Neoliberal effects as seen in village health dispensaries within the Kedougou Region of Southeast Senegal

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Neoliberal effects as seen in village health dispensaries within the Kedougou Region of Southeast Senegal

by

Samantha Salter

A thesis submitted to the graduate faculty
in partial fulfillment of the requirements for the degree of

MASTER OF ARTS

Major: Anthropology

Program of Study Committee:
Nell Gabiam, Major Professor
Sebastian Braun
Donna Winham

The student author, whose presentation of the scholarship herein was approved by the program of study committee, is solely responsible for the content of this thesis. The Graduate College will ensure this thesis is globally accessible and will not permit alterations after a degree is conferred.

Iowa State University
Ames, Iowa
2018

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In addition, I would also like to thank my friends, colleagues, the department faculty and staff for making my time at Iowa State University a wonderful experience. I want to also offer my appreciation to those who were willing to participate in my interviews and observations, without whom, this thesis would not have been possible. Lastly, I would like to thank Baba, who took me into his home and family and helped facilitate this research.
My research lead me to the Kedougou Region of southeastern Senegal, a rural area struggling for accessible healthcare. This paper explores how neoliberal health reforms have negatively affected access to quality health care in rural Senegal. I used ethnographic research methods, such as in person interviews and participant observation during my fieldwork in Senegal from May through August 2017. In analyzing my interview and observation data, I applied a localist, semi-structured approach and utilized a critical ethnographic perspective. Over 2-months worth of observations and 15 interviews yielded data that illustrates the lasting effects of neoliberal economic reforms from 30 years ago in Senegal. These enduring effects are seen in independent village dispensaries in how they are able to provide basic health services and how community members are able to access those services. This paper tells the story of community members and health workers in their struggle to receive and provide sustainable health care.
CHAPTER 1. THE BACKGROUND

“Where are you traveling to?”
“Kedougou.”
“Oh, you know that’s the hottest place in Senegal?!”
“Yeah...we’ve been told.”
“Good luck!”
“Thanks.”

(An example of several interactions with people in Dakar and on the way to Kedougou.)

1.1 Introduction

This paper explores how neoliberal health reforms have affected access to quality health care in rural Senegal. This paper tells the story of community members and health workers in their struggle to receive and provide sustainable health care. Recent literature tells us that market-based health reforms fail to acknowledge complexities of vulnerability to disease, illness experiences, and health-seeking behavior. These reforms have altered Senegal’s health systems both financially and organizationally (Foley 2008). While, neoliberal economic efforts strive to increase laissez-faire or free market strategies, these efforts have negatively impacted citizens across Senegal, especially in rural areas. The basis of this paper is an investigation into the ineffective health development in Kedougou, Senegal. Specifically, I will be focusing on neoliberal economic reforms and how they have affected the health sector throughout the Kedougou Region. I attempt to explore the effects of neoliberalism in Senegal in this paper, as well as specific example of the effects seen in the Kedougou Region.

During my fieldwork, I questioned why health dispensaries are poorly managed, from observations I had made and interviews I conducted. Dispensary in the context of this research is
defined as a small, village-specific building specializing in basic health services such as first aid, malaria testing, and malaria treatment. Some dispensaries also provide prenatal and birthing care. The use of the term “dispensary” was a conscience choice to keep language use consistent with the terminology used by each research participant. It then became necessary to trace back health sector reforms within the country. That resulted in discovering research regarding neoliberal economic changes and how they have affected health care throughout Senegal. Understanding these impacts can demonstrate how citizens view health and illness and what decisions they make when seeking (or not seeking) health care services. These neoliberal health reforms are not isolated to Senegal; they have swept across much of the African continent.

In the early 1980s, many African governments experienced debt crises and were urged to reduce funding on public health care by global economic institutions like the World Bank and IMF (Foley 2010). Due to mounting pressure and outright insistence from those institutions, African governments in debt should dissolve all social spending in favor of privatization. If they did not follow economic guidelines, these already vulnerable governments would suffer from further economic penalties.

These demands included putting debt repayment ahead of their domestic priorities, contributing to inequity in health outcomes (Kim et. al. 2002). One example of economic guidelines is the Bamako Initiative in Senegal, which will be discussed in more detail later, which was designed to combat reduced public spending by increasing availability of essential medicines and drug procurement through resale strategies at health centers. The initiative placed responsibility on community financing instead of state funding (Kanji 1989). These changes in health care services have resulted in continued malnutrition of children, high maternal mortality,
rampant malarial infections, and yellow fever in rural areas. Bond & Dor report that household expenditures on health services have dwindled, as well as nutritional status.

Price inflation for health services creates an unbearable burden on households, which affects disposable income and food consumption (Bond & Dor 2003). Poor health care across Africa is exacerbated by an attempt at a free market health system. Milton urges opponents of privatization to “…continue and to intensify their important work for the defense of public health…” (Milton 1999). This topic helps us understand health experiences throughout Senegal and it is central to improving health across the continent.

My specific research focuses on the Kedougou Region and how the health dispensaries in that area exhibit what is illustrated within the literature and previous research. The data from this research show the lasting effects of economic policies established three decades ago.
The Research Site

I arrived in the town of Kedougou on the evening of May 25th, 2017 after a 12+ hour drive in a hatchback with five other people (the driver, myself, Jill Pruetz, and three other graduate students). We were hot, sweaty, covered in dirt and dust, and tired. We had left Dakar at 5:00am that day and driving the length of the country, stopping for breakfast and lunch and for our driver to pray at mosques along the way. My white Columbia hiking shirt and khaki pants were no longer those colors. Everything had a layer of orange grime from the dirt roads and dry weather. Our clothes would remain slightly discolored for the remainder of the trip, unable to get rid of the constant dirt and sweat. Upon arrival, I was introduced to my host and translator, Baba and his family. I was given my own room in the house, with a bed, desk, and platform for my bags. I even had my own floor fan and two mice to keep me company at night. I was so exhausted that first night that I did not even eat dinner and went to sleep at 8:00pm. I was nervous about being in a new place, essentially alone since the other graduate students and Jill were staying at her field site. However, I was excited for what was to come and all the new experiences that Kedougou would give me.

The Kedougou Region in Senegal is located in the southeastern corner bordering Guinea to the south and Mali to the east (Bradt). The Kedougou Region is home to an estimated population of 75,000 - 143,000 inhabitants and comprises twenty-three health posts, three health centers, and the regional hospital (Peacecare). It is also the most humid region in the nation and one of the largest, making up 8.6% of the national territory. This region experiences three seasons throughout the year. From March-June, there is the hot and dry season, from July-
October the rainy season, and from November to February a cooler dry season (EcoSenegal).
The Kedougou Region is home to many ethnic groups such as, Bedik, Basari, Mandingue, Diakhanke, Malinke, Wolof, among others. The majority of residents identify as Muslim (96.6%) with small percentages of Christians and Animists (EcoSenegal). This area is very rich in gold, which has resulted in large commercial investments after a spike in gold prices, as well as tarmac routes carrying substantial traffic to Tambacounda and Mali (Bradt). However, these developments have not resulted in the desired benefits to the communities and some say that it has even increased child labor, increased environmental issues, as well as an increase in poor health (Actionaid). Although, gold mining has increased in recent years, agriculture remains the region’s main economic activity (Actionaid). Profits from agricultural production are meager and do not result in prosperity for individual families, nor the town of Kedougou. This research took place within the larger Kedougou Region, as well as the town of the same name. I utilized ethnographic research methods, specifically participant observation, cultural sensitivity, and interviews. Informants will be broken into 3 groups: community members, health workers, and community leaders. I was able to interview 15 informants between May 23rd, 2017 and August 2nd, 2017. I was able to recruit informants for this research through personal connections with my host and translator, Baba. He aided me in the recruitment of informants and scheduling of interviews. Baba’s role and background will be discussed in Chapter 2.
1.3 Literature

The following section details research on development, the technicalities of neoliberalism, as well as how neoliberalism manifested specifically in Senegal. Discussing the background theories and studies of development and neoliberal practices gives us the lens through which this study was conducted. Studying neoliberalism as seen in Senegal specifically, sets the stage for the effects seen in the Kedougou Region, which I discuss in Chapter 3.

1.3.1 Development

Development organizations spend a lot of time and money to set up health services throughout the world. This money and time is used in vain if the services continue to fail. Even more importantly, continued failure means that areas continue to decline in health, education, economics, etc. For a world that has a plethora of development organizations and claims that development is necessary, it only makes sense to constantly analyze development. A main component of analysis is looking at how the services are perceived in the locations they are being implemented in. Health services are most beneficial when they are utilized and implemented into everyday life of native populations. Health is an important aspect of overall quality of life. Healthier villages will be more successful in other areas of life. Development is multifaceted and health is an important component to achieving overarching goals of development programs. A community cannot improve literacy, food security, life skills, etc. if health remains unaddressed.
Western ideals dominate development health services and many programs and dispensaries lack basic sustainability practices.

Anthropologist James Ferguson tells us that in the discourse, development can be separated into two meanings. The first meaning refers to the process of transition toward a modern, capitalist, industrial economy. The second meaning is defined in terms of quality of life and standard of living and refers to the reduction or amelioration of poverty and material want (Ferguson, 1994). For the purposes of this study, development is distinct from humanitarianism, which is emergency aid during times of immediate life threatening events, such as natural disasters and war. This study will focus on the transition toward a modern economy through structural adjustment programs, which lead into neoliberal policies. Many times the two meanings are conflated by implicitly equating modernization with the elimination of poverty. However, critics insist that the two are separate and often the transition to modern economy is the cause of poverty and not its cure. Often, a rural development project is part of “the expansion of the capitalist mode of production”, which is not good for the poor (Ferguson, 1994). As Ferguson details, administrators tend to remain convinced that everyone would eventually come to their senses, and agree that the decentralized plan was good, even when it was failing (1994). Ferguson also explains that planned interventions can produce unintended outcomes and that some of the most important political effects of an intervention may occur unconsciously, or even behind the backs of the planners (1994). Overall, the goal of development should be to empower the powerless (Ferguson 1994). Although, Ferguson published this book in 1994, many development agencies still attempt to remain apolitical. We can see how emergency humanitarianism does not have the luxury (for lack of a better word) to step into political
situations. Some humanitarian agencies have become more political in hopes of helping people in need from a structural standpoint. Although, the intentions are good, there is the potential for alienation of the people humanitarians are trying to help. Being involved politically can be working with or for the oppressor instead of for the oppressed. Even with these dangers, long-term development cannot hope to succeed if people are unwilling to act on the root causes of suffering.

Colombian-American Anthropologist, Arturo Escobar equates development with neocolonialism. He tells us that development began in the 1940s as a way for America to spread its ideals to the rest of the world (Escobar 1995). Health development is a tool in the endeavor to expand western customs to poorer countries. Escobar discusses how development has achieved a status of certainty and that “Wherever one looked, one found the repetitive and omnipresent reality of development” (Escobar 1995). Development has become a concept accepted as a necessity, without question. In this way, development policies are able to become their own mechanisms of control. Escobar believes that development is another form of imperialism by the West to reassert their moral and cultural superiority. Furthermore, he explained that development was not only a form of colonialism in its failure, but also in its success, because it set the terms for how people in poorer countries can live (Escobar 1995).

Tania Li Murray also discusses development in action by addressing the attempts at improvement by donor-funded initiatives in Indonesia (Murray 2007). Her book demonstrates how the will to improve has a long and troubled history, that it is stubborn and will often survive the misadventures of development. She situates her argument in Foucault’s field of power, which he terms “government”. In this context, Foucault defines government by the attempt to shape
human conduct by calculated means. In development, people with the will to improve, often do not have the common sense to listen to what locals think, want, and need. Instead, these improvers think they know what is best for locals and attempt to reshape their communities through calculated means. Murray thus identifies how these mentalities are enduring continuities from colonial to the present (2007).

In his book *The White Man’s Burden*, William Easterly also focuses on the will to improve and how “planners” of interventions know what’s best. He introduces two world tragedies, the first being the extreme poverty afflicting billions of people and millions of children dying from easily preventable diseases. The second tragedy is the focal point for this book and entails how the West has spent $2.3 trillion on foreign aid over the last five decades yet poverty and death from preventable diseases are still a major issue (Easterly 2007). According to Easterly, aid agencies have been working under a “Big Plan” – asking the big question: “How can the West end poverty for the Rest”. He suggests that instead, agencies should be asking a simpler question: “What can foreign aid do for poor people”. He goes on to explain that aid agencies hire people he considers Planners. They announce good intentions, but Planners do not motivate people to achieve them. Planners raise expectations, but they do not take any responsibility for meeting them. Planners determine what to supply and they apply global blueprints to aid situations. In contrast, Easterly suggests that aid agencies should employ Searchers. Searchers work on a more micro level and find things that work and accept responsibility. Searchers find out what is in demand and they adapt to local conditions. Furthermore, Searchers find out the result – they find out if the customer is satisfied (Easterly 2007). Towards the end of the book, Easterly outlines a six (6)-step action plan for how to aid the
poor. His steps include keeping aid agents accountable for their individual projects, incorporating a reward system for programs that are working, and evaluating projects using feedback from the recipients (Easterly 2007). Easterly’s book, published ten years ago, yet aid agencies and governments remain unaccountable for failing health care services. Health care services are rarely reviewed for sustainability and effectiveness from the perspectives of those receiving the services. My particular research questions involve recipient feedback to a large degree. I think it is more important to incorporate the feedback and perspectives of the recipients than what statistics say or what program developers think. Qualitative research allows researchers to gain lived experience perspectives from informants and is imperative to similar situations. Easterly illustrates in this book, that there continues to be a debate within development studies on the best approach for successful development. While Sachs focuses on economic growth and increased Gross Domestic Product (GDP), Easterly criticizes that concept by explaining a more integrated and complex route to successful development.

In The End of Poverty (2005), Jeffrey Sachs outlines steps to transform impoverished countries into prosperous ones, via economic development by presenting solutions to the economic, political, environmental, and social problems that affect the poorest countries. He expresses the seriousness of the world’s situation by stating that five-sixths of the world’s population is one step above extreme poverty. He then claims that we can envision a world without extreme poverty by 2025 (Sachs 2005). Sachs goes on to address two beliefs that he regards as misconceptions, that the poor are poor because they are lazy or because their governments are corrupt (Sachs 2005). However, as Sachs explains, “Economic growth is rarely uniformly distributed” (Sachs 2005). The inconsistency of economic growth is influenced by
cultural and religious norms in some societies that block the role of women. These norms undermine half the population its potential contribution to the overall development of their country (Sachs 2005). Sachs gives us a five point development plan: agricultural inputs such as sustainable agricultural practices, investments in basic health, investments in education, power, transport, communication services, and we need safe drinking water (Sachs 2005). Although he mentions all five of the above, he spends most of the book discussing the need for investments and how investments will make economic development successful. For example, “…we need a strategy for scaling up the investments that will end poverty” (Sachs 2005) and “Extreme poverty…can be released through targeted investments” (Sachs 2005). The key is to create a global network that reaches from impoverished communities to the centers of power and then back again (Sachs 2005). Sachs makes it a point to mention that “…rich countries do not have to invest enough in the poorest countries to make them rich; they need to invest enough so that these countries can get their foot on the ladder (Sachs 2005). Although, Sachs recognizes the interwoven problems of the world, his view is faulted in the belief that economic development is the solution to ending poverty. His, belief follows that of basic neoliberalism – economic development equals less poverty equals better life for everyone. However, the history of neoliberalism across African illustrates unsustainable health development.
1.3.2 Neoliberalism Across the Continent

Neoliberalism is generally understood as a system of ideas circulated by a network of right-wing intellectuals or as an economic system mutation resulting from crises of profitability in capitalism. Both interpretations prioritize the global North. However, from Southern perspectives, a distinct set of issues about neoliberalism becomes central: the formative role of the state including the military, the expansion of world commodity trade including minerals, agriculture, informality, and the transformation of rural society (Connell & Dado, 2014).

