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Why didn't you write this in your diary? Or how nurses (mis)used clinic diaries to (re)claim shared reflexive spaces in Senegal

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Abstract

Between 2015 and 2017, we implemented the clinic diaries project as part of the qualitative component of an evaluation of a supply chain intervention for family planning in Senegal. This project combined different tools including the diaries and participatory workshops with nurses. At the intersection between writings and silences, this paper explores the role played by the clinic diaries to mediate ethnographic encounters, and the iterative nature of 'doing fieldwork' to produce knowledge in hierarchical health systems. This paper also reflects on the processes through which the diaries created a space where accounts of lived experiences

routinely unfolding in health facilities could be shared, in the context of a health system increasingly dominated by metrics, performances and vertical reporting mechanisms. The clinic diaries research process therefore sheds light on the limits of approaching bureaucratic norms and practices as coming from the top, an approach reinforced by data reporting and coordination mechanisms in the Senegalese pyramidal health system. In contrast, the diaries suggest a role for participative ethnography to identify collegial spaces to reflect on shared experiences in and of bureaucratic spaces.

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Introduction: Embarking on the diary project

In 2015, we embarked on a journey with nurses managing health posts across Senegal by implementing the clinic diaries project as part of the qualitative component of a programme evaluation in Senegal. We used the clinic diaries tool ([Munyewende and Rispel, 2014](#)) and organised participatory workshops with nurses. Beyond the evaluation, this study highlights the potential of participative processes in state bureaucracies research, and the importance of identifying platforms where stories can be shared and circulated.

The ethnographers involved in the evaluation – referred to as ‘we’ throughout this paper despite a more polyphonic reality – were four research supervisors based in London and Dakar and four Dakar-based research assistants (two MSc students and two PhD students in Sociology). The intervention we contributed to evaluating was a supply chain model designed to prevent contraceptives’ stock-outs in health facilities in Senegal. When the classic supply chain model relies on facilities submitting stock requests to the level above, this intervention introduced third-party logisticians – referred to as private operators on the field and thereafter

– working under performance-based contracting to update inventories and deliver contraceptives in health posts ([Cavallaro et al., 2016](#)). Evaluating an intervention entails to understand its language and its embodiment into practices, relationships, institutions and policies; as well as its constant reconfigurations and negotiations in space and time. In view of documenting the dynamic character of this supply chain model, we identified various research tools. We reviewed funding documents, proposals and project reports related to the intervention. We conducted in-depth interviews with key national and international stakeholders, with all cadres of personnel involved in the supply chain and family planning activities at the regional, district and facility levels (including clinic staff, programme implementers and private operators contracted for the intervention). In-depth interviews were administered using topic guides, which were piloted and developed iteratively as data emerged. In addition, ethnographic work was carried out to understand the logics and practices of implementation on the ground. Researchers travelled with private operators while they were performing deliveries of contraceptives and carrying out stock inventories in the health posts' storerooms. The research team also conducted observations during coordination meetings at the district level to get a sense of how stocks and family planning data were discussed and analysed.

It is within this broader research design that we asked nurses in charge of health posts across Senegal if they would be willing to account for meaningful events taking place in their facility by filling-in notebooks for a few months. Ten diaries were introduced individually during our visits in the posts, at the end of an in-depth interview. We explained why and how they could be used upon distribution, and wrote guidelines on the first page:

You can write in this note any information you find useful for our understanding of the evaluation. You can share one episode that you find particularly relevant for the

implementation of the intervention. This can be a positive or negative event. Feel free to share the difficulties you might have encountered. You can also write about any important event that took place in your post that is not related to the intervention but kept you busy. You will be contacted fortnightly to kindly remind you to fill the diary.

