prove himself, and six months later he was facing a military coup d'état led by army general Raoul Cédras; Philippe Biamby, army chief of staff; and Michel François, chief of the national police. It was alleged that Aristide's actions against drug smuggling might have contributed to his political failure. During the military regime of Raoul Cédras that lasted until 1994, the United States and the Organization of American States (OAS) imposed a diplomatic, economic, and financial embargo that crippled Haiti and affected people's health and nutrition (Farmer et al. 2003). Although the embargo's goal was to oppose the military regime, it did not reach its goals but instead affected poor rural populations, women who were heads of households and unskilled factory workers. In Haiti's assembly industries 29,750 workers lost their jobs (Gibbons and Garfield 1999). People ate one meal a day or every other day because shipments of food did not arrive and the local production of food declined by 25 percent due to shortage of seeds and fertilizers. Children suffered more than adults because of protein deficiencies represented by kwashiorkor (pigmentation of the hair and skin, bloated belly, and stunted growth), and pregnant women suffered from malnutrition and anemia, all of which were due to a lack of macronutrient intake.

THE U.S. EMBARGO OF 1991–1994

I left the island in 1991 and worked as a freelance international consultant evaluating various programs in developing countries. In 1995, I had the opportunity to return to Haiti for a short-term consultancy about macronutrient intake in a mountainous community called Mont Organisé in the municipality of Ouanaminthe in the northeast department of Haiti. The program, sponsored by USAID, was distributing vitamin A for people who were affected by xerophthalmia (a dry eye condition) and also distributed iron pills for pregnant anemic women. The goals were to evaluate the program and to report about the need of the people. I was happy to return to Haiti to see my friends, and I was anxious to find out if the embargo had once again added to their life burden.

The trip to Mont Organisé turned out to be very difficult because there were no roads and the chauffeur had to drive through rivers and mountain paths. When I arrived, I realized that the whole community was suffering from the embargo. They had not received the seeds and the fertilizers for their crops for the last two years; therefore, they could not produce any crops and they ate all the seeds left for crop plants. The situation was horrific. In addition inhabitants had cut most of their fruit trees for fuel because they did not have any kerosene with which to cook. The worst part was that I was supposed to inquire about their daily food intake, and my questionnaires[9] were filled with questions related to food and the type of seeds they needed for their future crops. I felt horrible and was really mad at myself for accepting this consultancy.

Most of the children exhibited the symptoms of kwashiorkor in addition to xerophthalmia (locally called *ye de poul*, chicken's eyes), often caused by vitamin A deficiency and malnutrition. Pregnant women were anemic, which is culturally understood as a lack of blood (*manke san*) in the body. The macronutrient program was distributing vitamin A, along with some iron pills for pregnant women. Infants were born underweight, and two-thirds of the population exhibited goiters so large they reached their chest. Goiter is the enlargement of the thyroid gland and is usually not cancerous. Goiters are painless, but if they are very large, patients might have problems swallowing properly and might have an associated cough. People were very conscious of their goiters and asked for a cure. Culturally, the explanation for having a goiter was related to a fright, or was blamed on carrying heavy loads. Most of the goiters were caused by a lack of iodine in the ground and in the salt. Inhabitants were using rock salt that was cheaper than the import salt, but this salt did not have any iodine. In addition, they did not have the money to buy the imported salt with iodine at the market located several miles away, nor did they have the money for the trip to the market. The program was not involved in curing individuals with goiters, and I was very frustrated because I could not help them.

The population was starving, and the fact that I had to ask questions about food was deleterious; they would say they drink tea with bread or anything that was edible. Parents were aware of the type of food they should give to their children, and during the inquiry they mentioned several fruits and vegetables (okra, mango, chayote). However, since the embargo, they were not able to work the fields and they had no seed to grow produce. Due to their lack of cash to buy food, they ate mostly rice with *catalou gumbo* (a vegetable) on a daily basis. They did not understand why the medical staff asked them to take pills instead of giving them food. Also, the medical staff did not understand why pregnant women would not come back to the hospital for another supply of pills. Instead many went to the traditional healer for their health problems such as xerophthalmia, anemia, and kwashiorkor.

The health promoters were not well trained and could not explain the reasons for the goiter and the benefits of the vitamin A and iron pills. At that time there was an epidemic of measles in the country and a lack of vaccines because of the shortage of electricity and gasoline for transportation caused by the embargo. Therefore, when they were sick, the population would seek help from the traditional healer, but if the sickness persisted they would go to the hospital.

One day I was interviewing a nurse in the hospital about her knowledge of macronutrients, asking her what she recommended for the feeding of infants and children on a daily basis. After the interviews she brought me a little boy about seven years old. His hair was blond; he had a bloated belly and his skin was gray. He was extremely skinny and small; his eyes were rolling without focus. He had all the symptoms of kwashiorkor, and he was dying while standing up in front of me. I asked the nurse to call his grandmother, and I gave her all my money so she could buy some food for the child. I asked her to take the bus and go to the market, but I am not sure she did it. The parents had a large family, nine children, and could not feed them all. They gave this child to the grandmother knowing that his condition was very serious. I was desperate, because the medical personnel told me that they could not do anything for him because his advanced state of kwashiorkor was irreversible. Over the years I witnessed so many sad and uncontrollable situations, but this one was one of the hardest during my career.

LESSONS LEARNED?

Fertility seemed to be a cultural asset for a woman, and women used it to their own advantage depending on their marital and economic situation. If they felt that they had a good man, they would not mind getting pregnant. But if they knew that their partner was unstable, drinking, and womanizing, they would use contraception—modern or traditional or abortions. Poor women wanted to control their fertility and their family size with the use of contraception, but they were facing the same constraints as the Quechua Indian women: poor quality of care, erroneous gossip about side effects, not understanding the medical staff explanations, difficult access to health facilities, high fees for visits and lab tests, rude attitude from the medical staff, lack of choice of methods, and lack of access to successful users and the health facilities. The commonalities of the barriers to the use of contraception seemed to be universal, as I found the same problems confronting women in various countries.

In Haiti, I experienced for the first time the problem of corruption that exists in various countries. I was dedicated to my work and realized that I could not change the structure of corruption that spread through the projects.

I worked with it, trying to take care of the main programmatic problems. I became more secure about my decisions and acquired a huge amount of experience that served me for the rest of my consulting life. The time I spent working in Haiti expanded my knowledge of applied anthropology, my knowledge of development, and how to deal with donors, NGOs, and the women/informants. I realized that the donors represented a rigid bureaucracy and that if the NGOs are at times more flexible, they are not independent from donors because they need funding.

The next chapter relates the years I spent as an international[10] consultant in various countries and the experiences I acquired dealing with short-term consultancies. This requires conducting research/evaluation of a program in a few weeks rather than a year and the development of a strategic improvement plan for programmatic changes that are feasible for donors, local governments, and most of all for the beneficiaries. I was soon on my way to Africa.

NOTES

1. USAID, United States Aid in Development, was the donor agency. This international NGO had successfully won the bid proposed by USAID, which had a mission (office) in Haiti and officers in charge of the supervision of the project.

2. I use interchangeably the words *clients* and *patients* to refer to the women who used the facilities for getting contraceptive methods. Women were patients when they needed sterilization or insertion of Norplant and when they were examined by physicians.

3. Promoters are trained individuals who promote health education awareness such as nutrition and drug uses and misuses, including family planning and HIV prevention, depending on the goals of the program. They are the keys to a well-performing program.

4. Data are based on survey results of the CHI (1990). The survey was a two-stage cluster sample of ninety-four census districts of the whole nation based on interviews of women in the age groups fifteen to forty-nine years. The highest use of contraception, 16 percent, was among women thirty to thirty-nine years of age.

5. Data reported here are based on one year of observations (from April 1990 to April 1991) of fourteen institutions, including hospitals, clinics, and health posts, most of them private voluntary organizations (PVOs) for service delivery. They were observed on a monthly and rotating basis by mystery clients. Institutions were located in Port-au-Prince and its vicinity (G. Maynard-Tucker, "Indigenous Perceptions and Quality of Care of Family Planning Services in Haiti," *Health Policy and Planning* 9, no. 3 (1994): 300–317.

6. Research on the Internet shows that the "mystery client" procedures are now widely used in various countries for evaluating and monitoring health-care services.

7. Voodoo is also a type of health system that people use for ailments. *Hougans* (Voodoo priests and healers) treat with herbs, rituals, massages, and incantations and refer patients for biomedical treatments (Kirmayer 2010).

8. *Plasaj*, or *viv'avek* (living with), is not recognized as legitimate marriage, but in rural and among lower-class communities these relationships are considered normal and accepted within the society. *Plasaj* also refer to a system in which a man may have several common-law wives and is expected to provide for them and the children (Allman 1980).

9. Findings are based on the answers to twenty-two questionnaires and six home observations of food preparation and feeding practice (Technical Assistance for Qualitative Research Concerning Formative KAP Study Inquiring into Parents and Health Providers' Behavior toward the Use of Micronutrients in the Northeast Region of Haiti, OMNI/CDS/USAID 1995).

10. From 1991 to 2011, I worked as a short term (freelance) consultant in Africa, Asia, Latin America, the Caribbean, and India. The work and the methods were different and gave me additional experiences concerning the evaluations of programs.

Chapter Four

Africa

Women's Conditions

This chapter examines women's conditions in several countries of Africa and uses vignettes (based on fieldwork during evaluation of projects) that illustrate cultural customs and reports on traditions such as female genital mutilation (FGM), customary law, levirate, prearranged marriage, violence against women, and HIV discrimination. Because the HIV epidemic is also related to women's conditions, the following gives some perspective of the HIV impact and statistics that are forever changing (see Pisani 2008).

AIDS (acquired immune deficiency syndrome) is an infection with a retrovirus called HIV or human immunodeficiency virus.[1] During a process not clearly understood, HIV infects the CD4+ cells, or T-helper cells of the immune system. The virus appears to have originated in the 1930s in Africa when chimpanzee hunters became infected by simian immunodeficiency virus (SIV). In the United States it was first identified in the 1980s from reports of opportunistic illnesses caused by an unknown agent. How the epidemic spread from the 1930s to the 1980s, when it became obvious that we were facing a new virus, is difficult to trace and is not yet resolved, despite many theories. The spread of the epidemic has obliged local governments, donors, and the international community to carefully examine the medical assistance and the sociopolitical, economic, cultural, and environmental problems of each country in order to prevent and fight the spread of the virus.

The statistics about HIV/AIDS estimated that in 2011, 34 million people were living with HIV/AIDS, while 3.4 million of them were under the age of fifteen. Also, 1.7 million people died from AIDS, 230,000 of whom were under the age of fifteen. Since the beginning of the epidemic, more than 60

million people have contracted HIV and 30 million have died of HIV-related causes (UNAIDS 2008).

How does HIV affect countries and people who must deal with the virus? First, there is a reduction of life expectancy, such as in sub-Saharan countries where life expectancy is now fifty-two years for both sexes. Sickness brings an enormous stress on the household and the family, especially if the income earner dies, or both parents die, resulting in children being taken care of by the extended family. There is also less productivity because the majority contracting HIV are in the workforce, between sixteen and fifty years old. This affects the agricultural industries and the health systems because of lack of human resources. Finally, the enormous stress on the health systems cannot be overstated because of greater demand for health care, lack of local funds for treatment, and lack of human and material resources.

By the end of 2010 it was estimated that out of 34 million adults living with HIV/AIDS, half were women. Because of their physiology, women are more likely to get infected, especially if they do not use safe sex and/or are unable to negotiate condom use with their partners. In addition many women are subjected to nonconsensual sex. There are more women infected with HIV/AIDS (12 million) than men (8.3 million) (UNAIDS 2008), yet prevention programs have not developed specific information for women, especially rural, nonliterate women, and governments do not take a legal stand against nonconsensual sex. Therefore, the problem remains.

CULTURAL CUSTOMS

In many parts of Africa, depending on the ethnicity and religious tenets, girls will go through genital mutilation (clipping the clitoris and/or the labia superior called infibulation). The World Health Organization (WHO) estimates that 130 million girls have undergone one of these procedures globally. Outlawed by most governments, those customs are still practiced in Asia, sub-Saharan Africa, and the Middle East. Here again, girls have no say about the violent ceremony and are expected to participate fully. The ritual endangers women's reproductive health during delivery and also reminds women that sex is only for the pleasure of men. For the few who do not conform to the customs, the family and the community reject them. In addition, girls represent an asset at marriage and are exchanged for cattle or sheep. Based on the practice of arranged marriage at an early age, and depending on her tribe affiliation, a girl will never be able to decide about her future. In the event that her husband dies, she will have to assume the custom of levirate, where she becomes the wife of her husband's brother. On the other hand if she is single and her married sister dies, she will become the wife of her dead sister's husband. These customs are based on inheritance laws that favor

males and in case of death leave the woman without recourse but to join the in-laws.

> *I remember that while I was evaluating a clinic in Guinea, Aisha (a client) was telling me that she needed a contraceptive method. She had lost her husband, was thirty-six years old with three children, and under the levirate law was now one of the wives of her much younger brother-in-law. She was not pleased with the arrangement and did not want any more children. Aisha's young husband wanted her to reproduce, hoping to get a boy, because his two wives had given him only daughters. She also did not have any education or skills to find a job in order to live independently.*[2]

CUSTOMARY LAW

In most African countries 70 percent to 80 percent of farmers are women but are denied land tenure based on cultural norms and values in which the land is inherited through the males or is allocated by the headman of the community. Customary law is the indigenous law of various ethnic groups of Africa; however, there are variations, depending on the group. It was reported that the group village headman of Chakoma in northern Malawi during an interview said, "I never knew that women also had the right to own land because according to our culture a woman is supposed to use her husband's land" (Potani 2012). Those values are reinforced through customary law and through gender inequality. Men secure their authority with violence, decision making, and economic contribution to the household. Worst off are widows and divorced women who have to support children with no help from their kin and no legal help for financial support from the fathers. In some countries men are supposed to maintain their families after a divorce, but they usually do not.

Overall the land tenure in Africa belongs to the males, and for most parts of Africa the customary law places women as inferior to men. Women's status is rooted in the cultural context of each ethnic society, and the customary law is there to emphasize women's subservience and low status. In addition, marriage reinforces succession and inheritance and traditional authority through the male lines. It lacks specific rules dealing with domestic violence because violence is understood as a private issue. In some situations, customary law is used conjointly with English laws; for example, educated Africans are now contracting marriages under the statutory English law, because it gives more equality to the sexes and women have more rights.

> *In Senegal, I met Sidonie, who told me her story while waiting for her visit at the clinic. Her husband beat her up almost every night when he was drunk. She ran away with her two children, a son, five years old, and a daughter, two*

years old. Her husband found her and was able to get the children legally because she was married under the customary law.[3]

RAISING GIRLS

In most rural parts of the developing countries a girl's life starts with an unmet need for education. Boys are sent to school, and they usually learn a trade to become self-sufficient. In rural areas, girls are rarely sent to school because they have to assume the household responsibilities with their mothers. Or if they are attending primary school, many are pulled out because they must work as domestics or merchants or take care of siblings while their parents are working (UN 2010). Girls grow up identifying themselves with their mothers' subservient role and status. Cultural norms and religious upbringing in many countries favor men's role and status, usually associated with men's sociopolitical and economic input along with decision making. Most men have more freedom and are more educated than women. They represent power and authority and are the decision makers. On the other hand, women are brought up to be dependent on men for survival; they are not used to making decisions because it is usually the father or the husband who decides. In rural areas women's role and status are unchanged; their status is lower than men's because they lack economic independence, self-esteem, schooling, and skills to become equal to men.

With globalization, those gender roles are slowly eroding because of economic stress, labor migration (male and female), urbanization, and the change to the nucleus family. This modern/urban world has become full of violence for women who cannot read or write. Immersed in an urban city without help from kin, their survival objective is to make enough daily cash to survive. In doing so they are limited to reselling food or produce at markets or in the streets for very little money or to embracing prostitution.

Kidou in Madagascar left her village because she did not want to be married to the suitor chosen by her father. She has no schooling, came to Antananarivo to find work, and became a domestic. The man of the house abused her, and she left. A girlfriend working as a prostitute in a bar convinced her that she should join her.[4]

WOMEN AND WORK

Professional women live in urban cities, have a career, and some of them work the political arena with men. In Morocco, I met women who were ministers and had no idea about the lack of power of rural women. Women's associations based in cities mostly focus on helping urban women against domestic violence and know their rights. I have rarely found local women's

associations working in rural regions of the world, except NGOs. In rural and semirural African communities, the majority of women have no skills to get jobs. They usually work the land for no money, because what they produce goes to their in-laws or husbands. If they live in urban areas, they usually work as domestics or resell food or produce at markets or in the streets. If they are married, the husband supplies most of the needs of the family, but if partners or husbands abandoned them, their daily earnings barely covers the family's needs. Women represent 70 percent of the world poor, and even if they have a profession, there is discrimination. Women's salaries are usually 17 percent lower than men's salaries (UN 2010).