In 1951, economist Milton Friedrich wrote an essay titled “Neo-liberalism and Its Prospects”, stating that there was a need for market competition and privatization of funding for schools, bridges, and roads. He saw neoliberalism (economic liberty) as the safeguard of all freedoms. Market competition protects consumers from exploitation, workers and property owners from employers, and enterprises themselves. Neoliberalism requires two major tasks: “the preservation of freedom to establish enterprises in any field, to enter any profession… and the provision of monetary stability”. The emphasis of Friedrich’s work was on the individual (1951). In this study, neoliberalism represents the method of economic reform based in decentralization and privatization of government services, specifically related to health care systems.

Neoliberalism has consolidated itself in African states by expanding its boundaries from macroeconomic fundamentals into broader concerns of state reconstruction. The full realization of neoliberal social transition relies on expectations about the way societies behave. Reflecting
on historical and structuralist approaches to the way markets have evolved, leads to conclusions of bringing accumulation back in as a way of understanding markets and their development possibilities. Neoliberal approaches often reveal themselves as nothing more than faith statements or convictions about the market-like sociability of African communities (Harrison 2005).

Post WWII saw a wave of state, market, and democratic institutions guaranteeing peace, inclusion, well-being, and stability. This era was also marked by regulation of free trade and postwar economies saw gradual growth. Eventually, however this growth began to falter after the 1960s (Harvey 2007). One of the main tenets of neoliberal economic reforms is to keep state interference minimal. Furthermore, this minimal interference is dressed up as a form of freedom for citizens, because open markets create more freedom (Harvey 2007). Neoliberal changes have placed responsibility on individual people and local communities to improve and manage their own health care. These privatization policies have led to community-based and human resource management techniques in the development sector. Community-based programs are now becoming the norm for many development organizations and projects. Organizations have seen the benefits of conducting community-based programs in measurable behavior changes within communities that enhance success rates of education (Diop and Askew, 2009). Additionally, community-based interaction has contributed to the reduction of malaria in certain communities and has helped workers better reach program objectives (Linn et al., 2015). Whereas research shows the benefits of community-based programs on educating communities and engaging residents, they do not take into consideration the quality of healthcare overall. Malaria rates may
have decreased in the past decade, but health services throughout Africa are still struggling to keep up with the demand for medicines and materials.

A methodology that is becoming used in development programs is human resource management. Although this is a common practice in many business professions, it has not been historically utilized in development. A recurring theme in development literature is that oftentimes development health workers lack certain expertise and necessary skills to run projects. In fact, there are often instances reported that the health workers can and do directly work against the objectives of a project – refusing services and information. Therefore, researchers have begun to advocate for the need of human resource management within development organizations for community workers. This management change would alleviate many issues in projects and bring much needed support to community workers (Raven et al., 2015). However, within the Kedougou Region of Senegal, most health dispensaries are not run through development organizations or the government. Separate villages are tasked with funding the construction of a dispensary, supplying it with materials, staff, and keeping an inventory of medicine. No manner of human resource management helps these villages create and manage successful dispensaries. Knowledge is helpful, but without government support, knowledge can only take these health workers so far.

Political Economy Professor Patrick Bond and colleague George Dor implore us to ask, “In the wake of the devastation wrought in Africa by two decades of ‘neoliberalism’: have matters improved now that the World Bank and International Monetary Fund are permitting countries to improve their state health systems and increase spending” (Bond & Dor 2003)? Neoliberal health sector reform has had implications that were not readily apparent in their
original formulation, yet as Foley states in 2008, health officials and policymakers have yet to address many of these effects (Foley 2008). Patients are paying out of pocket for services that were once free or provided for a nominal charge (Turshen 1999). Villages in rural Senegal are still suffering the consequences of neoliberal reforms. They either cannot afford to pay for health services, or the services are so poor in quality that they do not want to. Medicines quickly run out, especially during malaria season, women still struggle to give birth in a safe environment, the injured and sick must travel far distances for medical care, people are still dying from malaria and yellow fever – preventable diseases. The intentions of health sector reforms may have had good intentions. One study states, “Neoliberalism sought to promote economic growth by an upward redistribution of income and wealth, a greater reliance on the free market, and a downsizing of the state” (Abramovitz & Zelnick 2010). Yet, Foley reminds us that these reforms should be judged by the changes they actually produce, not their intentions (Foley 2010).

Neoliberal economic policies have affected many African countries, and even the United States. Author Mimi Abramovitz and Associate Professor Jennifer Zelnick studied the effects of neoliberal policies on health services in South Africa and the United States. According to their research, since the 1970s, neoliberal health and social policies around the world have shifted from the public to the private sector, reduced benefits to recipients, and affected the lives of clients and workers (Abramovitz & Zelnick 2010). In both countries, agencies and hospitals were left with fewer resources to meet the increasing needs of their patients (Abramovitz & Zelnick 2010). Many countries have actively pursued neoliberal disinvestment in health and social services and as a result undermined the well-being of citizens. The exact health outcomes and consequences to specific households should not be used to generalize the effects of
neoliberalism. However, the effects of neoliberalism can be applied to many areas in the world. It only takes a little digging to see what the lived realities are of people within a certain area, study their current health services, and trace back the history of those services.

Even with the utilization of community-based methodology or human resource management, these two practices cannot benefit all health development, especially as separate and mutually exclusive entities. Governments and development organizations should consider a more holistic approach to improving development management. Indeed, development in certain circumstances can breed contempt as Nanne et al discuss. When programs are initiated by external organizations and then transitioned to community workers, projects ultimately fail due to poor transition (2015). This is the case with some of the dispensaries in this study. Some were funded through missionaries, development organizations, or politically associated donations. However, the initial funding was just that, initial. The funding bought supplies for constructing the dispensary and supplying it with materials and medicine. However, it did not cover future needs or salaries for health workers. Sarah Michael identifies a range of strategies available to local NGOs to increase their influence and power in her book *African Issues, Undermining Development* (2004). It offers advice to governments and development agencies on how to refocus their work to encourage the growth of vibrant NGOs in Africa. According to Michael, Senegal’s relative political stability lies within the strength of the relationship between religious elites and government officials. Islamic social structures replace development structures in many areas because these Islamic brotherhoods wield considerable influence and are the key force in Senegal’s social, economic, and political processes (Michael 2004). Michael further assesses that the disengagement of the state from many development sectors has been a driving force behind
the growth of local NGOs (Michael 2004). However, Senegalese NGOs have continued to be unable to gain substantial power. They do exhibit the ability to refuse donor funds, enjoy strong relationships with the government and generate antennae organizations, but they still lack space, financial independence, and links to the international development communities while their counterparts in other parts of the developing world do not (Michael 2004). Local NGOs play a unique role in development.

1.3.3. **Brief Social History of Senegal**

In pre-colonial Senegal, the social system was hierarchical and divided into three endogamous classes:

1. Freeborn - nobility and peasant cultivators
2. Caste-presons - occupational artisans
3. Slaves

Interestingly, Wolof had a double descent system with property being transferred both patrilineally and matrilineally. Senegal’s economy was more self-sustaining than market-based, however some trade did exist. The basic unit of economic organization was the household headed by the master of the house. Several households formed a village and most villagers were farmers who cultivated food crops at a subsistence level of production. Political power was hierarchical and decentralized with four types of titleholders who exercised political power. These groups included members of the royal family, some of whom help territorial commands, territorial chiefs who inherited their positions, representatives of castes and minorities, and direct
agents of the ruler. The head of state was the king who inherited his position through patrilineal descent. The king focused on domestic and foreign policy, led the country in times of war, and judged important cases brought to his attention. Nobles with territorial commands administered their respective territories autonomously, appointing chiefs and collecting taxes. A percentage of crop production was given to the area chief and then passed up the line to the territorial leaders and ultimately, the king. Initially, the French came to Senegal to establish trade posts throughout the country, not for colonization. The French traded with the Senegalese for gum, cattle, and slaves. However, the French divided the country into five cantons after France’s changing attitude to empire was supported by a technological superiority which gave it clear military advantage over African armies. Ultimately, French imperialism engulfed the Senegalese independent states one by one (Eunice, 1977).

1.3.4. Neoliberalism in Senegal

Not only did economic development predate the advent of colonialism in many instances, but also that the African territories thereafter underwent relatively little political change and economic development and that the policies and practices of the metropolitan powers tended to intensify dependency, while engendering structural underdevelopment. Throughout the 60 years of French rule, Senegal underwent relatively little political modernization and economic development. Colonial practices and policies intensified the country’s political and economic dependency, while fostering structural underdevelopment. From 1885-1945 there was no significant degree of political modernization. There was no transfer to the colony of democratic
representative political institutions, such that existed in France. There was a small African participation in politics, namely from the four main metropolitan areas. Rural masses remained isolated from the mainstream political arena. French colonial policies and institutions tended to create new forms of political dependency between France and Senegal rather than contribute to the modernization of Senegal’s African societies along western lines (Gellar 1976).

Senegalese elites helped to redefine neoliberalism through the use of African nationalism and structural adjustment. As governments proved incapable of addressing economic woes, elites grew increasingly willing to import policies from powerful nations and neighboring countries. In a way, neoliberalism was exported from developed countries and imported to developing countries. The collapse of socialism left many leaders searching for an alternative and international finance institutions took advantage. Economic policies began to incorporate fewer African nationalist ideals, but the failure of structural adjustment continued to deter elites from fully embracing neoliberalism.

While a variety of factors caused countries across the African continent to model neoliberal policy, not all leaders supported this transition. The decline in quality of life and fear for the future of their nations was shared among citizens and some leadership. For example, Leopold Sedar Senghar was elected Senegal’s first president in 1960 and was considered a moderate socialist who favored maintaining close ties with France and the western world. (Given 1964).

As president, Senghor focused mainly on foreign relations, whereas country development was left to his prime minister, Mamadou Dia. Senghor was the first Afican leader to received Peace Corps volunteers, and he was said to teach his people democracy and nurture political
opposition (The Economist). Senghor went on to win five presidential terms. He is known for creating a performing education system, Senegalese currency remaining fixed by France, French remaining the language of learning and ruling with French advisors (African Bureau, 1960). In 1982, Senghor co-founded Association France, whose objective was to bring attention to the problems of developing countries (Hakim, 2003). Throughout his presidency, Senghor focused on a middle ground between capitalism and socialism. He was quoted stating “…the disadvantage of the capitalist system is that it gives too much importance to the private sector and the disadvantage of the communist societies is that they nationalize everything lock, stock, and barrel” and that he would continue a “middle course between out and out capitalism and socialism” (Dash 1980).

Mamadou Dia was the first Senegalese prime minister and considered a radical socialist. He often clashed with President Senghor and was eventually arrested for an attempted coup d'état. Dia advocated for the poor to form cooperatives for political representation and he took control of the economy with radical ideas. His ideas offended many of the vested interests of the elites and also snubbed the French who supported the more casual approach toward socialism (famouspeople).

Thomas Sankara, “Africa’s Che Guevara”, was president of Burkina Faso from 1983-1987 (Bonkougou). He was anti-imperialist and eschewed all foreign aid. He pushed for debt reduction and nationalizing all land and mineral wealth, averting the power and influence of the IMF and World Bank powers (Omar). He focused domestic policies on preventing famine, nationwide literacy, and vaccinations. Sankara ordered every village to build a medical dispensary and education center with their own labor (California News). He further increased
authoritarian control over the country by banning unions, free press, and prosecuting corrupt officials, alleged counter-revolutionaries, and lazy workers (California News). Sankara remained an icon to many of Africa’s poor, but his policies alienated and antagonized the vested interests of several groups, which included the powerful middle class, tribunal leaders, France, and the Ivory Coast (BBC News).

The leadership and careers of these men point to a Senegal that was resistant to neoliberal policy, despite international economic pressure. It is important to name these men, not only for historical accuracy in our perceptions of the transition to neoliberal government structures, but also to interrupt a dangerous narrative. Often, when talking about external pressures and influences in the Global South and specifically the African continent, it paints a picture of a downtrodden and defenseless people who did nothing to stop the progress of international economic machines. Again, not only is that inaccurate, but it is also a very disempowering story. When we discuss the power of global economic institutions and their influence on society, it is not helpful to pretend they operate without resistance.

Prior to the economic recession of the 1970s, African elites focused on nation-building with development as the central component while socialist and capitalist countries continued to divide the continent. Leaders shared a commitment to the nationalist project, but the debt crisis offered international finance institutions an entry point into the micromanagement of African states. The debt crises led to “bourgeoisie aspirations” (Adesina), leading development into a framework of foreign investment, private sector vitality, and trade liberalization (Hedin, 2007).

Senegal has been marked by profound social inequalities, even prior to neoliberalism. These inequalities were institutionalized in the pre-colonial era in societies that were highly
stratified by social order. French conquest coincided with the rise of religious elites and an almost complete expansion of Islam, which resulted in further social disparities among the urban and rural residents (Foley, 2010). However, the religious elites were no match for the French expansionists, French commercial foothold, and French military strength (Foley, 2010). 1960 saw Senegal’s declaration of independence from France (Foley, 2010), but economic stagnation resulted due in part by the ruling class’ lack of political leadership, as well as lack of a vision for the country in the face of neoliberalism (Foley, 2010). Continued economic stagnation throughout the 1970s resulted in Senegal taking on high levels of debt in the name of state-led development. The state was attempting to promote growth, diversify their economic strategies, and provide greater food security. The foreign debt was further aggravated when global market prices dropped for peanuts and phosphate. Additionally, rice production was not enough to alleviate the need for food imports. As a result, state-led development projects lost momentum (Foley, 2010).

Prior to the debt crises in the 1980s, Senegal was portrayed as a paternalistic caretaker of its citizens. Now, the state stresses partnership with the citizens, in which citizens must ‘do their part’. This change includes consultation fees, community management structures, and the process of decentralization (Foley 2009). This type of rhetoric is something that is central to the social narrative of neoliberalism. In contrast to a collectivist mentality of community support, neoliberal ideology again promotes a free market solution. Individuals are supposed to be able to lean into the free market in order to access the abundance of resources available. Similar to a “pull yourself up by your bootstraps” mentality, if you contribute to the system it will care for
you. This emphasis on personal responsibility to stay financially stable and maintain your connection to the wealth of the markets is reflected in a much larger way through policy.

Neoliberal policy on social services asserts that any service provided by the government can be, and should be, provided in a more efficient and high quality manner through the private sector. If it is the individual’s responsibility to participate in the markets in order to meet their basic needs, it follows that it is the market’s responsibility to provide them. Providing these services, like health care, for a profitable price is supposed to ensure quality and accessibility. I assert that this has not been the case with neoliberalism in Senegal.

