

**FACTORS THAT INFLUENCE HEALTH-SEEKING  
BEHAVIOUR IN LAIKIPIA DISTRICT.**

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**BY**

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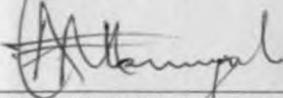
**A Thesis submitted in partial fulfilment of the requirements for  
the award of the degree of Master of Arts in Anthropology.**

**Institute of African Studies, University of Nairobi.**

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# DECLARATION

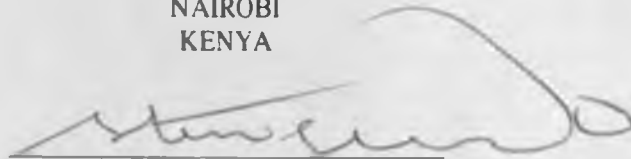
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# DEDICATION

To my Dad Michael Mbeja Onyango and Mum Winfred Akinyi Mbeja for their continuous support throughout my life and during the writing of this thesis.

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## ACKNOWLEDGEMENT

I am indebted to Dr. Stevie M. Nangendo, Dr. Dorothea Hecht, and Professor Simiyu Wandibba of the Institute of African Studies, for their comments, suggestions and encouragement. To them my sincere thanks is owed for the great patience they exhibited and an overwhelming interest in my work. To the teaching fraternity of the Institute of African Studies whose invaluable comments helped me shape this thesis, I return my thanks. I would also like to thank the non-teaching staff for their encouragement and help. Special thanks to Dr. Urs Herren, of the Laikipia Research Programme, who availed the scholarship through the Institute of African Studies. To him and his team the data collected in this study are owed.

I acknowledge Mrs Juweiriya Mohammed for typing the drafts, Mrs. Agnes Anyango Olulo, Mrs. Ruphine A. Omondi and Ms. Kanini Kioko for typing the final drafts. Their efforts greatly contributed towards the completion of this thesis. I would also like to thank my classmates for being there. To Ezekiel Esipisu thanks is owed for his various reminders, the Laikipia group of Reuben Nyandoro, Anna Kyonda, Charles Mukhombe and Mbogo for making the field work an adventure. I acknowledge my family's patience and understanding and help towards this noble effort.

To all of them and many others who contributed to this work in one way or another I say, Thank you.

CHARLES ADEYA MBEJA

# ABSTRACT

This study examines the factors which influence the health-seeking behaviour of the people residing in Laikipia District. The study mainly focuses on the way in which accessibility to modern treatment, (as determined by distance, cost, the delivery of health care and other factors like socio-economic status, religious affiliation and the type of disease one is suffering from), influence the health-seeking behaviour exhibited during sickness.

The factors which influence health-seeking behaviour in this study are explained within the context of the functionalist theoretical frameworks which examines how various schools of medicines function in the provision of medicine and health care in the area under study. Standard questionnaires, focused group discussions, key informants, non-participant observation and documentary sources of information were the chief techniques employed in collecting the data.

The data analysis shows that despite the enormous awareness and utilization of modern health facilities, a majority of the respondents still use traditional medicine to combat various diseases mostly thought to be best cured by traditional medicine. However, due to cost, an increasing number of respondents are resorting to traditional cures for an increasing number of diseases both slight and complicated.

The findings showed that health-seeking behaviour is dynamic, shaped varyingly by factors such as socio-economic status, disease type and religious affiliation. The findings therefore call for a need for a multi-dimensional approach in health care planning and provision. Traditional medicine should be addressed as a major source of treatment. Primary health care should be strived for as well as taking into account the improvement and provision of facilities, development and provision of curative and preventive medicines that will effectively tackle the prevalent diseases in Laikipia District.



## CHAPTER ONE

### INTRODUCTION AND PROBLEM STATEMENT

#### 1.1 Introduction

It has been said several times that a healthy nation makes tomorrow a better one. In essence, then, a nation that is ill has a gloomy future. Indeed, societies and communities all over the world have since time immemorial tried to improve their health. Despite this concerted effort to eradicate disease, new ones have cropped up and some of the old ones have persisted. All the same, people continue to strive to eradicate disease in their midst both in the developed as well as in the developing world.

The effort in the developing world is compounded by the need to provide the simplest basic necessities in life such as shelter and food the lack of which are in themselves a principal cause of disease. However, the effort continues, amidst food insecurity, poor infrastructure and health facilities and generally a poor economic base. Without improving a nation's health, economic development cannot be fruitfully achieved. For most of the developing countries, the pathway is two-fold ( Mbiti 1969). Most people, apart from seeking treatment in the modern health centres, still also resort to traditional medicines for various ailments and diseases (Ngubane 1977).

As already noted, people all over the world continue striving to improve their health. The developing countries are no exception. For example, having embarked on Westernisation at the turn of the century, Africa finds itself still trying to industrialise. Strategies of modernisation in health have been undertaken. Hospitals, clinics, health centres and dispensaries have been built. Also, training of personnel has been, and continues to be, undertaken.

However, with a rapidly expanding population, the Third World finds itself with fewer health facilities than the demand. Also, trained personnel are not adequate for the population, therefore, to satisfy the demand for health, people try various options. This may range from the use of over the counter drugs to traditional medicine.

It, therefore, becomes increasingly important to re-evaluate the strategies that have been used by the governments to improve health. These strategies should address nutrition, basic education, gender, development, and social mobilisation. These factors, singly or collectively, affect a given people's health, and, most important is the need to consider the needs of the local population when designing health programmes.

The situation in rural health centres in many Third World countries has deteriorated so much that it is becoming increasingly difficult to get the right type of medicine. The majority of the people do, therefore, resort to buying the drugs over-the-counter. This is a cheaper option, although, it is extremely dangerous since most of the people may not have the appropriate knowledge of the use of the various drugs.

The medical systems of a majority of the Third World countries are thus problem-ridden. The future does not appear to offer much hope. Currently, Kenya is having to face up to a strict implementation of the Structural Adjustment Programmes if the country expects continued foreign aid. In essence, cost-sharing in health institutions cannot be done away with at a time when there are no finances to improve existing facilities. There is, thus, a need for communities to strive towards more autonomous health systems that will reduce dependence on a trouble-ridden and inefficient health care system.

## **1.2 Problem Statement.**

In the 1980's the developed north, represented by the World Bank and the International Monetary Fund, demanded that the developing countries adopt a set of measures under the Structural Adjustment Programmes. These measures were designed by the two bodies to help steer the Third World into economic recovery.

One of the features of this package was the institution of a cost recovery policy in health. The masses and the elite were, therefore, required to contribute towards their health requirements. And the Third World governments, due to the economic crisis they are undergoing, find themselves with less and

less money for health. Health services have thus deteriorated. Child mortality and malnutrition are on the rise, with a recrudescence of immunizeable diseases such as measles and cholera. The once tamed malaria is once again on the increase as a major threat .

In Kenya, the implementation of the Structural Adjustment Programme in health led to the introduction of cost-sharing in 1990. The initial cost-sharing structure was as follows: health centres were to charge Kshs. 10. Pre-diagnosis fee Kshs. 20 a day for in-patients, while Kenyatta National Hospital, being a referral hospital, would charge Kshs.100. Women giving birth were required to pay Kshs.50 at health centres and Kshs. 100 at the district and provincial hospitals daily.

As small as these fees may seem, the figures were above the means of a majority of Kenyans, and the ensuing public outcry was a testimony to this. Eventually the rates were lowered by a Presidential decree. This demonstrates the inability of Kenyans to meet the cost of modern health care. Unfortunately, in Kenya cost-sharing has been re-introduced since 1992 while inflation continues to rise to even higher levels. The living conditions of a majority of Kenyans continues to deteriorate.

However, since diseases have existed since time immemorial, so has been the purposeful response to the threat of diseases. In all societies, however small or technologically less developed, there has existed a set of beliefs about the nature of diseases, causes and cures, and their relations to other aspects of group life. From these beliefs there have developed preventive and curative practices that are highly integrated in the belief and cultural systems of each society. Whereas cost is the primal factor affecting the use of modern medicine, other factors also play a role. This range from class (Simons 1966; Koos 1954), to age and sex (Cockerham 1978; Anderson 1972). This thesis is interested in finding answers to the following questions:

What are the solutions that a rural immigrant population employ in the midst of these problems? What other factors affect their health-seeking behaviour? Do such factors encourage or discourage the use of modern medicine?

These issues, that abound in health care delivery in an era where inflationary pressures have left a majority of Kenyans unable to meet their medical bills, are tackled in this study. The aim is to describe

the best approach that should be employed in tackling various diseases that are found within the study area. Of importance are the solutions that the people themselves employ during sickness amidst the meagre resources that they have.

### **1.3 Objectives of the study**

The overall objective of this study is to analyze the health-seeking behaviour of the people of Laikipia District and the factors that influences such behaviour. The specific objectives were;

- i) To identify the range of Western medical institutions and the non-western medical practices that are used by the people of Laikipia District.
- ii) To establish the level of accessibility and utilisation of both western and non-western medicine in Laikipia District.
- (iii) To prioritise the various needs of the people of Laikipia District that are essential in improving their health.

### **1.4 Rationale for the Study**

The desire to develop healthy people in the less industrialised countries has increasingly made health care an area of primary concern for policy makers. However, the provision of modern health care to a whole population, although desirable, is limited by among other factors, a lack of resources, among other factors. It is, therefore, necessary to exploit to the maximum the available resources.

In order to help the health workers perform their duties to their level best and to make the local population exploit the existing scarce health facilities, health workers have to be made aware of how diseases are perceived by specific societies. It is also important to find out how much such perceptions reflect the socio-economic status of the society in question or if it is purely based on beliefs and cultural practices.

Health workers in rural areas also need to know how the local people's perception of diseases influence their overall attitudes and practices of both western and non-western medicine. It is necessary

to establish a rural population's perception of diseases and explore the role that socio-economic and cultural factors play in influencing people's preferences for either western or non-western medicine. This will help health workers in rural areas to distinguish which socio-economic groups are more predisposed to resist or accept western medicine. In essence, health workers would then be able to adjust the approach to individual patients, accordingly, when administering medicine. The group of patients, perceived to be more resistant to western medicine can be approached differently from those who are perceived to be cooperative and readily willing to use western medicine.

On the other hand, there is a need to allow the community to articulate and prioritise its needs. In this way the involvement of the people in health care programmes can best be achieved if their needs are known. A community's participation in health delivery is important if success in health care programmes have to be achieved.

This study is also important as it contributes to an understanding of the relationship between socio-cultural and economic factors and health seeking behaviour. By assessing the use of the various health institutions in the area of study it helps to describe the most exploited modern health institution.

## CHAPTER TWO

### LITERATURE REVIEW AND THEORETICAL FRAMEWORK

#### 2.0 Introduction

The literature review below is divided into three main parts. The first one explores the perceived causes of various diseases in African societies. Examples from all over Africa are drawn to point out the similarities and differences in the perceived causes of various diseases. Of particular importance to this study, is the influence that the perceived cause of a disease has on the subsequent steps that are normally taken to obtain treatment and subsequent recovery. The second part of the review explores the various health-seeking patterns that individuals follow during sickness. The various factors that influence individual or group health-seeking patterns are explored. In the third part of the literature review the co-existence of traditional and modern medicine is examined. The way the two compliment each other is shown by findings from various societies. The focus in this part is on the way the two forms of medicine interact to constitute the medical system of various Third World societies. The strengths and weaknesses of the two are reviewed and solutions proposed by various authors towards improvement are discussed.

#### 2.1 Notions of Disease Causation.

It is probably important here to distinguish between 'illness' and 'disease', two terms repeatedly used in this work. Donald and Grahams (1982) distinction will suffice for us here. They define illness as being the subjective interpretation of problems which are perceived to be health related. Contrary to that, disease is a medical conception of a pathological abnormality diagnosed by means of signs and symptoms.

Usage in this thesis of the two terms does not strictly conform to the above definition. However, I would like to look at both illness and disease as representing a departure from the normal physiological and psychological state, whether such a departure is capable or not of disrupting daily activities due to

abnormalities in one's state of health. As related to their casual agents, the two terms will be treated more or less the same. What causes disease and what causes illness is to a large extent the same.

The age distribution in Kenya is such that there are fewer old people relative to the youth. This may arouse speculation as to the existence of a relationship between age and mortality. How possible it is to compare mortality with age is, however, questionable. Nonetheless, there is an exponential increase in the probability of dying with an increase in age which reflects a generally increased inability to withstand destruction. However, mortality can best be represented if a constant term to represent the causes of death not attributed to age is added to the probability of dying. Gavrilova and Gavrilova (1991) referred to these expressions as the Gompertz-Makeham law. However, one thing that is notable here is that whereas the Gompertz-Makeham law may be detailing a pattern, it does not necessarily suffice as a causal explanation. Infact, Gavrilova and Gavrilova (1991) in the end reject the idea of basing mortality on age. They emphasise that in the early ages the Gompertz-Makeham law may not really be the main principle. This assertion, therefore, would mean that mortality must have a particular cause. Whatever the cause which is attributed to a disease, societal values and beliefs play a major role. All human societies maintain a set of values and beliefs which may help define daily actions. These values and beliefs do influence individuals into acting in a pre-determined way and they are, indeed, the blue print the individual uses in explaining illness (Knutson 1965).

The cause of an illness is primary in explaining the health-seeking behaviour in traditional societies compared to modern societies. In traditional medicine once the sick state has been detected, the cause has to be identified. And in all cases of serious illness, there is a tendency to attribute it to a specific individual (Maclean 1971a). Maclean (1971a) compares this with western society where peoples' conception of a likelihood of positive recovery influences the decision to see a doctor or not without necessarily pondering the cause. It is the doctor, after analyzing the symptoms as hazily recollected by the patient, who is then able to suggest a cause, for instance, malaria by a mosquito bite, and so on.

It is imperative then that both western and traditional medicine recognise a cause. This causal explanation then directs the process to recovery. However, this is not uniformly perceived. Disease

causation in traditional society is perceived differently from the concept expounded in modern western societies. According to Lambo (1979), traditional medicine considers man as an integral somatic and extra-material entity. Therefore, the cause is explained as being possible through supernatural forces arising from the displeasure of ancestral gods, evil spirits, the effect of witchcraft, spirit possession, or the intrusion of a foreign object into the body. The differences in the explanation of disease in the traditional and western societies point to the important role played by culture in not only explaining disease but also its management.

Smith (1966) views the social structure, beliefs and values as being the chief causes of diseases and which also influence disease management. She sees beliefs and values transmitted in a particular society as being able to influence practices relevant to health. Where, for example, cultural restrictions of food exist, food-deficiency diseases may be prevalent even when the foods that could supply the deficiency are available. On the other hand, she sees the society's social structure as influencing the transmission of contagious diseases since such diseases travel in structures that pattern the encounters between persons. For example, the social patterning of sexual encounters influences the spread of venereal diseases. Thus, those societies with a loose patterning are seen as having a higher incidence of venereal diseases against those with a strict patterning. Usually this patterning is also influenced by a society's level of westernisation. Traditional societies in Africa were essentially conservative on issues related to sex. There was less promiscuity compared to western societies. Peoples' mode of life, therefore, has an influence on disease level and susceptibility to certain illnesses. Susser and Watson (1962) see disease not as natural calamities that strike in a haphazard way but as being injuries implicated on people by the nature of their daily life, occupations and customary modes of life. The incidence and prognosis of disease are also, therefore, determined by a persons social and economic environment.

A nation's stage of development then would more or less determine, to a reasonable extent, the most prevalent disease at any one particular time according to the above study. Susser and Watson (1962) emphasised that transitional societies were currently dealing with health problems similar to those experienced in Western Europe during the industrial revolution. In that line of reasoning then, when the



developing economies finally become as developed as Western countries, they will have to deal with the kind of diseases that are being experienced by the developed world at present. This observation is quite correct. In Kenya, an ever increasing number of people are developing heart related diseases. This is being explained by an increase in the number of people leading an affluent lifestyle which is associated more with the Western countries.

The way people conduct their affairs on a daily basis, therefore, has a big influence on their medical behaviour and such behaviour is triggered by the occurrence of diseases. Lambo (1979) emphasises the close relationship between culture and traditional medicine. According to Lambo, medicine is linked to people's beliefs due to its close relationship with their culture. The traditional way of explaining and understanding diseases and illnesses is usually by unravelling its causation first. This is because causation varies from society to society. As already pointed out, traditional medicine has a tendency to attribute cause to a specific individual (Maclean 1971a). However, it is not the individual on his own who causes the disease. The individual manipulates various forces which, in turn, cause illness to the intended party. These are the diseases that are due to supernatural causes. Naturally occurring diseases are also represented in various communities in Africa. Among the Zulu (Ngubane 1977) naturally occurring diseases are called, 'Umkhuhlane', that is 'disease that just happens'. These range from serious colds to serious epidemics like smallpox. These diseases have seasonal changes and stages as in measles for children. Susceptibility to some of these diseases is believed to be hereditary within specific families. Illness due to natural causes were also recognised by the Banyankole (Roscoe 1923). One such natural cause was old age, others were eating beef from a cow that had died from a certain illness and going out in the hot sun. In most instances, for example, among the Banyankole, like in many other traditional societies, illnesses were attributed to some god, ghost or magic.

The foregoing examples appreciate that disease can occur naturally, however, not all illnesses do occur naturally. In fact, the explanation for the cause of disease in Africa is dualistic (Warren 1975). That is to say that, apart from naturally occurring diseases, there are also diseases that are caused by supernatural forces. In Warren's (1975) study, this is presented by variations found among the Bono of

Ghana. The author describes the complex systems of words used by the Bono of Ghana for naturally and spiritually caused diseases to bring out the Bono's distinction of naturally occurring diseases against spiritually occurring ones.

Despite this recognition and understanding of naturally occurring diseases, supernaturally caused diseases account for a larger share. The supernatural forces vary from witchcraft to sorcery, spirits, ghosts, ancestors and acts of magic. It is important to realise that the type of supernatural forces that are usually viewed to be at work and their level of effectiveness vary from one society to another. Imperator (1977), for example, recognizes four types of supernatural forces which are believed to be responsible for illnesses and misfortunes. These are spirits, ghosts, witchcraft and sorcery. Imperator is, however, careful not to generalise this for all societies. And even the supernatural forces themselves operate in various ways. Sorcery, for example, is used to harm or for personal gain, as among the Zulu (Ngubane, 1977). Marwick (1952), in his work on the Gewa of Mali, presents the notion of the use of sorcery to bring out segmentation of a homestead. Among the Gewa such sorcery comes from without. Marwick also differentiates between day and night sorcerers. The night sorcerers are variously viewed as witches. They are, therefore, more dangerous and are held responsible for more misfortunes and diseases than the day sorcerers. This is not to say that day sorcerers do not cause diseases. Day sorcery among the Zulu (Ngubane, 1977) occurs in a situation that is full of jealousy, competition and rivalry. This is seen as a cause of serious illness and, at most, death.

Closely related to sorcery is witchcraft. In his illuminating study of the Azande, Evans-Pritchard (1937) points out the nature of witchcraft. An individual's witchcraft often functions without him/her being aware of it. Witches are also thought to be more active at night. Their power is thought to attack the spiritual parts of their victim's organs. The open practice of witchcraft is not widely reported except perhaps for the Luo of Tanzania who are reported to have seen witchcraft substance at night as round, red glowing balls of fire moving across the countryside (Imperator 1966). However, the phenomenon is widely believed to exist and several studies have been carried out to that respect (Parrinder 1958; Horton 1967; Douglas 1967).

Witchcraft and sorcery are social and not psychological phenomena (Middleton and Winter 1963). Whereas some authors distinguish the two, others do not. Evans-Pitchard (1937) distinguishes between these two beliefs. Opposed to that, Middleton and Winter (1963) point out that this distinction does not really exist among some African societies. For example, the Nandi of Kenya are such a group that does not have a distinction between witchcraft and sorcery (Huntingford 1953). Imperator (1966), in his study of the Luo of Tanzania, did find out that those who are suspected of being witches may also practice sorcery. Several works on witchcraft and sorcery do not inform us on how and where accusations have been made in instances where the sorcerer's accuser is known (Marwick 1963; Wilson 1951, 1963; Nadel 1952; Krige 1947). This trend has been corrected by some later authors such as Turner (1957) and Middleton (1960). Identity is important here since, as already pointed out, traditional medicine tends to explain cause in individualistic terms (Maclean 1971a). The sorcerer, witch and magician are agents through whom individuals inflict upon others diseases. Also the witches and sorcerers themselves, due to malice, may inflict various diseases upon their victims.

The most feared of all the supernatural forces that are responsible for diseases in Africa is magical art. Magic has since time immemorial been considered the chief cause of a wide range of diseases all over Africa. Magical art is, in fact, held to be one of the principal causes of death. The Baganda (Roscoe 1965), for example, do not consider death as being due to natural causes. Death is attributed to malice vent in magical art, or as an outcome of sickness which the skill and art of the medicineman had failed to overcome. Sometimes this is attributed to a ghost and at other times to an indigenous god. Magical art can be manipulated in various ways. In his study of the Akamba, Lindblom (1920) found that a person's name has got a magical power and is viewed as an identical part to the one who bears it so that if an ill-disposed person learns it and mentions it, he/she can acquire power over the bearer and so injure him/her by black magic.

