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# Women Bargaining to Seek Healthcare: Norms, Domestic Practices, and Implications in Rural Burkina Faso

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**Summary.** — Based on a qualitative study contrasting a gender-relationally restrictive socio-cultural setting with a rather liberal one, we explain how social norms shape resource negotiation for women seeking modern healthcare. A system of "protection and dependency" covers them in principle for obviously serious illness, as far as household resources permit. In both settings, however, women must have "well behaved" and justify less-obvious needs in an unequal bargaining process with ambivalent recourse opportunities. Consequently, women may suffer delays in or exclusion from healthcare. Moreover, their self-esteem may lower and the domestic power imbalance may increase. The results suggest sectoral and sector-crosscutting solutions.


*Key words* — social norms, gender relations, women's access to resources, healthcare financing, Burkina Faso, West Africa

## 1. INTRODUCTION

Traditional norms and mechanisms of intra-household resource allocation continue to influence women's access to healthcare in Sub-Saharan Africa (SSA) in particular because health insurance is rare and does generally not extend to the more vulnerable groups (Arhin-Tenkorang, 2001; Ridde & Girard, 2004; Stierle, Kaddar, Tchicaya, & Schmidt-Ehry, 1999). Despite renewed efforts to promote community-based models of health insurance (Atim, 1998; Wiesmann & Jütting, 2000), their acceptance is weak or in decline (Criel & Waelkens, 2003). Therefore, women's capacity to afford modern healthcare depends not only on the momentary availability of cash in the household, it is also subject to the local, traditional ways of responding to health needs and of allocating resources between household members. The underlying domestic decision process co-determines if, when, and to what extent one can afford to seek modern healthcare. While this raises questions about allocative justice between all household members, our focus here is on adult women's status in SSA: First, because we have reasons to expect that women are disadvantaged by the traditional allocation system in at least some situations; second, because there seems to be a paradox between pronounced social and economic gender inequalities on the one hand,

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and, on the other hand, absence of a clear gender gap in healthcare.

The link between gender asymmetry and disadvantage in access to healthcare has mainly been established in South Asia: A strong patriarchal social structure, gender roles, preference for sons, and unbalanced gender relationships expose women (and girls) to various discriminatory attitudes and behaviors that prevent them from affording adequate healthcare (Borooah, 2004; Das Gupta, 1987; Filmer, King, & Pritchett, 1998).

In SSA, the influence of gender on access to healthcare has mostly been examined among children. Some studies failed to prove discrimination against girls in vaccine coverage and in the treatment of diarrhea and acute respiratory infections (Garenne, 2003; Hill & Upchurch, 1995); others found them to be slightly disadvantaged (Klasen, 1996). These results are taken to reflect parental gender values. However, even if boys and girls were treated equally, this would not exclude gender inequalities among adults. Women's under-use of reproductive health services was attributed to asymmetric gender relationships and imbalances in power, while being already constrained by poverty, low education, and work overload (Fonck *et al*., 2002; Hodgkin, 1996; Morrison, 2000; Prevention of Maternal Mortality Network [PMNN], 1992). Results on women's access to general curative and palliative health services are sparse and vary from a slight advantage for women (Kloos *et al*., 1987) to no difference between the sexes (Fabricant & Kamara, 1991; Sauerborn, Berman, & Nougtara, 1996) to a slight female disadvantage (Buor, 2004; Kaona, Siziya, & Mushanga, 1990). Women were also reported to rely on self-medication, traditional medicine, or health center care while men may prefer health center or hospital care, respectively (Gertler & van der Gaag, 1990; Haddad, 1992). Nevertheless, relevant differentials may have gone undetected because, beyond the mere fact of having or not resorted to care, evidence is at best sketchy on the important aspects like timeliness of use, volume of care consumed, and difficulties to be overcome for accessing care.

The inconclusiveness is astounding because of women's marked social and economic disadvantages in African societies. Compared with men, women generally control fewer resources and have less access to education, paid work, inheritance, and credit. They also suffer more time poverty (due to volume and time-overlap of tasks) and depend in many areas of life on their husbands' consent (Blackden, Canagarajah, Klasen, & Lawson, 2006; Dacher & Lallemand, 1992; Kevane, 2004; World Bank, 2001; Zwarteveen, 1996). Household resources are mostly controlled by men. Although women may negotiate within and outside the household for resources, their restricted bargaining power limits their access to and control over agricultural and household resources (Abbas, 1997; Johnson, 2004; Kevane & Gray, 1999; Kevane & Wydick, 2001; Thorsten, 2002; Udry, Hoddinott, Alderman, & Haddad, 1995). One would expect these socio-economic disadvantages to constrain African women's ability to mobilize resources for healthcare—unless compensatory mechanisms exist, which would themselves be worth understanding.

Little is known about how households in SSA allocate resources in response to healthcare needs of their members. Sauerborn *et al*. (1996) and Sauerborn *et al*. (1996, sections 9.2.1-2) combine quantitative and qualitative information about differentials mainly between age groups and hypothesize that the underlying rationale of household allocative behavior may be to maintain economic production. Their results imply that, in case of competition between adult members, women's access to resources could depend on the perception of their productive contribution. There are also indications that women must negotiate before seeking healthcare (PMMN, 1992, 1995). However, we still lack information about *how* this negotiation and decision over allocation proceeds, who intervenes where in the process, and how it is guided by social norms and other reasons. A better understanding could certainly be important for adapting service provision to local needs as well as to the potentials and restrictions of the traditional system of responding to healthcare needs.

We studied this system following a qualitative and predominantly inductive approach. Our objective was to describe the domestic negotiation process and to explore how traditional norms and approaches to evaluating health needs and allocating resources facilitate or hamper women's capacity to seek modern healthcare. Throughout, we contrasted a gender-relationally restrictive socio-cultural setting with a rather liberal one, both sharing the same physical environment. As a necessary groundwork, we establish in Section 4a which norms instruct the mobilization of resources for women's healthcare. In Section 4b, we examine how these norms are applied under the influence of other factors in the process leading

(or not) to the decision to allocate resources and allow a woman to use modern healthcare. Section 5 relates the findings with existing knowledge and Section 6 addresses practical implications.

