

Health expenditure and household budgets in rural Liberia*



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Abstract

Fieldwork conducted in a Kpelle village in north-central Liberia revealed that health-care expenses constitute a major part of domestic spending. The actual transactions for major health-care expenditures are handled by men, typically using income that jointly belongs to the couple in addition to the husband's personal income. Women are likely to spend their personal incomes on minor health expenses for themselves and their children. Women's health expenditure, as well as their income handling arrangements, seem to differ according to the type of conjugal union they are in. Although Kpelle wives have input in most financial decisions, they tend to defer to men on issues which are associated with the Western world, namely Western health care, educational and tax expenditures.

Introduction

Decision-making regarding health issues among rural people is not clearly understood because there has been relatively little research in this area, particularly in the African context. A number of studies which examine health behaviour in rural Third World settings identify several factors which determine treatment choices (Young 1980; Stock 1983; Okafor 1983; Mwabu 1986; Kloos et al. 1987; Csete n.d.). These include the seriousness of the illness, knowledge and indigenous categorization of the illness, degree of confidence in home remedies and traditional medicine for the illness, and expenses associated with seeking Western treatment. This paper contributes to the discussion of health behaviour by focusing on health-care expenditure in the context of domestic budgets; based on a case study of the Kpelle, the largest ethnic group in Liberia, it investigates different conjugal budgetary patterns for medical expenditure.

Domestic budgeting in West Africa

In the past decade or so, a growing literature has emerged on gender and the household economy in the Third World in general (Dwyer 1983; Beneria and Roldan 1987; Dwyer and Bruce 1988; Wilks 1989), and in West African societies in particular (Guyer 1980, 1988; Whitehead 1981; Abu 1983; Steady 1987; David 1991). This body of writing is part of a wider discussion among feminists and others about the effects of commercialization¹ on gender relations at the household level and how these effects

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¹ It is worthwhile to define several terms used in this paper to characterize the impact of capitalism on pre-capitalist societies. Commoditization refers to the degree to which the reproduction cycle (i.e. the reproduction of the labour force) is realized through the production and exchange of commodities (Bernstein 1979). When capitalist relations

interact with political and economic changes at the macro level, in contexts where capitalist relations were introduced from the outside. This new attention to how men and women dispose of their resources, particularly income, complements the considerable literature on the economic activities of Third World women.

Research on domestic budgeting in West African societies has produced consistent findings that shatter a number of Western-derived assumptions about the household economy. Despite important variations between societies, certain commonalities have been documented. Numerous studies have verified that husbands and wives in West African societies do not necessarily pool their incomes and often have totally separate budgets because of the practice of polygyny, the stronger allegiance of individuals to their lineage than to their spouses, and individuals' desire to control their own income (Guyer 1980; Abu 1983; David 1991). In both urban and rural West African societies there is a sexual division in financial responsibilities whereby men are usually expected to assume responsibility for major periodic expenditures such as school fees, clothing, housing and health care, while women bear the cost of provisioning the household on a daily basis, providing food and other household necessities, minor health expenditures, additional clothing (Abu 1983; Fapohunda 1988; Guyer 1988; Moran 1988). But women's often smaller monetary contributions to the upkeep of the household should not be seen as merely supplementary to men's (e.g. Handwerker 1974). To understand the importance of husbands' and wives' economic contributions to the household requires more than an assessment of actual cash inputs; the ideologies underlying the role of the provider must be examined, since at this ideological level value is assigned to the economic contributions of men and women.

There has been insufficient examination of how expenditures introduced with the spread of Westernization and the cash economy (e.g. school fees, purchased food, clothing, health care) are incorporated into the 'conjugal contract' and assigned to spouses. Here it is important to distinguish which spouse is expected by cultural designation² to provide particular items in the domestic budget and which spouse actually pays for those expenditures or provides those items.

Clearly, an understanding of husbands' and wives' areas of economic responsibilities before the spread of capitalism is central to understanding how the 'conjugal contract' has evolved with the spread of the cash economy. Information on how the marriage system has evolved with the spread of commercialization is also important for explaining which spouse assumes responsibility for certain newly introduced expenditures. The increase or decrease in the incidence of polygyny and the replacement of more formal by less formal types of marriage (e.g. cohabitation, marriage involving payment of token amounts instead of full bridewealth) may have important implications for the assignment of financial responsibility between spouses.

The sexual division of budgetary responsibilities in rural West Africa appears to be linked to factors such as the regularity and seasonality of men's and women's income which is determined by differences in the types of crops they grow and the income generating opportunities available to each sex. Since men tend to grow cash crops which are harvested at specific times during the year and bring in relatively large sums of money, and since men have greater access than women to off-farm employment, they tend to be responsible for large periodic expenditures such as school fees, clothing

exist, this process is characterized by the monetization (the creation of a system of monetary exchange) and commercialization (the production and exchange of commodities) of the economy.

² Whitehead (1981) has aptly used the term 'conjugal contract' to refer to the terms under which husbands and wives exchange goods, income services and rights. In some societies, like the Kpelle, conjugal economic or financial responsibilities may be legally sanctioned in that the delinquent spouse can technically be sued for not meeting his or her responsibilities. It was a common occurrence for wives in Gbaomu to sue their husbands for non-support.

and major health costs. By contrast, women's major dependence on the sale of food crops, which bring in small amounts of income throughout the year, makes it logical for them to take responsibility for daily household needs, such as food. Men's responsibility for Western-oriented expenditures may also be associated with their greater exposure to, and familiarity with, Western culture relative to women. For example, rural Liberian men generally are more likely than women to travel frequently from villages to towns, to attend school, to speak English and to migrate to cities or concession areas for employment (Christiansen, Gay and Tamba 1971-72; Gay 1976; Carter and Mends-Cole 1982; David 1991).