> *In Dakar (Senegal), late afternoon on the main street, it is common to see secretaries or young women who work in offices supplementing their salaries with informal prostitution after work. These women walk certain areas of the main street waiting for clients who drive by.*[5]

MARRIAGE

Depending on the ethnic society, young girls in Africa go through child marriage arranged by parents along with an exchange of bride wealth. Young girls are married to older men and become part of polygamous unions. There are numerous stories of sexual and physical violence administered by the mother-in-law, the jealous wives, and the old husband. Girls are seen as assets in cultures that demand bride wealth. Girls are often married in their teens to older men and become the servant of the mother-in-law, or the older wives. Girls as young as nine years old are married to older men due to religious, economic, and cultural reasons (Ponticelli 2005). If the girl gets pregnant, she risks dying during childbirth or living with disabling injuries from childbirth complications such as vaginal or rectovaginal fistula because she was too young to reproduce (UN 2010; UNICEF 2001; Nour 2006). If unhappy, she might run back home, to be admonished by her father about her lack of love for her family because they will have to reimburse the bride price. Do Espirito Santo and Etheredge (2004: 141) reported that many women decide to embrace sex work because of forced or arranged marriages, divorce, supporting the family, and/or greed. The authors write, "Forced and arranged marriages are at the origin of much recourse to prostitution for young women." This is the story of many women who found themselves selling sex (Ebin 2000; Do Espirito Santo and Etheredge 2004; Renaud 1997).

> *Soya escaped from her family at fifteen years old because she did not want to marry the suitor chosen by her family, a man fifty-five years old with two wives. She went to her aunt, who lives in an urban center, and looked for jobs,*

but she was unskilled and semiliterate. After taking reselling market jobs and domestic jobs for little money, she took up prostitution.[6]

USE OF CONTRACEPTION

Women's fertility is praised especially when associated with the birth of males. Without family planning services, women would spend most of their reproductive lives pregnant and raising children. For example, in Mali the average children per woman is 6.6 (May and Guengant 2008). Men are the deciders about reproduction and contraception. Some women are using contraceptive methods covertly, but methods like sterilization, Norplant, and the IUD often need the husband's authorization. Most women are not free to decide for themselves, and if caught by a jealous husband, the wife will face physical punishment.

During a household survey in the countryside outside of Marrakech (Morocco), we inquired about the use of contraceptives. I was accompanied by a promoter who spoke the local dialect. We asked personal questions to the woman of the house, who was veiled and wore traditional clothing. Her husband stood by her side and answered most of the questions, including questions related to her menstruation cycle. He was the one who decided if she needed contraceptives. She had had eight children and was in poor health.[7]

DOMESTIC VIOLENCE

In 1981, the Committee on the Elimination of Discrimination against Women (CEDAW) was officially established. In 1992, the Committee affirmed that violence against women was a "violation of the internationally recognized human rights," and in 1995, the Fourth World Conference on Women in Beijing specified actions to protect women from discrimination and violence. Several countries pledged to change their laws and policies, but we have yet to see the actual change. Collective actions of women (elites and educated) have attempted to modify the patriarchal structure of most governments, but there is much to do, especially in rural areas.

"In one tragic case in Nigeria, a twelve-year-old girl ran away so often that he (her husband) cut off her legs to prevent her absconding. She subsequently died" (UNICEF 2001).

"Women are told to respect their husbands even if they are abused or beaten up" (BBC News 2002). Most nonliterate women do not know their legal rights and/or would be too ashamed to go to the police station to complain about their husbands' or their partners' violence. Even if women know about their legal stand, they also know that the police and the department of justice do not get involved in private relationships. In addition, the

impact of domestic violence witnessed by male children is usually replicated when they become adults, as they will adopt the same violent behavior toward their partners, resulting in a vicious cycle.

In Ghana, more women (50 percent) than men (43 percent) believed that a man was justified in beating his wife if she used a family planning method without his consent (Kimani 2007).

GIRLS, WOMEN, AND HIV

In Africa, more girls aged fifteen to twenty-four years are infected with HIV because of the practice of intergenerational sex that is common between older men and young girls for money or gifts. Girls use the money for school registration, supplies, or for luxury items. The spread of HIV can be traced from older men to younger girls, who then infect their slightly older male partners, who will infect their casual/regular partners. In sub-Saharan countries women are the most vulnerable group infected by HIV. The vulnerability of women is found in a wide range of factors: physiological, cultural and societal, economic, religious, and governmental. The physiology of the female tract makes women more vulnerable because of the vaginal mucous membrane and the risk of irritation. Rural girls and women have poor access to information because they are mostly nonliterate. Women are mostly dependent on men for economic survival, and adherence to kinship and traditions reinforces the sexes' inequities. The Muslim religion, depending on its interpretation and the sects, does not recognize women as equal to men. Governments do not provide any enforcement for the equality of women's status and have no social services for single women with children.

WHO SHOULD BE BLAMED FOR HIV PROPAGATION?

More women than men are HIV positive. In 2007, there were around 12 million women living with HIV and AIDS, compared to 8.3 million men. UNAIDS estimated that around three-quarters of all women with HIV live in sub-Saharan Africa (UNAIDS 2008). Women who are pregnant and seek medical care are tested for HIV, but if they are positive, they are usually blamed for getting the virus through unfaithful sexual relationships, although most were infected by their husbands and partners. In Rwanda, 25 percent of girls who became pregnant at seventeen or younger were infected with HIV, although many reported having sex only with their husbands (UNICEF 2001: 10). In those situations women faced physical violence and/or abandonment by their husbands/partners and their kin because of stigma and fear of infection.

In Senegal, Hanna, a mother of three children (five-, three-, and one-year-olds) came to the clinic asking for help because her husband abandoned her with the children when he found out that she was HIV positive. He infected her but refused to get tested. She could not get any help from her family because they feared that she might infect them. After he left, she was penniless and had to sell her belongings to buy drugs for her sick children. Not having any support from family or husband, she was considering sex work as an outlet for rapid cash.[8]

HOW MUCH DO WOMEN KNOW ABOUT HIV IN AFRICA?

Knowledge about HIV and its transmission is variable, depending on the countries, the locations (urban or rural), and the level of education. For instance in Nigeria 95 percent of the urban women were aware of AIDS compared to 82 percent of the rural women, while in the Somali region only 50 percent of the women and 64 percent of the men had heard of AIDS (Burgoyne and Drummond 2008: 15).

During my twenty-five years in the field I realized that there was a gap between urban and rural women, and it was based on a lack of schooling and comprehension of modern medicine and treatment along with health facilities offering very deficient health care. In rural communities, it is common to use traditional medicine because the healers and midwives live in the community; they are trusted, and their services can be bartered or are cheaper than the services at the health posts or the clinics. Explanations about ailments are given within the context of the culture and usually involve supernatural powers. At the health post, medical explanations are aimed at educated patients, and for women who have no schooling, it is very difficult to understand the complexities of the immune system and how the body functions. Information about transmission, the impact of the virus, and lately the CD4+ cell counts for the antiretroviral therapy (ARV) treatment is not well understood because the medical staff is speaking a different tongue. Because rural people shy away from the medical facilities as long as they can, they receive their information through the radio that is aimed at a literate audience or by word of mouth, and they integrate that information into their beliefs and traditional concepts, resulting in misconception and erroneous beliefs.

> *How to take an ARV regimen is not understood by many. For example, during a focus group in Malawi about informants' knowledge of prevention and adherence to treatment, some informants told us that they were sharing ARV treatment with members of their family who were not infected, when they were not feeling well.*[9]

In many parts of Africa rural populations believe that HIV can be transmitted through touching, eating, or witchcraft (Burgoyne and Drummond 2008: 20), the reason many patients hide their status from their families.

> *In rural Senegal, the doctor told me that Aicha, an HIV-positive patient, was kicked out of her parents' house with her three children because they thought that they would catch HIV if she lived with them.* [10]

MEN AND HIV

African men overall know more about HIV/AIDS than women, because they are literate or semiliterate, practice labor migration, listen to the media, and talk to their friends about HIV, and most are not afraid. Barriers to HIV prevention are based on the fact that people are not afraid of the virus because they deny the consequences and also because they practice a sort of fatalism about health.

> *When I asked a group of male informants in Madagascar if they were scared of catching HIV/AIDS because they frequented sex workers and practiced unsafe sex, they answered that they were not scared because it was one sickness that they had to avoid from the long list that already exists: malaria, eye sickness, dysentery, tuberculosis, gonorrhea, syphilis, and now HIV/AIDS.* [11]

SEX IS WORK

Women take care of the family and have to accomplish numerous chores during the day in order to raise children, feed the family, work the fields, and take care of animals. No wonder that they call having sex "work" just like the Quechua women. It is difficult to change their behavior because they are embedded in traditions and beliefs and have little opportunity to expand their life routine outside their household and community. Burgoyne and Drummond wrote, "Education gives women more opportunities for employment and gender equality and increases the likelihood of protection against HIV infection" (2008: 26). It is culturally accepted that men have multiple sexual partners; they might be in polygamous unions and also visit prostitutes, or they might be in monogamous unions but have sexual relationships on a long- or short-term basis with girlfriends and also visit prostitutes. Women are supposed to be faithful, and in rural areas gossips keep women from having sexual relationships outside the marriage. However, with male long labor migration and depending on his cash support for the family survival, this has changed. Women too might exchange sex for money if they are in need.

In rural Senegal, Louise was married and sold produce at markets while her husband took up labor migration for a month or two. She met a miner while selling her produce at a market a few kilometers from her home and moved in with him in a rough mining town. She agreed to be his sex slave for two weeks, while her husband was away. It was a contract, and she would get paid after the two weeks. The husband came back earlier and went looking for her. He found her, but she could not leave the miner because she had agreed to stay for the two weeks in order to get paid. She risked violence from the husband and the miner. [12]

CONDOM USE

Depending on the country, condom use varies. UNAIDS reports 6 percent in Madagascar and 74 percent in Namibia. Overall Country Progress Reports show that the median percentage of condom use at last sex for males with more than one partner in the past twelve months is 48 percent versus 38 percent for women (UNAIDS Global Report 2010: 70).

In rural regions, unless women visit a medical facility for family planning or HIV prevention, they are not aware of condom use. Men usually do not use condoms with their wives. On the other hand, women who are aware of condoms cannot request their husbands to wear one. Men make reproductive decisions, and women do not object because they do not talk about sex to their partners and are afraid of physical punishment. If a woman would request her husband to wear a condom, he would be suspicious of her behavior and would accuse her of being unfaithful. Many women are afraid to get HIV tested because if they are found to be HIV positive, they will be accused of infecting their partner, and the woman would risk violence and/or abandonment by her partner along with stigmatization by the community and rejection by her family.

In Senegal, during a focus group with married and unmarried women practicing informal prostitution, they told us that some clients requested sex without condoms and offered more money; women in need of money would comply. [13]

LESSONS LEARNED?

Women in Africa living in rural regions are facing the same dilemma as the women in South America and the Caribbean. Cultures, traditions, and beliefs are different, but constraints about gender inequalities, lack of schooling, lack of spousal communication, male labor migration, household responsibilities, and raising children are the same. Men are the decision makers; they are polygamous and often irresponsible (not economically supporting their children, refusing to be tested for HIV if the wife is positive, and abandoning

their families). Stigmatization and discrimination will last until people are able to understand the information provided by the media and the medical personnel. This means developing strategic, comprehensible messages for the rural populations that can be understood. Keep in mind that rural populations are in transition between tradition and modernity but do not have enough schooling to understand the regimen of therapy as prescribed and the process of transmission.

NOTES ON THE UNAIDS REPORT 2011

The UNAIDS Summary from 2011 reports that "[w]omen, especially young women, remain disproportionately affected in sub-Saharan Africa, highlighting the need to address gender inequality and harmful gender norms as a control component of the global response to HIV" (4). However, the report does not offer any recommendations for new approaches and strategies to raise women's status and to empower women in their future programs. The report discusses at length the circumcision of males for HIV prevention, a fact that has also been distorted by some circumcised males who think that they are now safe and do not need to wear condoms anymore. Obviously, they did not understand the counseling, or the counseling was not adequate.

The focus of UNAIDS is on mother and child transmission, and this has been successful in most countries, if pregnant women visit health facilities. However, violence against women and gender inequities are mentioned but are rarely the topic of UNAIDS' programs, because they are culturally and deeply rooted in the minds of the people and would require developing new methodologies for behavior change, using new tools and more extensive research. In addition the report does not mention the gap between rural and urban populations and does not focus on new strategies to reinforce women's rights.

The next chapter examines the problem associated with the introduction of change in a traditional society and the role of mothers in administrating children's medication in Morocco.

NOTES

1. HIV or human immunodeficiency virus in nonhuman primates in sub-Saharan Africa was transferred to humans during the nineteenth or early twentieth century. HIV-1 is the most virulent (Evans 2008).

2. Evaluation of the project PRISM (Pour Renforcer les Interventions en Santé Reproductive et MST/SIDA [STIs/AIDS]). Evaluated the reproductive health services delivery and quality of care of PRISM in various regions of Guinea (USAID/Guinea/MSH/LTG, 2001).

3. Midterm evaluation of Senegal HIV/TB Prevention Project. The evaluation focused on USAID interventions in providing assistance to the ministry of health (MOH) and to the local organizations in charge of high-risk groups: sex workers, men having sex with men, and people

living with HIV/AIDS. It also provided technical assistance to the medical personnel working for the MOH in order to strengthen capacities and ensure quality of care in the medical facilities of Thies, Kaolack, Kolda, and Kedougou (a project of USAID/Senegal/GH Tech/USAID, 2008).

4. Conducted focus groups with sex workers, clients, and STD patients concerning the prevention of STDs/AIDS and investigated the barriers to the use of condoms among sex workers who are not registered in STD clinics, their clients, and STD patients in Antananarivo, Madagascar (World Bank/Futures Group International, 1996).
5. Midterm evaluation of Senegal HIV/TB Prevention Project, 2009.
6. Madagascar, World Bank/Futures Group International, 1996.
7. Review of Experiences in Operationalizing Reproductive Health Programs. Analysis of UNFPA's support to reproductive health counseling, information, education and communication strategies, and programs and activities in Morocco. Analysis of IEC activities in relation to the sociocultural environment, including AIDS prevention, gender, and women's rights. UNFPA/Morocco, 1999.
8. Midterm evaluation of Senegal HIV/TB Prevention Project, 2009.
9. Evaluation of the Enhanced HIV/AIDS Prevention and Improved Family Health in Malawi Program (EHAP-IFH) examined the objectives related to the impact of HIV/AIDS, malaria, and diarrheal diseases, contributing to improved health status of Malawians and provided recommendations for future activities and directions for the project (USAID/PSI/GH Tech, 2008). Report online at www.ghtecgproject.com/resources.aspx.
10. Midterm evaluation of Senegal HIV/TB Prevention Project, 2009.
11. Madagascar, World Bank/Futures Group International, 1996.
12. Midterm evaluation of Senegal HIV/TB Prevention Project, 2009.
13. Midterm evaluation of Senegal HIV/TB Prevention Project, 2009.

Chapter Five

Indonesia and Morocco

Birthing Huts and Self-Medication

This chapter reports on two consultations: one in Indonesia and the other in Morocco. The purpose is to illustrate women's behavior when confronted by change and also when they are seeking care for their children. The first consultation reports the implementation of birthing huts (*Polindes*) in a very traditional community where women were used to giving birth at home. The second consultation examines the role of mothers and the impact of health literacy as they medicate sick infants and children with modern drugs and traditional remedies in Morocco. The chapter also comments on the easy access to modern drugs at markets and public places in Africa, all of which is associated with an excess of self-medicated behaviors practiced without much knowledge of the impact of dosage, side effects, and combination of drugs.

INDONESIA

In Indonesia, I evaluated the implementation of the Perinatal Regionalization project, in Tanjungsari, West Java Indonesia, sponsored by USAID in 1991. The project was implementing birthing huts for pregnant women in rural areas so they would be able to deliver their babies in *Polindes*[1] under the supervision of a trained traditional birth attendant (TBA). The project was based on the high maternal mortality of women (650/100,000; WHO 1996) with 80 percent to 90 percent of women delivering at home with traditional midwives. In addition the study examined the role of traditional midwives in dealing with birth complications. Thus, reproductive health-care services

were available at hospitals, clinics, and health posts (*Puskesmas* and *Posyandus*), yet very few women visited those facilities to seek medical care during the prenatal, natal, and postnatal periods (Evast 1992).