## 2. CONTEXT

Burkina Faso offers a rich spectrum for studying socio-cultural contrasts, harboring some 60 different ethnic groups. Like in other Sahelian countries, the population is predominantly rural and relatively disadvantaged in Sub-Saharan Africa, in terms of average income, functional literacy and public infrastructure. In 2003, 46% of Burkina Faso's population was living below the national poverty line (with an annual income of 82,672 CFA francs or about US$141, that is, less than half a dollar per person and day), 92% of them in rural areas (Institut National de la Statistique et de la Démographie, 2004). Cultivation and livestock breeding are the main sources of income in rural areas, where 80% of the population lives. Ninety percent of farming households depend on subsistence agriculture and are therefore particularly vulnerable to the vagaries of the Sahelian climate and, inter alia, food insecurity (International Monetary Fund, 2005; Ministry of Economy & Finance, 2000).

The study took place in the northwestern part of the country. At least five ethnic groups are living in the study area: *Bwaba*, *Dafing*, *Mossi*, *Peulh*, and *Samo*. They are earning their livelihood as agropastoralists. Household members make up the work force to which women contribute substantially: their daily working time being 1.2 that of men when comparing annual means (Sauerborn *et al*., 1996, section 7.1.2). Mainly during the dry season, women may operate small-scale self-profit activities including sorghum-beer brewing, trading raw and transformed agricultural products, and handicraft. Most adults are illiterate (76%), particularly villagers (84%) and women (87%) (Würthwein, 2002). Ethno-specific economic, educational, and health statistics are unavailable.

Multiple sources of healthcare co-exist: self-medication with plants, herbalists, ambulant drug vendors, spiritual healers, and rural health centers (*CSPS—Centres de santé et de promotion sociale*). *CSPS* are the normal entry point into the public healthcare system and provide care for a fee. Out of the six study villages (see Section 3), two contained a health center, while the others were 2–28 km from the closest health center. The nearest hospital (with the nearest physician and operating theater) was located within 20–40 km from the study villages.

## 3. METHODS

Our qualitative inquiry contrasts two gender-relationally different socio-cultural settings. We purposively selected pairs of villages, with households being almost exclusively of *Bwaba* origin in one village and of *Mossi* origin in the other. Only villages of at least 1,000 inhabitants were eligible. Each pair shared the same health facility and geo-climatic and administrative influences.

Our motive for contrasting *Bwaba* and *Mossi* was to capture a range of gender-relational scenarios, and *not* to compare these particular two cultures. *Mossi* and *Bwaba* represent opposite realities of gender relations among the ethnic groups in Burkina Faso, although both are patriarchal and patrilineal. The *Mossi* are characterized as a highly hierarchic society in which the elder members outrank the younger ones, and where women's submission to men is considered to be strongest (Lallemand, 1977; Retel-Laurentin, 1979). By contrast, the *Bwaba* are known to be culturally more egalitarian (Savonnet-Guyot, 1986), providing women with relatively liberal marital relationships and tolerating, for example, births out of wedlock (Capron, 1973; Fiske, 1990; Konaté, 1993; Retel-Laurentin, 1979). In the study region, the two groups differ in other respects. *Bwaba* are indigenous and predominantly animists or Christian, whereas *Mossi* have immigrated and are mostly Muslim. The socio-cultural contrast in our study is thus due to a combination of factors.

We triangulate information from three sources: in-depth interviews (IDIs) with 24 women, interviews with village key informants (KIs) of both genders, and male and female focus groups (FGs) (see Table 1 and detailed descriptions below). Iterative cycles of data collection and analysis followed the logic of grounded theory as presented by Paillé (1994): As our point of departure, IDIs collected women's personal experiences, themes, and stories. Every four IDIs (two from each socio-cultural group) were transcribed and preliminarily analyzed, to further target the structure of the following interviews. After

Table 1. *Methods of data collection and numbers of units*

| Method | Ethnic group and gender | | | | Totals |
|---|---|---|---|---|---|
| | Bwaba (Bwa) | | Mossi (Mos) | | |
| | Female (f) | Male (m) | f | m | |
| In-depth interview (IDI) | 12 (10 twice)[a] | – | 12 (9 twice)[a] | – | 24 |
| Key informant interview (KI) | 9 | 9 | 9 | 9 | 36 |
| Focus group (FG) | 3 | 3 | 3 | 3 | 12 |

[a] Ten out of 12 Bwaba women and nine out of 12 Mossi women were interviewed twice. Reasons for not completing the second interview included communication difficulties (i.e., differences in dialect between the interviewer and the two Bwaba participants); intended participants attending a funeral (two Mossi women); and one husband withdrawing his consent to his wife's interview.

preliminary syntheses and comparison of results in the two ethnic groups, a second round of IDIs was conducted with the same women to confirm and clarify ideas and obtain answers to new questions that had since been generated. Saturation, that is, the point where further data yielded no new aspects regarding the research question, was reached after 1/2 of *Bwaba* and 2/3 of *Mossi* IDIs. The preliminary IDI results helped to shape the KI interview and FG discussion guidelines. The KI aimed at general information about social rules and institutions governing women's access to resources for healthcare. Syntheses of the individual KI interviews were validated the following day during a meeting with all KIs from the same village. The FGs aimed to generalize ideas gained from personal stories and to explore degrees of consensus on the collected themes and rules.

The study was approved by the Burkinabè Ministry of Health and the ethics committees of *Université de Montréal* and *CRSN* (*Centre de Recherche en Santé de Nouna*), a demographic and public health surveillance laboratory operating since 1992 in the study area. Prior to contacting potential study participants, community representatives were informed about study objectives, procedures, and content, and their consent was obtained as required by local habits. Women selected for IDIs and their husbands were informed about study objectives and interview procedures. We obtained each IDI respondent's written consent. As required by local norms, the husband's oral consent was also obtained. Participants in the KI and FG gave their oral consent. For all tape recordings, we had the participants' oral consent.

All IDIs, KIs, and FGs were conducted in the respective languages, that is, *Bwamu* or *Mooré*, by experienced qualitative interviewers of *Bwaba* and *Mossi* ethnic backgrounds. The two female interviewers and principal moderators were sociology graduates, and both male moderators were permanent *CRSN* field workers. These people and the four assistant moderators all had experience in qualitative techniques and group moderation. During two one-week sessions, before the IDIs and again before the KIs and FGs, we used role-plays and individual field exercises to practise interviews, recording, transcription, translation, and coding.