Researchers who had introduced the diaries personally called the nurses every two weeks to remind them to fill their notebooks. We also built into our work plan a workshop to share preliminary findings from the diary study with nurses as a way to discuss our interpretation of their writings and to give them a further opportunity voice their perspectives on the intervention evaluated, and on the diary project. Underlying our decision to use this method was the idea that no health intervention can be understood outside its inner ‘social life’ at the local and (inter)personal levels. To avoid evaluating this intervention in a vacuum, we therefore needed to have a grasp on its embeddedness into bureaucratic practices enabling or restricting the circulation of commodities and information inside the Senegalese health system. Within our evaluation frame, we also aimed to understand how the intervention behaved in a variety of settings in Senegal, and how it had evolved over time. The black box (Latour, 1987) of ‘doing ethnography’ within a project evaluation still needs to be opened, as ‘conducting ethnography for or with evaluation research may give rise to new forms of relating that shape how ethnographic knowledge is produced, and what it can offer to interpretations of an intervention’s impact on health or social outcomes’ (Reynolds, 2016). However, what does it practically mean to reflect on how we generate data, if not by acknowledging the uncertainties and detours that also constitute fieldwork?

At the intersection between writings and silences, this paper seeks to reflect on the role played by the clinic diaries to mediate ethnographic encounters, and on the iterative nature of ‘doing fieldwork’ to produce knowledge in hierarchical bureaucratic systems. Across and

beyond the programme evaluation that initiated this research, we reflect on the role the diaries played to create space where lived experiences routinely unfolding in health facilities can be shared, in the context of a health system increasingly dominated by metrics, performances and vertical reporting mechanisms. In their introduction to this special issue, Hahonou and Martin identify stages, positions and techniques as three ethnographic pathways which researchers may engage with as they seek to immerse in bureaucratic fieldworks. Our paper reflects on the 'diary' as a space through which we could capture how nurses (as actors part of a hierarchic health system) stage their practices and perform certain narratives. How does introducing objects that may be associated with the domestic and private spheres impact processes of keeping records and processing data? How do these objects simultaneously speak to certain forms of domination (including the legitimisation of directions in which reports and decision-making processes flow), and create space with the potential to challenge them?

Diaries' use and the 'insider's voice' imaginary

Personal and public published and unpublished diaries have been studied by historians for a long time, considered as individual glimpses into a time, an organisation or a social group. As noted by Alazewski (2006: 37), in social research,

diaries can be used not only to identify patterns of behaviour, but also to provide greater insight into how individuals interpret situations and ascribe meanings to actions and event and therefore how actions that may appear irrational to outsiders are rational to the diarist.

The use of diaries as a research method designed to generate specific knowledge to address research questions has been important in organisational studies (Symon, 1998), and used to unveil existing norms shaping how change happens in organisations (Plowman, 2010). While diaries may also be used in medical research as a support to implement checklists, here, we

focus on the use of diaries as a way of generating personal and professional accounts within qualitative research projects. Solicited diaries can take many designs (for example event-based or time-based), and relies on various technologies (from pencil and paper diary to electronic and audio- or video-recorded diaries) ([Bolger et al., 2003](#)). In health research, diaries have been solicited to enter daily worlds of patients ([Jacelon and Imperio, 2005](#)), and to generate grounded accounts of health and illness ([Elliott, 1997](#); [Roghman and Haggerty, 1972](#)). Meth's study (2003) on violence against women in South Africa demonstrated the potential of diaries to research sensitive topics. In health system research, diaries have been used to gain access into organisational management practices and performances, while revealing structural issues faced by managers, and the emotional impact it had on health personnel ([Munyewende and Rispel, 2014](#)). Uses of diaries in health research combined with other modes of qualitative data collection such as interviews suggested that this tool could provide 'important means of uncovering the routine or everyday processes and events that may be viewed as trivial and therefore easily forgotten' ([Milligan et al., 2005](#)). Furthermore, the high degree of reflexivity on such routines and events enabled by this tool in the context of a broader qualitative approach ([Bedwel and Lavender, 2010](#)), would offer original insights in the studies of bureaucracies in a programme evaluation. Our focus on nurses in charge of health posts was driven by a need to locate the supply chain intervention we were studying in the social life of health posts, and somehow to break with the assumed verticality of supply chains and health systems. Clinic diaries were brought in our research to take some distance with a top-down lens looking at how an intervention is adapted through the different levels involved in the implementation. In contrast, the diaries offered an opportunity to think from the level of the health post to understand an intervention in light of co-existing practices.