The pilot study conducted in Tanjungsari,[2] a rural community sixty kilometers from Bandung, examined the practices and role of the TBAs during pregnancy, delivery, and postpartum period and inquired into TBAs' awareness of birth complications. It also assessed the newly implemented birthing huts in the communities. The rationale for these facilities was to curb mortality and morbidity during delivery by asking women to deliver at the *Polindes*, where TBAs could be assisted by a doctor or a bidan (modern midwife with medical training) in case of complications.

The community had only one paved road, and women were coming from nearby rural communities to get medical services at the *Polindes*. The birthing huts were furnished with the bare materials, two beds, one incubator, an examination table, and some medical supplies. In case of delivery complications the woman would have to be transported to the main hospital in Bandung (Tsui et al. 1997). The trip usually took several hours, depending on the availability of the hospital's ambulance.

TRADITIONAL BIRTH ATTENDANTS (TBAS)

In Tanjungsari in 1991 there were about 150 TBAs for a population of about 87,000 inhabitants. Some were *Parajis* (TBAs who specialized in prenatal care, delivery, and postnatal care), and others *Paraji-Dukun*, or mystic healers who specialized in birth delivery in addition to practicing sorcery. *Dukuns* had the power to destroy *Hantu*, the malevolent ghosts responsible for sickness, misery, and death. In the eyes of the villagers *Dukuns* had more esoteric power than *Parajis* to deal with uncontrollable situations. Both types of healers used traditional medicine such as herbal teas, either for consumption or as compresses; hot and cold foodstuffs; as well as prayers, rituals, and incantations to treat patients. Based on the hot and cold humoral theory, they performed traditional rituals before and after the birth to ensure good health to the mother and child. In addition to their birth delivery skills they treated fever, diarrhea, headache, backache, and convulsions. Their knowledge of anatomy and physiology of reproduction was not rooted in modern science but was based on practical experience and traditional practices along with beliefs about the power of the hot and cold humoral theory.

CHILD DELIVERY

Rural women were mostly illiterate and worked the fields with their husbands; they produced rice, tobacco, cassava, coffee, chocolate, and numerous

tubers. During child delivery the TBA massaged the woman's abdomen, guided the baby out of the uterus, and cut the umbilical cord (with scissors, razor, or blade). Their husband helped during delivery by applying pressure on the shoulders of the woman, who knelt on the floor. Most TBAs did not have the knowledge to treat complications, and if the woman refused to leave her home, they treated complications with traditional methods. Women reported that they preferred to deliver at home with the assistance of the TBA, with whom they were able to establish a friendly relationship and were able to celebrate rituals against evil spirits with food offerings. The assistance of the TBAs was paid with foodstuff and a small fee. For most complications, women reported preferring calling a *Dukun* because of their esoteric talents. Others factors for choosing to deliver at home included the family's economic hardship, taking care of the children, transportation constraints, and conflicting decision making among husbands and extended families.

During my observations of the *Polindes* I realized why women did not want to use the birthing huts to have their babies. First, they were obliged to use a bed, whereas traditionally they slept on mats on the floor and knelt on a sheet of plastic for delivery. At the maternity ward of the hospital in Bandung, women were sitting or lying on the floor rather than using the beds.

CULTURAL CONSTRAINTS

During the four months after their implementation, the *Polindes* were used for only thirteen deliveries. The mild response showed that the women resisted changing their cultural customs and their traditional behavior. Besides the use of beds that was not culturally acceptable, women could not have their extended family in the room to celebrate the birth as they do in their homes with rituals and specific meals. There were also beliefs associated with the humoral theory that could not be practiced, along with the burial of the placenta in the back of the house, and the belief that the colostrum (mother's first milk) was harmful, causing the newborn diarrhea and vomiting. Also, women who were using the *Polindes* for their delivery had to be brought food by their families because none was provided at the *Polindes*, and visitors were limited to two hours. In addition, the price for delivery was three times more expensive than the delivery price of a TBA who delivered at the mother's home.

RURAL CONSTRAINTS

During home deliveries when complications occurred, villagers were faced with transportation problems because of the lack of vehicles in the communities and very bad roads. I witnessed a very sick woman being transported

on a stretcher made out of tree branches and carried by four men. The nearest hospital was a four- to six-hour walk from the community. Very few patients survive the transportation. Furthermore, if the husband was away, the extended family would make the decision to transport the woman to a health center, but they usually opted for the *Dukun*. In most cases of complications the delay in decision making, the refusal to be transported to a hospital, and the TBA's treatment were fatal to the woman.

IMPLICATIONS OF CHANGE

This pilot study illustrates the problem of introducing change in a traditional society where 80 percent of the rural population was illiterate. Rituals and traditional customs were performed daily, and those included pregnancy and delivery rituals. In Tanjungsari, women resisted change, and some would have rather died due to complications than used the *Polindes*. TBAs who were trained to use hygiene (washing their hands and using gloves for delivery) did not always follow their training and often reverted back to their old routine. They only had three days of training with a follow-up session six months later. When I visited the *Polindes*, the TBA who opened the door had gloves on, but there were no patients. I asked her why she was wearing the gloves, and she answered, "to protect my hands."

I witnessed many times that when dealing with illiterate or semiliterate individuals, their training has to be specific and should focus on the capacity of the trainees to understand and change their routine. This can be done by offering repeated training sessions every three months for the period of a year and developing strategic supervision/counseling and follow-up so that trainees can correct their mistakes or erroneous understanding.

MOROCCO

This section demonstrates that illiteracy does not only affect women's health and behavior, but also the health of the children. This study was conducted in 1993 for the World Health Organization (WHO) in Morocco to study mothers' behavior when confronted by infants and children who had acute respiratory infections (ARIs).[3] The purpose was to improve health programs for mothers and children in rural communities, to identify the constraints associated with health care in health facilities, to inquire about mothers' drug therapy, and to understand cultural beliefs about ARI (Daulaire and Weierbach 1992).

Findings revealed that coughing was not alarming to mothers[4] unless the child could not breathe properly or vomited. The association of illnesses such as diarrhea or earache worried the mothers more than the cough. The cold

weather was blamed for the children's illnesses from colds to pneumonia, along with the bird *Tira*, who brings bad luck by flying over the clothes while they are drying outside. If a child became sick with a fever and showed signs of ARI, the mother would first try to medicate the child by giving aspirin, herbal teas (fennel, sesame, and oregano), and rubbing the child's chest with olive oil. If after a day or two there was no improvement, the mother would take the infant to a traditional healer (*ferrag male/ferraga female*) who specialized in ARI treatments. The cause of the sickness along with the treatment was diagnosed by measuring the length of the infant using the length of the healer's hand. If the healer's hand was shorter than the infant's body, the cause of the illness was revealed along with the treatment. Treatment consisted of putting a concoction made of herbs mixed with olive oil in the mouth of the infant along with rubbing the chest with olive oil. Another treatment consisted of lacerating the chest of the infant with a blade so that the "bad blood" would come out, or "burning the chest" of the infant with a piece of wood through a blanket. The latter is based on the humoral theory that a cold condition has to be treated by the opposite. The most dangerous treatment consisted of cutting the epiglottis with a blade or scissors so that the infant would not choke while vomiting or breathing.

Traditional healers were very popular because they charged much less than the physicians and they knew the cause of the sickness that is usually blamed on uncontrollable cultural factors such as *Tira*, the bad luck bird; being in contact with bad odors; having bad blood; or being exposed to too much sun or to sudden cold. For mothers, seeking care depended on environmental factors such as level of education, economic means, access to transport, presence or absence of husband, beliefs in traditional/modern treatments, and mothers' anxiety level. In general, if the child did not get better after two to three days, the mother would bring the child to the traditional healer, or a pharmacist. Mothers would wait longer to seek care if the child was older than if it was an infant. Most mothers preferred treatments from private physicians if they could afford it, "because the cure is more rapid."

Private physicians were preferred because they use X-rays and were able "to see where the sickness was located in the body." All physicians had X-ray equipment in their office; one of them told me, "A physician without X-ray equipment is not a physician in the eyes of his patients." The medical examination with X-rays was relatively expensive, costing between $10 and $15 depending upon the doctors. Some doctors reported that they faked the X-ray examination,[5] while others mentioned that using X-ray equipment was helpful for their diagnosis of lower respiratory infections (Maynard-Tucker 1998).

Overall, it was found that the more education the mother had, the faster she would respond to the child's illness by seeking care at the health centers or the hospitals if she had the means to do so. The majority who were

illiterate and could not afford the fees of a private doctor or the health centers visited the traditional healer and sometimes lost time and money on treatments that did not cure the child or worsened his/her condition. Doctors at the hospital complained that mothers waited too long and brought children when it was often impossible to reverse their fatal condition. There was also the fact that women could not leave the house without the permission of their husband, and often the husband was away for wage labor. For instance, one informant had a very sick child with ARI who needed hospitalization. She lived in a rural community outside Marrakech, and her husband was away for work; she could not leave the house. She had to wait for her mother-in-law, who came a day later and gave her the permission to take the child to the hospital. In addition, it was very difficult for rural people to change their routine and their trust in the traditional healer. One day, as I was coming out of the health facility, I recognized one of my informants and asked her why she was sitting outside the health post with a sick infant in her arms and a doctor's prescription in her hands. She told me that she was waiting for the traditional healer in order to hear his diagnosis before going to the pharmacy.

The following section will illustrate the role of mothers when sicknesses occurred and their intention to cure their children with modern and traditional remedies.

ILLITERACY AND SELF-MEDICATION

Among rural populations the complexity of pharmaceutical drug medication is poorly understood because these drugs require accurate dosage, timing, and adherence to a definite length of treatment. Consumers are not aware of modes of action of modern drugs and side effects because they usually lack scientific understanding of basic anatomy and physiology. In addition, people are accustomed to treating themselves with traditional medicines, (teas, massages, rituals, concoctions, and cataplasms), none of which require specific dosage or timing. The popularity of modern drugs was often based on successful past experiences in which healing occurred more rapidly than with traditional remedies or rituals. During the first five years of a child's life the mother has an important role, because if a child is sick, the recovery depends on the mother's best judgment for treatment. However, mothers were not always able to detect complications of illnesses or associations of illnesses, and their selection of drugs was done haphazardly, often based on the success of previous drugs or on friends' and relatives' recommendations. Moreover, economic and cultural constraints, traditional beliefs, and also the mother's degree of literacy and anxiety influenced her choice of health systems in time of illness (LeVine et al. 2012; Hough 2012).

MOTHERS' HOME MEDICATION

In Marrakech[6] mothers reported that home medication for ARIs included teas with or without tablets of paracetamol or aspirin and/or nasal drops and antipyretics, syrups, and suppositories (with or without antibiotics) along with massages and concoctions of herbs mixed with olive oil, which caused sweating. The mother might also use drugs recommended by kin or friends, or drugs previously prescribed whether or not they were appropriate for the current illness. When questioned by the health worker, the mother usually did not report medicating the child with various drugs and remedies because she either had forgotten the names of the drugs or was intimidated by the medical staff. Sometimes the combination of drugs given to the child was dangerous and could not be traced by the health provider because mothers used various sources to buy drugs (pharmacies and market and street vendors). In addition, because of economic stress, mothers usually bought only a partial treatment (one or two pills and/or suppositories that would last one or two days) (Oshikoya et al. 2009). Although mothers preferred private physicians, they could not afford their fees; however, their multiple sources of seeking health, such as home medication, traditional healers, and pharmacists, prior to visiting a physician account for the doubling or tripling of the physician's fees (Maynard-Tucker 1998).

CHILDREN'S EPISODES OF DIARRHEA

In rural regions, lack of hygiene, water pollution, contamination, and poor nutrition were endemic and were often the causes of infants'/children's diarrhea. For the mothers diarrhea episodes were anticipated and seasonal, and the causes were often attributed to transgression of social/religious norms, beliefs, and traditions. Usually, mothers treated diarrhea with herbal teas and with nutrition tips, using cultural beliefs based on the hot/cold food complex of the humoral theory. Mothers who attempted to medicate the child with solid food, or withdrew food, or gave antibiotics, worsened the condition of the child. If the child did not improve after a day or two, the mother would bring the child to a traditional healer for a cure, which usually consisted of concoctions, massages, and rituals. Mothers knew that diarrhea killed infants; therefore, they would visit a physician more rapidly than if a child two to five years old became sick with diarrhea. In addition, oral rehydration therapy (ORT)[7] promoted by international agencies through public health facilities was not well understood, and mothers' lack of health literacy impeded the preparation of ORT, as they were not careful with the dosage of the ingredients. Also, because ORT did not stop diarrhea, mothers exhibited doubt about its effectiveness and did not understand its purpose. Some doc-

tors prescribed antibiotics for viral episodes of diarrhea, and some pharmacists often sold drugs instead of recommending ORT packages. After using all their resources, traditional healers' and the mothers' own treatment, if the child was still sick after two to three days, they would bring the child to the hospital. Sometimes the child's condition was fatal.

MALARIA

Malaria is endemic to most African countries and is a major killer of children under five years old. Malaria prevention was not widely practiced, and its source was often ignored. Mothers treated malaria episodes at home with traditional medicine, herbal teas, baths and massages, and/or chloroquine or Fansidar tablets purchased in pharmacies or markets (Menon et al. 1988; Van der Geest 1987). When mothers administered the medication, side effects related to gastrointestinal disturbance or skin allergy were not understood and led to more drug experimentation. Underdosing was also common and led to complications and medication resistance (Foster 1995; Glick et al. 1989). Data revealed that during the first days of the illness, mothers had a difficult time distinguishing malarial symptoms from flu or pneumonia. Mothers' home medication often included antipyretics in conjunction with or in place of antimalarials. Conversely, some women treated feverish children with chloroquine tablets to prevent malaria although malaria had not been diagnosed, a preventive measure that has created resistance to malaria in various parts of Africa. Usually mothers visited traditional healers for severe cases of malaria, such as convulsions. Convulsions are the expertise of the traditional healer, because they are understood as possession by spirits and/or uncontrollable elements. Women who are literate or semiliterate would seek medical care from the hospital as soon as the symptoms appeared, but nonliterate women waited too long to seek health care.

AVAILABILITY OF DRUGS IN DEVELOPING COUNTRIES

Although most developing countries have national policies that prohibit the free sale of prescribed drugs and antibiotics, these policies are rarely enforced, and pharmaceutical drugs can be obtained freely from numerous sources at a wide range of prices. One can buy pharmaceutical drugs on the streets, in commodities stores, in markets, and in pharmacies without prescriptions (Fassin 1988). In rural communities pharmaceuticals are sometimes retailed by private individuals from their homes, at marketplaces, or at fairgrounds. Drug retailers usually do not give any instructions about dosage or side effects of the drugs; they have no knowledge of medicine and are only interested in making a small profit on the sale.

In Africa some drugs are manufactured locally without any pharmaceutical or chemical control because governments do not enforce these policies. These drugs do not bear any generic or trade names and sometimes are counterfeited and mixed with such impurities as sugar, flour, and/or chemicals. In addition, often these drugs are exposed to sun, dust, rain, dirt, and extreme temperatures. Retail drugs are sold in small quantities or by unit and are cheaper than the drugs bought in pharmacies or health facilities. For many years social scientists have reported the danger of overusing and misusing drugs in the literature (Haak and Claeson 1996; Kanyi et al. 1992; Melrose 1982; Michel 1985; Nichter and Vuckovic 1994; Reynolds 1992; Shakoor et al. 1997; Silverman et al. 1992; Trostle 1996; van der Geest and Whyte 1988), but the problem remains. Free access to medication increases self-medication practices, and the misuse and overuse of antibiotics and prescribed drugs decrease their effectiveness and create bacterial resistance.

DRUG MARKETING

Pharmaceutical drugs represent a growing market of wealth and are exploited by everyone involved: manufacturers, buyers, retailers, medical personnel, and opportunistic individuals (Toscano 2011). Mortality attributed to poisoning from badly manufactured drugs or due to misuse of drugs is seldom reported officially because of lack of postmortem autopsies and inquiries about previous treatments (Alubo 1993). Every market has a pharmaceutical stand where someone sells drugs that are counterfeit or have been manufactured without inspection or supervision. These drugs are cheap and are sold by unit. At the markets, drugs are often outdated, have been in the sun for days or in the rain, and are dangerous. The government knows about it, but they do not enforce the policies and laws against buying drugs outside pharmacies and health facilities. I observed these market stands in various countries as I inquired about family planning methods. For instance, packages of hormonal pills were sold without explanations about side effects or how to take them. But they were cheaper than the ones sold at the pharmacy. Sellers prey on poor rural women who are anxious to buy drugs for their families. Antiretroviral therapy (ART) can also be found at the market; the medications are cheaper than the ones for sale at the hospitals but are not manufactured by official pharmaceutical firms. These counterfeit drugs do not cure patients, and because of their toxicology, they are very dangerous. Overall, because of corruption at the higher levels of governments and disinterest about public health policies and laws, the illicit drug business is booming and probably kills many people (Fassin 1988; WHO 2012).