— *In-depth interviews* (*IDIs*) involved married women who had the same ethnic background as their husbands. They were randomly selected from a list of members of *Bwaba* and *Mossi* households, provided by *CRSN*. Twelve *Bwaba* and 12 *Mossi* women were interviewed, with respective mean ages (interquartile age ranges) of 36 (30–41) and 35 (31–38) years. Four *Bwaba* and nine *Mossi* women were living in polygamy; only four *Bwaba* and two *Mossi* women had received some primary education. The interviews were carried out by female interviewers in the women's homes. At the time of the interviews, *CRSN* field workers conversed with the husbands to prevent them from influencing their wives. The women were encouraged to tell the story of their most recent personal health problem and how it was handled. They elaborated on strategies used to mobilize resources, bargaining with the husband for resources, sources of healthcare considered or actually used, economic constraints of the household, other difficulties encountered, and perceived access to household resources. The interviews were tape-recorded.

— *Key informant interviews* (*KIs*) were conducted in each village with three women and three men. They were selected for their knowledge of the village with the help of *CRSN* field workers and informants. The interviews addressed history and organization of the village; domestic responsibilities of spouses and their justification; explanation of gender-specific rules of conduct in response to healthcare needs; and related mechanisms of social control. Extensive notes were taken.

— *Focus groups* (*FGs*). In each village, we convened simultaneously one female and one male focus group. Each group included 10–12 participants who had to be married, living in mono- or polygamy, and be known to express themselves with ease. They were also selected with the help of *CRSN* field workers and informants. We excluded spouses of participants already selected, persons of influence, and those who had been approached for an IDI or a KI. The female groups were hosted by a female moderator and a female assistant; the male groups by a male moderator and a male assistant. The discussion guides invited participants to describe their strategies for mobilizing resources in case a member of their household, in particular a woman, was ill and needed modern healthcare. Then, influences on the process of resource mobilization for healthcare and economic coping strategies were addressed. The sessions lasted one-and-a-half hours, on average, and were tape-recorded.

Quotations from these three data sources will be indexed, in Section 4, in the following format: $\text{METHOD}_{gender}$—$Ethnic\ group_{\text{serial number}}$. For example, $\text{FG}_{m}$-$Mos_2$ designates the 2nd focus group with *Mossi* men and IDI-$Bwa_3$, the third in-depth interview of a *Bwaba* woman (without gender index, because IDIs concerned only women).

Interviewers transcribed tapes into French. Data were first analyzed manually. The team (i.e., interviewers, assistant moderators, and the first author) collectively proposed an initial set of codes based on the material collected during the first training session. The first author and a third sociologist then performed the coding of IDIs, added new codes as more IDIs were completed, grouped codes into themes, and prepared summary charts with interpretive notes for both socio-cultural groups. The team collectively compared results within and between the groups at the end of the first wave of IDIs. The first author continued coding the second round of IDIs together with the third sociologist, and completed alone the analysis of KI field notes and FG transcripts, as well as the detailed analysis of the IDIs, using the themes produced by the first IDI round and their interpretation.

## 4. RESULTS

### (a) *Norms and institutions*

#### (i) *Introduction*

Among both ethnic groups studied, men must provide for their wives (according to all IDIs, KIs, and FGs). While each spouse is expected to look after the other's health, husbands must bear their wives' healthcare expenses. This responsibility is acquired by marriage. ''Because he has married and taken you home, he must take charge of you.'' This phrase is a typical example of what almost all the women expressed. However, there are nuances between ethnic groups. While *Mossi* often referred to a notion that may be labeled ''woman as property'', *Bwaba* tended to conceive of the ''woman as a worker''.

*Mossi women* did not consider their husband's responsibility to protect them as a right, but rather as a favor granted by their *soala* (owner or lord). The *Mossi* key informants confirmed that a woman becomes her husband's ''property''. [1] From this perspective, men's responsibility to protect their wives seems so self-evident that one respondent was astonished that the interviewer would even question her on the subject:

> ''He took you with him and you sit in his home and bear him children. You fall ill, go to the dispensary, and would have to use your own money to care for yourself? He's your owner, he's the one who must care for you!'' (IDI-$Mos_6$ – these abbreviations were explained at the end of Section 3)

While *Bwaba women* also see their husbands' moral responsibility to protect them, they perceive the husbands' paying for their healthcare as a fair compensation for their contribution to his prosperity, as illustrated by the following statement:

> ''...The person for whom I work is the one who must look after me when I get sick. If he doesn't do so and

> someone else, like my father or brother, does instead, I could not continue to work for my husband and leave the one who cared for me—that would be unacceptable." (IDI-$Bwa_7$)

*Men* also relate their responsibility as a protector to their "owner" status, but place it within the wider frame of their responsibilities as household heads: to protect *all* members of the household, including their spouse. This underpins their legal ownership of all household assets, even those acquired by the help of their wife or wives. Female participants recognized their husbands' property rights over these assets, but denounced abuses. For example, one of the female FGs used a popular refrain reporting a wife's complaint to her husband and in-laws ($FG_f$-$Mos_3$):

> "When it's time to plant coffee, we all have the same mother.
> When it's time to plant cacao, we all have the same father.
> When it comes to money, [you tell me,] go back to your parents because you are a foreigner."

Men seem to be aware of the vulnerability that the "foreigner" status confers upon women. All $FG_m$-*Mos* and two out of three $FG_m$-*Bwa* explained their obligation to provide for care because of the isolation in which their wives had been living since marriage, precluding them from other sources of support. In addition, some male focus groups perceived that women's capacity to fend for themselves is reduced, which was seen as another justification for supporting them in obtaining healthcare.

Among both ethnic groups and with all three interview methods, we consistently found the following rules:

(ii) *Rules of conduct for husbands*

As head of the household, the man manages all the business of the couple. He is obliged to pay for his wife's healthcare, and the wife needs to not reimburse him. However, if poverty prevents a man from paying, he would not be blamed. Such situations are "obvious" according to male focus groups, as explained by $FG_m$-$Mos_3$: When "somebody has no chicken, goats, or anything at all and suffers even to get enough to eat, he clearly can do nothing else". The community (besides the extended family, see below) may help him in case of sudden illness in his household, if his misfortune is not perceived due to laziness. By contrast, a husband who is not poor and does not help his wife will not be excused unless he can show that his wife has misbehaved, for example, through infidelity, insubordination, or lack of respect.