According to Foley’s research, decentralization has had a larger impact on the health sector than any other reform of the previous decade (Foley 2010). Decentralization and privatization as a result of structural adjustment policies. Most health reforms have been grounded in frameworks that emphasize cost-effectiveness, but these intentions still result in avoidable health inequities (Foley 2010). There has been a shift from “health for all” to user fees. In 1978, Senegal designed a strategy for primary health care to achieve health for all by the year 2000. This strategy was designed to provide equitable access to health services and emphasized community participation. It involved low-cost medicine and treatment at dispensaries (Foley 2010). Primary health care recognizes socio-economic determinants to health and treats health services as a basic right that should be provided by the government. This basic right to health has been replaced by market-based pharmaceutical and medical service sales. Healthcare costs have been shifted from nation-states to citizens, including vulnerable populations. Citizens are now responsible for contributing to the management of their neighborhood health facilities (Foley
2010). These changes do not take into consideration other issues affected health outcomes and access to health services.

By the 1980s, Senegal was experiencing conditional bail-outs by the International Monetary Fund (IMF), which resulted in neoliberal reforms that have also become common throughout the world. These neoliberal reforms included policies on deregulation, privatization of state industries, and liberalization of trade regulations (Foley, 2010). Foley explains that, “the implementation of structural adjustment programs in the 1980s and 1990s brought an end to decades of ineffective economic policy and highly centralized government, yet the short and long term returns on economic austerity have proved elusive” (Foley, 2010). We will explore these effects throughout this paper. In 1985, Robert Hall conducted a study on village health care, in which he discusses issues of financing. He states, “…the health sector budget is woefully inadequate…” despite formal recognition from the state of the importance of health care (Hall 1985). The Ministry of Health was unable to maintain its share of funding during Hall’s study, and thirty years later that is still the case. Hall also reported that health workers in rural areas were struggling to keep up stocks of medicine and would remain depleted for most of the year (Hall 1985), which is still a complaint that I myself heard. The underprivileged populations bare the brunt of structural adjustment programs, because they are the most distanced from policymakers and are often unable to oppose new policies (Kanji 1989). Increasing the prices of subsidized commodities and decreasing government services hurts those with the fewest resources most. Structural adjustment has served as a platform for an ambitious form of political monopoly through the importation into new states of practices, routines, and mentality of the colonial state. Structural adjustment was one of the main economic platforms that inspired
neoliberal reforms. Structural adjustment policies focused on decentralizing and privatizing social service programs and departments in an effort to relieve monetary stress on the government. The monetary stress on the government was a result of massive debt from international loans. Adjustment policies were pushed by international finance organizations onto African governments as an incentive. The incentive was the ability to pay back their international debts. This pressure can be seen as a form of neocolonialism, with Western powers dictating foreign economies by over loaning massive amounts of money and then forcing countries to focus on repayment instead of development. The colonial state legacy decanted into autocracy, which then decayed into crisis by the 1980s, bringing external and internal pressures for economic and political reconfiguration.

Serious erosion of stateness in many African politics by the 1990s limited the scope for effective reform and opened the door for a complex web of novel civil conflicts (Young 2004). Structural adjustment in Ghana and Senegal helped create an improved framework for economic growth. However, it is a fragile trend that can be disrupted by bad weather, adverse terms of trade, and vagaries of international assistance. Weak performance on equity issues and rising political

![Figure 3: A list of The Bamako Initiative Principles. Sourced from Ridde Valery 2011](image-url)
expectations generated threats to sustainable structural adjustment and overall political stability. Thus, the current version has done little to alleviate poverty (Weissman 1990). Analysis of adjustment loans often overlooks their repetition to the same country, which changes the nature of the selection problem. None of the top 20 recipients of repeated adjustment lending over 1980 - 1999 were able to achieve the reasonable growth (Easterly 2005).

The late 1970s and early 1980s saw a deceleration of growth in industrialized countries, which led to an increase in the number of countries undertaking economic adjustment programs. This led to The Bamako Initiative in 1987, a good example of how structural adjustment policies were implemented. The Initiative was proposed as a joint effort of the World Health Organization (WHO), UNICEF, African Development Bank, and The World Bank. The goal of the initiative was to provide $180 million USD to subSaharan Africa from 1989-1991. This money would provide funds for the initial launching or development costs of primary health services. Costs covered by the fund included basic equipment, provision of a limited number of basic medicine during the 1989-1991 period, and support costs for supervision, training, and social mobilization. Adjustment programs such as The Bamako Initiative aim to reduce imbalances in the economy by cutting down on expenditures by governments and households (Kanji 1989). However, as we have seen through the literature and my current research, households often end up paying hiring prices for food and services. These policies affect the health sector through service reduction and less money for drugs, supervision, and fuel, and fees for services are either raised or introduced in areas where they previously did not exist. The Bamako Initiative was designed to introduce drug and treatment charges to set up a revolving drug fund to finance medicine, operational costs, and salaries of community health workers
Unfortunately, the plan of the Initiative and the result were two different realities. As we can see from Kanji’s work and others, including this specific paper, there is a question of feasibility of implementing equitable fee systems. According to my informants, the current fee systems are not equitable and do not cover the costs of health dispensaries as they are meant to.

Decentralization meant that urban mayors and rural council presidents were given the right to manage their own budgets. Furthermore, the state focused on empowering citizens to take responsibility for their health and it remains the official state and NGO discourse today (Foley 2010). The state rarely disburses enough money to allow these local governments to carry out their roles effectively. Foley quotes Gellar (1995) who states, “even decisions about decentralization have been centralized” (Foley, 2010). The rise of neoliberalism created a vacuum of political vision, which resulted in an all but abandonment of state-led development. Leys (1996) is quoted as saying, “…in the neoliberal era, the only possible development strategy, is to not have one”. Neoliberal policies charge national governments with opening their borders to global capitalism and creating attractions for foreign investment (Foley, 2010). By the end of the 1990s, poverty had worsened, health infrastructure was failing, children had difficulty attending school, and households were sacrificing spending on health and education to ensure basic necessities and survival (Foley, 2010). The significant changes during this neoliberal era, greatly affected the health sector via cost-recovery strategies and a departure from free medical care (Foley, 2010). By lending money to states for privatization of health services, financial institutions were also forcing countries to increase exports that repay loans, which has resulted in a trend to use charities and aid agencies to deliver health services. Governments cannot afford to offer health and social services that they once did, and therefore it is up to aid agencies and
charities (Turshen 1999) (meaning no standard operating procedures for neighborhood dispensaries and no worker representation).

Instead of flowing through the Ministry of Health, funds now flow through local and regional channels. Officials at the local and regional levels have a general misunderstanding about new laws, lack of institutional capacity, and lack the resources to make these new responsibilities feasible (Foley 2010). These local and regional leaders are now tasked with including health costs in their annual budgets and medical personnel have become essentially financial managers. Furthermore, personnel and health committees are now expected to establish priorities for investing revenues to meet their community’s health needs. By using medicine sales and user fees, the government is relieved from having to fully subsidize health care, because they expect these minimal funds to cover a significant portion of dispensary operating costs (Foley 2010). Patients report user fees as being either too expensive for them to pay or the quality of the services provided is so poor that they do not want to pay (Foley 2010). The state places an obligation on the individual to take charge of their own health, yet does not help provide adequate resources for them to do so.

In the Senegalese health system, primary care is available at rural health huts and dispensaries for a fee. Patients can purchase generic medicines in these facilities as well. In rural areas, even modest fees can present a significant challenge, which often leads to people delaying seeking care. Services available at these dispensaries are quite limited and patients are often referred to a larger facility (Foley 2009) with more resources and which is further away and more difficult to travel to. User fees are still a main area of concern for citizens (Bond & Dor 2003), as I discovered during fieldwork in Senegal in 2017. A direct impact of neoliberal policies has been
disincentives for citizens to seek health services. Bond & Dor report this impact through lower utilization rates in neighborhood dispensaries and declines in the perceived cost and quality of services offered (2003). The main theme discussed during interviews I conducted in rural Senegal in the summer of 2017, was money. My informants expressed the difficulties they face with paying use fees, buying medicines, traveling to medical huts, as well as the dispensaries’ difficulties keeping medicine in stock, replacing materials, and paying workers. Health sector reforms in Senegal have lead to significant changes in how health services are financed (Foley 2008), which has a direct effect on citizens’ ability to access services.

People are struggling on the edge of survival, where just one poor harvest or an additional charge at a health center can have disastrous consequences (Kim et. al 2002). There are discrepancies between lived realities of sickness and death and the ideology of health participation envisioned by the state. These neoliberal economic policies dramatically affect susceptibility to disease and health-seeking behavior (Foley 2008). At the heart of neoliberalism is the perceived relationship between economic growth and quality of life. “The idea that robust economic growth will automatically lead to a better life for everybody is comforting. Unfortunately, it is also wrong” (Kim et. al. 2002). According to Kim et. al. in the late 1990s there were more than 1.6 billion people worse off economically what in the late 1980s. They conclude that the challenge is to make improved health a central goal in the planning, execution, and evaluation of economic and social policy (Kim et. al. 2002). The latest published research on the effects of neoliberalism on the health sector is from 2010. Seven years and Senegal is still utilizing a decentralized, market-based model for their neighborhood health dispensaries. Although, the state is being relieved of a financial burden by placing responsibility on the
citizens, the dispensaries are failing and the citizens are suffering. Suffering citizens do not a
great nation, make.

My own research follows the story of local dispensaries in various villages within the
Kedougou Region of southeastern Senegal. Interviewing patients, health workers, and village
leaders brought to light the issues facing not only the villagers but also the dispensaries
themselves. The neoliberal reforms have resulted in a lack of resources throughout the rural
areas. People reported poor quality of services within the town of Kedougou, where the main
hospital is, as well as the high entrance fee 1000 CFA\(^1\), approximately $1.88 USD. Due to the
privatization of health services, people with money can just come to a village, build a health
facility, and name their price for entrance and medicine. If people can pay for the services, great;
but if they cannot, it does not seem to matter. I visited approximately seven different villages
with health dispensaries. None of these dispensaries were associated with one another or a single
organization. Each dispensary was built either by missionaries, a wealthy individual, or the
village pooled money. As a result, the dispensary workers have no salaries, so they are left
juggling health work with farming; most cannot afford electricity and running water, which are
essentials for proper health care; none can provide beyond the basics of first aid, malaria testing
and medicine, as well as cold and stomach medicines. Every single one of my informants
expressed these issues and stressed how they feel the government does not care about its citizens.
The next section will cover the history of health discourse in Senegal and bring us up to speed on
the current situation regarding health.

\(^1\) 1000 CFA is the equivalent of $1.88 USD. The conversion rate is 1 CFA = $0.00188467 USD.
https://www.xe.com/currencyconverter/convert/?Amount=1000&From=XOF&To=USD
1.3.5. Health Discourse in Senegal

Established literature brings the relationship between international economic order of “capitalism without border” and population health. It focuses on the observation and analysis of how political factors relate to public health. Two interconnected hegemonic phenomena, neoliberalism and globalization are adversely affecting the human development of our population. Neoliberalism can be defined as the assault on the post-war consensus that serves as the ideology and practice of the determinant classes of the developed and developing worlds alike. There are visible consequences, market deregulation, and state retrenchment, coexist with the internationalization of economic activities. There should be observation and analysis of how political factors relate to public health. Political determinants of health need to be understood and acted upon (Navarro 2007).

How people view health and illness is important when trying to understand what they look for in health services. I was told a story about health discourse in a village of the Kedougou Region that really stuck with me. I was interviewing a Maribou (traditional medicine man) and I asked him how people in his village think of health and illness. He told me a story about a man who had come to him for a blessing. The man had been out in the woods and had come across a particular bird known as a harbinger of bad luck. Recognizing the bird as a sign of ill will, whether it manifest itself in illness or bad crop, the man sought out the Maribou. The Maribou’s job is to consult with patients on what it causes their distress, bad luck birds, curses from enemies, malaria, a broken bone, etc. After the consultation, the Maribou uses his knowledge of the Quran and commences with his cleansing ritual, which can take various forms. From this
story, we learn that traditional beliefs about health and illness still permeate the rural areas, such as the Kedougou Region. These beliefs result in varied ways in which citizens consider different health services.

Going back to colonial Senegal, Professor of African History, Myron Echenberg examines the social, political, and medical context of a recurring epidemic of bubonic plague. The author organizes the book around four main themes. The first theme examines how French colonial authorities constructed the plague epidemic. The second theme contrasts French with Senegalese responses to the challenge of devastating epidemic disease. The third theme touches on the urban residential policies and how infectious disease affected these policies. Finally, the fourth theme discusses the changing disease ecology of Senegal (Echenberg 2002). During the construction of the epidemic plague, scapegoating substituted structural change as French officials imposed control measures in an authoritarian manner with no appreciation for local environmental or empirical knowledge. The postcolonial state in Senegal resembles colonial times with its continued attitude toward the poor [scapegoats] and public health (Echenberg 2002). This book presents an interesting theory on how French colonials constructed the epidemic and health knowledge in Senegal. Those who control knowledge have the power and those in power are the ones who control knowledge.

Therefore, health literacy and policies are controlled by an institutionalized construction of what disease is, what causes it, who causes it, and what can be done to stop it. Considering
that this research surrounds the perspectives on health, this book provides important insight into the construction the health discourse throughout Senegal’s colonization. Most importantly, Echenberg states that postcolonial Senegal still resembles the past with continued practice of scapegoating the poor for the spread of disease and the general attitude toward public health. I saw this through my fieldwork and the emphasis on individuals to be responsible for their own health and healthcare, which resulted from neoliberal practices.

Similarly, to Echenberg, Kalala Ngalamulume, an Associate Professor at Bryn Mawr College, focuses on the history of health and disease discourse in colonial Senegal. Ngalamulme’s book analyzes experiences with sanitation and epidemics in the second half of the nineteenth century and in early twentieth in Saint Louis, Senegal (Ngalamulume 2012). He outlines five dominant themes throughout the book. The first theme surrounds the ways in which the French public health authorities constructed medical knowledge. The second theme discusses the link between the emergence of Senegal’s hot climate cliché and the increasing role of the physicians within the colonial administration. The third theme examines the stigmatization of urban poor. The fourth theme relates to the responses of various parts of urban populations to the sanitary and medical measures during this crisis. The fifth theme deals with urban residential segregation policies that were used as permanent solutions to the ‘native problem’ associated with the spread of disease. One of the author’s main arguments is that the outbreaks of disease gave way to fear and suspicion, stigmatization of the indigenous, and the adoption of drastic sanitary measures. All of these things lead to conflict between the interests of competing conceptions of public health and interests of commerce, civil liberties, and popular culture (Ngalamulume 2012).
Officials tended to use scapegoats to explain the spread of disease, blaming the sufferer’s cultural and religious practices instead of trying to understand how biological and social aspects can affect disease. The perceptions of societies, cultures, and environments in Africa influenced epidemics and diseases were categorizes as “White man’s disease” and “Black man’s disease” (Ngalamulume 2012). Health ordinances reflected the divide between sanitary citizens who obeyed the law and unsanitary subjects whose lifestyle, risky behaviors, economic activities, and social practices were contributing factors of disease. These unsanitary subjects were a threat against all of Senegal. In this way, the municipal ordinances were a direct assault on social and cultural norms, as well as the religious practices of the urban poor (Ngalamulume 2012). Being aware of the underlying opinions and “knowledge” on health and illness is critical to the findings of this research. Underlying opinions shape how people view their susceptibility and risk of illness, which dictates when and how they seek medical care.