Some sort of private magic is also occasionally seen to be at work in several African societies. Among the Akamba, inverted jars would be left in various plots in order to bring rain (Lindblom 1920). Various other superstitions which are intended to work for the benefit of the whole society are included

here. However, also in one of its most diverse forms in Africa is black magic, which is attributed to many serious illness and is punishable by death (Lindblom, 1920). Various other forms of magic do exist in Africa. One notable effect of magic is that it causes illness and may result in death. One such diverse form of magic is what Seligman and Seligman (1932), in their study of the Dinka, described as evil tongue. A person who desires another one ill may harm him by evil wishes and uttering evil words.

Magic, as seen in the African context, may be viewed as negative and more often it is associated with bad intentions and malice. However, magic can be used to achieve positive ends. For example, it can be used to protect oneself against other magic and evil spirits (Hauge 1974). Roscoe (1915), in a study of the Luo, talks about powerful magic which people used to protect themselves against magic and evil spirits. So does Seligman and Seligman (1932) in their study of the Nilotic Dinka who live north of the Luo people. It is important to appreciate here that magic can be used against magic. Experience and prowess play a major role. The most efficacious and powerful magic usually triumphs; and, like in most victories, the victor wins praise.

In western medicine several diseases are classified as contagious. An example is small-pox which is usually characterised by sores on the surface of the skin and any contact with the sufferer will lead to infection by the non-sufferer. There is a similar understanding of disease causation as being possible in this way in traditional medicine. In his study of the Luo, Hauge (1974) also found that illness can be transferred from one person to another. Roscoe's study of the Luo revealed how sometimes this transfer can be stage-managed. The Luo often rub the patient with a plant which is then buried under the surface of a thoroughfare, and the next person who steps over it catches the disease. I am personally aware of such a transfer among the community I come from. Among the Abamarachi of the Luyia community a stubborn cold can be transferred from one sufferer to the next unsuspecting member of the society. The sufferer would ordinarily smear mucus on a coin. This would then be deliberately thrown on a footpath commonly used by members of the community and other people. The next person who passes through that path and picks up the coin will catch the cold. This will correspond with an automatic healing of the sufferer. This belief is also held by most of the other sub-groups of the Luyia.

Spirits, ghosts and ancestors are the other supernatural agents that are considered to cause illnesses. The belief in spirits is evident among several African communities and these are principally categorised as water spirits, forest spirits and mountain spirits (Parrinder 1958; Hauge 1974). Each society has its own understanding of the nature of such spirits and how these affect the lives of people in particular societies. In Bambara philosophy, there is a belief in a spiritual force known as "Tere" which becomes "Nyama" after death (Imperator 1966). Among these people it is believed that many eruptive diseases like smallpox and urticaria are caused by "Nyama" spirits of trees or animals (both of which are believed to have the "Tere" spirit) which the patient might have killed or come into contact within the spirit's dwelling places.

To the Safwa, a Bantu people who live in the southern highland region of Tanzania, illness and death are due to the departure or weakening of the "inzyogoni" which is the principal life force of existence which every individual receives at conception (Harwood 1970). This concept of life force resembles the concept of life force ascribed by Tempels (1959) to all the Bantu. An ancestor may also be held responsible for the illness of a descendant. This is in cases of deviant behaviour where ancestors, as the guardians of society, are always ready to punish those who deviate from the societal norms. To the Tiv (Rupert 1964), the chief spirits associated with disease causation are known as 'a Kombo' or 'Mbatsai'. There are various other spirits among the Tiv but these two are chiefly associated with disease causation. Whereas Evans-Prichard (1937) viewed the spirits to be a diverse manifestation of the Supreme Being, Beattie and Middleton (1969) recognized ghosts as part of spiritual elements which remains behind on earth after a person's death. Before Beattie's and Middleton's study quoted above, an earlier study of the Banyoro of Uganda revealed that the ghosts of the ancient heroes and kings called the Cwezi, did exert a powerful influence in the affairs of the living and were only appeased and prevented from doing harm through the Cwezi spirit cult (Beattie 1957). These few examples illustrate the divergent nature of ideas relating to the understanding of spirits in Africa.

In Islamized areas, including the Kenya coast, there is a strong belief in "Jinn", which are spiritual beings, (Imperator 1977) and not ghosts of deceased humans. They are believed to assume a number of

terrifying corporeal forms. There is also a belief in "Shetani" which is a group of spirits which do not assume corporeal forms. "Shetani" are believed to cause illness by the possession of an individual, unlike "Jinn" (Gray 1969).

Although Africans often explain their illnesses as being due to the ancestral wrath, the extent of this wrath in direct disease causation is markedly limited. Radcliffe-Brown (1952) maintains that the paternal ancestors are believed to be non-benevolent because paternal relatives in patrilineal societies, in whom jural authority rests, are not benevolent. In this example, ancestors maintain the status-quo in the two worlds. Their temperament towards their descendants is the same as what usually occurs in the every day life of the living. Wilson (1957), in a study of the Nyakyusa of Tanzania, found that female ancestors are benevolent in very rare cases. On the other hand, Middleton (1960) contents that the extra decent group ancestors can make an infant ill. They use him or her to bargain for their rights in the affinal relationship. Any such harm is not directly aimed at him.

*He is the victim merely because being connected by 'blood' it is only he who is liable to be affected (Middleton 1960 )*

Vilakazi (1962) reports of the ancestral wrath of the marriage obligation by an ancestor to his own descendants or the bride's husbands people and vice versa if the ancestor is from the husband's lineage.

The interaction of human beings with the environment is an obvious fact since they exist within the environment. Both the physical, biological and social aspects of the environment are ever with us; they are constant sources of stimulation for our individual psychophysiologic energy system (Ngubane, 1977). The environment has both constructive and destructive effects on us which may sometimes result in stress. The consequence of environmental "stress" is body response or a series of responses which result in a spectre of psychophysiologic reactions. These reactions vary from the maintenance of equilibrium or state of equilibrium with the establishment of altered states of equilibria which we later call "disease" or "illness". In this sense then drought can lead to crop and livestock destruction and, thus, lead to the stress

of food deficiency with its consequent strain of starvation. And in its pronounced state, starvation is characterised by several states of illness.

Various societies have different ways of conceptualising the environmental equilibrium and the effect of destabilising the equilibrium. The event of ritual pollution is associated with two adjacent parts forming the environment which exist in a continuum. Two sections which are recognised as discrete and separate have a section of the continuum which is marginal and adjacent to both discriminate sections. It is the marginal section that becomes the object of inhibition or taboo (Leach, 1971).

Ngubane (1977) presents the Zulu notion of health which she views as an outcome of a balance in the relationship of man to the environment. This is itself both the geographical and ecological background to social as well as the ambience of individual and family life charged with mystical forces and hazards. It is this environment that provides safety. Disturbances to this balance are reflected in diseases. In the Zulu understanding, diseases are used to refer not only to both the health disturbances as manifested by various symptoms but also to various forms of misfortunes and also to a state of vulnerability to misfortunes and diseases. The environment is held to cause diseases. The Zulu believe that people co-exist within an ecological niche. Therefore, contact with a foreign environment is capable of causing diseases. Dangerous snakes and certain wild animals are the major causes of the poisoning of an environment which becomes prone to many dangers.

This Zulu example illustrates the notion of environmental disturbances as being the cause of diseases. Whatever the belief held by any community throughout the world, drastic changes to the environment are usually accompanied by major physical, cultural and, even, social changes. Environmentalists are fond of focusing their concerns on the economic effect. However, such physical changes in the physical environment have an important socio-cultural effects within a community. Sexual contact is one such activity which is seen as causing ritual pollution among the Zulu (Ngubane 1977; Bryant 1949). These situations of pollution are dangerous because they are marginal and ambiguous. Due to this ambiguity and marginality, a person in such a state is vulnerable to disease and other deformities of all kinds.

The above examples are drawn from various ethnic groups in Africa. The newly settled areas of Laikipia and, indeed, specific areas sampled in this study, are predominantly occupied by the Agikuyu. It is, therefore, important to understand how the Agikuyu perceive illness. Kenyatta, (1978) detailed the Agikuyu explanation of the cause of death in his book "Facing Mount Kenya". The traditional Agikuyu believed in a deity, Ngai, who lived somewhere in the distant past. This god was deemed as being able to punish in order to correct those who had gone a stray. Such punishment would take the form of sickness or even death where the offence is grave. The medicineman was deemed as being the only person who could intercede in cases of sickness caused by broken taboos. In his study, Kenyatta (1978), brings out the close relationship between the living and dead. Illness is perceived as being due to a person not following the laid down Agikuyu customs and values. This usually triggers anger among the ancestors who punish the victim with a disease. And that is why corrective measures which have the intention of appeasing the ancestors are undertaken during illness. This concept of disease causation has an overwhelming influence on the Agikuyu people's health-seeking behaviour.

The foregoing paragraphs have reviewed the circumstances under which disease is explained in traditional Africa. Examples of the common cause factors have been highlighted. These factors help to describe the circumstances under which members of various communities in Africa respond to diseases.

## **2.2 Health-Seeking Behaviour**

When an individual falls sick, the usual reaction is to try, in the best way possible, to revert to the normal health state. As simple as it sounds, this process is complex and has various patterns that can sometimes be predicted. The therapeutic process widely varies in western societies (Imperator 1977). For instance, some people would embark on the therapeutic process immediately at the onset of symptoms, others wait for a longer period of time before consulting a physician while some other people may opt to start the process of treatment on their own. This variability in health-seeking behaviour is also reported in Africa. Pearson (1989) acknowledges that response to illness is indeed not uniform. From the time an individual realises something is wrong to the time he/she decides to make an initial corrective measure



varies from individual to individual. It is based on one's usual "baseline" state of well being; the perceived seriousness of that symptom, and the extent to which the discomfort disrupts what he/she wants to do. Most important is the prevailing culture. Indeed, societal values and beliefs, which are the principal guidelines to a people's culture, play an important role in influencing the cause of action taken by individuals during sickness. And these values and beliefs vary from society to society; whereas in some societies there is a definite path, in others individual choice and preference play a major role. Law's (1976) example of ancient Egyptian practices provide us with a good example of a rigid system in health seeking behaviour, which were greatly influenced by the prevailing cultural beliefs and values. Ancient Egyptians had the house of life to which sick people were taken for restoration to health. Then there was the house of death to which those who had been judged as being beyond repair were taken where they were taught how to meet the end of their bodies and how to behave when entering the spirit world.

Although this example may be viewed by a casual observer as being set in ancient times and, therefore, not being able to reflect the contemporary practices, it helps to portray the massive influence cultural beliefs and practices have in determining people's health-seeking behaviour.

Illness behaviour is, by and large, a culturally and socially learned response (Jones and Jones 1975). In societies that have distinct social class structures this is demonstrated in the different reactions to illness that are characteristic of each social class. The middle class are thus quicker and more eager to seek medical advice than lower class people. This difference, although more extensively demonstrated in the Western medical practice, is also mildly exhibited in traditional medical behaviour. Since cultural patterns vary from one society to another, it follows that different societies exhibit different behavioral patterns in their common goal of pursuing better health. It is, therefore, apparent that whereas in some societies the role of the traditional practitioner is almost discarded in certain cultures he continues to play as significant a role as the western medical practitioner. This is, despite the latter's presence being overwhelmingly obvious, especially in the Third World.

One important thing to appreciate is that a human being is born into a culture. That is to say, that he/she exists within patterns of social interaction, normative and behavioural systems and products of these systems. These systems do not necessarily provide a single way of doing things but rather defines alternatives within the boundaries of prescription and taboo. In these systems then, the definition of ill-health and curative steps that may be undertaken are found (White 1966).

Culture itself is subject to change since societies are not static. Smith (1966) contends that with development and industrialisation, societies are becoming organic. Inter-personal relationships are lessened. With wealth increasingly personalised, social stratification based on riches becomes more distinct. In most cases the patient and the physician are not necessarily of the same social class. Where a patient is from a lower social class the relationship may be domineering with the patient on the receiving end. The working class patient is likely to expect the physician to act in an authoritative manner, to give him/her advise and tell him/her what to do, compared to the middle or upper class patient who may engage in a discussion with the physician.

The effect social class has on determining people's health-seeking behaviours is varied and enormous as shown above, and it can affect one's behaviour during consultation. One's social class not only affects one's behaviour during consultation but social class also accounts for the differences in obligations, restrictions, privileges and rewards among different groups in any particular society (Simons 1966). It is clear that one's social class may affect one's awareness of the existence of a certain disease plus the corrective measures that should be applied in western medical cycles. It will, therefore, affect one's definition of what disease is and thereby determine the diseases that require a physician's attention.

The argument here does not dislodge the earlier credit on the effect of culture. What needs to be acknowledged is that although individual reaction to illness is guided by societal beliefs and values it is as varied as the individuals themselves. And that this variability is to some extent a function of social class. In Koos' (1954) study of the health of the peoples of Regionville in the United States of America, it was shown that there are wide contrasts in people's reaction to signs of illness, both trivial and serious. In his study, 57% of the high social class persons thought that the loss of appetite needed attention while only 20% of the low class thought so. On the other hand, while 100% of the higher class held that blood in the urine would warrant a doctor's attention only 69% of the lower class thought that blood in urine would warrant a doctors attention. Essentially then, while in the first instance of loss of appetite 57% of the upper class are likely to embark on the health -seeking process, only 20% of the lower class would. This is irrespective of whether they are suffering or not.

One important point to note in the above example is that while only 57% of the upper class people interviewed thought that loss of appetite warrants seeing a doctor, all of them held that blood in urine would warrant seeing a physician. This demonstrates the role the type of disease one is suffering from plays in determining the process towards recovery.

As in the Zulu case, a slight illness is taken lightly, while a serious illness is taken with the seriousness it deserves (Ngubane 1977). As has already been pointed out, the Zulu are a warrior tribe. Courage is, therefore, esteemed. In fact, among these people, coping with disease courageously was generally appreciated by everybody. This could, therefore, affect what ailments they would deem as warranting a physician's attention. Harwood (1970), in his study of the aetiology of sickness and death, 'empogo', among the Safwa, found that the diagnosis of a case of 'empogo' in medical terms initiates a different chain of behaviour, a different set of social processes and dynamics from those which follow a diagnosis of one or several manifestation of witchcraft, 'itonga'. Harwood's example demonstrates how the type and cause of a disease can affect the path one will embark on while striving for a better health

(Jones and Jones 1975). The more serious a disease is conceived to be the more attention it will receive. Therefore, while acknowledging the role played by social class in influencing health-seeking behaviour, it is important to appreciate various other factors which, put together, define the pattern of the therapeutic process. Social class does not have a homogeneous influence on health. Of particular importance are other factors like gender and other differences which together with social class play a major role in shaping one's health-seeking behaviour (Pearson 1989). Pearson, indeed, appreciates that social and material conditions have an impact on one's health, be it through generating stress that leads to ill-health or through economic inability that makes one unable to seek appropriate treatment. Stress need not to be caused by only material conditions. It can be caused by other factors such as racism in populations that are multi-racial (Pearson 1989). However, it often leads to the so-called stress-related diseases. Social class affects one's access to some of the minimal conditions of health; adequate food, pure water and air, reasonable housing conditions, as well as the general quality of medical care received (Smith 1966).

Pearson (1989) also states that social class influences individual patterns in response to sickness. The lower class patients visit the physicians less frequently than the upper and middle class patients. Middle class patients participate more, communicate more items of information, and ask more questions during consultation than do working class patients. On the other hand, Lois (1973) disputed assumptions that low income persons underutilise physician services. Her study affirmed that during illness, there is an equal tendency among all income groups to see a physician. And this is more so when publicly financed care is available. Availability of publicly financed health care services resulted in an increased use of health services by the poor. Whatever argument that may be propounded, one factor to acknowledge is that there is a patterning which is to a large extent influenced by the individual's social class. However, apart from social class, other factors exist which do affect people's health-seeking behaviour. Cockerham (1978) notes the important role age and sex play in determining people's utilization of health services. His findings were that utilization of health services is greater amongst males than females and more so for the elderly.

Several other studies have concurred with the contention. Anderson (1972), in their study, showed that females report a higher rate of morbidity than men and also have a higher rate of admissions into hospitals than men. Jones and Jones, (1975), on the other hand, contend that the rate of death for males is constantly higher than women due mainly to habits attributed to men than women.

Whereas it is important to review various findings without undue prejudices, they should not in themselves introduce certain prejudices within the reviewers. In the three examples quoted above that show the effect of physical differences on health facilities, some contradictions come to light to the casual reader. Jones and Jones (1975), did compare the mortality rates based on death caused by diseases due to lifestyle and behavioursim. For example, in Kenya, if the number of people suffering from gout caused by 'nyama choma' was to be studied, there would be a higher likelihood of having a higher rate of death caused by gout due to 'nyama choma' among men than women. But this would not imply that most deaths in Kenya are among men.

According to Cockerham (1978), knowledge of disease and family authority are seen as the other significant factors that influence an individual's health seeking behaviour. Knowledge of diseases assist in an easier recognition of symptoms and, thereby, activates one into assuming the sick role. The family, on the other hand, helps one to impel into professional health care system where lack of one would otherwise act as an inhibiting factor in obtaining professional treatment. Cockerham (1978), also dismissed ethnicity as being a major factor in determining one's health seeking behaviour. He however, appreciates ethnicity as representing a social experience. This social experience influences how a particular person perceives his or her health situation. Therefore, in most patrilineal societies the decision concerning the mode of treatment and when to take it rests heavily on men. In the absence of a male household head, his subordinates may get medicines to relieve pain or even consult a Western doctor. However, the decision making process is limited where major decisions are to be made without his knowledge.

It is also important to appreciate the regional and occupational variations as well as sex differences in the prevalence of diseases, since it is the differences in the prevalence of diseases that result in the difference, in the therapeutic processes. When compared to the developed world, the Third World has a higher mortality rate. This is partly explained by the poorly developed medical systems found in the Third World which are additionally handicapped by lack of materials and expertise. Some occupations are more prone to certain diseases than others, for example, workers involved in sun-blasting, mining and glass-blowing have a generally higher mortality rate compared to workers in different professions (Jones and Jones 1975). As a consequence of these differences, therapeutic practices are also heterogeneous.

This heterogeneity is a function of various factors which determine an individual's behaviour during sickness. Just as important as the physiological factors are in determining the response to pain, so are the cultural factors, cultural group membership, socio-economic class and expectations of treatment (Wolf and Langley 1968). However, one thing that is not in contention here is that the central player here is the individual, who once in a while falls sick and either recovers or passes on, whether to his or her ancestors as in traditional beliefs as seen earlier or to his or her creator as in modern Christian sense. Sickness is the behaviour of the whole person (Smith 1966). An individual's behaviour usually arises out of organic, social and psychological processes. These processes help to define the entry into, and the termination of, the sick role. Through socialisation one learns how to assign special meaning and patterns of action to the experience of pain. One may, for example, learn to pay attention to certain kinds of symptoms rather than others. In other words, one may have learned to be sick in certain ways. For reasons not connected to his/her psychological state, the individual may want to avoid being defined as sick when sick or when he/she is not, for example, during stress. This is in order for him/her to secure the release from obligations which he/she is expected to perform in his or her healthy state.

It is, therefore, an agreed fact that sickness behaviour is influenced by the way one's role is affected by pain, the symptoms of the disease as well as the changes in the feeling state.

However, whereas these are important, the way one perceives a disease is paramount in determining one's likely behaviour. Whereas some illnesses such as appendicitis, are easy to recognise, others may not be easily recognisable, as in the case of cancer. It does not also follow that once one recognises the symptoms, the process to recovery will commence. Some people will not consult the physician despite having recognised the symptoms of a disease. Cancer patients have been known to avoid cancer screening procedures because of their anxiety about learning the truth and being forced to confront what it means to have cancer (Becker and Maiman 1975).

Whatever the perceived alternatives, during sickness against the clear cut option of seeking physician health, there is a general pattern or stages that those individuals who perceived themselves as becoming sick pass (Suchman 1965). The initial stage is the symptom experience stage. During this stage the individual may or may not realise that something is wrong. The most common behaviour in this stage is the application of folk medicine and self-medication. The second stage is the assumption of the sick role stage where the individual relinquishes his/her normal roles. Also, during this stage the individual will still request for provisional validation for the sick role from members of the lay referral system. He/she will also continue with lay remedies. At the medical care contact stage, the individual, if he/she does not accept the provisional sick role, will seek professional advice. This is to authoritatively legitimise the sick role and also negotiate for treatment procedures. At the fourth stage of dependent patient role, the individual, who is now a full patient, will accept professional treatment. He/she will thus undergo treatment procedures for illness. Also, he/she will follow instructions as instructed. Finally, there is the recovery and rehabilitation stage where the patient relinquishes the sick role and reassumes his/her normal role. It should be noted that the patient always has an alternative decision to move to which either propels him/her to the next stage or he/she abandons the whole process. This does not mean that the individual acts in isolation. He/she is still part of society and is, in fact, constrained by cultural values and beliefs. In the

traditional African societies, this process followed a common path:

...his (the patient's) wife and relatives would try what effect home treatment would have on him, and only when that failed would they send for a medicine man ... to find by consulting his fetishes the cause of illness and to direct the treatment (Roscoe 1923:128).