In the academic literature, diaries are sometimes perceived as 'magical objects' that can show us the inside of organisations through their assumed intimate and 'unobtrusive' nature

([Symon, 1998](#): 94). The idea of individuals confidentially writing in their diaries away from the interviewer or peer pressure to reveal the unseen or unnoticed is seducing when researching bureaucratic practices, and hard to let go of. It is however important to acknowledge and critique the imagery associated with diaries in light of broader ethnographic encounters, to better understand their potential for researchers studying bureaucracies. The positioning of ethnographers in the field – including their rapport with participants and how it affects the setting they study and the writing up of ethnographies – has long been a concern for anthropology, leading to a pivotal reflexive turn in the 1970s and 1980s ([Clifford and Marcus, 1986](#)). Active involvement of anthropologists in international development projects has created spaces where ethnographic practices in relation to aid beneficiaries and policy makers are put under scrutiny ([Lewis, 2005](#)). Ethnographic encounters between researcher and study participants can be more constrained in a programme evaluation – due to an agenda tied to the pace of the intervention, the other research components of the intervention and the deliverables to funders. In addition, evaluations suggest that ‘program evaluators hold the power to affect the very nature or future of phenomena they investigate’ ([Harklau and Norwood, 2005](#)). This ‘power to affect’ does not always translate into policy or programmatic change, but is constitutive of the participant–researcher relationship. This relationship between researchers, donors and implementers feed into a common confusion between the evaluator on the one hand, and the programme evaluated on the other hand. In this context, there is a need for creative methodologies to mediate ethnographic encounters in the frame of an evaluation, including in bureaucratic settings such as hierarchic clinical systems.

From the moment we started the diaries project in 2015, to the moment we organised our final workshop in September 2017, the relationship between researchers and the participants – but also between participants themselves – had developed into a trustful one, allowing in-

depth discussions to take place. During this three day event, researchers facilitating the lively debates taking place in the meeting room often found themselves saying: ‘What you are saying is so interesting, why didn’t you write this in your diary?’

Envisioned diaries: Researching the pyramidal bureaucracies of health systems

When we started the diary project, it was still unclear how the diaries would sit in the broader ethnographic work we were planning, and the knowledge and social ties they will produce was largely unforeseen. In many aspects, the diaries took on a life on their own: initially planned to last for six months, the diaries’ episodes would in the end take place over a two-year period. The diaries as mobile objects opened a door into day-to-day clinical lives (with their satisfactions, challenges and frustrations) from the perspective of female and male nurses who are tasked with more and more activities. Not to forget that most nurses in charge live in the clinic they are responsible for, making the border between one’s professional and personal life at least unstable, if not inexistent. Nurses receive their salary from the state or from local authorities. Nurses are highly involved in the local life, they attend ceremonies, greet neighbouring families who have lost a loved one, and sometimes become godmother or godfather of children. Interestingly, ethnography can help us capture such entanglements between the professional and the personal inside health system bureaucracies. The ethnographic study of health systems also offers insights into how the state manifests itself through clinical practices and encounters, public health interventions and policies, as well through the governance of health information, and through managerial strategies. The Senegalese health system is structured as a pyramid made of three levels: the central level, the intermediary (or regional) level, the district level where activities related to national policies are implemented through the different health posts and centres situated at the periphery level. Nurses are prominent actors present at all levels. According to Seck (2010), nurses are by their numbers key in successfully implementing any national health policy.