Even with governmental and colonial attempts at health knowledge control Foley states that biomedicine in Senegal continues to coexist alongside many other types of medical knowledge and the various religious practices provide additional frameworks for addressing health (Foley 2010). According to her take on Fassin’s research, Senegalese people make use of multiple therapies when it comes to health and illness (Foley 2010). The Senegalese identify what illnesses to treat with modern medicine and those that require a more traditional type of medicine (Foley 2010). This diverse medical knowledge and practices makes boundaries between the traditions very fluid. Even the broad category of Wolof medicine has integrations from Islamic practices (Foley 2010). However, Foley does note that while some biomedical illnesses have gained much attention, there continues to be a lack of seriousness given to other
endemic diseases, such as malaria (Foley 2010). In many areas, there is little medical plurality and when there is some, it is oftentimes viewed negatively.

Development agencies tend to disregard indigenous medicine in many areas of the world. “This works for us, we know what we are doing, so you should do it too” is a mentality that echoes through the history of health development efforts. However, Foley illustrates that this is not the case for Senegal. Senegal seems to utilize a diverse array of medical practices. The people of the Kedougou Region specifically still utilize basic traditional methods, much like the old wives tales some people in America practice. However, no matter the ethnic or religious affiliation of my informants, they all explained the importance and usefulness of the village dispensaries. Below I have provided some general observations and interview results from my time in the field. This data provides a close up of my own experiences with health services in the Kedougou Region and my informants’ experiences with traditional and modern medicine.

1.4. Conclusion

As we saw in the previous sections, neoliberal economic reforms can trickle down to the health sector and affect population health. We will soon look at a specific village dispensary, once a large state-of-the-art hospital, and how economic reforms affect that particular community even thirty years later.
1.4.1 The Role of Anthropology

Anthropology has a lot to offer global health development. Social Anthropologist David Mosse uses the power of ethnographic method to illustrate the necessity and value of anthropological engagement with development. He does this through analyzing a 1990s British aid program in rural India, using his particular anthropological perspective. He shows the complex relationship between policy and practice and shows the fragmented and complex relationship of policymakers, agencies, and the community. He presses the audience to consider now whether development works, but how development works and suggests that instead of policy producing practice, practice should possibly produce policy (Mosse 2004). This paper uses anthropological perspective and ethnographic method to illustrate how the policies of neoliberal economic reforms produced poorly managed health dispensaries in the Kedougou Region of southeastern Senegal.

Medical Anthropologists Craig Janes and Kitty Corbett suggest four key contributions: ethnographic studies of health in political and economic contexts, analyses of the impact of science and technology on the local level, interrogation, analysis, and critique of international health programs and policies, and analyses of the health consequences resulting from social relations in international health development (Janes & Corbett 2009). Janes further emphasizes the need for medical anthropology to innovate conceptual and methodological tools to combat the consequences of global neoliberal health reforms (Janes 2004). However, as anthropologists, we also must consider the ethics of our information exchange between ourselves and our informants. Regarding global health services, we have to question if our work is contributing to
social justice and the remediation of violence, or if we are simply practicing a new form of colonialism: extending uses of sites in the global south to study disease burdens in order to satisfy the needs of science and academia (Janes & Corbett 2009). Anthropology has the methodology and vision to create partnerships with our informants, to help promote and engage potential solutions.

Professors Katy Gardner and David Lewis focus on the relationship between anthropology and development. They use case studies to explore the issues and problems of development and how anthropology can impact the discourse. Most importantly, one of the central understandings of anthropology is that cultural and social organization does not exist inside a vacuum; it is determined by and in turn determines specific political and economic contexts (Gardner & Lewis 1996). The authors provide three themes of anthropology development: the social and cultural effects of economic change, the social and cultural effects of development projects, and the internal workings and discourses of the ‘aid industry’. They also suggest that it can be used to challenge development’s key assumptions and representations. This challenge helps work towards constructive change and provide alternative ways of seeing the foundation of developmental thought” (Gardner & Lewis 1996). Anthropology can have these impacts by realizing that development discourse is no unchangeable and it can change development from within. There are various ways that anthropologists can help reorient development in order to transform it into a “post-development discourse” (Gardner & Lewis 1996). Anthropology offers a continuous questioning of development processes, assumptions, and agencies (Gardner & Lewis 1996). The authors then discuss the role of community development as it has a tendency to become largely cosmetic when excluding active community
participation in the planning stages of projects. Without strengthening local communities and encouraging people to take an active role in projects, strategies for improvement will fail (Gardner & Lewis 1996). However, the authors point out a final note to the reader, “Ultimately, for the quality of people’s lives in poorer countries to improve, global conditions must change” (Gardner & Lewis 1996). I went to Senegal, I saw the struggles of the local dispensaries, and I questioned why there was not a formal management system. Through this research, I now know the answer – it is due to the decentralization of the government and privatization of health services throughout the nation.

Looking back at research done in the 80s, 90s, and 00s shows that the same issues have been reported on throughout the years. Yet, it is 2017 and I saw these issues with my own eyes, I listened to the stories of the people dealing with these issues. The realization that these are the same problems people faced in the 1980s, 1990s, etc. and yet nothing has been done to change them, further fuels my desire to work within international health development. The following chapters detail the methods used throughout this study and specific effects within the Kedougou Region of past neoliberal reforms.
CHAPTER 2. THE METHODS

The most entertaining patient/doctor interaction I was privileged enough to observe was after an interview with a village dispensary manager. The patient in question was a young boy, probably around 8-10 years old and he apparently had a rock in his ear. The first question was, “how did the rock get into your ear?” The answer: he put it in there himself. At this point there’s a handful of people around, the boy patient, his two older friend (perhaps brothers), myself, my translator, my additional guide, the doctor, and another gentlemen. So, here this young boy sits in the middle of us all, with a rock in his ear, and us laughing about it. Poor kid.

(Field Work Journal – Samantha Salter)

2.1 Introduction

I went to the Kedougou Region from May 24, 2017 until July 31, 2017, living with a local family in the town of Kedougou. My host, Baba was also my translator and he travelled with me to individual homes, villages, and health dispensaries to conduct interviews and observations of the perspectives of modern medicine. Initially, my research was focused on how modern health programs impacted traditional rituals in Senegal. I was looking to answer questions related to how traditional practitioners viewed modern medicine, how locals determined whether to use traditional or modern medicine, and how health program workers implemented programs in different locations. My main goal was to illustrate the importance of acknowledging differences in cultural realities when developing and implementing health development. I came into this study with the assumption that at least one person in this area would have a negative perception of modern medicine and feel that modern medicine had pushed out important traditional methods. My assumption came from research I had read prior to going into the field. Some of the research discussed the failings of health programs and how organizations needed to accept different cultural realities in order for the programs to be
success. I wanted to emphasize the importance of incorporating culture into health
development in order to preserve traditional aspects important to indigenous populations.

However, as I was conducting my fieldwork, it became apparent to me that my
informants were not concerned about my perceived conflict between traditional and modern
medicine. For my informants, they felt that in many ways, traditional and modern medicine work
together to improve health. They did mention that traditional methods are used less today than in
the past, however they were not perturbed by that fact. Furthermore, my focus on health
programs was unfruitful. My informants wanted to talk about the dispensaries and access to
medical care and were unable to provide any insights into health programs in the area. Because
of this realization, I adjusted my interviews to include questions about local dispensaries, the
good, the bad, what could be improved upon, and what obstacles people faced when seeking
medical care. This change was not necessarily a situation for which I was prepared for, but I
quickly learned that methodology could change between its conception and reality.

Therefore, instead of working with a specific organization to study how they plan and
implement health programs, I switched my focus to independent dispensaries in surrounding
villages. My new research questions revolved around how local village dispensaries were
managed and how they affected the lives of the workers and patients. I still utilized participant
observation and in person interviews for my new research questions. Through this
methodological change, I was able to focus on what my informants’ perspectives were with
regard to village dispensaries, which lead me to analyzing neoliberal economic effects within the
Kedougou Region.
2.1.1 Background Data on Senegalese Healthcare

In 1985, Robert Hall conducted a study on health services in Senegal during the late 70s. According to Hall’s study, rural areas (such as Kedougou) are characterized by inadequate facilities, insufficient medical staff, shortages of medicine, and severe sanitation issues (Hall 1985). For example, Hall provides statistics on the serious issue of staffing; in 1977, there were a recorded 334 physicians in Senegal and of that 334, 162 of them were foreign. Additionally, the staffing issues escalate further from the urban centers. Secondary health posts are supposed to have a state nurse, sanitationist, orderly, midwife, and assistant, however that is rarely the case (Hall 1985). Official reports provide a general picture of the health throughout Senegal. Illnesses linked to malnutrition, parasitic diseases such as malaria, gastro-intestinal diseases, and tuberculosis are among the main causes of death in the nation. Unfortunately, there are few reliable epidemiological studies due to limited health services, especially in rural areas (Hall 1985).

Health service financing can help explain the lack of health services for rural areas. In 1976, 44% of the health service budget went to urban-based health services. Of the overall national budget, health services constituted only 6% in 1978/79 (Hall 1985). Few rural health posts have electricity or running water, necessities for living a healthy life and providing key medical services. Hall states that, “The national health care infrastructure is largely incapable of meeting the current, and future health needs of the population” (Hall 1985). He said this in 1985, based on statistics from the 1970s and his statement is still applicable today. Currently, the health coverage in Kedougou estimates two physicians per a population of 75,000. The national
Senegal average is one physician per 13,000 residents. Compare this to the WHO standard of one physician per 3,000 residents (Actionaid). With so few physicians throughout Senegal, and most stationed in urban centers, rural areas such as Kedougou suffer greatly.

2.1.2 Reflexivity Statement

Prior to travelling to Senegal, Jill told the graduate students about a specific handshake that we should be aware of. This handshake involved using your right hand to shake normally, but you bring your left hand perpendicular to your right and place it on your right foreman. The significance of the handshake is respect for those in higher social status, such as mayors and respected businessmen. Due to its honorable meaning, it will henceforth be referred to as The Handshake, to emphasize its importance. My second day in Kedougou began with a strategic meeting with Baba to discuss my research plans and interview protocols. This meeting would set the tone for the remainder of my fieldwork, in more ways than one. The following is an excerpt from our conversation.

Baba: “So, you are the chief’s daughter?”
Me: “What?”
Baba: “The chief of the school, he is your father?”
Me: “No, what do you mean?”
Baba: “Jill said you are the chief’s daughter.”
Me: “OH! You mean the President of the university. No, he is not my father, I just know him.”

This perception followed me throughout my fieldwork and that combined with Baba’s social status resulted in an interesting dynamic. When Baba introduced me to his colleagues, friends, and my informants, I would often receive the honor of The Handshake. It was a surreal
experience considering women hardly ever receive The Handshake, usually reserved for officials' wives.

My position as a white American researcher lead me to enter this research with the assumption that health services are not what they should be. I already had a negative bias on current health development and I know that ended up framing what questions I asked and my reactions to answers. I did attempt to make questions reveal both positives and negatives instead of just asking what the negatives were. Originally, my focus was to find information to support my theory that traditional rituals were being replaced with modern medicine and that was a bad thing. However, I soon discovered this was not the case at all. People did not consider the declining use of traditional methods to be negative, just a part of their lives and their journey to having healthy families. So, right off the bat my negative theory was proven incorrect for this particular region and I had to figure out what to focus on moving forward.

At this point, I continued to interview my participants and I let their answers lead me to a new focus – unsustainable development due to lack of financial resources as a result of neoliberal reforms. I spent the majority of my time in the field being angry and frustrated about what these villages were experiencing. I used that frustration to fuel the research, to seek more informants, visit more dispensaries, and look for ways to improve current health services. There were also times when I felt hopeless and guilty for not being able to physically and immediately help my participants and their villages. It was very difficult at times to remain impartial during interviews. But, at the end of it all, I think that my emotional reactions were what fueled my passion for this topic. I already knew I wanted to work within health development, but seeing these situations in person just reconfirms my goals for the future.
As for future research possibilities, I would suggest a better government representation by interviewing government officials and health workers. I also suggest research archival government data focused on health sector budgeting and resources. Furthermore, a working knowledge of several local languages in the Kedougou Region would help mitigate and loss of information/meaning during interviews.

2.2 The Study Design

2.2.1 The Study Approach

Qualitative studies are interested in physical events and behavior taking place, how participants make sense of those events and behavior, and how their understanding influences behavior. My initial approach to this study was to utilize ethnographic research methods. Ethnographic research uses culture as the theoretical framework for studying and describing a group. Through long term immersion in the field, collecting data primarily by participant observation and interviewing, the researcher documents how people within a cultural group construct and share meaning (Maxwell 2013). Ethnographic research provides a more comfortable environment for the informant. Interviews and observations took place in a day-to-day setting that allow informants to remain comfortable and for the researcher to experience the everyday settings of their informants. Observing someone outside of his/her daily setting may alter that person’s answers to questions and overall attitude. Not everyone is comfortable talking about personal experiences in a public setting or an austere laboratory setting. Ethnography can help put the researcher into the world of the informant, at the discretion of the informant. Even in
ethnographic research the informant can feel that the researcher still holds all the power. Therefore, it was very important to me that my informants knew that they held the power in our interviews. Informants can withhold information just to give answers they think the researcher wants to hear. They can withhold information to protect themselves depending on the research topic. I was there at their discretion and they had every right to deny me access to their homes, villages, dispensaries, lives, etc. I made sure to preface every interview with a statement letting the informant know they could pass on any question and stop the interview at any point.

After further research on study approaches, I decided on phenomenology. Phenomenology focuses on individual perceptions of a phenomenon. The philosophical foundations of phenomenology argue that the scientific method is inappropriate for studying human thoughts and actions. Phenomenology tries to bring life to descriptions of what the researcher experiences. Good ethnography “is usually good phenomenology, and there is still no substitute for a good story, well told, especially if you’re trying to make people understand how the people you’ve studied think and feel about their lives” (Bernard 2011). What I like about phenomenological research is that the focus is on the informant’s perspective; it seeks to understand a person’s experience and how that person interprets that experience. This approach was vital to my research, because I was heavily focused on how people viewed modern medicine. Did they view it as a negative entity that was brought in and took over all of their traditional rituals? Did they view it as a positive entity that helps their children stay healthy? How do they understand illness and what modern medicine does? Although, I was researching a specific phenomenon – Modern medicine in Kedougou, Senegal – that focus was really secondary. The main research was about the informants and how they were affected by the
phenomenon. Yes, the phenomenon is important, but the perspectives of the informants were central to answering my research questions.

At some point during my research, I decided that it was not enough to just answer my research questions. I wanted to ultimately effect change for my informants, by sharing their stories and searching for a solution to their problems. Neoliberal effects should be addressed to promote positive change. Critical ethnography/action research has at its essence the intent to change something, to solve some sort of problem, to take action (Glesne 2011). Action research uses interpretivism and the method has progressed to observing, reflecting, and acting (Kimmis and McTaggart 1988; Stringer 1999 as quoted in Maxwell 2013), using primarily qualitative interviews, observations, surveys, and quantifiable data. In this form of research, the researcher works with others as agents of change. “Stringer (1999) elaborates on what he calls community-based action research which assists a group, community, or organization in defining a problem; better understanding the situation; and then in resolving their problems” (Maxwell 2013). From the beginning of this research, I was interested in outlining cultural issues associated with unsustainable health development. I initially, was not considering a specific resolution proposal. However, the act of outlining a problem, is itself action-based research. By stating that there is a problem and then providing details on the parameters surrounding the problem, I am also stating that action is necessary. If there is a problem, then consequently there is also a resolution. Action is required to reach that resolution.