(iii) *Rules of conduct for wives*

A woman must conform to the code of conduct for wives to be able to claim resources for her treatment. She must be a good worker and respect her husband and in-laws. Basically, "the wife must do what the husband wants and the husband, what he wants" (IDI-$Bwa_2$). The general process for obtaining household resources is the following: The wife informs her husband of her illness, if he has not noticed it. She then lets him decide, either alone or in consultation with his natal family, what action to take, especially regarding modern health services, as well as what type and amount of resources to allocate.

Propriety among *Bwaba* or *Mossi* dictates that a woman cannot seek care without her husband's authorization, even if she owns the necessary means. To cite only one of many similar responses:

> "When you live with a husband, you cannot go to a dispensary without informing him. It would show a lack of respect... As a woman, you cannot decide to go to the dispensary even if you have the money for treatment." ($FG_f$-$Bwa_3$)

The wife must also not use household resources without her husband's consent. In the husband's absence, household affairs are temporarily managed by his father, brothers, or paternal uncles, and the wife must turn to them if she needs healthcare.

(iv) *Role of the extended family*

While the responsibility to look after his wife falls primarily upon the husband, his parents share a part of it. The wife's parents may also offer to contribute in kind or cash, out of solidarity or to offset any difficulties the husband's family may be experiencing, however, letting them lead the process.

The spouses' natal families are also responsible for conflict arbitration. If a man declines to supply his wife's health expenses, she may first turn to his family, who has the obligation to reason with him. Her in-laws may ensure that she receives the required care, to the extent possible. If this recourse fails, the wife's family (father, brothers, uncles) may become involved in resolving the conflict. As was similarly stated several times:

> "[If your husband refuses to take care of you,] you will go and say to his uncles or his brothers: Ah, your son

has refused to look after me; ask him what I have done to him? But if they intervene and he still refuses, you will turn to your parents to seek your health." (IDI-$Bwa_{10}$)

If a woman is considered at fault, her family will strongly advise her to respect her husband's authority. If the husband is considered at fault, her family may initiate discussions, put pressure on his family, care for their daughter themselves in her husband's home, or even take her back. A wife may also decide herself to return to her parents for care or in protest. Once she is with her family and a family council concludes she is within her rights, the husband must formally apologize to her and her family and obtain forgiveness to woo her back. *Mossi* male elders of the wife's natal family may themselves forgive the husband. By contrast, *Bwaba* elders must invoke their ancestors with ritual sacrifices provided by the husband.

### (b) *Bargaining for scarce resources*

The norms are applied with variable rigor. Husbands and wives apply them strategically during a negotiation process. Women's ease of access to resources for healthcare depends also on their marital relationship, the health problem, available personal and household resources, and the socio-cultural setting.

(i) *Men's willingness to provide support*

Men appear to accept their role as protector and maintain it is in their own interests to pay for their spouse's healthcare if the required means are not out of their reach.

— First, as expressed in all *Mossi* and *Bwaba* male focus groups, a husband will benefit from meeting his wife's healthcare needs if he hopes to preserve the proper functioning of his household and his own well-being. For example:

"She is the one who prepares your meals. If you have two or three people at home [to feed], what will you do [if your wife becomes ill]? . . . day and night you will be on your feet. With a child fallen ill you can still sleep, but if your wife is sick, you can never sleep, otherwise your household will fall into ruin." ($FG_m$-$Mos_3$)

— Second, no man wants to be held responsible for the death of his wife, the mother of his children, by failing to adequately care for her. Almost all male and female focus groups mentioned this perspective and the related possibility of social sanction, which is well illustrated in this woman's response:

"If you refuse [to pay for her treatment] and she dies, how would you explain. . .? [Louder] You will know!" (IDI-$Mos_3$)

The warning "You will know!" means, for instance, that his in-laws could accuse him and his family of neglecting their daughter to death, which in turn could provoke conflict between the two families.

— Third, successfully protecting one's wife against hunger, illness, and death is a matter of honor and a source of pride. This idea was mentioned in all focus groups with *Mossi* men and was vigorously expressed by the three *Bwaba* male groups, for example, as follows:

"Doing for her everything she wants and giving her anything she asks for means you can support her. . . And because a man loves glory, he will always 'kill' himself for his wife." ($FG_m$-$Bwa_3$)

As the second and third points above suggest, social control is in fact exerted not only by the wider family, but also by the community, given the closeness of the dwellings to one another in the study area and the sharing of daily activities between women from different households.

(ii) *Not every health problem is eligible*

Men will likely commit to mobilizing resources in case of obviously urgent maternal health problems. This may be due to the awareness of maternity-related risks. However, almost all IDIs affirmed that husbands, having "caused" the pregnancy, feel a shared responsibility for their wives' ensuing health problems. Resources may also be swiftly mobilized for treating incapacitating illnesses, conditions perceived as severe, or conditions believed to be curable only by modern medicine (as meningitis or obstruction of the intestines). IDI-$Bwa_1$'s problem was both pregnancy-related and obviously life-threatening:

After her last delivery, the placenta did not come out. She was bleeding and the traditional midwife had exhausted all the maneuvers she knew. When informed, her husband immediately commissioned a younger brother to convey her to a hospital, with all the cash he had available. It was the middle of the night and she insisted on waiting until the morning, but the husband did not listen to her.

Yet, women are not necessarily guaranteed access to household resources in order to receive care. Men often think women are too sensitive to pain and thus tend to underestimate their need for professional intervention. We cite a male and a female perspective:

> "At the least discomfort, they keep on crying, saying: 'I'm sick, I'm sick.' Even if they can tolerate the pain, even if they can still work, they come to you saying: 'I can't work today, I can't work today'. They are constantly complaining." ($FG_m$-$Mos_3$)
> If "it's not serious enough so that it's obvious to everyone, if the sick person is still walking, [husbands] refuse to consider her sick." (IDI-$Mos_8$)

Men may also suspect their wives of feigning illness, since being sick is almost the only acceptable excuse for getting out of daily chores: "... if you tell your husband you are sick, he'll tell you that you are just lazy, that's why you lie down, you don't want to work." ($FG_f$-$Bwa_3$).