Although it is often helpful to discuss expenditure on Western health-care treatment together with other newly introduced areas of domestic expenditure, this area of spending has particular characteristics which have implications for how it is handled by spouses. Unlike other areas of spending, health treatment is neither regular nor predictable. Moreover, all household members are likely to require health treatment, although women, children and the elderly suffer most from poor health. Unlike other categories of expenditure, since illness may involve a life-or-death situation, spending on health treatment is often unavoidable. However, the amounts spent may be highly variable and can be determined to some extent by the persons making the treatment decision, depending on the nature of the illness, the treatment and the type of health-care system from which treatment is sought. A seminal study by Orubuloye and colleagues (1991) in southern Nigeria concludes that, despite a separation of husbands' and wives' budgets, women are largely dependent on their husbands to meet the health needs of their children and themselves since men are financially better off and have a larger say in treatment decisions. The authors suggest that divided budgets and treatment decision-making responsibilities in this context may delay treatment and consequently contribute to high mortality rates (Orubuloye et al. 1991:207). Analysis of the implications of the Kpelle conjugal budgeting practices for treatment behaviour will further test the generalizability of these findings to other parts of West Africa.

Despite the specific nature of health expenditures and the urgent health-care situation in Africa generally, few studies on West Africa address this area of spending in any detail. Where health expenditures are discussed, the emphasis is on understanding health-care-seeking behaviour rather than the nuances of resource allocation and decision-making between spouses. Yet it is clear that gender power struggles over the allocation of income and other resources are a central factor in understanding health-care decisions and health-seeking behaviour. With the increasing cost of health care in many African countries due to structural adjustment programs and austerity measures adopted by governments, the issue of household domestic budgeting patterns and health expenditure is a vital area for research which may illustrate the detrimental impact of introducing fees for health care, and propose areas for suitable policy interventions.

The treatment of illness by Liberians

Rural Liberians, like the majority of Africans, face the choice of using home remedies for their health problems, or consulting traditional healers or Western health practitioners. But little is known about how rural people in Liberia make choices about health treatments. Among a rural sample, Ross (1972-74) found that women and old people showed a stronger preference for traditional medicine than did men and young people. The association between age and type of health-care system preferred was corroborated by Dennis and Harrison's (1979:84) study of high school students which showed that respondents only resorted to traditional medicine when they lacked money or when hospital emergency rooms were overcrowded. There is also evidence that Liberians tend to seek Western treatments for cough, fever, diarrhoea, sores, worms, hernia, and epilepsy and prefer to seek traditional remedies for

broken bones, illnesses thought to be caused by witchcraft, and insanity (Christiansen, Gay and Tamba 1971-72; Ross 1972-74).

Knowledge about local classification of disease perceptions is scanty in the Liberian literature. Schwab (1947) and Welmers (1949) contribute some of the earliest descriptions of Liberian traditional medical treatments. Wintrob and Wittkower (1968) focus specifically on traditional treatments for mental disorders. Orr's (1968) preliminary discussion of health treatment in a Kpelle village provides substantial insight into Kpelle classification of illnesses. While the scanty literature on health-care behaviour among Liberians points to illness classification, age, gender and cost as being factors which influence treatment decisions, none of these factors has been investigated in any detail. Moreover, none of these studies mention health-care decision-making between spouses or the allocation of responsibility between husbands and wives for spending on health treatment.

The research

This paper presents a discussion of health-care expenditure in the context of household budgets in a Liberian rural economy which has been undergoing a process of rapid commercialization since the 1930s. The data are drawn from a wider study of conjugal economics in a Kpelle community in Bong County (north-central Liberia) conducted in 1989-90 (David 1991),³ just before the onset of the civil war.⁴ The objective of the discussion is to investigate the dynamics of income handling by husbands and wives with regard to health-care expenditure.

Data for the study were collected between March 1989 and March 1990 using a variety of methodologies: participant observation, a village census, key-informant interviews, a detailed budget study of four married couples and five unmarried women and a survey based on a sample of 37 husband-wife units of which seven were polygynous units (see David 1991 for methodological details).

The setting

Bong County, where the study was conducted, is characterized by small communities (the majority of villages have fewer than 100 inhabitants) of semi-subsistence farmers, as is typical of other parts of rural Liberia. The commoditization and monetization of the pre-capitalist economies of north-central Liberia can be traced back to the early part of this century when the Liberian Government, in its attempt to impose its political and economic authority over the existing autonomous monarchic units, imposed a hut tax on the population in 1916 (David 1991). Apart from the imposition of hut tax, the spread of the cash economy has been characterized by the expansion of road networks, the spread of cash cropping, the availability of manufactured items, the sale of food crops, urban migration and the introduction of Western practices and institutions such as Western medicine and schooling. In most parts of the country, mission hospitals and schools were first established in county capitals or large towns, but beginning in the 1960s, Government health facilities and schools spread to smaller communities.

Gbaomu, the village where I conducted fieldwork, is in Upper Bong County, approximately 138 miles north of Monrovia, the capital city of Liberia. Gbaomu is on a feeder road about 13 miles from Gbarnga, the capital of Bong County; the closest health facilities are in Gbarnga and the surrounding areas. In 1989-1990 Gbaomu had a population of approximately 772 people, making up 127

³ Field research, which was conducted for my doctoral dissertation (David 1991), was supported by a grant from the Joint Committee on African Studies of the Social Science Research Council and the American Council of Learned Societies with funds provided by the Rockefeller Foundation.

⁴ The Liberian civil war began in late December 1989 as an insurrection led by the National Patriotic Front of Liberia (NPFL) against the dictatorship of President Samuel Doe. At the time of writing, the country remains divided into two parts.

households. The rate of polygyny in Gbaomu is high, with the heads of 28 per cent of male-headed households in 1989-1990 having multiple wives. Relatively few households, 15 or 12 per cent, were headed by women. The average household size was 6.1 persons.