Interpretive research is focused on meaning in a group and is a fundamental aspect of most qualitative research (Maxwell 2013). Tolmen and Brydon-Miller (2001) advocated for interpretive methods, because the methods actively involve the relationships between the researcher and the participants. However, Burman (2001) reminds us that dominant humanitarian
agendas of such research can be used to perpetuate existing power struggles (Maxwell 2013). For my own research, I needed to consider what power struggles existed for my participants. Especially how neoliberalism fits into current power dynamics. Using interpretive strategies, the researcher contributes to the multiplicity of voices and realities within groups and gives witness to lives that are otherwise ignored or silenced. Pointing out multiple meanings and significance can inspire others to think in different ways and to become more aware of people’s actions and words (Maxwell, 2013). I wanted to use my research to bring voice to the struggles of the people of Kedougou and bring realization to the effects of neoliberalism.

Neoliberalism was not an initial part of this research, but came into the picture upon further literature research on how medical dispensaries became independent and unassociated with the government. I utilized scholarly articles and books detailing the technicalities, history, and ideology of neoliberal economic practices. Using these sources enabled me to compare the situation in Kedougou with the rest of Africa, through the resulting effects of neoliberalism.

2.2.2 Observations and Interviews

I chose a localist, semi-structured approach to my interviews. Semi-structured interviews involve guided questioning using identified themes in a systematic manner and interjected with probes designed to reveal more elaborate information. These types of interviews are flexible, accessible, and intelligible. They give the researcher the capability of discovering important facets of human behavior. Especially important to my research, semi-structured interviews enabled informants to answer my questions in their own terms and in the way that they think and use language. Furthermore, this strategy is valuable for understanding the way interviewees
perceive the world under study. The localist perspective addresses the need to approach the world from the informants’ perspective (Qu and Dumay 2011), which is the basis for my original research question and was a themed upheld throughout the changes in my research – how individuals perceived traditional and modern medicine and what was the perspective on the village dispensaries.

“The development of good interview questions and observational strategies depends fundamentally on your understanding of the context of the research, including your participants’ definitions of this, and how the interview questions and observational strategies will actually work in practice” (Maxwell 2013). First, I anticipated how people would understand my research questions, and how they were likely to respond. I tried to put myself in the informant’s place and imagined how I would react to these questions. I then sat down with Baba and went over the questions to ensure simplicity and understanding. Additionally, we discussed possible cultural settings where it would be inappropriate to ask certain questions. According to Baba, none of my questions would be perceived as offensive or inappropriate.

Although, there are a few varying forms of participant observation (Complete participant, observing participant, complete observer, participating observer)², I took on the role as a participating observer during my time in Kedouogu. I lived in close quarters with Baba’s family, ate every meal with them, and generally spent all my free time around the house with them. I also utilized an immersion strategy on brief occasions. These occasions occurred when I went to

² Complete Participant: “becoming a member of a group without letting on that you’re there to do research” (Bernard 2011: 260).
Observing Participant: “insiders who observe and record some aspects of life around them” (Bernard 2011: 260).
Complete Observer: “involves following people around and recording their behavior with little if any interaction” (Bernard 2011: 260).
Participating Observer: “outsiders who participate in some aspects of life around them and record what they can” (Bernard 2011: 260).
the hospital and became a patient myself. I was able to be in a similar experience as other patients in the hospital. Immersion techniques, referred to as “becoming the phenomenon, helps researchers penetrate and gain experience of their informants’ life (Jorgensen 1989, as quoted in Bernard 2011). However, my attempts at complete immersion were unsuccessful. Because of my skin color, I was treated differently. I still waited alongside other patients, but my wait time was significantly less than others. Additionally, my dispensary and hospital visits were similar to time allocation research. I would drop by the hospital at differing, unannounced times and observed the procedures and human behavior. By using this method, I was able to reduce the chance that people would notice my observations and alter their behavior (Bernard 2011). However, again my skin color stood out and therefore, I was not as inconspicuous as I would have wanted.

2.3 The Data Collection Process

2.3.1 Anticipated Problems

The main problems I anticipated were related to access and response effects. I was concerned about gaining access to facilities and programs through international development organizations. This proved to be a problem that was not solved. I was on friendly terms with a local development worker who was very interested in my research and attempted to facilitate an agreement between Jill Pruetz, the organization, and myself. However, his superior was uncommunicative after several weeks of attempted contact. Fortunately, I was still able to gain access to village dispensaries that were independent from organizations in the area. There was
one exception to this; one village had a dispensary funded through a development organization, but the dispensary manager was not directly employed by the organization mentioned previously, so I was able to interview him. Therefore, Baba and I decided to continue the research through independent facilities.

Regarding response effects, I was concerned about the third-party-present effect, the social desirability effect, and the deference effect. Although, my expectation was to conduct each interview privately, with my interpreter, my informant, and myself the reality was not even close. This is where the third-party-present effect comes in. In reality, out of fifteen interviews, only two were conducted in “private”. I use quotations around the word private, because even in those two instances, there were interruptions and people milling about outside the dispensary. In all the other thirteen interviews, people other than the informant were always present. For one, it was very hot and therefore people congregated outside on the porches and in the shade to stay cool. Secondly, the culture of this region is very hospitable and individuals of the same ethnic, family, or area will typically spend time socializing together. Everywhere I went there were groups of people around while I conducted the interviews. As a researcher, I was aware that some of the informants might have altered their answers after hearing another informant’s answer, or because their family members were present (Bernard 2011). The social desirability effect was also a concern, I was aware that informants may be likely to answer my questions in a way that made them look like good people (Bernard 2011). For example, one gentleman who only uses traditional medicine for himself brewed some traditional tea for his daughter, because her stomach hurt. However, he was also adamant that whenever the children are sick, he immediately takes them to the dispensary for medicine. To me, this suggested that he felt the need to clarify that he indeed does take care of his children by taking them to the dispensary.
where they can receive modern medical help. Lastly, I was concerned with the deference effect, which was an issue brought to my attention prior to leaving for fieldwork. Myself, as a white westerner studying perspectives on modern medicine and use of modern dispensaries, it was easy for informants to assume that I preferred modern medicine. I knew it was possible that informants would exaggerate their reliance on modern medicine, because they thought that is what I wanted to hear (Bernard 2011). Unfortunately, these response effects are difficult to eliminate, but as Bernard advises, it is better to identify sources of bias than not identifying them (2011). Therefore, I made sure to keep in the back of my mind my position in relation to my informants. I attempted to ask open-ended questions to allow the informants to answer as honestly and thoroughly as possible.

2.3.2 Ethics

Some of the ethical issues that I considered were those regarding direct observation and indirect observation. People may feel uncomfortable that a researcher is watching them and documenting their behavior. However, in participant observation, researchers attempt to put people at ease, and since people can see you taking down their behavior, they can ask you to stop (Bernard 2011). My direct observations were made through on site tours of village dispensaries, during times of little to no patient activity. The dispensary workers agreed to show me around the dispensaries and were aware and comfortable with my observations. As for indirect observation, is it ethical to observe and record the behavior of people without their knowing? According to Bernard,
when indirect observation occurs during ordinary activities, out in the open, in public spaces, there is little to no invasion of privacy (2011). My indirect observations were mostly conducted through my various visits to the hospital. It was indirect, because it was a public location, people were unaware of the observation, but I did not record any specific information on individual patients. I observed them in the waiting area, which was open to the egress of people.

Possibly, one of the more controversial ethical issues related to anthropological fieldwork is the concept of “hanging out”. Evans-Pritchard himself described how manipulative ethnography could be through winning the good will of informants and persuading them to divulge specific information. In 2005, Harry Wolcott claimed that “hanging out” is considered one of the darker arts of fieldwork (As quoted in Bernard 2011). For myself, a lot of my field time was spent “hanging out” and building rapport. However, the majority of the individuals I spent extra time with, were not considered informants for me. I did not feel it appropriate to officially interview them and include that data in my research. Of course, we would discuss my research and what people were saying and what their (my friends’) opinions were, but I did not record these in any data-related way. I felt that the information divulged to me in private, “hanging out” moments, was to be kept separate from my official informant interviews. If there was a topic that came up in conversation through “hanging out”, that I felt was important to my research, I asked their permission to use it officially in my data.

Lastly, the most difficult ethical dilemma for myself during fieldwork was discussing with people what the issues were in their health care and not being able to offer solid solutions or contribute to the betterment of the village dispensaries. My informants were more than happy and willing to discuss my research topic, but at the end of every interview, they would express their desire for me to keep them in mind for the future. I heard things like,
“whatever you can do to help us…”
“keep us in mind while you finish school and afterwards…”
“do you know of people who can help us?”

They clearly wanted my research to result in action to help them, even though I had previously made it clear that I was doing research for my thesis to get a Master’s degree and I could not provide them with any direct benefit. It was the most difficult part of my fieldwork; interviewing and getting to know these people, seeing in person the problems they face daily, and being unable to actively help change. I do hope that this study can bring light to the issues my informants are facing and I can continue to use this information and experience to advocate for better health dispensary management throughout Senegal.

2.4 Approaches to Data Analysis

My approach to data analysis began by establishing the importance of staying true to my participants’ voices in order for them to be heard by others. Analyzing the data through a neoliberal lens, allowed me to interpret the lived experiences of my participants within the context of my research. Each audio-recorded interview was transcribed verbatim using ExpressScribe and Microsoft Word and then each line of text was numbered. I then coded each line by hand on a hard copy of each transcript. I made notes in the margins, highlighted, and named sections of the text. This helped me identify topics, issues, similarities, and differences within each person’s narrative and enabled me to begin understanding each person’s perspective. After coding, I asked a fellow graduate student to code one of the transcripts with all information removed except the informant’s responses. We then discussed similarities and differences in the two resulting sets of codes. This enabled me to revise some of the codes and helped clarify and
confirm my research findings. Next, I drew together codes from across my transcripts to form themes. These themes helped organize my findings in a coherent and meaningful way. The result of this coding was a specific dispensary whose story stood out. It was a dispensary mentioned by several informants and expressed to be an important symbol of their struggle for quality health care services. The following chapter explores this story and how its management was affected by politically associated donations and neoliberalism, as well as its lasting effects on the surrounding communities.

I then used established literature and research on neoliberal economic theory and practice to view my data through another lense. I analyzed the interview results and my observations through a neoliberal lense, searching for causes and effects of unsustainable development in Kedougou.
CHAPTER 3. THE RESULTS

“But, since that time he is still trying, but they don’t seriously want to do it, you know. Even for his pay, the missionary usually was the [unclear] like each rainy season the population could go in his field and help him to farm you know. That was working a couple years ago, but now that stop. So, he want to stop also to the, the, the dispensary, but he can’t because people use to it, and all the this area, some of the villages here have a dispensary, but they don’t have medicine so, all this area, people come from here, so you know, it’s hard for him to stop. But, he don’t have a salary and people don’t want to go farm for him and he have a family you know, so it’s difficult. Seriously, difficult.”

(Interview with a dispensary manager)

3.1 Introduction

Up until this point, we have discussed the background information for this study, the Kedougou Region, and established research. We also discussed the methodologies utilized pre-fieldwork, in the field, and during data analysis. This chapter will explore how previously stated information on neoliberalism has affected the Kedougou Region specifically. This chapter outlines the results of my research detailing brief history of health in Senegal, informant stories and the effects felt within the Kedougou Region.

Neoliberal economic policies led to the privatization of the health sector in Senegal. The effects of which, are seen in the management of medical dispensaries in rural villages throughout the country. These neoliberal effects manifested in the form of monetary struggles for medical dispensaries. Through interview questions such as,

“What obstacles do you face when seeking medical care?”
“What obstacles do you face when managing a health dispensary?”
“What would you change about the dispensary in your village?”
money dominated the majority of informants’ answers. The various forms that money came up in each interview included entrance costs, medicine prices, salaries, and more. Money will be detailed in specific forms later in this chapter. The following sections will also describe the lived experiences of dispensary workers, the role of government, and cultural ideologies about health and community.

The stories I chose to tell within this chapter may seem irrelevant to the overall research problem of neoliberalism and its effect on health development in the Kedougou Region. However, I chose these anecdotes as a way to humanize the research and show the lives of the people directly affected by neoliberal policies and perceived abandonment by the government. Discussing the role (or lack of) of women within medical dispensaries shows the cultural family dynamic in the Kedougou Region. Typically, women are thought of as the nurturer within the family and therefore, would naturally be drawn to health work. However, within this region, women are so relied upon within the home, households cannot run efficiently without them. Therefore, they are expected to remain within the home working not within the medical dispensaries. Of course, there are always exceptions, which I did observe, showing the diversity of the region in cultural practices. Discussing cultural traditions in comparison with medical dispensaries is important in showing that there is little to no association between traditional beliefs and utilization of the dispensaries. This was important for me to illustrate, because I came into this research expecting to see an association between the two. However, the unsustainability of medical dispensaries is not due to cultural traditions, but due to economic pressures that led to privatization. Telling the stories of the various dispensaries I visited are important anecdotes, because they share the lives of my informants and their struggles. They are examples of the lived
experiences of these workers and the result of neoliberal policies. The following sections detail
the anecdotes that I felt compelled to and the responsibility to share.

3.2 The Data

I toured five village dispensaries and two hospitals. One of the villages I visited did not
have a dispensary but did have a designated individual who managed the medicine (mostly
malaria treatment) and attended regular training in Kedougou. The data for this research results
from fifteen individual interviews, ranging from middle-aged to elder, two females, and thirteen
males.

Over the two-month period, I was able to conduct fifteen in-person interviews with two
being handwritten, and thirteen bring recorded on an audio recording device to be later
transcribed. My informants were found through my translator Baba, who is a local businessman,
well known throughout the region. Baba’s work with Jill Pruetz was an “in” to people since
everyone in that area knows who she is. We were able to meet a few informants through a
previous worker of Jill’s from the Djinji village that was a central research site the past summer.

Out of the fifteen informants, two were middle-aged women both dispensary workers,
with one specializing in midwifery. The other thirteen informants were adult men, ranging from
middle-aged to elderly. Within these thirteen male informants, four were dispensary workers,
and two were traditional healers – Maribou – four were community members, and three were
village leaders. Male informants were more readily available and willing to be interviewed,
because of their status within villages.
The interviews ranged in time, usually between 45 minutes to 90 minutes depending on the content. I guided each conversation with a set list of questions that I asked each informant verbally in English. The questions were then translated orally into a language understood by the informant, most often it was French, but some were converted into Pulaar, Malinke, and Wolof, which are local ethnic languages of that region. The informant would respond in their chosen language and Baba would then repeat their answers in English for me, which would be recorded via a voice recorder.

