Malnutrition and gender relations in Western Kenya

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Abstract
Child malnutrition, which is an increasing problem in Western Kenya, is addressed primarily through efforts to reach the individual mother with information about proper feeding of her children. A study carried out in Siaya, Kisumu and Busia Districts showed that mothers perceived nutrition problems differently, emphasizing their embeddedness in gender and family relations. In situations of marital conflict, male labour migration, and impoverishment, women must rely on support from others; thus health education should be addressed to husbands, grandmothers and mothers-in-law as well as mothers.

Although Kenya has made substantial achievements in providing for the well-being of its citizens, malnutrition in young children remains a matter for concern. National nutrition surveys carried out in 1977, 1979 and 1982 indicate that the situation is particularly severe and is worsening, in Coast, Nyanza and Western Provinces (Rep. of Kenya 1983). Malnutrition has been recognized as a national problem (Rep. of Kenya 1981), whose root causes and treatment must be addressed through planning and interministerial co-ordination. It is a District problem in that District Development Plans often mention it. The Ministry of Health defines it as a ‘family problem’ in that the nutrition unit is placed within the Division of Family Health. Yet in practice, childhood malnutrition is a women’s problem, and is treated as such by health authorities, who address their nutrition intervention efforts to mothers.

This means that women’s situations and changes in gender relations are particularly important for an adequate understanding of childhood malnutrition. In this paper we explore some of the gender issues relevant to the problem of child malnutrition. We are not so much interested in isolating causes of malnutrition, as in examining the social situations in which it exists and must be addressed. We emphasize women’s own versions of nutrition problems, which contrast in some important ways with the views of health planners and personnel. While nutrition-intervention programs tend to treat women as individual actors, women see themselves as enmeshed in social relationships which affect their ability to care for their children.

In 1987 and 1988, a study (Whyte 1988) was carried out in Western Kenya to examine the impact of the Family Life Training Programme (FLTP), a nutrition-intervention program which has existed

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under the Ministry of Culture and Social Services since 1974. Under this program, mothers with malnourished children are admitted to residential centres for a three-week period of training and intensive feeding of the children. One part of the study consisted of structured data on two categories of women. A community survey was made in six sub-locations, which involved interviews with 300 mothers and weighing of 460 children under five years. Another sample was composed of 151 women (referred to as trainees) and their malnourished children who had been admitted to the Family Life Training Centres (FLTCs) at Ahero, Lwak and Butula. They were interviewed in their homes and the children weighed three to four months after discharge.

The other part of the study was qualitative. Data collection entailed many open discussions and less structured interviews with mothers and other family and community members. Three university students engaged in participant observation at the centres for three months. Attempts were made to fit the information gathered on malnutrition into a broader framework of culture and society in Western Kenya: this was facilitated by the fact that one of the authors had earlier carried out a year of ethnographic fieldwork in this part of Kenya. Here we present themes from the qualitative part of the study. The cases we have selected illuminate conceptions and relational patterns that have general relevance for understanding the situations of Western Kenyan mothers. Although we mention some figures from our survey results, we have not chosen our cases as representative in a statistical sense. They are exemplary in a way we hope will be useful for discussion and for policy and planning.

The communities studied were located in Siaya and Kisumu Districts, where the populations are mainly Luo-speaking, and in Busia District, where Luyia speakers predominate. These areas are strongly patrilineal, with Luo people in particular known for their well-developed lineage ideology and male dominance (Parkin 1978).

**Malnutrition - a problem of feeding or family life?**

We found that 38 per cent of the 460 children under five in our community sample were malnourished in that they weighed 80 per cent or less of the standard weight for their age. The situation was worst in Busia District where 42 per cent of the children fell into this category. The figure for Kisumu District was 33 per cent. In Siaya 40 per cent of the sample was malnourished; a baseline survey had been carried out using the same methodology in the same area of Siaya (Uyoma) in 1983, when 34 per cent of a similar sample fell into the malnourished category (Kaseje et al. 1986).

Malnutrition in Kenya is recognized by health workers as taking two forms. *Marasmus* is characterized by extreme thinness; the child’s weight is very low in relation to its age. *Kwashiorkor* is characterized by swelling of the limbs, face and abdomen, and changes in hair and skin colour and texture. The child’s weight may not be quite so low because of retention of fluid in the tissues. In the view of health workers, the primary cause of malnutrition is poor feeding, especially at the time of weaning and up to the age of five years; efforts are made to teach mothers the principles of a balanced diet and the importance of suitable weaning foods given frequently during the day. It is recognized that the roots of malnutrition are complex. Sickness, especially measles, diarrhoea and chronic malaria, may precipitate malnutrition; and health workers realize that there may be factors in the social and economic situation of the household which inhibit good feeding. Still, the overwhelming emphasis in nutrition programs is on feeding practices. Proper feeding of children is both the best prevention and the best cure for malnutrition.

