Women’s Roles in Production, Consumption and Reproduction.

A Case Study in The Gambia

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Executive summary .................................................................................................................. 4
Acknowledgements .................................................................................................................. 8
Acronyms .................................................................................................................................. 9
Chapter 1 Introduction .............................................................................................................. 10
Chapter 2 Methods .................................................................................................................... 12
  2.1. Study design ..................................................................................................................... 13
  2.2. Data analysis .................................................................................................................... 16
Chapter 3 .................................................................................................................................... 17
Women in production and consumption ................................................................................. 17
  3.1. Gender relations in production ......................................................................................... 17
  3.2. Access to land and water ................................................................................................. 18
  3.3. Women’s roles and responsibilities in providing for the family ........................................ 18
  3.4. Women’s access and control of income ........................................................................... 20
  3.5. Informal support systems to relieve women’s work burden in farming ......................... 21
  3.6. Household resource allocation systems – consumption and marketing ....................... 23
Chapter 4 .................................................................................................................................... 25
Vulnerable women .................................................................................................................... 25
  4.1. Female Headed Households ............................................................................................ 25
  4.2. Divorce ............................................................................................................................. 25
  4.3. Widowhood and inheritance ............................................................................................ 26
Chapter 5 – Women in Reproduction ...................................................................................... 29
  5.1. Factors affecting ANC attendance: reaching and receiving care ..................................... 29
  5.2. Pregnancy norms – deciding to seek ANC ....................................................................... 31
  5.3. Work burden during pregnancy ....................................................................................... 34
    5.3.1. Diversity in support to pregnant women ...................................................................... 37
  5.4. Birth location – challenges and preferences ..................................................................... 38
  5.5. Newborn care and exclusive breastfeeding ....................................................................... 42
    5.5.1. Exclusive breastfeeding for 6 months ......................................................................... 43
  5.6. Maternal mortality risk perceptions .................................................................................. 46
Chapter 6 Discussion and implications .................................................................................... 47
  6.1. Resource perceptions and land use changes .................................................................... 47
  6.2. Women’s socio-economic mobility constraints ............................................................. 47
  6.3. Women’s mobility constraints in seeking maternal and child health services ................ 48
6.4. Healthcare system gaps in meeting women’s reproductive needs ........................................ 49
6.4.1. Antenatal care as pregnancy risk .................................................................................. 49
6.5. Willingness to change relative status of men and women .................................................. 49
6.6. Limitations of the study.................................................................................................... 50
Chapter 7 Conclusions ........................................................................................................ 51
Annex 1 Bottleneck study conducted by the UNICEF/MOH .................................................. 52
Annex 2 People met during missions in March and May 2014 ................................................ 53
Annex 3 Description of the four case villages ....................................................................... 54
References ............................................................................................................................ 57
Executive summary

Introduction:

Relationships across gender and generation carry social and cultural meanings of significance to maternal and child health-related processes. Contextualizing women’s healthcare services usage during pregnancy and child delivery can generate insights of value for the healthcare system. With this background a case study was conducted in four villages in different rural areas of The Gambia.

The main objective of the study was to gain knowledge on women’s roles in production, consumption and reproduction that are of relevance for the implementation of two World Bank/Government of the Gambia investments: The “Maternal and Child Nutrition and Health Results Project” and the “Commercial Agriculture and Value Chain Management Project”.

The division of labor and economic empowerment of women is linked to ethnicity. The four case study villages were therefore selected to represent four of the large ethnic groups - Mandinka, Fula, Wolof and Serahuli. Within each of the ethnic groups, the typical livelihood system for the region was selected. The four selected villages included rain-fed lowland rice production and upland farming; two-season (rain-fed and tidal irrigation) low-land rice production; and upland farming and livestock.

Methods:

Data was collected through March to May 2014 by a team of three consultants each with experience from qualitative data collections in rural areas on reproductive health issues. Data was collected during three days in each of the villages. Data collection was sequenced with initial group discussions with Village Development Committee (VDC) members to produce lists of eligible participants for interviews and focus group discussions. Three separate group discussions were later conducted in each village with: mothers of children under two, fathers of children under two, and Mothers-in-law who live with grandchildren under two. Each group consisted of 6-8 members to ensure good interaction. Walk-throughs in each village provided additional information about the location of farming fields, vegetable gardens, schools, and an impression of the living conditions for the poorest and best off households. Additionally, individual interviews were conducted in each village with: women who recently had exclusively breastfed their youngest child; men who within the last 12 months had become fathers to a child born at a health facility; and with women who were identified by the Alkali/VDC members as particularly vulnerable.

Provision of services and challenges of reaching communities were discussed with Community Health Nurses, head of staff and/or nurses at a Minor health center, Major health center and a hospital that were serving the villages. Finally before leaving each village a group discussion was held with the Village Support Group members including Village Health Worker and trained Traditional Birth Attendant during which preliminary findings also were discussed.

Results:

Women are acknowledged as hard working farmers at the same time as they are responsible for keeping the household in order, cooking meals and caring for children. In addition, women are directly contributing financially to “the needs of the family” which was acknowledged by both men
and women alike. Women’s income is thus not associated with consumption of luxury items for women and children, but as an integrated part of the basic income generated in the household. The income of women is covering essential and ad hoc needs of children in addition to reciprocal and collective contributions to social events. Keeping the household within the norms of participation in social life was an important additional use of women’s income.

A critical finding in all four villages is that the concept of individual and independent income for women is recognized by both men and women. Women are used to manage resources including cash and men recognized that they do not have decision-making power of these resources. Women describe that their opportunities for making own decisions are good when they cultivate by themselves, such as lowland rice plots and vegetable gardens. When men and women’s work are complementary, such as weeding together on all plots or harvesting together, women report that their influence on the farming process decreases radically. Men’s willingness to take advice from women on farming related topics and women’s opportunities of starting up new businesses, were limited. Women do give advice to their husbands on farming decisions, but women rarely share observations with other males in the compound and much less at the village level. The VDC was not identified as a source of information or support for women in farming in any of the villages.

Women’s limited rights as divorced and as widows directly and most often negatively influenced the conditions under which they could bring up young children. When women were divorced or lost their spouse during the upbringing of young children, women’s opportunities to care for children and for themselves were very restrained and solely dependent on the socio-economic conditions of her parents and brothers.

To be able to conceive and deliver a healthy child is a profound expectation for women in rural Gambia and strong norms related to women’s reproductive behavior were elaborated by participants. Antenatal care (ANC) clinics were mostly described in positive terms by women. Nurses were mostly described as providing good quality services at the same time as it was acknowledged that some nurses treat women less respectful than wished for. When discussing the benefits of the services there was an emphasis on diagnosis and subsequent treatment of disease with medicine – in particular anemia, referred to as “low blood” and malaria prevention. Later in pregnancy, checking if “the fetus was in the right position” was an important aspect of the services. Men did not accompany their wives to ANC and did not consider this as a need. As long as the pregnancy was progressing normal, men considered this a task for women. Men did not provide suggestions on how they could become more involved during the pregnancy of their wives.

Women’s decision making power to tell or withhold information about a new pregnancy is an important dimension of understanding the currently low utilization of first trimester ANC services. Both men and women recognized that pregnancy can be detected early. A content analysis was conducted on themes related to use of ANC. Four sub-themes illustrate the dilemmas women face during pregnancy: (i) ANC makes private information on women’s sexuality and reproductive health public; (ii) women cope with stigma on sexual behavior while also wanting to utilize ANC services; (iii) women have to live up to expectations of becoming mothers easily; and (iv) early ANC is perceived as a potential pregnancy risk. ANC is viewed as helpful in knowing “the position of the baby”, to adjust “levels of the blood” and to identify women who should deliver at the hospital. But these services are seen as more relevant towards the end of the pregnancy and less in the beginning of the pregnancy where privacy on the other hand is perceived to reduce risks of miscarriage. It is rare for a woman not to attend ANC at all during her pregnancy according to all participants, however. Keeping the pregnancy private also signifies the social value placed on respecting the connections between the social and the spiritual world and thus securing the survival of the lineage.

Norms on work burden in pregnancy reflect the connections between women’s roles in production, consumption and reproduction. Health system recommendations are not well aligned with local
perceptions, however. Nurses emphasize the importance of reducing the work burden during pregnancy while traditional values underscore the benefit of staying active and strong until child delivery. In addition, men and women did not agree on the amount of support women received during pregnancy where men perceived that they provided more support than women reportedly had experienced. Three sub-themes on work burden were developed: (i) Pregnancy is a normal part of a woman’s work life; (ii) work and to some extent hard work during pregnancy is beneficial; (iii) advice on work burden from doctors and nurses to women at risk for complications during pregnancy and delivery is valuable.

In the four villages the most frequent and strongest expressed preference was to deliver at home with a local, well-known and respected trained or untrained traditional midwife (TBA). TBAs were active in all four villages and the respective Community Health Nurse (CHN) confirmed that the traditional birth attendants were helping the majority of women in the villages. The CHNs confirmed the high level of activity of the TBAs in mobilizing women during outreach clinics, assistance during delivery, multiple home visits during the first week after child birth, verbal report of new pregnancies and deliveries since the last visit of the CHN. Facility-based deliveries are associated with complications. A strong wish to avoid complications with difficult transportation of the woman in labor and a risk of referral from the nearest health facility to a facility that can handle blood transfusions and C-sections was also a constraint in seeking delivery services at the health center.

The attitudes to and experiences of delivery services at a health facility were mixed according to men and women. Negative experiences of delivering at a health facility included the lack of continuity of care from one or two nurses throughout the labor and delivery. In addition, being left alone in the labor ward was associated with fear and uncertainty. TBAs often escorted women to the labor ward but did not participate once at the health facility.

Exclusive breastfeeding during the first six months of the life of a newborn was not the norm in any of the four villages. The first constraint in following the advice of nurses to breastfeed exclusively was the perceived need and benefit of drinking water from birth and throughout life. Timing of initiation of breastfeeding was influenced by the birth attendant, however. Women who had delivered in a health facility and women who had delivered at home with a TBA who explicitly encouraged the woman to start breastfeeding early were reporting early initiation. Women who had home deliveries with TBAs who did not actively recommend early initiation were more likely to wait several hours or up to two-three days before breastfeeding were initiated.

Discussion:

Farmers experience increased vulnerability due to pressure on getting access to fertile low-and upland. Increasing inequality between households is another result of limited fertile land. In areas with tidal irrigated lowland, men had started to cultivate rice in the dry season. Dry season cultivation is the main source of securing women’s access to independent earnings. There were reportedly no gender-based conflicts over use of lowland in the dry season in the study villages yet, but the risks of future tensions exist.

Women’s lack of control of farm land is an economic mobility constraint. Rehabilitation of farm land, which is one of the objectives of the Commercial Agriculture and Value Chain Management Project, does in itself not improve this situation. The reported tensions relate to women’s lack of control of access to land. Women help men with their farm work first in order to secure that men will help women in their fields afterwards. When households face food crisis there is pressure on women to help their husbands on their responsibility to provide food for the family. Women will use the earnings that were intended for children’s and own needs. Women’s lack of control of land is a
reflection of women’s lack of opportunity to own farm land. Neither project proposes activities to address women’s empowerment in this respect.

The households that will be targeted by the Nutrition and Health Results Project (MCNHRP) have no prior experience of social protection systems such as formal retirement schemes, maternal leave payment, health insurance or other formal systems. Therefore it is not possible to conclude whether the cash transfers to women will follow the same system of income allocation as the current income from farming. The social protection activities of the MCNHRP in providing conditional cash transfers to women could be interpreted as a timely compensation for the loss of women’s income during pregnancy. This could reduce the risk of gender-based conflicts arising due to transfers to women only.

Women’s dependency on husbands in deciding to seek care outside the village is one source of conflict during pregnancy and child birth complications. When men delay in arranging for transport to the health facility women are not able to arrange for the transport themselves. Women’s control of individual income is important for the conditional cash transfer scheme in the MCNHR project since the transfers could be introduced as a similar type of income for women. This could decrease the risk of gender related conflicts on how to spend the transfers. Yet, it would be important to link women’s capacity to pay for the transport to actual access to vehicles and drivers.

The labor ward at a health facility is associated with obstetric complications and emergency. The health system has not been able to adjust itself to good quality care during normal deliveries. This may contribute to men’s reluctance to transport women in labor to a health facility. Strengthening the primary health and nutrition care including a functional referral system through the MCNHRP can directly improve women’s access to quality care and in turn health outcomes.

Men and women’s trust in TBAs extended beyond her role as a health practitioner. TBAs contributed to decreasing all three delays of seeking, reaching and receiving obstetric emergency care according to Community Health Nurses. In villages where the TBA is trusted, she is an important link between the communities and the health facilities. The trust in TBAs is of continued importance for the healthcare system in strengthening the referral system and communications with the communities.

Men’s involvement in maternal health is restricted to complications during pregnancy and child delivery. Engaging men during normal pregnancies were not encountered in the study. The healthcare system is not well adjusted to involve men during ANC or child delivery at a facility. The lack of social, cultural and even physical space for men in the current healthcare system was pointed out by men.
Acknowledgements

We wish to take this opportunity to register our thanks to the Governments of Norway through NORAD and United Kingdom through DFID who are the financiers of the World Bank’s Health Results Innovation Trust Fund that provided the funds for this study.

Our thanks also go to the National Nutrition Agency (NaNA) Project Implementation Committee (PIC) for their guidance and recommendations on study design and sample.

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We wish to express our sincere gratitude to Menno Mulder-Sibanda and Rifat Hasan both at the World Bank for your contribution and guidance in the conceptualization and planning of the study.

Lastly but by no means the least, we wish to express our sincere thanks and appreciation to all the women and men in the four case villages who participated in the discussions and interviews for their willingness to share their thoughts and personal experiences on gender roles and health. We are very grateful to the VDCs and people of the study communities for your welcome and hospitality during the study period. Without this openness and cooperation, the study would not have been concluded successfully.
<table>
<thead>
<tr>
<th>Acronyms</th>
<th>-</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ANC</td>
<td>-</td>
<td>Ante-natal Care</td>
</tr>
<tr>
<td>CHN</td>
<td>-</td>
<td>Community Health Nurse</td>
</tr>
<tr>
<td>CRR</td>
<td>-</td>
<td>Central River Region</td>
</tr>
<tr>
<td>EBF</td>
<td>-</td>
<td>Exclusive Breast Feeding</td>
</tr>
<tr>
<td>FP</td>
<td>-</td>
<td>Family Planning</td>
</tr>
<tr>
<td>HF</td>
<td>-</td>
<td>Health Facility</td>
</tr>
<tr>
<td>MCH</td>
<td>-</td>
<td>Maternal and Child Health</td>
</tr>
<tr>
<td>MoH</td>
<td>-</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NaNA</td>
<td>-</td>
<td>National Nutrition Agency</td>
</tr>
<tr>
<td>NBRW</td>
<td>-</td>
<td>North Bank Region - Western</td>
</tr>
<tr>
<td>NFO</td>
<td>-</td>
<td>Nutrition Field Officers</td>
</tr>
<tr>
<td>OIC</td>
<td>-</td>
<td>Officer in Charge</td>
</tr>
<tr>
<td>PIC</td>
<td>-</td>
<td>Project Implementation Committee</td>
</tr>
<tr>
<td>PNC</td>
<td>-</td>
<td>Post-natal Care</td>
</tr>
<tr>
<td>RBF</td>
<td>-</td>
<td>Results Based Financing</td>
</tr>
<tr>
<td>RCH</td>
<td>-</td>
<td>Reproductive and Child Health</td>
</tr>
<tr>
<td>RHT</td>
<td>-</td>
<td>Regional Health Team</td>
</tr>
<tr>
<td>TBA</td>
<td>-</td>
<td>Traditional Birth Attendant</td>
</tr>
<tr>
<td>URR</td>
<td>-</td>
<td>Upper River Region</td>
</tr>
<tr>
<td>VDC</td>
<td>-</td>
<td>Village Development Committee</td>
</tr>
<tr>
<td>VHW</td>
<td>-</td>
<td>Village Health Worker</td>
</tr>
<tr>
<td>VSG</td>
<td>-</td>
<td>Village Support Group</td>
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<tr>
<td>WB</td>
<td>-</td>
<td>World Bank</td>
</tr>
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</table>
Chapter 1 Introduction

Utilization rates of essential maternal and child health and nutrition services remain low in rural regions of The Gambia. The slow progress in reducing maternal and child mortality, and in increasing utilization of antenatal care and skilled delivery (MDG 4 and 5)[1] can be explained by factors such as inadequate financing for implementation of primary health care services, uneven access to healthcare services and limited community mobilization [2]. Longitudinal data from the North Bank Region in the country suggest that deployment of simple health services can contribute significantly to the reduction of child mortality [3]. Delays in seeking (first delay), reaching (second delay) and receiving (third delay) healthcare are increasingly recognized as important restrictions in achieving better maternal and child health outcomes [4, 5]. Strengthening women’s roles, social space and power in relation to decision making in healthcare and related to household consumption and income generation, is globally emphasized as important in reducing gender disparity[6, 7]. MDG gender targets in primary education in The Gambia have been met but the goals for the secondary and tertiary levels are yet to be achieved as are gender targets on women’s employment in the non-agricultural sector [1].