Domestic budgeting among the Kpelle

The Kpelle are primarily subsistence farmers who mainly inhabit the central part of Liberia (Bong County). They practise swidden cultivation of rice and grow tubers, vegetables, and fruits as secondary food crops. Kpelle men have access to cash from wage labour, most commonly by working as rubber tappers at the Firestone Plantation or other rubber farms and through employment at iron ore mines. They also control income derived from coffee, cocoa, sugar cane (sold in the form of a crude rum called 'cane juice'), citrus, fruits, cola nuts and palm oil.

Among the Kpelle, women provide the bulk of labour in food production and make money from the sale of tubers, vegetables, fruits, as well as from rum produced from sugar cane (grown on personal as well as household farms), processed foods and petty marketing. The Kpelle accept that the income made by a woman's individual efforts is hers to control, although she is expected to turn her personal earnings over to her husband to keep (she still maintains control over it) or at least show him her earnings and give him a certain amount of it out of respect for his status as head of household.

Because men have more varied income-earning possibilities than women, their personal budgets are generally more constant throughout the year, although they are affected by the seasonality of crops. Women's personal budgets experience greater fluctuations than men's, since they rely on only one cash crop, sugar cane, and are more dependent on income from the sale of food crops which bring in small amounts of cash at certain times of the year. From the income data I collected over a two-month period (September–October, 1989 and November–December 1989) from four married men and 12 women⁵ with a range of current incomes, I calculated a rough average annual cash income of L\$683 (about US\$228) for men and L\$358 (about US\$119) for women. Although estimating annual income from two-month budgets is not valid, it does give some idea of people's cash incomes and of the difference between the cash incomes of men and women.⁶

Kpelle marriage is based on a set of formal rights and obligations which spouses legally have toward each other in that if obligations are not met, theoretically the wronged spouse can seek legal recourse by reporting the other spouse to relatives, suing the other in court or divorcing him or her. A husband's obligations are to perform male agricultural tasks, and to support his wife by buying her clothes, paying for her medical expenses, paying for agricultural labour, buying food and other household necessities, paying government taxes and contributing toward the support of his wife's parents and family in general. He is also responsible for supporting any children the couple may have by paying their school fees, medical expenses, clothing and so on.

A wife's obligations are to undertake female farm tasks, perform domestic tasks, give birth to children and raise them and help her husband to support his relatives. In today's cash economy, a wife is also expected to help her husband fulfil his obligations of providing for the family and herself by engaging in income-generating activities. The Kpelle feel that the husband plays the most important economic role in the family as provider and economic manager, the wife's economic contribution being construed as 'helping'. Based on the notion of the husband as the provider, the ideal income-management pattern is for the husband to keep and manage all income made by the couple together, as

⁵ Of the 12 women, seven were married and five were single.

⁶ I included only cash transfers in the calculation of cash income but in-kind transfers, which constitute an important source of income, are omitted because of difficulties in quantifying them.

well as any significant income made by the wife privately, which amounts to a pooling of resources.⁷ I observed the ideal husband-as-financial-manager pattern to be the most common income-handling arrangement among monogamous households. Couples who maintained this arrangement generally felt that either spouse had to obtain the other's consent regarding use of jointly-owned income. In the majority of these cases, it is unlikely that wives know where jointly-owned income is kept (David 1991:235). When wives know where joint savings are kept, they sometimes use some of this money in their husbands' absence and later report their spending to their husbands. Beside this income-handling pattern, at least three other patterns exist: one arrangement where wives keep their own privately-earned money, especially common in polygynous households; another where the wife handles the conjugal budget; and a third where the husband keeps the wife's personal income without having control over it. Regardless of which income-handling arrangement exists between a couple, in most cases wives keep some money on their own, although the amount varies considerably among women.

My observation is that although men in Gbaomu generally had higher incomes than women and generally contributed more to the maintenance of the household, the notion of the husband as the breadwinner is an ideological construct based on the perception of men as superior to women, as the controllers and apportioners of land and as those legally responsible for women and having legal rights in them. Because the notion of male support is ideologically derived and has little to do with the actual financial and economic contributions of men, the level of support society expects from a husband is not clearly defined and remains a moral issue. Therefore the support provided by Kpelle husbands is extremely variable and appears to depend on the type of conjugal union (monogamous or polygynous), the level of male or household wealth, the age and health of the husband, the relationship between the spouses, and the husband's commitment to his wife and family. Women's ideological definition as dependants in Kpelle society leads to an undervaluation by society of the contributions they make in labour and cash to the survival of the household.

Health care in Gbaomu

The health situation in Gbaomu is typical of that found in most rural areas of Africa. The most vulnerable to health problems are children, particularly those under five, women of childbearing age (15-44) and old people. The major causes of morbidity and mortality among children in Liberia, resulting in a national infant mortality rate of 112 deaths per 1000 births, are malaria, diarrhoea, measles, pneumonia, neonatal tetanus and protein-energy malnutrition (UNICEF 1985). These illnesses are exacerbated or compounded by the unsafe water available to most of the rural population; only six per cent of rural people had access to safe water in the mid-1980s (UNICEF 1985). The major illnesses and causes of death among adults are malaria, gastroenteritis, upper respiratory infections and intestinal parasites. Women between 15 and 44 are particularly vulnerable to these and other illnesses through frequent pregnancies (the crude birth rate in 1983 was 45 per 1000 population) and ineffective antenatal and postnatal care (UNICEF 1985). Other health problems found in rural areas of Liberia, that are not normally mentioned, include illnesses related to farming such as schistosomiasis, leeches and sores,⁸ and accidents resulting from swidden cultivation and farming in general: cuts, snakebites, falls from palm trees, loss of limbs in sugar cane crushing machinery. Illnesses related to alcoholism are

⁷ Of monogamous wives 54.5 per cent interviewed for the survey gave the earnings from the sale of cane juice produced on their personal farms to their husbands to keep, while 45.5 per cent kept this money themselves. Of polygynous wives 42 per cent kept income from this source themselves, while 33 per cent gave it to their husbands to keep.