An interesting note is that women in this region are more likely to manage household finances. I was even told of a women’s council in charge of a village’s pooled funds for healthcare services. This council would manage the acquirement of funds from each family, hold onto the funds, and disburse funds when needed, for occasions such as illness or death of a community member. Unfortunately, I was unable to interview any women’s councils. This was an interesting data point within the research, especially with the majority male informants, with males dominating the health sector.

3.2.1 Women Health Workers

There is a skew towards male participants in my interviews. There are several practical and logistical explanations for this sample having a significant proportion of men. First, the majority of the people involved in the healthcare systems I observed were male. Second, social norms lead to men feeling more comfortable talking to me due to Baba being male and his status as a well-known and popular businessman. Third, women’s daily responsibilities kept them very busy throughout the entire day, while many of the men I encountered had a more relaxed regular
schedule and therefore more time to talk. Women have a list of household chores to complete every day, meals to prepare, and children to watch over. The only thing pressing for men is their farmland and many do not go into the fields until 10:00 am.

Maribous (traditional medicine men) are always male, to keep vital traditional healing information within the village. If women learn ways of the Maribou, they could take the information to whatever community they migrate to after marriage. I found this out during an interview with my second Maribou informant. I was asking about the process of training new maribous. I was told that young boys are chosen from that are interested in the workings of the Quran and helping their community. These boys are then trained for years in the practices of the Maribou and all that the responsibilities entail. When asked for training details and practice details, I was laughed at, good heartedly so and informed that no Maribou practices would be revealed to women. The Maribous cannot risk their specific knowledge and specialty to be carried to other villages by migrating women. There is also concern about using the knowledge of Maribous in money making schemes, defiling the tradition. Men are also more likely to have higher education or approached by village leaders to manage the dispensary. Men have more freedom to attend school regularly, whereas young women are expected to help with the daily chores of the household and raising younger siblings. If the mother of the household is ill and cannot complete her daily responsibilities, they fall to the eldest daughter, who would have to remain home from school that day. One of my female informants, a midwife, was training someone to take over for her in a few years. However, I was surprised to discover that the person was male, not female. It seems in general that women are just less likely to become involved in health work.
3.2.2 Culture versus Healthcare

I chose to focus my interviews on individuals directly related to health within their respective villages and community members who used health services. I started out the interview process asking about traditional healing methods, perspectives on modern medicine, etc. and all the informants exhibited positive attitudes toward modern medicine. In fact, many claimed that there was no issue between traditional methods and going to local dispensaries for medicine. Frequently, the informants thought of them as working together, if one did not work then a person would try the other method and sometimes they would try both processes at the same time.

When I asked my medically trained informants about this, they all agreed and said that the only times they are concerned about traditional healing, is when individuals with yellow fever or malaria try traditional methods and wait too long to get proper medication. However, these conversations always ended with the notion that most people know the symptoms of malaria and went to the dispensary immediately. Those exhibiting symptoms of yellow fever, however, do not necessarily do the same. There is an interesting dichotomy between the acceptance of treatment for malaria and rejection of treatment for yellow fever. A gentleman I was interviewing was explaining how he still uses traditional methods for stomach aches and headaches, but anything more he takes the children to the dispensary. Except for one exception, yellow fever. He told me a story about someone who was diagnosed with yellow fever, went to the dispensary to get the treatment, received the procedure (a shot), and promptly died.

People circulate stories such as this and avoid getting treatment for yellow fever due to the belief that they will automatically die from the shot. I asked several other informants about
yellow fever and they confirmed the previous story that many people are wary of getting treatment.

### 3.2.3 Kedougou Hospital Experiences

Tall concrete walls surround the hospital in Kedougou with a large gate in the middle to allow for ambulance vehicles. Patients arriving on their own must enter through a roped sidewalk that leads to a ticket window. This is where patients pay for their entrance ticket into the hospital. The cost per person per ticket per hospital visit is 1000 CFA ($1.88 USD). Every day around 10:00am no fewer than 20 patients wait in line; that is the line to get an entrance ticket.

I observed Kedougou hospital procedures on three occasions. One was with a fellow student who was getting a malaria test. One was a personal experience, also for a malaria test, and one was to visit a family friend. Once inside, patients enter into a large open room with benches. Usually, this room is packed full of people sitting on the benches and standing. Staff approaches patients on one side of the room or the other, from one door here, or another entry there. I observed this both as an observer and a participant. My participation in the healthcare process was a chance opportunity that helped me gain deeper insight into the processes.

I was interested in observing patient/physician interactions at the hospital in Kedougou for a several day period. However, that was not feasible, due to the chaotic nature of the local hospital’s procedures. For example, most mornings there would be a line of patients waiting to get into the waiting room. The waiting room was a large open room, filled with people sitting and standing. There were particular areas of waiting for specific nurses/doctors, but I could never figure out how that worked. At one point during a visit, I ended up waiting in the wrong line.
Furthermore, on another occasion, I purchased my entrance ticket, waited for about twenty
minutes, left for an hour, and came back to be still waiting for the same patients as before.
Therefore, my observations came mostly from personal experience or interview interruptions.

On one occasion, another graduate student and I went to the hospital for a malaria test
and after a while, a staff member informs us that we had been waiting at the wrong door. That
was after we left for an hour and a half and returned. People ahead of us were still waiting when
we returned to the hospital. Finally, our guide kept speaking to various staff until they pulled us
into a room for examination by a doctor. I do not think this was because it was our “turn,” I think
it was because we were white, our guide had spoken for us, and he is a respected member of the
community. There apparently was a method to the madness, yet I have still not figured it out.

3.2.4 Dispensaries and Their Stories

The first dispensary I visited was in a very small village named Petit Oubadjji, which is located
between the Fongoli field site and the Djinji village. This particular dispensary was originally funded
and built by an international development organization. This organization provided an initial
supply of materials and medicines and helped train the current manager. The manager of the dispensary is currently the only health worker in Petit Oubadjji and runs the dispensary alone. A missionary that was working in the village, who then petitioned an organization to help fund the building of a dispensary, selected him for the job. The
organization then worked with the manager for six months after construction to train him how to administer the correct medicines and record everything. Now, he uses the service fees to pay for more medicine. When asked what he would change about the dispensary, he responded with, “more materials, a motorcycle, and lights”. Currently, he has to use flashlights when it is too dark outside and someone needs medicine. The motorcycle he wishes to have would be a three-wheeled motorcycle to provide for more stability. He explained the necessity for this motorcycle with a story.

“One day there was a woman who wanted to give birth, he take her on the motorcycle, but before they got to the hospital, she give birth, but the baby was dead. So, that is why he thinks the three-wheel motorcycle will be better.”

The dispensary worker at Petit Oubadji finished his story by explaining that he wishes to have a younger person to replace him and whom he can train well to take over the dispensary. He is alone, getting older, and feels a new person could have more skills and knowledge to help the community.

The next dispensary I visited was in Djinji, however the dispensary was not finished yet. I was able to see the exterior of the building and interview some community workers, but they did not have a health worker selected yet. The third dispensary I visited was close to the Gambia River in a village called Baitilaye. Baitilaye had three health workers, a midwife,
a trainee, and a Maribou who worked out of his home. The dispensary in Baitilaye is made out of the same materials and about the same size as most of the other village dispensaries; a waiting area out front, an office for the manager and medicines, and a room for patient consultations/treatments. Unfortunately, the issues at Baitilaye were similar to other stories I was told. The dispensary had broken doors, poor storage for medicines, no wages for the workers, and no electricity.

The fourth dispensary I visited was actually in Baba’s home village of Chiobo (or spelled Thiobo). This was the second dispensary for Chiobo, the first having burnt down years ago. This particular dispensary was made possible through the donations and contributions of several missionary families over the years. Most of these families are now retired, but still travel to the village once a year. The current manager is the only health worker in the village and services approximately 250 people just from Chiobo. However, during the wet season, when malarial infections are high, he said between 30 and 40 people a day come to his dispensary for medicine. When asked what he would change about the dispensary in Chiobo, the manager desired more medicine, a salary, and better transportation for patients, especially when travelling from the village into the town of Kedougou to the hospital. Patients who have serious injuries and/or illnesses that cannot be treated at the village dispensary, have to travel the hour to Kedougou hospital. The manager has been requesting aid from the village to pool money for more medicine, but has not gotten a positive response. He also explained:
“...for his pay, each rainy season the population could go in his field and help him to farm. That was working a couple years ago, but now that stop. So, he want to stop also, but he can’t because people use to it, and all this area, some of the villages here have a dispensary, but they don’t have medicine so, all this area, people come to [Chiobo], so you know, it’s hard for him to stop. But, he don’t have a salary and people don’t want to go farm for him and he have a family you know, so it’s difficult. Seriously, difficult.”

The manager further explained that he cannot even find someone to train and replace him due to the lack of pay for the position and the struggle he himself experiences with running the dispensary and taking care of his own family.

The last dispensary that I visited was in a village called Syllacounda. This village is larger than the other villages I saw and seems to have more incoming money. When I came into the village, I could see piles of construction supplies and asked what it was for. Someone said it was for building an area to put up solar panels. The dispensary is also a bit nicer than the others I toured. They have separate buildings for patient consultation and a resting area for patients. This dispensary has several health workers, including a trained physician who splits his time between the dispensary and other areas. Syllacounda has an interesting social dynamic, as many families work to send the eldest child out of the country for work. The eldest child then funnels money back to their family in the village. Furthermore, a wealthy French individual almost solely funds the dispensary. Some of the funds do come from Dakar, but the financial situation is complicated and the physician was unable to give me specific details. The patron of the Syllacounda dispensary sends money for new medicine, materials, transportation, and repairs. They even have their own ambulance there, which is a type of SUV. The main thing that workers wanted to
change about the Syllacounda dispensary was more money for salaries. Although, they are able to retain a supply of medicines and materials, the health workers still go with very little, or no pay. This results in a burden not only on these workers but also on their families.

3.2.5 Common Thread

An unexpected topic came up in every single conversation: money. Money was the central theme of every interview I conducted. Initially, I was not even asking questions related to money. However, some of the questions I was asking were open-ended and allowed the conversation to turn to the issue of money. These questions were,

“What are some of the challenges you face when seeking medical care?”
“What would you change about the dispensary in your village?”

Every informant said that they wished there was more money to pay for medicines, materials, and salaries for the workers. For me, it was completely unexpected to find that these health workers were not compensated and that the dispensaries struggled to maintain inventory and working materials. Throughout the interview process, I added questions such as,

“What do you get a salary for working in the dispensary?”
“What kind of training have you had for working in the dispensary?”

Although each informant was able to pass on any question, none ever did. The informants were forthcoming with answers and happy to discuss the issues I was asking. For example, when asked about challenges they face when seeking healthcare, participants responded that lack of transportation, good roads, and cost of services prevented them from seeking quality healthcare.
In interviews, participants also discussed what, if any, changes should be made to dispensaries to make them more effective, listing things such as more medicine and materials, more money for repairs, and more money to pay the staff.

Of the nine health-related workers I interviewed, two had salaries. They explained to me that most of the dispensary workers go without salary entirely for most of the year, having to split their time between the dispensary and farming.

![Figure 11: Medicine Prices. Taken by Samantha Salter.](image)

### 3.3 Money

Only 3.3% of public spending was allocated to the health sector from 2007-2011 (UNICEF). Money was the central theme of

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<th>Table 1. Senegalese Budget</th>
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<th>Table 2. Percentage of Healthcare Costs per Individual: (Monthly)</th>
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<td>1% low end</td>
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<td>22% high end</td>
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<th>Table 3 Monthly Budget Example</th>
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<table>
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<th>Expenses</th>
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<td>Healthcare</td>
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<td>Total</td>
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(Source: Trading Economics & Expatisan)
every interview I conducted and was brought up through various topics such as the cost of entrance tickets, cost of medication, cost of construction, cost of medical materials, money for upkeep and repairs, and decent salaries for health workers.

Cost of Entrance Tickets: Throughout Senegal, patients must pay an entrance fee and receive a ticket from a specific ticket holder before even entering a dispensary or hospital. These entrance tickets range in price from 200 CFA to 1,000 CFA ($0.38 USD to $1.88 USD) in the Kedougou Region alone. Infants are typically free, small children 200 CFA ($0.38 USD), and adults 500 - 1,000 CFA ($0.94 USD to $1.88 USD). Informants did admit that the cost of entrance tickets and medicine is a deterrent and keeps people from going to the dispensary. Not to mention the transportation struggles that many people in this region face.

Cost of Medication: Examples of medical expenses for patients include, but are not limited to Oroperidys, helps with nausea and vomiting: 2036 CFA ($3.84 USD); Loliprane, pain and fever reliever: 1124 CFA ($2.12 USD); Vormex, worm treatment: 1237 CFA ($2.33 USD). Typically, medication related to malaria treatment is free for patients at village dispensaries. However, malaria treatment costs between 3800 CFA to 6000 CFA ($7.16 USD to $11.31 USD) in town when bought from a pharmacy. One dispensary has a revolving pot of money worth 40000 CFA ($75.39 USD) used for medicines. Any money earned from selling medicine in placed back into the pot.

Cost of Construction: Villages often must pool their money to buy supplies such as bricks, concrete, metal roofing, wooden beams, and pay for men for constructing the building.

Cost of Medical Materials: Dispensaries must find money for patient beds, first aid supplies, thermometers, blood pressure cuffs, sanitary wipes, bio-waste disposal buckets, and essential medicines.
Money for Upkeep and Repairs: Repairs for dispensaries can range from 3000 CFA to 80,000 CFA ($5.65 USD to $150.77 USD), depending on the materials needed. For example, repairing broken locks can cost 3000 CFA ($5.65 USD), but buying a solar panel to have some form of electricity could cost 80,000 CFA ($150.77 USD) or more.

Proper Salaries: The majority of individuals in the Kedougou Region rely on agriculture for their livelihoods. Male dispensary workers must also mainly rely on farming to support their families, which can become difficult for those dispensaries with only one worker and who serve multiple villages. Several informants reported no salary earnings for working in the dispensary. One man receives about 10,000 CFA ($18.85 USD) a month as a salary, but that is from the doctor in Syllacounda. He was unsure where the doctor gets the money. Others reported receiving less due to lack of profit from entrance tickets and medicine sells. There just is not enough money to pay for everything needed to keep the dispensaries running efficiently (Salter 2017).

As seen in Table 1 Senegalese Budget, healthcare costs can range from 1% of a person’s monthly income, up to 22% percent. These percentages are based on the low and high end expense costs as reported on Trader Economics and Expatisan websites. The Monthly Budget Example shows that the majority of a person’s income goes to housing and utilities, with medical expenses third, and food last. Please note that most of these figures were collected from urban areas within Senegal, as rural monetary information is not regularly collected or readily available.


3.3.1 The Ninefescha Story

The commonality between every participant I interviewed was concerned over money. Their concern was so apparent that it was a theme that presented itself, unanticipated and frank. One specific case study surfaced time and again as an essential example of the more significant problem my informants were trying to impress upon me. In this case study, a critical dispensary and the story of how it has affected the lives of those in nearby villages, as well as how past neoliberal reforms are still affecting the Kedougou Region today.

The former First Lady set up a foundation to promote better education and health throughout the country. During her stay as First Lady she raised considerable money for her projects in Ninefescha, however, when her husband lost re-election in 2012, she dissolved the foundation and dismissed all the hospital workers (SenePlus 2013). This left the village and surrounding communities to fend for themselves in the aftermath of the most significant hospital in the region closing.