Community involvement is an important element in improving maternal and newborn healthcare utilization levels [8, 9]. Relationships across gender and generation carry social and cultural meanings of significance to maternal and child health-related processes. It is important to understand the broader cultural picture when analyzing women’s ability to make or influence healthcare-and economic decisions within their nuclear and extended family and healthcare utilization. Gender norms and practices in particular in relation to healthcare decision-making processes have been studied only to a limited extent in The Gambia[10].

The Government of The Gambia in collaboration with the World Bank (WB) and Development Partners has indicated a growing concern for the continued high levels of child malnutrition and maternal mortality; stagnating income levels from agriculture and continued vulnerability due to external financial and climatic shocks. Against this background, two WB financed projects have been prepared. The development objective of the Commercial Agriculture and Value Chain Management Project in The Gambia is to improve production systems and access to markets of targeted agricultural commodities [11]. The Maternal and Child Nutrition and Health Results Project (MCNHRP) has the development objective to increase the utilization of community nutrition and primary maternal and child health care services and the adoption of good nutrition and health practices in selected region [12].

The main objective of this study is to gain knowledge on women’s roles in production, consumption and reproduction that are of relevance for the upcoming implementation of the two projects. The two main questions of the study are:

- How will gender norms and practices in The Gambia affect the achievement of sustainable project results?
- How will the proposed project results affect the relative status of men and women – including possible unintentional positive and negative outcomes?
This gender analysis [13-18] should strengthen the projects’ responsiveness to gender-based constraints of accessing health services, participating in community-based activities and of strengthening girls’ and women’s economic empowerment.
Chapter 2 Methods

The key research questions are presented in Box 1. The research questions span from preferences in the timing of seeking antenatal care and location of childbirth, agenda setting discussions on husbands’ and Mothers-in-law’ willingness to provide additional support to pregnant women, to critical questions on women’s access and control of individual income. The broad and diverse nature of gender relations in health is reflected in the conceptual framework and study design developed for this study. The study is guided by the following four issues that emerged in the literature before the primary data collection:

- The broader context of health perceptions and preferences can inform healthcare utilization patterns.
- Gender relations extend beyond the marital relations and involve relationships across generations within households and communities.
- The household is conceptualized as dynamic and subject to change through different processes.
- Differences between ethnic groups and livelihood systems can imply variation in gender relations.

Place the targeted behaviors and the project goals into a broader context: An anthropological study approach implies that the everyday lives of men and/or women are seen as shaping gender norms and practices. As a consequence, the questions of direct interest such as reasons for attending or not attending antenatal care in the first trimester, are analyzed as part of broader ideas on for example healthy pregnancies, normative expectations on women’s attitudes and behaviors, experiences of available formal and informal health providers [19-21].

Studies on the distribution, frequency and preferences of seeking care at health facilities, pharmacies and traditional healers are very scarce in the Gambia. Treatment from a health facility was sought for 60-70 percent of children with acute respiratory infection, fever or diarrhea according to preliminary data analysis [22]. Another study found however that while 81.5% of caregivers of children with diarrhea during the last two weeks had sought healthcare outside their home, only 48.4% of them visited a health center [23].

Gendered and generational relationships can influence maternal and child health: Women are not isolated decision-makers in issues related to health but rely on others in matters of their own health and the health of their children. Decisions related to reproduction is particularly influenced by other social actors who have their own stakes in reproductive decisions and outcomes [19]. One case in point is fertility decisions that are influenced by the fertility of co-wives in polygamous unions and/or on the fertility of other women in the residential compound [24]. Women’s lives take different forms as they become mothers and Mothers-in-law.

The household is dynamic and subject to different types of changes: These processes of change can be looked at within the household and also beyond the household. Structural processes of change within the health system or within income generation opportunities are recognized to impact gender relations [6]. The two projects under preparation are likely to impact attitudes towards the support provided by the Government.
The ethnic background of men and women is of significance in the type of livelihood, division of labor and also in preferences in healthcare seeking behaviors. A few anthropological and several epidemiological studies have been conducted in Mandinka, Fula and Serahuli communities on specific aspects of health, household and livelihood system. The increasing ethnic inter-marriage rate is not yet reflected in the literature to our knowledge. The studies on particular practices among the different ethnic groups will be referred to in the relevant chapters below.

<table>
<thead>
<tr>
<th>Box 1: Research questions</th>
</tr>
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<tbody>
<tr>
<td>o  What resources are perceived as scarce by men and women? How does access to land (water, markets) vary between households or social groups within the community? Has land use patterns changed?</td>
</tr>
<tr>
<td>o  Who within a household has access to/decision power over which resources and for what purposes? What are women’s economic responsibilities in the household? What are women’s opportunities for accessing and keeping the decision power over earned or transferred income?</td>
</tr>
<tr>
<td>o  What are women’s mobility constraints in situations related to economic activities in agriculture and of seeking maternal and child health services?</td>
</tr>
<tr>
<td>o  Decision-making processes and family/household dynamics in relation to reproduction:</td>
</tr>
<tr>
<td>▪ Who do women consider their important sources of support during pregnancy; delivery; post-partum period and young child care period? Who would women prefer to become more involved?</td>
</tr>
<tr>
<td>▪ What is the role of husbands during pregnancy, delivery, and during complications? What is the willingness of men to decrease delays in seeking, reaching and receiving care related to pregnancy and delivery?</td>
</tr>
<tr>
<td>▪ What are the perceptions of Mothers-in-law and co-wives towards their support to young women during pregnancy, delivery, post-partum and during complications? Willingness to change?</td>
</tr>
<tr>
<td>o  What impedes women to spend more time on caring for their children? What are women’s experiences with exclusive breastfeeding for six months? What constraints do women face in accessing the kind of foods needed to feed the family?</td>
</tr>
<tr>
<td>o  What are the attitudes of Village Development Committees towards reducing maternal and child mortality?</td>
</tr>
</tbody>
</table>

2.1. Study design
The data collection took place in March-May 2014. Based on the points of departure mentioned above the study was designed as a case study. Primary data was collected in four rural villages and the small number of villages allowed for collecting data of an in-depth character.

The selection of the villages was based on pre-determined criteria that included:

- Located in the intervention regions of the MCNHR project (North Bank, Upper River and Central River Regions);
- Major ethnic groups represented;
- Different livelihood systems represented (upland-lowland, two-season/one-season production, with or without vegetable garden)
- Access to the nearest health center should be average of the region (around 5 - 8 km)
- A BFCl village
- Not a “Key village” with a Community Health Nurse (CHN) resident in the village
The division of labor and economic empowerment of women is linked to ethnicity. The four case study villages were therefore selected to represent four of the large ethnic groups (Mandinka, Fula, Wolof and Serahuli). Each selected village was inhabited by a majority ethnic group, yet with increasing intra-ethnic marriages and ethnic mobility. A mix of ethnic groups was thus found in each of the four villages. Within each of the ethnic groups, the typical livelihood system for the region was selected with the help of the respective Nutrition Field Officers (NFO) and CHN. The two main farming systems are upland and lowland. The upland system includes groundnuts, millet, coos, sorghum, maize and horticultural crops as well as livestock husbandry. The lowland rain-fed and tidal irrigated farming system is predominantly rice-based (swamp rice). The four villages included thus rain-fed lowland rice production and upland farming; two-season (rain-fed and tidal irrigation) lowland rice production; upland farming and livestock (See table 1 below).

Table 1: Overview of characteristics of four case villages

<table>
<thead>
<tr>
<th>Case villages</th>
<th>Region</th>
<th>Ethnic majority group</th>
<th>Livelihood system</th>
</tr>
</thead>
<tbody>
<tr>
<td>Village 1</td>
<td>Central River Region</td>
<td>Fula</td>
<td>Lowland &amp; upland: Two season rice cultivation, one season vegetable garden</td>
</tr>
<tr>
<td>Village 2</td>
<td>Central River Region</td>
<td>Mandinka</td>
<td>Lowland &amp; upland: Two season rice cultivation, one season vegetable garden</td>
</tr>
<tr>
<td>Village 3</td>
<td>Upper River Region</td>
<td>Serahuli</td>
<td>Upland farming, livestock</td>
</tr>
<tr>
<td>Village 4</td>
<td>North Bank Region</td>
<td>Wolof</td>
<td>Lowland &amp; upland, two-season vegetable garden</td>
</tr>
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</table>

Data was collected during three days in each of the villages. The data collection was sequenced as follows:

- Introductory discussions with the village head (Alkali/o) and available members of the Village Development Committee (VDC) on the objective of the study. Selection criteria for participants were discussed.
- A subgroup of the VDC members helped the field team to select the participants for interview and Focus Group Discussions (FGD). (See Table 2 on selection criteria).
- Three separate FGDs were conducted with mothers of children under two, fathers of children under two, and Mothers-in-law who live with grandchildren under two. Each group consisted of 6-8 members to ensure good interaction.
- A walk-through was conducted to see the farming fields, vegetable gardens, school, and housing conditions for poor and better off households.
- Two interviews with women who recently had exclusively breastfed their youngest child.
- Two interviews with fathers of children who were delivered at a health facility during the last 12 months.
- Two interviews with women who were identified by the Alkali/VDC members as particularly vulnerable. Causes of vulnerability included: widowed (stay in marital compound or moved back to parents compound), divorced, destitute with many young children, teenage pregnancy, or female headed household.
- Interview with the Community Health Nurse (CHN) providing services in the villages selected
- Visit at nearest health facility (Minor health center, Major health center and hospital) and interview with head of staff and/or nurses.
• FGD with Village Support Group members (VSG) including Village Health Worker (VHW) and trained Traditional Birth Attendant (TBA).

The eligible FGD participants were selected using simple random sampling. Purposive sampling was used to identify participants with experiences of the phenomenon being studied e.g. exclusive breastfeeding, vulnerability and institutional delivery. This purposive sampling ensured that participants with varied yet personal experiences of the phenomenon were included. Table 2 shows the sampling strategies applied and the number of participants.

Table 2. Type of data collection method, sampling strategy and number of participants

<table>
<thead>
<tr>
<th>Data collection method</th>
<th>Participant</th>
<th>Total No. (participant)</th>
<th>Sampling of Participants</th>
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<tbody>
<tr>
<td><strong>Selection</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus Group Discussion</td>
<td>Mothers</td>
<td>4 (31)</td>
<td>o Child under two years old</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o About 25 years old or younger/four or less children</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Not a VSG member</td>
</tr>
<tr>
<td></td>
<td>Fathers</td>
<td>4(28)</td>
<td>o Child under two years old</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Not the husband to selected wife</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Not a VSG member</td>
</tr>
<tr>
<td></td>
<td>Mothers-in-law</td>
<td>4(29)</td>
<td>o Living in same compound as grandchild under 2 years old</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Not living in same compound as mothers or fathers selected</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Not a VSG member</td>
</tr>
<tr>
<td><strong>Selection</strong></td>
<td>Village Support Group</td>
<td>4 (22)</td>
<td>o <strong>Total population</strong></td>
</tr>
<tr>
<td><strong>Selection</strong></td>
<td>Mother (ExclusivelyBreastfeeding)</td>
<td>8</td>
<td>o Mother who VSG members believe exclusively breastfed youngest child under 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Not a FGD participant</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Not a VSG member</td>
</tr>
<tr>
<td>Father (institutional delivery)</td>
<td>8</td>
<td>o Father to child born during last 12 months at a health facility</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Not a FGD participant</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Not a VSG member</td>
</tr>
<tr>
<td>Vulnerable woman</td>
<td>8</td>
<td>o Widowed, divorced, destitute, teenage pregnancy, female headed household</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Two different main causes were selected in each village</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Not a VSG member</td>
</tr>
<tr>
<td><strong>Selection</strong></td>
<td>Community Health Nurse</td>
<td>4</td>
<td>o <strong>Total population</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o The CHN providing the services to the selected village</td>
</tr>
</tbody>
</table>
2.2. Data analysis

The field team consisted of three consultants (one international anthropologist and two Gambian moderators fluent in three local languages) with extensive field experiences on community and reproductive health in The Gambia. FGDs were conducted in the local languages except in the Serahuli village where Mandinka and Fula languages were used. This worked well in the groups with fathers and mothers-in-law but among the selected eight mothers, two were replaced because they did not understand nor speak Mandinka or Fula. All participants gave individual informed consent prior to the start of each FGD and interview.

The FGDs were recorded and transcribed verbatim in English by the moderator conducting the FGDs. The transcriptions were complemented with notes taken during each FGD. Interviews were either recorded and transcribed verbatim or analyzed based on recordings, immediate verbal translation and handwritten notes. The transcriptions were entered in the qualitative data analysis program Nvivo 10. Notes were analyzed manually. The analysis is inspired by interpretative description [25]. An analysis of content [26] was developed on selected topics such as reasons for not attending early ANC and perceptions on work burden during pregnancy. Transcripts were discussed among the authors during the process of analysis. The first author (HMA) coded the transcripts and the analysis was conducted through a comparison of codes and statements within the same village and across type of participants.
Chapter 3
Women in production and consumption

Description of the four case villages including demographic data, livelihood system, access to health services and community perceptions on poverty is presented in Annex 3.

3.1. Gender relations in production
The social organization in all four villages is tightly linked to the patrilineal kinship system. Land, both the land on which the extended family compound is built, and the land for farming is owned by the compound head who traditionally is the oldest male in the compound. Residence is virilocal with women moving into her husband’s family compound at marriage. Many first marriages are arranged and women often marry within the village or the neighboring village.

Farming land serves as the primary source of survival. Private land ownership of land was not framed as a current debate either among men nor women. Land belongs to the particular family and the oldest male is representing the family as the head. Men are thus not owners of the land in the sense that they can sell it. One father explains:

*What is happening is that the way we found the system of land ownership this is the way we continued with it. Here what we have is this land area belongs to this Kunda or that Kunda but to say this is men’s land or women’s land we do not have that here [Father 6 Village 2].*

Land thus belongs to the extended family that in turn is part of a specific “kunda” or lineage. Land secures the reproduction of the lineage.