⁸ These three problems are encountered during the cultivation of swamp rice.

undocumented but appear to be common in many rural areas. Owing to the seasonal shortage of certain important foods, such as rice, vegetables and meat; to food taboos, which apply mainly to women and children; and to the general harshness of life, rural Liberians follow a constant cycle of ill-health. With the spread of the monetized economy, a central feature of life even in the most remote village is the generation of a cash income and monetary expenditure on a variety of items, especially food, health and labour.

Gbaomu is not typical of most Liberian villages in its inhabitants' access to Western health-care facilities. Its proximity to Gbarnga means that the county's major hospital (Phebe Hospital) and several public and private health institutions are less than one hour's drive away. In addition, since the mid-1970s, Gbaomu has been served once a month by a mobile health unit from Phebe Hospital. Other less conventional Western health-care treatments were available from a 'medicine store' in the nearby town of Weinsu, from a local man who had previously worked at a clinic in Monrovia and occasionally from travelling medics of dubious qualifications ('black baggers'). The village had four midwives in 1989-1990, two of whom had been trained under a program for traditional birth attendants.

Various traditional health practitioners were also available to Gbaomu residents. A number of people, both men and women, were knowledgeable herbalists; there were two female and three male ritual specialists (*foe*) associated with the male and female secret societies (*Poro* and *Sande*, respectively⁹); a local chapter of the Snake Society, which specializes in treating snake bites; two 'traditional' (i.e., untrained) midwives and a bone setter in the neighbouring town of Weinsu. Furthermore, most people, especially women, have basic knowledge of herbal and other treatments for common illnesses and health problems such as skin infections, body pain, worms, diarrhoea, hepatitis, contraception and the inducement of abortion.

Health expenditure in Gbaomu

People in Gbaomu use both traditional and Western medicine; I did not investigate which health-care system is most used. It was apparent, however, that people select one of the two systems on the basis of several considerations, including the perceived nature of the illness (whether the illness is seen as having an underlying spiritual cause), the perceived efficacy of the treatment, and the availability of time and money. Some of my informants felt that traditional medicine has become less effective in curing certain illnesses such as malaria or that Western medicine cures certain illnesses better than 'country' medicine. I was constantly being asked for pain-killers to treat headaches and body pain for which the traditional treatment is the smearing of certain kinds of chalk over the afflicted part of the body. Other requests were for antimalarial drugs and anti-diarrhoeal medicine. Some people felt that traditional medicines take longer to work than *kwii* or Western medicine. For example, although there are herbal treatments for extracting teeth, a woman who was suffering from a toothache preferred to go to Phebe Hospital to have her tooth extracted because, she observed, 'I am a working woman and don't want to waste time'. In other cases, people sought Western medicine because traditional applications caused too much pain, as for example in the treatment of conjunctivitis. Often people turn to Western medicine as a last resort, in some cases because of the high cost involved.

One important observation I made was that although traditional cures are for the most part less expensive than Western health treatments, they are not necessarily inexpensive. In one case that I knew about, a bone setter charged a family L\$150 (US\$50) to set the broken leg of a little girl. Since the bone setter was related to the family in question, the final fee paid only amounted to L\$18.50 (US\$6),

⁹ The *Poro* and *Sande* societies are gender-based initiation schools that are indigenous to most ethnic groups of Western and Central Liberia. These societies are universal: virtually all members of rural communities join them.

part of which was paid in kind. Thus, a major difference between payment for Western and traditional health care is that since the latter is provided by a member of the community, often a relative, the fees are negotiable and can often be paid in kind.¹⁰ Western health treatments, by contrast, must be paid for immediately in cash, which is often a scarce commodity in rural areas. On the other hand, treatment by a *zoe* may result in a situation of continual debt in that the former patient is expected to show respect to the *zoe* by periodically offering him or her gifts or working for him or her on request (Orr 1968; Murphy 1981).

Some examples of the cost of traditional medical interventions are helpful. The majority of childbirths in Gbaomu were managed by the local midwives who charged L\$15 a delivery, a fee set by Phebe Hospital; but when faced with a complicated delivery, they referred the mother to a midwife in Weinsu or to Phebe Hospital. Some families brought in Western health personnel (a physician-assistant) from the county hospital to perform male circumcision. In the one case I knew about, where a physician-assistant performed male circumcision, the family spent five Liberian dollars per child plus feeding expenses. The cost of a form of traditional contraceptive, a specially prepared 'string' worn by men or women around the waist, in 1989-1990 was about L\$20, but this price was negotiable. Ingredients that have to be purchased in making abortifacients, such as terramycin and indigo, cost less than L\$2.

Most of the health expenses paid by Gbaomu residents were for the treatment of children, major illnesses that required hospitalization (e.g., operations), childbirth, and minor problems such as male circumcision, traditional forms of contraceptives and ingredients for abortifacients. Children's illnesses were frequently treated with either traditional remedies or Western medicine provided by Phebe's Outreach Clinic. Since Phebe Hospital is a mission-run institution, fees are charged: in 1989-1990, 25 Liberian cents for the registration of a child and 50 Liberian cents for an adult,¹¹ plus an additional fee for medicines. Hospitalization fees at Phebe were based on a family's socioeconomic status, so that farmers were usually charged L\$3 a night and an additional L\$15 if the patient was admitted through the emergency room. Health expenses, both traditional and Western, therefore ranged from a few dollars to several hundred dollars, the latter for operations and hospitalization at private health institutions. Expenditure is spread across the various treatment options, although the largest cash outlays are made at Phebe Hospital.