Nurses are very active at all levels of the system: they provide health services, are involved in health workers' training activities, and plan and implement curative and preventive activities as well as managing tasks.

In Senegal, health posts are spaces where bureaucratic norms perceived as 'coming from above' (from national, regional and district public health services and from development aid agencies) translate into mediated and embedded clinical and social practices. Following decentralisation of the health Systems in West Africa, districts have been performed as the interface between national orientations and communities' concerns. In her contribution to this issue, Gomez-Temesio highlights the importance of ethnography in researching the social and intimate lives of donors-funded interventions in the context of post-structural-adjustments Senegal. In our study, bureaucratic processes mainly manifested through the reporting of consultation and consumption data related to family planning services, and through coordination processes implemented between actors involved. Other studies have highlighted the working conditions of nurses and professional cultures in different contexts, as well as the contrast between ideals associated with nursing roles and the lived experiences of providing health services in resource-limited countries ([Martin, 2009](#)). Literature from South Africa shows that it is impossible to understand the positionality of nurses without understanding the politics of a health system ([Ditlopo et al., 2014](#); [Fassin, 2008](#); [Harris et al., 2016](#); [Lewin and Green, 2009](#); [Rispel, 2015](#); [Schneider et al., 2010](#); [Walker and Gilson, 2004](#)). In Senegal, female and male nurses are present at all levels of the health system; however, they are not present at the central level in national decision-making processes ([Seck, 2010](#)). At the periphery level, nurses are in charge of health posts, thus taking charge of two third of the provision of health services in Senegal ([Seck, 2010](#)). Nurses in charge of health posts typically work at the intersection between the health district (nurses receive information on policies and aid interventions from the district and report data to the district)

and the communities they serve. In the context of family planning, nurses are involved in service provision in the absence of a midwife, and in reporting consultation data (the intervention we evaluated released nurses and midwives from filling quarterly stock reports on contraceptives stocks). Furthermore, nurses need to accommodate a wide range of health interventions in their post, with sometimes competing incentives and heterogeneous reporting mechanisms. As such, they can be seen key 'brokers' ([Blundo, 1995](#)) of national and international norms. Research has shown how health services in West Africa are embedded in a broader bureaucratic culture, and how certain professions operate at the interface between bureaucratic and health public services users ([Jaffre and Suh, 2016](#)). **AQ1** In this paper, we do not label nurses as 'bureaucrats', but rather explore how clinicians managing health posts are necessarily embedded in bureaucratic processes that shape their medical and managerial practices, but also shape the ways in which they respond to ethnographic encounters.

In her research on medical records in boundary work over the treatment of complications of spontaneous and induced abortion in Senegal, [Siri Suh \(2014, 2017\)](#) shows that jurisdictional disputes are key sites that need to be ethnographically investigated, to make sense of how health providers engage with legal contexts and professional obligations to treat cases of suspected cases of illegal abortion in Senegal. By doing so, she demonstrates that clinical, legal and bureaucratic spheres routinely intersect, and that the quality of care provided to women can only be improved if we take into account the conflicting normative environments that providers negotiate. Our evaluation of a supply chain intervention for family planning sheds light on the heavy bureaucratic reporting activities of consultation and stock data, and on the performance targets imposed on health facilities that occupy more and more territory during the monthly coordination meetings nurses in charge health posts attend in their respective district. In this paper, we wish to shift the ground from picturing the nurse as a 'street level' ([Lipsky, 1980](#)) interface between a public health manifestation of the state and

patients; and think about health bureaucracies as spaces that can be occupied, confiscated and challenged, but also reshaped through the development of alternative flows and platforms. By contrasting ideas of ‘sharing experiences’ with ‘reporting’ in bureaucratic spaces, there is room to reflect on what counts or what is being masked in global health ([Adams, 2016](#)).