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1. The program consists of fourteen residential centres to which mothers and their malnourished children are admitted for a period of three weeks. The mothers are trained in principles of good nutrition and family health and they are helped to feed their children intensively, using local foods. The program is currently being supported by the Danish International Development Agency, which also financed this study.
These views contrast with those of the mothers in the communities we studied. Although there were points of overlap, there was a very marked difference in emphasis in the way local people perceived the health problems of young children. When we described the symptoms of marasmus and kwashiorkor, most mothers said that they recognized them. Well over half the mothers knew of children with these conditions and about 20 per cent said that their own children had suffered from at least one of them. The most common causes to which kwashiorkor was attributed were poor feeding (lack of quantity and variety in food) and sickness with concomitant loss of appetite.² Mothers whose own children were malnourished tended to point to sickness as a cause; poor feeding was usually seen as the cause of kwashiorkor in other women’s children. For marasmus, sickness and poor feeding were also mentioned by some. But in the Luo-speaking areas, the most common explanation was that rules about family relationships had been broken. Extreme thinness was often called by the term chira, which suggests a dangerous state of pollution; almost all of the causes of chira have to do with the transgression of principles governing sexuality or seniority. It can come about because of adultery, contact with an uninherited widow, or disregard of seniority rules, such as those requiring that a senior wife should sow and harvest before a junior one, or that an elder brother should build a house before a younger one (Parkin 1973, 1978; Ocholla-Ayayo 1976; Abe 1981; Thorup 1988; Whyte 1990). Chira, or ishira as it is called in Luyia languages, can also arise because of carelessness in observing the proper separation of sexuality between generations. Thus many families say that a grandmother who is still sleeping with her husband should not hold her grandchild.

The idea of appropriate separation also underlies the notion of ledho or heru, another concept used to explain thinness and failure to thrive in very small children. If a breastfeeding mother becomes pregnant, it is thought that the nursing child is in a dangerous relationship to the child in its mother’s womb. It is weaned immediately ‘for its own good’; in explaining this people did not speak of the quality of the breastmilk (cf. van de Walle and van de Walle 1991) so much as the inappropriate contact between siblings. That it is a matter of separation and not ‘bad milk’ seems to be confirmed by the fact that some mothers even avoid holding the ‘displaced’ child, in order to protect it from ledho caused by contact with its unborn sibling.

Some health workers try to explain to mothers that such ideas are wrong: that pregnant mothers should continue breastfeeding and that improper feeding, not wrong relationships, causes malnutrition. Others are less concerned to criticize and concentrate on teaching good child-care practices; their approach seems to be that chira concepts do no harm as long as children are also fed well. We want to stress that mothers who talk about chira and ledho have a fundamental insight that is not always appreciated in nutrition programs; that child health is embedded in a context of family relations and gender relations. The individual mother and child should not be seen in isolation from their social relations to significant others.

The family context of malnutrition

The strains to which marriage in Western Kenya is being subjected have been reported by a number of researchers (Parkin 1978; Potash 1978; HŒkansson 1988; Whyte 1979-80; Pala 1980). Yet despite widespread concern among Luo and Luyia people themselves about the deterioration of marriage as an institution, more than 90 per cent of the mothers in our community sample reported that they were married. Marriage is confirmed by the payment (or promise) of bridewealth and ideally is permanent. Only two out of the 300 women in our community sample said that they were divorced. In fact women

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² On the basis of research in Samia Location, Olenja (1988) found that kwashiorkor was often attributed to sorcery. Swelling of parts of the body often provokes suspicion of sorcery in East Africa. But in our study, we found only a few examples of sorcery as an explanation of kwashiorkor.
do separate from their husbands, but bridewealth is rarely repaid and, in many situations, such women would be considered still married (see Potash 1978).

Two patterns are especially significant for the marital situations of Western Kenyan women. One is polygyny which means that a man’s attention and resources must be shared with another woman and her children. Of mothers in the Luo-speaking districts, 37 per cent had co-wives in comparison to 16 per cent in Luyia-speaking Busia District. The other characteristic of marriage is the absence of husbands due to labour migration. Only 53 per cent of the mothers in the community sample had their husbands at home. That is to say, roughly half of the mothers and children we visited were having to manage their daily affairs without a husband and father.

It is unclear whether or not the absence of the father in itself affects the child’s nutrition. Kennedy and Cogill (1987) found that in South Nyanza District, children in female-headed households were actually better nourished, and they suggested that this is because such mothers have more control over household income and are more likely to spend it in ways that benefit children’s health. In our study, we found that the women who were admitted with their children at the nutrition centres were more likely than others in the community to have no husband or to have a husband who was absent. But this may be because such women were more likely to be referred to a centre and they were more likely to be able to go. The material from the community sample did not indicate a significant relation between the presence of a father and the nutritional status of the children.

We suggest that figures on marital status and presence of husband tell only part of the story. The real issues have to do with the quality of co-operation between husband and wife, and the possibility of support from other family members.