Ownership is confirmed verbally and it is the responsibility of the village head “Alkali” to maintain the village memory on this. In practice, the “Alkali” keeps a list of names of compound owners as reference for the tax authorities when they annually collect residential tax. The “Alkali” did not issue land titles on the compound or farm land in any of the villages.

In contrast, land in urban areas can be purchased or sold by both men and women. This land will normally be documented through an official land title deed issued by the local government. A few women in each of the villages held title deeds on land that was located outside the village that they had inherited through their father and/or a deceased husband.

Women are acknowledged as hard working farmers at the same time as they are responsible for keeping the household in order, cook all meals and care for children. The categorization of different types of land and produce in each village was the study entry point to describe women’s work burden and decision making power on production and consumption.
3.2. Access to land and water
The four villages experienced an increased pressure on land. All four villages used upland fields and it was reported that almost all land that could be cleared was now in use. Still, new families who wanted to settle in the villages were able to get pieces of upland for usage. Land was not sold in the four villages, and newcomers would only gain the user rights as long as they lived in the village. Their children inherit the user right but will not be able to sell the land.

In addition to a beginning land scarcity, farmers were not able to let the land rest for one to three years as they could a generation ago. Shifting cultivation between for example groundnuts and millets was now applied as a way to conserve as many minerals in the ground as possible. Fertilizer was also necessary now each year to achieve a fair harvest. Reportedly, fertilizer every second year had been the rule only a few years ago. In the meantime, prices of fertilizer had doubled. As a result, poor households were not able to purchase fertilizer. The villages located close to the Senegal border found cheaper fertilizer there.

Lowland rice fields are even scarcer than the upland fields. In both villages with lowland rice fields, there were compounds without access to lowland and lived on farming upland in addition to working as day laborers in the rice fields. Newcomers in the two villages with lowland rice would only be offered user rights to upland fields. In village 1 and 2 there were several compounds without access to lowland. Land use patterns had changed radically in one of the villages several years ago. Lowland rice plots had been redistributed since the village was experiencing increased inequality among households with and without lowland. This process of redistribution was led by a rice irrigation project. Poverty among the compounds that earlier were related to landlessness has decreased according to the VDC. However, increased settlement in the area has again resulted in several compounds being without lowland. In one of the villages, the rice fields were located several kilometers from the village and took more than two hours to reach. As a result, the work days were very long for both men and women. Compounds without horse or donkey carts are suffering most.

In village 3, the better off compounds constructed wells within the compound, which eased the work burden on women and young girls considerably. For other women the communal wells were used. In other villages, wells were identified as a scarcity.

3.3. Women’s roles and responsibilities in providing for the family
Women perform different tasks both in lowland rice cultivation and upland farming systems (see box 2-5). Women in the two villages cultivating two-season rice (no. 1 and 2) are daily working several hours in the fields throughout the year. Women are the main farmers of rice during the rainy season when men are cultivating in the upland fields. In these two villages both women and men report that women often have to work in the rice fields throughout pregnancy and go back straight after the naming ceremony of a newborn. This will be elaborated on later in the report but it is introduced here as an indicator of the work burden of women in lowland rice cultivation. The shorter season of upland farming (3-4 months per year) gives women more flexibility and time for other income generating activities. In the upland cultivating villages (no. 3 and 4) women in better off households...
who delivered a baby during the rainy season could occasionally be exempted from working during that rainy season’s farm work.

Decision making related to farming differs among the upland and lowland farming villages. In the upland farming villages, decision making is in principle the responsibility of the head of the compound in collaboration with the household heads within the compound. One father in village 4 describes:

*When it comes to decisions on farming by the women, they do not have much say. It is mainly the head of household and other village household heads that will make decisions. Whatever time is up for a farming task it is these people who will decide and let the household members know. For example, at this current time we are preparing the farm lands and women have no business in it so the heads of household will decide and inform the other men or their sons as to what to do. The women at this time are concentrating on the vegetable garden. So when the rains come we will just continue with planting our seeds. We will first plant the farms of the head of household, then the farms of the other men within the household then the farms of women. By the time we finish planting all the farms, the first farms will be due for weeding and we will start weeding straightaway. The women will know that it is time for weeding so they will come and join us to weed the farms* [Father 3 in village 4].

Women confirm that men are dominating the decisions on timing of planting and harvesting and that women have little involvement in this process. Women’s dependency on their husbands to prepare their fields is an illustrative point. Women in the same two upland farming villages also mentioned this dependence on their husbands when it was time to weed the fields even though this task is conducted together:

*For example if it is time to weed the farms the women will join the men and weed their farms first so that the men will help them to weed their own farms* [Mother 1 Village 3].

For women in the two lowland farming villages, the situation is different. When asked who is responsible for making decisions on for example planting and weeding, women in Village 1 and 2 agreed that women were the decision makers on their own plots of rice during the rainy season. One woman describes the difference between cultivating rice during the dry and the rainy season:

*In the dry season when the men work with us in the rice fields then their voice is more important in the matters of the rice farm. During the rainy season - because it is only us women who work on the rice fields - our opinion is more important* [Mother 2 Village 1].

Women in Village 2 clarify the decision-making during the rainy season:

... (all talking at the same time) *there is no one particular person or group responsible. It is the farm owner who decides when it is time for me to go and start planting. Mother 8: for example my rice farms, it is me who will decide that it is time for me to go start planting or weeding or my rice is ripe enough for me to start harvesting. Mother 5: you will be checking on and observing your crops every day and if you think the rice is ripe you will cut a bit and take to show to other people and say please check for me this rice to confirm if it is ready for harvest and they will say “yes” it is ripe so you can harvest it now. Sometimes other women who are your farm neighbors will also observe and say to you “I think your rice is ripe now for harvest so please check it and see for yourself” [Women FGD in Village 2].

Women have clear responsibilities in farming and men expressed satisfaction with women’s hard work. Women directly contribute to “the needs of the family” which was often mentioned in FGD as
the essential aspect of life as a farmer. Women’s income is not associated with consumption of luxury items for women and children, but as an integrated part of the basic income generated in the household.

3.4. Women’s access and control of income

The farming system and division of labor is indicative of women’s opportunity for accessing and controlling assets and income. In all four villages, women had access and control over at least one type of income from farming.

Table 4. Women’s control of type of farming asset

<table>
<thead>
<tr>
<th>Village</th>
<th>Women’s control of farming asset</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Groundnuts farmed on woman’s upland plotSelected produce from vegetable garden</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Rice cultivated on “kamanyang” (individual) rice plots during dry and rainy seasonSelected produce from vegetable garden</td>
<td>Rice from shared plots is for consumption only.</td>
</tr>
<tr>
<td>3</td>
<td>Handpicked groundnuts on fields cultivated by women.Selected produce from vegetable garden</td>
<td>Rice is for consumption only, not for selling.</td>
</tr>
<tr>
<td>4</td>
<td>Groundnuts farmed on woman’s upland plotSelected produce from individual vegetable backyard garden</td>
<td></td>
</tr>
</tbody>
</table>

In one of the two-season rice producing villages (Village no 2), the rice fields were divided into two different types: one type of plot was farmed together by all women in the household for family consumption while a second part was defined as an individual plot which the female farmer had control over. A woman in the FGD explains:

We have “kamanyang” and “marouwol”. The produce from the “marouwol” is for family consumption and will not be for selling. The produce from the “kamanyang” is the woman’s own and will be for selling [Village 2, mother 8].

The “kamanyang” is the individual woman’s own rice plots – she is responsible for all the tasks on these plots and has control over the produce. She has user-rights but does not own the land and cannot sell it. If she is unable to grow rice due to pregnancy, illness or other reasons she can lend the plot to another woman within the compound. There will be no cash payment for the use of the plot but the woman can give a bag of rice or similar as a token of appreciation. The user of the plot will mainly sell the produced rice and spend the earnings as she wishes. Men confirmed in FGDs that they did not have information or access to this income. The income is thus managed independently by women even though there is some aspect of shared agreement as to what type of expenditure this income is used for. Some variation was found within the village: some men also cultivate individual plots in the dry season; while other compounds share the workload and income of all types of plots both during the dry and the rainy season.

In the other village with two-season rice cultivation and upland farming, the farming structure was divided by season:

Rice is grown by both men and women, women will grow rice in the rainy season only and men will grow rice in the dry season only. Some men also grow upland rice during the rainy season and...
this rice is called “Narika” rice. Both men and women grow groundnuts. Millet and coos is grown by men only and maize/corn is also grown by men only [Father 4, Village 1].

During the rainy season women were cultivating groundnuts and this was the source from which women gained individual income. One mother explains in a FGD on the type of groundnut harvests:

You know it has two types when you harvest your groundnut farm and get say 4 bags you then go back to the farm to pick harvest leftovers in the ground and you get say 2 bags. You sell these 2 bags and use the money on yourself and you can buy things like clothes, jewellery, body creams, body spray. For this type no other person has a say in that money. It is you the woman only who can decide what to do with this money[Village 1 mother 1]

In the two upland cultivating villages, women also had opportunity for earning individual income. For women farming groundnuts they contribute to the feeding of the family including seeds for next year’s plantation. A second part of the groundnuts are defined as the farmer’s individual asset. Two female groundnut farmers describe the different types of earnings:

For the harvested ones [groundnuts] you take say half and keep as seeds for next season. For the other half you sell some and buy other foods for feeding, and you also keep some for family consumption for later. [Village 1]

The critical finding in all four villages is that the concept of individual and independent income for women is recognized by both men and women. Women are used to manage resources including cash and men recognized that they do not have decision-making power on these types of resources. This is important for the conditional cash transfer scheme in the MCNHR project since the transfers could be introduced as a similar type of income for women. This would decrease the risk of gender related conflicts on how to spend the transfers. In terms of decision-making power, women describe that their opportunities for making own decisions are good when they cultivate by themselves, such as lowland rice plots and vegetable garden. When men and women work is complementary, such as weeding together on all plots or harvesting together, women report that their influence on the farming process decreases. This suggests that the cash transfer scheme should include clear instructions on the intended purpose of the transfers in order to maintain women’s control of the transfers.

Men’s willingness to take advice from women on farming related topics and women’s opportunities of starting up new businesses, were described in the discussions as limited. Women give advice to their husbands on farming decisions, but they rarely share observations with other males in the compound and much less at the village level. The VDC was not identified as a source of information or support for women in farming in any of the villages.

3.5. Informal support systems to relieve women’s work burden in farming
When women fall behind schedule in farm work, they have some options for mobilizing help:

(i) call upon their brothers;
(ii) ask women in the community if they will accept to work in her fields during one day. She will pay her friends by providing lunch; and/or

(iii) hire a group of day laborers (most often younger unmarried or newly married women or men in the village) to work for them in the fields. This group will be paid in cash after the work is completed.

Requesting help from women’s relatives is within the scope of the kinship system where brothers are expected to stand by their sisters in times of crisis. Asking help from friends of other women farmers to assist in farming work is now also a well-recognized and accepted strategy. The number of women that a farmer can mobilize for a day’s work varies however. The number reflects the woman’s social status and how she gets along with other women in the community. There is also an important dimension of reciprocity in this exchange. Therefore women who have been requested to help will generally accommodate the request. One mother exemplifies:

People do respond/answer to this kind of request because it has now become the norm and you know you would want to go because if your turn comes you will want people to attend. The only time someone will not attend is if the day coincides with important occasions like burial, wedding or when they are sick. If a pregnant woman is away for any important reason like burial, being in hospital or taking care of sick child or family member, the woman can ask someone to take the mint/cola nuts to a certain person and request help on their behalf [Mother 1 Village 2].

Hiring of day labor against a cash payment was described as an option which solely depends on the woman’s economic situation. If she can pay, she will be able to mobilize a group of farmers to conduct her tasks.

The cause of delay in farm work is often pregnancy, in particular if the woman is in the third trimester during preparation or harvesting of crops (see chapter 5). Other mentioned causes were disease in the household or when the husband is traveling and not returning during the rainy season.

Box 6. Communal vegetable garden

Communal vegetable gardens are very appreciated and makes cultivation of a range of vegetables possible such as spinach, okra, eggplant, bitter tomato, tomato, pepper/chili, cabbage, onions, “nana” – green leaves and carrots. Yet, in all three villages that had a communal garden, the fence was broken or partly broken, which had reduced the cultivation to a minimum:

Village 1: funds had not been mobilized for repairing the garden.

Village 2: the garden fence had been broken for two years. Two of four sides were repaired by funds of the garden committee and the VDC respectively. Two sides were still not fixed and women were protecting small plots of green leaves individually. This was the third time during the 20 years since the garden was created that the fence was broken. Some women had started cultivating a different plot of fenced land this year.

Village 4: the communal fence had been given up for now. Lack of funds for purchase of wire fence was the reason. Individual gardens within the communal garden were established. The majority of active gardeners were now men.

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1 See section on inheritance, widowhood and divorce.
3.6. Household resource allocation systems – consumption and marketing

In deciding the balance of consuming or selling produce, the main principle was that it is the producer who makes this decision. In the three villages with vegetable gardens, the use of vegetable was dependent on the current situation of the family feeding needs and on the market demand:

Some of the vegetables like okra and spinach we use for family consumption only. Vegetables like bitter tomato, tomato and eggplant are taken to the markets, when there are any left after going to the markets or if they don’t sell at all, these don’t get spoiled because we will use them in cooking the family meals [Mother 4 Village 2].

Middlemen are the preferred buyers of groundnuts and more recently also of water melons and pumpkins. In villages 1 and 3, middlemen “banabanas” come to the village and bought groundnuts saving the farmers the hassle of transportation and the concern of not being able to sell the groundnuts. However, due to a poor harvest and low quality of the groundnuts last year, the middlemen had not come in the numbers as they used to in village 3. Women who sold smaller amounts of groundnuts in village 3 also sold directly to middlemen and were pleased with this set up.

Marketing strategies of vegetables are centered on the weekly markets. Only in one village producing groundnuts (village 4) did women ask men to sell their groundnuts at the local market. The main constraints mentioned by male and female FGD participants alike were paying for transportation, lack of donkey carts to take all vegetables to the market and price fluctuations related to seasonality. In addition, women with children under 18 months who were still breastfeeding were identified as a group with additional constraints since they have to bring the infant to the market.

Transportation of produce to the market is a main work burden implying costs for households that do not own a car, horse or donkey cart. Seasonality of vegetables strongly influence the prices. No storage facility was available in any of the villages or at the marketplaces so farmers argued they had no way around this. One female farmer described:

The price of the products is also a constraint because it fluctuates as the day goes by. Because many communities use this same market those who get to the market very early in the morning will get the good price and those who get there late or later will get a lower price for the same product because the price reduces as the day goes. If you don’t accept that low price you will have to come back home with your produce and wait for the next market day. You will find that you would still have to pay for the transportation of the produce again and again until you sell [Mother 5 Village 2].

One village had been mobilized by a project which promoted the cultivation of different vegetables in each village in an attempt to have a diversity of vegetables grown in the local area. In the high season of specific vegetables the price was reported to fall dramatically, which this initiative tried to prevent.

As a response to the low prices in the high season, some women in village 4 in the North Bank, made the trip to Banjul to sell at the central market instead. This is considered physically a very demanding task, also requiring
contacts to be able to find a place to sell and maybe place to spend the night if sales are not as successful as hoped.

Certain crops cultivated on certain plots of land are designated for basic needs of food and is assisted by both men and women. Millet, coos and rice is thus expected to cover the needs of food of the household. In addition, husbands are expected to provide for “fish money” – a daily allowance given to women for securing sauce on the cultivated coos/millet and rice for consumption and medical costs. A third part of men’s earnings is kept for their own needs. Needs of children’s clothing appear to be paid by both men and women while women are expected to cover their own needs for clothes and personal items.