This reveals that there were definite stages through which one had to go through. In the African situation, illness was a community affair. The individual acted in concert with his/her family and ultimately with the community. However, the base at which much of the treatment was, and still is, administered was at home for most ordinary ailments. When treatment at home does not seem to be achieving positive results then the illness, according to the Bantu concept of illness, is not ordinary in nature. There is, in other words, a dualistic system of disease causation which is a departure from the western world scientific cannons of patho-genesis.

A common area that is realised between traditional and modern medicine is an initial flexibility in choice. In western medicine the patient, in the initial stage of sickness, can either consult a doctor or buy medicine on his own:

People need not always hire the services of a practitioner, they may instead buy prepared medicines from one for a definite ailment. In that case they pay for the medicine only (Ngubane 1977: 104-105).

The above examples show the general need for better health among societies. The normal and usual action would be to strive to achieve health during sickness. The examples have also shown the strong commitment that the whole community puts towards assuring that their member has achieved the health status. Usually the community allows concessions in its quest for this goal as in the case of allowing the patient to abandon his normal roles without any loss in status. Astonishingly, and contrary to this general pattern of caring for the sick, Roscoe reports that among the Bakyiga of Kigezi nursing of the sick was entirely unknown and only little attention was accorded the sick, even infants. This is, however, an isolated case. One point that should be noted here is that societies vary but humanity is universal. And this single



case can not be of any consequence to the general pattern all over the world. Infact, the present Bakyiga are very particular about the recovery of their patients.

The foregoing review of health-seeking behaviour is based on examples from communities and societies in Africa and the rest of the world. These examples have been drawn from both the past as well as the present. The present research was carried out in the Laikipia District of Kenya in what are currently settlement schemes predominantly occupied by Agikuyu people. It is, therefore, important to understand how the Agikuyu today perceive sickness and how these perceptions are likely to influence their health-seeking behaviour.

Kenyatta (1978) notes the important role that used to be played by the medicine men in the society. The medicine man was the only person who could intercede in the case of sickness caused by a broken taboo, through the ancestors to Ngai for pardon; such pardon resulting in the victim's cure. Where the illness of the victim was serious, sacrifices were offered, as was the case during drought or the outbreak of an epidemic. One thing to note in the Agikuyu case, as in many other traditional societies, is that before ancestors are communicated to, in the event of serious illness, ordinary medical knowledge is applied. This process may be by the application of known remedies before the medicineman's talent is sort. Additionally, when the sickness does not yield to treatment, then, Ngai himself has to be consulted through the performance of sacrifices. In Kenyatta's study a close relationship between the living and the dead is eminently shown. Kenyatta (1978) does not see this relationship as being religious, as has often been misunderstood. It is a communal relationship in which the living foster a strong relationship with their departed kin. The latter are instrumental when contact with the deity is desirable as it is usually done during droughts or during an outbreak of an epidemic. The health-seeking process is thus established and the common belief and values that are associated with them. These may not have the same impact they had long ago. However, it is the guideline to which the interpretation of the current therapeutic practises can be based.

This study is about a migrant Agikuyu population. And being a migrant population, some of their traditional practises have been done away with, over time. The migrant Agikuyu population has immigrated into Laikipia District from the neighbouring highland populations from the districts of Embu, Meru, Nyeri and Nyandarua.

The issue that should be clarified here is whether the migrant population exhibit a different pattern of health seeking behaviour when contrasted to the indigenous population, and whether this is due to the different forces that they have to contend with within this new environment. The factors affecting health-seeking behaviour enumerated above do also apply to migrant populations. The disease rates are, however, affected by age at and years since migration, among other things, and will vary from disease to disease (Marmot 1989). Where the disease pattern of migrants resembles that of indigenous populations after settling, it can be concluded that environmental factors play a major role in influencing the disease patterns of the area that has been migrated into.

Such environmental influences act in concert with most of the other factors that were mentioned earlier. Social class is, for example, also an explanation for disease rates in an immigrant population (Marmot 1989) and influences the therapeutic process. While acknowledging the influence of social class on the pattern of diseases among immigrant populations, Marmot (1989) does also clarify that the social and economic positions of immigrants are unlikely to be the only factors that determine their disease patterns. A better understanding of their disease patterns can be achieved by focusing on other cultural or lifestyle features.

An example of the differences that can sometimes be seen in the disease patterns of an immigrant population to its source population is given in Poulter's (1989) study of the urban and rural Luo of Kenya. The Luo who are a low blood pressure group, reside mostly on the shores of Lake Victoria. According to Poulter, however, there has been a dramatic increase in the blood pressure among the urban residing Luo of Nairobi. His study revealed that this was primarily because of their lifestyle and socio-economic

status. The rural Luo consume less salt than the urban counterpart mainly due to an increasingly western lifestyle adopted by the urban Luo. The study also demonstrated the association between the years of education and blood pressure. The more educated Luo are generally with high blood pressure and this was explained by their inherently Westernised lifestyle.

The general conclusion from this study would point to the fact that by migrating into the environment that is not compatible with their land of origin that offers different economic opportunities, immigrant populations' disease pattern may vary from the pattern exhibited by the source population. However, the factors that affect their health-seeking behaviour in their original homeland do continue to exert pressure towards conformity to their cultural beliefs and taboos although these may not be in exact proportion to the degree of influence in the homeland. This indicates, that although the therapeutic process varies from one individual to another, these variations are within the general cultural and social systems of the communities to which they belong.

### **2.3. A Dual Medical System**

At the turn of the century, the introduction of the western medical system began to take root in Africa. However, nine decades later, this has not led to the eradication of traditional medical practices. There exists, for much of the Third World, a dual medical system, traditional and western, operating side by side, although not necessarily clearly defined. Most of the Third World's poor still resort to traditional medicine, especially for those ailments where traditional medicine are found to be more effective in treatment (Melrose 1982). Occasionally, this is due to the prohibitive cost of modern medicine.

Despite an often hostile recipient population, Western medical practitioners are always willing to pass on their knowledge in a variety of ways. This has been the spirit since the introduction of western medicine in most of the Third World countries where western medicine has been viewed variously as superior and should, thus, be imparted.

In a survey of Bambara country, it was found that modern medical practitioners have varied attitudes towards the various traditional practitioners (Imperator 1969). 78% of the physicians, for

example, expressed a willingness to cooperate only with herbalists, and not with other types of practitioners. This is a show of solidarity that can be achieved in the efforts of fostering co-operation between traditional and western medical practitioners. However, the fact that this trust can only be extended to herbalists is in itself a pointer to the limitations in the field of co-operation. Of course, Imperator's (1969) study is just one example of the current intermix or parallel occurrence of traditional and western medicine side by side. Traditional medical practices still flourish in much of the rural and urban areas of Africa (Maclean 1971b; Imperator 1977).

One of the best examples of traditional medical experts who have been encouraged and are used within modern medical circles are traditional midwives (Namboze 1964). This is proved by the increasing effort to teach midwives some basic concepts of antiseptics in the diagnosis of potentially dangerous complications and to improve their techniques. Throughout contemporary history, midwives have been used in most societies in the delivery of children. The midwives played this key role in most traditional African societies such as among the Kabish of Sudan (Seligman and Seligman 1932), the Yao of Malawi (Stanus 1922), the Bakongo of Equatorial Africa (Cureau 1915), the Banyankole of Uganda (Roscoe 1915, 1923), as well as the Hausa and Fulani of northern Nigeria (Fleischer 1975).

Apart from midwives, another category of traditional practitioners who enjoy a lot of support is that of bonesetters who have much success as found out by Zeller (1975) in the study of the Baganda. Ulin (1975), in a study in Botswana, reports that apart from general herbalists, there are diviner-healers who also practice bone-divination.

Several other authors confirm the continued practice of traditional African medicine. Some of these authors also stresses the need to develop a positive attitude towards such type of medicine by the western medical profession. For example, Mbiti (1969) underlines the fact that traditional medical practices are not ceasing but increasing in Africa as well as other Third World countries. Due to the high prices of modern medicine more people are resorting to traditional medicine. Of course, the scale of

traditional medical practice may not necessarily be increasing. The argument, however, is that traditional medicine, long discarded as of no positive consequence, is increasingly being appreciated by a growing quarter of the population within the modernising Third World. Since both forms of medical practices are found coexisting within the same environment, there is constant competition between the two systems, with each trying to outdo the other. There develops "camps" of those who prefer western medicine, and those who do not and a middle group of those who use both traditional and modern medicine. This process is characterised by criticism of the opposite camp, and vice versa.

However, a close scrutiny of the two, traditional and western medicine, will reveal that they are closely interwoven. There are drugs which are directly derived from traditional remedies and which are used in whatever dosage for the same ailments as in traditional medicine (Sofowara 1982). Sofowara quotes examples from Britain to illustrate this.

One cannot, therefore, completely divorce traditional from western medicine. Even where the bias is towards western medicine, especially in the Third World, traditional medicine continues to be a ready alternative. Law (1976) describes several alternatives to the established forms of western medicine which have been tried and seen to work. These alternatives range from herbalism, acupuncture, the Alexander method, hair therapy, apple cider, vinegar and honey to auras and baths. It suffices to mention here that several of these alternatives to modern medicine are currently recognised and recommended in western medicine. Whereas it is worth to appreciate that traditional practices are effective and generally positive in the majority of instances of their application, there are some bad traditional practices that do not work towards the improvement of a community (Melrose 1982). Some of these practices are being discouraged and are gradually being phased out, for example, cliteridectomy in Kenya.

Several other criticisms are levelled against traditional medicine. One such criticism is that there is no exact dosage and standardization. The proponents of these criticism argue that no set quantity of drugs per each intake is set (Sofowara 1982). In modern medicine, prescriptions of two table spoonfuls

three times a day are common. The critics also argue that there is no distinction in the dosage required for a child and that ordinarily prescribed for an adult. Whereas this argument may have some validity it should suffice here to point out that usually the amount of medicine that a grown up requires against that which a child is given is to a large extent left to common sense.

It would be erroneous to criticise traditional medicine without appreciating that it also has some positive aspects. Having shown the dual medical systems that current Third World societies exhibit, it is important to mention the role the individual plays in seeking health in both the traditional and modern health practices. Essentially illness perception in African societies is the same when compared to the western process, except, perhaps the attention received from the family member is greater in the traditional practice (Imperator 1969).

Maclean (1971b), in his comparison of the traditional healer and the western physician, noted that whereas the western physician is concerned about how and why the patient became ill, the traditional practitioners, due to their training, are successful at solving the howfulness of the disease. The traditional healer rarely fails in explaining the why, because most illnesses are self-limiting in explanation, with credit for cure being given to the healer. Maclean also summarises the sick state in western medicine against the sick state in traditional medicine. In Western medicine, the individual plays the main initiative towards his/her becoming a patient. It is mainly the individual who feels discomfort. Basing on the intensity of the pain caused by the individual state one then decides whether it is serious enough. This decision is what makes him/her a patient or not. Meanwhile, based on his/her behaviour, his/her close relatives also examine the situation, and decide whether the patient's state requires immediate attention. In traditional medicine the family plays a major role in directing the patient throughout the period that he/she is sick and the ultimate goal of restoring health is sought with a lot of communal effort.

Both traditional medicine and western medicine strive to achieve better health for the patients. The diversity of the different processes should not cloud the common goal. This diversity offers unique features that greatly influence the success of the introduction of one medical system into a population that is dominantly used to another medical system.

Illich (1977) argues that modern medicine has instead had a negative contribution as it has raised public expectation of wonder cures which are not effective. It has also extended too far the kind of problems that are held to be medical. He also holds modern medicine as largely being responsible for large amounts of iatrogenic (medically-produced) illnesses. Illich's contention is that modern medicine has eroded people's personal responsibility towards themselves. It has severely decreased the ability of individuals to cope with their own illness by fostering a debilitating dependence on the medical expert. The patient's contribution towards his/her own health is during diagnosis, and even here he/she plays a minimal role.

A doctor's preconceptions and assumptions inevitably play an important part in the diagnostic process (Pearson 1989). In the end, there are flaws, with accuracy falling well below perfection (Jones and Jones 1975). The problem here is not really with the patient, but more with the whole 'modus operandi'. The whole idea of diagnosis based on the patient's hazy recollections sometimes leaves out small and important details that would in any ideal circumstance lead to proper identification. Western diagnosis relies upon the patient's description. Most people are unable to explain their problems in medical terms, during sickness and, in most cases, they are usually in too much pain or under nervous strain to tell the doctor more details. Although one can argue that modern doctors are equipped with instruments for diagnosis, these instruments are, to a great extent, geared to answering the quest of the nature of the germs and viruses which have attacked the body. The herbalist, on the other hand, has a very different conception of illness. The herbalist seeks to find out which organs and systems of the body of the patient are failing in their function so that they no longer resist as they should this alien development, that is, illness (Law 1976).

The process of healing in serious illnesses, like all other illnesses, is mainly carried out in a centralised institution which may be a hospital, nursing home or clinic. It is this institution that is charged with receiving the sick day in day out and a good part of the corrective measures are carried out here. However, is the modern hospital as an institution ready to deal with the sick?

The hospital can sometimes be a malfunctioning bureaucratic organisation that is embroiled in conflict, making it hard for the patient to get the best of the services. There is a dual line of authority which is expounded by Jones and Jones (1975). It consists of the administrative and medical sections. Jones and Jones (1975) maintain that it is the medical section which has more authority than the administrative line. Whereas I do accept that there is a dual line of authority, I do not think that the medical line holds the power to decide the direction the organisation takes. Several cases have come to light in Kenya where hospital administrators have given instructions to physicians not to treat patients in critical conditions before administrative conditions and procedures are met and fulfilled. Common are cases where a given percentage of money has to be paid before certain operations are carried out. Essentially, a physician's overall objective is the recovery of his/her patients. The physician does, therefore, strive towards this cause and uses all his/her authority within the hospital organisation towards achieving this goal. However, as in the case stated above, it is apparent that the wishes of a physician may sometimes be delayed or may not be fulfilled by the administrators.

And so it goes that despite advances in medicine, the majority of the Third World population are still experiencing the same health problems as their grand fathers, if not worse. In fact, to the poorest of these countries it can be said that during their lifetime most of their people are likely to experience as much ill-health as their great-grand-fathers during their lifetime. It is, therefore, not just enough to tackle disease alone when seeking for a health solution for these poor countries but to direct much effort to the eradication of poverty (Melrose 1982).

Not all the drugs usually prescribed in modern medicine lack side-effects. Penicillin, widely used to treat bacterial infections, is capable of producing sudden death, heart diseases and incurable skin diseases. Some other drugs also have certain side-effects. For example, Aureomycin has been known to cause liver damage and internal bleeding. Cortisone is known to bring about kidney diseases and is also capable of reviving latent tuberculosis and can even bring about insanity. Indeed, the development of iatrogenic medicines (medicines to heal diseases caused by taking other medicines) is proof of the wide range of risks caused by modern drugs (Law 1976).



Apart from the problems of iatrogenic medicines, there is also the cost factor. The most useful drugs may be out of reach of the poor due to their often prohibitive costs or unavailability from the local drug retailers. Some of the most marketed drugs (the ones most frequently bought) may not be the most essential, but due to advertisements which corrupt people's minds, they are the most sought for drugs. One can talk of the poor value for the poor (Law 1976). Within the Third World, the poor, being unable to pay for consultation fees demanded by private doctors, resort to drug stores and buy drugs from the shop counters which may be, in the short term, right for the pocket but, in the long term, expensive as they may not readily achieve the stated objective of returning the patient to health (Melrose 1982).

This state of affairs needs urgent corrective measures that will not only strive to solve the problems but strive for a healthier populace. It is, therefore, important that problems of drugs supply, delivery of medicine and formulation of policy be addressed.

The trend in modern science has been to combat diseases with the most modern drugs available. This trend has gone on too far such that even doctors are unable to keep up with the numerous drugs and other pharmaceutical products that are being advertised. If this trend may be explained by an increase of new diseases, then modern medicine should not seek the most modern method to combat diseases but the most suitable way to destroy the origins of the disease. Because, if new diseases are being created, then they must have origins and by eradicating them we destroy the source and, thus, the disease. And this can be achieved by exploring, hitherto, neglected ideas of healing, as old as possible, to enable us to gain a new perspective which will enlighten us as to the nature of disease.

If the discovery of the germ is an example then it would not be a fallacy to say since its discovery, as a major cause agent, the germ has thrived far much better than its victims. Consequently, disease continue to exalt as firm a hold upon humanity as heretofore (Law 1976). The problem of drug supply should be addressed to help the populace receive the most essential drugs. One thing to note is that in the Third World, whereas a limited number of drugs are vital to health needs, not all drugs are essential or

useful. Therefore, medicines play a relatively small role in the alleviation of the overall health of the Third World countries (Melrose 1982). What needs to be done is the formulation of comprehensive national drug policies which, should also give a clear priority to essential drugs for primary health care. This can be achieved through essential drugs lists provided by the government (Melrose 1982). And, for most Third World countries, there is hope towards achieving this. For example, the Kenya government has moved steadily towards formulating a drug policy.

However, such policies can only work when the socio-economic environment into which they are being introduced is well understood. This means that, medicine should also strive to be social medicine which in effect implies that the individual should be well understood. Also the background and the environment in which an individual operates should be well studied. It is, therefore, important to understand how individuals react to sickness, the pattern of health seeking behaviour and the influencing factors.

In much of the Third World, it is not a disputed fact that traditional medicine exist alongside western medicine and people still practice both types of traditional medicine. Whereas some authors advocate for the idea of continuing with the traditional health practices some do not. For example, Maclean (1971b), in a study of households in Ibadan, found that several healers and their clients use certain medicines that are toxic. They continue to use such medicines even though they know they are toxic. Maclean's (1971b) example here is typical of a case that advocates for the urgent need to revert to a medical system that is both hygienic and readily available to people in the rural setting all over Africa. On the other hand, Koumare (1972; cited in Imperator 1977) advances the argument that there is a need to resort to traditional medicines because modern drugs are expensive to buy and are relatively scarce compared to herbal remedies. However, according to Imperator (1971), because herbal medicines are in short supply in urban centres they tend to be more expensive than the western drugs.

Whatever the argument, Africa presents a unique case. Most African societies still live under very unhygienic conditions. This is brought to light by several authors. Tonako (1980) found that the rate of the San people getting stomachache and diarrhoea is very minimal despite the fact that they frequently eat rotten meat. These bad hygienic conditions, as demonstrated above, may not automatically lead to diseases. Diseases in Africa are managed using both western and traditional African medical practices. Perhaps, one author who captures the harmonious existence of western and traditional health practises is Myere' Fortes, who in his August 1976 foreword to Harriet Ngubane's book on Zulu medicine, made the observation that:

*...scientific medicine is also available to the Nyuswa. They have access to a hospital and western trained doctors, and they make use of these facilities for many types of illness. But the traditional ways of interpreting and coping with disease still maintain their hold, either for disease or affliction that is defined as precariously African or to fall back upon when western medicine fails (Ngubane 1977:IX).*

Having established that traditional medicine thrives amidst us, it follows that ways have to be explored towards making it work for the populace positively as nations strive for healthier populations.

Efforts are currently more than ever before being geared to establishing scientific evidence for the efficacy claimed for medicinal plants in Africa. The intention is to incorporate the efficacious medicinal plants into the health system of each country and discard the toxic ones. This will encourage the production of drugs in Africa. Such efforts will reduce the total dependence of most African countries on imported drugs and lead to greater self-reliance in their own pharmaceutical services. If this trend is maintained, Africa should be able to provide health for all its people by the year 2000, at least, at primary health care level (Sofowara 1982). Several traditional medicinal plants found within the Third World have been developed into drugs by the industrialised countries. However, mechanisation of the production and commercialisation of the distribution of traditional medicine destroy their advantage by pricing them out of the reach of the poor (Melrose 1982).

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Within traditional medicine itself there have been notable improvements. Small gourds originally used to store medicinal preparations have now been replaced by bottles. Other containers originally used include earthenware pots, the shells of tortoise, horse hooves, horns of various animals, brass pots as well as hollow tin rods plugged at both ends or sealed at one end into a conical shape (Sofawara 1982). These changes are geared to a more hygienic health delivery system that resembles the practice of western medicine.

There is, therefore, a growing need to integrate traditional medicine into the current mainstream health system. This has been recognised by the World Health Organization whose objectives are to foster a realistic approach to traditional medicine in order to promote and further contribute to health care. Secondly, it aims at exploring the merits of traditional medicine in the light of modern science in order to maximise useful and effective practices and discourage harmful ones. The third objective is to promote the integration of proven valuable knowledge and skills in traditional medicine into western medicine (Sofawara 1982).

## **2.4 Conclusion**

In the proceeding three parts of the literature review, works on medical behaviour have been reviewed. The review focused on literature that show the various explanations for diseases in traditional African societies. The literature review also examined the health-seeking patterns that are exhibited during sickness. Finally, the review did look at the existence of traditional medicine and modern medicine side by side in contemporary practise.

The literature shows examples of how various societies perceive the cause of diseases and how these causes do influence the action taken toward recovery. Of particular focus here, were the causal factors of disease in traditional African societies. The extent and nature of supernatural causal agents were shown. The supernatural forces are perceived as being the single most common causes of diseases in

African societies. The various supernatural forces illicit a different chain of reaction when they are seen to be the cause of disease. The variability in the health seeking behaviour of individuals was shown. Of particular importance is the concerted desire among the patients, health practitioners, be they traditional or modern, as well as the family and the community, to revert to normal health. The literature showed how varied this effort is and how it is realised. The various factors that influence the health-seeking behaviour were numerated.