SYNTHESIS

Cultural traditions are very strong and lasting. In Indonesia women adhered strongly to their customs, and they were not ready to change their routine ways of life. The *Polindes* were too Westernized and too different from their cultural customs, and not well utilized even though women had a better probability to survive delivery complications. The project lacked knowledge of the culture and the logistics confronting the communities along with a strategy for the traditional midwives' training. It takes a long time for TBAs to change their routine and to learn new skills.

Several studies have reported the correlation between mothers' illiteracy and the health of children (Levine et al. 2012; Hough 2012). The realization of the dangerous turn of an illness comes from being aware of signs and symptoms that are serious and sometimes irreversible. Rural women do not deal with illnesses the same way as urban, educated women do, because rural women are involved in the survival of the whole family, and they have no means to go to visit a physician. They try to solve health problems by doing what is the most practical for them; that is, to self-medicate and/or call the traditional healer. In addition, because of cultural customs that confine women in many countries to the household and prevent them from leaving the compound without their husbands' or the mother-in-laws' authorization, they have no opportunities to explore other strategies. Studies have shown that small-size families and healthier children are strongly related to the mother's literacy background. A few years of schooling would change women's behavior and reduce childhood mortality by 5 percent to 10 percent (May 2012: UNESCO 2011). Women would understand the need to control their fertility and the benefit of having fewer children (Creango et al. 2011). They would learn hygiene more quickly, understand the benefit of childhood immunizations, and would understand the importance of returning to the health facilities for the second and third injections. Nonliterate women do not return for the full series of vaccinations (Hough 2012).

Everywhere in rural communities, people did not understand the modes of action of children's immunizations. If a child was immunized and happened to get sick afterward, parents would blame the sickness on the immunization and no one would trust the health workers anymore. Although there were campaigns on the radio about the importance of immunizations, rural populations did not understand the modes of action of the immunization; therefore, they thought that immunizations were not trustworthy and could be dangerous.

Development organizations should develop specific, basic explanatory strategies for rural populations. Nonliterate people are visual and would understand better the advantages of immunizations if it could be explained with drawings, using their own concepts about prevention of illnesses.

In the next chapter, we will examine the involvement of poor women in clandestine prostitution due to poverty, partners' abandonment, gender inequities, and as providers for children and family.

NOTES

1. *Polindes*, or birthing huts, were small health posts furnished with a gynecological table and medical material for birth delivery. They had a trained midwife in attendance, but in case of complications the patient had to be transported to the hospital in Bandung.

2. Data presented here were collected through focus group discussions and in-depth interviews by students from the University of Pachacharang in Bandung under my supervision. Focus groups were conducted with $N = 18$ married women (aged eighteen to forty-five) and $N = 10$ husbands (aged twenty-five to forty). In addition in-depth questionnaires were administered to $N = 30$ couples. Also, TBAs $N = 11$ participated in focus group discussions and answered the questionnaire. Students translated the data from Sudanese to English.

3. Dr. Rahma Bourqia of the University of Rabat, with two Moroccan graduate students and the author, interviewed a total of $N = 100$ informants. Dr. Bourqia and the two students interviewed the mothers who spoke Arabic and Berber, and I interviewed the medical staff: doctors, nurses, health workers, and pharmacists who spoke French in three rural communities outside Marrakech.

4. Mothers' age group was eighteen to forty-five; they were agriculturists and were illiterate. In 1990 there were only 38 percent literate women in the country (Census Bureau 1993).

5. Depending on the patients' illness, some doctors would not use the X-ray equipment because the patients did not need it although patients requested it—the reason for faking the X-ray examination.

6. Data about mothers medicating the children were collected through focus group discussions, exit interviews, oral histories, and in-depth interviews conducted in informants' homes and/or at medical facilities. In 1993, $N = 100$ mothers and $N = 23$ medical staff were interviewed in Morocco.

7. Oral rehydration therapy (ORT) homemade solutions included one liter of clean water, six teaspoons of sugar, and one teaspoon of salt.

Chapter Six

Madagascar, Senegal, and India

Sex Work

This chapter reports on three consultations conducted among sex workers in Madagascar in 1996, in Senegal in 2009, and in India in 2011. The three studies are based on both focus group discussions and private interviews. Although several years have passed since the first study, I was back in Madagascar in 2011, and very little had changed. Political turmoil and economic stress kept 50 percent of the Malagasy population below poverty level.

All over the world, clandestine (informal, illegal, nonregistered, irregular) sex work is a major determinant for the transmission of HIV because women do it secretly, are difficult to track, and avoid STI (sexually transmitted infection) and HIV testing. In all of the countries that I visited, I found poor women practicing prostitution because most were destitute and needed to take care of their children. In Madagascar prostitution was illegal, but sex workers willingly registered in an STI clinic sponsored by an international donor and received medical services at a low rate. In Senegal, women who were HIV positive were involved in clandestine prostitution because they had no other resources to survive. In Karnataka, India, prostitution was institutionalized within the customs and the religious beliefs of the society but became illegal because of new laws and the abuse of young girls and sex trafficking.

Overall, prostitution is illegal in most countries, and sex workers suffer from discrimination and stigmatization. However, in some countries prostitution is legalized but soliciting in the streets is not, and brothels are outlawed. In addition, the police maintain control over prostitutes and abuse them physically or by extorting money. Prostitution is associated with the level of poverty of the populations and the fact that there are not social programs or

job opportunities for poor women. During times of civil war and economic collapse the rate of prostitution rises. Poverty is one of the main causes of prostitution that involves both sexes. For the purpose of this chapter, I will report only on female clandestine prostitution.

There are many types of prostitution, legal and illegal. Legal prostitution is permitted by the governance and sex workers are registered[1] at health facilities and must check every month for STI and HIV testing. Legal prostitution in Africa is practiced in Ethiopia, Ivory Coast, and Senegal. Although prostitution is legalized, sex workers are confronted with discrimination and stigmatization by the society. Legal and illegal sex workers suffer from poverty and the decline of the economy. Illegal (or clandestine) prostitution is characterized by women who choose to prostitute themselves when in need of cash. They are usually nonliterate and are single and/or abandoned by partners. Others are married but the husband is unemployed, and they usually have children. Clandestine prostitution is practiced irregularly and kept secret. Another form of prostitution for males and females is sex tourism, which is getting more popular in poor countries because foreigners pay with gifts and cash for sexual encounters. Sexual relations are often intergenerational; that is, the women are older and the local men are younger. There are also transactional sexual relationships characterized by young girls having "sugar daddies"—teens who agree to have sexual relationships with older men. Men are asked to pay for schooling, or clothes, or give cash in exchange for sex. Finally, child prostitution and sex trafficking are practiced everywhere but more prevalent in Nepal, India, and Asian countries.

SEX WORK IN ANTANANARIVO, MADAGASCAR

This study conducted for the World Bank[2] was revealing because it was the first time I conducted a study about sex workers and their clients, and I was able to talk informally with them over lunch after the focus groups. The sex workers were recruited from an STI clinic and were invited to participate in a focus group followed by a lunch. Dr. Jocelyne Andriamiadana, a medical doctor in charge of the STI clinic, was the key informant in this study and facilitated the focus groups with some of her medical staff. We asked the sex workers to meet us at noon for lunch in a restaurant located close to their workplaces. We had planned to conduct focus group discussions before the lunch but did not realize that sex workers worked all night and noon was too early for them. The lunch served after the focus group was really a great idea because informants were relaxed and talked about their life and their constraints. To supplement the number of sex workers recruited from the clinic, we had to recruit women who were working the streets and the bars and

found that there were no differences between the two groups—one recruited in the streets and bars and one recruited by the STI staff of the clinic.

Clients of sex workers were also recruited from an STI clinic and the bars. They were eager to discuss their sex life and HIV/AIDS prevention. Within the society, it is culturally accepted that men who are married or single frequently visit brothels and have more than one sexual partner. Usually, young men experience their first sexual encounter with sex workers as a rite de passage, often arranged by close male relatives.[3]

THE SEX WORKERS

Women who attended the focus group were clandestine sex workers between the ages of nineteen and forty-five years old. I was stunned to find out that the women involved in clandestine sex work did not fit my vision of a well-groomed sex worker wearing sexy clothes and heavy makeup. Most of them did not look neat; they were wearing everyday clothing, and their hair was not neatly combed. One of them came from the market and was carrying two big bags of produce. I thought that she was working for the restaurant kitchen. The majority had attended high school but quit before graduation, although one of them was a university student. This particular sex worker was working only in the afternoon, hiding her work from her boyfriend, who thought that she was studying. She explained that they did not have any money because they were both university students, and she was doing this because she "needed money to buy clothes." About half of the sex workers said that their husbands or partners knew about their activities, while the others did not inform their partners about their clandestine work. In most of the cases, women were the sole providers because partners were unemployed or could not find any work. Some women were single mothers and were supporting children and aged parents who lived in the countryside. These women were ashamed of their work and were hiding it from their parents, telling them that they were working in factories. Asked how they felt about sex work, they said that it was disgusting but it permitted them to support their families. They were making between $2 and $4 a night compared to factory work, which paid $1 a day.

VIOLENCE

Sexual abuse and violence characterized some of the sexual encounters related during the private interviews. Women said that sometimes clients would rob them of their money and beat or rape them (see also Behets et al. 2001: 209). One sex worker reported that she had been gang raped and left alone in an isolated part of town in the middle of the night without money for trans-

portation. Women reported that there were clients who could not ejaculate and became violent during intercourse if the woman complained that they were taking too much time. There were also clients who got drunk or took drugs and became violent during sexual encounters. Furthermore, clients became violent if they found out that the woman was menstruating, because they feared menstrual blood.[4] To avoid this, some of them said that they work the first day and the last day of their menstruation.

Women said that Indian and African men were the most violent, while "white" and Chinese men were the most respectful. Prostitution was outlawed, so they did not report physical or sexual abuse to the police. Women said that they were afraid of the policemen, because they would put them in jail. When clients were violent, sex workers could not negotiate the use of condoms and they could not protect themselves from HIV.

The government was aware of the spread of prostitution and offered STI and HIV testing in a few clinics for sex workers, clients, and pregnant women. However, sex workers did not always use these services because of social prejudices exhibited by the medical personnel and social discrimination.

THE CLIENTS

This study recruited clients through the STI clinic and through the local bars. All of the men represented the lowest socioeconomic strata and had some schooling. There were no other cultural behavioral differences. Clients were between nineteen and forty years old; their employment included driving trucks, buses, or taxis; ship ownership; military and police force; factory work; teaching; and one client was a student. The majority had attended high school, but only a few graduated. Two-thirds were married, and others were single but had girlfriends. On average, they said that they visited sex workers about twice a week, depending on their cash flow. All said that they could not ask their wives or girlfriends to do what they were doing with the sex workers. They explained that they respect their partners and also assumed that their partners would not comply with their sexual demands.

Some respondents said that they practiced unprotected sex with sex workers, their wives, and their girlfriends. During the discussion they acknowledged that being monogamous was a way to prevent AIDS. However, they explained that men have strong sexual needs, which are difficult to control, and that in order to have a full sexual life, they need more than one partner. In addition, the men reported that they frequently watched pornographic videos with male friends and then visited the sex workers. They said that the videos, which cost a dollar to view, were visually exciting and aroused them. These video rooms were becoming more numerous throughout the city and were very popular.

PORNOGRAPHY

Sex workers reported that pornographic videos changed men's sexual behavior. Since the implementation of video theaters in the vicinity of the bars where they worked, men wanted to act out sexual fantasies usually inspired by the viewing of the videos. Sex workers reported that clients who watched pornographic material requested new positions (i.e., sideways and backward, sitting astride, anal sex, oral sex, and multiple partners). Sex workers commented that these sexual activities were rarely requested before the advent of video theaters. Most sex workers said that they refused to perform anal sex with clients because "it hurts," but a few reported that they complied with the desire of their partners. Male respondents were asked why they would not ask their wives to participate in their sexual fantasies, to which they responded that they would be ashamed to ask their wives or girlfriends because they "respected" these women. They also would not use condoms with their wives because it would be insulting to them, as wives were supposedly clean, honest, and faithful to their husbands.

Asked about their consumption of alcohol, men said that they were "shy" and needed to drink in order to approach sex workers. On the other hand, sex workers also said that they needed to drink so that they would be able to solicit clients without shame. Most sex workers reported that they did not drink in excess or take drugs because they were afraid that clients would rob them of their money or might want more sex than they paid for, although a few reported smoking hashish with clients.

THE WORKPLACES

At night in some sections of Antananarivo the streets were filled with women of all ages waiting for clients, and in many instances sexual encounters were conducted in the open in nearby dark places. In addition, there were bars and brothels that were open during the day but closed at night, while some were open only at night. Most brothels offered rooms for rent by the hour or by the length of time the couple spent in the room. One particular brothel was located above a popular bar. The rooms were small and dark, furnished with a soiled mattress placed on the floor, a small table, a lamp, and a chair. The rooms did not have a private bathroom, and the women used the public bathroom downstairs behind the bar. The air was full of rotten smell and moisture.

At the bar I talked to a dozen women sitting close by and asked them if they had condoms with them. Six out of ten showed me their condoms and said that they got condoms free of charge from programs sponsoring HIV prevention. All the women were afraid of getting HIV; however, they also

said that if they needed cash and the client would offer more money for not wearing a condom, they would do it.

During preliminary discussions sex workers established the fees with the clients depending on the positions requested and the price of the room (starting at $2.50 up to $5.00, depending on the place and the length of time). Prices increased for the whole night and if the deal included multiple partners. Also, prices fluctuated if it was a "regular client" or if the client appeared to be richer than the others were (e.g., better dressed). In the poorest section of the city, a room costs about 15 cents. The missionary position (called traditional, or rapid trick) was the cheapest and cost about $2, while the most expensive was fellatio, which cost $7. In the poorest sections of the city a missionary position cost 50 cents. Sex workers average between ten and twenty clients weekly, depending on their need for cash. They recruited clients in the streets, bars, or brothels.

NONUSE OF CONTRACEPTION

During the focus group discussions sex workers said that they were not using contraception for the following reasons: their husbands/partners were opposed to it mostly because they thought that it was harmful to their health, they were afraid of side effects, and/or they did not have the money to buy the contraceptive methods. Some women had a limited knowledge of the methods, while others feared the side effects. They had heard that the birth control pill causes headaches, mood changes, and heart or liver diseases. Many reported using abortion in case of unwanted pregnancy. Although it was/is outlawed, abortion was/is widely practiced by doctors, nurses, midwives, and traditional healers. Women reported an average of two to three abortions. An abortion costs $10 for the first month of a pregnancy and another $10 for each additional month. During a private interview with a nineteen-year-old sex worker, she revealed that she had four abortions in two years, all of them performed by a midwife. Asked why she was not using contraception, she said that she could not because her partner was opposed to it. He knew about her sex work but thought that the Pill was harmful to her health.

KNOWLEDGE OF STIS AND HIV/AIDS

Informants knew about some symptoms of STIs. For example, sex workers mentioned itching, discharge, and pain in the lower abdomen, while clients reported burning, discharge, and warts. In order to avoid STIs, sex workers said that they do not have sex with clients who are dirty, smell bad, or exhibit pathological signs, such as pimples, sores, or warts/moles on their genital

organs. On the other hand, some sex workers do not stop working if their STIs are not painful and if they think drinking herbal teas or taking antibiotics protects them. Two-thirds of the men reported episodes of STIs (i.e., syphilis, gonorrhea, ulceration, and warts) in the last three years. All the male informants reported having had a STI in their life; gonorrhea was the most cited. Giggling, they explained that for a man, having had gonorrhea is like a rite of passage from boyhood to manhood. Some of them said that after sexual intercourse with women who had "burning vaginas," they became sick or had ulceration on their sexual organs. All participants were aware of certain signs associated with STIs for men, but knew that for women it was difficult to detect except for a bad smell and sores. However, all participants knew about the modes of transmission and prevention of HIV/AIDS and knew that there is no cure and that it is deadly. But they were not overly afraid and thought that it was overemphasized and rare, because they did not know anyone infected with AIDS. People hid their HIV status because of the related stigmatization and discrimination.

SELF-MEDICATION

When sick with STIs, sex workers explained that they usually treated themselves with herbal teas that could be bought in the streets. These herbal remedies were used to avoid pregnancies or to cure STIs and other diseases (Outwater et al. 2001). If the treatment did not work after several days, they usually went to a physician. Three sex workers said that they took tetracycline and extencilline capsules as a preventive measure against STIs when they were working. One of them said, "I take three capsules of tetracycline morning, noon, and at night on the days I work to protect me from getting an illness." A physician gave this treatment to a sex worker who had an STI and she told her friends, who in turn were using the treatment as prevention against STIs.[5] None of the informants were aware of the link between STIs and HIV.