(iii) *Women's strategies*

To succeed in obtaining resources, the ground has to be prepared in advance. There is a widespread assumption, even among women, that "if a man refuses to provide care for his wife, it is most often her own fault", as it was frequently phrased. A man is justified in refusing to look after his wife if she declines to "carry water for him, to prepare *tô*[2] for him to eat, or to help him with important work" (IDI-$Mos_{12}$), or "does not consider her husband, behaves wrongly, and responds badly when he speaks" (IDI-$Bwa_{10}$). Then the woman gets only "what she deserves". Caught within this guilt-based logic and unwilling to take chances, women will make sure they play according to the rules and maintain good relations with their husbands. Indeed, those IDI respondents whose husbands had ever refused to pay for their care reported that they had been in conflict on that occasion.

Even if they have no reason to blame themselves, women take care not to annoy their husbands when it comes to negotiating resources. Typically, the process is gradual. First, they will adopt strategies that respect the husband's authority; only when these have been exhausted would they resort to defiance.

— *Waiting*: The wife informs her husband that she is ill and waits for his reaction. Meanwhile, she may treat herself with plants. The time waited depends on perceived gravity and personal resources but also reflects respect for the husband's authority.

— *Offering to make a contribution*: If the wife has savings or convertible personal items, she tries to influence the decision by proposing to share the costs.

— *Imploring the husband*: If she has waited a long time, has no personal resources, or believes to be at fault, she may try to sway her husband by her entreaties and pitiful behavior.

— *Turning to mediation*: Intermediaries chosen for their influence on the husband are asked to intervene. In addition to her in-laws, who are always involved as required by the norms, the wife may contact friends or acquaintances. In polygamous households, younger wives may turn to older ones. However, the presence of another wife may also complicate the process.

— *Confrontation*: She reminds her husband of his responsibilities toward her, threatens to return to her parents, or demonstrates her discontent (e.g., by refusing certain tasks or services for the husband, or complaining loudly to draw the attention of neighbors).

— *Revolt*: The wife returns to her parents. She thereby breaks off negotiations with her in-laws and puts herself under the protection of her own family.

IDIs from both ethnic groups show that waiting, offering a contribution, supplication, and mediation were the strategies most often used. Confrontation occurs from time to time. Returning to the paternal home is rare.

(iv) *Impact of women's own resources*

The husbands' decision-making authority seems tempered when women are able to contribute. In that case, almost all IDI respondents said they would have easier access to the modern health services they want. Nevertheless, the husbands' authority must be visibly respected: everything must proceed as if the money were coming out of his pocket. Protecting the husband's pride is essential and women who succeed in doing so have a distinct advantage. One male focus group pointed out:

> "There are manners... A woman cannot come and say to her husband: 'Get up, we're going to the health center!', just because she has money and can pay for the services. If she uses good manners and her husband understands, they will go to the health center and, afterwards, the husband will reimburse her the money." ($FG_m$-$Bwa_3$)

However, women's willingness to use own resources depends on the degree to which they wish to enjoy their spousal rights. Some believe mutual aid should be the rule at home and do not expect a contribution from their husbands if they can pay their own way. Others feel their

contribution should complement their husbands'. Yet others expect that their husband should be alone responsible and say they will insist on reimbursement in case they spend their own money for a treatment.

(v) *Room for intra-marital arrangements*

Some *Bwaba* women consider themselves to have free movement. Requesting the husband's authorization for seeking healthcare, although still mandatory, becomes a formality that these wives observe out of respect to keep their husbands informed. Several of them reported being free to use household assets in the absence of their husbands, provided care is urgent; they would only inform him upon his return. In contrast, *Mossi* women did not report any such arrangements, even when asked explicitly (all IDI-*Mos* and FG$_f$-*Mos*). A typical reaction was "I can use something that belongs to me, but not what belongs to my husband... When it involves a lot [a great value], it cannot be taken... *Mossi* do not tolerate that" (IDI-*Mos*$_{10}$).

(vi) *Availability of household resources*

Lack of resources is perceived as being the main constraint preventing men from responding to their wives' healthcare needs (according to all FGs and almost all IDIs). Many women had to postpone or forego treatment due to lack of resources. Here is the example of a woman who was relatively lucky in obtaining care:

> "He said he did not have money to buy medicine... He told me to wait but, before daylight, it was no longer tolerable, so he told me to go to the health center... I was the one who went in to the pharmacist to ask him to give me the pills on credit and to promise I would pay when I had sold my things. He accepted. The product cost 1,650 CFA francs (US$2.75), my husband had 750 CFA francs (US$1.25). I paid this amount and later I paid the rest." (IDI-*Bwa*$_6$)

Lack of resources also inspires additional negotiation and tactics. The husband's privilege as decisionmaker may become embarrassing for him when he is unable to bear the cost. In some focus groups, men admitted laughingly that they may start a quarrel just to hide their incapacity to meet their wives' expectations, for instance:

> "If the wife suggests going to the dispensary, the husband answers: 'Didn't we cure us ourselves, before the health center was here?'... If you are told to bring the sick person to the health center and you have nothing and don't know where to go [to find money], you start a quarrel, saying: 'Try the leaves'!" (FG$_m$-*Bwa*$_3$)

Non-verbal intimidation may be as effective as direct talk. As a woman reported, if her husband "gets up and stares wide-eyed", she avoids to ask for anything (IDI-*Mos*$_6$). Wives thus learn over time to anticipate their husbands' reactions, relative to the household's economic situation and the quality of the couple's relationship, and to adjust bargaining strategies and pressure tactics.

(vii) *Resorting to in-laws and natal family*

Just as men may suspect their wives of "faking" illness, wives may suppose their husbands claim lack of money to conceal their unwillingness to pay for their spouse's care. In such situations (let alone when the couple is lacking the necessary resources), the extended family comes in. Both *Mossi* and *Bwaba* wives seek first the intervention of their in-laws, as the general rule suggests. These rarely used recourses may or may not work. A woman's in-laws may be unwilling to defend her if they have an uneasy relationship with her; they may also fail to convince their son or lack the resources needed to compensate for his refusal. When resorting to in-laws does not work or seems unpromising, *Bwaba* and *Mossi* women do not always adopt the same strategies.