In the third focus the continuous existence of traditional medicine and modern medicine side by side was shown. The important role traditional medicine plays in the maintenance of the health status of the community was also shown. The continued trust that people have in traditional medicine was pointed out. As the prices of modern medicine continue to rocket to ever high levels the need for an alternative sources of medication has become more paramount. How various societies have resorted to traditional medicine has been clearly indicated. Both systems of medicine have their shortcomings. Several authors criticise modern medicine and others traditional medicine. These criticisms are healthy as they enable planners and policy makers to review the weaknesses that abound in the systems of health delivery so as to design the best possible programmes to tackle these problems as authors point out the shortcomings of modern medicine. Some of the authors like Illich (1977) outrightly criticise modern medicine.

## 2.5 THEORETICAL FRAMEWORK

### The Functionalist Orientation

Bronislaw Malinowski (1961) and Radcliffe-Brown (1935) are both known in anthropological literature for their contributions on theories of how a society maintains itself. The theory of functionalism postulates that all aspects of a culture have a function towards the maintenance of the whole. According to Malinowski, the only way to explain facts was to define the function that the facts may perform in a given society. Such an approach may perceive the society as an organic whole with various parts functioning toward the maintenance of the whole. In his study, Malinowski (1961) outlined the importance magic plays in the economic activities of the Trobriand Islanders for the welfare and, indeed, the very existence of the community. Magic wields an immense influence over the whole life and thought of the Trobriand Islanders.

In functionalism the acts of behaviour, which is the manifestation of culture, have significance not as distinct acts but as dynamic aspects of culture. In this respect, native medicine functions towards the maintenance of the society. However, since all cultures are not the same, there exist various differences. Ackerknecht (1942a, 1942b, 1946) defines the element of a particular medical system as being functionally inter-related in the same system of a particular group. Ackerknecht further states that the degree of functional integration of the element at both levels varies from one to another. This brings in the aspect of the uniqueness of each culture.

Functionalism is here understood in the sense of the whole system and the impending changes since:

*One way to learn what a particular organ contribute to the functioning of the whole organic system is to see what happens when the organ is altered or removed. The same method is applied in the study of social system (Paul 1955:325)*

Both western and non-western medicines function towards the maintenance of the good health of members of a society and have similar aspects. That is to say that just as in western medicine, there is an

expert who is sought in the event of illness so it is in traditional medicine. And both medical systems are aspects of present African societies. Traditional medicine has undergone enormous changes over the years and is bound to undergo still more changes in the coming years. Still, its existence is unquestionable. It still plays a role in most African societies, since as an aspect of culture, it is part of it (Rivers 1924, 1926) and does, therefore, function towards the maintenance of the society. Rivers postulated that primitive medical practices follow logically from underlying medical beliefs, they are, therefore, not a

*Meddley of disconnected and meaningless customs... (but)... are inspired by definite ideas concerning the causation of disease (Rivers 1924:15)*

Whereas Rivers did acknowledge the function of 'primitive' medicine, he did not, however, acknowledge the naturalistic world view of non-Western medicine. His emphasis was more on the magical and religious world-view. Slightly departing from that, the view taken in the study encompasses both the magic-religious and naturalistic world view as making what is collectively referred to as traditional medicine. Rivers also perceived modern and traditional medicines as two different entities and concentrated on 'primitive' medicine. The framework adopted in this study perceives both Western and non-Western medicine as functioning towards the whole. African communities have both western and traditional medical practices side by side for the preservation of societies. The role traditional medicine plays is for the welfare and survival of the community.

## **2.6 Research Hypotheses**

1. The more accessible modern health institutions are the less the likelihood that one will use traditional medicine.
2. Health seeking behaviour is mainly determined by the type of disease one is suffering from.
3. Religious affiliation influences health seeking behaviour.
4. Socio-economic status influences the practice of both traditional and modern medicine.

### **2.7.0 Operationalisations of the variables.**

There are seven variables, four are independent and three are dependent. The distinction independent here is used to denote those variables that affect other variables and may have no relation to one another. On the other hand, the dependent variables are the ones which are affected by independent variables. The dependent variables vary according to the variations in the independent variables.

### **2.7.1 Independent Variables**

#### **(i) Accessibility of modern health institutions.**

Accessibility includes distance, quantity and quality of the service. The cost factor is also important. For example, a hospital may be near but too costly or the staff are not able to communicate in the local language, or any such problem that hinders the use of the hospital.

#### **(ii) Disease type**

Disease is used here to imply a state of departure from the normal physiological and psychological state. To define a disease type respondents were asked to identify the type of disease that they were last afflicted with. Their response would, therefore, be deemed to be the disease, even though in real scientific terms it represents a symptom.



### **(iii) Religious affiliations**

This refers to the religious denomination one belongs to. The majority of the respondents are Christians. They do, however, belong to specific denominations like Catholics, Church of the Province of Kenya, Protestants, and among others.

### **(iv) Socio-Economical Status**

This includes one's education and wealth. Since the research was concentrated in the settlement schemes, wealth was determined by the ownership of property like land and the number of heads of domestic animals which includes both sheep, goats and cattle. The more domestic animals one has the higher one's socio-economic status will be considered to be.

## **2.7.2 Dependent variables**

### **(i) Use of traditional medicine**

The use of all efforts that do not employ Western but, rather African knowledge and science plus materials or medicines to achieve recovery, were defined here as traditional. These will range from traditional medicines of all kinds, traditional surgery, traditional physiotherapy, like steaming to treat measles, use of home-made instruments to extract teeth, plus traditional modes of child delivery. The total combination of knowledge and practices employed in diagnosing, preventing or eliminating physical, mental or social diseases and which rely extensively on knowledge passed down over generations, through verbal instructions is referred to here as traditional medicine.

### **(ii) Use of western medicine**

Use of modern medical practices that employ western science. This includes the taking of western medical drugs. The use of western medicine was measured by asking the respondents whether they had visited the hospital, clinics, and dispensary plus other official health centres when they fell sick. The frequency of such visits was also sought to help establish how often western medicine is utilised.

### (iii) Health-seeking behaviour

The course of action that the respondents resort to during sickness was defined as their health-seeking behaviour. The respondents were asked what action they took when they last fell sick. The action or set of actions that they took were categorised into desirable patterns. This is what was referred to as their health-seeking behaviour.

## CHAPTER THREE

### METHODOLOGY

#### 3.1 Sampling Procedure

Due to limited time and the cost factor, the entire district could not be included in the sampling frame. One division was thus chosen due to its convenience and characteristics. Central division is both closer to Nanyuki Municipality, which was the study base, and is also inhabited by immigrants from the neighbouring districts of Embu, Meru, Nyeri and Nyandarua. The main economic activity is agriculture. Central division has four health facilities which are sparsely scattered in the division. This was deemed ideal in this study which had the objective of finding out the impact of modern health facilities on the health behaviour of the immigrant population.

The second stage, in this multi-cluster sampling procedure, was to identify clusters of populations. Two clusters of populations which do not have a health facility nearby were chosen. These were Burguret and North Tetu which are referred to in this study as Area A. On the other hand, Area B was designated in this study to consist of two population clusters which have a health facility within the cluster. These were Mumarati and Weruine. Listing the households in these clusters did not present any specific problem. The clusters consist of members of single settlement schemes. A full list of the number of plots within each settlement scheme was obtained from the Laikipia Research Programme. Using this data base a full list of the settled households was obtained. At the time of the research Burguret had 94 plots, while Tetu had 69 settled plots. Mumarati had 113 settled plots while Weruine, which was the biggest and the most expansive, had a total of 222 settled plots. A total of 335 plots in area B were settled. This brings up the total settled plots in the sampling universe to 498.

Cost and the time constraints could not allow for such a large sample to be interviewed. Therefore, a random sample of 168 samples, 42 from each settlement scheme was drawn independently. The process was done four times. For each settlement scheme numbers of the settled plots were written on a small piece of paper and these were placed in a tin. The tin was shaken then

one of the papers picked. The number written on the piece of paper was included in the sample. The same piece of paper was again folded and replaced in the tin. The next lottery was chosen. This was to ensure that each household had an equal chance of being chosen. This was repeated until 42 households had been drawn for the first settlement scheme, Burguret. The tin was then emptied and re-filled with the pieces of paper representing the settled households of North Tetu. The same procedure was repeated and 42 households were selected for North Tetu. This procedure was repeated until a total of 168 samples had been drawn. However, when it came to the administration of the questionnaire only 163 interviews were done. Five of the households were not interviewed because the owners were not present; they had gone for several errands in Nanyuki and Nairobi. Repeated attempts to get them were fruitless.

### **3.2 Methods of data collection**

Many studies in anthropology are behavioural studies. That is, studies that attempt to give an in-depth description of an aspect of community behaviour. It is not always easy to study behaviour and come up with conclusive findings on how behaviour is manifested in its natural settings. Behaviour is dynamic and has situation-based features which are the prime target of the anthropologist. To achieve this the anthropologist, being a scientist, employs various methods to gather data on an aspect of behaviour in the community he/she is studying. The application of these methods must be done with utmost care and tact. In this study, various methods were employed to gather data on the health-seeking behaviour of the immigrant population of Laikipia District. Special care was taken to ensure that the objective of the data collection process was achieved. This objective was to collect both quantitative and qualitative data that best depict the actual health-seeking behaviour in the communities living in the district.

### 3.3 Standard Questionnaire

A standard questionnaire was administered to a total of 163 household heads. The household heads were determined by first establishing the extent of the family tree. Most of the husbands were found either to be away in Nanyuki town, Nairobi or some other town working. In such cases the wife was interviewed as she is the one who is involved in the day-to-day decision making on health matters affecting herself and the family. The questionnaire was administered with the help of three research assistants during the whole period of research. Health behaviour is an intimate subject. A lot of rapport had to be established in order to embark on the questions themselves. In cases involving female respondents who were shy a female interpreter was used. The rest of the interpreters would in this case be away from the place where the research was being carried out.

Establishing rapport did not pose any particular problem. All the interpreters were from Laikipia Research Programme and had in one way or another done some research in much of the area under study. In some cases, the respondents knew the research assistants by name. However, it was essential to explain why such questions were being asked. Most important, what was the study for? And when the explanation was given, that it was a student from the University of Nairobi who was conducting a study, most of the respondents were willing to give the information.

The questionnaire had the aim of providing a description of the population under study and to measure their attitudes towards various modes of treatment. Information on the following characteristics was collected: Age, sex, family size, types of medicines, preference of various modes of treatment and health facilities and practitioners, ownership of various properties, religious membership and years of education. Also attitude to various western and traditional health facilities and practitioners, religiosity and other phenomena were measured.

### **3.4 Focused Group Discussion**

In order to understand the dynamism of medical behaviour in the communities under study it was important to have groups of people to deliberate on the matters of the research. These groups were either stage managed or simultaneous. The stage managed groups mainly involved health workers and village elder groups while simultaneous group discussants, who yielded a lot of valuable information, were mainly found in market centres. One important aspect on the latter is that they mostly contributed on attitudinal variables. They provided information as to the general pattern of medical behaviour. They were a good source of criticism of what is happening. They talked freely and provided a lot of qualitative data. These groups gave credence to the information which had been collected from key informants, questionnaires and secondary data sources.

### **3.5 Key Informants**

Within each society, there is a group of people who are likely to control a lot of information about their culture by virtue of their age, profession, experience and disposition. Most of the key informers, were selected because of their formal statuses. The key informers who held formal statuses include nurses and medical personnel who head the health centres in the research areas, local administration officials as well as teachers. Of particular importance were the nurses who gave an account of their experiences in the administration of medicine among the communities living in the Central division of Laikipia.

The traditional medical practitioners, especially herbalists and uvula surgeons, were also useful. The information received from them was quite qualitative and informative. This information was elicited through verbal communication. Through this verbal interaction the respondents were quizzed to highlight specific aspects of information which only they were in a position to provide. Traditional medicine specialists were especially useful here in describing how various traditional remedies are used for a series of ailments.

### **3.6 Non-particant Observation**

Observation captures the various situational based features of conduct in their settings. The method was especially useful in health centres where the researcher observed the day-to-day treatment of patients. The enthusiasm with which western medicine is sought and received was observed and noted. This method was used in the whole process of the research. People's reactions to various questions during the administration of the questionnaires did point out to more than what they were saying. Of course their answers to the questions put to them were adequate. However, fidgeting when a question is put across implies that there is a difficulty in answering the question. Observation of day-to-day activities was on the whole very useful to the researcher. It helped in the overall understanding of the culture of the communities in the research area.

### **3.7 Secondary Sources of Information**

Journals, books, data banks at Laikipia Research Programme offices, and other written materials available in public offices and archives were used. These mainly helped provide the necessary background information on the problem under investigation. Valuable information on the Agikuyu and other communities all over the African continent was especially valuable. These past studies were important in enabling the researcher to compare the Agikuyu and other African communities. At the end of the research it was also possible to appreciate the enormous changes that have occurred and thereby appreciating the usefulness of the study at hand.

### **3.8 Problems Encountered During the Research.**

The majority of the population now living in the Central division of Laikipia District are Agikuyu. The researcher in this study is not an Agikuyu. This proved to be a major constraint throughout the research. The initial solution was to get interpreters who could administer the questionnaire in Agikuyu. Once they were identified, the questionnaire was partly translated. The

translation of the questionnaire concentrated on the technical aspects of the research. The local words for circumciser, uvula surgeon, medicineman and herbalists were essential. This made the respondents easily understand what the researcher meant.

The research was carried out during the height of ethnic clashes in the Rift Valley. The researcher, not being a Agikuyu, was conspicuous. Most respondents were very concerned about the researchers ethnic background and some did not settle until they were told and assured the researcher was not a Kalenjin whom they considered their adversary. Since the ethnic difference initially caused apprehension, it was quite difficult to explain the purpose of the research. Especially important, the locals had to be assured that the research had no ill-motive but was just a study by the University of Nairobi in collaboration with the Laikipia Research Programme, which they were more familiar with.

In creating rapport the researcher depended on the interpreters and research assistants from the Laikipia Research Programme who were familiar with many of the respondents. They were particularly useful in locating the households, since they were familiar with the research terrain and scope.

The familiarity of the respondents with the research assistants was fairly close. Close to the extent that the respondents were always ready to abandon for a while their daily chores to answer the questions that were put to them.

One constraint felt was where there were more than one female and male informants. In such cases, the flow of information was not free. This was so especially when the female respondent was shy. On observing a shy respondent, the researcher would without making it obvious, request through the research assistant, the rest of the group to go out of the house where the questionnaire was being administered. This was very important as some of the questions were of a personal nature. On the whole, the questions were openly answered, enabling the collection of valuable information.



### 3.9 Methods of Data Analysis

The essential aim here is to quantify the data into meaningful and readily discernible patterns and to interpret the patterns. In the analysis of the data gathered here descriptive statistics were used. Of particular use were tables and frequency percentages. The researchers' main aim here is to show the relationship exhibited in the statistics clearly, an aim that is fulfilled by the various tables that are used in this study. The tables display the variations in the various variables under study.

For comparison purposes, percentages are worked out. These percentages show the proportion of the population responding positively or negatively to the various variables. For example by stating the percentage of the highly religious respondents who do not use traditional medicine, the effect of religiosity on the use of traditional medicine was duly shown. For the purposes of testing the truthfulness of the various hypothesis that had been postulated, the presentation which follows was found to be adequate.

## CHAPTER FOUR

### ATTITUDES TO VARIOUS MODES OF TREATMENT

#### 4.0 Introduction

In this chapter the data on the various attitudes towards the modes of treatment, both western and traditional, that are employed by the immigrant population of Laikipia District will be analytically presented. The presentation has four focal points. The principal focus is on the relationship between the accessibility of modern medicine and use of both modern and traditional medicine. The second focus is on the various types of diseases that afflict the people of Laikipia District and how the incidence of certain diseases does influence the people's health-seeking behaviour. The role that Christianity plays in determining the use or non use of Western medicine is the third focus. Finally, the socio-economic status of the people of Laikipia is analysed especially in relation to how it influences the particular use of traditional and western medicine. In the four-pronged presentation of the data the four hypotheses that are set out in the initial chapters will be tested and either accepted or rejected.

#### 4.1 Accessibility and utilization of modern health facilities

In the literature, the use of modern medicine is widely reported (Melrose 1982; Namboze 1964; Ngubane 1977). This is a fact that is reinforced in this study. All the respondents, except 2 (1.2%) have been to a modern health facility in their lifetime. Despite this enormous awareness of the existence of modern health facilities, there are various differences in the frequency in the use of these facilities. This is a phenomenon that could be explained by either the lack of enough health facilities or their location far away from the population. The mere presence or lack of enough health facilities and their distance affects the level of use of modern health facilities.

In the Central division of Laikipia District there are four health facilities according to the 1989-1993 development plan. Due to the fact that the population is dispersed over the division, the average

walking distance to the nearest health facilities is 10 km. Given the poor infrastructures in the division and district as a whole, access to health facilities is especially difficult. For instance, while Area B in this study which consists of Muramati and Waruine, have a dispensary, Burguret and North Tetu, forming area A, do not have a dispensary. On the other hand, 47.6% of the respondents from area A resort to the dispensary at Matanya (Waruine) while 35.7% to Muramati dispensary as their closest. The remaining 16.7% resort to Nanyuki District Hospital (9.5%) and Sirimon Dispensary (7.1%), which are both far.

Due to the proximity of dispensaries, 49.4% of the area B respondents consider Matanya dispensary to be close while 50.6% of the respondents consider Muramati dispensary to be close. The respondents also rely on the district hospital since 154 of the 163 respondents interviewed use it. Being the biggest hospital it is endowed with more facilities and medicines than the rest of the other health facilities. The population is, therefore, left with no choice but to trek long distances in search of health. The district hospital plays a primal role in the health lives of people. Compared to the other dispensaries which are further away, 43 of the 163 respondents utilize the Sirimon dispensary, 13(8%) Immaculate Sisters, 9(5.5%) Kalalu dispensary, 8(4.9%) Muthangila Mission Hospital and only 4(2.45%) utilize Nanyuki cottage Hospital. When considering the type of health facility that one uses, there are various factors that must be taken into account. Of principal importance is the role such a medical facility plays towards the maintenance of the health of the individual and community. Secondly, other factors like distance and cost, are also taken into account. For instance, only 2.45% of the 163 respondents utilize the Nanyuki Cottage Hospital, a private hospital situated in Nanyuki, which is itself far from them. So before undertaking to visit the hospital the cost factor is carefully evaluated. Given the low socio-economic status of the population the majority do not go to the high cost medical centres.

Accessibility was considered here in terms of both distance, cost and the satisfaction that the people get from the various health facilities. The more accessible one is to the modern health facilities the more one is able to make use of the services offered.

#### 4.1.1 Proximity and use of Modern Medicine

To assess how the accessibility to modern medicine affect the use of the health facilities, respondents were first asked how close or far the various modern health facilities were to them. Their rating of the various health facilities was also assessed.

**Table 4.1 Distance to the various Modern Health Institutions and Sources of Modern Medicines**

##### AREA A

Source of Medicine	Very Far	Far	Near	Very Near	Unknown	Total
Clinic	(64.3)54	(29.8)25	(2.4)2	(0.0)0	(3.6)3	84(100)
Hospital	(65.5)55	(33.3)28	(1.2)1	(0.0)0	(0.0)0	84(100)
Shop	(3.6)3	(9.5)8	(51.2)43	(35.1)30	(0.0)0	84(100)
Chemist	(64.3)54	(34.5)29	(1.2)1	(0.0)0	(0.0)0	84(100)
Dispensary	(7.1)6	(73.8)62	(17.9)15	(0.0)0	(1.2)1	84(100)

##### AREA B

Source of Medicine	Very Far	Far	Near	Very Near	Unknown	Total
Clinic	46(58.2)	31(39.2)	1(1.3)	0(0.0)	1(1.3)	79(100)
Hospital	44(55.7)	34(43.0)	0(0.0)	1(1.3)	0(0.0)	79(100)
Shop	2(2.5)	7(8.9)	43(54.4)	27(34.2)	0(0.0)	79(100)
Chemist	45(55.7)	31(39.2)	0(0.0)	3(3.8)	0(0.0)	79(100)
Dispensary	2(2.5)	2(2.5)	43(54.4)	32(40.5)	0(0.0)	79(100)

Note: The percentages are in parentheses.