The budget and survey data I collected clearly show that health care is a major expenditure in most households in Gbaomu, probably ranking as the third major expense after food and agricultural labour. Unlike these last two expenses, however, health expenses are not regular nor constant in amount. As a major expenditure, there is a clear-cut gender division in who pays for health care, given the Kpelle norm of men as providers and the ideal income management arrangement whereby men keep the bulk of the income earned by a couple. Unlike other regular expenditures such as for food or minor household items, which some men are able to avoid paying, knowing that their wives will somehow struggle to provide from their own earnings, women's health problems often involve a matter of life or death or the cessation of farm work and cannot easily be ignored, especially since a husband runs the risk of being sued by his in-laws if he does not attend to his wife's health needs. The seriousness of men's obligation to respond to their wives' health needs was shown in a household where the husband and the head wife were involved in a major domestic conflict which resulted in his refusal to provide

¹⁰ Bone setters charge fees higher than any other traditional healer in Kpelle communities (D. Brown, personal communication).

¹¹ During 1989-1990, on average, US\$1 was equivalent to L\$3 on the black market. Officially the two currencies were on par.

her with any financial support. This husband, however, unwillingly paid for his wife's hospital bills when she contracted cholera.

Table 1 presents estimates of health expenditures made by a sample of married men and women in 1989. From a sample of 37 married men, 33 or 89 per cent spent money on health care in 1989. The majority of men (26 or 70%) spent money on their own health care and 28 (76%) paid for health care for their children and wife. In addition, a significant proportion of men (78%) paid child-delivery costs, which also include the cost of a feast to celebrate the birth. Although men reported these expenditures and actually handled those transactions, in most cases, part of the money spent was jointly owned by the couple and was recognized as such.

Table 1
Estimates of annual expenditure on health care during 1989, as reported by husbands and wives

		Wives (N=48)		Husbands N=37)	
		N	%	N	%
Own medical expenses	None	21	43.8	11	29.7
	<L\$20	18	37.5	17	45.9
	L\$20+	9	18.8	9	24.3
Children's medical expenses	None	16	33.3	—	—
	<L\$20	13	27.1	—	—
	L\$20+	19	39.6	—	—
Children's and wife's medical expenses	None	—	—	9	24.3
	<L\$20	—	—	15	40.5
	L\$20+	—	—	13	35.1
Childbirth ^a	None	—	—	8	21.6
	<L\$20	—	—	24	64.9
	L\$20+	—	—	5	13.5

^aOnly husbands were asked about expenditure on childbirth since, culturally, they are responsible for this expense.

Of the 47 wives surveyed, 27 or 56 per cent reported spending money on their own health care in 1989 and 33 or 70 per cent paid their children's health expenses. It is likely that some wives reported health expenditures paid with money belonging to the couple which was kept by the husband. Given the existence of both couple-owned income and personal income, it is difficult to distinguish the source of payments for health care. However, the lower percentage of women than men who reported spending on their own health care (56 per cent of women compared with 70 per cent of men) suggests that husbands tend to pay for a significant portion of their wives' health care, either using jointly-owned money, their personal income or a combination of the two.

Budget data from four sets of spouses and five single women give more details on health expenditure and on the amount of money women spend from their personal income. A breakdown of the number of people each individual in the sample was responsible for is provided in Table 2 to allow for a more meaningful comparison of expenditure by men and women. The total average amount spent on health care by the four husbands¹² in the sample during 1989 was L\$101.75 (US\$34), while the yearly average for the women, married and single, was L\$4.39 (US\$1). Only two of the seven wives

¹² This includes money jointly owned by the couple in most cases, as well as the husband's personal income.

reported spending their personal income on health care; in both cases the amounts involved L\$3 or less. Estimates of annual health expenditure made by the larger sample of husbands and wives surveyed (see Table 1) provide further evidence of the relatively large amounts some households spend on health care: 19 per cent of wives and 24 per cent of husbands who reported health expenditures on themselves spent over L\$20 (US\$7), while 40 per cent of wives spent L\$20 and above on their children's health and 35 per cent of husbands reported spending L\$20 and above on their children's and wife's health. Two explanations may be offered for the slightly higher proportion of wives than husbands reporting high expenditure on the health care of dependants: the expenditure of polygynous wives (N=18) from their personal incomes may account for higher female expenditure, or alternatively, women may be inadvertently inflating the amount spent by husbands who invariably handle major health transactions.

Table 2
Breakdown of dependants^a of respondents in the budget study (N=16)

	Children ^b	Wives
Household A		
Husband	5	3
Wife 1	3	—
Wife 2	4	—
Wife 3	1	—
Household B		
Husband	5	2
Wife 1	4	—
Wife 2	1	—
Household C		
Husband	2	1
Wife	2	—
Household D		
Husband	1	1
Wife	1	—
Single women		
Case 1	3	—
Case 2	5	—
Case 3	1	—
Case 4	7	—
Case 5	2	—

^aRespondents only considered themselves to be supporting children and wives (in the case of husbands), although wives clearly contributed financially toward the support of their husbands.

^bIn some, but not all cases, children were supported by more than one woman.