In talking to mothers and their families, it became clear that a number of the children became malnourished or failed to recover, in the context of marital conflicts. Many women who said they were married were in fact co-operating very poorly with their husbands. Because of marital discord, women sometimes left home for periods of time, and the children became sickly while in the care of someone else. Sometimes, husbands devoted all of their attention and resources to another wife.

Elizabeth, married to a man of Nyakach, had been staying with her husband in Nairobi, where he worked. Their firstborn child was staying with her mother, and the new baby was still breastfeeding. When Elizabeth found out that her husband had taken a second wife, who was staying at his home in Nyakach, she was very annoyed, but remained in Nairobi with her husband. One day her mother-in-law brought the new wife to town and there was a dramatic confrontation in which her husband and five of his clansmen demanded that she return to the country immediately, allowing the new wife to stay with their husband in Nairobi. She said she could not leave until daylight, and they chased her. She laid the baby down and ran. When she returned to the house later that night, the baby, her husband and in-laws were gone. She went home to her mother in the country and although she heard that the baby had been taken by her mother-in-law, she did not go to their home to fetch it. The mother-in-law was a trader, so she often left her grandchild in the care of someone else. After two months, she bought medicine from a local shop ‘for swollen belly’ and gave the child vitamin pills and tried to give it a good diet. But she did not take it to the mission hospital; she thought that really should be Elizabeth’s responsibility. After a period of improvement, the child suddenly took a turn for the worse. The grandmother sent for Elizabeth, who was annoyed to find her mother had agreed to care for the child when it was so poorly. Nevertheless she went to the
Family Life Training Centre at Ahero with her child. From there she was sent to New Nyanza General Hospital in Kisumu, where her child died. Her husband’s people came and took the corpse for burial at their home. Elizabeth went for the funeral ceremony; according to Luo custom her husband should have come to complete the ceremony with her. But after two weeks he still had not appeared and she left for good.

This case study illustrates a number of the social factors forming the gender context of malnutrition in Western Kenya. There is the movement back and forth between the husband’s place of work and the family’s home in the country. There is the conflict between husband and wife, not infrequently over polygynous marriages. There is the question of child custody and responsibility in the event of separation or divorce, as well as the role of grandmothers and other care providers in situations where the mother is not caring for her own child.

Many mothers of malnourished children told of difficult relations with their husbands. Some men who were away working neglected their wives and children, not only economically (as we discuss in the next section), but also in terms of showing interest, concern and responsibility. They did not come home for months on end, nor send for their wives to visit them. Such a wife was left to seek support from her in-laws when her children fell ill; and they were not always willing or able to give it.

Even husbands who were at home were not always supportive. Rose of North Wanga came to the FLTC with a malnourished child and aching ribs after the most recent beating by her husband. She said he was a heavy drinker and very authoritarian. He would not allow her to use family planning, always checked through her possessions and always favoured his new wife. In this situation it was important to Rose that her own relatives visited her often, that her mother-in-law tried to help her and that she was a member of an active church women’s group.

In their book on Siaya, Cohen and Odhiambo (1989) point out the problem of unwed mothers and the way in which kwashiorkor afflicts the ‘children of children’, who are begotten in the grass. Luyia people speak likewise of the growing number of ‘children of the unmarried hut’ whose fathers refuse to recognize them. These children remain in their mothers’ homes and when the mothers marry or go away to school or work, they are often left in the care of their grandmothers. Many Luo and Luyia people think it is inappropriate or even dangerous for a woman to bring her child by another man with her when she marries (Whyte 1990:106). And if she does so, her husband may not feel obliged to support the child as he does his own biological children.

Antonina from Bukhayo was caring for two of her daughter’s children – by two different men. The daughter had lived with each for a year, but neither had paid bridewealth and now she was staying with a third man in Nakuru. When the youngest grandchild became sickly and malnourished, the grandmother took him to the hospital and later to a health centre. She said bitterly that the child’s father had refused to help her with food or money to take the children for treatment- and yet he was a teacher. ‘In the old days, girls also got pregnant without being married. Then the elders held a meeting and the girl named the father of the child and he had to marry her or pay something to her family’.

Thus one of the problems grandmothers faced was that they did not have adequate support in caring for their grandchildren. Sometimes too, infants were left with them when they were so young that they should have been breastfeeding. We met one great-grandmother at Butula FLTC who had breastfed two grandchildren. Her great-grandchild was left with her when it was only a few months old; the mother had to go back to her studies at a teacher’s training college. The old woman did not have enough milk and the child became malnourished.
There is still another situation in which the health of children is directly dependent upon support from other women. When mothers fall ill and die, their children are cared for by grandmothers, older sisters, and less frequently, stepmothers rather than by their fathers (although widowers are occasionally admitted to the FLTCs with their malnourished children). It is often the case that small children become malnourished while their mothers are ill; when the mother dies, the child who is handed into another woman’s care is already in poor condition.