From Table 4.1 the differences in distances to the various modern health facilities is clearly depicted. The variability in proximity to the various health institutions and sources of modern medicines between area A and area B is clearly shown. In both area A and area B the chemist, the clince and hospital are considered far or very far. On the other hand, the local *duka*, which is a ready source of over the counter drugs, is near for both areas. The striking difference lies in the perceived distance to the dispensaries. In area A, 7.1% and 73.8%, of the total 84 respondents, considered the dispensary to be very far and far, respectively, while for area B it is 2.5% and 2.5% of the respondents, respectively. Comparatively, 94.9% considered the dispensary to be either near or very near in area B, as compared to 17.9% of the 84 respondents in area A who said the dispensary was near. The basic differences between area A and area B is that whereas respondents in area B have a dispensary within

their proximity, the inhabitants of Burguret and North Tetu, which make up area A, for the purpose of this study, do not have a dispensary within their locality and consequently no major modern health facility. The findings do, therefore, conform to the actual health facility provision in the district. According to the 1989-1993 Laikipia District Development Plan, the only hospital is in Nanyuki town. However, Nanyuki Hospital is not readily accessible to the population due to a rather poor infrastructure in the area. The few roads that serve most of the settlement schemes are insufficient. And where there are roads there is lack of sufficient public transport like buses or matatus. Transportation is a major handicap to most of the respondents. As a consequence the number of people who are able to utilise the health facilities is to a large extent determined by the easy accessibility of the health facilities by road. Informal group discussants unanimously agreed on this. They felt that if the transportation system was improved then a greater number of them would be able to utilise the health facilities that abound in Nanyuki town which also include the chemist, the private clinics and the district hospital. Due to their location far away from the people who need them most, the number of people who visit the chemist, hospital and private clinics are less compared to the dispensary which is closer.

In Table 4.2 below, 75% of the respondents in area A and 81% of the respondents in area B, have never visited the private clinics mostly found in Nanyuki town. A high percentage of 39.3% and 53.2% of the area A and B respondents have never visited the district hospital at Nanyuki. Though the percentage of the respondents who have never visited the district hospital in Nanyuki town is lower than the percentage which has never visited the clinics in Nanyuki, the difference is not by chance.

**Table 4.2: Frequency of visits to modern health facilities, over the last one year.**

**AREA A**

	Never visited	1-2 times	3-5 times	6-10 times	Over 10 times
Clinic	63(75.0)	13(15.5)	5(6.0)	1(1.2)	2(2.4)
Hospital	33(39.3)	33(39.3)	8(9.5)	5(6.0)	5(6.0)
Mobile Clinic	79(94.0)	3(3.6)	2(2.4)	0(0.0)	0(0.0)
Dispensary	22(26.2)	26(31.0)	21(25.0)	12(14.3)	1(1.2)

**AREA B**

	Never visited	1-2 times	3-5 times	6-10 times	Over 10 times
Clinic	84(81.0)	8(10.1)	4(5.1)	1(1.3)	2(2.5)
Hospital	42(53.24)	22(27.8)	13(16.5)	1(1.3)	1(1.3)
Mobile Clinic	66(83.5)	6(7.6)	4(5.1)	2(2.5)	1(1.3)
Dispensary	11(12.7)	18(22.8)	26(32.9)	9(11.4)	15(19.0)

Note: The percentages are in parentheses

Most of the respondents do not visit the private clinics due to the cost factor, a fact emphasised by a majority of the respondents. This, coupled with the fact that they are far, makes private clinics not readily accessible to a majority of the people of Laikipia District. The district hospital, though far, is a referral hospital. It is better equipped with medicine and facilities than the dispensaries. There is a compulsion about visiting it and a good number of the respondents do. However, of the 60.8% of the respondents in area A who visited the District Hospital in the last one year prior to the research, more than half did visit the hospital only once or twice. In area B 46.9% of the respondents visited the hospital during the last one year preceding the study and 27.8% of the respondents visited the hospital only once or twice in the same period (Table 4.2). Despite the necessity to visit the referral hospital

only a few of the respondents are able to visit the district hospital more than twice in a year. And the major influencing factor is distance. With the introduction of cost sharing, this has also been a major influencing factor. Most of the respondents agreed that even though they would like to visit the district hospital when they are sick, it is sometimes very hard, especially during the night when the few *matatus*, which are the only source of transport, are not operating. Distance is a principal factor influencing the use and non-use of modern health facilities. The farther the respondents are the more difficult it is to actually make use of the health facilities. This supports the idea that the more accessible a health institution is the more the institution is utilised.

The institutions that are closely located to the people play a very important function to them. A very high percentage of the respondents have used modern medicine once in their lifetime. Modern medicine plays a significant role in the community. Its function in the improvement of the health of the members of the community that this research was carried out is acknowledged. However, this function is realised differently within each settlement scheme. The various settlement schemes exhibit different frequencies in the use of modern medicine. This is because, through use, the members of the community come to either accept or reject the various modes and forms of treatment available from modern health facilities. The people's acceptance or rejection of the various modes and forms of treatment available from modern health facilities is in itself a function of cost and satisfaction with the service being offered. This is, to a large extent, determined by whether recovery is achieved after treatment and whether the treatment itself is usually available when sought.

#### **4.1.2 Rating of Treatment versus use of Modern Health Facilities**

In order to measure how satisfied the respondents were with the services they received, the respondents were asked to rate the treatment received. The respondents were asked to consider, among other things, the cost, availability of drugs, friendliness of the hospital staff and recovery from illness after treatment. Their scores were categorised into those who rate the various health facilities highly

and those who rate them poorly (Table 4.3).

The most favourably rated health institution is the district hospital. Only 3.6% of the respondents rated the treatment in the hospital as very bad out of the 79.9% of the respondents who commented on their visit to the hospital in area A. Yet 6.0% of the 83.4% of the respondents in area A who commented on the treatment received from the dispensary said it was very bad. In area B, 1.3% of the respondents consider the treatment in the hospital very bad while a higher percent of the respondents (5.1%), consider the treatment in the dispensary very bad. This reinforces the observation made earlier that the hospital is highly rated than the dispensary. This is so despite the fact that a higher percentage of the respondents frequent the dispensary. Despite the poor services offered by the dispensaries, the respondents still frequent them being the closest health facilities. The key informants, and, indeed, many of the respondents, were open about their stand on the local dispensary. While acknowledging that the type of treatment accorded patients at the local dispensary was insufficient or poor, they have no option but to continue visiting the dispensary. And it is only when their search for medicine at the local dispensary is futile that many of the respondents look for alternative sources of medicine.



**Table 4.3: Rating of treatment in the various Modern Health Institutions**

**AREA A**

	No comment	Very good	Satisfactory	Bad	very bad
Pharmacy	57(67.9)	7(8.3)	16(19.0)	3(3.6)	1(1.2)
Hospital	17(20.2)	23(27.4)	36(42.9)	5(6.0)	3(3.6)
Mobile Clinic	76(90.5)	3(3.6)	5(6.0)	0(0.0)	0(0.0)
Dispensary	14(16.7)	16(19.0)	44(52.4)	5(6.0)	5(6.0)

**AREA B**

	No Comment	Very good	Satisfactory	Bad	Very Bad
Clinic	57(72.2)	11(13.9)	11(13.9)	0(0.0)	0(0.0)
Hospital	18(22.8)	8(10.0)	50(62.3)	2(2.5)	1(1.3)
Mobile Clinic	62(78.5)	5(6.3)	11(13.9)	1(1.3)	0(0.0)
Dispensary	7(8.9)	18(22.8)	49(62.0)	1(1.3)	4(5.1)

Note: The percentages are in parentheses

**4.1.3 Alternative sources of medicine**

Due to distance, cost and quality of services, factors that determine the accessibility of the modern health facilities to the people of Laikipia, a majority of the respondent resort to various alternative sources for day-to-day medication. The alternative sources of medicine are the chemist, shop, and traditional medicines. However, some people indicated that they have no alternative source of medicine. For both areas A and B respondents, the single most easily resorted to alternative source of medicine is the local *duka* which is not only near but the cost of drugs from these shops is relatively cheap. 80.4% of the respondents use drugs from the shop, while 55.2% from the chemist, 8.0% use the traditional medicine and 4.9% use no medicine at all. Most

of the drugs bought from these shops are painkillers and Malaria tablets. These drugs which come in sets of two are easily affordable. The knowledge of these drugs is through the mass media and peer groups. However, the knowledge of the functioning of the drugs is severely limited. Most of the respondents buy the drugs without any idea of the consequences of an overdose. A fact that is particularly worrying is that the little knowledge the respondents have on the drugs is through hazy recollections of media advertisements. The medicines are easily bought without the prescription of a doctor and usually the quantity is determined by the amount one is able to afford. A total of 8.4% of the respondents use over the counter drugs. Most of the respondents explained that this was due to a constant lack of drugs at the dispensary.

A closer comparison of the percentage of the respondents in areas A and B who resort to alternative sources of medicines reveals that a bigger majority of the respondents in area B resort to alternative medicine than area A respondents. On the other hand, a majority of respondents in area B visit modern health institutions compared to area A. It would seem then that the more exposed one is to modern health facilities the more one resorts to the various alternative sources of medicine. On the whole, few of the respondents, 8.0%, consider traditional medicine as an alternative source of medicine. However, as will be shown later, more of the respondents use traditional medicine. This would lend credence to the fact that traditional medicine is viewed as an independent school of medicine. Traditional medicine does not supplement but compliments modern medicine. They are two parts of the one whole which functions towards the maintenance of the whole.

#### **4.1.4 Proximity to Treatment and Other Sources of Medicine as they may Influence use of Traditional Medicine.**

More than half of the respondents interviewed openly admitted that they used traditional medicine (89 of the 163 respondents, representing 55%). The sources of medicine includes the clinic, hospitals, local *duka* (shop), chemist, and, the dispensary which is the closest. An analysis of the perceived distance to the various sources of western medicine listed above and the use of traditional medicine was done. The following trends became apparent.

(i). **The Clinic**

The general consensus of the informants was that the clinic is far. This is because of the total respondents 88, (56.4%) of the 156 respondents, who find the clinic far, use traditional medicine. Only 3 respondents hold that the clinic is near. And 2 of them do not use traditional medicine. One notable aspect here is that the 2 respondents who do not use traditional medicine are from area A. The number here, though small, shows the possibility that if the clinic were easily accessible in terms of distance to the respondents then there is a likelihood that they would not resort to traditional medicine in large numbers as they do.

(ii) **The Hospital**

To all the respondents in the study, except two, the hospital is far. In fact, the only hospital in Laikipia is the district hospital in Nanyuki which serves the five divisions. Apart from this, there is the Nyahururu district hospital which serves the population to the west of Laikipia district. Nanyuki cottage hospital is a private institution which caters mainly for the well-off members of the society who comprise mainly the white ranch-owners and the business community in Nanyuki town. It is not, therefore, coincidental that the majority of the respondents find the hospital far and similarly use traditional medicine and this comprises of 42% and 67% of the Area A and B, respectively.

It would seem at a casual glance that area A has fewer people using traditional medicine despite the fact that 83 of the 84 respondents from area A admitted that the hospital is far. This figure is influenced by Burguret area where a majority of the respondents do not use traditional medicine. Specifically, 28 out of the 42 respondents representing 67% of the total respondents in Burguret do not use traditional medicine.

On the whole, the respondents stated that the hospital is far. And since it is very difficult to reach Nanyuki town at odd hours, traditional medicine comes in handy. This supports the contention that the further away the hospital is the more likelihood that the majority of the people will resort to traditional medicine. However, in the case of Burguret this does not apply apparently due to other intervening factors.

### (iii) The Shop

The local *duka* is a ready source of medicine. It is usually a very small grocery shop equipped with the most minimal and essential requirements for the people who depend on it. Usually stocked along side other household groceries like salt, bread, tea and sugar, are medicines mainly in tablet and syrup form. Most of the medicines are pain killers and anti-malaria tablets, cough syrup and medicines that tackle ailments like worm infections and diarrhoea. The shop is a very ready source of medication when the physicians' advice is too far, too costly to be obtained or the situation requires urgent attendance as in emergency situations.

Most of the respondents agreed that the shop is very close to them. The general trend, however, depicts a continued use of traditional medicine despite the close proximity and availability of over the counter drugs. In area A, 73 out of 84 respondents, live close to a shop. This represents 87% of area A respondents. In area B, 70 out of 79 respondents, live close to a shop. This represents 89% of area B respondents. These people who live near shops can readily buy drugs but out of 87% of area A respondents who live close to a shop, 44% use traditional medicine and out of 89% of area B respondents who live close to a shop, 63% of them still use traditional medicine.

In total, 53% of those who live near a shop use traditional medicine. Apparently, then, the proximity to a shop where simple medicine can be obtained does not necessarily make people turn away from traditional medicine. Most people continue to use traditional medicine either because they lack knowledge of the medicines in the shop or are dissatisfied with the medicine in the shop or because the medicines are priced out of their reach. The main underlying factor, however, was because, as one of the key informants put it, the medicine found in the shops can not effectively combat complicated cases. The medicines are mainly pain killers, with the rest only able to combat a half a dozen disease states, like diarrhoea and worm infection. When it comes to serious diseases, the respondents fall back to traditional medicine and the modern health institutions.

**(iv) The Chemist**

The closest chemist to most of the population but which is still far away, is in Nanyuki town. Infact, only 4 of the 163 of the respondents held that the chemist is near. This represents 2% of the residents. The percentage of those who view the chemist as far and use traditional medicine varies from 33%, 54%, 66% and 66% for Burguret, North Tetu, Muramati and Weruine, respectively.

The following percentages represent those respondents who perceived the chemist to be too far. 100%, 97.6%, 92.7% and 100% of the respondents in Burguret, North Tetu, Muramati and Weruine, respectively. There is no clear pattern between distance to the chemist and use or non-use of traditional medicine. The chemist, apart from being far, is very expensive for most of the respondents. Informal group discussants were very particular about their inaccessibility to the chemist. Most of the respondents also acknowledged that good medicine is in the chemist, but since they cannot afford it, they are left with little choice.

**(v) Dispensary**

Burguret and North Tetu do not have a dispensary in the locality while Muramati and Weruine have each a dispensary within their locality. However, the area covered by Weruine is very large and it is not automatic that all the people of Weruine live near a dispensary. In area A 17.9% of the respondents live near a dispensary indicating that a majority of the respondents live far from a dispensary. However, 57.1% of the respondents use traditional medicine, but, as shown in Table 4.1, 94.9% of the respondents in area B live near a dispensary. In the same area, 59.5% of the respondents use traditional medicine. Despite the respondents' close proximity to the dispensary, a majority of the respondents still use traditional medicine. The dispensaries are incapable of catering for all the health demands of the people of Laikipia District. The dispensaries are themselves accommodated in unsatisfactory wooden structures formerly owned as farm houses and most of them are in dire need of a face-lift. Inaccessibility, occasioned by distance and cost, does greatly determine the use of the available health facilities as stated by most of the respondents. They would like to utilise the medical

facilities available. However, they are not able to readily utilise them due to their location and cost. They readily resort to the most readily accessible form of treatment when they fall sick. In most occasions, this happens to be traditional medicine.

#### **4.1.5 Rating of Treating in Dispensary and use of Traditional Medicine.**

The dispensary is the most frequented of the modern health institutions. It is the single most common source of medication. However, not all of the respondents are satisfied with the treatment received from dispensaries. Only a minority of the respondents (20.9%) rated the treatment received from the dispensaries as good. Of the respondents who rated the dispensary as good 52.9% do not use traditional medicine. On the other hand, 33.3% of the respondents who rated the dispensary as bad do not use traditional medicine. A majority of the respondents who are dissatisfied with the service received from the dispensaries use traditional medicine. Most of the respondents were, indeed, aware of the serious lack of facilities and medicine at the local dispensaries and this was one major shortcoming. Key informants, especially the nurses who were manning the dispensaries, acknowledged this. They stressed that this was a major problem which did also affect the district hospital at Nanyuki. However, most of the respondents continue to flock to the dispensaries. They do so reluctantly as they are limited in choice. The recently introduced cost-sharing was cited as a burden to the sick. Most of the respondents argued that it should be scrapped altogether as there was no justification for the nurses to ask for attendance fee when in the end they will be told to go and get the medicine from Nanyuki District Hospital.

A direct link between poor provision of health and use of traditional medicine was established. Most of the respondents who openly admitted they use traditional medicine pointed out the various shortfalls of the dispensaries, among which were cost-sharing, lack of medicines, poor quality of treatment, rude nurses who tended to be harsh, as principal factors. Most of this category of respondents see traditional medicine as it is both cheap and easily available. It is their ready source of medication. However, no clear line can be drawn where traditional medicine is used without modern medicine. As already pointed out, all, except 2 of the

respondents, have been to a modern health facility in their lifetime. Arguably, some of the respondents will not have anything to do with traditional medicine. However, normal traditional ways of treatment for small ailments are universally employed. Traditional modes of treatment are embedded in the community. Whilst acknowledging this, the role the dispensary plays in the community is also acknowledged. The dispensary and traditional medicine are both used simultaneously. Their role in the community's health is paramount.

Elderly informal group discussants pointed out that the contribution that the dispensary and the other modern health institutions play in maintaining the community's health is obvious. However, the dispensary alone and the rest of modern health institutions cannot in themselves tackle the illness and diseases that abound throughout the district. The two, modern and traditional medicine, work alongside each other, each with its' function, complimenting and not supplementing the other. Each is recognised. However, the frequency of use of each institution is influenced by the easy accessibility of the institutions to the majority of the populations of Laikipia District.

#### **4.1.6 The Function of Traditional Medicine**

The term traditional medicine, as used in this study, includes the total combination of knowledge and practices employed in diagnosing, preventing or eliminating a physical, mental or social disease which may rely entirely on knowledge passed down over the generations, through verbal instructions or in writing. This knowledge is universal to the whole community. However, within each community there is a group of persons who, due to their lineage or training, are endowed with more knowledge in the practice of traditional medicine than the lay person.

In the literature it is an accepted fact that traditional medicine continues to contribute to the welfare of a majority of Third World societies (Maclean 1971; Namboze 1964; Mbiti 1969). Traditional healers continue to play a very primal role in a majority of the African societies. Among the agricultural populations of Laikipia District, as was found out in this study, the role of traditional medicine was overwhelmingly present. For instance, 33%, 52.4%, 68.3% and 65.8% of the respondents from Burguret, North Tetu, Muramati and

Weruine, respectively, declare that they use traditional medicine. A majority of the respondents who did not openly admit that they use traditional medicine use some home remedy or another which do not draw their knowledge from the Western scientific knowledge of medicine.

While 54.6%, of the total respondents, admitted they use traditional medicine, 28.2% of the respondents do not know of a traditional specialist. Apparently, then, it is not only those respondents who use traditional medicine who are aware of the presence of the traditional specialists. They do not use traditional medicine not that they are unaware of it but because they have not had the need to use it.

Traditional medicine is used for a variety of ailments. The elderly group discussants who admitted that traditional medicine is vital for the well-being of the community, pointed out that traditional medicine is especially useful where modern medicine has failed. But even then, a variety of cures are available for slight ailments which are used on a daily basis. In Table 4.4 the level of awareness of traditional medical specialists is shown. It can outrightly be seen that the herbalist is the most commonly referred to specialist. He is followed by uvula surgeon, medicine-man and, finally, the circumciser.

**Table 4.4: Known Traditional Medical Specialists**

	Area A	Area B	Total
Herbalist	27 (32.1)	43(54.4)	70(42.9)
Uvula Surgeon	37(44.05)	25(31.6)	62(38.0)
Medicineman	12(14.3)	15(19.0)	27(16.6)
Circumciser	9(10.7)	16(20.25)	25(15.3)
None	31(36.9)	15(19.0)	46(28.2)

Note: The percentages are in parentheses

These specialists are usually men and women whose knowledge of medical matters is beyond the grasp of the lay members of the community. This knowledge has been acquired through succession and/or lengthy training (Mbiti 1969). They were basically charged with the role of curing illnesses and diseases. They also oversee the smooth running of the affairs of the community. When an epidemic breaks out, it is the medicine-man who is brought in to use his talents and lead the community in seeking an end to the calamity. During



ceremonies like initiation and harvesting, their role was immensely defined and paramount. Traditional medicine is embedded in the community's day-to-day affairs. This means that the normal functioning of the community cannot be comprehended without acknowledging the role traditional medicine plays. Most of the herbalists and uvula surgeons interviewed were emphatic as to their role. They keep the society alive. They are the directors of the society. Their role is social compared to the modern health practitioners. Apart from attending to the sick, they are also concerned with the cleansing of the community of any bad omen that may be the cause of an epidemic or any other calamity. Interviews with traditional medical specialists were carried out and of particular interest were three, namely, one medicine man (*Mundu Mugo*), one uvula surgeon (*Mundu wa Kiriimi*) and one female herbalist (*Daktari wa miti*). One notable characteristic of the three is that they were all very old. The medicine man stated his age was 98. This advanced age is an asset. They have through their experiences and training acquired more than the average knowledge of their community's customs. They are, therefore, a source of wisdom.

The medicine-man, who boasted of intensive training during his youth, was emphatic that they have a positive role to play in the society. Nonetheless, he stated that there was a need for them to integrate with the modern medical practitioners. According to him, there are certain diseases which only they can treat best. This is because some of these diseases are understood by them. These are the diseases that are closely linked with peoples' beliefs and taboos. These are diseases which are primarily believed to have been caused by breaking cultural norms and taboos. A majority of these diseases have a supernatural element. Their experiences and training places them in the best position to tackle these category of diseases. The medicineman also stated that the clinical features of these diseases and, indeed, their names do appear normal at the onset. It is only when a disease is not responding to treatment that the cause has to be established. When this occurs, their services would then be required. And in most cases they are successful, though, occasionally the patient does not recover and passes away to the next world. Like the uvula surgeon and the herbalists interviewed, the medicineman enumerated some of the common plants that the Agikuyu utilise for treating a variety of diseases. Most were similar in use. One plant is capable of treating several illnesses while one illness can be treated by

the use of several plants. A full list of these plants is included (Appendix II).