The importance of male contributions to health expenditures is clearly seen in the problems faced by single women in finding money to cover this expense. A case in which I was closely involved illustrates the dilemma faced by single women. When I noticed something strange about the eyes of a boy of about seven, I advised his mother, Kwitaa, to have him treated at the county hospital. Kwitaa, a woman in her thirties, was separated from her husband and had returned to Gbaomu in 1988 from the Firestone Rubber Plantation with five of her seven children, leaving the other two with her husband in another village. She lived with her sister and her family and had no regular source of income apart from the money she received occasionally for working on other people's farms, from the sale of vegetables and snails, and from male kin and male friends, possibly a boyfriend. Given her financial predicament,

Kwitaa chose to seek the cheapest form of Western medical treatment and paid for an itinerant 'black bagger' to give the boy an injection. When the boy's condition did not improve, she decided to go to his father, who lived in a nearby village, to get money to have him treated at the hospital. The father decided to treat a swelling on the boy's ear with country medicine before taking him to hospital, the rationale being that the hospital might have to operate on the swelling which would increase the cost of treatment. By the time the swelling went down, the boy had gone completely blind and it became clear that the father had no money to send him to hospital. Kwitaa felt that she could not borrow money since she had no source of income. She was approached by a man in the village who claimed that he could open her son's eyes; before deciding to proceed with this treatment, Kwitaa consulted a diviner who advised her against it. At this point I intervened and gave her money to go to the hospital, but it was too late to save the boy's sight.

The budget data I collected do not allow for a comparison of the expenditures of male and female-headed households on food and health care, since only one of the single women included in the study constituted a household: the rest of the women ate and farmed with other people whose budgets were not studied; however, such a comparison would be revealing of the gender-specific nature of expenditure in this area. Evidence from other parts of the world suggests that nutrition in female-headed households is better than in other types of households because women are more likely to spend on food and health care (Kennedy and Cogill 1987; Dwyer 1989:986). A similar pattern is suggested by the evidence from Gbaomu which shows that men on average spent a much smaller proportion (18%) of their income on food than was spent by women (36%). This tendency for women to devote a larger portion of their income for collective purposes than men, especially where children are concerned, may be explained by maternal altruism (Whitehead 1981).

Source of money for health expenditure

Since many health problems arise as emergencies, it is important to consider the sources available to farmers for obtaining money quickly. Analysis of the source of money for health expenses also allows for an assessment of the gender divisions in financial responsibilities. The source of money for health expenses was investigated by asking men about this issue directly and questioning couples about their use of borrowed money. Men reported the following major sources of income spent on health care: non-agricultural activities such as palm wine sales, hunting, sale of handicrafts (42%), the income from which would be considered personal; rum jointly produced by the couple (33%); a variety of other crops (30%); coffee or cocoa (27%); palm oil (21%), and pensions received by former rubber tappers (18%).

Men were more likely than women to use borrowed money to pay for medical expenses: of the 21 men who borrowed L\$10 (US\$3.32) or more in 1989, five spent some of the money on family medical expenses and one used borrowed money for his own medical expenses. Women were more likely to use borrowed money to pay for agricultural labour expenses, family food, and clothes for themselves and their children.

Of the eleven women who borrowed money, five did so on their own; the rest reported loans that they considered the joint responsibility of their husbands and themselves. Only two of the eleven women who borrowed more than L\$10 in 1989 used that money for family medical expenses and one woman used it for her own medical expenses. The different use of borrowed money by husbands and wives indicates not so much different priorities as differences in male and female financial obligations according to Kpelle norms and the different access men and women have to borrowed money. Health expenses for which people borrow money may involve considerable sums of money which are more likely to be lent to men than to women, given women's lower income-earning capacity. Another important deterrent to lending women money is the inability of the lender to use the debt as a political tool, since women have no rights in themselves or others (Bledsoe 1980:111). However, even if men

borrow money in their name, the loan may be considered a burden to be jointly shared with their wives, depending on what it is spent and the source of the money used to repay the debt. For example, in the case of a young husband who borrowed money to take his wife to the hospital, the wife considered the borrowed money as belonging to both of them, since it would be repaid with money made from rum produced by herself and her husband.

People borrowed money from various sources including friends, relatives and saving societies, called *koral kuu* or 'clubs'.¹³ There was a clear gender distinction between the sources from which men and women borrowed money: women were more likely than men to borrow from relatives (64 per cent of women compared to 43 per cent of men), while men depended more on friends (29 per cent of men compared to 18 per cent of women) and clubs (29 per cent of men compared to nine per cent of women). Borrowing from clubs can provide large sums of money (one couple borrowed L\$350), but is often viewed as a last resort because of the interest that is charged on loans. Rates of interest depend on membership in the club and varied between 25 per cent for members and 40-50 per cent for non-members. An alternative source of obtaining money is the pawning of an item or property in return for cash. Pawning consists of giving the creditor an item (a piece of clothing, a gun, a sugar cane or coffee farm) to guarantee or pledge the repayment of the debt. It is unclear whether people pawn property to obtain money for health expenses. If this is the case, men are more likely to do so since they own more property of value than do most women.

Some general observations about the pattern of male and female incomes in Gbaomu are important for understanding women's dependence on men to pay health expenses from their personal income or income that they control. Not only are women generally poorer than men, but because they depend on a narrow range of income sources which are largely seasonal, their incomes are likely to drop during the rainy season, May to October, and peak during the dry season, November to April, because of the sugar-cane harvest. By contrast, many men in Gbaomu receive slightly higher incomes in the rainy season than in the dry season because of the coffee and cocoa harvests, the proceeds of which they control. An important observation that emerges from the Gbaomu data is that men's contribution to provisioning the household increases during the period when women's incomes are lowest (the rainy season) and decreases only slightly (as a proportion of their total expenditure) when women's incomes rise. In other societies, such as the two regions in south India studied by Mencher (1988), men tended to make higher contributions to the household budget in both relative and absolute terms when women were earning the most. This suggests that their contributions are more in line with their earnings than with the needs of the family. With regard to the Kpelle, budget data suggest that men's contributions toward household upkeep are in line with the needs of the household.

The politics of income control

Because money has become such a necessary currency in Kpelle society, financial matters have become a central area of conflict between husbands and wives.