In times of crisis or shortage the allocation principles changed and women contributed more on the family basic needs of food. Women were contributing to the family consumption with produce that was set aside for other purposes.

Now, the dry season times are hard and difficult. When you sell say a bag of onions the most pressing thing is food for the family so you will have to help your husband. We decide ourselves to spend the money to buy food for the family. Our husbands do not have a say in it. It’s you who thinks of this and as you have children and before they tell their father “I am hungry I want to eat” they tell the mother [Mother 1 Village 1].

If the household was not facing a crisis, the earnings that women have control over was spent on different needs; some is reinvested, spent on social events, needs of children and of the women themselves:

(all talking at the same time – some of it inaudible) We use the money to buy clothes for ourselves and our children, body creams, laundry soap and for lunch money for our children when they are going to school [Village 2 Several mothers].

When your relatives have an occasion - say marriage or child naming ceremony - you use some of the money to go and attend [Village 2 mother 1].

When we want to start rearing livestock, we use some of the money from our rice sale and buy the stock slowly until you get enough to build up the stock. We do the same for chicken, goat and sheep [Village 2 mother 5]

The income of women is thus covering essential and ad hoc needs of children in addition to collective contribution to social events. Keeping the household within the norms of participation in social life was thus an important additional use of women’s income.
Chapter 4
Vulnerable women

Widows, divorced women, head of a female headed household, household with a daughter having a baby outside marriage, husband and/or wife being unable to work, and women with many young children without enough farm land were the characteristics of vulnerable women according to VDC members in all four villages. Subsequent interviews with individual women revealed that women in these circumstances face several constraints in re-stabilizing their lives and that they are at risk of not utilizing health care services during this period.

4.1. Female Headed Households
The latest Demographic Health Survey [22] indicates that as many as 20 percent of households are female headed. There is some uncertainty on the causes of this high percentage. In each of the study villages the VDC identified few households that were permanently female headed. Many husbands travel for work especially during the dry season but they were for the most part expected home again to contribute to the household.

4.2. Divorce
With reference to the religion of Islam or simply tradition, divorce can reportedly only be initiated and agreed by the husband according to discussions in FGDs. The husband informs his wife that he is divorcing her; women are not entitled to initiate the divorce except in particular cases where her family supports her in leaving. Violence, severe threats in combination with alcoholism are examples of behavior that had women seek help from her parents to support her in divorcing her husband. Except in cases of abuse and suspected infertility, it is assumed that women do not want a divorce because women have no rights after a divorce. Women have no right to shared property or to financial support after a divorce. Moreover, children are considered to belong to the patrilineal lineage and should thus remain in the compound of their father (children older than 7-9 years old). When children are young, especially daughters, they will remain with the mother however. Child support was not provided by fathers, which endangers the health and livelihood of women from poor backgrounds. In addition to the financial and judicial implications of a divorce, the attitudes towards divorced women are mixed. The divorced woman is not necessarily supported by anybody in the compound of marriage or village. As was discussed in one FGD with women:

...the divorced woman - it may be because of her behavior or attitude that she is divorced and if that is the case she will not get any help or sympathy from the family or relatives (of her husband) [Mother in Village 1].

Men explained that it was not easy to provide help to a divorced woman because people around would assume he was looking for sexual favors in return. A father explains:

Also if you try to help the divorced woman in this community people may interpret it as you are expecting something in return and because the religion is quite strong here we avoid being in that kind of situation [Father 2 Village 2].
According to the religion a woman should stay in the marital home 3 months after the husband has requested a divorce to assure the woman does not leave the compound pregnant. However, according to the discussions this rarely happens now. If a woman stays too long after her husband has told her to move, the rumors will start. One woman described:

...the divorced women if she stays in the household people will be making comments like why is she still staying there when her husband has divorced her or some will say she is the cause of the divorce. So the woman will not be happy in this situation therefore she will go back to her parents’ home. If she reconciles with her husband then she will return to the marital household. You know the divorced woman is an easy target for negative comments from people in the community [Mother 5 Village 4].

Interviews with newly divorced women with young children confirmed the shame and subsequent vulnerability related to a divorce. The conditions of livelihood of a divorced woman with young children are entirely dependent on the conditions in her family home. Interviews in the homes of divorced women in each village indicated that women were very aware of the fact that they were a financial burden on their parents and brothers. Even though women were given a bedroom and feeding, generating some income to provide for basic needs such as soap and clothing was of high priority among these women. The lack of support from the ex-husband and women’s coping strategies in turn made the woman and her children more vulnerable. (See Box 7)

Box 7. Divorce leading to poverty and excluding exclusive breastfeeding

<table>
<thead>
<tr>
<th>Interview summary with young newly divorced mother to two children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sari was identified by the VDC as one of the most vulnerable women in the village. She is the young mother of 24 years old with a 2½ year old daughter and a 4 months old son. She was divorced from the father of the children 2 months ago (at the time of the interview) and is now living in her parental home with her mother and father, brothers and their wives. She has been given a bedroom for herself and her two children in the compound. Since the divorce she has no news from her ex-husband and he has not sent any support to their children. Since her divorce she has gone to the market in Banjul five times to sell “nana”-green leaves. She brings her youngest child with her while her mother takes care of her first born. She leaves early in the morning before breakfast is ready; she will not eat much during the whole day before coming back to the village late at night. She brings water and powder to feed her baby during the day because she finds that she is not able to produce enough milk during the full day outside the village. She is well aware that this is not the best choice for the baby and she has already observed that he often has diarrhea, which her first born rarely had. She understands the advice received from nurses and her own mother on exclusive breastfeeding. Sari describes how different she could care for her firstborn because she was supported by her husband. Her mother would visit her and help her too. After the divorce everything has changed. She feels she has no choice but try to generate some income to support herself and her children. Her son is still looking healthy and the nurses have not mentioned that he is off his growth curve. She is planning to go to the local market in two days [based on author’s notes].</td>
</tr>
</tbody>
</table>

4.3. Widowhood and inheritance

Widows were reportedly getting more support from the family and the community than divorced women. But strong norms on widow’s behavior were still discussed in FGDs. In all four villages the traditional practice of levirate marriage between the widow and a brother of the deceased husband was practiced. It is no longer mandatory as allegedly practiced earlier, however.
Inheritance is reflecting the patrilineal kinship system. Sons inherit land of their father; sons and daughters inherit cattle and other wealth in a 2:1 ratio. The rationale is that sons should inherit their father to continue the lineage in the compound while the daughters will move and marry into another man’s lineage. One eighth (1/8) of the wealth will be inherited by the wife. If the children are small and the widow remains in the compound she has user rights to the land of her deceased husband. One father explains:

*If the woman’s children are young and not yet able to work on the land then the wife can inherit the land but when the children grow up the land belongs to them because it is their father’s*  
[Father 1 Village 1]

The formal idea in the levirate marriage is that a widow who stays in the marital home - whether she marries a brother or remains a widow in the compound - will together with her children keep the status she had before the death of her spouse. If the woman was the head of all women (the first woman to marry a brother) then she will normally retain that position. Yet, in practice it is difficult for a widow to remain unmarried in the marital home: to stay in the compound requires a new marriage with a brother or close relative to the deceased husband. Whether that will happen or not depends on several factors. FGD participants describe that the first priority of a widow will be to stay in the compound to keep her children and family together: (i) Staying in the marital compound secures her continued livelihood and access to farm land and support; (ii) it secures her children’s inheritance from their father and thus their ability to take care of their mother later in life; (iii) keeps her children together and secures that the mother will continue bringing up the children. It was stated that the care from another woman rarely will be as complete as that from the mother. One mother describes:

*For the divorced women they will prefer to have stayed in the marriage until they die so that their children will be brought up in a stable home. For the widow she will prefer to remain/stay in the marital home and look after her children because no woman would like to be moving around marital home with their young children and if you leave your young children behind in the family home you know some people can only take good care of their own children but not others. So the woman will not be relaxed in such a situation*  
[Village 4 mother 5]

These judicial, economic and social reasons were compared to the widow’s personal feelings about de facto marrying a brother. Young widows were said to most often stay in the compound which FGD participants also framed as the best option for widows to secure their future.

Interviews with young widows with young children who had left the marital home and not married a brother and moved back to their parental home, were in economically and judicially in a similarly difficult situation as the divorced women. They had left the marital home with only their personal belonging and were not supported by the marital compound. They also expressed high insecurity of whether their sons when they grew up, would inherit land from their deceased father. The risk of continued poverty was a serious concern for these women. Men in a FGD confirm:

*Sometimes when a woman is divorced or widowed and goes back to her father’s home with young children she will depend on her brothers or relatives for help in her farming tasks. If this assistance is not there she will struggle and have difficulty to feed her family and take care of her children. Sometimes these women will depend on the goodwill of their neighbors and other villagers.*  
[Father 31 years old, 2 wives, 5 children, Fula village]

The reason for leaving the marital home was lack of a brother to marry or that brothers had not asked them to stay. The behavior of the widow was mentioned as very important when the marital home decided whether to offer her to stay or not:
Sometimes it may not be because of the children but the way you are as a person and your rapport with people that will make the family of the deceased want you to remain in the family. Some of the widows, even if they had many children, if their attitude towards people is not good then no one in the deceased’s family would want to remarry her [Mother 7 Village 2].

Women’s lack of rights as divorced and as widows directly and most often negatively influenced the conditions under which they could bring up their children. When divorce or death happens during a child’s first years of life, women’s opportunities to care for them and for themselves are very restrained and solely dependent on the socio-economic conditions of her parents and brothers. Young widows who have no children do occasionally remain in the compound and marry a brother; but are more likely to move back to their parents and eventually remarry. As one man summaries the discussion on women’s opportunities for independent decision-making as married, divorced or widowed:

For women no matter how old they get or what their level of livelihood is, they will be dependent on someone like their husband, husband’s family or her own relatives like her brothers who will take care of them [Father 4 Village 2]

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2 Old widows without own children are normally provided for by the grown sons of their co-wife and will remain in the compound after the death of her husband.
Chapter 5– Women in Reproduction

To be able to conceive and deliver a healthy child is a profound expectation for women in rural Gambia and pregnancy is surrounded by strong norms of behavior on women. Antenatal care was framed as support in diagnosing disease and only to some extent in preventing disease during pregnancy. In discussing the amount of support provided to pregnant women discrepancies between men and women’s views were identified.

5.1. Factors affecting ANC attendance: reaching and receiving care

A variety of factors determines when women attend their first ANC consultation. Accessibility was described as good in three of the four villages. In these villages the outreach clinic was conducted in the village, which also served as a visible reminder for women who might have forgotten the day of the clinic. In contrast, constraints in reaching the outreach antenatal clinic were brought up in Village 1 (one to two hours walk away). In the rainy season women in village 1 were not able to reach the outreach clinic due to flooding. Only in one of the villages did women report a fee of Fifty Dalasi (D50.00) for the ANC card during their first visit. Women without Gambian ID cards were charged for ANC consultations and for deliveries at the health center or hospital. Medicines were distributed for free.

Women incurred the opportunity cost of missing at least half a day of work by attending the ANC clinic. Two husbands describe:

*What my wife tells me when she returns from the clinic is that when they go to the clinic there are so many people and the queues are so long and there is no food there for them to eat. They leave home around 8 in the morning and do not return till 2 or sometimes 3 in the afternoon. The women who go with their children will find it very hard because there is no space to sit or lie down so the mothers will carry their babies strolling around. This is difficult. Around 2 or 3 in the afternoon when the sun is very hot some women will walk back home hungry and when they come they will say “I am so so tired today” [Husband 1 Village 1]*

*Some of the women - if they are the only wife in their household - when they return from the clinic 2-3 in the afternoon they will find the lunch cooking is awaiting for them. When they come from the clinic they will be so tired and hungry and will have to cook the family lunch and by the time she finishes cooking lunch it is already time for the evening household chores [Husband 4, Village 1]*

ANC clinics were mostly described in positive terms by women. Attitudes to ANC included several benefits but also some disadvantages (See Table 5). The nurses were mostly described as providing good quality services at the same time as it was acknowledged that some nurses treat women less respectful than wished for. Nurses are reported to shout at women if their ANC card is not well kept or if they have missed ANC visits. One father and mother exemplify:
If you were supposed to attend last clinic day but you could not attend - you were due to receive certain medicines at this visit. Then when you attend the next clinic the nurses will shout and scream at you for not attending the last clinic day and some will even refuse to give you any medicine [Father 1 Village 1].

Nowadays they will send you away if you come to join the clinic that late and even if they don’t send you away they will talk hard at you, the pregnant woman [Woman 4 Village 2].

When discussing the benefits of the services there was an emphasis on diagnosing and treating disease with medicine – in particular anemia, referred to as “low blood”. Malaria prevention and distribution of medicine was also emphasized. Distribution of medicine for anemia and checking if the baby was in the right position were other benefits associated with ANC. There were no significant differences between men and women’s perceived benefits of ANC (See table 5).

Table 5. Attitudes towards ANC

<table>
<thead>
<tr>
<th>Quotation</th>
<th>Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>They will check your blood and if it is “low” they will tell you, give you medicine for this and</td>
<td>Mother 1 Village 4</td>
</tr>
<tr>
<td>advice you on what foods to eat. They will also give you injections</td>
<td></td>
</tr>
<tr>
<td>To protect you and your baby from diseases. The nurses will give you medicine (Fansidar) to</td>
<td>Mother 5, Village 4</td>
</tr>
<tr>
<td>protect you and the baby from malaria.</td>
<td></td>
</tr>
<tr>
<td>To ensure you have a safe delivery for example there are some medicines or injections that if you</td>
<td>Mother 4, Village 2</td>
</tr>
<tr>
<td>don’t get during pregnancy you will have a difficult delivery</td>
<td></td>
</tr>
<tr>
<td>So that they will check you and know the baby’s condition in your stomach because you will not</td>
<td>Mother 7, Village 2</td>
</tr>
<tr>
<td>know this and there could be a problem inside with the baby that you will not know until you get</td>
<td></td>
</tr>
<tr>
<td>checked at the clinic</td>
<td></td>
</tr>
<tr>
<td>The nurses will check the pregnant woman and they will tell them when their delivery is due or</td>
<td>Father 5 Village 3</td>
</tr>
<tr>
<td>approaching. They will say so and so month is when you are due to deliver.</td>
<td></td>
</tr>
<tr>
<td>It is to improve the health of the woman and her baby. The pregnant women and the baby inside will</td>
<td>Father 7 Village 4</td>
</tr>
<tr>
<td>be checked and the nurses will know how they are faring. If there is any problem then they will</td>
<td></td>
</tr>
<tr>
<td>give them medicine to treat them.</td>
<td></td>
</tr>
<tr>
<td>When you are 4 months pregnant the nurses will give you medicine to protect you and the baby from</td>
<td>Mother 1 Village 2</td>
</tr>
<tr>
<td>malaria</td>
<td></td>
</tr>
</tbody>
</table>

The importance of sequencing the intake of malaria prophylaxis during 6 months was only discussed in one FGD with women:

The way we see it is that the pregnant women who go join clinic early and the ones who want the best for themselves because you need to take Fansidar for 3 visits which will protect you and your baby from disease. Those pregnant women who wait for 6 months to join clinic may only have the Fansidar once or twice instead of the recommended 3 times [Mother 5 Village 2].

Perceptions regarding the rationale for multiple visits were otherwise limited.

When asking fathers in FGDs what roles they have during their wife’s pregnancy men in all groups listed:

- remind wife of ANC clinic day;
- remind wife to take medicine;
- mobilize and pay for transport if she cannot walk to ANC; and
- pay for medicines and additional foods as needed during pregnancy.