Auma of North Wanga arrived at Butula FLTC one day with two grandchildren: 7-year-old Teresa carrying a shrunken and weak 6-month-old baby. Auma’s daughter had become pregnant again immediately after giving birth to her seventh child. Auma (who was trained as a ‘traditional birth attendant’) thought perhaps her daughter had been anaemic. She fell ill and was admitted to hospital where she stayed for two months. During this time she was separated from her baby, who was cared for by 7 year old Teresa. By the time the mother died the baby was very severely marasmic and dehydrated.

Sometimes cultural characteristics seem to constrain good care for such motherless children. If a grandmother is still sexually active, she may not want to hold her grandchild for fear of exposing it to chira. In the case above, Auma never touched the sickly child, although she clearly cared about the baby and had made the long journey to the FLTC in a desperate attempt to save its life.

Other cultural patterns directly support children whose mothers have died: for example, the custom of a dead woman being replaced by her sister who marries the widower and cares for the children.

We met a very young replacement mother at the Ahero FLTC. Shortly after her sister died, she was asked in a dream to care for the surviving infant. At the age of 15, she dropped out of school and married her brother-in-law. When the baby became sickly and malnourished, she took it from clinic to clinic and struggled to feed it properly. Her husband is a labourer on a sugar estate and she stays with him there. She says that her parents-in-law love her very much for having agreed to quit school in order to care for their grandchild.

In general the women admitted to the FLTCs were younger than the average mother of small children in the community (based on our survey of 300 mothers). But again, this may be a reflection of the greater responsibilities which prevent older women from leaving home for three weeks.

The most striking characteristic of the mothers of malnourished children was that they were poor. This brings us to the issue of economy and gender.

**Malnutrition and the ‘gorogoro economy’**

The ‘gorogoro economy’ is the term Cohen and Odhiambo (1989) use to describe the Western Kenya rural economy in which staples are sold by a standard measure (a gorogoro) whose size has steadily decreased while its price has remained the same. Characteristic for this economy is that inadequate subsistence agriculture is supplemented by insufficient, irregular remittances from migrant men. When a home’s own crops have been eaten, food is bought by the gorogoro to tide the family through to the next harvest.

Practically all of the mothers in our two samples had access to land. The acreages tended to be larger in Busia District where more than 80 per cent said that they farmed more than three acres. In the Kisumu and Siaya samples, less than 15 per cent had so much land. The staple crops are maize, sorghum and cassava, with cassava particularly important in Busia District.

Although almost all women in our sample were farmers, there were very few who were able to produce a nutritionally balanced variety of foods all the year round. Most families are not even able to produce enough staples to last from one harvest to the next. In some parts of Kisumu and Siaya...
Districts, the second rains are very unreliable, so only a single harvest each year can be counted on. In the dry season, there are not many vegetables. Most families do not have their own supply of milk; those who are fortunate enough to have milking cows usually sell at least some of the milk.

Given the difficulties of producing an adequate diet, it is clear that some food must be purchased. The remittances sent home by husbands working on the sugar and tea estates, or in towns, have to buy food as well as paying for school fees, taxes, medicine, transport and clothing. Both our quantitative material and our discussions with mothers of small children revealed lack of cash as an absolutely central problem for child nutrition.

The communities with the highest rate of malnutrition were those in Busia District, where 45 per cent of the mothers reported a monthly income of 100 shillings (about six U.S. dollars) or less. In Siaya and Kisumu Districts, 18-19 per cent of mothers in the community sample were in this very low income bracket. The mothers of malnourished children admitted to the FLTCs were even more likely to have a minimal income. Thus 77 per cent of the Butula trainees interviewed were trying to manage on 100/- a month or less; the corresponding figures for Lwak (Siaya) and Ahero (Kisumu) were 57 per cent and 38 per cent.

Interviews with mothers three months after their training at the centres revealed that they were well aware of what foods they should give their small children, but were often unable to afford them. Only five of the 42 ex-trainees from Butula FLTC said that they were able to feed their children as they had learned at the centre, and even those added ‘but not always’. They explained that they did not themselves produce a sufficient quantity and variety of food and that they could not afford beans, green grams, groundnuts, milk, eggs, fruits and meat. This fits with our finding that although 81 per cent of the malnourished children gained weight during their three weeks at the Butula FLTC, only 34 per cent of the same sample gained any weight at all in the three months after discharge.

In this situation a mother’s ability to earn a little cash on her own is critical. We found considerable variation in the extent to which women in the sample areas had their own income through trade, sale of handicrafts or day labour. The women in the Busia District sample were much less involved in independent economic activities. The Kisumu and Siaya women, being closer to the lake, and to major transport arteries, seemed to have more opportunities: many traded in fish, for example. In an otherwise isolated village in Siaya, women were earning cash by selling firewood to those who smoked Nile perch on the lakeshore.