It was challenging to find any news-related sources on this hospital, even though it was a multi-million dollar project. The only source I saw was the above referenced SenePlus, who provided a five-sentence article stating that the hospital was closing in 2013. The only other piece of
literature I was able to dig up about this specific location was a study done by Almamy Malick Kante and Gilles Pison in 2010. They examined the impact of the Ninefescha hospital on the populations intended to use the facilities. They begin by questioning whether the building of new healthcare facilities is enough to improve health.

Although, their study takes a different direction by focusing on how the population is using or not using the facilities, their central question is relevant to my research. The First Lady’s priority was building an entirely new and modern health facility, but what happens next? As I discovered, what happened was the closing of the hospital entirely until the village mayor was able to fund some essential medicines and supplies and bring back a manager. Because the focus was building the facility and creating the access, the sustainable management practices were not thought out. Now, the large, modern hospital is a husk of what it once was, struggling to aid the sick in surrounding communities.

When discussing Ninefescha, patients, health workers, and village leaders again made a point to impress how severe the financial strains could be. User fees, medicine costs, transportation costs, and salaries. Kante et al. report that in a 2005 survey, patients reported high cost of medication and admission fees as some of the obstacles keeping them from utilizing the Ninefescha facility (2010). In 2007, these costs were reduced to free for children zero – five years old; 300 CFA ($0.57 USD) for children five years old – fourteen; and 500 CFA ($0.94 USD) for patients fourteen years and older (Kante 2010 & Salter 15M72417NF).

User/admission fees are standard for dispensaries and hospitals throughout Senegal; however, according to my participants, residents are not taken into consideration when these prices are set. In fact, in one interview it was stated that people with money come and build a facility, they give their entrance price and if people have the money to come, great but if not, oh
well. Kante’s research also mentioned that when the Ninefescha hospital was operational, people from Kedougou would travel there instead of utilizing their local hospital. This was because Ninefescha had specialist skills and equipment that Kedougou did not have.

The entrance fee at Kedougou Hospital is 1000 CFA ($1.88 USD). Imagine what these people are experiencing now that the Ninefescha hospital is a shadow of what it once was. The cost is cheaper, but the services are rare. Additionally, health workers expressed that most patients attending the dispensaries and hospitals are within that zero – five years old range, resulting in free admission. Most older children and adults avoid the dispensary due to the cost of entrance and medicine.

While the free admission is a benefit to the parents of young children, it is a massive disadvantage to the dispensary. The dispensary runs on user fees and medicine sales. I use the phrase “runs on” very loosely here since the dispensary, in reality, is barely able to run. User fees and medicine sales are used to resupply the dispensary with medicine and supplies. When there is not enough money to cover these costs, typically the village mayor helps by giving money.

Transportation to Ninefescha and Kedougou from the surrounding villages is an additional price. It can cost patients between 10000 and 15000 CFA ($18.85 USD and $28.27 USD) for the use of the ambulance. Unfortunately, as one of my participants informed me, “Sometimes in the villages, people don’t have money, so you should first do everything and if they come back, maybe they will sell a goat or something” to cover the costs. Again, we have to consider this from both the patient perspective and that of the dispensary. In an emergency, patients need access to a reliable vehicle that can make the transport to Ninefescha and to Kedougou, which can be dangerous during the rainy season.
However, people have difficulty paying for these services, so they sell either a goat or other cattle, or they just cannot pay. From the dispensary perspective, they need money to maintain the vehicle and pay for fuel. Without money, the ambulance would not be useful to anyone. As for salaries, the dispensary manager does not have a legitimate wage. He sometimes receives 15000 CFA ($28.27 USD) a month just for motivation to keep him there. However, this is not consistent. Therefore, he must attempt to farm, like the majority of people in this area. This is already a struggle for individuals who can devote all of their time to it. For the dispensary workers, they must balance both health work and farming to support their families. Without a sustainable budget to replace medicine, buy fuel, maintain the ambulance, refill supplies, pay for electricity and running water, and pay salaries for the workers, it is only a matter of time before the dispensary is forced to close again. The facilities have the capability for electricity and running water; they have an operating room and radiology equipment, but without money to keep the electricity and plumbing running, the equipment sits there rusting away, no help to anyone.

Despite lack of salary and viable funding, health workers persist, solely for the benefit of the community. Health workers although concerned about pay and being able to provide for their families, are unwilling to leave dispensary work. I found that this theme was right for all of the health workers I interviewed, not just at Ninifescha. These workers began health work to help their fellow village members and want to continue supporting them. However, it is becoming increasingly difficult due to lack of funding and resources.
3.3.2 Caring for the Community

Caring for their communities does fall within the previous theme of money, but I believe the emphasis my participants placed on helping people is significant enough to be a theme. It shows how committed these individuals are to their community, even putting their patients as a priority over their own families. The dispensary manager at Ninefescha is so dedicated that patients will call him personally to see when he is working at the dispensary. Some patients will even wait to go to the dispensary until he returns. One of my other participants expressed that his desire to help people was the motivation for becoming a teacher and council president.

By establishing a place in leadership within the village, he can make a difference and enhance the lives of those around him. This passion for health work and helping people is what is keeping medical dispensaries going. They have little to no resources or funding, as well as few workers. However, they are all persisting through the obstacles to keep medical services and medicine within accessibility for their communities. Because, this was such a common story throughout my research, I believe it is due to cultural ideologies about taking care of your community. None of the health workers that I interviewed went into health for money or prestige, they simply wanted the opportunity for education and to give back to their community. These workers continue to fight against adversity in order to keep their fellow community members healthy and safe.
3.3.3 Government

The role of government in rural health services is severely lacking. In Kante’s research, they discovered a lack of coordination between politicians, health authorities, and target populations. There is a failure to take socioeconomic, cultural, and geographical factors into account when planning development of health services (Kante 2010). Governments have been privatizing health services for years, leaving openings that only nonprofits and private donors have been filling.

Ninefescha was one of these empty spaces whose lack of quality health services caught the attention of an individual. This individual happened to be the nation’s First Lady who then created a non-profit organization to funnel funds into the project. The issue here is that the donations she received were a result of her status. Once her status changed in the 2012 elections, donations stopped. She used her political status to start the Ninefescha hospital and kept it running for ten years. Since the politics of the nation changed, so did the funding for her private project. It was only after the election that the First Lady attempted to involve the government in Ninefescha. She wanted the government to take over the project and oversee its continuation. Naturally, she failed in this endeavor and she closed the hospital, employees terminated, and the non-profit organization dissolved.
The government has very little involvement in health services throughout Senegal, especially rural areas such as Ninefescha. The relationship between rural areas and the government is detached. For example, Figure 7 shows a 160-foot tall bronze monument built in 2010 in Dakar. This monument has received much criticism, resulted in protests, and is considered by many a monument to the failure of the Senegalese government. The statue was commissioned by President Wade and cost $27 million USD (14326701312.67 CFA) (Dylan). This is a prime example of the disconnect between the government and its citizens. Although, the First Lady’s intentions were admirable and she wanted to help people, the project did nothing to bring together the government and the people of Ninefescha. She did not have the foresight to involve the government from day one and create a sustainable plan for the hospital. Now, there are a large facility, medical huts, and homes that are sitting empty. There are equipment and water tanks unused. The resources and money that went into this project were all in vain, because the government and the project managers did not collaborate in a sustainable manner.

The government is not necessarily suffering the repercussions of neoliberal health reforms; it is the people of rural areas. State-citizen relationships are fragile in this area. People believe the government should help take care of their people, to help fund the health dispensaries – salaries for the workers, replenishing medicine and supplies, providing electricity and running water. However, the only government involvement at Ninefescha is one employee who sent as a worker to help the dispensary manager. She receives a salary from the government and aids the manager inpatient consultations and medicine sales. Although she is there to help, the manager expressed that he still feels that he is doing everything and that he continues to feel the weight of responsibility solely on his shoulders to keep the dispensary running.
3.4 Discussion

Senegal has experienced social inequalities due to pre-colonial social order, colonial experiences, and the rise of political and religious elites before and after independence. At independence, the urban, cosmopolitan, French-educated political elite inherited state power. Although, the state powers suggested a modern vision of African socialism, it masked Senegal’s vulnerable stability, based on distribution of wealth, jobs, and resources. Economic adjustment programs in the 1980s help alleviate ineffective policy and centralized government. However, these programs had unforeseen effects, as we have explored throughout this paper. Without government involvement, communities must scramble for resources and funds to build, staff, supply, and maintain health centers. The government has had very little involvement with Ninefescha since 2001. In fact, the only involvement the government currently has is a woman sent to help the one other employee. Other dispensaries within this region continue with no government aid or acknowledgement.

Instead of using her political affiliations to form her organization to funnel donations through, First Lady Wade should have advocated for government involvement from the beginning. As we saw with Ninefescha, political alliances are fickle, but government organizations can be more difficult to dissolve. The communities near Ninefescha indeed did benefit from Lady Wade’s efforts. They had a well-run hospital for ten years and at least they currently have a building and center of operations for their basic health needs.

In Chapter 1, I discussed literature from Tania Li Murray, specifically the effect of donor-funded initiatives on local populations (2007). Her literature is directly relatable to the Ninefescha story, with donors believing they know what is best, creating a dependency on donor
funds and then leaving these vulnerable populations without aid when donor affiliations change. Neoliberal ideologies continue to put pressure on village dispensaries like Ninefescha. These dispensaries remain small, understaffed, without running water, without electricity, without a sustainable inventory of medicines, and without money for staff and repairs.

Decentralization and privatization of health services create a struggle for quality health care in the Kedougou Region. The state and international sectors can easily overlook these impacts. However, at the local level people are suffering. The image drawn from lived experiences of dispensary workers throughout this research can extend to other rural areas and provide a general idea of how neoliberalism affects similar regions. Furthermore, politically associated donations have severe consequences on the recipients, as we also saw in the example of Ninefescha. These specific circumstances are a crucial example of unsustainable health development throughout the Kedougou Region in Senegal.

This research can also be extrapolated to industrialized nations such as the United States, as we saw with Ambramovitz et. al. work in Chapter 1. The U.S. also suffers lasting effects of neoliberal reforms, especially within the health sector. Medical services are highly privatized throughout the United States, allowing for high prices that are pushed onto the consumer/patient. Due to these high prices, both for health services and for treatment and medicines, many people experience severe medical debt that they carry for the remainder of their lives. Additionally, many people have begun to travel to other countries for services, because they are more affordable. The Kedougou Region is not the only place where health services are inaccessible due to cost.

Unsustainable health development results in loss of money, time, materials, and resources, which have a detrimental effect on community health and state-citizen relations. To
achieve a higher standard of global health, program advisors and government sectors should review health development efforts and analyze them to ensure sustainability. Furthermore, donations whether politically associated or not should be sustainably disbursed according to the needs expressed by the population. Donating money and constructing facilities is not enough to better health in rural areas. There is a need to consider the consequences of donations and the building of facilities. Working with the local populations, taking into consideration their socioeconomic statuses, their health needs, their geography, and more should be the priority of health development efforts.

Along this line of thinking, authors Connell and Dado (2014) propose an approach to neoliberalism that prioritizes the experience of the global South and sees neoliberalism gaining its main political strength as a development strategy displacing those hegemonic before the 1970s. Thinkers from the global South who have foregrounded these issues need close attention from the North and exemplify a new architecture of knowledge in critical social science (Connell & Dado 2014). It is critical for the poor to obtain more effective representation in decision making through indigenous non government organizations to incorporate equity and sustainability objectives (Weissman 1990).

3.5 Final Conclusions

This paper discussed the history of Development, neoliberalism, health, and neoliberalism in Senegal and the health care situation today in the Kedougou Region. Through these discussions, we can see that development and neoliberal economic changes have good intentions at their core, however, after years of implementation, we can see the many adverse
effects. My goal with this research is to illustrate how shortsighted development plans and long-lasting economic reforms still have a hold on the health services in the Kedougou Region.

As discussed in Chapter 1, anthropology is an important field with a lot to offer health development. Using anthropological methods opens up perspectives on neoliberal policies and their effect on the medical dispensaries discussed throughout this paper. By using semi-structured interviews, I was able to uncover important data that I would not have otherwise. Semi-structured interview procedures allowed my informants to reveal information that they considered important, instead of answering close-ended questions. Anthropology establishes methodology and visions to create partnerships with informants and helps promote potential solutions. Gardner and Lewis state, “ultimately, for the quality of people’s lives in poorer countries to improve, global conditions must change” and anthropology is the key to promoting that change (1996).

This research can be used as an example of other rural areas having potentially the same issues with quality health care. If the Senegalese government continues to push responsibility onto local officials and individuals who lack resources, health dispensaries will progressively decline in quality and close down. Anthropology gives us the opportunity to tell stories such as that of Ninefescha and the other dispensaries. It allowed me to see the perspective of the people who are directly affected by rural health care services and this paper was an attempt at giving those stories a voice. For example, one of my informants explained that he only visited the medical dispensaries when one of his children was sick. If he experienced any sort of illness, he would simply wait it out or rely on traditional methods, in an effort to avoid the costs of medicine and entrance fees. Furthermore, one of my confidants during my fieldwork, shared with me that he would often go without medicine for malaria, due to lack of money to pay for it.
I want to give voice to show that aid organizations, wealthy individuals, and missionaries can continue to fight against the ever-encroaching tide, but eventually, the wave will overcome the rural areas of the world. Dispensaries will continue to fall into disrepair, be understaffed, undersupplied, and close down. Hopefully, with this research alongside the studies already mentioned, positive change can be ignited for governments and organizations to work against neoliberalism and its devastating effects on rural healthcare systems.

Ferguson writes that the transition to a modern economy is often seen as a solution to poverty (1994). Sachs even dedicates his work to explaining how modern economic policies are the key to creating a global network that reaches from the impoverished communities to the centers of power and back again (2005). However, as Ferguson also tells us, this is not the case for those living in poverty. Rural development is often an expansion of capitalist (Ferguson 1994) ideologies, as we’ve seen throughout this paper and the spread of neoliberalism. The focus of privatization within neoliberal policies led to a decentralized health sector in Senegal. These changes resulted in independent medical dispensaries throughout rural areas with little to no government support. Support is left to the communities, whose resources are limited and strained as people continue to work as subsistence farmers throughout the region. Escobar maintains that development is a form of neocolonialism and a way to expand western customs (1995). While this is partially true in Senegal, I believe it would be careless to reduce the situation in Senegal to one explanation, like neocolonialism. What is happening in Senegal is more nuanced than that. From my research, I conclude that neoliberal policies were seen as a way out of the debt crises by the leaders and elites of Senegal. Unfortunately, with these changes came the privatization and decentralization of the health sector. State-led development was no longer central to the elites’ agenda for nationalism. I do think that neoliberalism contributed to the spread of western
ideologies, however I do not think that was the sole intent. Leaders and elites simply emulated powerful nations in hopes of also becoming powerful. Unfortunately, this has resulted in unsustainable health development throughout rural areas of the country, which has been exasperated by corrupt leaders and bourgeoisie aspirations.