Beyond the idea of bureaucratic spaces as necessarily secretive and static, our study engages with nuanced negotiations of power between health workers to gain necessary space to reflect on ‘public good’ oriented practices ([Bear and Mathur, 2015](#)).

Embedded-diaries: Implementing the diary within a programme evaluation

Prior to accessing health posts, the lead from the evaluation team based within the University of Dakar sent a letter to all the medical officers whose regions and districts were about to be visited by the research teams. In addition, during field activities, we would always stop by at the regional medical officer, followed by district medical officers for a ‘courtesy visit’, before visiting nurses and midwives in their facility. On few occasions, when nurses in charge of the health facility we visited had not been informed of our visit, we were kindly asked to wait until the nurse got a phone confirmation from the district. To some extent, our research pathway to gain access to nurses initially reproduced the bureaucratic architecture of the Senegalese health system, but the diary project simultaneously made this structure unstable.

‘Words fly away, writings remain’

Clinic diaries were (re)negotiated at several stages in our study. Most of the negotiation had to do with the writing component of this research tool. The use of diaries was first debated internally within our qualitative team. Senegalese researchers raised concerns early on about introducing a tool relying on writing activities in Senegal. It was anticipated that nurses in charge would not consider the writing process as something private, and therefore this media would trigger personal insights on their work. In fact, when we collected the diaries, we

realised that they had all been stamped by the nurses with the facility stamp – even though we had explained when introducing the diaries that we would maintain confidentiality of our informants by specifying that all names and elements enabling the identification of participants and places would be removed. ‘Words fly away but writings remain’ is an expression that was first enunciated by researchers among us as a ‘warning’ on using a written media. This expression kept coming back along the project and resonated until now as we write this paper. However, along the road, the ‘remaining’ aspect of the writing including its materiality through the existence and circulation of diaries, was progressively seen less as an obstacle, and more as a positive output. Looking back, we can see that when we introduced these diaries – even with guidelines and what we felt was reassuring guarantee of confidentiality – we actually also introduced a great deal of uncertainty around objects nurses did not have any ownership on, especially as they were meant to be taken away from them and examined in the capital. Researchers and participants projected in this object a set of beliefs and expectations that were not initially explicitly recognised and discussed. On the contrary, assumptions identifying the diary as a private object vs. assumptions identifying the diary as another layer of reporting affected the use and interpretation of this technology (Hahonou and Martin, this issue). Introducing a writing support to collect data requires extensive amounts of time to articulate and negotiate mutual expectations. Rushing participants into writing activities could result in the absorption of the diaries in a bureaucratic system reproducing existing practices, where it has the potential to challenge its vertical information reporting and coordination system.

Exploring the ‘told’ and the ‘untold’

Over the implementation of the diary project, what we had planned to be a ‘logistic’ component of our study (reminding busy health workers to make some time to fill the diary) turned out to be a core element in building trustful and lasting interpersonal relationships.

The first calls were very formal; the researchers were sometimes embarrassed to remind providers to fill-in the clinics diaries. If some providers welcomed the phone calls, others showed signs of impatience. Once, after having listened to the usual greetings, a participant told us in a very direct way that ‘he has no time for such things’, and cut the discussion short. Over time, nurses became more enthusiastic and started to inquire about the project. These moments spent on the phone became more and more meaningful with providers talking about their week to researchers. Six months after distributing the diaries, the researchers who had introduced the notebooks and followed-up on the phone with nurses every two weeks, visited the posts to collect the diaries. The lapse of time between the distribution and collection of the diaries had made some nurses think that they would never be collected. Researchers coming in person to collect the diaries in their post were valued by participants. Some remote posts were especially hard to reach during the rainy seasons, and their visit by researchers was perceived by the nurses as a positive sign of commitment.