Interestingly it was mentioned in one male FGD that men have a learning curve in
behavior during pregnancy and delivery. They do not know much when their first child is born and are dependent on their wife and fellow fathers. One father describes:

Those men who have experience from several times they will start the support to their wife as soon as they know the woman is pregnant. Those of us with less experience in this area we just go by what the woman asks. Say that she will come and say “please give me money to buy such and such food” or “can you buy me some meat”. The men who are more experienced will do more things for their pregnant women than some of us inexperienced men as we go by the pregnant woman’s demands [Village 2 father 7].

Yet, reminding women of ANC was not always stated to be enough for women to actually attend ANC. Men did not accompany their wives to ANC and did not consider this a need. As long as pregnancy was progressing normal, men considered this a woman’s world in which they did not take much part. There was also a paucity of ideas of how they could be more involved.

5.2. Pregnancy norms – deciding to seek ANC

Women’s agency when deciding to tell others about their new pregnancy is an important dimension of understanding the currently low utilization of first trimester ANC services. Both men and women recognized that pregnancy can be detected early, however. Some women realize they are pregnant after missing one period, or because of other signs such as vomiting, dislike or likes of foods. Few women will tell anybody they have missed one period according to women in FGDs. Women agreed that the majority of women tell their husband, mother or occasionally Mothers-in-law after missing two or three periods. When women tell, some husbands and mothers-in-law have already suspected the pregnancy by observing that the woman has not stopped praying and had not had her period. One husband describes:

The husbands will know after his wife misses three periods. If you sleep with your wife and observe that she missed one period, then she missed the second month’s period - when she misses the third month you should know that your wife is pregnant because it cannot be due to disease. Even if the women don’t tell us we the men will observe and know for ourselves that our wives are pregnant. If they don’t tell us we do not ask but we know from our own observation [Father 7 Village 1]

Women and men generally reported that the best time to start ANC is when a woman is three to four months pregnant. A few women start to attend in the second month, which is perceived as early. In practice women attend their first visit between three and six months according to men and women. Later than six months was perceived as late, if not too late. Yet, men and women confirmed that there are women in each village who delay their first visit even to the later part of the third trimester. These women will hide the pregnancy for as long as possible.

When listing the roles of husbands during their wives pregnancies, reminding to attend ANC was one of them, which women confirmed. Men stated that women will not openly refuse to attend ANC if asked to go, but they will in fact decide themselves when and if to go. One father in a FGD commented on women’s agentic behavior:

The pregnant women who do not want to go for antenatal care, when you remind them to attend they will say “my time to join the clinic is not yet due”. The pregnant women who want to seek antenatal care when you remind them, they go [Father 5 Village 2].

The most frequently stated first reason for not attending ANC before the fourth or fifth month was for women “shyness”. Different dimensions of shyness and reasons for wanting to keep
the pregnancy secret were discussed in the FGDs. Four sub-themes were developed on the basis of the statements and presented in Table 6. The four sub-themes are:

(i) ANC makes pregnancy a public matter;
(ii) coping with stigma;
(iii) expectations on motherhood; and
(iv) early ANC as pregnancy risk.

The sub-themes are contributing to a broad theme of: women’s trade-offs between benefiting from biomedical care and becoming mothers in a culturally approved manner.

Table 6. Content analysis on perceptions of not attending early antenatal care

<table>
<thead>
<tr>
<th>Statement</th>
<th>Condensed statement</th>
<th>Interpreted statement</th>
<th>Sub-theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>I don’t think there are any concerns you just want to keep your pregnancy private.</td>
<td>Keep your pregnancy private.</td>
<td>Pregnancy in the early stages is a private matter</td>
<td>ANC makes pregnancy a public matter</td>
</tr>
<tr>
<td>When you conceive and you are not sick and no morning sickness and you are healthy you keep the pregnancy to yourself for privacy.</td>
<td>You are healthy and keep the pregnancy to yourself.</td>
<td>Pregnancy can have a healthy start</td>
<td></td>
</tr>
<tr>
<td>they are shy and do not want people to know that they are pregnant or they don’t want other people to tease them and say so and so is pregnant</td>
<td>Women are shy and do not want people to know... and women do not appreciate teasing about pregnancy</td>
<td>Information and gossip about the women’s pregnancy is violated through teasing – if kind-hearted</td>
<td></td>
</tr>
<tr>
<td>women who tend to join antenatal care late in pregnancy are mostly the young women who are pregnant for the first time. I think it is because they are young and shy and may not be even aware of the importance of or need for antenatal care</td>
<td>Young women pregnant for the first time are shy and might lack knowledge</td>
<td>Delay pregnancy disclosure</td>
<td></td>
</tr>
<tr>
<td>wait until the clinic is quieter and many people have already gone then they will come to the clinic</td>
<td>Clinic is quieter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>some of the women who got pregnant outside of marriage they will keep it secret and they will not attend antenatal care because they don’t like people to know</td>
<td>Pregnant outside marriage will keep pregnancy secret</td>
<td>Avert that disapproved behaviors on women’ sexuality become public</td>
<td>Women coping with stigma on sexual behavior while also wanting to utilize ANC services</td>
</tr>
<tr>
<td>women whose husband is abroad and they get pregnant in his absence they will go late for antenatal care</td>
<td>Pregnant in husbands’ absence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>women who get pregnant while breastfeeding they are shy to attend antenatal care because they don’t want people to know that they got pregnant while still breastfeeding</td>
<td>Pregnant while breastfeeding they are shy and do not want people to know</td>
<td></td>
<td></td>
</tr>
<tr>
<td>you will be embarrassed if it turns out not to be a pregnancy and people will say “so and so woman was trying for a baby but she could not have”</td>
<td>Embarrassed if it is not a pregnancy....woman was trying for a baby but could not have</td>
<td>Shame to think you are pregnant when you are not. Stigma of not being able to conceive</td>
<td>Living up to expectations of women becoming mothers easily</td>
</tr>
<tr>
<td>people will say “oh so and so has joined the antenatal clinic too soon” ....</td>
<td>Joining the antenatal clinic too soon</td>
<td>Joining too soon is a way to show off pregnancy and to not respect the risk of miscarriage</td>
<td>Early antenatal care as pregnancy risk</td>
</tr>
</tbody>
</table>
ANC makes pregnancy a public matter: The connotations of “shyness” revealed at least two dimensions: (a) women are shy to make the pregnancy official especially for first time pregnant women. They want to avoid the attention and the teasing even though it is meant to be kindhearted; and (b) pregnancy is perceived as a private matter to women. Women purposely restrict her pregnancy news within the family compound and even more so in the community at large if possible. For women with morning sickness this is not possible, but for the woman who passes the first three months without any visible symptoms, she will prefer to keep the news to her herself and her nearest. In contrast, ANC consultations are conducted on designated days and the exams are performed in designated ANC rooms, which make it very difficult if not impossible for women to seek the services without being noticed. One mother-in-law says:

*Only when you see the woman going to “nurse” (attend clinic) or they tell you I am going to get a paper from the nurse then you know [Village 1 mother-in-law]*

The lack of anonymity is an important constraint for seeking ANC during the first trimester.

Women coping with stigma on sexual behavior while also wanting to utilize ANC services: The norms on women’s sexual and reproductive health are concentrated on pregnancy within marriage. Teenage pregnancies and pregnancies out of wedlock are recognized to happen – especially in villages where husbands travel abroad for longer periods – but these behaviors are not approved of in the community. Women will therefore try to hide the pregnancy as long as possible, which public ANC does not accommodate for.

Women who also were mentioned to rarely attend early ANC were women who got pregnant while still breastfeeding; that is women with a pregnancy interval shorter than 18 months. As will be described later the preferred breastfeeding period is 18 months after which women can have sexual relations again. However, the seclusion or separation of husband and wife during the breastfeeding period has changed radically during the last decades according to Mothers-in-law.

Living up to expectations of women becoming mothers easily: A third reason for not disclosing pregnancy and therefore not attending ANC before the pregnancy clearly shows, was fear of miscarriage. In extension there was a fear that one miscarriage can indicate a risk of permanent problems in carrying a pregnancy to term. Infertility and pregnancy complications are ascribed to the woman and are stigmatizing potentially for life.

This sub-theme is capturing the responsibility placed on women to secure reproduction and the importance of transitioning from woman to mother. It is closely linked with the fourth sub-theme on risk perceptions.

Early antenatal care as pregnancy risk: Women were concerned that the pregnancy was not yet “established” before three months. To attend ANC “too early” was interpreted as pushing your luck.
and not showing respect to the risks during early pregnancy. Pregnancy is recognized as a vulnerable period when women should reduce exposure to potentially evil forces in the spiritual world. By not showing the pregnancy in public, the spirits will have more difficulty in knowing about it and will not bring harm. By hiding pregnancy, women are in fact trying to protect themselves and their pregnancy. As mentioned above, women are well aware that ANC transforms private matter into public matter, which constrains them from going early.

These four sub-themes illustrate the dilemmas women face during pregnancy. ANC is viewed as helpful in knowing the position of the baby, to adjust "levels of the blood" and to identify women who should deliver at the hospital. But these services are seen as more relevant towards the end of the pregnancy and less in the beginning of the pregnancy where privacy on the other hand is perceived to reduce risk of miscarriage. It is rare for a woman not to attend ANC at all during her pregnancy according to all participants. This is also confirmed in survey data indicating that more than 90 percent of women attend ANC at least once [22]. Keeping the pregnancy private also signifies the social value placed on respecting the connections between the social and the spiritual world. In extension women’s behavior acknowledges their important role in reproduction of the family and survival of the lineage.

5.3. Work burden during pregnancy

Norms on work burden in pregnancy connect women’s roles in production, consumption and reproduction. No time-burden studies in pregnancy in The Gambia are available to our knowledge. Yet, it is an area in which nurses’ global recommendations are not well aligned with local perceptions. Nurses emphasize the importance of reducing the work burden during pregnancy while traditional values underscore the benefit of staying active and strong until child delivery. In addition, men and women did not agree on the amount of support women received during pregnancy.

Husbands described in general a willingness to support their wife when she is pregnant. Husbands also described that the pressure on households to generate income during pregnancies, which makes the support less than it ought to be. One husband describes the risks of a high work burden:

When your wife is pregnant whatever help she needs to ensure she is healthy and strong you the husband will do your best to give. If you find a pregnant woman who suffers during pregnancy or childbirth and she dies then you will find that it is because the husband was unable to provide the necessary help. Even if you want to provide the help if the required help is beyond your means how can you help her? What you can do to help is to tell her to reduce her workload and have more rest [Village 1 father 3].

Mothers-in-law also observed that husbands help their wives more now compared to their time. Even though there is a seemingly positive trend, women were calling for far more support from husbands and co-wives in particular. The work burden was framed as heavy in all four FGDs with young mothers. Two mothers exemplify:

You don’t get help when you are pregnant. You will go to work on the farm yourself and bend down and do the tasks yourself. When your pregnancy is advanced and heavy and you can no longer perform your farming task that is when your husband will take over and perform the remaining tasks. If he can afford it he will pay other people to go and complete the remaining tasks [Village 1 mother 1].
When you are pregnant and you are not jointly farming with other people in the household then you will work for yourself on your farms and garden until you can no longer work on the farms whether you have finished or not. Then maybe your peers will say “now this woman cannot work on her farms anymore let us ask for help on her behalf and organize a day’s work on her farm”. When this happens and the people spend a day working on your farm - maybe they will finish or not finish depending on how far you had come. If your farm is not finished after this then it will remain like that [Village 1 mother 2].

Three cultural perceptions on work burden in pregnancy were developed on the basis of FGDs:

- Pregnancy is a normal part of a woman’s work life;
- Work and to some extent hard work during pregnancy is beneficial;
- Advice on work burden from doctors and nurses to women at risk is valuable.

These three perceptions were mainly developed from a question in FGDs where participants were asked what women, men and Mothers-in-law respectively would say about a pregnant woman who in her second trimester was complaining about her work burden (See Table 7).

### Table 7. Cultural perceptions on work burden in pregnancy

<table>
<thead>
<tr>
<th>Statements</th>
<th>Condensed statements</th>
<th>Interpreted statements</th>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>The women will say to this woman are you the only one who has ever been pregnant? That the woman is behaving like her pregnancy is something that has never happened before [Village 2, father 3].</td>
<td>.the only women to have been pregnant?..</td>
<td>Women have shared experiences related to pregnancy</td>
<td>Pregnancy is a normal part of women’s work life</td>
</tr>
<tr>
<td>Sometimes if your daughter gets married and this is her first pregnancy you will say “let me leave her and make her work hard” because whatever way you start with your pregnancies that is how you will continue [Village 2 mother 1].</td>
<td>Leave daughter to conduct hard work to get used to it</td>
<td>Young women have to adapt to high work load during pregnancy.</td>
<td>Women who can work until child birth are favored</td>
</tr>
<tr>
<td>You know that we have many women whose pregnancy is heavy [advanced] and from the start of their pregnancy they are healthy and they work throughout and some will even work until the day they deliver. Some will cook lunch for the family and then you will hear they delivered during the night [Village 2 mother 1]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The way we men view this kind of woman is that she refuses to work or she is lazy and if she goes into labor there can be problems with her blood. If she is not near to a hospital this may not be good for her. But if she is doing some kind of work and moving about and “shaking her body” her labor becomes easy and less difficult [Village 2 father 3]</td>
<td>When a woman is lazy it can lead to problems in her blood which in turn can lead to problems in child birth. If women work her labor becomes easy and less difficult</td>
<td>Physical work and activity will make labor easy</td>
<td>Work is beneficial for pregnancy outcome</td>
</tr>
</tbody>
</table>

| Some mothers-in-law will say leave her to do as she wants when the time comes she will see it for | | | |
**Pregnancy is a normal part of a woman’s work life:** Pregnancy is ideally, and for most women also in reality, a normal and happy part of their life. A strong and healthy woman is the woman who goes home to deliver a baby after a day of work in the field. As discussed in the previous paragraph pregnancy is recognized to imply increased risk, which can be mitigated by hiding the pregnancy and behaving as normal as possible in terms of household chores and activities. Women with easy pregnancies that did not influence much on the everyday life of husbands and other family members were said to be favored by men. One mother describes this point of view:

*Men like a pregnant woman who will try and work as normal during pregnancy which will help the household income and welfare. Only if the pregnant woman is not well or has problems with the pregnancy she will not work [Village 3 mother 6].*

**Work is beneficial for pregnancy outcome:** To remain strong and healthy throughout pregnancy it is recommended to keep up the women’s work in the field and in the home. Women are recognized to need help and will be helped by young girls in the compound. But it is important to note that the support women get from husbands and co-wives is primarily on work in the family fields to produce food for the whole family. One woman clarifies:

*If it is in the rice fields all the wives of the same husband share work in the rice farms so if the pregnant one can no longer work on the rice field the co-wives will continue the work as normal [Village 2 Mother 2]*