CONDOM USE

Informants were aware that the use of condoms was a method to prevent HIV, but for various reasons, they did not always practice safe sex. Sex workers reported that four out ten clients refused to wear condoms for the familiar reasons: loss of pleasure, poor condom quality, condom sizes were either too tight or too large, or condoms could get lost in the vagina or break. Men explained that condoms do not permit them to ejaculate, prevent them from feeling pleasure, and often break during penetration. One informant

said, "It is like sucking on candy with a wrapper." Another said, "It is like eating with the tongue wrapped up in plastic."

Sex workers reported that frequent intercourse with condoms was painful during penetration because condoms cause "dryness." Other problems with condoms included that they could not always be obtained when needed because the drugstores were closed; they were embarrassed to buy them; or because they did not have enough money to buy them in bars where they were sold at high prices. Most men said that they are embarrassed to remove the soiled condom after intercourse. Sex workers reported that when with "regular clients," they have unprotected sex because they trust them. Also, if the clients insist on having unprotected sex and pay more for it, sex workers would go along for the money (Wojcicki 2002: 339; API 2011).

HIV/AIDS PREVALENCE

The HIV/AIDS prevalence in Madagascar has been low compared to other countries in Africa; however, it has been rising from 0.06 percent in 1999 to 1.1 percent in 2004 (UNAIDS 2006). Recent data show the total prevalence for the whole population (fifteen to forty-nine years of age) at 0.4 percent (World Bank 2013). Sex workers who visited STI/HIV prevention clinics who were tested for HIV have shown less than 1 percent prevalence (UNAIDS 2010). The low HIV prevalence is based on the testing of sex workers who visited the STI/HIV prevention clinics. There are many sex workers who do not frequent the clinics and many who do not want to be tested because they fear the results due to stigmatization and discrimination by society.[6] HIV prevention is confronted by several societal issues, among others: low literacy, poverty, limited access to health and social services, teens' early sexual relationships and multiple partnerships, the high rate of STIs, syphilis, and gonorrhea, and the influx of transient populations.

LEGALIZED PROSTITUTION

In Senegal, a small group of elite and educated women are working toward social, economic, and cultural reforms. However, rural women are discriminated against, repressed, and very poor. This study was part of an evaluation for a USAID/Senegal project conducted in 2008. In Senegal, prostitution has been legalized since 1969. Legal sex workers are registered at the Institute d'Hygiene Sociale (Social Hygiene Institute), where they are issued a health card. They must be at least twenty-one years old and visit a specific clinic for bimonthly checkups for STIs and HIV testing. They are given free condoms, and if they test positive for HIV, they get treatment with ART (antiretroviral therapy) (Do Espirito Santo and Etheredge 2004; Homaifar and Wasik 2005).

The other group of women practicing illegal or clandestine sex work are not registered, work irregularly, and use sex work to supplement their need for cash. These women are often married or have partners and children; they live in cities and/or in rural communities. The women interviewed for the focus groups lived in a rural community a few kilometers from Dakar. They were wearing the traditional African costume and were different from the sex workers who worked the streets of Dakar dressed in jeans with tight tops and wearing heavy makeup. The women of the focus groups looked like any housewife.

HEALTH CARE

Interviews with the medical staff of the public sector in Dakar and the provinces revealed that for every registered sex worker, there are numerous women and young girls involved in prostitution who are not registered and do not visit the medical services. A doctor in Kedougou told us, "*Dés qu'il fait nuit il y a des centaines de femmes et jeune filles qui font le trottoir*" (as soon as night falls there are hundreds of women and young girls who are soliciting in the streets). In Dakar, it was estimated that from 2006 to 2009, the number of registered sex workers grew from 1,800 to 6,412 (Ndiaye 2010). Registering sex workers for medical checkups helps to control the spread of STIs and encourages testing for HIV. If sex workers are found to be HIV positive, they are not prevented from working as long as they are treated, examined at the clinic, and get counseling and support (Homaifar and Wasik 2005: 123). But if their *carnet sanitaire* (health card) is retained by the medical staff because they have an STI, they must stop working. If they are pressed for cash, they might still "go out."[7]

CLANDESTINE PROSTITUTION

Poor women who were single or abandoned by partners were forced to fend for themselves by practicing clandestine prostitution because of their lack of schooling and skills. Clandestine sex workers were housewives, widows, single women with children, and young girls. They were clandestine because they hid their sexual activities due to shame and stigmatization associated with prostitution. They were not registered and did not consider themselves sex workers because they worked occasionally when in need of money. Both groups (registered and clandestine) used sex for exchange of cash, goods, and /or favors, and both groups were affected by the global economic stress and extreme poverty. Clandestine sex workers were afraid of the police, being obliged to register as sex workers, going to prison for soliciting in the streets, and having their family, friends, and children know about their activities.

Shame was associated with prostitution because high-risk groups were blamed through the media for spreading the epidemic.

Like in Madagascar, women in Senegal were faced with violence from partners and from clients of prostitution. Although there are sanctions against rape and assault in Senegal, sanctions are not enforced at the level of the governance and at the level of the police because of corruption. Sex workers (registered and clandestine) were afraid of the police, because the police were abusive or demanded money or sexual favors to avoid arrest and mistreated them. Furthermore, most governments do not sanction criminals for violence against women even if they have instituted laws to protect women (Kimani 2007; Mustapher 2010; UNICEF 2000, 2001; Wojcicki 2002).

DATA FROM FOCUS GROUPS

> *"We know that we infect our clients, but we do not have any choice, we have no ways to make a living."*[8]

The women sitting in a circle at Enda Santé's premises in a rural community outside Dakar were at first bashful about answering the questions, almost in denial of their activities. However, during the discussion led by one of the promoters, they started to open up about their daily problems and why they were selling sex. The women of the focus group looked like any woman one would encounter in a market. They wore the traditional clothing; they were widows, HIV-positive women who had been abandoned, women with HIV-infected children, students, and single women. Most had a part-time job (i.e., reselling produce, cleaning), and some were unable to pay for the children's medication (in case of HIV treatment) or clothing and food needs of the family because their husbands/partners abandoned them or could not find employment.

> *"I go out because I need money for the children's medication," said one participant, while another explained, "My husband abandoned me five years ago; I was left with three children and I had to take care of them."*

Data[9] reported here was collected from focus group discussions with twenty clandestine sex workers in Thies, a rural community, in addition to interviews with thirty members of the medical staff. Participants were between twenty and forty-eight years of age. About a third were migrants from nearby countries. The majority were nonliterate and had no specific skills. They recruited clients in bars, markets, and streets. They used cheap hotels or isolated places for their encounters. Clandestine sex workers usually do not have as many clients as registered sex workers. They average four to six clients a week versus fifteen-plus clients for the registered sex workers.

When recruited by peer educators, most do not have a clear knowledge of STI symptoms, modes of transmission of HIV, and the methods of contraception. In case of STIs, they did not go to the clinic for checkups. They said, "*It is too costly*." Instead they tried first to cure themselves with traditional medicine such as herbal teas or potions. Some of them still "go out" although infected. When asked why they would not go to the clinic to get tested for STIs, they mentioned that they cannot afford the cost and/or the medical staff does not treat them well. "*On doit faire la queue pendant des heures pour voir le docteur*" (we must stay in line for hours to see the doctor). Another constraint was that they could not establish friendly ties with the doctor "*ils changent de docteur très souvent*" because doctors rotated often; in addition "*les infirmiéres ne sont pas aimables*" (the nurses are unfriendly). Furthermore, they were afraid to be questioned about their behavior and/or forced to register, which would have brought "shame" to their family and children.

Most felt ashamed about their activities. Among them, one woman with an HIV-infected child was outspoken and explained that they were driven to clandestine sex work because they could not get any medical or social welfare for their sick children. Asked if they were using condoms, they said that they have to convince their clients to use condoms, and some clients refused or offered more money for unprotected sex. Similar findings have been reported (Do Espirito Santo and Etheredge 2004: 144; Laurent et al. 2003: 1813; Quist-Ardon 2001).

Asked if they were using female condoms, they said they knew about them, but not all of them were using them because of the expense. Others said the female condom is noisy, the client did not like it, and it hurt them because it was too dry. However, one said she lubricated the female condom before inserting it and held it in place during sex with no problems. All of them said they were thankful for the directives and organized meetings where they learned about HIV prevention and received counseling and support. They all agreed that their lives were lonely and they felt marginal to the mainstream society because they could not talk to anyone about their activities and their stress.

They said that the weekly meetings scheduled with other clandestine sex workers were extremely beneficial because they could talk about their family's situation and their stress, and they were learning how to protect themselves from STIs and HIV transmission. In addition, they were supporting each other by talking about their life burden. Some of the women had been tested for HIV during their last pregnancy and knew that they were HIV positive, but the majority did not know their status. Finally, the women in the group expressed their wish that they could get financial aid such as microcredit loans that would assist them in becoming economically independent.

Because of the high level of poverty in many African countries, prostitution became a means to survive economically (Ayadele 2009; Raymond

1999). In Senegal, the proportion of the population living in poverty ($2 US/day) was 60 percent in 2008, while 34 percent were living in absolute poverty (at $1.25 US/day) (World Bank 2010). Poor rural women living in urban settings away from kin and abandoned by partners had no opportunities to find jobs, especially if they were illiterate and unskilled (Ebin 2000). It is difficult to get statistical data on clandestine prostitution because women usually do not visit health facilities and tend to deny their own activities because of shame and stigma.

Compared to other African countries, HIV prevalence for the general population in Senegal is low; it was estimated at 0.7 percent in 2005 and in 2007 at 1.4 percent (UNAIDS 2008). Prevalence rates varied on a regional basis; for instance, in the regions of Kolda and Ziguichor, HIV rates for the population reached 2.8 percent and 2.35 percent, respectively (USAID 2008). Other countries such as Nigeria and Malawi have HIV rates of 3.6 percent and 11 percent, respectively (UNAIDS 2010). The prevalence of HIV infection among registered sex workers ranges from 11 percent to 30 percent depending on the locations (CNLS 2010). Enda Santé (2007) estimated that unregistered sex workers represent 80 percent of the sex workers.

INDIA: SEX, RELIGION, AND POVERTY, THE LIFE CYCLE OF THE DEVADASIS

In the state of Karnataka (South India) the Devadasi system existed since the third century AD. The Devadasi tradition (being the servant of God) is a religious tradition in which girls are married or dedicated to deities in a temple. At its origins, dancing and singing were the major parts of the worship. The girls enjoyed high status and learned and practiced traditional dances, "Sadir" (*Bharatnatyam*). Literary data also reported that they were expected to provide sexual gratification to the main priest, who was considered part of the deity. In addition they lived as concubines with men who protected them financially and physically. During the British rule in the 1800s, kings who were the patrons of the temples became powerless, and the temples along with the Devadasis were left without support. Yet based on religious and superstitious beliefs, the custom survived and became a way to institutionalize prostitution.

The Devadasi system was outlawed in 1982 in Karnataka and in 1988 in Andhra Pradesh; however, it is still practiced in several northern districts of Karnataka and Andhra Pradesh. Although they are now going underground, rituals are performed in private homes, and priests make money from conducting rituals. In Bagalkot, Belgaum, and Bellary the girls are mostly dedicated to the Goddess Yellamma.[10] Devadasis are from the lowest caste, the "dalit,"[11] or intouchable. They are poor and mostly illiterate; their beliefs and

practices are interlinked with religious, superstitious beliefs and social customs. In the districts where the Devadasi system prevails, girls' prostitution has become a way for many to survive.

THE DEDICATED GIRLS

Girls are "dedicated" from a very young age (four years old or younger up to sixteen years old) by parents or relatives through a ritual conducted by a priest in a temple. The ritual includes cleansing and body decorations, singing, and dancing. At menstruation the girl's virginity is auctioned to the highest bidder, usually a man of higher caste (Torri 2009). She may have a long-term sexual relationship with him in addition to being available to other men who visit the temple, or she might be sent to the brothels in Mumbai. There were incidences of sex trafficking associated with the girls' "dedication." Parents would sell the dedicated girl to a recruiter working for the brothels in Mumbai, Delhi, and Karnataka.

The majority of the Devadasis come from poor, landless families. Most are nonliterate in the districts where the illiteracy rate is 64 percent to 70 percent for girls (Majunder 2005: 181). They are brainwashed about mythological/religious beliefs and traditions, and they are not able to marry because parents cannot afford the dowry. In the state of Karnataka, there are 5,000 to 15,000 girls dedicated each year, and it is estimated that out of the 135,000 sex workers in Karnataka, over a quarter are Devadasis (Gurav and Blanchard 2013: 27; Kusum 2012; Sathyanarayana and Babu 2012). Children of the Devadasis do not have a legal father because Devadasis cannot marry, as they are married to the deities.

Findings from the interviews revealed that the Devadasis requested the use of condoms with new clients but did not use condoms with regular partners and lovers. They said that they did not need to use other contraceptive methods because they used condoms, and used abortion in case of unwanted pregnancy. In Karnataka abortions are 1.3 times the national average and 80 percent are induced (Population Foundation of India 2004). If the women were found to be HIV positive, they would follow counseling and treatment; however, they could not stop working because they were supporting the family, including brothers who did not work. They are respected during festivals that involve the Goddess Yellamma and sometimes they are invited to weddings and funerals because they are the emissaries of Yellamma. NGOs have tried to promote some new skills such as making and selling candles; however, during interviews the Devadasis reported that making and selling candles was time consuming and did not support them as well as prostitution.

Currently, prostitution seems to be the answer to their economic stress in the rural communities of Karnataka and Andhra Pradesh because an increasing number of non-Devadasi women are dedicating their daughters as a means of earning income for the family. Older Devadasis usually become beggars in front of temples, in the streets, or at marketplaces and are called Ioghatis (old Devadasis); if not sick with AIDS or other ailments, they might survive through the financial aid of their dedicated daughters and begging.

THE PARENTS

Parents' choice to have their daughters dedicated is based on the lack of economic resources, their beliefs in the deities' redemption, superstition, illiteracy, male gender preference, poverty, and lack of dowry for girls. The dowry system was abolished in 1961 but is still practiced. Girls who want to marry must bring a substantial dowry to the groom, such as a television, refrigerator, money, or cell phones, which are material things that they cannot afford, living on $2 daily. Also, parents dedicate young girls at birth if the girl presents some characteristic signs of predestination, like copper-colored hair or a physical handicap. Furthermore, it is a custom that is passed on from mother to daughter(s), and it is not stigmatized by the communities. Asked how they felt about their parents involving them in prostitution, respondents said "they did not know better."

LOCATION AND FEES FOR SEX WORK

Some Devadasis work from brothels located near the temple, while others work from their home or from public places. The fees are what the client is willing to contribute, usually $1 or less. Women average five to ten clients a day, depending on their location. The total gain is divided between the temple and the family. Clients are field-workers, truck drivers and their assistants, and the local residents. They belong to the low economic class and caste.

SOME CHANGES

The Devadasis interviewed[12] were aware of HIV prevention and the risk of acquiring STIs because they were the beneficiaries of a USAID HIV prevention program. However, the majority of the Devadasis, who did not benefit from this medical program were not as informed about STIs and HIV transmission and prevention, continue with the traditions of sex work without medical checkups. The findings reported in the next section reflect the program's efforts to empower the Devadasis.

Rama was dedicated at the age of six years old and started to work for the temple and her family at the age of twelve. She worked for fifteen years as a Devadasi in her home supporting her family. Two years ago, she was recruited by an NGO because she had some schooling. She is now an activist against the dedication of girls in her community. She told me that she has forgiven her parents for her dedication.

In general, the Devadasis interviewed think that this custom imposed by their parents belongs to another generation, and they would not impose it on their daughters. They said that they want their children to be educated and go to college. They were informed about the danger of STIs and HIV because the program provided medical checkups every three months. The NGO in charge of the program developed support groups for the Devadasis, trying to help them obtain housing, an identity card and ration card, and insurance. This proposal had been submitted to the government in 2010, and they were waiting for an answer from the government. With the help of the NGO, this group of Devadasis learned to sign their names and open a bank account for 2 percent interest, and as a group they were saving money. In case of emergency, money was distributed to a group member in need of such things as emergency surgery or hospital care. Some NGOs were empowering them through the development of a cooperative, and lecturing them on condom use and getting help in case of violence.