Overall, I suggest a better relationship between rural areas and the national government. Currently, there is little to no relationship between these groups and the small relationship that is there, is viewed in a negative light. The government should work to connect with their rural populations by acknowledging their wants and needs. The health services in the Kedougou Region would greatly benefit from better training opportunities for health workers, access to resources, and more funding. I do not think that the country has benefited from a privatized health sector nor the continued focus and favoritism of urban centers. Rural areas need attention and acknowledgement from the government in order to gain trust and build relationships. The people of rural areas strongly believe that their government is responsible for their wellbeing. The people of Kedougou feel abandoned by their government due to the neoliberal policies that have spread across their country. In several interviews, informants expressed how they did not receive any help from the government and that they felt the government did not care about them. “We receive no help, none, we have to do everything ourselves” was a common phrase that I heard several times. People expressed the desire for their government to help them by sending money, paying for the salaries of the dispensary workers and helping keep important medicines in stock, which would help decrease the entrance fees and medicine costs. Not only was the health sector privatized, but it was essentially abandoned all together. Rural areas are left alone in the struggle to not only build their own medical dispensaries, but to also staff them, supply them, manage them, and maintain them. For an area that still has strong ties with subsistence
farming, there is little income available to sustain these dispensaries. In my view, this research has convinced me that the Senegalese government should rethink the privatization policies brought in through neoliberal ideologies. Especially, within a country that is known for its political stability, a resolution is possible. The only thing stopping a resolution and advancement and improvement of the health sector is the government’s non-priority of the issue.

Governmental budgets should allocate enough money to cover expenses of all medical dispensaries and should help establish revolving funds for the dispensaries to maintain services and supplies. These dispensary workers are not looking for profits, simply a living wage and the ability to help their communities as well as support their families. This desire is not beyond the scope of the government and should be one of the priorities of the nation’s leaders.
REFERENCES


Easterly, William. 2007. The White Man’s Burden: Why the West’s Efforts to Aid the Rest Have Done So Much Ill and So Little Good. Penguin Group.


Harvey, David. 2007. *A Brief History of Neoliberalism.* Oxford University Press.


APPENDIX A PROJECT PHOTOGRAPHS

Above Left: Plaque outside the Ninefescha hospital commemorating its construction.
Above Right: Waiting Room and location of Ninefescha interviews.
Middle: Ninefescha Ambulance.
Bottom Left: Generator Room, no longer in use.
Bottom Right: Water Tower, no longer in use.

Photographs taken by Principal Investigator Samantha Salter on July 24, 2017.
APPENDIX B MAP
APPENDIX C IRB APPROVAL MEMO

IOWA STATE UNIVERSITY
OF SCIENCE AND TECHNOLOGY

Institutional Review Board
Office for Responsible Research
Vice President for Research
2520 Lincoln Way, Suite 302
Ames, Iowa 50011
515-294-4566

Date: 5/9/2017
To: Samantha Salter
2410 Aspen Rd. Apt. 304
Ames, IA 50010

CC: Dr. Jill Pruett
324 Curtiss Hall
Dr. Neil Gabiam
324 Curtiss Hall

From: Office for Responsible Research

Title: Health Program Observation in Kedougou, Senegal

IRB ID: 17-170

Approval Date: 5/9/2017
Date for Continuing Review: 5/1/2019

Submission Type: New
Review Type: Full Committee

The project referenced above has received approval from the Institutional Review Board (IRB) at Iowa State University according to the dates shown above. Please refer to the IRB ID number shown above in all correspondence regarding this study.

To ensure compliance with federal regulations (45 CFR 46 & 21 CFR 56), please be sure to:

- Use only the approved study materials in your research, including the recruitment materials and informed consent documents that have the IRB approval stamp.
- Retain signed informed consent documents for 3 years after the close of the study, when documented consent is required.
- Obtain IRB approval prior to implementing any changes to the study by submitting a Modification Form for Non-Exempt Research or Amendment for Personnel Changes form, as necessary.
- Immediately inform the IRB of (1) all serious and/or unexpected adverse experiences involving risks to subjects or others; and (2) any other unanticipated problems involving risks to subjects or others.
- Stop all research activity if IRB approval lapses, unless continuation is necessary to prevent harm to research participants. Research activity can resume once IRB approval is reestablished.
- Complete a new continuing review form at least three to four weeks prior to the date for continuing review as noted above to provide sufficient time for the IRB to review and approve continuation of the study. We will send a courtesy reminder as this date approaches.

Please be aware that IRB approval means that you have met the requirements of federal regulations and ISU policies governing human subjects research. Approval from other entities may also be needed. For example, access to data from private records (e.g., student, medical, or employment records, etc.) that are protected by FERPA, HIPAA, or other confidentiality policies requires permission from the holders of those records. Similarly, for research conducted in institutions other than ISU (e.g., schools, other colleges or universities, medical facilities, companies, etc.), investigators must obtain permission from the institution(s) as required by their policies. IRB approval in no way implies or guarantees that permission from these other entities will be granted.

Upon completion of the project, please submit a Project Closure Form to the Office for Responsible Research, 202 Kingland, to officially close the project.

Please don't hesitate to contact us if you have questions or concerns at 515-294-4566 or IRB@iastate.edu.
APPENDIX D IRB APPROVED CONSENT FORM

- Study records will be kept in a locked briefcase and on a protected computer.

*Risks and Benefits:*

There are no foreseeable risks if you chose to participate in this study. It may be uncomfortable for you to discuss your personal decisions to use the health clinics versus traditional medicine. I will keep your information private and confidential, so anything you say to me will not be linked to you or made available to your community.

My research project may benefit you and your community, but may also have no direct benefits.

Potential benefits include:
- Opportunities for improving health programs
- Improvements include better understanding of your needs as a patient, health knowledge, and cultural understanding,
- This offers better customer service, communication between health workers and patients, improving the overall the relationship between workers and community. Better relationships will help improve treatments and aid in the lessening of illness.

*Questions, Concerns or Comments:*

If you have questions about this research project, you may contact the following people:
- Dondo Johnny Kante, Cuartier Gomba, Kedougou Senegal: 221-77-550-7271
- Samantha Salter: 221-77-550-7271 or saltersj@iaistate.edu
- Jill Pruetz: pruetz@iaistate.edu or jillpruetz@yahoo.fr

If you have questions about your rights as a research participant, you may contact the following:
- ISU IRB: You may contact the Institutional Review Board at Iowa State University at IRB@iaistate.edu of 515-294-4566. The ISU Institutional Review Board (IRB) is a committee that reviews and approves research studies with human subjects.

*Consent and Authorization*

After being provided this information, do you consent to being interviewed and observed as part of this research project?

Your access to health care or medical treatment in your community. You reserve the right to skip any interview questions you do not wish to answer.

*Confidentiality and privacy:*

You have the right to confidentiality (privacy). Records of interviews and observations will be kept confidential (private), to the extent allowed by relevant laws and regulations. Records will not be made available to the public or health agency. I will take these steps to ensure your confidentiality (privacy):

- Your actual name will not be used in study records.
- Your interview and other information will be labeled using a code.
- A false name will be used in written reports and no other personal information will be used.
APPENDIX E INTERVIEW QUESTIONS

All Informants:
1. Where are you from originally? What village/country?
2. What do you know about World Vision?
3. Do you know of other health clinics or health programs other than World Vision?
4. Apart from health clinics, has World Vision conducted specific health programs promoting better health? (Such as, nutrition, clean water, reproductive health, etc).
   a. Has any other organization done anything like this?
5. Have you used other clinics besides those established by World Vision?
   a. If so, when and why
   b. If not, why
6. If given the choice, would you continue to use World Vision’s facilities or use another?
   a. Why?
7. Can you tell me what you know about western medicine in comparison to traditional medicine?
8. Do you consider traditional and indigenous medicine the same or different?
9. Have you and your family always used more western health resources here?
10. When or how do you decide/choose between traditional methods and western medicine?
11. Can you describe a time when you chose one method over the other?
12. Do you think traditional methods are used more, less, or about the same as before western medicine became available to your community?
13. Can you tell me about a time when you had a bad experience when seeking western medical aid?
14. Can you tell me about a time when you had a bad experience when seeking traditional methods?
15. What, if anything, do you like about the health clinics and programs in this area?
16. Do you think having access to western medicine is good, bad, or neither? Is it a benefit to your community?
17. If possible, would you want more, less, or the same amount of access to western medicine for your community?
18. In your opinion, is there anything the clinics of programs can improve upon?
19. In your opinion, what is beneficial about using traditional methods?
20. What is most important to you when seeking medical aid?
21. Will you continue to use traditional methods in certain circumstances, even if western medicine becomes more accessible to your community?
22. Do you think there will ever be a time when traditional methods are completely gone?
23. How close is the nearest health clinic?
24. How close is the nearest traditional practitioner?
25. Has there ever been a time when you did not understand what a health worker was telling you about your illness or medicine treatment?
26. In your own words, what is health to you?
27. What is disease to you?
28. Do you ever use a combination of both traditional and western medicine?
   a. If so, when and why?
29. If there was one thing you could change about health clinics or programs, what would it be?
30. Do you identify with one specific religion?

Health Workers:
1. Can you tell me a little about the health clinics in Kedougou?
2. Are there specific health programs also in this area?
3. What do you think is World Vision’s main strategy for success in health programs here?
4. How do you personally measure how successful a program or clinic is?
5. What attracted you to work for the western medical organizations?
6. Have you experienced cultural challenges during the beginning stages of health clinics or projects? If so, can you share an example?
7. Have you experienced cultural challenges still? If so, can you share an example?
8. Are there times when your traditional or religious beliefs are at odds with health projects in this area?
9. Have you ever been asked to share program strategies with other World Vision field offices?
10. Do you know if any program analyses for the clinics and programs done in this area?
11. Would you say the bulk of World Vision’s work in this area is establishing sustainable health clinics or health promotion outreach programs?
12. Has there ever been a time when a patient did not understand their diagnosis and/or medicine treatment?
   a. If so, how was it resolved?
13. How do people in this area understand health and disease? What are their beliefs about health and disease?
14. Do you think the clinics and outreach programs address the needs of this area?
15. In your opinion, what can be done to improve the clinics and outreach programs?
16. If you could change one thing about the clinics and programs, what would it be?
APPENDIX F TRANSCRIPT EXCERPTS

(15M72417NF)

Interviewer: Does the money for the tickets, does that pay for the medicine?
<Translator asks question to informant in French>

Informant 15M72417NF: <responds in French and is translated verbally by Translator> Yes, he said yes, but sometimes also the mayor, he give money to buy medicine.

Interviewer: Um, does he know, like the committee what exactly do they do? I mean, are they the ones managing the money, so when people come they are paying him for a ticket and does he hand that money off to the committee and they deal with it? Um, you know if something is broken does he have to fix it or are they using that money to fix things? I mean, they aren’t giving him money for a salary, so just curious exactly what do these people do? [awkward laugh]
<Translator asks question to informant in French>

Informant 15M72417NF: <responds in French and is translated verbally by Translator> He said, yeah exactly, because each end of the month, the committee should have a meeting to see the money. Like the money for the ticket, the percentage for the tickets, the percentage for medicine money. So, they will decide how much to put again to the medicine and how much to give to them, like just uh motivation money and the committee also should have something for motivation. So, everything is done by the committee.

Interviewer: Um, besides having a salary, is there anything else he would want to change about the dispensary?
<Translator asks question to informant in French>

Informant 15M72417NF: <responds in French and is translated verbally by Translator> He says yeah, what he is wishing is to have some [unclear] for the laboratory and uh, of course for him he could have uh more money by working in Kedougou or in another dispensary you know, but he think, he is worried about his population. All the people working before are all gone, there is one, only one accept to stay, so if he also just think about money and leave here they dispensary would close. That is why he stay here, but yeah if he could have more medicine and more laboratory things that are working, can give more money and you know more medicine can give more money because they would be able to do more things. He said, he think, he is talking about the electricity, without that it is hard to get things done.
## APPENDIX G INFORMANTS AND DISPENSARIES

<table>
<thead>
<tr>
<th>Dispensary</th>
<th>Informant Age</th>
<th>Informant Sex</th>
<th>Informant Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baitilaye</td>
<td>Older Individual</td>
<td>Male</td>
<td>Maribou</td>
</tr>
<tr>
<td>Baitilaye</td>
<td>Middle Aged</td>
<td>Female</td>
<td>Midwife</td>
</tr>
<tr>
<td>D.C.</td>
<td>Middle Aged</td>
<td>Male</td>
<td>Manager/Physician</td>
</tr>
<tr>
<td>Djinji</td>
<td>Middle Aged</td>
<td>Male</td>
<td>Community Member</td>
</tr>
<tr>
<td>Djinji</td>
<td>Pre-Middle Aged</td>
<td>Male</td>
<td>Community Member</td>
</tr>
<tr>
<td>Djinji</td>
<td>Older Individual</td>
<td>Male</td>
<td>Community Member</td>
</tr>
<tr>
<td>Djinji</td>
<td>Middle Aged</td>
<td>Male</td>
<td>Maribou</td>
</tr>
<tr>
<td>Kedougou</td>
<td>Middle Aged</td>
<td>Male</td>
<td>Community Member</td>
</tr>
<tr>
<td>Mako</td>
<td>Older Individual</td>
<td>Male</td>
<td>Mayor</td>
</tr>
<tr>
<td>Ninefescha</td>
<td>Older Individual</td>
<td>Male</td>
<td>Teacher</td>
</tr>
<tr>
<td>Ninefescha</td>
<td>Middle Aged</td>
<td>Male</td>
<td>Mayor</td>
</tr>
<tr>
<td>Ninefescha</td>
<td>Middle Aged</td>
<td>Male</td>
<td>Manager/Physician</td>
</tr>
<tr>
<td>Petit Oubadji</td>
<td>Older Individual</td>
<td>Male</td>
<td>Manager/Physician</td>
</tr>
<tr>
<td>Syllacounda</td>
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<td>Female</td>
<td>Nurse</td>
</tr>
<tr>
<td>Syllacounda</td>
<td>Middle Aged</td>
<td>Male</td>
<td>Manager/Physician</td>
</tr>
<tr>
<td>Wakilari - just</td>
<td>Middle Aged/Older</td>
<td>Male</td>
<td>Medicine Man</td>
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<tr>
<td>medicine, no</td>
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<td></td>
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<td>building</td>
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</tr>
</tbody>
</table>
Conducting a participant feedback process was not feasible for my project. I chose to focus my project on a specific health dispensary that I visited which conducting research in Senegal. The individuals I spoke with, whose interviews I used do not have access to Internet services, most do not own a computer or smart phone either. It is also very difficult to connect via telephone, due to the high prices they are charged for calling and texting, especially to the United States. Furthermore, my data plan does not allow me to call to Africa – I have tried several times and receive the same automated message.

It does bother me that I was unable to complete this section of the project. However, my participants were all informed about what their interviews were being used for. We discussed why I was conducted my research, what my interests were, what I hoped to achieve, how I was going to use the information they gave me, etc. What is important to my own research is to ensure that I represent their stories accurately and fairly. All of my informants expressed hope that I would keep them in my mind and do anything I could to better their situation. Unfortunately, I am unable to help financially or physically, but I feel that by using this data in various ways can help bring attention to the issues. Bringing attention to the lived realities of my participants provides opportunities for those who are financially and physically able to help, to learn about and understand what these people experience everyday. I wanted to use these interviews and my observations in this project to shed light on what happened to a state-of-the-art hospital in a remote area once political interests waned. So, even though I was unable to receive feedback directly from my participants, I do feel that they would approve of how I am using this information.