<table>
<thead>
<tr>
<th>herself. Some will say if the pregnant women don’t hear with their ears they will see with their eyes [Village 1 Mother-in-law]</th>
<th>It will benefit the woman at the time of childbirth because they will not have a difficult labor and that is why when the pregnant women who work through their pregnancy give birth people are surprised as they will say “oh I met her fetching water just earlier”. These women they have easy labor and delivery [Village 3 Mother 6]</th>
<th>You know the older women and the mothers-in-law they will not push any pregnant woman to work when their condition does not allow it. The way it happens here is the older women and mothers-in-law will tell people that you do not need to force so and so pregnant woman because at her stage now she should not be working and should be resting [Village 2 father 1]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mothers-in-law will not push pregnant women when condition does not allow it</td>
<td>Mothers-in-law will not push pregnant women when condition does not allow it</td>
<td>Mothers-in-law have influencing advice on reducing work load late in pregnancy</td>
</tr>
<tr>
<td>...unless if you attend “nurse” (antenatal clinic) and they advise you not to work then you will perform all your tasks as normal [Mother 4 Village 2]</td>
<td>If nurse advise you not to work you should follow advice</td>
<td>Nurses can see during ANC if a woman works too much</td>
</tr>
<tr>
<td>If you are not well or you feel sick then you should say it, so that people will know why you will not work... [Village 3 Mother 7]</td>
<td>If you feel sick you should say it</td>
<td>Sickness during pregnancy is a legitimate reason not to work</td>
</tr>
</tbody>
</table>

Advice to reduce work burden is valuable
When it comes to women’s independent income generating activities, she will in general not receive support from the household members. Their private income sources are thus ceasing or decreasing the closer a woman gets to delivering. One mother describes:

*Here if you have co-wives and you are pregnant they will leave you to do your farming and household tasks. Even if they want to help you, everyone is busy on their own farms and the co-wives will concentrate on working on their own farms. The co-wives will work on the “marouwol” [shared rice plots] and when the produce from the “marouwol” is brought home it is for the whole family's feeding but they will not help you with your “kamanyang” [individual rice plots]. You will not have any of the co-wives to take over some of the tasks there even if you have three co-wives [Village 2, mother 5].*

The fact that women will lose out on own income if they do not conduct the work themselves should be kept in mind when husbands in FGDs complain that women follow their own mind and do not easily take the advice to reduce work load during late pregnancy:

*(some of them talking at the same time) some of the women are following their own mind and insist on continuing to work even when people advise that it will not be good for them [Village 2 fathers].*

**Advice on work burden from health staff is valuable:** Risks that hard work can result in breech deliveries is some of the advice that got more attention than general statements on reducing work load. One mother-in-law described the kind of tasks that health staff have warned pregnant women about:

*Women are not allowed to carry heavy loads because this will push the baby down your sides, bend down when washing clothes because this can turn the baby upside down in the stomach. When your pregnancy is heavy they say that bending down for long hours will make the baby to turn upside down [Village 1 mother-in-law]*

In addition, it was acknowledged by FGD participants that health staff are able to see problems in individual women, and can identify women who have risks of complications. This father explains his understanding of the advice to women at risk of health staff:

*When the pregnant woman attends clinic they say to her that she should not do any kind of work during her pregnancy maybe because the woman’s blood is low, or blood is high or they will advise the woman to reduce the salt she eats - something like that [Village 1, Father 5]*

Fathers noted that they do not take part in the ANC and therefore mainly have the information that women communicate to them.

**5.3.1. Diversity in support to pregnant women**

In FGDs with men, they agreed that the support to pregnant women is similar for all women, while the women’s groups were quite explicit that many differences among women exists. Economic conditions and the household composition were factors influencing the actual support that was provided to pregnant women. In villages with large socio-economic differences women explained:

*There is a difference in the help a pregnant woman gets. For example if I am pregnant and my peer will try to organize work on my farm she may go round the village and not get one person willing to help whereas other pregnant woman will get a lot of people willing to help them on their farms [Village 1, Mother]*
The amount of help you get will depend on you the woman. Sometimes it is your behavior towards others that will determine how much help you get. Sometimes if the woman is well off (financially) then she tends to get more help, the woman who is not well off will tend to get less help so people are drawn towards the one who is better off [Village 2, mother 5].

Not all women in FGDs agreed with this perception and argued that the difference in support depends on the behavior of the woman before and during her pregnancy:

It does not matter whether you are from this village or came to marry here from another village and it does not matter what your family or husband’s status is in the village....It solely depends on your behavior and attitude towards other people - the way you interact with others. If you marry into a household and humble yourself and know and respect that you have elders and those younger than you - whatever help is requested you will get it and this will include help with household chores. You will find young people helping some pregnant woman with laundry, cleaning, fetching water, ironing and other things because you are pregnant [Village 1 Mother 2].

Certain tasks are considered inappropriate for pregnant women such as “pulling the rope” of the bucket in wells. Yet, not all pregnant women are able to protect themselves even against this very strenuous task as reported and observed during the field visits.

Box 8. Mother-in-law’s personal description of her first child birth during a focus group discussion

Moderator: At the time of the birth of your first child where did women deliver?
Mother-in-law: On the day I delivered my first child I cooked lunch and then went to work on the rice field. I was having pains all this time and after a few minutes of tilling the pains would come on again. I was in the field with my mother-in-law and her co-wife. After a while my mother-in-law’s co-wife noticed that I was stopping often and she came over to me and asked me what was wrong. I told her that I was having stomach pains so she called my mother-in-law who came over and asked me to stop work and return home. I went home on my own under the hot sun and went straight to my grandmother’s house and soon after getting there I delivered my baby assisted by my grandmother in her bathroom ("Hurrgo"). That’s how my first delivery went. [Village 1, 2 live children and 8 grandchildren].

5.4. Birth location – challenges and preferences

Left to us alone we would prefer our “ting mutala” [TBA] to assist us in our homes here in the village until we deliver [Village 1 young mother in FGD].

In the four villages the most frequent and strongest expressed preference was to deliver at home with a local, well-known and respected TBA. Trained or untrained traditional midwives were active in
all four villages and the respective Community Health Nurse (CHN) confirmed during interviews that the TBAs were helping the majority of women in the villages. CHNs confirmed the high level of activity of the TBAs in mobilizing women during outreach clinics, assistance during delivery, multiple home visits during the first week after child birth, verbal report of new pregnancies and deliveries since the last visit of the CHN.

Except for women who have been told by nurses during ANC to seek care at the hospital as soon as labor starts, the majority of women would inform the TBA that labor had started. Very few women are reportedly delivering alone and without assistance. It is unclear what makes women inform her husband or mother-in-law that labor has started. Some women will keep that information to themselves until a point when labor becomes too difficult to manage alone, while others will inform their husband soon after labor has started. But it is also confirmed that TBAs are only contacted after one to two days of ineffective labor.

Women and men were asked to describe positive and negative features of home deliveries supported by the TBA respective health facility deliveries. These descriptions are listed non-ranked. See Box 9 below.

Box 9. Comparison of home deliveries and health facility deliveries

<table>
<thead>
<tr>
<th>Positive aspects of home delivery</th>
<th>Negative aspects of home delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>The “ting mutala” [TBA] is very nearby here in the village [Village 1, mother]</td>
<td>The disadvantages are that the TBAs cannot deal with complications so if any arises the woman has to be taken to hospital and the delay in the time to get to the hospital is not good for the woman. Sometimes if the delivery is during the night and there is a problem then arranging transport becomes even more difficult. [Village 4 father 7]</td>
</tr>
<tr>
<td>Because our TBA has been trained and she is very skilled and experienced, it saves us the time we spend going back and forth to the hospital and the cost that we will incur when we have to take our pregnant wives to the hospital to deliver [Village 2 father 2]</td>
<td></td>
</tr>
<tr>
<td>The TBA attends to women in labor and conducts all normal deliveries that have no difficulty here in the village. She will send to hospital only those with problems like long labor and bleeding at the start of labor before the baby is born.....if she cannot deliver the woman here she will tell the husband to arrange a cart to take the woman to hospital in [area] and she will accompany the woman to the hospital [Village 1 mother 2]</td>
<td></td>
</tr>
<tr>
<td>If the women give birth here they will be assured of privacy and their dignity will be maintained. In the hospital this can be a problem sometimes [Village 1 father 6]</td>
<td></td>
</tr>
<tr>
<td>When the woman is in labor she is under the care of the TBA and she will be the one who will say to us whether the woman can stay and deliver at home or whether the woman will be taken to hospital [Village 2 father 2]</td>
<td></td>
</tr>
<tr>
<td>Because of the way she cares for us she is so good, her patience, her gentleness and her respect is the reason why we would prefer to deliver with her than go to the hospital [Village 2 mother 4]</td>
<td></td>
</tr>
<tr>
<td>The TBA will also massage your whole body and the stomach to help you to expel any blood clots that may be left in your stomach [Village 3 mother 7]</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Positive aspects of health facility delivery</th>
<th>Negative aspects of health facility delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the hospital if something happens say the woman is</td>
<td>If you deliver on the way then you are just wrapped in rags</td>
</tr>
</tbody>
</table>

3 This is a topic that is beyond the scope of this study. It would be relevant to explore further; in particular to understand what makes women suspect complications are underway.
bleeding too much they can give blood and they can also give medicine/injection to stop the bleeding this you cannot get if you deliver at home [Village 4 father 7] until you reach the hospital in [the area]. These are all difficulties for us the women [Village 1 mother].

There are some women who bleed and feel dizzy after childbirth and they will fall down and hurt themselves and this is why nowadays people go to hospital because they will give you injection and tablets to help stop the bleeding and they will keep you there until you are fit to go home [Village 2 mother 1] You know when a woman in labor has problems and is being taken to the hospital the whole village will know about it. But if you deliver here then no one will know until you tell them so and so has given birth [Village 2 father 7]

If the facility is there and you are able to get there then we should all deliver in hospital [Village 3 mother 4] The reason why we prefer to deliver with our TBA is when you go to the hospital, the nurse you find on duty some of them are clean hearted and will care for you respectfully but some of them can be very harsh and impatient which will make you scared whereas our TBA she will be very patient and gentle with you until such time you deliver safely in her hands [Village 2 mother 6]

The nurses will keep your privacy and they will put curtains between the women so that your dignity is also maintained [Village 3 Mother 7] Women who delivered in a hospital especially [health center] they say they would prefer to give birth at home because in the hospital they are left alone in a room and they feel alone and scared there [Village 1 father 5]

<table>
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<tr>
<th>If it is Friday, Saturday and Sunday if you should be sick or you take a pregnant woman or a woman in labor to the hospital during these days if you don’t know anyone among the nurses then you will not be seen or attended to because whoever staff you ask for help they will say “I am not on duty” and send you to the next staff and that one will also say the same thing. You will find that on these days only two people will be working and you will find it difficult to get any care or attention [Village 2 father 7]</th>
</tr>
</thead>
<tbody>
<tr>
<td>The difficulties and problems we encounter at the hospital when we take a sick person especially a woman in labor we will not have to go through if our women give birth here at home with the help of our TBA. If we are able to get women to deliver in the hands of the TBA at home, then we will not worry about transportation, health staff attitude and all the cost that is involved [Village 1 father 8]</td>
</tr>
</tbody>
</table>

The positive aspects of TBA’s services were many: easy access, interpersonal skills and knowledge of TBA that secures women’s preference of privacy and that the TBA overall takes charge over needs of women. She will take charge in terms of assessing the progress of the birth, the information given to the husband at the same time as she is familiar to the woman in labor. The trust in TBAs also included a belief that she was capable of knowing when women needed referral to a health facility, and that she would accompany the woman and her husband and/or mother-in-law.

Men described relief when the TBA arrives for the home birth. They were sent out of the house and would wait. One father describes:

*When the woman is in labor the husband informs the “ting mutala” [TBA] and the TBA will come and take over caring for her. You the husband will go and sit down so when the woman delivers the TBA will come and say your wife has delivered [Village 1 father 1]*

As long as the delivery was progressing normally the husband was expected to wait out. Husbands’ passive role was transformed into an active one if complications arose and the TBA wanted to refer the woman to a health facility. Husbands were asked to actively take over the process of seeking means of transportation and mobilize funds for payment of transport and potential medical costs. The timely mobilization of transport was occasionally an issue of disagreement between fathers and TBAs.
The perceived uncertainty in services at health facilities during delivery was described as a severe constraint for men. This in turn pushed them towards a preference of the TBA in spite of TBAs known limitations in medical knowledge and treatment. Yet, men most clearly expressed concern about medical risks during home deliveries. The offer by TBAs to accompany the woman together with her husband to the health facility was a service highly appreciated. Interviews with the attending nurse at the closest health center or hospital to each of the four villages confirmed this.

Facility-based deliveries are associated with complications. A strong wish to avoid complications with difficult transportation of the woman in labor and a risk of referral from the nearest health facility to a facility that can handle blood transfusions and C-sections was also a constraint in seeking delivery services at the health center. The attitudes to and experiences of delivery services at a health facility were mixed. Negative experiences of delivering at a health facility included the lack of continuity of care from one or two nurses throughout the labor and delivery. In addition, being left alone in the labor ward was associated with fear. Yet, privacy was not guaranteed even though it was mentioned that one of the labor wards had curtains to protect the dignity of women in labor.

Men described that they would not have a place to be during a facility based delivery but would wander around on the hospital grounds. Only if complications arose were they called upon and sometimes asked to mobilize additional funds for a blood transfusion. They were only entering the labor ward in very severe cases when nurses feared for the life of the woman in labor. The lack of presence of men in the labor ward seemed to accommodate both men and health staff, however. Nurses in labor wards explained that men did not want to see the birth of their child for cultural reasons, which men mainly agreed on. One man mentions this diversity:

*Some men will not mind but generally most men will not want to be present in the delivery room because you know the women would like to maintain their privacy and they will be ashamed for their husband to be present in the room. We would like to be present there if the birth is becoming difficult or there are problems [Village 2 father 8].*

Yet, men also claimed that there was no room for them and that nurses sent them out of the labor ward.

To follow traditional birth practices at the health facility on disposal of the placenta was not mentioned as an obstacle. The placenta is traditionally buried with the opening turning upwards and conducted by a woman who has delivered a child. These practices serve to secure the continued fertility of the woman. According to FGD participants and interviews with nurses at health centers, the placenta is given to a relative in a bag after the delivery at a health facility. The health facilities had adapted well to the preferences of women and their relatives.

Birthing position in the health facility is limited to the bed and women are requested to lie down. During home deliveries some women prefer to lie down but more often to kneel down. At the hospital women are not allowed to deliver on the floor and nurses described how some women are reluctant to get high up on the delivery table.
Individual interviews with husbands who had a wife delivering at a health facility described gratitude of the survival of mother and child, and for those fathers who had experienced a loss of a newborn at the health facility the services had been experienced as chaotic without being able to understand what could have been done differently.

5.5. Newborn care and exclusive breastfeeding

Seclusion of the newly delivered mother and her newborn is upheld among the four ethnic groups. From birth to the naming ceremony of the newborn on the 8th day, the mother is resting in her bedroom or in the bedroom of her mother or mother-in-law. She will take care of her own healing while the TBA or another older woman will help her wash the newborn every day or every second day until the naming ceremony. She will keep the newborn within the room of seclusion.

The naming ceremony signifies the introduction of the newborn into the family and lineage. It is a celebratory event, which involves sharing of foods and gifts depending on the economic conditions and also personal preferences of the father. It is an occasion to position the family within the social map and there is pride and status attached to throwing a big party for the newborn among the better off households. The naming ceremony also marks the end of the seclusion period for newly become mothers. Returning to the fields with the newborn is expected of women and family members in the compound will start taking care of the newborn after the naming ceremony. One mother-in-law exemplifies:

*After the naming ceremony people in the household will all help in taking care of the baby and the baby is passed round from one person to another so that she [mother] can get on with her chores [Village 1 In-laws].*

Mothers-in-law described how many of them are active in caregiving of the young children. During the FGDs themselves we also had grandmothers bringing the children to be breastfed to the FGD and thereafter bringing the baby back. A young girl can accompany the mother to the field to keep an eye on the baby while the mother is working. Only in one village without lowland fields was it reported that women occasionally are offered to stay at home and take care of household cooking and chores and not go to the upland fields during the few months of upland cultivation. In one village, a shed, financed through NaNA, was used for newborn care and as breastfeeding station for working mothers.
Through comparison of interview data with the most vulnerable women and FGD statements, it is clear that newborns’ caring conditions vary greatly with the social and economic conditions of the mother. Without family support, newborns to poor mothers will join their mother’s income generating activities as soon as the mother is able to.