Back in the Senegalese capital, the team opened the diaries with excitement, only to discover that they had hardly been filled. What to do with this scarce yet uneven content? One nurse turned out to be the exception and had written extensively. Others had just written a few bullet points. Other diaries were completely blank – except from the stamp from the post all nurses had put in there. We initially focused our analyses on the one diary that fitted – or even exceeded – our expectations from what could be achieved with this method. This diary started with these words: ‘ready, steady go!’ followed by a powerful prose that took us to a remote post where the nurse in charge and ‘his’ midwife had to travel on flooded roads on an old motorcycle for kilometres to conduct outreach activities, and collect medicines from the district storeroom:

The rainy season remains a difficult time for everyone. It is not only the people from the intervention who are concerned. At the level of the post, we are faced with great difficulties and are on duty 24 hours a day, seven days a week. We live a real nightmare and all we have is a motorcycle in very bad shape and we still risk our lives every day to satisfy the patients. And no one ever says thank you (...) The intervention has great vehicles and we only have a carcass of motorcycle, that regularly stop working in the middle of the bush. Despite all of this, we do everything we can to satisfy the facility and keep it running. (Excerpt from a diary, round one)

While clinical episodes shared by this participant fitted with the kind of information we hoped to access, how could we make sense of the more minimalist – if not inexistent – accounts we received? The two workshops organised with the nurses involved in the research – one in the North and one in the South of the country – offered an opportunity to address the silences conveyed by their diaries with the participants; and turned out to be another necessary step of our fieldwork ([Vidal, 2011](#)). Both textual accounts and silences conveyed by the diaries were discussed over two days. Having met with the nurses twice, talked to them regularly over the phone and interviewed them in their health facility influenced the running and content of the workshops. There was a sense that we, the researchers, were able to understand the challenges that they, the nurses in charge, faced, ‘having been there’. From these workshops, it quickly emerged that the diaries had been perceived as ambiguous and unsettling objects. When, upon introduction of the diaries, we argued that we wished to voice concerns from frontline health workers having to deal with this supply chain intervention on top of other activities, it was somehow heard that we were after another layer of ‘reporting’ that we would move up to the ‘upper’ levels of the health system. In sum, our research got caught into the dominant bureaucratic practice of ‘reporting-up’. During the workshops, we did not try to justify the relevance of the diaries at all costs, but we rather facilitated

discussions on key themes that emerged from the diaries (such as challenges related to medicines stockouts and the need for training for providers on long acting contraceptive methods), on themes we had identified (e.g. adjustments needed to integrate the new private operators into the health system), and finally we engaged with the nurses on specific questions that had emerged from our broader evaluation research. This led to collegial discussions where nurses could not only provide information and share their expertise, but also engage with their colleagues on specific issues, such as how to deal with women who are seeking family planning services without their husband's consent. While many common concerns were shared by all participants, during the feedback session from the findings from the diaries, nurses were confronted to experiences from other areas, and expressed genuine curiosity towards unknown contexts. At the end of the workshops, faced with the growing enthusiasm of the nurses towards the diaries, we offered them to take the diaries back to their post, and to pursue the experience for a few additional months. All the participants agreed to take the diaries back and to write some more: 'now we understand what you are doing with them'. Participants also expressed interest in meeting with their colleagues from other regions for the next workshop. It appears that while nurses are somehow overwhelmed with meetings, they rarely get a chance to meet with their peers working outside their district.

The diaries were collected again after a few months. In this round, we found more narratives from the diverse health posts, often accounting from frustrating episodes upon which nurses seemed to lack control:

I received a patient who was complaining about abdominal pains, followed by an haemorrhage. I prescribed her an ultrasound. On arrival, the doctor told her they had stopped ultrasounds for the day. The patients tried other health facilities but in the end she had a miscarriage. (Excerpt from a diary, round 2) **AQ2**

In this second round of writing, we found information on the daily activities taking place in different health posts, mainly related to specific training for family planning long acting methods, or related to the introduction of new contraceptive methods. We were also provided insight into feelings of frustration triggered by the implementation of the supply chain intervention we were evaluating: the accreditation¹ component was for instance perceived as unfair, because ignoring specific challenges faced by the context in which health posts were performing. The diaries also informed us on remaining challenges faced by health workers to provide contraceptives to clients when required auxiliary products and sterilisation material are not available in the post. Closely related to what was (not) written in the notebooks is the environment and events that enabled the participants' writing process.