The relation between child nutrition and mother’s work has been reviewed by Carloni (1984). She contrasts the view of women-in-development experts, that families benefit from women’s income-earning activities outside the home, with the concern by nutritionists that working mothers are unable to care for and feed their children adequately. She concludes that both approaches share the assumption that women’s work is the independent variable and the nutritional status of children the dependent one. This cause-and-effect assumption is oversimplified, she suggests. Both women’s work and nutrition may be affected by other variables, and it is more useful to examine closely the household situations of mothers involved in off-farm earning activities.

In many cases, women are forced to seek casual wage labour because the family is too poor to survive without their earnings. So many other factors (e.g. landlessness, market dependency, declining employment opportunities, rising food prices, erosion of real wages, poor access to markets) may be responsible for malnutrition that it makes little sense to view the mother’s employment as its cause (Carloni 1984:3).

Our material suggests that the interplay of factors may be even more complex than Carloni proposed. When a child becomes sickly and malnourished, an economically active mother may spend her trading capital on medical care. She may have to discontinue her paid work in order to care for her
sick child. It must be borne in mind that malnutrition is usually a long-term condition, often beginning with a serious illness. This means that a mother’s work may be disrupted over a considerable period, reducing family income and interfering with subsistence farming.

One mother interviewed upon admission to Ahero FLTC was from Oyugis, a trading centre between the lake and the Kisii highlands. Her husband was a teapicker in Sotik and he was able to send her 100-150/- a month. She supplemented that income by trading in *omena* (Swahili *dagaa*; small sardine-like fish that are dried). She used to go to the lake often, buying fish for 40/- and selling in Oyugis for 100/-. But eight months ago her child got measles and subsequently developed marasmus and kwashiorkor. Since then she has given up her trading and now lives on her husband’s remittance.

Other mothers told similar stories, leading us to see the relation between economic circumstances and malnutrition as one of mutual influence, where a child’s ill-health is both a result of and a factor contributing to the family’s poverty.

**Women as health-care providers**

Research on the causes of malnutrition has pointed to the characteristics of child care that are crucial for helping children to grow well. The intimate association between disease and malnutrition means that prevention of disease by immunization and improved hygiene and early, effective treatment of sickness episodes are absolutely essential. Feeding patterns should include a long period of breastfeeding, avoidance of bottles and gradual weaning to a varied diet with high energy in relation to bulk, given in frequent feedings (King et al. 1972). The quality of child care is also important and there is apparently a feedback effect here: attention, stimulation and consistent sensitivity to the child’s needs are necessary so that the child becomes active and develops the ability to respond to its care-takers (Peters and Niemeijer 1987). Adequate child spacing ensures that children are not weaned too early and that they receive sufficient care during the dangerous first two to three years of life.

Who is responsible for providing this kind of child care? Mothers are. Mothers must be motivated to bring their children for immunization, mothers wait with their sick children in the long queues at health centres. They nurse and feed the children, and grow the food to provide a good diet. They are alert to the child’s needs and they interact most intimately with it. Mother’s bodies are the locus of conception and pregnancy, and they must ensure that babies are properly spaced. The primary role of mothers seems so self-evident that it is rarely questioned.

The view that mothers as individuals are responsible for child health seems to be supported by the consistent finding in Kenya and other developing countries that educated mothers have healthier children (Mosley 1989; Cleland and van Ginneken 1989). Although the exact mechanisms by which education influences the mother’s ability to provide better child care are the subject of debate, there seems little doubt that it does so. Our material from Western Kenya agreed with other findings in that the communities with the highest rates of malnutrition had the lowest rate of maternal education: in the Busia District samples, 54 per cent of the mothers of small children had no formal schooling at all, while the figures for Siaya and Kisumu were 17 per cent and 23 per cent respectively. With the increase in primary school enrolment in Kenya, it seems likely that in the next generation of mothers, nearly all will have at least a few years of school, with whatever benefits that brings in health knowledge, attitudes, discipline, self-confidence and status. But for the present, many unschooled mothers are caring for children and nutrition programs cannot change that fact.

What they can do is provide responsible mothers with information and try to motivate them in certain directions. Most nutrition intervention and health-education programs are based on the assumption that teaching individual mothers to care well for their children will reduce malnutrition.
The question we want to consider is: to what extent should mothers as *individuals* be seen as providers of health care? There is a good argument for treating mothers as autonomous subjects who can learn and take decisions about their children and their lives. A program addressed to individual actors is more tangible than one addressed to a ‘situation’ or to ‘society’ or ‘the economy’ or ‘the system’. Individual mothers must perceive themselves as having control and being able to influence their child’s health (cf. Simons 1989). At the same time mothers are social beings who exist within a particular set of relationships to men and other women, within specific economic and cultural contexts. The gender organization of Western Kenya sets limits and gives possibilities for child health care. We have already given some examples of how malnutrition is enmeshed within social relations. Now we want to explore further and more specifically the way mothers as individuals and as socially-embedded persons provide health care.