The uvula surgeon detailed his training which he said was out of necessity. During the struggle for independence he, like most able Agikuyu men, joined the Mau Mau. Various injuries sustained during the war had to be attended to. He thus utilised knowledge he had acquired during the earlier days in a ceremony called *kerugo*. In this ceremony bulls would usually be slaughtered. The meat would be eaten only after some medicinal herbs had been applied. Through this ceremony, he became very conversant with various traditional plants. And he has used this knowledge and his surgical experience during the Mau Mau to operate on, mainly, children with enlarged uvulas. All the three traditional specialists exhibited a thorough knowledge of their work and were willing to share their experiences. They also expressed a willingness to work a long side modern doctors.

#### 4.2 The Influence of Disease Type on the Health-Seeking Behaviour

Diseases abound all over the world, developed or developing. However, the types of diseases that are experienced within a given community are not identical in others. In order to know the type of diseases that the respondents are frequently afflicted with, this study sought to know first when they were last sick.

A majority of the respondents recalled their last sickness as having been between the last 2 years before the time of the research. For instance, in area A, 82.1% of the respondents have fallen sick within the last two years compared to 78.5% of area B respondents. However, there does not exist any major differences in the percentages of the population that has been sick within the last 2 years for both areas A and B (Table 4.5).

Those who recall having been sick in the week of the research were 9.5% for area A and 5.1 for area B, while those who were last sick within the month of the research were 14.3% for area A and 17.7% for B. Those who recalled being sick between 2-6 months ago were 20.2% for area A and 31.6% for area B. And between 7-11 months ago, they were 13.1% for area A and 13.9% for area B. 25.0% of area A respondents recall being sick 1-2 years ago compared to 10.1% of area B respondents 9.5% and 11.4% of the respondents

of area A and B, respectively, recall being sick 3-5 years ago. In area A, 2.4% of the respondents could recall having been sick 5 years ago compared to 7.6% of the respondents in area B. 4.8% of the respondents of area A could not remember the last time they were sick compared to 7.6% of the respondents in area B. Only 1 respondent could not recall ever having fallen sick. He was from area A.

One respondent in area A adamantly stated that he has never been sick in the whole of his life time. When pressed further he accepted he has had flu now and then but had not actually been sick. The type of diseases that people consider as diseases warranting attention greatly varies from one individual to another (Koos 1954). However, there is no exceptional human being who can claim not to have been sick in his or her life time.

**Table 4.5: Frequency of sickness**

Last sickness	Frequency of sickness	
	Area A (%)	Area B (%)
This week	9.5	5.1
This month	14.3	17.7
2-6 months	20.2	31.6
7-11 months	13.1	13.9
1-2 years ago	25.0	10.1
3-5 years ago	9.5	11.4
Over 5 years ago	2.4	7.6
Can't remember	4.8	7.6

Among the agricultural immigrant population of Laikipia district, the most common disease is malaria, followed by common cold and coughs, both upper respiratory track infections, and headaches (Table 4.6).

**Table 4.6 : Last Affliction**

	Area A	Area B	Total
Malaria	(14.3)12	(13.9)11	(14.1)23
Headache	(8.3)7	(6.3)5	(7.4)12
Diarrhoea	(4.8)4	(2.5)2	(3.7)12
Common cold/cough	(20.2)17	(24.1)19	(22.1)36
Pneumonia	(7.1)6	(15.2)12	(11.0)18
Skin infections	(55.95)5	(1.3)1	(3.7)6
Body pains	(10.7)9	(13.9)11	(12.3)20

Note: The percentages are in parentheses

Apart from the kinds of afflictions listed above, other afflictions that have recently occurred include nausea, stomachache, epilepsy, kidney, liver, bone and body pains, diabetes, asthma, paralysis and stroke, bladder infection, cuts, burns, dysentery, eye infection, worm infection, measles and many others which are discussed below. The range of diseases is, indeed, very wide ranging from simple ailments, like a cough, to very complicated cases, like measles. Whatever the ailment, all diseases are attributed to a cause. All of the respondents attributed disease to a specific cause. These causes range from simple recognizable states like bad weather to super-natural powers (Table 4.7).

The single most common cause of disease is the super-natural, non-human agency. There is not a clear division of the type of diseases that are caused by forces that cannot readily be comprehended. In fact, according to the informal group discussants, when a disease starts as a simple headache and persist on and on to a stage where the headache becomes more complicated, then it would be attributed to a super-natural force.

The key informants, agreed on one fact. The diseases caused by forces not readily comprehensible were sent by *Ngai*, the god of Agikuyu, who though his influence is not openly apparent, many people still refer to him, and behind the scenes depend on him for their continued existence. One of the diseases so caused and which is most feared is measles. This is a deadly disease which afflicts mostly young children. It is characterised by rushes during the first three days of infection and can be deadly when not treated in time. Supernaturally caused disease, indeed, exist in various other African societies as was seen (Imperator 1977; Marwick 1952). Most of the diseases which belonged to this category included infectious diseases like small-pox, mumps and chicken-pox.

Most of the respondents agreed that modern vaccination when carried out at the correct time

is very effective in combating small-pox. Elderly informal discussants pointed out that even the Agikuyu had their own method of vaccination which was effective. Among the diseases caused by supernatural forces are those which are due to witchcraft (Evans-Pritchard 1937;) and when taboos are broken, departed spirits were also held to cause disease. (Parrinder 1958, Haunge 1974).

**Table 4.7: Cause of sickness**

Cause	Area A	Area B	Total
Weather	9(10.7)	17(21.5)	25(15.95)
Jealousy	3(3.6)	1(1.3)	4(2.45)
Hard work	3(3.6)	6(7.6)	9(5.5)
Accident	10(11.9)	11(13.9)	21(12.9)
Chewing Miraa	2(2.4)	0(0.0)	2(1.2)
Natural	1(1.2)	1(1.3)	2(1.2)
Smoking & Drinking	1(1.2)	0(0.0)	1(0.6)
Epidemic	1(1.2)	0(0.0)	1(0.6)
Strong tea & Githeri	2(2.4)	0(0.0)	2(1.2)
Never thought of it	6(3.6)	0(0.0)	3(1.8)
Some Supernatural force	45(53.6)	40(50.6)	85(52.15)
Contaminated water	3(3.6)	0(0.0)	3(1.8)
Old age	1(1.2)	1(1.3)	2(1.2)
Others	0(0.0)	2(2.6)	2(1.2)

Note: The percentages are in parentheses

Table 4.7 shows that, jealousy is considered as being a cause of disease by 2.45% of the total respondents. The diseases so caused were through magical art (Seligman 1932; Turner 1957; Middleton 1960) and sorcery by persons who are envious of other peoples progress and success or where threat from an opposing clan or group was felt.

Informal group discussants agreed that these forces still exist though to a limited extent. This was echoed by the elderly group discussants and the traditional practitioners who were interviewed. From Table 4.7 it can be seen that 0.6% of the respondents attribute their sickness to epidemics. Such epidemics happened a long ago and are, therefore, not the immediate cause of the ailments of most of the respondents. The high percentage of respondents who explained their last affliction to some supernatural powers (52.15%) are a

testimony to the fact that the influence of supernatural forces is still held to cause diseases. Jealous persons are held to be capable, with the help of a witch doctor, of causing one to be afflicted with a variety of diseases. Most of these diseases cannot, thereafter, be cured through normal treatment.

The medicineman held that such jealous persons are driven by a variety of situations from one's normal contact with members of the society. This jealousy is due to hatred created by dissatisfaction of one party by the second party's conduct. This is usually among close relatives. When, for instance, a young man marries and fails to pay all the bride price demanded. Other examples, include when a young man talks rudely to an old man. Indeed, most of the examples are derived from anti-social behaviours. Which the society does not advocate for. The process of treatment is, therefore, straight forward. Apart from taking the medicine that would commonly be taken when one is suffering from the disease, one is also required to remedy his anti-social actions for example, if the full dowry has not been paid, the remainder should be paid.

#### **4.2.1 Cause and Health-seeking Behaviour.**

When one falls sick, the immediate desire is to get well so as to resume one's normal role which may have been abandoned due to the illness. To achieve this desire, various corrective steps are taken by the individual which are referred to here as the health-seeking behaviour. Behaviour is dynamic and so is the process of seeking health. In the literature the variability in the response to health is acknowledged (Pearson 1989; Cockerham 1978; Anderson 1972; Wolf and Langley 1968). However, this variability is realised within the set out cultural patterns and norms (Jones and Jones 1975) which are themselves subject to change (Smith 1966). It is, therefore, apparent that various patterns are discernible in a people's search for health, and that these patterns vary from one society to another, and from time to time.

This study sought to show the health seeking behaviour patterns of the people of Laikipia. The study discerned 19 behaviour patterns, however, five of these patterns were more common. Most of the respondents (29.45%) obtain their medicine from the dispensary. For the rest of the respondents, the path to health is not

that simple. The second most common path to recovery is where the sick go to the hospital from where the treatment is obtained. For 22.1% of the respondents, whenever they fall sick they do not go to the local dispensary first; they bypass it despite the fact that it is near. This is mainly because of the poor services at the local dispensary ranging from the lack of drugs and facilities to rude nurses.

The third path is where the sick go for drugs at the local *duka*. This may not itself accord treatment, upon which they resort to treatment at the district hospital. This group of respondents, which comprises of 3.7% of the respondents, also skip the dispensary. A comparison of the differences between Area A and Area B reveals that none of this group of people is from Area B. The unique feature in Area B is that the distance to the dispensary is shorter and, thus, more people are able to visit it. A comparison of the fourth group of patients, who seek recovery by solely buying drugs from the local *duka* shows that they are concentrated in Area A with 9.5% while Area B has 8.9%. Though not a big difference, it supports the earlier contention that due to their relatives closeness to a dispensary, most of Area B respondents do not go for over the counter drugs.

The fifth single most common path used in seeking health is where respondents seek treatment at the dispensary and when the illness does not respond to treatment they turn to the traditional healer where treatment is obtained. The group which followed this path comprised 9.2% of the respondents; 8.3% of area A respondents and 10.1% of area B respondents. There are those respondents who go to the local dispensary from where they are referred to the district hospital, once treatment is received the patients are referred back to the local dispensary to complete their medication there. This consist of 1.8% of the total respondents; 1.2% and 2.5% of the area A and area B, respectively. 1.2% of the respondents, however, reported to private clinics when treatment in the dispensary was not adequate. The low percentage is due to the high cost of treatment in a private hospital.

There are those respondents who do not visit the local dispensary, they resort to the district hospital first, and only when they are referred to one of the dispensaries, do they go back there to complete their treatment. This consisted of 1.2% of the respondents all of whom are from area A. This is due to the fact that,

to most of the respondents in area A, the dispensary is far.

The next path is similar to the preceding one. The dispensary is initially skipped and treatment is sought directly from the district hospital. When the disease does not respond to treatment the patient is referred to Kenyatta National hospital. If the patient does not fully recover, he/she resorts to traditional medicine. This group of people, which comprised 1.2% of the total sample population, held that their sickness was caused by poor living conditions which is a normal thing to be expected in life. However, there are those respondents (1.8%), who when referred to Kenyatta National hospital were able to recover from their illnesses and did, therefore, resume their normal roles. Closely connected to these are those respondents who did go to the district hospital of a neighbouring district and were later referred to Kenyatta National hospital where treatment was effectively obtained. This comprised of 1.2% of the respondents. However, only 1.2% of the respondents will ordinarily go to a private hospital straight for treatment in the event of illness and these were all from area A which has no dispensary of its own.

Among the respondents, are those who strongly trust traditional medicine to combat any ailments that come up at any time. These respondents have their varied pathways to health as well. These are those who visit traditional specialists, and obtain treatment. When the situation does not improve, the respondents will go straight to the hospital and when the treatment in the hospital does not yield any result they will resort to traditional medicine once again. And usually, this time around they will get cured. This comprised of 0.6% of the total respondents, all from area A. 2.4% of the respondents would make traditional medicine at home from where treatment will be fully achieved. There are no hospitals or dispensaries for them. This comprises of 3.6% and 1.3% of area A and B respondents, respectively.

Some of the respondents would just stay at home until the condition got worse. At this point the patient would be taken to a close relative who knew how to make traditional medicine through which recovery would be achieved. For 0.6% of the respondents, their health seeking cycle would revolve around going to the hospital from where treatment may not be achieved readily. At this point they would resort to the traditional medicineman.



The above pathways to health are, indeed, the major ones that the sick people of Laikipia District follow during sickness. These paths are completely varied and the low frequencies are a testimony. In fact, medical behaviour is essentially an individual thing (Smith 1966). However, the individual finds expression within society and since all the behaviour of an individual is determined by cultural patterns the realisation of this behavioral patterns are within accepted taboo and cultural norms.

The health-seeking patterns were compared with the perceived cause of a disease to discover if there exists any relationship between health-seeking behaviour and the perceived cause. Among the traditional African societies, the cause of a disease is, indeed, viewed as of paramount importance in determining the corrective measures employed to correct the disease state. This is a fact which was echoed in the study. However, this study also set out to find at what stage of illness does the cause become of prime importance. 52.15% of the respondents explain disease as being due to some supernatural force. Of these, 28.2% of them resort to the dispensary for treatment, 21% resort to the district hospital, and 12.9% buy drugs from the shop and get well. Apparently then, the most common initial step is to go to the dispensary, hospital or to buy the drugs from the nearby shop. The three steps are the most common remedies during sickness. However, not all treatment sought this way ends in recovery. It is only when treatment has been sought this way and failed that the other remedial steps are undertaken by a majority of the respondents. On the other hand, 10.6% do nothing about supernaturally caused diseases, while 5.9% make traditional medicine and take, where recovery is realised. 8.2% of the respondents do actually visit the dispensary and later resort to traditional medicine. This shows that there is a sizeable number of respondents who resort to traditional medicine where the cause is deemed to be supernatural in nature.

Evidence was further sought by analysing the perceived cause of disease among the respondents who resorted to traditional medicine as their first mode of treatment. These groups consisted of 2.4% of the respondents and this is a very small proportion. However, all of them (100%) held that the cause of their last sickness was not natural it was due to some supernatural force. A trend that implies that the diseases that are held to be supernaturally caused will ordinarily be referred to traditional specialists. Most of the elderly

informal discussants admitted that some of these diseases do, indeed, start as a small headache and sometimes take a long time before the seriousness of the disease becomes obvious and, consequently, the cause is re-evaluated. A sense of resignation over the supernaturally caused diseases exist. Of the 7.8% of the respondents who did nothing about their diseases, 62.2% held that the cause was supernatural, 7.7% attributed it to the weather, 15.4% attributed their ailments to accidents and 7.7% to the chewing of *miraa*. This resignation is due to the fact that the respondents feel impotent to face the supernatural force. In most instances this supernatural force is constructed to be *Ngai* whom they let deal with them as he best finds right. In the past the community would rise up to *Ngai* and ask for appeasement through their departed ancestors: sacrifices would then be offered and the whole effort would involve the community.

For the naturally caused diseases, the second most common perceived cause of disease, is the weather (Table 4.7). Of the respondents who attributed their last affliction to the weather, 20% of them visited the dispensary from where treatment was received, 28% went to the hospital from where treatment was received. On the other hand, 16% bought medicines from the shop and were able to receive full recovery. None of the respondents who attributed their ailments to bad weather resorted to traditional medicine straight away, while none of the respondents who attributed the weather to their last disease did nothing about it. The trend is similar with the action taken by respondents who became sick as a result of accidents (these are mainly minor mishaps at home like burns and cuts) 42.1% of them rushed to the dispensary and 10.5% to the hospital. Only one of them did nothing. None of the respondents who attributed their last medical problem to an accident used traditional medicine to combat the problem.

The above comparison establishes a relationship between the perceived cause and the action taken towards recovery. The respondents who perceived the cause as being supernatural are more likely to resort to traditional medicine. However, whereas a majority of the respondents view diseases as being, by and large, a result of some non-natural agent, not all of them resort to traditional medicine. Essentially, then, the role played by traditional medicine is still enormous. It is still perceived as being a strong school of medicine. The mainly Agikuyu agricultural population in the settlement schemes still fall back to traditional medicine for those diseases that are perceived to be best treated by traditional medicine.

#### 4.2.2 Disease Type and Action During Sickness.

There is an enormous variation in the health seeking behaviour of the people of Laikipia district. In fact, each disease evokes as varied responses as the respondents themselves. However, a close analysis reveals that there are those diseases which evokes a higher frequency of a single course of action. For instance, a majority of the population suffered from upper respiratory tract infections the last time they were sick. This comprised 22.1% of the total respondents: 20.2% and 24.1% from area A and area B, respectively. Upper respiratory tract infections includes ailments like common colds, coughs and tonsils. Of the 22.1% of the respondents who were last afflicted with upper respiratory tract infections, 37.1% of them went to the dispensary from where treatment was obtained, 20% bought medicine at the shop and 17.1% did nothing at all about the ailment. However, 5.7% went straight to the district hospital. Compared to malaria which was the last ailment suffered by 14.1% of the respondents, 32% went to the dispensary signalling an increase in the number of respondents who seek treatment in the dispensaries. On the other hand, while only 5.7% of the respondents went directly to the district hospital when afflicted with upper respiratory tract infections, 28% of the respondents who were afflicted with malaria went to the hospital directly. Malaria is a deadly disease and many of the respondents are aware of this fact, therefore, a majority of them resort to hospital treatment whenever malaria strikes because they do not want to take chances.

The same applies to pneumonia which is the fourth common disease which last afflicted the respondents. Of the 11.0% of the respondents whose last affliction was pneumonia, 37.5% of these respondents went directly to the district hospital from where treatment was obtained and 18.75% of the respondents resorted to the dispensary.

For general body pains, 42.9% of the respondents resort to treatment at the dispensary. This is because general body pains may themselves signal the advent of a further complication. Only 14.3% of the respondents whose last ailment was body pains went to the hospital directly and a further 6.25% went to Nanyuki District Hospital and were referred to Kenyatta National Hospital and later went to a traditional medicineman from whom the desired treatment was obtained.

The above description does concur with the observation that the type of disease that one is afflicted with greatly determines the health seeking behaviour of a majority of the population. This, may also be influenced by other factors such as income (Koos 1954). However, the type of disease one is afflicted with in itself determines the path that one follows when seeking corrective measures. The type of a disease influences the level of discomfort felt by the patient which results into the loss so realised by the patient and society due to the patient's illness.

#### **4.2.3 Preferred Course of Action when Afflicted with Various Ailments.**

The courses of action which are described above are beset with several problems. They are the actual courses of action which were followed by the respondents when they were last sick. However, these may not really be the preferred course of action since many people showed dissatisfaction with the treatment received in various health centres. In order to find out their preferred course of action during sickness, the respondents were asked what course of action they preferred when they are afflicted with upper respiratory tract infections, diarrhoea, worm infection, malaria, skin disease, eye disease and accidents. These diseases are the most commonly reported ailments in Laikipia District according to the 1989-1993 District Development plan.

As shown in Table 4.8 below, most people would go to the dispensary if they were suffering from upper respiratory tract infections, diarrhoea, worm infection, malaria, skin disease, eye disease. A majority would, however, resort to the hospital and not dispensaries during accidents. There are, however, various differences between area A and area B.

**Table 4.8 Preferred action when afflicted with various ailments**

**AREA A**

Treatment preferred	Type of diseases						
	U R T I	Diarrhoea	Worm Infection	Malaria	Skin Disease	Eye Disease	Accidents
Local dispensary	(36.9)31	(39.3)33	(34.5)29	(37.7)30	(41.7)35	(44.0)37	(33.3)28
District Hospital	(29.8)25	(41.7)35	(42.9)36	(42.9)36	(48.8)41	(50.0)42	(63.1)53
Traditional Specialist	(1.2)1	(2.4)2	(1.2)1	(6.0)5	(2.4)2	(2.4)2	(1.2)1
Some home remedy	(1.2)1	(10.7)9	(0.0)0	(2.4)2	(2.4)2	(0.0)0	(0.0)0
Does nothing	(30.95)26	(6.0)5	(21.4)2	(13.1)11	(4.8)4	(3.6)3	(2.4)2

**AREA B**

Treatment preferred	Type of diseases						
	U R T I	Diarrhoea	Worm Infection	Malaria	Skin Disease	Eye Disease	Accidents
Local dispensary	(75.9)60	(70.9)56	(68.4)54	(70.9)56	(78.5)62	(79.7)63	(67.1)53
District Hospital	(6.3)5	(15.2)12	(12.7)10	(15.2)12	(16.5)13	(16.5)13	(37.9)30
Traditional Specialist	(3.8)3	(7.6)6	(6.3)5	(12.7)10	(2.5)2	(1.3)1	(0.0)0
Some home remedy	(1.3)1	(5.1)4	(1.3)1	(0.0)0	(1.3)1	(1.3)1	(1.3)1
Does nothing	(12.7)10	(1.3)1	(11.4)9	(1.3)1	(1.3)1	(1.3)1	(0.0)0

**SAMPLE TOTAL**

Treatment preferred	Type of diseases						
	U R T I	Diarrhoea	Worm Infection	Malaria	Skin Disease	Eye Disease	Accidents
Local dispensary	(55.8)91	(54.6)89	(50.9)83	(52.8)86	(56.4)92	(61.3)100	(49.7)81
District Hospital	(18.4)30	(28.8)47	(28.2)46	(29.45)48	(33.1)54	(33.7)55	(50.9)83
Traditional Specialist	(2.45)4	(4.9)8	(3.7)6	(9.2)15	(2.45)4	(1.8)3	(0.6)1
Some Home Remedy	(1.2)2	(8.0)13	(0.6)1	(1.2)2	(1.8)3	(0.6)1	(0.6)1
Does Nothing	(22.1)36	(3.6)6	(16.6)27	(7.4)12	(3.1)5	(2.45)4	(1.2)2

Note The percentages are in parentheses

Whereas 29.8% of the area A respondents would rather go to the hospital when afflicted with upper respiratory tract infections, only 6.3% of the area B respondents would resort to the hospital and the trend is duplicated for diarrhoea, worm infections, malaria, skin and eye diseases as well as during accidents. Area A respondents tend to prefer the hospital treatment than area B respondents. This is the exact reverse when those who would rather go to the dispensary for the same ailments is compared. A majority of area B respondents prefer treatment in the dispensaries than area A respondents. This applies to all the seven diseases that were compared.