A final workshop gathering the ten nurses in charge was organised in September 2017 to share our findings and reflections on the diaries' experiences. During the workshop, it was recalled that the writing was more likely to occur when drinking a cup of tea, or when having trouble falling asleep; when something important had happened and sometimes when there was no one to talk to, a need to confide after something shocking had happened in the post. Most of the writing took place in the evening after all the consultations were over.

Mediated ethnographic encounters through the diaries

The clinic diaries, as both material supports and mediators, unveiled information that had not emerged from in-depth interviews. The diaries acted as a material continuum that empowered and displaced clinical encounters. This co-production of knowledge was enabled by the repeated visits and keeping in touch activities: in other words, if the diary can provide creative ways to mediate encounters they cannot replace the 'having been there' component of ethnographic work. 'I wrote because I felt bad for the poor researchers ... They come all the way, we have to write something...' (participant during the final workshop).

Having the nurses together sharing experience triggered a deep and nuanced understanding of what it means to be a family planning provider, a ‘frontline’ health worker in contexts where women sometimes use family planning services clandestinely. Several situations were accounted for to illustrate how providers creatively cope with obstacles arising when providing family planning services:

Anecdote: we (the nurse and a midwife) were undertaking outreach activities and a woman wanted to do the jadelle (contraceptive implant). But if we insert the jadelle we need to put a plaster. She said that if we put a plaster she cannot choose this method. It is going to be noticed back home and there will be a war. It is better if she takes the Depo (contraceptive injection) and leave her appointment card in the facility, because men would notice the appointment card. (Excerpt from a diary, round two)

Beyond the strict frame of the intervention we were evaluating, the diaries evolved as a potential ‘territorial’ tool the nurses appropriated to air a sense of injustice: for instance, the accreditation process implemented by the NGO in charge of the intervention consisted in distributing rewards to health posts which matched a set of pre-established criteria. However, such criteria did not consider the difficulties encountered in certain contexts (e.g. related to insecurity or isolation during the rainy season). Another tension that arises from the diary is about vehicles: while the private operators recruited by the implementing NGO delivering contraceptives in the posts travelled in 4 × 4 cars, the nurses usually had to use an old motorcycle or walk long hours to collect medicines from the district and conduct outreach activities in this area. Even if the cars owned by the private operators were not necessarily financed by the NGO implementing the supply chain intervention, such tensions around vehicles reflect broader discussions on a sense of injustice felt by nurses in charge of remote or harder to access health posts regarding their efforts – that we, as researchers, would label

as dedication – not being valued by their hierarchy. Finally, the diaries were used to reclaim a reflexive space where data can be discussed with peers outside the increasingly dominant paradigm of numeric performances. Nurses took the opportunity of the diary project to discuss daily ‘experiences’ encountered in their posts, as opposed to discussing ‘data’. However, they did not challenge the vertical functioning of the health system but rather provided a critique of the type of information that can circulate between different levels.

Although the diaries have been introduced in accordance with bureaucratic practices, the ways in which nurses appropriated them in the context of a participative research paradigm challenged this architecture by helping to create space for sharing and reflecting on lived experiences in a health post. The ‘format’ of these stories (clinical episodes accounted for in the diary, strategies developed by nurses to cope with certain contexts discussed during the workshop, etc.) do not travel well through the reporting and coordination mechanisms in place. The clinic diaries experience contributes to the critical and reflexive ethnographic turn initiated in the 1980s, illustrating the shift from ‘learning from informants’ to ‘learning with participants’, and to the re-scoping of traditional ethnographic fieldwork. This research tool evolved into becoming a medium allowing knowledge to be shared between participants and researchers, but also between participants themselves. The level of involvement from participants and the relationship we developed with them along the journey informed us on the ethics of researching health systems. As stated by Molyneux et al. (2016: 176), research findings always depend on

building appropriate relationships with these partners and other health system actors is essential not only to making sure the right research questions are asked, but also to how much of these individuals’ knowledge is accessible to researchers, particularly their tacit knowledge.