Such conflicts arise from the disparity between the ideology of the male provider and the reality of male support, as well as from the flexibility and variation in arrangements for the provision of domestic needs. Variations in the level of male support between households are manifest in the financial obligations undertaken by polygynously married men compared with those of monogamously married men. Although nominally a polygynously married man has the obligation to support all of his wives and children, the Kpelle recognize that a man with several wives cannot support them in the same way

¹³ 'Clubs' are savings societies that operate on a yearly basis. Members contribute an amount, in this case \$1, once a week throughout the year and collect their savings at the end of the year, in addition to any interest the club has generated from loans. In Gbaomu, men and women joined clubs in equal numbers.

as a man with one wife. The handling of wives' medical expenses in polygynous households provides an example of the reciprocal nature of men's support of women and of the great potential for conflict when the notion of the male provider coexists with women having their own incomes.

Two cases illustrate these points: the first involves Gormah, a junior wife among three in a fairly wealthy and large household. Gormah felt that a woman should give any significant money she makes to her husband because he takes care of her. Moreover, she said that she shows her husband any amount more than L\$25 that she makes and likes him to take a portion. Her reasoning was that if he did not take any of her money, he might refuse to pay her medical expenses or send her to hospital if she got sick, and would taunt her by saying 'I didn't take any of your money, so carry yourself to hospital'. This example suggests that women's support is contingent upon their contributions, whether in cash or labour, to their husbands.

The second case involved Lorpu, a head wife in a large, fairly wealthy polygynous household where there were three other wives. Once when Lorpu had a large sore on her foot, which prevented her from working, her husband volunteered to send her to hospital, but she refused. She explained that if she had accepted his offer, her husband would have used this opportunity to seize her personal earnings to recover the money he spent on her. She used her own money to pay for an injection given by a local man. Although this case may not exemplify the typical attitude of Kpelle men toward their conjugal responsibilities, I think it shows the level of exchange that is implicit in female support, which can easily be overlooked when household budgets are studied from a purely quantitative approach and when the unit of analysis is the household, rather than both the household and the individual. The notion of exchange implicit in female support is based on calculable relations of obligations and rights between a husband and wife; a woman's right to financial assistance from her husband is contingent upon her cash contributions to his personal budget or the household budget and her labour contributions to the household. The conjugal contract regarding health care among the Kpelle is similar to that of the Kusasi of northern-eastern Ghana which Whitehead (1981:99) describes. Although the Kusasi have different budgeting and household arrangements from the Kpelle, rights to income for hospital visits are dependent on whether or not the household member is giving a fair share of labour contribution to household production, as assessed by the head of household.

Decision-making about health-care expenditures

The male-breadwinner ideology may be associated with strong patriarchal norms and a high degree of gender inequality in economic decision-making within the household. But although Kpelle society is highly patriarchal, I found that women had a major voice in economic decision-making. For example, even though most monogamously married husbands and wives followed the pattern of the husband keeping any significant money jointly owned by the couple, in most cases, wives had detailed knowledge about the spending of that money; this implies that they are consulted or informed by their husbands about expenditures. However, it was also clear that many wives defer to their husbands on most decisions, especially those regarding matters to do with the Western world, such as health-care decisions involving Western treatment, which is considered men's domain. In one case where a small boy was hospitalized for malnutrition, the decision to take him out of hospital prematurely was made by the father who claimed not to have enough money to pay the bill. The father paid the hospital bill mainly with money from his personal budget. The boy's mother (one of four wives) had no say in the decision to discharge him from hospital.

The degree of husband-wife negotiation over an income-related decision appears to be determined by the order or category (*meni*) of the decision at hand, as defined from the Kpelle perspective (Frankel 1979). Western-style health care, along with education, taxes and other matters associated with the Western world, are construed as the domain of men, so women, in most cases, willingly defer to male

authority. The issue is therefore not that Kpelle husbands make decisions unilaterally, but that the manner in which decisions are made involves the wife generally complying with the decision or suggestion made by the husband. Notwithstanding women's diffidence in decision-making on Western-type expenditures, economic relations between Kpelle couples are generally open to negotiation or bargaining, the outcome of which is partly determined by the resources available to individual women (cash income, age, the type of marital union) and the strategies of bargaining they choose (David 1991).

Lessons from the Kpelle case

The Kpelle case highlights the importance of several issues for understanding the implications of conjugal budgeting patterns for health-care treatment and decision-making. These include men's and women's different access to cash incomes, gender ideologies underlying budgeting patterns, marital status and the form of marriage, monogamy or polygyny. The preliminary nature of this study perhaps raises more questions than it answers and therefore the observed trends should be interpreted with caution. A major recommendation is therefore for more focused studies on health expenditures and domestic budgeting based on relatively large samples living in a cross-section of villages, for instance having different degrees of access to Western health-care facilities.

The division of responsibility for payment for health care and decision-making in Gbaomu may be determined largely by the amount of money involved and the type of treatment being sought, traditional or Western. Owing to their irregular access to cash incomes, Kpelle women tend to pay from their own money for the treatment of minor health conditions which require relatively small expenditures, using either traditional or Western treatments. In such cases it is highly likely that they do not consult their husbands. By contrast, because Kpelle men are more familiar with the Western world, have access to larger sums of money from their personal budgets, have greater control than their wives over pooled conjugal income and are ideologically and legally construed as providers and heads of the domestic unit, they tend to have a greater voice in decisions regarding the use of Western treatments for major illnesses and make the actual expenditures in those cases. To confirm the importance of gender ideologies in determining budgeting patterns, more investigation is needed on the level of expenditure and types of illness which women and men generally consider to fall under the domain of each sex. It can be hypothesized that, reflecting inconsistencies in the Kpelle male-provider ideology, societal expectations regarding the level of expenditure expected of Kpelle spouses will be determined by the type of marital union and the wife's level of personal income.¹⁴ An understanding of the ideologies underlying gender domains of expenditure is important because strategies devised by individuals to enforce change derive from ideology. Furthermore, any policy intervention must necessarily take into consideration such ideologies.