Several *Bwaba* respondents had already returned to their parents to protest and put pressure on their husbands. Some male *Bwaba* focus group participants complained that women over-use this recourse at the risk of "ruining" their husbands. However, "returning home" may be also risky for the wife:

> IDI-*Bwa*$_5$ recounted that she had to move back to her husband without obtaining the desired reimbursement. She did so before the usual deadline expired (one to two years according to the reported *Bwaba* norm), otherwise her husband could renounce her. Her self-esteem was damaged and power imbalance reinforced in her relationship, but she paid this price for keeping her assets and, especially, her rights over her children.

*Mossi* women prefer to "wash dirty laundry in the family". If resorting to in-laws fails, they rarely turn to their natal families. This recourse seems to work less well among the *Mossi* and many women expressed resignation in this respect: "You go home [to your parents] and they will tell you to return to your husband, because everything comes to an end" (FG$_f$-*Mos*$_3$). Given it is elder men who handle the conflict once

natal families are consulted, some women suspect that "men" conspire against them. Never being sure of winning, they make compromises to keep both their own families and their in-laws happy. The threat of losing rights over their children keeps them in the conjugal home even if they are very unhappy, as voiced by this woman, punctuated by the typical laughter that often accompanies statements of powerlessness:

> "Among the *Mossi*, if things didn't work out [because of discord in the household] and you have to leave home, you can't take anything except what belongs to you... even the children [laughter]... even this [5-month-old] baby, if you take it with you, they will come and take it back... Because it has been said that the child belongs to the man, it's for sure they will come to get their child (laughter)." (IDI-$Mos_{11}$)

Though women's bargaining succeeds in some situations, it may fail in others. Earlier experiences influence strategies at new occasions. Resignation appeared to be more common among our *Mossi* participants, but occurred also among the *Bwaba*. However, even if a husband pays for his wife's health expenses, she is sometimes the victim of humiliation because he may keep on reproaching her with his paying for her. Since they have little choice, women often play "the man's game", through apparent or real submission. Almost all female focus groups spontaneously mentioned similar experiences: "When you have nothing and don't know where to turn to keep peace and at the same time preserve your health, you chew on your pride and your bitterness, and swallow them" ($FG_f$-$Mos_3$).

## 5. SYNTHESIS AND DISCUSSION

### (a) *A matter of entitlements*

As in many societies in SSA, gendered norms require women's subordination to their husbands among both socio-cultural groups studied. While husbands enjoy their right to own all household assets that have been acquired together, women's benefits from their entitlements to private budget and certain properties are clearly restricted. However, we observed that the effect of women's disadvantage on their capability to purchase modern healthcare is mitigated by a kind of reallocation mechanism that derives from the same traditional norms that create gender asymmetry. While a wife must contribute to her husband's prosperity, he is in turn responsible for looking after her needs. This responsibility is supervised and sometimes aided by in-laws and natal families. Thereby, a wife's capability to mobilize resources for her healthcare depends less on her personal means and more on her rights to benefit from joint resources. Both determine her "exchange entitlements" (Sen, 1981), which encompass goods and services she *can obtain* by exchanging her marketable and non-marketable resources, that is, her assets, skills, fecundity, and benefits from her social relationships.

We further observed how access to these resources is negotiated within a system of hierarchical social relationships where wives, husbands, in-laws, and women's natal families are exchanging rights against duties. A wife exchanges her labor, expertise in traditionally feminine tasks, and fecundity for the husband's commitment to protect her, which includes paying for her healthcare. Behaving toward her in-laws in an exemplary fashion will earn her their support and willingness to defend her case when necessary. Thereby, she will also preserve her natal family's honor and be able to count on them when difficulties arise in her household.

### (b) *Relationships of "protection and dependency"*

We represent these relationships as a matrix of "protection and dependency" (Figure 1). Each matrix cell shows reciprocity at a particular interface, by representing both a right and a duty, depending on the perspective chosen.

The phrase "protection and dependency" was used by Raynaut (1990). In a framework that is more general than ours, similar relationships are shown to have sustained survival and security in traditional West-African societies. The principles of asymmetry and obligation to share were observed not only between spouses but also between chiefs and subordinates, rich and poor, and elders and youth. Thereby, flows of goods and services were supported between protectors and dependents, with the former relying on the latter to prosper while being obliged to reward them generously. These relations were complementary rather than antagonistic. Raynaut argued that societies were thus able to perpetuate their institutions while ensuring the survival of their weaker members.

Elements of similar strategies have been found for agricultural production in Burkina Faso. In rural communities that are dealing with long-term economic hardship and struggle

| Duties → | Rights ↓ | Wife ... | Husband ... | Husband's family ... | Wife's family ... |
|---|---|---|---|---|---|
| | | ... CAN EXPECT | | | |
| Wife ... | | | Submission, contribution to prosperity, fecundity | Submission, taking care | Exemplary conduct |
| Husband ... | ... OWES | Satisfaction of wife's needs | | Respect, honorable conduct, assistance | Respect of marital commitment |
| Husband's family ... | | Help, defense, arbitration | Help, arbitration | | Cooperation |
| Wife's family ... | | Help, defense, arbitration | Help, arbitration | Cooperation | |

Figure 1. *Matrix of protection and dependency. The rights of a party are read down the column named after it, the duties across its row. Examples of duties (first row): A wife OWES submission TO her husband and exemplary conduct TO her natal family. Examples of rights (first column): A wife CAN EXPECT satisfaction of needs FROM her husband and help FROM her natal family.*

continuously for survival, concentration of power and wealth in the hands of household heads may be a matter of risk management, aimed at preserving a household's property and production capacity (Whitehead & Kabeer, 2001). Within such a relational framework, women have legitimate claims on common resources by virtue of being a wife, mother, daughter, or sister (Kevane & Wydick, 2001). We saw another element of reciprocity: the division of tasks between genders, together with the related difficulty to replace women's contribution to production and social life, keeps households dependent on women and reinforces the perception of their value.

The system of "protection and dependency" fits well with a rationale of future household viability (Sauerborn *et al*., 1996) for allocating resources to women's healthcare. Beyond this imperative of economic rationality, we found that other motives may be socially relevant: compensation for the wives' past productive contribution; husbands' care for their own property (as which women may be considered); moral obligation because of the wives' marriage-induced relative isolation and reduced autonomy; and social accountability of household heads, controlled by the extended family and also the community.