Taking small children for immunization and treatment is the responsibility of a mother, unless she is not living with them: in the case of Elizabeth of Nyakach, remember that her mother wanted her to come home and take the child to the hospital. The significance of sickness and the consequent need for treatment in Western Kenya can scarcely be over-emphasized. One study from South Nyanza District found that the average woman and child are ill one out of every four days (Kennedy and Cogill 1987:42); the Baseline Study for the FLTP carried out in Siaya in 1983 found that 68 per cent of children under five had been ill during the two weeks before the interview (Kaseje et al. 1986:31).

A father or other family member can go to buy medicine for the child at home, but a mother takes her child to the health facility. What determines whether or not she does this? Apart from factors like distance to the health facility and evaluation of the service available there, we should recall the argument about mother’s work and how it impinges on child health care. Sempebwa (1988) reports on a study in Kisumu District showing that children whose mothers were away from home more than six hours a day were less likely to be taken for immunization and treatment. A mother’s work load, which is a consequence of the gender organization of the economy, may inhibit her ability to take advantage of the health system’s facilities. The FLTCs reported that fewer mothers brought children for nutritional rehabilitation during the season of heavy agricultural work. In part, the issue here is what priority the mother as an individual gives to her work in relation to the perceived value of visiting government health facilities. But that evaluation is not made in isolation; it may well be influenced by her husband, relatives and neighbours. Thus some men did not want their wives to go to the FLTC for three weeks, because there was no one else to cook. A young wife who is still cultivating together with her mother-in-law may find it easier to take her child to the clinic, because she is not solely responsible for the domestic and farming work.

Even more important is the role that significant others have in mobilizing the mother to seek treatment. In medical anthropology, the term ‘therapy managing group’ (Janzen 1978) or ‘therapeutic support structure’ (Janzen 1990) is used to refer to the people who mobilize and support a sick person in seeking therapy. Our interviews with the women who brought their malnourished children to FLTCs gave some indication of how this process works in Western Kenya. The role played by family and others is well illustrated by the story told by Penina, whom we met at Ahero FLTC with her child who was suffering from severe kwashiorkor.

My child fell sick four months ago with fever, diarrhoea and vomiting. At first I bought aspirin and aspro - he refused to take chloroquin because that’s so bitter. There was a health centre near my home, but I didn’t go there because I didn’t know anyone working there. If you don’t know someone you aren’t treated well, and besides health centres these days often don’t have drugs. So I came here to Ahero where my mother lives; she knows the retired clinical officer who runs a private clinic here. He said my child had measles and I paid 50/- for
treatment, but the child was not admitted. The sickness continued and I saw the child’s body swelling. I thought it might be chira – maybe my husband was moving with other women. I asked him and he said maybe it was him, that we should just get treatment. But when the practitioner (ajuoga) came, he told us that this was not chira because that makes a child thin and ours was swollen. (Our neighbours said this was akuodi which makes the body to swell, the hair to turn brown and the skin to change). The practitioner said maybe our child passed where a child with akuodi had been washed and that’s how he caught it. Soon after, the Aga Khan health workers visited us at home; they suggested we come to the FLTC and they brought us here the same day.

When we met Penina she was chatting with a relative who had come to see her. Her husband was living at home; they both made papyrus mats which she sold in the market, using the money as she saw fit to buy what the family needed. ‘I just live peacefully with my husband’, she said. From the health workers’ point of view, Penina’s child became malnourished because of measles, and also perhaps because, as she told us, she used to feed him on tea and bread, as she sat selling mats in the market. She also saw the measles and the child’s swollen body and she acted; but her response was very much shaped and supported by her relations to others. The only treatment attempt in which she seems to have acted on her own was the initial purchase of medicines (cf. van der Geest and Whyte 1989).

We have already touched on some of the economic factors that limit a mother’s ability to feed her children an adequate diet. The local staff at the FLTCs recognized that many mothers were unable to buy the oil, eggs, milk and beans that would enrich their children’s food. But, they said, even if a mother has very little, she should know how to use it. If she has ten shillings, she should buy dried fish and not fried bread and soda for the child. If she only has porridge made with water, she should at least know to feed the child five times a day. She can go to the butcher and ask him to give her the blood from slaughtered animals: that costs nothing. This response emphasizes that mothers as individuals can learn and act to improve the child’s diet.

Yet not all mothers actually prepare the food which their children eat: a young wife does not usually form an independent consumption unit until she is allocated land of her own; that is, her husband will assign fields to her when his father has given him his share of land. When she begins to harvest from her own fields, she will get her own kitchen. Until then, she and her children eat from her mother-in-law’s kitchen. The position of a daughter-in-law, particularly in the first years of marriage, is one of dependence. She and her children eat what her mother-in-law provides. This situation has been documented by Kryger (n.d.), who gives the example of a young Luo mother who had recently moved into her husband’s home bringing a malnourished child. When asked why she had not given beans and milk to the child, as she had been advised at the nutrition centre, she replied that her mother-in-law had not offered them beans or milk.

There are other situations too where a mother might not be cooking herself: if she were staying with relatives, on an extended visit, or if she were sick. A woman who has been staying elsewhere with her husband might also cook with her mother-in-law for a period when she returns to her husband’s home. The situation of Mary, whom we met at Butula FLTC, provides a dramatic example of how a woman’s ability to feed her children might be inhibited by her position in a larger household.