The preference was influenced mainly by distance to various modern institutions. For area B, due to the close proximity of the dispensary, most of the respondents would rather go to the dispensary during sickness. However, the hospital though generally far from both area A and B, is more frequented by respondents from area A as the

The above analysis does show how the various diseases are preferably tackled. The diseases which are deemed as serious, such as malaria, are more frequently referred to traditional specialist while accidents, due to their nature, are more frequently referred to the hospital. There are variations in how each disease is handled, however. A comparison of area A and area B does reveal a contrast in the way this is realised. However, the differences point to the importance of the individual communities as they realise their daily existence. The difference in the level of preference of hospitals and dispensaries from disease to disease shows how there are, indeed, variations from one group of people to the next group of people. Likewise, the function of each of the health institutions though relative is present. This is, for example, shown in the level of preference for the various health facilities which varies from disease to disease. The level with which traditional medicine is preferred also varies. However, the fact that it is preferred in certain instances is a testimony that it plays a vital role in the lives of the respondents. The home remedies which are discussed below play an important role in the health lives of the respondents. They are applied continuously as testified by the respondents' preference for them, for tackling various ailments, chief among them being diarrhoea. To treat diarrhoea the following traditional remedies are common. The fruits of the *muthigio (Rhus vulgaris)* plant are boiled and the extract is drunk in soup. The second common remedy comes from the *mukuyu (Ficus sycomorus)* tree. The bark of this plant is boiled in soup and is drunk. The *mugumo (Ficus thoningii)* tree, which is one of the ancestral trees of the Agikuyu, is also useful in the treatment of diarrhoea. The bark is boiled and drunk in soup. There is a resounding similarity in the manner of the preparation of the plants that are used in the treatment of diarrhoea. The bark is the most common part of the plants that is used for the treatment of diarrhoea ( Further examples are provided in Appendix II).

dispensaries are equally far. The number of respondents who frequent the dispensary is higher in area B than in area A.

One fact that is also clear is that the level of preference for treatment in hospital or dispensary varies from disease to disease. In area A, 44.0% of the respondents prefer dispensary treatment for eye diseases, compared to 34.5% for worm infection. In area B, 79.7% of the respondents prefer dispensary treatment for eye disease compared to 68.4% for worm infection. It is apparent that in both areas A and B, the highest number of respondents prefer the dispensary for treating eye ailments. The total score for area A and B confirms this. 61.3% of the respondents prefer the dispensary for the treatment of eye diseases. A higher percentage of the respondents also prefer hospital treatment for eye diseases. This comprises 50.0% of area A respondents and 16.5% of area B respondents. In contrast, only 1.8% of the respondents prefer traditional medicine for the treatment of eye diseases. This lends credence to the fact that some diseases will evoke corrective action leaning towards modern medicine, while there are those diseases where an increasing number of respondents will tend to resort more and more to traditional medicine.

The range of traditional herbs available for the treatment of eye diseases were few. Only one, out of the thirty eight herbal remedies, is used for treating eye problems. This herb is *murute* (*Erlangea cordifolia*). When one has sore eyes that produce waxy stuff, the leaves of the *murute* plant can be used to achieve recovery. First the leaves are pounded and boiled in water. This solution is left to cool and, thereafter, used to wash the affected eye.

When the frequencies of the respondents who prefer traditional medical treatment is compared one thing is clear and that is a majority of the respondents prefer traditional medicine for malaria than any other disease. This is followed by diarrhoea and worm infections. For instance, 8% of the respondents prefer using some of the home made remedies in combating diarrhoea, making it the one disease that most respondents would rather deal with at home followed by skin diseases and upper respiratory tract infections.

On the other hand, most of the respondents (22.1%) do nothing about upper respiratory tract infections while 16.6% of the total respondents declared that they would rather do nothing when afflicted with worms. Accidents, are the lowest with only 1.2% of the respondents declaring they would do nothing during accidents.

#### 4.2.4 Modern and Traditional Treatment

As already shown, a majority of the respondents resort to modern health institutions. And, during their visits, they are usually accorded treatment. This study sought to compare the actual attendance of the population at the two local dispensaries in the research area to beef up information on the type of diseases that afflicted the farmers in the settlement schemes in general. There are two dispensaries in the research area and both of them are found in what is referred to in this study as area B. Murammati dispensary is located in Muramati area while Matanya dispensary is located in Weruine area. The types of diseases and their frequencies in the last five months preceding the research is tabulated in Tables 4.9 and 4.10.

**Table 4.9: Total reported cases at Matanya Dispensary in the five months preceding the research**

Disease Type	Jan	Feb	Mar	Apr	May	Total
Diarrhoeal Diseases	(4.5)53	(2.9)32	(2.8)44	(4.0)39	(4.2)28	(3.6)196
Meninges	(0.6)3	(0.06)1	(0.6)6	(0.6)6	(0.15)1	(0.2)11
Mumps	(0.08)1	(0.0)0	(0.06)1	(0.0)0	(0.0)0	(0.04)2
Malaria	(16.9)198	(19.35)210	(10.1)159	(15.8)155	(22.9)153	(16.0)875
U.T.I	(1.28)15	(0.8)9	(1.3)21	(1.8)8	(4.5)3	(1.02)56
Intestinal Worms	(4.02)47	(2.3)25	(1.5)20	(2.2)22	(2.5)17	(2.5)135
Eye infections	(1.7)20	(2.1)23	(2.3)36	(0.8)8	(1.2)8	(1.7)95
Ear infections	(0.08)1	(1.6)17	(3.6)37	(0.4)4	(1.3)9	(1.6)88
U.R.T.I	(34.05)398	(39.45)428	(35.5)357	(41.4)407	(47.4)317	(38.5)2107
Pneumonia	(0.0)0	(0.0)0	(0.0)0	(0.0)0	(0.3)2	(0.04)2
Mental disorders	(0.0)0	(0.0)0	(0.0)0	(0.0)0	(0.3)2	(0.04)2
Skin diseases	(9.6)112	(9.1)199	(8.65)85	(8.65)85	(6.9)46	(8.9)485
Chicken Pox	(0.0)0	(0.0)0	(5.1)5	(5.1)5	(0.8)6	(0.2)11
Accidents	(6.1)71	(6.0)65	(12.2)120	(12.2)120	(7.9)53	(11.1)608
All others	(21.4)250	(16.3)177	(12.6)124	(12.6)124	(3.6)24	(14.6)801
Total	(100.0)1169	(100.0)1085	(100.0)983	(100.0)983	(100.0)669	(100.0)5474

Note: The percentages are in parentheses

From Tables 4.9 and table 4.10 it is apparent that the most common ailments are upper respiratory tract infections followed by malaria, accidents, skin disease, diarrhoeal diseases, worm infections and eye infections. These findings conform to the Laikipia District Development Plan which identifies the same ailments as the most common in the district. One striking difference is in the total frequencies from Matanya and Muramati dispensaries. This is because Matanya dispensary serves a very expanse population. Weruine farm, on which it is located, is itself very large. There is a very striking difference between the figures for upper respiratory tract infections in Matanya dispensary, comprising 38.5% of all the reported diseases, and those for skin disease which comprises 8.9% of the total reported cases in the same period.

According to a nurse at Matanya dispensary, this is due to the fact that most of the patients who come with upper respiratory tract infections complaints are children. And this explains why, as shown in Table 4.7,



the difference between the proportion of respondents whose last affliction were upper respiratory tract infections (22.1%) and the next common ailment which, in this case, is malaria, (14.1%) is not as enormous. The respondents were adults while those who attend the local dispensary include children, women, and men; and, the least, being men.

**Table 4.10: Total reported cases at Muramati Dispensary in the first five months proceeding the research.**

Disease Type	Jan	Feb	Mar	Apr	May	Total
Diarrhoeal Diseases	35(5.7)	26(5.9)	(1.6)10	(2.7)11	5(1.8)	87(3.7)
Malaria	121(19.6)	102(23.0)	110(18.0)	79(19.6)	33(11.7)	445(18.9)
Gonorrhoea	20(3.2)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	20(0.85)
Intestinal Worms	29(4.7)	21(4.7)	2(3.4)	9(2.2)	16(5.7)	96(4.1)
U.T.I	0(0.0)	4(0.9)	1(0.25)	1(0.35)	6(0.25)	6(0.25)
Eye infections	21(3.4)	9(2.0)	15(2.45)	8(2.0)	4(1.4)	57(2.4)
Ear infections	9(1.5)	5(1.1)	2(0.3)	6(1.5)	2(0.7)	24(1.0)
U.R.T.I	242(39.2)	81(18.3)	257(42.1)	151(37.5)	79(28.0)	810(34.4)
Skin diseases	81(13.1)	74(16.7)	51(8.35)	21(5.2)	26(9.2)	253(10.7)
Accidents	8(1.3)	1(0.2)	2(0.3)	2(0.5)	11(3.9)	24(1.0)
All others	52(8.4)	120(27.1)	143(23.4)	115(28.5)	105(37.2)	535(22.7)
Total	618(100.0)	443(100.0)	611(100.0)	403(100.0)	282(100.0)	2,357(100.0)

Note: The percentages are in parentheses

At Muramati dispensary, upper respiratory tract infections are still the most frequently reported ailments comprising 34.4% of all reported cases for the five months proceeding this research. This was followed by malaria, skin disease, worm infections, diarrhoea, eye infections and accidents. These diseases conform to the type of diseases that are listed as the most common diseases in Laikipia by the 1989 - 1993 District Development Plan, and to the most commonly reported diseases at Matanya dispensary (Table 4.9).

The nurses manning the two dispensaries gave a general overview of the behavioural patterns of their patients. According to both of them, children comprise the majority of the patients. However, whereas the nurse at Matanya held that females are the next major category followed by males, the one at Muramati held that the number of adult females visiting the dispensaries is not different from the number of males visiting the dispensary.

The primary drugs that are used at both Matanya and Muramati dispensaries are mainly tablets and capsules. However, whereas all forms of medicines are received with enthusiasm at Muramati dispensary, injections are disliked at Matanya dispensary. There used to be an emphatic interest in injections, but now they

are increasingly disliked due to pain and the fear of transmitting H.I.V. In order to allay this fear, the nurses do sterilize the injections in hot water. But since there is no electricity in the dispensaries they have to use paraffin. Lack of funds is the major hindrance here and the only alternative is to have the patients contribute towards the buying of paraffin, a perpetuation of the spirit of cost sharing. This state of affairs, the lack of proper facilities, signals the existence of a severe problem. The ideal situation would be where disposable syringes are in use. But this cannot be achieved due to lack of funds. In fact, occasionally the drugs themselves are not available and the sick have to be referred to Nanyuki district hospital which is a long way off.

The other forms of medicine available were powder, syrup and ointment. Tablets are the most frequently received form of medication. For instance, 87.1% of the respondents in the study admitted they received tablets during their last visit to a modern health institution, while 71.8% had their medicines administered in injection form. Other forms of medication received were: syrup 42.9%, ointment 9.8%, wound dressing 1.8%, while 1.2% of the respondents received other forms other than the ones described. The findings show that 1.8% of the respondents did not find any medicine at all during their visit. This number does not include those who did not find medicine and, subsequently, resorted to other health institutions. The above number, though small, helps to identify the existence of a very serious problem in the health institutions within Laikipia District: lack of medication is a common occurrence as was testified by the nurses at the dispensaries at Muramati and Matanya. This lack of proper and adequate medication is a contributory factor in determining the resident's health-seeking behaviour. A majority of the respondents prefer injections for the treatment of malaria as was revealed by the nurses and, therefore, when they are afflicted with malaria and they visit the dispensary which may not happen to have injections at the time, alternative sources of treatment are sought. The form in which these health seeking behaviour assumes, takes various dimensions. Among the various health-seeking courses of action, traditional medicine features very prominently. It is, therefore, an accepted way of seeking for health. This study did also seek to know the form and nature of traditional medicine and especially how it influences the health seeking behaviour of the respondents when faced with different diseases. Also, the study sought to know the form of traditional medicine that the respondents last used.

**Table 4.11: Forms of Traditional Medicine used**

Form	Area A	Area B	TOTAL
Leaves	132(38.1)	47(59.5)	79(48.5)
Roots	27(32.1)	26(32.9)	53(32.5)
Stem	8(9.5)	7(8.9)	15(9.2)
Barks	11(13.1)	21(26.6)	32(19.6)
Ashes	2(2.4)	2(2.5)	4(2.45)
Any other	3(3.6)	2(2.5)	15(3.1)

Note: The percentages are in parentheses

The most frequently used form of medicine are leaves (48.5%), followed by roots (32.5%) and barks (19.6%). Many of the traditional medicines are generally in plant form. This is not a surprise considering that 42.9% of the respondents admitted they know a traditional herbalist. The herbalist is the most famous of the traditional specialist followed by uvula surgeons. This study revealed that the respondents who use traditional medicine do themselves have an in-depth knowledge of the various plants that can be used for the treatment of various diseases (Table 4.12).

**Table 4.12 Most commonly used traditional medicine**

Type of medicine	Area A	Area B	Sample Total
<i>Njeri Wa Gana</i>	(13.1)11	(26.6)2	(19.6)32
<i>Muthiga</i>	(9.5)8	(7.6)6	(8.6)14
<i>Mueia</i>	(5.9)5	(5.1)4	(5.5)9
<i>Kiruma</i>	(9.5)8	(20.2)16	(14.7)24
<i>Mukawa</i>	(3.6)3	(3.8)3	(3.7)6
<i>Mwarubaine</i>	(3.6)3	(6.3)5	(4.9)8
<i>Mutogu</i>	(2.4)2	(3.8)3	(3.1)5
<i>Muthiriti</i>	(4.8)4	(1.3)1	(3.1)5
<i>Mutero</i>	(2.4)2	(5.1)4	(3.7)6
<i>None</i>	(57.1)48	(32.9)26	(45.4)74

Note: The percentages are in parentheses

For most of these plants, the general public have to a large extent, some knowledge concerning how to use them and for what disease. The herbalist is important since he has knowledge of most of the plants that have medicinal value that surpasses that of the lay person. For the purpose of this study only a few of the plants

and how they are used to combat some of the ailments which are common in Laikipia District are discussed below. Malaria is the one single disease where a majority of the respondents prefer traditional treatment. Malaria is also the most common disease, after upper respiratory tract infections, that afflict the respondents. There exists several herbal remedies for malaria, the most commonly used herbal remedy is *Njeri wa gana*; used by 19.6% of the respondents (Table 4.12). This herb is capable of treating malaria, stomachache and diarrhoea. For the treatment of malaria, the leaves of the plant are boiled in water. The water is then strained off and given to the patient to drink. The medicine is taken twice a day until the patient feels well.

Several methods of treating upper respiratory tract infections also exist. The traditional remedy in the treatment of common cold, which is one of the upper respiratory tract infections, was the use of the bark of *mukinduri tree* (*Croton megalocarpus*). The barks of this tree, which belong to the euphorbia family, is boiled in a pot. When the water has boiled the patient then sits with the head over the pot and inhales the steam. The water is then used to make *ugali* which the patient takes or is mixed with fresh blood and the patient takes it everyday until he/she is completely cured.

Accidents are listed as one of the seven most common ailments in the district. These accidents usually range from burns, small cuts to serious ones that are a threat to life. Most of the accidents are treated at the district hospital. However, there are those small cuts which the respondents do use traditional medicine. To treat wounds, the sap of the *Kiruma* plant is applied on the wound. In Table 4.12, *Kiruma* (*Aloe laterita*) is the second most commonly used traditional plant with 14.7% of the total respondents having used it.

The above three examples are but a drop in the ocean of the various curative skills of the Agikuyu which do not employ Western scientific knowledge to achieve treatment. These are some of the treatments that are associated with three of the seven most common ailments. There are various beliefs that were associated with the foregoing simple curative steps which depended mainly on the perceived cause of the specific disease. Sickness can be caused by agents like departed spirits or by enemies who bewitch you. When one of the taboos governing conduct is broken then sickness can be manifested directly on whoever breaks the taboo or indirectly to the relatives or cattle of the member of the community who broke the taboo. As a result, corrective measures have to be taken

This does involve the immediate family or the whole group as a whole, therefore, it becomes a community affair and, indeed, all serious illnesses draws the attention of the whole community.

#### 4.2.5 Diseases Best Treated By Traditional Medicine

The level with which traditional medicine is used has already been shown. Most of the respondents (65.64%), however, do not feel that there are specific diseases which are best cured by traditional medicine. For instance, 29.45% do feel that there are those diseases which are best treated traditionally and 4.91% do know of the diseases best treated traditionally. In order to find out which disease the respondents believe are best cured by traditional medicine, the respondents who believe there are certain diseases which are necessarily best treated by traditional medicine were asked to mention them. The findings showed that a majority of the respondents (15.3%), who believe some diseases are best treated traditionally, claim malaria is best treated by traditional medicine. This was followed by stomach problems which accounted for 6.75% of the respondents. Backache, bones and joint pains and epilepsy accounted for 3.1% each and, finally, gonorrhoea which accounted for 2.45% of the respondents.

The other disease states which are mentioned as best treated by traditional means include marasmus, paralysis, urethra, blockage, skin diseases, asthma, diarrhoea, kidney, liver, diabetes, high blood pressure, cold, stomach tumour, stomach ulcer, abortion and measles. It is evident, then, that a good range of diseases are believed to be best treated by traditional medicine. This study also sought to find out why there is this strong belief in traditional medicine. It was found out that 52.8% of the respondents, who have a strong belief in traditional medicine, said it was because traditional medicine achieves better results. 20.75% held their belief because they had heard from people and later adopted the ideas while 9.4% have a strong belief in traditional medicine because they have seen people who had tried traditional medicine and then recovered. On the other hand, 5.7% have a high belief in traditional medicine because of a personal experience with traditional medicine. For the above group of respondents, traditional medicine continues to play a very important role in their lives.

#### 4.2.6 Diseases Best Treated at Home

In the discussion above, the various ways in which several diseases are tackled have been evaluated. One aspect that came up is that there are those diseases where the respondents do nothing about them. This study further sought to know whether there are any diseases where the respondents would not seek modern treatment or traditional treatment from a specialist. The composition of the respondents who listed the various diseases not warranting attentions is shown in Table 4.13 below.

Table 4.13 Diseases Treated at home

Diseases	Area A	Area B	Total
None	12(4.3)	16(20.25)	28(17.2)
Headache	24(28.6)	20(25.3)	44(27.0)
Common Cold	29(58.3)	47(59.5)	96(59.0)
Cough	7(8.3)	9(8.9)	14(8.6)
Minor bruises & Cuts	14(16.7)	12(15.2)	26(16.0)

Note: The percentages are in parentheses

59.0% of the respondents would not necessarily take common cold for treatment either in a modern health institution or to a traditional specialist while 20.25% would not take slight malaria to the traditional or modern health specialist. Despite the deadly nature of malaria, it is only treated with much attention when the attack is strong. This is particularly dangerous as the personal judgement of whether the attack is mild or serious is left to the patient and in cases where a strong attack is treated lightly the consequences can be fatal.

Other diseases where home treatment is preferred include diarrhoea, stomachache, mild body pains, tonsils, bloat, toothache, backache and chest pain. These diseases are treated with remedies defined mostly by the patients themselves. The most common remedy is over the counter drugs. However, 47.2% of the respondents use some traditional medicine which they make and apply on their own. For instance, Salt solution and sugar solution are common with 12.9% and 5.5% of the respondents while 9.2% of the respondents do

completely nothing about certain ailments. Some respondents just relax for sometime when they are experiencing headaches especially so when the headache is slight. There are various home remedies which can be used for diarrhoeal diseases. The most common is a salt solution. However, sugar solution is also used or a mixture of salt and sugar while, some of the respondents simply take water.

Coughs and colds are the diseases which are mainly treated at home. To clear off a cough, the following mixtures are taken; Magadi soda and milk is mixed together and taken; alternatively, eggs, honey and milk are mixed and taken, and, for some raw eggs will simply do. On the other hand, colds are treated at home by either inhaling steam from eucalyptus leaves or by taking a mixture of half fried eggs and Magadi soda. Small cuts would ordinarily be treated by applying salt. Burns, on the other hand, would be treated by applying vaseline on the place where the skin has been burned and this only refers to small burns. The remedy for backache is to take soup while that for stomachache includes taking roasted bread. These simple home remedies are applied when a specific disease strikes some of the respondents. No individual holds any monopoly over this knowledge. The one single advantage which these informants have is that the home remedies are within their reach any time complications arise.