In Karnataka, a group of Devadasis supported by an NGO developed an association against the custom, in which they call the police when they learn of new dedications of girls in private homes. The real problem was that the police often did not respond because of the geographical marginality of the communities. The NGO has also involved this group of Devadasis in a self-help group (a type of microcredit) and gave them a lead to government programs. However, most of them could not read or write and needed someone to help them to fill out the forms. Some Devadasis, if approved by government programs, could send their children to schools sponsored by private organizations and the government, but the number of children accepted is very limited. In addition they have health programs offering prevention and treatment of STIs/HIV/AIDS established by the government and donors. Lack of transport is a problem to access medical facilities and also illiteracy to apply for social programs.

The parents who are not reached by government and/or donors' programs continue with the girls' dedication as a source of income for the family. In addition they are not aware of the government social services because of the marginality of the communities, the lack of transport to medical centers, and the NGOs' limited reach to the population.

NGOs empowering sex workers in Karnataka were inspired by the Sonagachi Project for sex workers founded in 1992 by Smarajit Jana in Kolkata

that focused on HIV prevention, STI risks, condom distribution, and STI management along with peer education (among sex workers in Kolkata, there is an average of 5.17 percent HIV-positive women). The project in Kolkata had three defined goals: respect sex work and those involved in it, reliance on sex workers to run the program, and recognition of sex workers' rights. Although the project improved the HIV prevention through condom usage, there were some lessons learned over the years, such as "health" was the main outcome of the donors' projects, while sex workers placed a greater priority on community development work (Swendeman et al. 2009). Also important is the involvement of the brothel owners to promote HIV prevention (Gruber 2007).

In Mysore, I visited the organization Ashodaya Samithi (the dawn of hope); the goals were to empower sex workers by raising their self-esteem and education about STIs and AIDS prevention with peer education and the use of condoms. At the community level the NGO was trying to get support for sex workers and recognition of their activities as a profession from the authorities along with more clemency from the police for the stigma and decriminalization of prostitution. With the support of international donors, the NGO developed two empowerment projects involving sex workers; one was the running of a restaurant that became very popular, and another was the implementation of a clinic offering medical services for sex workers.

SYNTHESIS

In Madagascar, Senegal, and India, the same constraints affected the women involved in sex work, although the countries and the cultures were different. Determinants included cultural gender preference for males, a lack of schooling for girls, a lack of job opportunities for women, and a lack of social programs for poor women. In Karnataka, the government is trying to establish social programs but seems overwhelmed by the problems of traditions, religion, and sex trafficking.

Clandestine prostitution is practiced everywhere women cannot feed their families because they do not have any skills and because they are nonliterate. They practice prostitution irregularly, usually do not go for medical checkups because of shame, and often work while sick with STIs. It is a high-risk group for HIV transmission, and because of their need to keep this part of their life secret, statistics are not available. The women do not think that they are sex workers because they don't "go out" on a regular basis. The majority of women said that it was disgusting and they would rather make a living having a decent job. However, prostitution is like a drug for some, because it is easy money. When NGOs tried to provide these women with manual skills such as making candles or making embroidered clothing in Madagascar

(Maynard-Tucker 2002), they complained that they did not make enough money and worked long hours for very little pay compared to prostitution. Because I visited the brothels in Madagascar and found the conditions horrific, I got involved in an empowerment project for the sex workers willing to leave their clandestine sex work. Based on past experience trying to rehabilitate sex workers in Madagascar, I found that it is extremely difficult to break the habit to make easy money and to regain self-esteem and dignity without psychological and economic support.

Male informants in Madagascar were very talkative about their sex life. They described two groups of women: One is the sex workers, with which sex is exciting and sensual, and the other group is their (respected) wives and girlfriends, with which sex is a routine. In addition, their machismo was defying their fear of HIV and the use of condoms. Their attitude and behavior point out the need for men's educational programs that already exist in some countries and should be replicated.

Data from Senegal show that donors need to work more closely with NGOs because NGOs like Enda Santé and others have already established strategies for recruiting clandestine sex workers, a high-risk group in urban and rural areas. They already have organized HIV prevention meetings and support meetings that were praised by the women.

In Karnataka, I was surprised by the acceptance of the Devadasis' system in the communities. Prostitution was entangled with religious and superstitious beliefs; therefore, the Devadasis had no inhibition, and many accepted prostitution as a job and a way to be economically independent. In the state of Karnataka, HIV/AIDS prevalence in antenatal clinics (ANCs) is estimated from 1.5 percent to 21.6 percent (mostly pregnant women). Among sex workers it is three times the national average. If the prevalence is 1 percent or more for low-risk groups such as ANC patients, the state is considered to have a generalized high-prevalence HIV epidemic. This suggests that the epidemic has spread into the sexually active general population (Population References Bureau, Foundation of India 2004: 6).

The next chapter will discuss some issues such as the impact of change in a traditional society and UNFPA global methods of evaluation applied to various countries that are divergent in their governance, economies, cultural customs, and responses to the donor's input about the decrease of maternal mortality.

NOTES

1. Sex workers are issued a card, and they must show this card to the police in case of a raid. The card is stamped each time they go for a checkup at the health facilities.

2. This was a qualitative study conducted for the World Bank in 1996 to complete an analysis of a previous survey, where participants had a high rate of STIs. The methodology for this research included focus group discussions with clandestine sex workers and in-depth

interviews and life stories. Sex workers ($N = 24$) and clients ($N = 27$) took part in the focus group sessions, plus three women were interviewed individually. Six facilitators, three men and three women, translated the group discussions from Malagasy to French. Etudes Qualitative des Comportements Sexuels des Groupes a risque: Prostituees non-Ficheés et Clients pour la Prevention du SIDA a Antananarivo, Madagascar, World Bank project CR-1067-MAG.

3. This custom is also popular in South America.

4. I found that in most regions of the world, semiliterate men believe that menstrual blood is dangerous to their health, leading to impotency and sicknesses.

5. In Madagascar, one can buy antibiotics from drugstores without prescriptions like in most developing countries.

6. Sex workers, legal or clandestine, fear going to the medical clinics because the medical staff is not friendly and because they might retain their card if they have an STI. Clandestine sex workers feel ashamed and fear the STI or HIV diagnosis; consequently, both groups avoid medical visits or medical checkups.

7. Sex workers use the expression "going out" for prostituting in Madagascar and in Africa.

8. This statement was given during a focus group discussion (October 2009, Senegal).

9. Enda Santé is an NGO specialized in working with both registered and clandestine sex workers. Enda Santé organized the focus groups in Thies. Twenty clandestine sex workers were asked several questions in Wolof, and a facilitator translated the answers from Wolof to French. The questions inquired about sex work, recruitment of clients, use of medical facilities, knowledge of HIV/AIDS, use of condoms (male and female), and how they foresee their future. In addition, I interviewed the medical personnel who spoke French $N = 30$ in the clinics and hospitals (Maynard-Tucker, "The Invisible Challenge to HIV/AIDS Prevention: Clandestine Prostitution in Senegal," *Journal of International Women's Studies* 13, no. 1 [2012]: 19–31).

10. There are many versions of this myth. One of them related to the story of Yellamma, who was married to sage Jamadgwi and the mother of five sons. One day she went to the river to fetch water and returned home late, which made her husband furious, and he accused her of being unfaithful. He ordered his sons to punish their mother, but four sons refused and the fifth son beheaded her. Yellamma's head multiplied and moved to different regions. This miracle made her sons worship her head.

11. The caste system was abolished in 1961; however, it is still practiced, and the *dalit* or *scheduled caste* belongs to the lower caste. There are 160 million who belong to the *dalit*, which means "downtrodden" (Torri 2009: 32).

12. In 2011, a total of fifty-four Devadasis (eighteen to sixty-five years old) were interviewed in Belgaum, Bellary, and Bagalkot in the state of Karnataka; a facilitator translated from Kannada to English. In addition $N = 25$ medical personnel and governmental officials working for the USAID/HIV prevention program were interviewed (Samastha Project Report, "Integrated HIV/AIDS Prevention Care and Support in Karnataka and Andhra Pradesh, USAID/KHPT India").

Chapter Seven

Nepal and Madagascar

Broadening the Reach of Health

This chapter presents two projects[1] in which donors had the power and the means to improve the life of the beneficiaries. One project addressed girls' continuing education in a Nepalese rural community, the other project attempted to decrease maternal mortality in Madagascar. The chapter also discusses donors' grants, administrative agency, and the role of the governance, three bureaucratic entities not united for the same cause and not always working in harmony. This is illustrated by reporting on programmatic and governmental issues confronting beneficiaries at the termination or cancellation of a project/program and the lack of sustainability of most programs when they are handed on to the ministry of health.

THE FEMALE EDUCATION SCHOLARSHIP PROGRAM (FESP)

Education in Nepal reflects the cultural values of the society. For centuries women have been oppressed by strict cultural customs, prearranged marriage, lack of economic independence, lack of education, large families, and the dowry system. Male children are preferred, and parents make sure that boys are educated because they expect sons to find jobs and support them in their old age. The overall literacy rate in Nepal is 71.6 percent for males and 44.5 percent for females, but in rural regions the rate for females is between 4 percent and 10 percent (UNESCO 2010).

The FESP was sponsored by USAID, administrated by the ASIA Foundation, and implemented by the Women Development Center (WDC) in Nepal-

gunj from 1991 to 1995 in the rural district of Banke, a locality in the Terai region of Nepal.[2]

In 1991, the FESP supported girls' education by giving a scholarship to all girls in grades six through nine (ages eleven to eighteen years old) who attended four selected schools. The scholarship consisted of a monthly allowance of 80.00 Nepalese rupees (NRs) (about $1.65 US) and provided funding toward the cost of tuition fees, stationery, books, and uniforms. The objective was to motivate parents to keep their daughters enrolled in school. This would hopefully encourage the parents to postpone early prearranged marriages, and the girls would become economically independent and ultimately change their attitudes toward early marriage and having large families.

This project involved female mentors who were educated Nepalese women and were used to urban/modern life compared to the women living in the rural communities. Mentors were volunteers who were assigned a number of schools to visit each month. During the visit they lectured the girls about the benefits of education and economic independence, late marriage, and the use of contraception to control the number of children they might have in the future to ensure a smaller family size. Mentors also checked on school attendance and absence. If a girl was absent for more than a week, the mentor would visit her home and question the parents regarding the reasons for her absence. Some of the reasons were that the girls had to help with household chores, babysit, or work the fields. Mentors established a close relationship with the girls and their parents and supervised the girls' behavior on a friendly basis, coaching them about finances and the use of the scholarship money.[3]

The research/evaluation of the project was based on observations of the schools, focus group discussions with the girls who received a scholarship, their parents, teachers, mentors, and the staff working at the WDC. The results showed that school attendance grew from 765 girls in 1991 to 3,314 girls in 1994. The majority of the girls were changing their lifestyle; they said that they would get married after finishing their studies and getting a job. They thought that they should marry between the ages of twenty and twenty-five years (traditionally they were married between the ages of twelve and fifteen years). They also said that they did not want more than two children, and did not have any gender preference. Traditionally boys were preferred and women had an average of 5.6 children.

> *"I want two children of any sex . . . it is difficult to nurture more children. I would not be able to provide proper diet and education"* (quote from a thirteen-year-old Nepalese student).

All the girls felt that "education was a dowry" and explained that if they acquired a skill or profession they would be able to buy their own dowry that

Figure 7.1. Going to School, Nepal, 1994

usually consisted of saris, jewelry, and household commodities. In addition they felt that they could get a better husband (one that did not drink or was not a womanizer).

The attitudes of the parents also changed in that they came to believe that education would help their daughters' future. Parents in both semiurban and rural areas thought that both sexes should be educated equally. The interviews with the girls and their parents reflected a change from traditional customs and beliefs. Education came to mean respect, status, knowledge, improvement, and economic independence.

Overall, the FESP provided a new focus on life for the girls. They felt assertive and conscious of their own roles and value. This was a change of attitude from their mothers' behavior that was characterized by passivity, low self-esteem, and dependence on their husbands. Both parents felt that their daughters' roles were becoming equal to their sons. They reasoned that if girls were educated they would support their parents in old age just like their sons.

The success of the project was based on the united work of the agencies (donors, administrative agency, and implementing NGO) that were working in harmony for the benefits of the girls. The education of the girls and the impact of the mentors who established close ties with the girls and parents promoted an intergenerational change in a short amount of time. Among the

girls, the program boosted self-confidence, self-assurance, decision making, and independence that was lacking among the girls' mothers because of illiteracy and dependence on husbands for decision making and survival. Although the project was terminated in 1995, its legacy impacted rural communities with an awareness of the importance of gender equality and education for women. The project was funded by USAID with a small budget ($450,000 US) but made some positive impact in the communities of the Terai region of Nepal.

Conversely, the following section reports on a very expensive project that was too ambitious and not well designed, and organizations involved did not work as a unit.

MATERNAL MORTALITY IN MADAGASCAR

Decreasing maternal mortality is one of the United Nations' 2015 Millennium Development Goals. It is the highest in rural regions of the world, including Madagascar. The Maternal Health Thematic Fund (MHTF), which was funded by the United Nations Populations Fund (UNFPA), developed a project to curb maternal mortality in thirty counties where statistics showed that maternal mortality was high. The project received $60,000,000 from seven European countries to evaluate these countries with high mortality, but the evaluation of the programs after implementation revealed weaknesses and a lack of in-depth research.

Located in the Indian Ocean in southern Africa east of Mozambique, Madagascar is a beautiful island. There are several unique species of flora and fauna that live there but are now endangered because of deforestation, overgrazing, desertification, and water contamination. I had worked in Madagascar in 1996, and on this second trip in 2011, I had hoped to see some economic improvement, but in the intervening time, the country had gone through political turmoil and economic struggle. I did not see any economic progress or women's advancement.

Madagascar has a population of 22 million and an annual population growth rate of 2.9 percent. Maternal mortality is estimated at 440/100,000 per live births (UNAIDS 2010), and the mortality of children under five year of age is 61 per 1,000 live births. Life expectancy is 64 years, and women average 4.96 children (DHS 2008). Government expenditure for health in 2009 was 6.2 percent of the GDP, and in 2007 there were only two doctors for 10,000 inhabitants (Global Health Facts 2010). About two-thirds of the population lives at least five kilometers from a medical center, and 50 percent of the population lives below poverty level (CIA 2011).

UNFPA'S MATERNAL HEALTH THEMATIC FUND (MHTF)

The project started in 2008 and was supported by Austria, Finland, Luxembourg, Netherlands, Norway, Spain, and Sweden as well as private donations. The purpose was to decrease maternal mortality in countries with more than 300/100,000 maternal mortality per live births and to evaluate the needs assessment for emergency obstetric neonatal care (EMONC) and the campaign to end obstetric fistula (the latter ranks high on the maternal mortality scale).[4] The program also provided national governments with funding and close coordination with the program Reproductive Health Commodity Security. It is a framework to assist countries in planning their own needs for essential reproductive health supplies (UNFPA 2010).

UNFPA'S CONSULTING AGENCY

A German consulting agency won the bid for the administration of the project and subsequently hired consultants for desk and field research.[5] The project involved an evaluation of twenty-two countries plus program evaluation of an additional ten countries based on field visits. These countries were Burkina Faso, Cambodia, Ethiopia, Ghana, the Democratic Republic of the Congo, Kenya, Laos, Madagascar, Sudan, and Zambia. Four consultants were assigned to do a desk review of published materials and country reports in order to select the primary indicators of maternal mortality in each of the twenty-two countries. The desk consultants' literary search was challenged because most country reports did not show any specific data about the UNFPA's program as a separate entity for the baseline indicators. Nevertheless, they selected some indicators of maternal mortality in the literature but focused mainly on the operational process of the program. Others consultants were hired to conduct field assessment, which consisted of visiting the ten countries and evaluating the progress of the MHTF.

CRITICAL METHODOLOGY

The desk consultants in charge of composing the questionnaires had little background in research and lacked knowledge of the countries involved. They composed three lengthy questionnaires based on the most important indicators found in the reading materials, which were applied in the field. In Madagascar, interviewees included UNFPA's partners, stakeholders, medical and administrative personnel, and three women who had fistula surgery. The questions were written in German first, translated in English, and again translated in French.[6] However, the consultants' knowledge of English and particularly French was below average. The questions were too long, difficult, and

confusing because they often included two different topics in one question. The focus of the evaluation related to the operational process of the program from the perspective of partners, along with partners' support, the harmonization and coordination of the services, community involvement, capacity building of the medical staff, equipment and supplies, training of the medical staff, outreach campaigns, integration at the ministry of health of a gender perspective[7] about health-care delivery, and the visibility and leadership of the UNFPA program.

There were no questionnaires for the rural women who use the medical facilities for birth delivery and/or for the rural women who did not because of constraints. When I raised the question, the consultancy agency told me that they had planned interviews with three women who were fistula patients in Togliari.