### (c) *How gender-bias comes in*

However, the implied gender-specific power inequality hampers the traditional "protection and dependency" system's ability to grant women full access to the resources required for healthcare. How far a particular woman may benefit from her rights depends on the strategic re-negotiation of norms within her household. One weakness of the traditional system is that the husband is both "judge and judged": He decides whether to mobilize resources, which ones, and when; it is also him who would have to give up "his" resources (since he owns the household's resources). These prerogatives, coupled with the wife's obligation to submit to her husband's authority, create an imbalance between the parties when bargaining for a share of the joint resources, and women may be exposed to abuses of power. The unequal bargaining power is reflected in the strategies available to men and women. When a health problem emerges, the husband may choose either not to recognize her need, to mobilize resources when the need is obvious to him, or to break off the negotiation ("quarreling"). The wife, on her part, is more or less forced to use strategies that respect the husband's authority. In addition, she must have invested in building up a capital of merit, long before her healthcare need arises, to free herself from the presumption of fault. Another handicap may be her current health problem *despite* which her patience and personal negotiation skills are put to test. Suspicion of a stigmatizing cause may further limit women's bargaining power, as observed in the

case of AIDS (Campbell, Foulis, Maimane, & Sibiya, 2005) and tuberculosis (Eastwood & Hill, 2004).

In addition, our results imply *long-term* burden. Until she has mastered the selection and implementation of situation-specific strategies, a woman may have to use trial and error. Failure in one instance may leave a mark on her, not only for the next illness but, more generally and possibly lasting, for her self-esteem in other areas of life. Here, our concern is no longer limited to healthcare access—we are back to gender asymmetry as a domain-crosscutting issue.

The focus on *process* allowed us to identify *how*, *when*, and *why* particular factors may exert influence on resource allocation and to see wider implications of the related social interaction. Such insight may be difficult to obtain when focusing on the allocative *result* rather than the preceding process. By contrast, our starting from *women's experience* of the allocation process has produced results that may *complement*, rather than conflict with, previous results from alternative perspectives. For instance, *male household heads' view* of the allocation process might in fact be more concerned with economic household viability and equilibrium. However, when invited to discuss the process from women's perspective, they acknowledged important aspects of women's disadvantage.

Our inquiry shows how women's entitlements may compete with other household priorities. Women's extra burden of bargaining underpins the weight of additional factors for the *conversion* of entitlements into *capability* (Sen, 1993). We saw "in action" and related to healthcare seeking, why "social conversion factors" (e.g., norms and rules) and "personal conversion factors" (e.g., negotiation skills, momentary physical, and mental condition) are critical for women's ability to bargain for household resources (Agarwal, 1997).

### (d) *Socio-cultural variation*

The normative framework and the decision process in the two socio-cultural groups, chosen to contrast liberal and restrictive gender-relations within a shared environment, were remarkably similar. Both groups described the same general system of "protection and dependence" associated with gender asymmetries. As far as women are disadvantaged in accessing resources for seeking modern health services, this appears to be produced by the same underlying mechanism in both settings. Similar support mechanisms and gender-asymmetric processes may be expected in other socio-cultural groups living in the study area or in adjacent regions and countries [for instance, David (1993) described a similar responsibility of husbands to pay for the healthcare of their wives in Liberia]. Of course, further and independent information about those populations would be needed (but not necessarily full-fledged qualitative studies in every group and locality) to allow this kind of generalization and practical application in and beyond the study area.

Despite this similarity, individual women's ability to defend their need for healthcare varied considerably. In the group representing rather *liberal* gender relationships (*Bwaba*), women seemed to be in a better position to negotiate, perceived themselves less as their husbands' "property", and were more inclined to insist on their rights. Several of them saw their bargaining power significantly enhanced by the actual or potential recourse to their in-laws and, further on, their natal family and ancestors. We also observed that certain rules were "softened-up" by some couples, thus enhancing these wives' autonomy in the absence of their husbands. By contrast, in the group representing rather *restrictive* gender relationships (*Mossi*), women's bargaining power relative to men's was generally constrained. While recourse to in-laws and natal families exists for these women as a possibility, they often chose not to use this option because of the potentially associated high social and human costs. By directly and indirectly limiting women's bargaining power relative to men's, the latter group's norms particularly reduce women's freedom to exercise their rights to household resources when they need healthcare.

The differences we found between the two groups in women's space for negotiating resources for healthcare are supported by previous studies comparing the two ethnic groups in social structure (Capron, 1973; Retel-Laurentin, 1979), agricultural production (Kevane & Gray, 1999), and similar constellation—*Bwaba* being indigenous, *Mossi* having migrated and living in diaspora (Kevane & Gray, 1999; Kevane & Wydick, 2001). Mossi women's mitigated recourse opportunity in their natal family has been stated (Rohatynskyj, 1988), as well as the close tie between their marital life and their status, rights, and livelihood, whereby any "misconduct" exposes them to social and

economic hardship, including the loss of their children in the case of divorce (Lallemand, 1977; Taverne, 1996).

Accounting for socio-cultural heterogeneity is particularly relevant in the pluralistic context of SSA. We found consistent evidence that these socio-cultural factors can significantly modify women's chances to negotiate resources for seeking healthcare, despite the similarity of normative frameworks and social mechanisms.

(e) *Interaction with poverty and other factors*

Economic poverty sets an absolute limit for the marriage-based exchange and *both partners'* ability to acquire healthcare. However, the described decision-making process exposes *women more than men* to additional burden, and the risk of delays and exclusion in care-seeking. Poverty likely contributes to the climate of tension in which they must negotiate. A wife's bargaining power becomes particularly critical when her health problem is not immediately and obviously incapacitating, when her marital relationship is rather conflictual, or when household resources are tight. Her and her husband's levels of education and other factors *amenable to intervention* may co-determine the process. These issues go beyond our objective—to describe the decision process in two settings—and beyond what our accordingly collected data allow to identify. A natural next step will be to analyze *quantitatively* the interplay of potential influences, in the light of the presented findings.

## 6. CONCLUSIONS

Women's experiences in a gender-relationally restrictive and a rather liberal socio-cultural setting showed how the tradition-based social support system provides them, in principle, with resources to seek healthcare. This result may partly explain the mentioned paradox that, despite general gender asymmetry, several studies failed to detect an obvious gender gap in healthcare utilization in SSA. Acknowledging this system may turn out useful for the further development of social protection and healthcare coverage.