5.5.1. Exclusive breastfeeding for 6 months was not the norm in any of the four villages. The first constraint in following the advice of nurses to breastfeed exclusively was the perceived need and benefit of drinking water throughout life. Timing of initiation of breastfeeding was influenced by the attendant during delivery.

After a facility based delivery, women and nurses alike reported that women were asked to wash their breast and start breastfeeding in the labor ward:

*Just after the birth of the baby the nurse who helped you to deliver will bring water and assist you to wash your breast then get the baby to start breast feeding [Village 1 mother 5]*

TBAs were well aware of the importance of EBF but communicated this in different ways. Some TBAs were helping women to “wash their breast and give the breast to the newborn shortly after delivery:

*I gave birth at home assisted by TBA1. As soon as the baby was born and the umbilical cord was cut she asked me to wash my breasts and feed the baby [Village 3 mother 6]*

Other TBAs simply instructed the woman “to not give water”.

The first challenge of practicing EBF is adding water to the diet of the baby. The second challenge to EBF was initiation of complementary feeding when the baby was eight months or older. The study mainly captured perceptions related to water during infancy.

While breast milk is considered essential for a newborn’s health and survival, water is also very important. Two rationales of giving water from birth or at least from around 2 months were presented:

(i) the newborn is thirsty and only water will solve thirst;
(ii) water is a vital composition in the person from birth and throughout life.

One mother-in-law describes:

*Because it is very hot and we feel the child gets thirsty with a dry throat. So we give them water to drink. Also if they do not drink water as a child then when they grow up they will lack water in their body [Village 4, Mother-in-law 2]*

A mother describes a similar view in that the body contains a place for food and one for water:

*I have not done this [EBF] but my children do not easily have small illnesses. My baby is in his 6th month and he is drinking water and breast milk only. I have not started him on other foods yet. Because it is so hot and the baby will be thirsty so I give him water to drink. When it is hot like this people’s throat becomes dry. The breast milk will go to fill up the place for the food in the body. But the place of the water in the body the breast milk can only cover some of it but not all and that is why I give him water so that the place for the water in the body is also fully covered. That is why I give my child water [Village 2 mother 1]*
Water is perceived to have qualities that address the well-being of the newborn (reduce thirst) and secondly it also constitutes a “balance” in the body over time. This balance is established in infancy. The view of water as a fundamental aspect of life and wellness was mainly elaborated in two of the four villages (Wolof and Fula). It would be relevant to study further the relevance of this concept among other ethnic groups.

Water is generally given to an infant when she/he is crying while being taken care of by others than the mother. Mothers-in-law stated in FGDs that they in fact often were the group of caregivers who would give the baby water. One mother gives an example of her youngest child:

*I breastfed him all the time, when he cries or when he is hungry...I do not always have time to feed him. After delivery I stayed at home for at least 4 months just to take care of my baby. From when he was 5-6 months that is when I resumed work in the field. I will just work on the farms for a maximum of 1.5hrs then return home to breastfeed him. Before I leave for the farm, I will express my breast milk into a clean container and leave with the babysitter to feed him with a spoon. I don’t leave him in the care of older children for fear of them not taking care with his feeding so I left him under the care of older girls to look after [Interview in village 2, EBF 6 of 8 children]*

Yet they were well aware of the recommendations of nurses during ANC of not giving water. The traditional practice of wet nursing was used when currently older Mothers-in-law were having their children. But breastfeeding each other’s child was stated not to be practiced anymore.

Interviews with mothers, who had recently exclusively breastfed their youngest child, were all very satisfied with the effects it had on child growth and health. Infants are expected to grow better and rarely fall ill. One mother compares her experiences of feeding her last two children:

*I was exclusively breastfeeding my first child and when she was three months my husband said my breast milk is not enough. So he bought all kinds of food items like potato power for me to prepare for the child which I did. But with my second child I refused to give the food and insisted on exclusive breastfeeding her for the complete 6 months before introducing water. Now look at the two of them (pointing at two little girls in the room): The younger one is far stronger and healthier than her sister. Up to tomorrow the younger one does not get sick but the older one is always sick and unwell. For the younger one I cannot say I have once taken her to hospital for being sick or unwell.*

Another woman describes that the amount of food other than breast milk is not equal to good growth in infants:

*The exclusively breastfed children don’t get sick and will not catch the diseases that come round. They are very healthy whereas the ones who had water are very sickly and easily catch diseases and diarrhea is a problem for them. It causes the mother problems because they will take them to hospital often. My husband himself says that the amount of food the first child got the second child did not get that yet the second child is far healthier than the first one.*

Women able to exclusively breastfeed report very positive experiences in terms of health of the child. Characteristics of women who were able to EBF had been encouraged by nurses and TBAs but also a fellow woman who had tried EBF; her husband had accepted to try this practice and her mother-in-law had also given her the space to decide. One mother explains why few practice EBF:

*Because may be they don’t understand or may not be aware of the importance of no water for the baby for 6 months they will continue to give water. The few women who practice this maybe*
they have the support of their husbands and families that is why they are able to do it [Village 4 mother 2]

In the communities at large there is still an expectation that infants drink water. One father gave an example:

Yes we have some women who breastfeed their baby and not give them water or anything else for up to 6 months. One of my neighbors she has a child less than 6 months and when she comes to our home and we offer to give the baby water she will say “no my baby has not started to drink water yet so don’t give” [Village 4 father 7].

Another father explains the limited practice of EBF to women’s work load:

Father 2: you know the main constraint is because of the lack of knowledge about it and the type of work women do that is the farming. It would be easy for women to exclusively breastfeed their children if they were staying home all the time and not having to go away to the field. We told you earlier that our women some of then a few days after the naming ceremony they resume their farm work and before the woman can concentrate on her work on the farm, she will breastfeed the baby and give them water until the baby is full then she will be able to work. For the baby not to eat anything and not drink water at all for 6 months we don’t know that here and we feel the woman will not be able to just breastfeed the baby and not give water [Village 3 father 2].

In the two villages where the TBAs were very communicative on EBF and where VSGs were active, it was easier for the field team to identify and select women who in fact had EBF for 6 months. In two villages, the TBA and VHW were only able to identify a few women who had followed the recommendations.

Box 10. Constraints in exclusive breastfeeding (response from interviews)

<table>
<thead>
<tr>
<th>Moderator: in your opinion what are the difficulties or constraints that make it hard for other women to breastfeed exclusively?</th>
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<tbody>
<tr>
<td>One constraint is women who have to work on the farms some will leave their children at home from 9am to 2/3pm which is a big problem in maintaining exclusive breastfeeding.</td>
</tr>
<tr>
<td>I think only the lack of enough breast milk in the only constraint.</td>
</tr>
<tr>
<td>I think it has more to do with the women not being fully aware of the need and benefits of exclusive breastfeeding. Also women don’t take the advice seriously because if they did then they would all practice exclusive breastfeeding.</td>
</tr>
<tr>
<td>I go to visit my family in my birth village and when my baby cries my mother will say “give him water to drink” and I will say “oh no and please don’t give water to my child I do not give water until he is 6 months old”. My family will ask why and I will explain that both my husband and co-wife advise me not to give water. They will say “please give him water because he is thirsty”. My mother will ask “did you yourself not drink water?” and I will say “yes I did but those days and now are different”. This is why it is difficult for many women to practice exclusive breastfeeding. Even here in our village the TBAs go round advising the women but still not all women do it. I tell my peers that I have seen the benefits - that is why when I did it with my 6th child I realized it was very good for my child. I did it with my following two children. Because when you try something new if it is not good you will not repeat it. You will only repeat it if you see good in it. Before I stop childbearing I will always practice exclusive breastfeeding for all my future children.</td>
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5.6. Maternal mortality risk perceptions

If a pregnant woman follows the advice of the nurses and TBA and she attends antenatal care and takes her medicines regularly as advised then these women rarely have problems during labor or childbirth [Village 2 father 3]

The trend on maternal and child mortality in the four villages was decreasing according to the VDC members and FGD participants. Yet, in all but one village a maternal death had occurred during the last two years. At least one newborn was reported dead during the last 12 months in all four villages. The risk of maternal mortality was visible even during the field team’s relatively short period in the field. A woman passed away in child birth in the neighboring village during our visits in one village.

Box 11. Interruption during FGD with fathers

A woman passes by and greets the group.

Father 1: Where are you up to – to the [neighboring] village?
Woman: I am going to [the nearby village] the wife of [inaudible name] passed away; you know the pregnant one.
Father 1: Oh my god! What happened?
Woman: I don’t know we just heard it now.

An emergency vehicle had been donated to one of the villages. The VDC had set the rules for its use and was responsible for its management. VDC members described that the vehicle was only allowed to be used for health emergencies. It was mentioned several times by men and women as a great relief in particular when women needed referral to a hospital during labor. Payment of gasoline had to be provided by the user, which still was a constraint for poor households. The driver was a young father who had volunteered the task. Neighboring villages were also using the vehicle under the same conditions. In the other three villages, VDCs expressed great concern on the delays in finding a vehicle for emergency transportation.

Box 13. Questions on gender relations in the rural villages

Women were asked in FGDs about the gender related questions and concerns that were relevant to them. Questions and comments are listed below. Women were also asked who they discussed these questions with and the answer was that they only debated these issues among women. They were not discussed with their husbands, at community village or with VDC members.

You can be in the household and feeding is a problem but you know your husband has money but he will not buy food so my question will be why are some men taking their money and spending outside and not contributing to the welfare of the family even though they have the means and the money to do so?
You will find that men do not help with household chores and women have to take care of the children’s welfare and the chores

Some husbands or co-wives go fooling around with other people until they become sick so I will like to ask why and where do husbands go to pick up infections (referring to STIs) that they will pass on to us and what kind of infections do they have?

The most important of them all and the one that is of difficulty for us is the transportation to attend clinic and go to hospital during labor and the men will also find this as the most important

You know when women are in labor and they have to go to hospital to deliver it is the husband who will arrange the transport so we would like that in such situation that the men will arrange the transportation quickly so that we do not have to wait for long or delay going/getting to the hospital
What help will the villagers give to women when they are pregnant until they deliver safely?

46
Chapter 6 Discussion and implications

6.1. Resource perceptions and land use changes
The pressure on access to fertile low-and upland is increasing the vulnerability of farmers. This scarcity has resulted in some changes in resource use patterns: The need of fertilizer has increased which only the better-off households can afford. Consumption patterns change towards eating more upland produce such as coos and millet but less rice. The longer cooking preparation of coos has in turn resulted in longer work hours for women. Increasing inequality between households is another result of limited fertile land. In areas with tidal irrigated lowland, men had started to cultivate rice in the dry season. Dry season cultivation is the main source of securing women’s access to independent earnings. There were reportedly no gender-based conflicts over use of lowland in the dry season in the study villages yet, but the risks of future tensions exist. Both the Women’s Bureau and NACOFAG expressed concern on the risks of women being pushed out from dry season lowland rice cultivation by men who previously only were generating income from rainy season upland farming. Women’s risk of losing access to land increases with the need to invest in farming technology at the same time as income from rainy season upland farming decreases. This risk could result in women losing access to independent income.

There is a renewed interest of men for dry season cultivation of vegetables and fruits which are mainly for marketing. The cultivation of, for example, watermelon on a larger scale has created new possibilities for men to make arrangements with middlemen to buy the produce in the village. Women market their produce themselves and reported many transportation constraints. Increased pressure on garden land, lack of investments in maintaining garden fences and improved income opportunities for marketing of specific vegetables imply a risk of privatization of gardens. This is a risk to women’s continued access to and control of land for gardening.

6.2. Women’s socio-economic mobility constraints
Women’s lack of control of farm land is an economic mobility constraint. Rehabilitation of farm land, which is one of the objectives of the Commercial Agriculture and Value Chain Management Project, does in itself not improve this situation. In all four villages, women had access and control over income from separate rice plots or upland fields in addition to vegetable gardens. Women managed and controlled these assets independently. Women do not own land but women have access to land. The tensions reported relate to women’s lack of control of access to land. Women help men with their farm work first in order to secure that men will help women in their fields afterwards. When households face food crisis there is pressure on women to help their husbands on their responsibility to provide food for the family. Women will use the earnings that were intended for children’s and own needs. Women’s lack of control of land is a reflection of women’s lack of opportunity to own farm land. Neither project proposes activities to address women’s empowerment in this respect.

Households described a principle of independent management of assets between husband and wife. Women do not have insights into the earnings or spending of their husband. Likewise, however, men are not automatically having insight into their wives earnings. Women during pregnancy and child delivery were sometimes forced to leave their individual plots uncultivated and thus reducing their access to and control of income.
The households that will be targeted by the Nutrition and Health Results Project (MCNHRP) have no prior experience of social protection systems such as formal retirement schemes, maternal leave payment, health insurance or other formal systems. Therefore it is not possible to conclude whether the cash transfers to women will follow the same system of income allocation as the current income from farming. The social protection activities of the MCNHRP in providing conditional cash transfers to women could be interpreted as a timely compensation for the loss of women’s income during pregnancy. This could reduce the risk of gender-based conflicts arising due to transfers to women only. Results from other conditional cash transfer programs indicate that features in program design can significantly influence program outcome [27]. The expected outcome of the conditional cash program should be communicated clearly and transparency in the allocation process to women would be an important feature. It is also important to specifically be transparent about how the transfer amounts were calculated, why they are transferred to women, what they are intended for and what the expected results are.

Another mobility constraint of women was the lack of support into producing new crops, storage opportunities and marketing strategies. Extreme seasonal fluctuations in prices on locally grown vegetables were reducing income from vegetable gardens. One woman cutting the popular green leaves (“nana”), which were abundant during the field visit, was saying that she could only dream of the high prices she could get if she was able to cultivate the leaves in the rainy season. Only one of the four villages had contact with an agricultural extension worker. There was no support offered directly to women in this village. Farmers’ organizations were not active in the villages. Women had no access to vegetable garden training or other inputs to increase productivity during the dry season gardening.

6.3. Women’s mobility constraints in seeking maternal and child health services

There are strong socio-economic dimensions to women’s access and control of income. The most vulnerable women interviewed in this study were young divorced, widowed or never married mothers with several young children without a husband to support the family income. These women lived in marital or parental home and were supported by brothers or in-laws but were struggling to find time and opportunity to generate income. They had no or extremely limited access to income and much less individual income. Money to cover personal needs of for example soap or indirect and direct costs of healthcare services were very difficult for these women to mobilize. The investment in ANC that women are encouraged to make in the MCNHRP in order to qualify for the conditional cash transfer could be a severe obstacle for these women. Women who currently face economic, social and judicial obstacles for supporting themselves and their children have large needs however. The MCNHRP could inadvertently discriminate women who are coping with structural constraints of low utilization of health services.

Women’s dependency on husbands in deciding to seek care outside the village is one source of conflict during pregnancy and child birth complications. When men delay in arranging for transport to the health facility women are not able to arrange for the transport themselves.
6.4. Healthcare system gaps in meeting women’s reproductive needs
The labor ward at a health facility is associated with obstetric complications and emergency. Current communications during ANC consultation that women with a risk profile should seek hospital care as soon as labor starts, reinforces this understanding. The risks, in addition to the costs of reaching the health facility and the uncertainty of the attitudes from healthcare workers, affect negatively women’s integrity of seeking obstetric emergency care. The health system has not been able to adjust itself to good quality care during normal deliveries. This may contribute to men’s reluctance to transport women in labor to a health facility. Strengthening the primary health and nutrition care including a functional referral system through the MCNHRP can directly improve women’s access to quality care and in turn health outcomes.