Mary and her husband were from Busia District, but had been living in Kampala where he worked as a charcoal dealer. She had two children and was caring for two other children of her dead co-wives. (One of her co-wives had been shot in Uganda, the other died of diarrhoea, she said). Her own youngest child became ill in Uganda, and failed to recover despite being admitted to Mulago Hospital for three weeks. Finally she brought all the children home, but there her own child’s condition worsened and her co-wife’s child developed kwashiorkor.
explained that she had no house of her own in her husband’s homestead and his mother cooked for her and also for her sister-in-law and her children. All the children of the home ate together, and the bigger ones ate faster so the younger ones did not get enough. Mary said that when she asked her mother-in-law to help her carry the sick children to the FLTC at Butula, the older woman said that everybody had to carry their own burden. If the children were bewitched in Uganda, she should have left them to die there. After admission to the FLTC, one of the children became so critical that it was referred to the district hospital. Mary asked her husband if she could take the child there and he in turn asked his father, who refused. Other evidence of the authority of the senior generation in this home came to light when our assistant visited the family and found another grandchild (the child of Mary’s sister-in-law) with severe kwashiorkor. Although she advised that this child be brought to the FLTC immediately, the mother-in-law refused. She said that she first wanted to see whether the treatment there worked for Mary’s children. In the weeks that followed Mary’s children improved at the centre, while the other child died. Mary seemed to be on good terms with her husband, who visited her almost every day while she was at the centre. But she was very unhappy with her mother-in-law, and hoped that her husband would put up a house for her so she could cook for her own family when she completed her stay at the centre.

The quality of child care is another aspect of health-care provision that is assumed to be the responsibility of the individual mother. We have already touched upon the issue of whether a mother’s work prevents her from caring for her child properly. Here again it is important to look more closely at the actual social situations of mothers. All mothers have to be away from home some of the time, if only to fetch water and firewood, and work in their gardens. We asked the 300 women in our community sample who cared for their small children when they had to leave home. The most common answer was that other children did so—either young children who were not yet in school, or older ones when they came home after school. Although practically no small children were left alone, it is clear that the care provided by a five-year-old, or even by a nine-year-old who has been in school all day, may not be as attentive as that provided by an adult. In the Siaya and Kisumu District samples, where large extended family compounds are common, small children are also left in the care of other adults, usually their paternal grandmothers. Hardly any mothers (only 4%) said that they always took their children with them when they went out. By contrast one third of the Busia District mothers said that they did not leave their children with others, but always took them with them. Thus an appreciation of the actual patterns of child care in Western Kenya suggests that both older women and school children should be involved in the kind of child-health education currently aimed at mothers.

One of the factors that most markedly affects the quality of care a mother provides is child spacing. The picture of a mother with a chubby, happy infant and a miserable, malnourished 18-month-old was all too common. As we have mentioned above, local concepts about ledho emphasize the need to wean a child abruptly as soon as the mother realizes she is pregnant again. Health workers teach that a pregnant mother can continue breastfeeding as long as she eats well. But here they are going against a local conception that seems to be confirmed by the common experience that ‘displaced’ children become sickly. Here too, health education needs to reach other members of the family, teaching them to provide extra care and attention to a young child whose mother is pregnant. The study on the relationship between malnutrition and the home environment in Coast Province (Peters and Niemeijer 1987) states that it is not clear whether a malnourished child generates a lower level of stimulation on the caretaker’s part, or whether lack of stimulation should be seen as causal, leading to increased risk of malnutrition. It seems logical that there is no one-way cause and effect here, but a mutual influence in
which passive, unhappy children get less attention. If one adds to that situation, a new breastfeeding baby, it is apparent that the ‘displaced’ child is at even greater risk.

Family planning as a method of spacing is an obvious solution, but very little used in Western Kenya. Only 4 per cent of the mothers in the community sample were using modern methods of family planning (pills, injections or IUD). This very low utilization rate, despite official promotion of family planning, is partly due to poor services. But it is certainly also due to the strong pro-fertility attitudes in this part of Kenya. Most people do not distinguish child spacing from child limitation, and they do not want to limit the number of their children, at least not until after the first eight. Here again, it is important to see the individual mother’s position in a social context. In discussing family planning with mothers, we found that many expressed an interest. But often they said that their husbands were opposed to the idea, or that they feared even to raise the topic, and they also feared to use family planning without their husbands’ permission. We did indeed encounter many men who spoke vehemently against birth control. Yet we suspect that many women are ambivalent about it, and it is somewhat convenient to blame their husbands for being antagonistic to family planning. Some health workers told us that polygyny promoted fertility in that co-wives, consciously or not, competed with one another as to children. Through their children they make claims on their husband’s attention and resources, so that it is disadvantageous to limit births if your co-wife does not.