One objective of this case study was to test the generalizability to other West African societies of an important hypothesis proposed by Orubuloye and colleagues (1991) concerning separate budgets and delays in the treatment of illness. The hypothesis that separate conjugal budgets give rise to bargaining over treatment and treatment delays does not appear to be applicable to the Kpelle case because of the ideologies on which conjugal-budgeting patterns are based. Moreover, the existence of partly pooled budgets in the majority of monogamous Kpelle households challenges the non-pooling household model documented in the West African literature. Because Kpelle men are expected to support their wives and families (although in reality women contribute significantly toward family support), women do not hesitate to approach their husbands for money for food, health care and other necessities even in

¹⁴ A study of urban Yoruba households (Fapohunda 1988) showed that as husbands' education and income rises, they tend to assume a greater part of expenditure on children's clothes. Husbands' share of this expenditure, however, declines as wives' education and income rise.

polygynous households where spouses maintain separate budgets. This behaviour, which deviates from patterns observed in certain West African societies (e.g. Yoruba, Ashanti, Beti) where women are expected to provide basic necessities for themselves and their children (Guyer 1980; Abu 1983; Orubuloye et al. 1991), suggests that Kpelle men are likely to have greater expenditure-related decision-making power than women. On the other hand, in support of the above hypothesis, the Kpelle material suggests that the existence of a unified household budget may increase the timeliness of treatment. Kpelle women in households where the couple partly pool their income and where both spouses know where joint savings are kept can seek treatment for themselves and children more quickly than in situations where couples maintain separate budgets. Thus, some women in Gbaomu, probably a minority, could seek treatment for their children and themselves in their husbands' absence using jointly-owned income which their husbands keep but over which they have rights. The important point emphasized by the Kpelle case is that although budgetary patterns may affect the timeliness of treatment, there is a need to consider the ideologies underlying these patterns in order to understand men's and women's control and rights over income and their bargaining over treatment decisions.

If Kpelle men are likely to make the majority of health-treatment decisions, it follows that delays in treatment decisions, where cash expenditure is involved, are likely to be attributed to men rather than women. At the policy level, this observation suggests the need to direct health messages regarding immunization and other preventive measures at both men and women, rather than to women only, especially in societies where the male-provider ideology prevails. Regardless of the income-handling and budgeting pattern, how quickly people seek treatment will ultimately be determined by the availability of funds. The timely response to illness, however, appears to be determined by other factors such as education, which is often correlated with wealth (Orubuloye et al. 1991).

Because of the high rate of divorce in Kpelle society this case study also highlights the dilemma of single women in seeking health treatment. Single women in Gbaomu tend to be poorer than married women (David 1991:291-294), and to compensate for their ability to generate adequate cash income from their agricultural enterprises, they depend on transfers from boyfriends and male relatives. While the case presented shows that some single women, like their married counterparts, rely on the fathers of their children for money, their dependence is much more precarious given the dual practices of exogamy and women moving back to their village after divorce. Consequently, in many cases, single women do not have easy access to estranged husbands or boyfriends. Kpelle women have the legal right to claim child support from former husbands and lovers but the enforcement of this right is highly problematical (David 1991:386-390). The absence of a husband may also mean a greater reliance by single women on the traditional health system because of their unfamiliarity with the Western health-care system. For example, single women are probably reluctant to go to the county hospital on their own because of their inability to speak English and unfamiliarity with hospital procedures.¹⁵ This reluctance may also be prompted by the greater shortage of cash experienced by single women since traditional cures are less expensive than Western forms of treatment, open to negotiation and payable in kind. Further investigation is required on whether married or single women use traditional medicine more frequently and for the same illnesses and whether the two groups differ in their use of near or distant health facilities.

¹⁵ At Phebe Hospital the staff were abrupt with a village woman who could not speak English and did not know her child's date of birth. Women are reluctant to sell their own products for some of the same reasons preventing them from going to hospital on their own. Most women in Gbaomu prefer to give the rum they produce on their own to their husbands to sell in the nearby market centre rather than make the trip themselves. Although this arrangement allows some husbands to cheat their wives, it prevailed because of women's poor command of English and their reluctance to take time from their busy schedules, among other reasons.

The Kpelle case also highlights the implications of different marriage forms for conjugal-budgeting patterns and consequently for health treatment. The two examples given suggest that especially in polygynous households, where partners typically do not pool their income, treatment of women's and children's health problems, where significant cash outlays are required, may be delayed by husbands, since economic exchange between spouses is often based on the notion of reciprocity. Thus, although polygynously married men appear to pay larger health expenditures from their personal income, it is important to recognize that some of this income is derived from their wives' personal budgets. Intrahousehold cash flows from wives to husbands appear to ensure that women in polygynous households lose decision-making power on health and other matters. Consequently, Kpelle women in polygynous households probably find themselves in a weaker bargaining position with their husbands in making treatment decisions than monogamously married women who maintain a joint budget with their husbands. The bargaining position of a polygynously married woman is certainly determined by her income and co-wife ranking, among other factors.

The implications of the type of conjugal-budgeting pattern, type of marriage and marital status for how quickly illnesses receive the appropriate treatment would be clearer with a better understanding of differences in men's and women's health-care decision-making, an issue not addressed by this study. Some general questions for future research among the Kpelle and in other rural African societies include: whether women are more alert than men to family health problems, whether they are more likely than men to seek treatment and what trends exist in the health-care system from which men and women seek treatment. More information is also needed on how women behave in situations of conflict with their husbands over health-care treatment. For example, we need to know whether they make and carry out health-care decisions to which their husbands are opposed by using their own incomes or relying on relatives for assistance. Answers to these and other questions are crucial to an understanding of the health-seeking behaviour of rural Africans in a period of cash shortage and increasing medical costs.

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