The relations developed with frontline health workers and health managers through the diaries enabled us to build-up ethical standards iteratively.

At the end of the final workshop, we gave the diaries back to the nurses.

A transformative research tool?

The diaries conveyed a ‘pulse’ into the daily functioning of a health post in Senegal, from the perspective of the events accounted for by the nurses, and in a context where only periodic reports mainly structured around quantitative metrics provide space to account for the lived experience of health facilities. The collegial nature of the workshops following the rare moments of solitude in the post when writing a diary was possible, provided participants with a space to reflect on their practices outside the ‘targets-oriented’ or ‘results-oriented’ logics that increasingly shape health workers’ ways of reporting on their activities. Interestingly, the final workshop suggested that the district coordination meetings in particular did not fulfil the role of creating a space to share experiences and address specific issues. Observations conducted during district coordination meetings showed that the possibility to discuss providers’ concerns was often constrained by the plurality of activities on the agenda, the role played by different projects and programmes which, by financing certain meetings, also set the agenda and intervene extensively in the meeting, or even by representatives coming to introduce new medicines. This context does not always offer an environment conducive of reflexive discussions and collegial problems solving. The diaries seem to have been used to fill a growing gap felt by providers who do not always have space to express themselves.

Anthropologists have often felt the necessity to explore silences in their work. In her paper accounting for her study with Iranian refugee women, Halleh Ghorashi (2008) argues for the necessity to create space for the untold – including for the silences that are part of the narrative process. Research on bureaucracies often associate what cannot be told with the

‘informal’, the ‘corrupted’. In other words, the ‘told’ and the ‘untold’, the ‘seen’ and the ‘unseen’ tend to be interpreted within a normative framework valuing transparency ([Lipsky, 1980](#)). In organisations like pyramidal health systems, hierarchic relationships also structure what can or cannot be accounted for. It can be challenging for an outsider to capture the boundary between the ‘speaking’, and the ‘unspeakable’, and to be able to contrast those with the ‘unspoken’ due to miscommunication on our research tools or lack of time and motivation from the participants’ side. In this context, creating spaces for silences to be heard and understood is crucial.

Conclusions

This paper engaged with the challenges and opportunities of ‘doing participative ethnography’ by making assumptions guiding our research paradigm explicit. This paper also documented the unknown, the unforeseen, and the doubts we had when embarking on the diary project, as well as the decisions made on the field to iteratively adjust our approach. We showed that the diaries did not produce knowledge only by the content they generated, but more importantly by the relationships that emerged and developed around them. If we initially used the diaries to generate accounts from the life in a health facility, diaries proved to find their function, as nurses reclaimed – through silences, written and oral accounts – a reflexive and collective space that seems more and more difficult to create in coordination meetings, where data are mainly discussed in quantitative terms. In contrast with previous studies using diaries to research organisations as unobtrusive tools, in our study, diaries proved to be highly visible objects that were used to convey specific claims to upper levels (the district in particular) and to the NGO implementing the intervention we were evaluating. Participative processes not only have the potential to unveil what can or cannot be told in bureaucratic spaces, but also to identify the right platforms where narratives can be shared and circulated.

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Note

¹'Accreditation' was implemented to reward health posts that were judged successful in their implementation of the intervention by providing posts with additional equipment (such as printer, a cell phone for the stockist, a computer, or a fan for the storeroom etc...).

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