Obstetric fistula is the second most common cause of maternal mortality. It is characterized by a tear between the rectum and the vagina or a tear between the bladder and the vagina, which can happen during difficult birth. The obstetric fistula is often found among teenagers who give birth too young, before their body is developed enough for the birthing process. The Demographic Health Survey (DHS) 2004 reported that mortality associated with the obstetric fistula was high with 157/100,000 deaths. Although a fistula can be repaired with surgery, most women do not know about it and live handicapped and often ostracized by society and relatives because they cannot control urine or feces. Since 2003, UNFPA has sponsored more than 27,000 surgical fistula repairs.

We interviewed three young women at the hospital in Togliari who had a fistula surgery sponsored by UNFPA. They were between eighteen and twenty-four years old; lived in Togliari, a semiurban community; got pregnant in their teens (fifteen to sixteen years old); and had birth complications because of their young age. They lost their babies and felt that they were lucky the hospital was offering the surgery sponsored by UNFPA. All of them were very satisfied about the surgery and were living a normal life.

WHY WOMEN PREFER HOME BIRTH DELIVERY

The young women interviewed about their fistula surgery focused mostly on their opinion of the UNFPA fistula services at the hospital. Furthermore, they did not fit the characteristics of rural women; they were educated and lived in semiurban localities close to health facilities.

In the following section I used data given by the director of the hospital in Togliari and data from a master's thesis collected by a student from the Catholic University of Madagascar (Leondaris 2011), who conducted field-

work in several rural communities and inquired about women's behavior toward home delivery.

The director of the hospital said that about 18 percent of the rural women delivered in a medical facility. The challenges for the women who wanted to deliver at a medical facility were (1) shortage of human resources in rural communities (there are few doctors or medical assistants); (2) shortage of facilities and medical supplies; (3) lack of transportation and roads (4) condescending attitudes from the health workers; and (5) fear of injections and surgery. Rural women prefer to give birth at home with traditional midwives because they were not treated well by the medical personnel at the health facilities. They did not trust the medical personnel, who were perceived as incompetent and often absent when needed. In addition they did not have the money for transportation and/or for hospitals' fees (Leondaris 2011: 48–49). Home delivery permitted them to practice their traditional customs usually based on the humoral theory of hot/cold food rituals to ensure good health, and women often develop a strong friendship with the midwife. In addition, women preferred to be home because they had to care for the other children and they felt they were in a secure and trusted environment.

TRADITIONAL MIDWIVES

Midwives were preferred for home delivery, although there were few available in rural communities in 2008; there was one midwife for 2,323 women in the communities studied (Leondaris 2011: 7). Midwives use massage and manipulation along with teas and respect the cultural taboos about pregnancy and birth delivery. Paradoxically, midwives are more expensive than the public health system; furthermore, they are not knowledgeable about birth complications and need to refer emergencies to the health facilities. Some traditional midwives were trained by the ministry of health about signs of complications during the last stage of the pregnancy. However, the training was typically only one to three days, and there was no follow-up to assess their assimilated knowledge.

Women prefer midwives to the medical staff, who are either a male doctor or male trained medical assistant (Leondaris 2011: 56). Also, women mentioned that the medical staff in health facilities commented on their lack of hygiene and the lack of clean clothing. Women mentioned that they would prefer that the medical staff be someone from their communities, who would understand their culture, beliefs, taboos, and their limitations (Leondaris 2011: 55)

CHALLENGES UNMET

During the evaluation, we discovered unmet challenges that could have been realistically addressed but were left unsolved by the governance and the stakeholders. Maternal deaths are the highest in rural communities because of difficult access to health facilities and lack of transportation. In case of emergency the patient had to be carried on a stretcher made out of tree branches. The distance to a health facility was/is very long, and sometimes the patient died during the transport or upon arrival at the facility. One solution to this problem would be to ask a doctor, trained health worker, or trained midwife to live in rural areas. The medical personnel refuse to live in rural areas because of poor sanitation and the lack of comfort, medical resources, and beds in some health posts. This problem has not been solved because the governance has not developed rural areas (piped water, electricity, and roads). It is a difficult challenge, and it must be solved because statistics show that maternal and children's mortality are the highest. In addition, some births and deaths are not reported because of time and transportation constraints; therefore, maternal and children's mortality might be even higher than reported during the national surveys.

RESULTS FROM THE EVALUATION

This project showed that there was a gap between donor, administrative, and implementing agencies. Results from the evaluation primarily related to the operational process of the program and were superficial, ultimately not benefiting the women in need. We did not get any statistics to show that the program had improved the safety of the birth process in rural communities, because there was a lack of baseline data. The medical staff also did not report any increase in deliveries at the rural health facilities. Overall, the evaluation was not effective. The main problems were that the global project was too ambitious, badly managed, and the four consultants who developed the questionnaires were lacking research skills and knowledge of the selected countries.

Another major issue was the lack of data collection about rural women as part of the evaluation. The opinions of the beneficiaries reflect the success or failure of a program, and there is an urgent need for better health care and decreased maternal mortality in most rural parts of the world.

The synthesis of these two programs reveals that donors can broaden the reach of health, if the program is well designed as it was for the FESP in Nepal. In a short time the FESP impacted years of cultural traditions, and participants were willing to make positive change in their lives. On the other hand, the launch of the MHTF project was too ambitious and ultimately did

not address the problems surrounding maternal mortality. This evaluation did not promote strategies for a decrease in maternal mortality. These two projects exemplify the power and the reach of donors among rural women and the complexities and bureaucratic entanglements that impact the success of a program.

The following sections will report on issues in development: the dependence on donors' grants for improving health care, the impact of the cancellation of programs on beneficiaries, patients' behavior, and the lack of sustainability of the programs when they are handed over to the ministries of health.

ISSUES IN DEVELOPMENT: THE IMPACT OF PROGRAM TERMINATION OR CANCELLATION

This section reports on a selection of issues that often confront beneficiaries and are due to bureaucratic ignorance, poor collaboration between donors and governance, and poor planning of the projects at their inception. It illustrates the problem of nonharmonization between the governance, donors, and field activities.

One day, when I arrived in the village of Markita in Peru, Elena came to me and was very upset. She had been taking the contraceptive pill for one year free of charge from an international program integrated into the public sector. She told me that when she went to get her refill of contraceptive pills at the health post, the nurse told her that it was the last time she would get the Pill gratis because the international program was canceled. Starting next month, she would have to pay for the pills and buy them through the public health sector; it would cost about $1.50 US monthly. She was living on $1 to $2 a day and did not have the money to buy the pills and as a result stopped taking them. She began to use traditional contraceptive methods again, drinking teas and performing rituals, and after a few months she got pregnant and ultimately had an abortion.

In Nepal, an international development agency sponsored an informal education program for rural women that taught them the alphabet over a six-month period. The women were eager to learn how to read and write, but the program only taught the alphabet. The women wanted to learn to sign their names and begged me to intervene with the agency to provide additional courses. I learned later on that they did not get their wish, but had to go through the alphabet class again.

In Bolivia, during the evaluation of a program about maternal and child health including family planning, the team leader, who was a devout Catholic, decided to recommend the cancellation of the program. He was strongly against family planning due to his religious beliefs. My colleague and I

argued with him, but as the team leader he had the last word writing the report, and the program was ultimately canceled. The women who had been enrolled in the program and received a contraceptive method gratis did not have any alternative because they could not afford to buy the contraceptives offered by the public sector.

Another problem is the lack of medical supplies (for example, contraceptives or HIV medication). For example, Rosita was taking the Pill for a year, and one day she learned that the health post did not receive or did not order the supply of the pills in time. For a few months the women were asked by the medical staff to switch to an injection of Depo-Provera or an IUD. Most of them refused to switch because of fear of side effects of the other methods. Some of them got pregnant, blamed it on their method, and had an abortion.

Shortage of HIV medication is very bothersome because patients have to buy the ART treatment out of pocket at pharmacies, and most of them cannot afford it. If they stop the treatment, they create resistance to the medication and are faced with buying more expensive medications that they cannot afford.

International funding is discontinued for many reasons, including political, economic and bureaucratic, and financial (e.g., lack of funding, underachievement of the program, dispute with local authorities, running out of money, and others). The result is that the patients getting treatments and drugs gratis from clinics and hospitals are greatly affected because they cannot continue their regimen or treatment. The ministry of health typically takes over the donor's program if the services have been integrated in the public sector. However, the public sector usually charges patients because of cost recovery. Most patients visiting the public sector do not have the money to pay for health services or drugs.

SUSTAINABILITY OF THE PROGRAMS

Sustainability implies maintaining something that already exists over time and is often equated with being "self-sustaining" or "self-sufficient," implying that no outside support is needed to continue its existence (Kimaro and Nhampossa 2007: 2; Reynolds and Stinson 1993).

Sustainability is based on the capabilities to build local technical, managerial, and financial capacities in order to sustain donors' projects (Kimaro and Nhampossa 2007); however, when the personnel is well trained, they search for work in the private sector or outside the country. In addition, large donors' grants are often lost in the multilevels of intermediary organizations before they reach the grassroots projects. This long funding chain spreads the funding sideways and creates a void for the beneficiaries.[8] For example, projects involving women's empowerment should start at the grassroots level

in order to stop the intermediary chain and then be expanded after consolidation. This would give more power to the communities and the local organizations with a supervisory role from the ministry of health. It would break the top-down system in which financial transparency is difficult because of the number of organizations involved.

Donor funding is typically short term, and local organizations are expected to continue with the projects after the withdrawal of the funding. Unfortunately, the local medical and administrative personnel lack the technical or managerial capabilities to continue the programs (Kimaro and Nhampossa 2007: 3). This lack of human resource competence does not insure the sustainability of the donors' projects. Furthermore, this lack of sustainability reflects faulty planning at the inception of a project from both the perspective of the donors and the local organizations.

BARRIERS TO ADHERENCE TO HIV TREATMENT AND CARE

In rural regions the barriers to HIV treatment and care are logistical, economic, political, and cultural. The logistical barriers most common are the lack of transportation and the time it takes to walk to health facilities located usually four to five kilometers or more away. The health facilities are where patients get refills of their medication and get care and treatment. Even if transportation is available, patients do not have the money to pay for it on a monthly basis. The political barriers are the noninvolvement of the governance in improving rural areas (developing roads, water access, and electricity). Cultural barriers are a lack of understanding of modern medicine and for HIV patients to be able to take their regimen on schedule and to understand their CD count tests. Furthermore, the medical personnel are not always well trained and do not treat patients with compassion. They are perceived as impatient and authoritarian with rural people, who think the medical staff is condescending because of the lack of education and personal hygiene of the patients. In addition, going to a clinic or hospital for HIV treatment and services can promote stigmatization and gossip from people who are not aware of the patient's positive status. Another problem is that patients forget to take their regimen daily. Strategies to supervise rural patients are very difficult because of the lack of transportation. Some promoters use a motorcycle and then have to walk to the village. It is not an easy solution to visit daily marginal communities. The idea to have two patients collaborating on their medication intake was put in motion in some communities. It was found that if the patient does not have a treatment "buddy," the patient would more likely lack adherence to treatment (Unge et al. 2010).

BEHAVIOR SIMILARITIES IN PATIENTS USING HIV TREATMENT AND MODERN CONTRACEPTIVES

When people are facing similar situations, behavior is often the same in spite of different cultures and beliefs. The behavior of nonliterate patients is the same in South America, India, Asia, and Africa, as they try to make sense of modern medicine and treatment. The use of modern contraceptive methods and HIV treatment requires discipline and a notion of a time schedule. Both are barriers to the compliance of patients living in rural communities. Women using a contraceptive method often reported that they forgot to take the pill, or the date of their clinical appointment for their next hormonal injection, or the date for their IUD medical checkup. For example, many women during my fieldwork in Peru, Haiti, and Africa reported visiting relatives in a different community for as long as a week and forgetting to take their contraceptive pills with them. Many eventually got pregnant and typically blamed it on the contraceptive method.

Lack of adherence to HIV treatment has serious consequences in that it can create resistance to the anti-HIV drugs. Changing the regimen to overcome resistance is very expensive and requires the patient to pay for the medications themselves. Many cannot afford it. They are warned about the consequences of poor adherence during counseling sessions, but they are unable to truly comprehend the issues because of their lack of literacy.

Some programs offer to train a family's member or a "buddy" to remind the patient to take his/her medication for HIV treatment, while other programs have trained promoters to go to the patient's home to assure adherence. The latest program was initiated in Haiti by Paul Farmer and then replicated in many countries. However, this is a very expensive way of dealing with the problem of adherence and does not address the real issue; that is, developing strategies to educate rural populations.

THE CONDITIONS OF THE HEALTH SYSTEMS

The Paris Declaration of 2005 aimed to harmonize the work of donors in order to eliminate replication of projects and to coordinate their activities (Kharas 2007, 2009). Ministries of health are often submerged by bureaucratic work from their multiple donors and do not have the skills to administer the various grants and demands from donors. Likewise, ministries of health have their own bureaucracy to deal with that involves manual office work, because not every department is computerized. In addition they have to follow their own policies about health and comply with the wishes of the donors to integrate their programs vertically or horizontally. Furthermore, in many countries health care is centralized in urban centers and hospitals. Decentral-

ization of health-care delivery has not yet been achieved but is the goal of many countries. At the moment, there is a gap between urban and rural health care, and it is reflected in the mortality statistics of the countries. Every year 4.4 million children, including 1.2 million newborns and 265,000 mothers, die in sub-Saharan African countries (Kinney et al. 2010).

In many countries the response to the problem of isolation of rural communities has included strategies such as ambulatory health care (primary care is offered from a bus equipped for it), walkie-talkies for communication, transportation with a motorcycle with sidecar, the training of the health workers in primary care, the training of traditional midwives concerning pregnancy and birth complications and referrals, and the training of healers. These strategies have not been really successful, because most need grants from donors in order to keep functioning and be sustainable.

Donors can broaden the reach of health because they have money and power to improve the health systems and the local organizations. The huge bureaucracies that represent donors and ministries of health become a handicap to the implementation phases of a project. Once a project is implemented, local organizations respond by trying to get the most coverage possible in a short period of time. This is a mistake, because when a project is overextended, it is difficult to control the quality of care and the supplies (drugs for family planning or HIV). There is often minimal supervision of the health facilities and the medical staff due to the lack of human resources. At first, the results might be statistically rewarding (e.g., increased number of new patients), but the lack of quality of care ultimately affects the adherence of the patients to the services after a few weeks. The project can run into problems including a shortage of medical resources and overworked personnel. The top-down approach used by donors illustrates the fact that technology, financial oversight, and management of projects are not fully institutionalized into the work processes of the local organizations (Kimaro and Nhampossa 2007).

BENEFICIAL IMPACT OF DEVELOPMENT

Although there are many challenges to overcome in the future, development has had a beneficial impact on the world's most needy populations. Major impacts have been made through children's immunizations projects reaching isolated communities through outreach programs. An important contribution has been the worldwide distribution of ARTs for people infected by HIV, family planning and reproductive health, and the Gates Foundation goals to decrease the mortality of children under five. Other projects included the fight against malaria and tuberculosis, maternal/child transmission of HIV (Global Fund/UNAIDS), the decrease of maternal mortality, and the increase

of family planning services, along with the awareness of HIV transmission in the general populations and among high-risk groups (USAID/UNAIDS/UNFPA/WHO). All these issues and projects are challenging. Development has promoted better health for the most needy populations in spite of the enormous political, economic, and cultural barriers. The critiques and comments in this book will hopefully inform donors, agencies, and local organizations of the problems found in the field in order to improve the programs and ultimately better the lives of women, children, and rural populations in general.

NOTES

1. I conducted the evaluation of the Female Education Scholarship Program (FESP) in 1994 in Nepal and the evaluation of the Maternal Health Thematic Fund program (MHTF) in Madagascar in 2011 with a German colleague.

2. In Nepal a total of sixty persons were interviewed during focus groups discussions: $N = 3$ focus groups with each group of informants: girls, mothers, fathers; $N = 2$ focus groups with teachers; $N = 3$ interviews with mentors and three case studies of FESP girls; and $N = 8$ interviews with the CWD staff.

3. In some families the parents were nonliterate and the girls were in charge of banking their scholarship because their parents could not read and write.

4. Obstetric fistula is a dangerous complication of childbirth among young girls. It is a tear between the rectum and the vagina and/or the bladder. It can be repaired with surgery, but it is costly if not sponsored by donors, and only a few doctors are trained to perform the surgery.

5. A desk research is a literary research on the topic, while the field research is characterized by a visit to the country and interviews with the primary stakeholders.

6. Interviews were conducted with the medical staff $N = 25$, stakeholders $N = 10$, partners $N = 3$, and administrative employees $N = 20$ at UNFPA/Madagascar and the ministry of health in Antananarivo and the medical personnel in Togliari.

7. Women resent being examined by male doctors or male medical assistants. There is a need to train nurses and formal midwives in gynecological examinations and complications of birth. It is done in some countries but on a small scale. Female doctors would be better, but they are very rare.