**Conclusion**

The significance of women’s position for the health of their children has been recognized by a number of scholars. In this paper we have contrasted the assumption that women as individuals care for children with the view of Western Kenyan women that they do so as socially connected persons. A consideration of the concept of autonomy may help to summarize our argument.

Caldwell argues that female autonomy (which he suggests is enhanced by education) is an important factor in mortality decline:
When a woman’s morality and behaviour in the widest sense are primarily her own responsibility rather than that of her male relatives, then she will assume broader responsibilities, including those of deciding early and with certainty that children are sick and need rest and treatment; she will not worry about waiting to consult her husband or his mother or brothers (Caldwell 1989:15).

Our case material provides detailed examples of how lack of autonomy may inhibit a woman’s ability to care for her children: the young bride who must feed her malnourished children whatever her mother-in-law provides, and the mother who must have her husband’s or father-in-law’s permission to take a child to hospital. Women’s highly dependent economic position is a consequence of the genderized political economy of Western Kenya with its combination of male labour migration and patrilineal, virilocal access to resources.

However our material also suggests that the value of female autonomy is conditional; we need to specify what we mean by autonomy and how it might be expressed in particular local settings. If autonomy is defined as individualism and lack of mutual obligation, even educated women cannot be, and may not want to be, autonomous. Social-support networks are probably even more important to health in developing countries than in Western settings. The difficulty is in distinguishing what is supportive from what is oppressive.

Western Kenyan women are enmeshed in social relations and their children are enmeshed with them. As Bledsoe (1990) has recently asserted, child care is never simply a question of the relation between child and adult; it is always also a matter of relationships among adults. Children are treated as symbols of adult relationships. A good example of this point was the way Elizabeth of Nyakach refused to go to her husband’s rural home to collect her breastfeeding baby, because she was angry at her husband and his family. Among co-wives, envy easily arises if a father is more concerned with the children of one wife, because treatment of the children is seen to reflect the relationship to their mother. The tendency for parents to invest more care in the children of unions that have current value for them, pointed out by Bledsoe for the Mende of Sierra Leone, was even more pronounced in Western Kenya, where mothers do not usually take children of a previous union with them into a new one. Those children are left to the care of grandmothers, and often neither the father nor the mother provide much support. Even educated mothers hand their children into the care of grandmothers; in fact, this is the common pattern when school girls get pregnant and try to continue their education after delivery.

Such examples illustrate the negative consequences that adult relationships and interests may have for child care. But children are also symbols of adult relationships in the positive sense that solidarity with the mother is expressed in concern for the child. Neighbours and relatives who help a mother to get treatment for her child, relatives who care for orphans, and siblings who babysit while their mother is working make survival possible. Women without support networks are very vulnerable, as are their children. Feierman (1981) documented this point some years ago in a study from Northwestern Tanzania. The children in her sample who died were children of mothers who were socially isolated. Perhaps they were autonomous in some sense, but they had no social resources to help them meet their children’s health crises.

This brings us to the point that female autonomy is valuable if it is defined as the ability to mobilize relevant resources, both social and economic: if it means the capacity to take initiatives and the knowledge to decide when they are necessary. It is irrelevant if it means independence in the sense of the ability to manage without the help of others. That kind of independence is only possible for people with a stronger economic situation than most women have in Western Kenya.

The mothers in our study wanted support more than independence from their husbands and families. They need assistance in the form of cash and help with agricultural labour; sometimes
husbands are unable to help more than they do, but many women felt that husbands did not use the resources they had sensibly, thus forcing wives to try to manage independently in very difficult circumstances. Mothers also need support in terms of concern for the welfare of their children. Some women complained that their husbands wanted many children, but showed no interest in caring for them because they saw that as a woman’s job. We noticed that men were quick to criticize women for failing to care for children properly, but they seldom took an interest themselves in what children were eating or whether they had been vaccinated. When men were attentive to a child’s health problems, mothers appreciated it as a sign of concern for the mother as well.

These considerations have implications for child-health programs in general, and nutrition programs in particular. It is important to teach individual mothers and to strengthen their perception of themselves as autonomous agents who can influence their children’s health. But it is also necessary to recognize that mothers like those in Western Kenya must have enlightened support in caring for their children. We say enlightened because it became clear to us in the course of our study that older siblings, mothers-in-law, grandmothers and especially husbands need to be aware of the same messages that health educators are aiming at mothers. In a gender system of the type we have examined here, mothers and children do not form isolated dyads. Perhaps they do not do so anywhere, but their social embeddedness is particularly clear in Western Kenya.

References


3 Recent work by Holmboe-Ottesen and Wandel (1991a,b) in Rukwa, Tanzania, emphasizes the importance of marital relations and particularly the significance of male contributions to the household economy, for the nutritional situation of children.
Holmboe-Ottesen, G. and Wandel, M. 1991a, Wife, today I only had money for pombe , in Gender and Social Change, ed. K.A. St¿len and M. Vaa, Norwegian University Press, Oslo.