At the same time, the domestic negotiation process showed how the tradition-based system insidiously hampers women's mobilization of resources needed to afford modern healthcare. The restriction to health problems perceived as severe, the conditioning on having "well behaved" as wives, the extra time and energy women must spend to convince others that they really need care, and the uncertain ability of the described recourses to protect them against their husbands' arbitrariness become important barriers to women's access to modern healthcare. We therefore expect to find relevant gender inequities in healthcare use in SSA, albeit after accounting for additional parameters: timing of use, level of care and volume consumed, degree to which recommended treatment is followed through, characteristics of the health problems likely impeding their acknowledgment, and interactions with household ability to pay and socio-culturally varying subordination of women.

At a more general level, we found that the negotiation process, which women must push forward while being vulnerable, and its long-term requirements, can have implications on women's life beyond their access to healthcare and beyond the instance of a particular illness—including a reinforcement of power imbalance. Our results also underline that the factors behind gender asymmetry are complex and rooted in a socio-cultural and economic context where personal needs compete with imperatives of economic viability, social reproduction, and social equilibrium at household level and beyond.

How could these findings be useful for public policies and other initiatives aiming to alleviate the burden? Our results suggest points of attack at various levels: *attenuating specific consequences* of the negotiation process (e.g., delay of, and exclusion from, certain services); *eliminating immediate constraints* that make women bargain (e.g., lack of cash or transport); *strengthening* women's *bargaining power*; and *influencing fundamental causes* of the unequal bargaining (asymmetry in rights).

Several *public health measures*, feasible in almost all contexts, could attenuate certain consequences. First, as we saw in Section 4.b.ii, obviously severe health problems prompt husbands to mobilize available resources for seeking modern healthcare, whereas conditions perceived as serious by the women but less intelligible to others may be neglected or acknowledged only at an advanced stage. Specific health education messages could inform the household-based evaluation of what justifies seeking modern healthcare. Second, awareness may be reinforced for the effect of treatment delay on outcome and costs of cer-

tain health problems; here health workers can draw on amply available, local empirical examples. Thereby, the sometimes time-consuming bargaining process may be accelerated and the benefit from the available treatment enhanced. Third, the results provide additional justification for lowering *tariffs* of preventive care and treatments for not obviously incapacitating health problems.

Promotion of *health insurance* in SSA remains crucial, not only because it could make healthcare less dependent on momentary available cash, but also because it could take part of the decision process out of the private sphere. Thereby, women's need to bargain could be partly eliminated, together with related treatment delays and under-use of health services. This may require family-wise rather than individual subscription. A study involving the same source population as ours suggested the risk of women's exclusion in individual-based schemes: heads of households (mostly male) were willing to pay more for themselves than for the other household members (Dong, Mugisha, Gbangou, Kouyaté, & Sauerborn, 2004). Promotion messages may build on men's traditional responsibility for all household members and their control over household resources: respectful incorporation of this pre-disposition may enhance the acceptance of family-wise subscription.

However, our results suggest that other concerns would have to be convincingly addressed, before health insurance can be expected to win people over from the traditional system of "protection and dependence", especially in the context of poverty. In this system, a rural household's savings (mainly its livestock and stock of cereals; Sauerborn *et al*., 1996, sections 2.2.5 and 9.4.1-2) are a general purpose resource and may be mobilized in case of any unforeseen need, including sickness, food shortage, funerals, hosting visitors, etc. Furthermore, payments are made *ad hoc*, when a problem arises, according to the amount of resources available at that particular moment and of course longer-term considerations. Contributors can follow-up their investment and its usage. They can also be confident to be "paid back" in the long run, should they fall sick or not, because resources may be used for needs of many kinds. This is in fact a social security system whose functioning, strengths, and weaknesses are well known to its users and which they feel they can control. It is against this system that any newly proposed health insurance scheme will be evaluated by the targeted population. By contrast, the new systems' advantage of a larger risk pool comes along with the loss of control over resources (Sommerfeld, Sanon, Kouyate, & Sauerborn, 2002) to people with whom no kinship or marital ties exist and the need to trust a system whose sustainability in the context of Sub-Saharan Africa has yet to be established. Adherence may well appear hazardous, because it requires to tap one's scarce household resources to advance payments for a hypothetical, *specific* risk, whereas the traditional system keeps household funds together for the much less hypothetical, next emergency of *any kind*. Not surprisingly, unaffordability and skepticism have been identified in the study region as important barriers to enrollment in a future community-based insurance scheme (De Allegri, Sanon, & Sauerborn, 2006). One might therefore reconsider the feasibility of more general "emergency" insurance schemes or similar forms of risk-sharing.

*Economic measures* that improve women's access to autonomous revenue (e.g., micro-credit and agricultural promotion) may in turn bring more women in a better position, specifically when bargaining over resources for healthcare (cf. Section 4.b.iv) and certainly in other areas of life.

The *educational system* may integrate the mentioned specific health education messages in its curricula, and thus facilitate a wider and possibly more lasting attenuation of specific consequences of the unequal negotiation process than health-sector measures alone. Of course, the vast potential of general education lies in strengthening women's capacities much more generally and in promoting sensitivity to gender inequity and its undesirable implications in many areas of life. The lack of outright female discrimination in the described "protection and dependency" system reminds us, however, to avoid aggressive or divisive gender messages and suggests accounting for the values represented by this system when promoting gender equity.

Though each of these approaches may provide benefit in specific areas, *sector-crosscutting* initiatives are needed to address the depicted problem completely, interlink sector-based measures, and instigate more profound change. While we provided justification from the health domain, drawing justification and resources from several involved domains and meeting people's priorities and potentials remain essential in order for more relevant, synergistic interventions to succeed.

## NOTES

1. Marriage can be contracted by modern law, religious rites, traditional practices, or all three combined, in Burkina Faso. In the study population, civil and religious marriages were almost always accompanied by traditional marriage ceremonies, according to KI. The husband owes a contribution to his wife's family, which may take several forms (cultivating the father-in-law's fields or herding his cattle, a variety of material goods, or money).

2. *Tô* is a Burkinabè national dish, prepared from millet, sorghum, or corn flours.

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