8. In Senegal a women's association wanted to start a microcredit club as part of the donor women's empowerment activities, but the project ran out of money as it reached the grassroots level. Donor funding was transferred to the administrative agency, the ministry of health, to a U.S. NGO, then to a local NGO in the countryside, to implementing partners and to a local association, and finally to the women's club. At each transfer, organizations are allotted a percentage of the grant.

Conclusion

Lessons Learned?

The following excerpt is from my field notes written during the evaluation of the HIV prevention Samastha project[1] in Belgaum, India, in 2011. The informant had no clue about her illness.

> *Chekicala is illiterate. She came from a distant village (110 kilometers from Belgaum) thirty-five years old, with two children, her husband abandoned her twelve years ago. . . . She came to the hospital Cardinal Gracias in Belgaum recommended by a friend who had had a good experience previously with the services at the hospital. She came because she had had diarrhea for several days and was tested at the hospital for HIV. Her test turned out to be positive and when I met her she was starting ART treatment (five days hospitalization in order to monitor the side effects of the drugs). She did not really comprehend what HIV was about. She praised the medical staff and the counselor for their care and compassion.*

My journey took me to many countries, and I met many people and developed many friendships. I am proud and thankful for my informants' relationships. The lessons I learned were unique and changed my perspective on life. I have been an observer and participant in their life's routines, and I used my skills as an anthropologist to do research, but always with respect and love. I was lucky to be able to develop trust and friendship during my inquiries because informants were willing to answer my questions and to open up about their intimate lives.

As an anthropologist, I have always put myself in their shoes and conducted interviews as if we were friends talking about life matters. I also lived the way they did, sat on the floor in India and Nepal for interviews, danced

with them in Peru, and with goodwill ate their foods and tasted their drinks even if sometimes it was difficult, including drinking Pisco (a strong liquor) in Peru early in the morning for a celebration. I also try to learn their languages and be a participant in their culture. It paid off, because I was able to establish long-lasting friendships, and they opened up about their life constraints.

Trust is an important element in doing research. Informants must trust you in order to confide in you. This requires time, because they will observe your behavior first, especially when people are marginal and have been abused by outsiders. Trust comes with honesty and their understanding of the reasons for participating in their lives. I also realized that comfort and material things so praised in the United States are nonexistent in developing countries. Priorities are basic: food, water, and shelter. Being able to adapt to various situations is a great asset (for example, not being able to wash yourself for a few weeks because of lack of water or because the weather was too cold). Women opened their hearts to me about their oppression (male authority and cultural customs), and I had to understand their strong ties to their cultural norms. It was at times frustrating, especially when they were assaulted by their partners.

My contact with women who used prostitution for their daily needs has been a lesson in survival and understanding, especially the women who were dedicated to the Goddess Yellamma in India. The Devadasis had forgiven their parents for leading them to a life of prostitution. By doing so, they reaffirmed their strong family ties and their innate responsibility to support the family.

My experiences also showed that men's and women's sexualities were used differently. Nonliterate poor women have adapted to their stressful economical lives by using the two elements that nature gave them, sexuality and fertility. They used their sexuality to generate cash and their fertility to get pregnant and tie a man to them, hoping that he would not abandon them. However, in some situations when men migrated for a long time, some women did not always wait for their partners to return from labor migration and chose to have multiple sexual relationships.

Conversely, men enjoyed their sexuality without limits and with little responsibility. Men migrate for wage labor and establish loose sexual relations, often creating a family in addition to their first family. In Haiti, women knew that their partner/husband was involved with two or three other women, but could not do anything about it. In Africa, women were supposed to be faithful and wait for the return of their partners/husbands after months of labor migration absence. If a woman was diagnosed with HIV during a clinical testing while pregnant, her family and husband would blame her for getting the virus, which for the majority of the women was transmitted by their husbands.

Gender inequalities are persistent in that women transmit their social status to their daughters, and women's subservience is emphasized by traditions in patriarchal societies. Because of illiteracy, women cannot improve their status, and most do not have any skills to find adequate employment. The global reach of modernization has transformed people and traditional societies with the wanting of luxury things or technology that are too modern for the lack of basic commodities where they live. One summer when I was doing my fieldwork in Peru, I rented a room from a couple who were the schoolteachers of the village, who had six children. They had bought a refrigerator (it cost a small fortune) and were very proud of it, but they had no electricity. So the refrigerator was used as a locker and as a symbol of modernity.

Women have shown that they used both traditional and modern medical systems, depending on the severity of the illness and their financial means. Sometimes they use both systems concurrently and sometimes one at a time, depending on the logistics, their cash flow, and cultural constraints. Traditional healers and midwives are able to treat minor illnesses and muscle aches that can be cured with herbal teas and manipulations. However, when they are presented with serious illnesses and complications, they need to know the symptoms and be trained for referrals related to malaria, diarrhea, birth delivery, and ARI. Some training of traditional midwives and healers has been done in some countries, but it was never long and persistent enough. In addition, promoters and health workers along with community health workers need to incorporate the concepts of the humoral theory (hot and cold elements) to explain illnesses and drug treatments, because it is easier to understand than modern medical jargon for many people.

After visiting numerous health facilities, hospitals, clinics, and health posts in many countries and observing the dialogue between doctors and patients, I realized that there should be ways to improve the relationship and communication between doctor and patient. My focus on the quality of the services of the health systems in various countries is related to the fact that women avoid going to health facilities because of the lack of quality of care. Most medical staff are prejudicial against rural people because of the illiteracy and lack of hygiene, comprehension, and communication. Government health facilities do not have enough funding to support the health services adequately. It is now even more difficult, as governments do not have the means to supply free ART for all, and there are many people who are infected with HIV/AIDS who cannot afford to buy the treatment. The high rates of maternal and child mortality and mortality particularly for children below the age of five are also related to the generally weak health systems. It is imperative that medical personnel receive training about communication and interaction with patients, because rural women avoid health facilities where they are mistreated or stigmatized.

Illiteracy and, indirectly, economic stress are responsible for the continuation of traditions such as vaginal mutilation rituals, early marriage, the endurance of gender inequalities, and traditional medicine. Beliefs and customs are hard to change even if the people are educated.[2] The preference for traditional medicine is very popular in many societies and illustrates that patients do not understand modern medicine, medical explanations, drug regimens, and information provided through counseling. In some instances, they would rather pay more to go to the traditional healer who takes the time to explain their sickness and tries to cure them within his/her realm of deities and offerings as a powerful intermediary to the will of God. Besides the esoteric side of healing, most healers have a great knowledge of plants, teas, and massages to treat most minor ailments.

THE MDG'S GOALS

The MDG's goals are advocating more emphasis on improving women's conditions in developing countries through literacy and expanding knowledge of reproductive health. Donors' responses have been slow because they have focused their efforts on HIV/AIDS care, treatment, and prevention. Globally, women's conditions have not progressed yet.[3] Every day women die from preventable causes related to pregnancy and birth; about one in five pregnancies end in abortion, the practice of which is mostly unsafe and illegal. Over two-thirds of the world's 793 million illiterate adults are women. Women suffer from lack of policies against violence from partners, and there are fewer women than men who participate in the labor market. UNFPA (2005) reported that there are nearly 600 million women globally who cannot read and write in our modern technological world. "It is like I have no eyes," a rural woman told me in Nepal, when she explained that she was unschooled. Reproductive health and the prevention of HIV are linked to women's understanding of medical staff's counseling, and adhering to medical prescriptions, drug regimens, and treatment. Women's empowerment starts with the ability to read and write, and nonliterate women should have access to informal/formal education through women's associations, mothers' clubs, and NGOs, such as TOSTAN,[4] an organization that specializes in informal education in rural areas of Africa, along with faith-based organizations. There is also a need to develop globally microfinance credit and self-help groups based on the work that has already been done in several countries and has been functioning with success in Guatemala, India, and South Africa (Mayoux 2003).

Women's empowerment can be accomplished with the assistance of the mothers' clubs, women's associations, NGOs involved in informal/formal education and the development of skill training (e.g., sewing, embroidery,

cosmetology, hairdressing, office work, and nursing) and the involvement of the communities. The Cash Transfer Programs in Kenya and the Kasiisi Project in Uganda have goals to keep girls in school and to prevent HIV (Pettifor 2012; PLOS One 2008). If these programs are successful on a long-term basis, they should be developed globally. At the level of the governance, new policies and laws should address gender inequalities and strengthen women's rights (Sen et al. 2007). Women cannot liberate themselves until they learn how to do it, which involves claiming their equality and their legal rights with a literacy background. Women's empowerment has to be accompanied by educational, economical, social, and political changes—by multilateral responses from local organizations and NGOs involved in development and working as a unit with the donors.

MEN'S PROGRAMS

Men's programs about health, family planning, and HIV/AIDS prevention have been functioning in some countries such as Kenya, Uganda, and South Africa but have not been developed globally (Mills et al. 2012). MenEngage, UNFPA, Promundo, and Sonke Justice Network are agencies working toward changing gender norms through gender transformative action. They have developed programs for boys and men in various countries promoting gender-equitable norms for men and boys, where men learn about women's chores and are lectured about violence against women. However, can they be sustained? Barker et al. (2010: 246) wrote about the evaluation of the fifty-eight interventions based on transformative behavior change and stated that only about ten of the fifty-eight represented longer-term or large-scale efforts to engage men and communities. These programs have been tested in developed and developing countries in North America, sub-Saharan Africa, the Middle East, and North Africa (Barker et al. 2007; Barker et al. 2010).

Lasting programs are men's circumcision programs sponsored by the Gates Foundation in some African countries for HIV prevention. Men migrate for wage labor, and some of them establish a second family or have multiple sexual relations during their absence from home. Men do not always take responsibility for their actions, and some are fearless toward HIV. For more than two decades the literature has demonstrated that men need male-oriented programs about health, family planning, and HIV prevention. The author proposes that men's programs could be supported by donors globally and sustained by the ministry of health of the countries. Likewise, men's behavior could be challenged with the development of peer education, role-playing while switching gender roles, and with an adaptation of the stepping-stone method and the effort of the communities.

DONORS' ROLE

Large donors rarely provide funds directly to local organizations at the community level. The process of channeling funds from top down leads to corruption, loss of time, and bureaucratic entanglement as the funding chain goes through administrative organizations, ministries of health, government-run AIDS organizations, local NGOs, and implementing partners. At the very bottom beneficiaries are forgotten and do not receive enough funding for their support: "very often the beneficiaries receive less than 1 percent worth of what is envisaged in the program" (Thomas 2009). In addition, because programs usually last from two to five years, implementing agencies expand programs rapidly in order to get the largest geographical coverage in a short time. However, problems such as poor road conditions, insufficient stockrooms, or the ruined condition of some health facilities affect the success of such programs. The rapid expansion of a program usually weakens the quality of care because of the lack of human resources, lack of adequate facilities and material, and absence of appropriate supervision.

Another solution to this problem would be to start at the community level and expand the program once it is consolidated; with control of quality of care, training of personnel, securing the material supplies chain, and a choice of facilities that are adequate for the program along with an established supervision/monitoring process. The benefits would include more transparency and control of the funds, less bureaucracy, and more community involvement. Working at the grassroots level would assure that beneficiaries actually benefit. Obviously, this type of approach should be selective, with a community-oriented goal.

Programs conceived for literate urban populations that are applied to illiterate rural populations have little impact. Rural populations live outside the realm of the modern world and practice ancestral traditions, believing in the use of traditional medicine and having their own concept of illness, treatment, biology, and anatomy. This gap between literate and illiterate populations related to family planning programs and HIV prevention programs as existing programs are applied to both populations without distinction; this is a major reason why illiterate women have so many difficulties comprehending the modes of action of hormonal contraceptives and/or the regimen of ART. This becomes a problematic barrier to health delivery, as illiterate people do not understand the context of modern medicine, drugs, and treatment. Health programs delivered in rural areas could be modified so that nonliterate populations can comprehend information, counseling, and prevention. The use of visual material[5] developed within the context of the culture would be beneficial along with the use of the hot/cold theory. In addition, there is a need for communities and beneficiaries to get involved with the delivery of health programs because they could make concise deci-

sions about their most urgent priorities as they relate to health prevention and/or treatment. For instance, some communities are fighting onchocerciasis (river blindness), while others battle malaria or tuberculosis and HIV/AIDS.

Reinforcement of the health systems in the public sector was a goal of WHO 2007 (Taylor 2012). The problem at the local level was that the lack of human resources and materials (e.g., laboratories and technicians), training, and supervision resulted in poor quality of care and services. Ministries of health need to give incentives to the medical personnel (e.g., doctors, health workers, and midwives)[6] to live in rural areas while establishing a rotation schedule for work. Transportation for patients who require emergent care could be done by motorcycle with sidecar, as currently available in Kenya and Malawi. Also, mobile delivery of primary care is important and would benefit many isolated communities.

THE FUTURE OF HEALTH-CARE DELIVERY

The future is far away for many rural communities without electricity, piped water, sanitation, and passable roads. With the popularity of the mobile and smartphones, health delivery and communication with doctors can improve, if there is a telephone relay nearby. Mobile phones are used in India, Uganda, Peru, South Africa, and the Philippines for many usages: connecting with medical staff and/or health workers, making medical appointments, reporting symptoms of sickness and making diagnosis, making referrals, reminding the patients to take their medication, promoting HIV/AIDS awareness, and/or testing of HIV (Wave 2009).

There is also information communication technologies (ICT), a program of computerized files that will permit the use of electronic health systems (e-health) and record patients' data in the hospital's computers. Telemedicine and the Internet can provide learning opportunities to the doctors and nurses in rural areas and also provide a way to get second opinions among professionals, if they are able to get the Internet (Ouma and Herselman 2008).

Electronic health records of patients are a must in developing countries where people change their locations often in search of paid labor. Many times I witnessed the frustration of the medical staff that did not have medical records of patients and had to start from the beginning with laboratory tests. It is especially frustrating with HIV patients that are lost to follow-up and change location. Modern medicine in rural areas will never develop adequately if governments and donors do not change their focus of interest from urban to rural.

The MDG's goals may not be reached by 2015, because health is not the primary interest of local governments that depend on international aid and

know that in the future there will be more grants. Meanwhile, donors and governance need to develop health programs with a multilateral response to the problem in collaboration with NGOs that include policies for mandatory schooling for girls, informal and/or formal education for illiterate women, skills training, microfinance projects, self-help groups, policies against violence to women, policies for legal-financial support from partners in case of abandonment, and social programs for abandoned women. Policies should be enforced by punishment (retribution, imprisonment). Many women are second-class citizens and need to unite in order to gain their independence. This can only be done if they are able to benefit from formal or informal education and by keeping girls attending school just like the boys

> *"If you educate a woman, you educate a family/nation."* —Dr. Kwegyir Aggrey, 1872–1927, Ghanaian scholar, educator, and missionary[7]

NOTES

1. The Samastha project goals were to prevent the transmission of HIV in rural areas of selected districts of Karnataka and Andhra Pradesh.

2. In Morocco, the facilitators (M.A. students) told me that they had a clitorectomy (the ablation of the clitoris) because it is a tradition. I asked them if they felt anything during their relations with their husbands, to which they respond that they would not know the difference because they do not have a clitoris, but they enjoyed their sexual relations.

3. Every day about eight hundred women die from preventable causes related to pregnancy and birth, 99 percent of whom live in developing countries, with mortality even higher in rural areas (UNFPA 2012). About one in five pregnancies end in abortion, the practice of which is mostly unsafe and illegal (twenty-nine per one thousand), and in developing countries 20 percent of all pregnancies end in induced abortion (Guttmacher Institute and WHO 2008). Over two-thirds of the world's 793 million illiterate adults (fifteen-plus years old) are women (UNESCO 2010). Violence from intimate partners and sexual violence against women is estimated to be 71 percent between the age groups fifteen and forty-nine. Further, from 1990 to 2010, only 52 percent of women participated in the labor market (United Nations 2010).

4. TOSTAN, meaning "breakthrough" in Wolof, is a Senegalese community-led development organization that works in eight African countries and focuses on community education and empowerment.

5. I witnessed some visual posters in Senegal intended for a rural population's family planning program that were not within the context of the culture but were too explicit of the male and female physiologies and probably shocked the audience.

6. There are no incentives for the medical staff to live in rural areas. In Peru, medical students in order to graduate have to work for one year offering services in general medicine in a rural community. In most African countries the ministry of health (if they have the funds) approves of the training of traditional midwives for hygiene, birth complications, and referrals, but the trainings are not consistent and lack follow-ups.

7. Richard Thurnwald, *Black and White in East Africa: The Fabric of a New Civilization; A Study in Social Contact and Adaptation of Life in East Africa.* London: Routledge, 1935.

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