Men and women’s trust in TBAs extended beyond her role as a health practitioner, which also have been found in another study [28]. TBAs also confronted husbands if they did not comply with her recommendations related to women’s health and to some extent negotiating gender relations. TBAs contributed to decreasing all three delays of seeking, reaching and receiving obstetric emergency care. In villages where the TBA is trusted, she is an important link between the communities and the health facilities. The trust in TBAs is of continued importance for the healthcare system in strengthening the referral system and communications with the communities.

6.4.1. Antenatal care as pregnancy risk
Pregnancy and childbirth has social and cultural meanings and they are key events that ascribe power and respect to women. The hidden pregnancy or hidden initiation of labor, represent women’s opportunity and rights to protect these reproductive processes. Women’s experience of risk of miscarriage in the first trimester is sometimes believed to be caused by witchcraft or other spiritual causes. The healthcare system does not appear to effectively communicate how medical preventive services on sexually transmitted disease, anemia and malaria in women can reduce the risk of miscarriage. The benefit of ANC was perceived to be of greater importance during the last period of the pregnancy. The medical benefits from attending ANC early can contribute to men and women’s understanding of the importance of ANC.

Reluctance in disclosing pregnancy in the first trimester was also linked to behaviors that the community does not approve off: pregnancy before or outside of marriage and shorter than 18 months inter pregnancy spacing. The norms on women’s sexuality and reproductive health are strong and the healthcare system is not well adjusted to women’s need of privacy in accessing reproductive health services. One of the few exceptions is the provision of family planning methods to women by the CHN. Women in rural villages have severe constraints in accessing reproductive healthcare services anonymously.

6.5. Willingness to change relative status of men and women
Men expressed willingness to support women during pregnancy and child birth through encouraging women to attend ANC and to follow recommendations from nurses, purchase additional foods and relief the pregnant woman from some of her farming tasks when her pregnancy was coming to an end. Division of labor is strictly gender-based. Men’s willingness to participate in domestic chores and child rearing was currently very limited. Even though men occasionally were reported to help pregnant women with heavy household chores, the domestic work was considered the woman’s responsibility. Mothers-in-law report a positive trend with increasing involvement of husbands in
relation to the health of women and children. But women themselves made it clear that the support they get from husbands is too limited.

Men’s involvement is restricted to complications during pregnancy and child delivery. Engaging men during normal pregnancy was not encountered in the study. Active male involvement in all stages of pregnancy and delivery has been suggested as an effective strategy to improve maternal survival [29]. Engaging men in the health needs of women was encouraged by the male VHWs and CHNs encountered in the study. The healthcare system is not well adjusted to involve men during ANC or child delivery at a facility. The lack of social, cultural and even physical space for men in the current healthcare system was pointed out by men. Changing gender relations within the healthcare system and within the communities should be considered a long term process.

6.6. Limitations of the study
The case study design provided in-depth information about a limited number of locations - selected purposely to assure representation of various ethnic groups and livelihood systems. The study is thus not designed to represent a national sample but the detailed cases (Annex 3, Box 2, 3, 4 and 5) provide an opportunity to compare and transfer the findings to villages in similar conditions when it comes to access to health services, land and markets. The purposive selection of study participants, assured that various lineages in a village were represented and that participants were familiar with the research topics. Conducting FGDs with men, women and mothers-in-law provided the team with an opportunity for data comparison. Views expressed in the FGDs by women were probed in subsequent FGDs with men and mothers-in-law and thus gave the team an opportunity to constantly compare the findings in each village. The overall findings were furthermore probed in the final group interview with VSGs, TBAs and VHWs, which gave the team an opportunity to validate the general findings. The study team consisted of specialists in reproductive health and medical anthropology and team members discussed the findings from different lenses in the field.
Chapter 7 Conclusions

Gender relations are closely tied to the social organization and decision-making processes related to reproductive health and household welfare.

There is a need to understand and acknowledge the connections between women’s asset management opportunity, mobility and reluctance to seek early ANC and plan childbirth at a health facility.

The healthcare system should provide acceptable care and support to a functional referral system closer and cheaper to the rural villages, as means of supporting the village’s ability to seek timely care during pregnancy, childbirth and newborn ill-health.

Lack of privacy in attending ANC is a major constraint for women fearing miscarriage but also for women who are stigmatized due to pregnancy before or outside of marriage.

To engage men in maternal and newborn health will require culturally sensitive ways that directly targets husbands over time.
Annex 1 Bottleneck study conducted by the UNICEF/MOH

Identified five interrelated factors that explain the slow progress towards health and nutrition-related MDGs:

Lack of comprehensive human resource strategy

1) Inadequate equipment, supplies and commodities
2) Inadequate community mobilization for maternal and child health and nutrition
3) Uneven access to and utilization of nutrition and health services by socio-economic status and by geographic region
4) Biased intra-sectoral allocation of the health budget where 54% remains at tertiary level

Health system strengthening strategies identified included:

1) Re-vitalize PHC
2) Initiate Child Health Weeks
3) Improve communication for behavior change
4) Improve supply chain management
5) Address equity
Annex 2 People met during missions in March and May 2014

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Annex 3 Description of the four case villages

Box 2 Village 1 – a rural Fula community

**Access:** The village has no road access; during the rainy season cars or donkey carts cannot pass the ordinary path due to flooding. Distance to nearest health center is 7 km in dry season. In the rainy season a more than double as far “back-way” can be passed by car. It is very difficult to convince a taxi driver to reach the village during the rains.

**Demographic data:** The number of inhabitants is estimated at 530. There are 9 lineages (“Kundas”) in the village that are living in 49 extended family compounds. The village has no written data available on the number of inhabitants or extended family compounds and it is a young male teacher that helps the team in writing names of the Kundas based on guidance from the Alkali, VDC members and women coming by. The VDC and TBA are not able to write.

**Access to services:** There are no active development projects in the village. There is no agriculture extension worker serving the village. There are groundnut and millet farmer associations in the area but they have received no support. Village is not connected to an electric network. No compound has solar panel or generator. Elementary school 1-6 grade in village. No teacher quarters. Koranic Madrassa school is offered but has no specific building/hut – a compound is used for teachings. Weekly market is located 7 km away.

The outreach clinic is held in neighboring village about 3 km away. There are a few traditional healers providing services in the village; there are no shops selling painkillers or vitamins.

**Livelihood system:** Lowland two season rice (rain-fed and tidal irrigated) + upland cultivation of millet, coos, maize, groundnuts, cassava, sorghum and “narika - rice” + vegetable garden (rain-fed and from a well in the dry season). Not all family compounds have access to lowland rice fields. All households have upland cultivation. Livestock is a complementary income source: goat, sheep, cow, chicken

**Division of labor in agriculture:** Rice is grown by both men and women. Women grow rice in two seasons. In the rainy season women farm the rice alone. Men farm upland rice in the dry season and some men also work on separate plots of lowland rice during the dry season. Both men and women grow groundnuts and maize. Millet and coos is grown by men only. Vegetable garden is cultivated in both rainy and dry season by women mainly.

**Sold produce:** groundnuts, vegetables and small livestock.

**Agricultural and economic shocks during last 12 months:** Flooding of tidal irrigated lowland rice. Affected about 70 percent of the fields. Price increase of fertilizer. Price decrease of groundnuts. (Pressure on upland farming which now requires the use of fertilizer every year instead of previously every 4th year).

**Characteristics of the poorest households according to VDC members:**
- Hunger
- Begging for food on a day to day basis
- Builds own house; not all family members have a bed
- Have no donkey cart or farming tools

Box 3. Village 2 – a rural Mandinka community

**Access:** The village has road access both in the dry and rainy season. Distance to nearest health center is 9 km.

**Demographic data:** The number of inhabitants is estimated at around 2000. There are 113 extended family compounds. The VHW keeps records of newborns in a register, which is reported to the CHN on a quarterly basis.

**Access to social services:** The village has received support from several agricultural projects and programs over the years. Currently support is received to improve tidal irrigation in the lowland fields through the FAO-EU financed “MDG c1” project. An agriculture extension worker lives in the village. Village is connected to an electric network (“cash power”). In 2013 1/3 of the households were connected. There is a Koranic Madrassa school for grades 1-6. Grades 7-9 are offered in neighboring village. Weekly market is located 9 km away.
Health center nurses hold outreach clinic in the village. There are a few shops in the village selling painkillers and multivitamins. There are about three traditional healers providing services. The village has been given a car by a philanthropist and it is used as a community ambulance.

Livelihood system: Lowland two season rice (rain-fed and tidal irrigated) + upland cultivation of millet, coos, maize, groundnuts, cassava, sorghum and “narika-rice” + vegetable garden (rain-fed and well used for dry season). Only the original family compounds initially had access to lowland plots leading to massive poverty among new compounds. About ten years ago, the lowland plots were redistributed (through Taiwanese run project) securing a smaller plot of lowland rice to all existing compounds (0.4-0.5 hectare). These rice plots can be worked with machines. Some families have in addition lowland rain-fed rice plots that are cultivated by hand by women. All households have upland cultivation. Livestock is a complementary income source: goat, sheep, cow, chicken

Division of labor in agriculture: Rice is grown by both men and women. Women grow rice in two seasons. In the rainy season women farm the rice alone. Men farm upland rice in the dry season and some men also work on separate plots of lowland rice during the dry season. Both men and women grow groundnuts and maize. Millet and coos is cultivated by men only. Vegetable garden is cultivated in both rainy and dry season by women mainly. Some men have recently started to produce watermelons as income generation.

Sold produce: groundnuts, upland rice, maize, watermelon, beans, pumpkins and sweet potatoes, now only “nana”-green leaves from the vegetable garden and small livestock.

Agricultural and economic shocks during last 12 months: Flooding of lowland rice fields due to high tide and heavy rains. The majority of lowland tidal-irrigated rice was destroyed. Salt intrusion of the rice fields. Households have not been able to sell any upland rice during 2013-14 as a result. Prize increase of fertilizers during one year from 750 to 1100 dalasi per bag. Price increase of food (sugar, oil, onion, rice).

Characteristics of the poorest households according to VDC members:
- Cannot buy fresh fish or meat as other households in the village
- Wanting to cook but cannot
- Begging for food on a daily basis

Box 4. Village 3 – a rural Serahuli community

Access: The village has road access both in the dry and rainy season. Distance to nearest health center is 16 km.

Demographic data: The number of inhabitants is estimated at 2800. There are 58 extended family compounds. The Ministry of Health requested the VDC to count the population last year. VHW keeps records of newborns in a register, which is reported to the CHN on a quarterly basis. Serahuli is the main ethnic group living in the village followed by Fulas and Mandinkas.

Access to social services: The village has received support from some rural development project to build health post and gravel road. Village is connected to an electric network (“cash power”) and some compounds have solar panels. There is a Koranic Madrassa school for grades 1-6. Grades 7-9 are offered in neighboring village. Weekly market is located 16 km away.

Health center nurses hold outreach clinic in the village. There are a few shops in the village selling painkillers and multivitamins. There are traditional healers providing services in the village. There are several compounds that have a private car and/or motorbikes.

Livelihood system: Upland cultivation during the rainy season. The main crops are groundnuts, millet, coos, maize, “findi” (cereal), cassava. In addition, some households grow vegetables – watermelons, okra and beans during the rainy season. Women cultivate sweet potato, bitter tomatoes, pumpkin, spinach, okra, tomatoes and onions on land within the extended compounds. There is no communal vegetable garden. Livestock is kept by many but not all compounds: cattle, goat, sheep, donkey, horse and chickens. Boys herd the cattle while women are responsible for milking the cows all year round.

Division of labor in agriculture: Groundnuts are cultivated by both men and women but on separate farm land. Men prepare the land and plant groundnuts on plots designated for both men and for women. Thereafter women are responsible for weeding their own plots. Harvesting of groundnuts is conducted complementary by men and women. Millet, coos and cassava is exclusively cultivated by men. Vegetables are cultivated in the rainy and to a limited extent in the dry season by both men and women.
Sold produce: groundnuts, watermelons, cassava and pumpkins in addition to livestock.

Agricultural and economic shocks during last 12 months: Drought affected the upland farming. As a result the groundnuts were harvested when they were still light. During marketing of the groundnuts the prize was almost reduced to half between 2013 and 2014. Residential tax was heavily increased in the region in 2014 (the tax is based on number of houses within the compound. Example: increase between 2013 and 2014 from 125 to 735 dalasi for one compound). Due to land pressure, fertilizer is now needed every year on land cultivating groundnuts. Households have not been able to sell any upland rice during 2013-14 as a result. Prize increase of fertilizers during one year from 750 to 1100 dalasi per bag. Price increase of food (sugar, oil, onion, rice).

Characteristics of the poorest households according to VDC members:
- Have no farming equipment and have poor harvest
- Compound is not proper and clean
- Problems with feeding the family, begging food
- Do not have land
- Has only young children who cannot help in farming

Box 5. Village 4 – a rural Wolof community

Access: The village has road access both in the dry and rainy season. Distance to nearest health center is 3 km.

Demographic data: The number of inhabitants is estimated at 3000. There are 85 extended family compounds. There are no records kept on newborn. The VSG stopped filling out the register more than a year ago. The VHW and TBA verbally inform the CHN on newborn every three months. Wolof is the main ethic group in addition to Fula, Serer and Bambara.

Access to social services: The village has received support from some rural development project to build health post and gravel road many years ago. Village is connected to an electric network (“cash power”). There is a primary school and Koranic Madrassa school. Grades 7-9 are offered in neighboring village. Weekly market is located 16 km away.

Health center nurses hold outreach clinic in the village. There are two shops in the village selling painkillers and multivitamins. There are seven traditional healers including Marabous providing services in the village. There are several compounds that have a private car and/or motorbikes.

Livelihood system: Upland cultivation during the rainy season. The main crops are groundnuts, millet, coos, maize, rice and sesame. There is a communal garden that was initially used by women. Two wells provide water. The garden is now used by both men and women. Increasingly numbers of garden plots are currently cultivated by men. The garden has fence problems and some individual plots within the garden have established their own private fences. Adjacent to the initial communal garden are several private gardens cultivated by men. The vegetables grown are onions, eggplant, okra, bitter tomatoes, green leaves and lettuce. Livestock is kept by many but not all compounds: cattle, goat, sheep, donkey, horse and chickens. In this community it is the men who milk the cows while women are responsible for getting them water. Women do not own horses and donkeys but can be owners of the other livestock mentioned.

Division of labor in agriculture: Men are preparing and planting all the upland farm land. The land of a compound is divided into plots of women, men and younger son. Each person is responsible for the designated plot during the period of weeding and harvesting but husband and wife normally work together. Only men are involved in the cultivation of sesame. During the harvest, the household keeps track of the harvest coming from each plot and each person is controlling the harvest from his/her plot.

Sold produce: groundnuts, sesame and a part of the vegetables.

Agricultural and economic shocks during last 12 months: Drought affected the upland farming especially the groundnuts, millet and the coos. The quality of the groundnuts was therefore very poor and the prices fell dramatically. The village was hit by a severe storm during the rainy period which caused damage to several houses and roofs. Due to land pressure, fertilizer is now needed every year on land cultivating groundnuts.

Characteristics of the poorest households according to VDC members:
- Begging food before they can eat
- Has no farming equipment and works as day laborers for others. As a result they farm own plot late and has poor harvest.
- Is not able to buy anything for the family
References