It is apparent that the type of disease one is suffering from does determine the corrective action that the individual will take. Though one disease may evoke varied reactions among the individuals, the majority of the respondents tend to follow a given defined path. For a particular disease, the majority of the respondents may prefer the hospital and for a different kind the dispensary or some home remedy altogether. This confirms the second hypothesis which states that disease type influences the course of action taken towards recovery. The hypothesis, is, therefore, accepted and incorporated with the above findings.

#### **4.3 The Influence of Religion on Health-Seeking Behaviour.**

All societies believe to some extent in a deity. The Agikuyu, who comprise the majority of the respondents in this study, believed in a deity whom they referred to as *Ngai* (Kenyatta, 1978). However, as admitted by Kenyatta, the role *Ngai* plays in the everyday lives of the Agikuyu is currently minimal. This role

has been overtaken by the new modern religions from the Western and Eastern worlds. The major religions in much of the Third World are Christianity and Islam. In this study, the major denomination that the respondents belong to was sought by asking their religious affiliations as well as their particular denominations since within each religion there are various denominations.

#### 4.3.1 Denomination and Attitude to Various Modes of Treatment

An analysis of the major denominations of the respondents showed that a majority of them are Catholics (33.1%), followed by Pentecostal church of East Africa (14.1%). Full Gospel Church accounted for 8.6% of the respondents while 1.8% of the respondents did not belong to any denomination. The denominational composition of the two areas A and B varies considerably when one considers the frequency of the respondents who are members of African Inland Pentecostal Church of Africa. For instance, 10.7% of the respondents in area A belong to the African Inland Pentecostal Church of Africa while only 2.5% of the area B respondents belong to the same denomination.

The Roman Catholic is the single most common denomination, therefore, the number of respondents who are Catholics and non-Catholics and who frequent the modern health institutions was compared. Of the 54 Catholics in the sample, 25.9% of them visit the clinics. On the other hand, of the 109 non-Catholics 20.2% do frequent the clinic. Proportionally, then, a higher majority of the Catholics frequent the clinics. As shown in Table 4.2 earlier, 88 of the respondents frequented the hospital at various times during the last one year preceding the research. Of these, 25 were Catholics and 63 were non-Catholics. The proportion of Catholics who visited the hospital was 46.3% of the total Catholics, while 57.8% of the total of non-Catholics frequently visit the hospital at Nanyuki town. Of the 54 Catholics interviewed, 11.1% of them frequent the mobile clinic, while 11.0% of the non-Catholics frequent the mobile clinic. On the other hand, 88.9% of the Catholics frequent the dispensary while 76.15% of the non-Catholics frequent the dispensary.

Except for the hospital, the proportion of the Catholics who frequent the modern health institutions is higher than that of the non-Catholics. This is because some of the denominations advocate against hospital



Focused group discussants pointed out that some of the denominations were wrong on this point. Their view was that there is nothing wrong with going to modern health institutions since, essentially, they are there to provide health care services, they should be utilised. This could also be as a result of the fact that the catholic Church has its own mission dispensaries in the district and, it encourages its congregation to utilise the modern health institutions. One's religious denomination does, therefore, influence the likelihood of using or not using modern health institutions during sickness, especially, the pattern of utilisation.

The action taken during sickness among the Catholics and non-Catholics was compared basing on the action that the respondents took during their last sickness and denomination. This showed the following trend. The proportion of all the Catholics who went to the dispensary straight during sickness was 35.25%. On the other hand, the proportion of Catholics who went to the district hospital straight away was 18.5% and 23.85% for the non-Catholics. Apparently then, more Catholics go to the dispensary when sickness strikes than do the non-Catholics. The influence of catholic teaching, which is usually accompanied by catholic schools and dispensaries, cannot be ruled out here. The enormous difference in the proportion of the respondents who utilise the dispensary is not because a majority of the Catholics live near a dispensary. 48.15% of the Catholics interviewed are from area A and this is a good proportion of the Catholics. The main reason of the first choice of a dispensary and a lesser majority going to the hospital first is because most of the Catholics seek medical attention immediately after the onset of symptoms. They do not wait for the conditions to deteriorate upon which they will rush to the hospital.

Basing on the respondents last action during their last sickness, 9.2% bought drugs from the shop and recovered. This included 7.4% of the Catholics and 10.0% of the non-Catholics. In this comparison more of the non-Catholics do use over the counter drugs than Catholics. From the above evidence, it is apparently clear that a major difference exists between Catholics and non-Catholics in as much as their medical seeking behaviour is concerned. The Catholics are more eager to seek medical attention, and will rely less on over-the-counter-drugs than non-Catholics.

The preferred source of treatment for upper respiratory tract infections and malaria among Catholics

and non-Catholics was compared. The results revealed the following trend. In combating upper respiratory tract infections, 66.7% of the Catholics prefer the dispensary in contrast to 55.5% of the non-Catholics. On the other hand, 13.0% of the Catholics prefer hospital treatment compared to 21.1% of the non-Catholics. Whereas more Catholics prefer dispensary treatment for combating upper respiratory tract infections more non-Catholics prefer hospital treatment for combating upper respiratory tract infections. The same trend is noticed in the preferred mode of tackling malaria since 53.7% of the Catholics respondents prefer dispensary treatment for malarial disease while 52.3% of the non-Catholics prefer the same. On the other hand, 22.2% of the Catholics prefer hospital treatment for malaria, while 33.0% of the respondents prefer hospital treatment for tackling malaria.

The pattern of those who prefer traditional medicine for treating malaria and upper respiratory tract infections among Catholics and non-Catholics greatly varies. Whereas 1.85% of the Catholics prefer traditional medicine for tackling upper respiratory tract infections, 2.75% of the non-Catholics do the same. On the other hand, 13.0% of the Catholics prefer traditional medicine for treating malaria while 7.3% of the non-Catholics prefer traditional medicine for the treatment of malaria. This indicates that more Catholics prefer traditional medicine for treating malaria than non-Catholics but fewer Catholics prefer traditional medicine for treating upper respiratory tract infections. It is, therefore, clear that different diseases are tackled differently considering the danger that the disease poses to the individual concerned. Thus, Catholics tend to use dispensaries more often, and they prefer the dispensaries for treating more diseases, whereas more non-Catholics prefer the hospital than the Catholics.

When it comes to the use or non-use of traditional medicine, more Catholics will use traditional medicine for those diseases that are a greater risk to a majority of the respondents. Malaria is a deadly tropical disease and most of the respondents are worried about it. It is taken very seriously. The problem, however, is that not all those who seek treatment for malaria at modern health institutions do recover. A majority of the respondents will, thus, resort to traditional medicine for the treatment of malaria compared to any other disease. Of the respondents who have used traditional medicine in their lives, the Catholics comprise 34.8%, while the non-Catholics are 65.2% implying that more non-Catholics have used traditional medicine than the Catholics. However, as the proportion shows Catholics

traditional medicine. Compared to the overall respondents who believe that some diseases are best cured by traditional medicine (29.44% of the total respondents), 35.4% of them are Catholics while 64.6% are non-Catholics.

The number of the respondents who use home remedies was compared between the Catholics and non-Catholics. Of the 17.2% of the respondents who do not use home remedies for treating several ailments, 46.4% of them are Catholics while 53.6% are non-Catholics. Fewer Catholics do not use home remedies against non-Catholics. From the above comparisons of the Catholics and the non-Catholics, the following general conclusions can be made. The likelihood of frequenting a dispensary is higher among Catholics than non-Catholics. On the other hand, the likelihood of frequenting a hospital as the first source of treatment is higher among non-Catholics than Catholics. Less Catholics use traditional medicine on the whole. However, the likelihood of using traditional medicine when afflicted by malaria is higher among the Catholics than the non-Catholics. More non-Catholics believe in traditional medicine and while more Catholics use home remedies than non-Catholics. From the foregoing, it is evident that the role religion plays in an individual's health-seeking behaviour cannot be underestimated. However, the results also show the importance of the individual in determining his or her own recovery. The realisation of one's desired recovery from illness must, however, follow accepted patterns and one's beliefs exert a major influence on the patterns used by individuals to restore health.

#### 4.3.2 Frequency of Visits to Places of Worship and Frequency of Visits to the Dispensary.

To find out further whether the more frequently one visits the Church influences whether one will utilise the modern health facilities more, the respondents were asked the last time they were in Church (Table 4.14).

**Table 4.14: Church Attendance**

	Area A	Area B	Sample Total
Never gone to Church	0(0.0)		3(3.8)
Last sunday	51(60.7)		49(62.0)
This month	20(23.8)		15(19.0)
2-6 months	1(1.2)		3(3.8)
7-12 months	2(2.4)		0(0.0)
Over 2 years ago	2(2.4)		3(3.8)
1-2 years	2(2.4)		3(3.8)
Cant remember	5(6.0)		3(3.8)
Not applicable	1(1.2)		0(0.0)

Note: The percentages are in parentheses

A majority of the respondents frequent places of worship, with 61.3% having been either in Church or a mosque during the last worship day. The respondents who frequent the dispensary very much are the ones who frequented the Church over ten times in the last one year prior to the research. As shown in Table 4.2, 68.75% of the respondents frequented the dispensary, 6 - 10 times in the last one year preceding this research. 61.9% of these had been in Church last Sunday. Of the 34 respondents who frequented the clinic 3 - 5 times in the same period, 61.7% had been in Church last Sunday. Of the 34 respondents who had frequented the dispensary 1 - 2 times in the same period, 79.4% had been in the Church the last Sunday preceding this research. From the above trend, it cannot be said that the more frequently one goes to Church, the more frequently one will visit the dispensary. Compared, for example, only 12.5% of the 16 respondents who have visited the dispensary over 10 times in the last one year preceding this research have not been in Church within the last one month. 14.7% of the respondents who have been to the dispensary 1-2 times in the last one year preceding this research, had not been to the Church within the last two months preceding the research. It can, therefore, generally be said that a small proportion of the respondents who frequent the dispensaries do not frequent the Church while a larger proportion of the respondents who frequent the dispensaries frequent the Church. This signals a relationship between religion and frequency of the use of modern health facilities, which as we have seen, exists but to an extent where one does not necessarily influence the other.

#### **4.3.3 Religious Belief and Health Seeking Behaviour.**

Basing on the answers that the respondents gave to the questions asking whether they are baptised, how frequently they visit Churches and what their opinions were on their religious devoutness, the respondents' religious devoutness was ranked from very high to negative. Most of the respondents (30.1%) are moderately devoted followed by those who are highly devoted comprising of 26.4% and 19.0%, respectively. 13.5% and 6.75% of the respondents have low and very low religious devoutness, respectively. 3.7% are not devoted while for 0.6% it does not apply. The religious devoutness of respondents was compared to their utilisation of dispensaries, since it is one of the most highly utilised modern health institutions.

When the proportion of the respondents whose religious devoutness was ranked as very high and high and who frequented the dispensary more than 10 times was compared to the proportion of the respondents whose religious devoutness is low and negative who frequented the dispensary over ten times, the proportions were found to be 10.8% and 6.45%, respectively. In essence, then, the more devout the respondents' are the more frequent they visit the dispensary. On the other hand, when the composition of the devoted respondents is analysed, the following is revealed. Most of the highly devoted respondents (32.1%) are from area A, and out of these, 29.6% are from north Tetu while 70.4% are from Burguret. Comparatively, of the 54.6% respondents who admitted they used traditional medicine, 40.45% are from area A and 59.55% from area B. And of the 40.45% of area respondents who use traditional medicine from area A, 38.9% are from Burguret while 61.1% are from North Tetu. Apparently, then, the highly devoted residents are concentrated in Burguret area and Burguret area has the least respondents who admitted they use traditional medicine. Further evidence from the informal discussants attested that the Burguret area residents belonged to a christian-linked land buying company. The religious influence among the respondents was quite noticeable and many of them, therefore, do not want anything to do with traditional medicine.

To the residents of Burguret, traditional medicine does not play a significant role compared to those of Mumarani, where 68.3% of the respondents use traditional medicine. The functional importance of any social fact like traditional medicine is relative in importance within each community setting, and as shown by evidence from Burguret, the ideals the community holds shapes the functional relevance of any social fact. The above evidence also shows the number of ways that religion influences peoples' health seeking behaviour. It is not true to generalise, on the whole, that religious people do not use traditional medicine; they do, however, there is a higher tendency of using traditional medicine among those people who are not devout than those who are devout.

#### 4.4 Socio-Economic Status and Health-Seeking Behaviour.

In the literature, two conflicting views concerning the influence of socio-economic status and health abound. One view holds that the higher one's socio-economic status is, the higher one is likely to utilise health (Pearson 1989, Smith 1966, Koos 1954, Simons 1966), while there were those authors who disputed this idea (Lois 1973). In this study, the initial step in comparing social class and the utilisation of both traditional medicine and modern medicine was to first assess the peoples' economic status. The respondents are mainly immigrant agriculturalist population who own small pieces of land averaging 2 acres and keep a few animals. Much of this land is semi-arid and, thus, not suitable for agriculture. Earnings from agriculture are, therefore, very minimal and cannot sustain an average family. Many families have not harvested any crops in the last two years, but they keep on trying their luck, therefore, the general population is poor. This study did classify the respondents whose material wealth was higher than the rest based on the number of animal heads owned, the number of other moveable assets owned and the nature of housing. A score was given for each asset owned and the number of domestic animals owned. The number of years spent in school was also assessed and the respondents who spent more years in formal schooling scored more. The total score was then combined. Those who scored 0-5 were classified as low class, while those with scores ranging from 6-9 and 10-20 were categorised as middle and high class respectively (Table 4.15).

**Table 4.15: Assessment of Social Economic Status.**

	Area A	Area B	Total
<b>A None</b>	36(42.9)	20(25.3)	56(34.4)
1-3 Cattle	30(35.7)	39(49.4)	69(43.3)
4-6 Cattle	15(17.9)	12(15.2)	27(16.6)
11-20 Cattle	2(2.44)	8(10.1)	10(6.1)
Over 20 Cattle	1.2(1)	0.0 (0)	0.6(1)
<b>B None</b>	32(38.1)	12(15.2)	44(27.0)
1-5 Sheep & goats	24(28.6))	20(25.3)	44(27.0)
6-10 Sheep & goats	15(17.9)	22(27.8)	32(19.6)
11-20 Sheep & goats	7(8.3))	13(16.5)	20(12.3)
Over 20	6(7.2)	12(15.2)	18(11.0)
<b>C Radio</b>	56(66.7)	54(68.4)	110(67.5)
T V/Video	2(2.4)	3(3.8)	5(3.1)
Bicycle	18(21.4)	36(45.6)	54(33.1)
Oxen plough	2(2.4)	1(1.3)	3(1.8)
Tractor	0(0.0)	0(0.0)	0(0.0)
Mabati House	76(90.5)	168(86.1)	144(88.3)
Stone House	2(2.4)	0(0.0)	2(1.2)
<b>D Level of education</b>			
Primary	46(54.8)	48(60.8)	94(57.7)
Secondary	15(17.9)	4(5.1)	19(11.7)
Certificate & Diploma College	0(0.0)	1(1.3)	1(0.6)
Never went to School	23(27.44)	26(32.9)	49(30.1)
<b>E High class</b>	7(8.3)	17(21.5)	24(14.7)
Middle Class	36(42.9)	37(46.8)	66(44.8)
Low class	41(48.8)	25(31.7)	66(40.5)

Note: The percentages are in parentheses

Only 14.7% of the respondents were categorised in the high class compared to 40.5% in the low class. However, a majority (44.8%) are middle class leading a sub-poverty lifestyle. Area A has less high class respondents than area B while area B has less low class respondents than area A. There is a significant difference in the number of the respondents who do not frequent the dispensary among the classes. The proportion of the high, middle and low class respondents who did not go to the dispensary in the last one year was 12.5%, 20.55% and 21.2%, respectively. A higher proportion of the upper class does not visit the dispensary. The intensity with which the respondents visit the dispensary is higher among the higher economic class respondents than the low social class. The composition of the low, middle and the upper class respondents who visited the dispensary 1-2 times in the last one year was 22.7%, 31.5% and 25.5%, respectively. On the other hand, only 1.5% of the low class respondents visited the dispensary more than 10 times in the last one year compared to 11.0% of the middle and 29.2% of the upper class respondents. The major influencing factor was cost. Many of the respondents spoke against the recently introduced cost sharing.

It is a burden which they cannot afford. They do, therefore, visit the dispensary only when it is absolutely necessary. The high class patients, due to their better off position, are able to pay the mandatory cost-sharing fee. The proportion among those who frequent the hospital reflected the same trend. 45.8% of the high class respondents had never visited the hospital in the last one year compared to 48.5% of the lower class respondents. There is, however, a smaller difference. The dispensary is the most frequented health institution as it is near most of the respondents compared to the hospital. The fact that more of the upper class respondents frequent the dispensary than they do the hospital is, therefore, explained. This does also apply for the lower class patients. However, the difference in the proportion of the lower and upper class respondents who had never visited the hospital is smaller than the difference in the proportion who do not frequent the dispensary. This would imply that the lower class patients do resort more to the hospital than the dispensary.

The proportion of the respondents who do not frequent the clinic does also conform to this trend. Less upper class respondents do not frequent the dispensary than the lower class respondents. On the whole, the clinics are the least frequented modern health facility after the mobile clinic with 75.0% and 81.0% of the respondents from area A and B, respectively, admitting not to have visited the private clinics at Nanyuki in the last one year preceding this research. However, a higher proportion of the upper class respondents (20.8%) have visited the clinic in the last one year preceding this research than the lower class (15.4%). The influencing factor here, as was emphasised by the informal group discussants, was cost. The private clinics, though desirable, are very expensive and are, therefore, beyond the reach of the average population. Therefore, these clinics serve only the well off. All, except 0.8% of the respondents who visited the clinic in the last one year, rated the treatment in the clinics as good. The high rate of satisfaction with the treatment received from the clinic is an indication of the good services that are provided in the clinics

One's social economic status, as shown above, does influence the range of modern health facilities that one is likely to use. And even those health facilities that are barely within their reach, the frequency with they are utilised are to a large extent influenced by one's social economic status.

The action that the respondents undertook during their last ailment or sickness was compared among



the three social classes. 28.8% of the low class respondents went directly to the dispensary, 27.4% of the middle class respondents, on the other hand, went directly to the dispensary. A larger majority of the upper class respondents (39.1%) went to the dispensary straight away. This corroborates the earlier assertion that the upper class respondents go to the dispensary more frequently than the lower class respondents. This is because the dispensary, being nearer than most of the other health institutions, can easily be reached. Only 8.7% of the upper class respondents went to the hospital first during their last sickness compared to 24.2% and 24.7% of the lower and middle class, respectively. This trend was because most of the lower class respondents dilly-dally with their ailments before any action is taken, and usually when the action is taken it is serious and warranting hospital attention.

While 8.7% of the upper class respondents went to the district hospital and later went to a district hospital in a neighbouring district, only 3.0% of the lower class respondents were able to follow this path. This reinforces the fact that the lowly placed respondents have very limited options when seeking for health, and even over-the-counter drugs which are used by a majority of the population, are beyond the reach of the lower class respondents. While only 3.0% of the lower class respondents bought drugs from their local *duka* and took during their last sickness, 12.3% and 17.4% of the middle and upper class respondents, respectively, bought and used over-the-counter drugs. This reflects their higher purchasing power which, undoubtedly, increases their choice of options and the speed with which such choices can be taken during illness.

But does this necessarily change their trust and belief in traditional medicine? To explore this, the proportion of the respondents who use traditional medicine was compared. It was found that 60.0% of the total lower class respondents use traditional medicine, while for the middle and upper class the proportion is 53.0% and 58.3%, respectively. The proportion of the lower class who use traditional medicine is higher than the proportion of the middle and upper class who use traditional medicine. However, the proportion of the middle class who use traditional medicine is lower than the proportion of the upper class who use traditional medicine. The use of traditional medicine does not necessarily decrease or increase with the social economic status but is high among the lower class respondents, and this trend is not uniform among the two areas identified in this study.

Traditional medicine as used by the communities living in area A is realized differently among the social economic classes than the traditional medicine as used in area B. Whereas, 43.9% of the lower class respondents in area A use traditional medicine, the proportion of the lower class respondents using traditional medicine in area B is far higher. This supports the idea of relativity on two fronts, that first, the use of traditional medicine is different within the social classes, and two, it also differs from one sub-community to another.

The use of home remedies among the social classes was also compared. The differences between the class categories also exist. However, whereas the proportion of lower class respondents using traditional medicine was higher than the rest, the proportion of the lower class respondents who use home remedies is lower to a smaller degree among the lower class respondents compared to the rest. 81.8% of the lower class respondents admitted they use home remedies during various illnesses against 83.6% and 83.3% of the middle and upper class respondents. The difference in percentage between the middle and upper class respondents is quite small (0.3%).

The belief the respondents have in traditional medicine is quite high among the upper class respondents than the lower class respondents but lower than the middle class respondents. Whereas 33.3% of the lower class have a strong faith in traditional medicine, the middle class and upper class composition is 47.9% and 37.5% respectively. This trust and faith in traditional medicine is borne out of several decades of practice. All the respondents were household heads and they have used traditional medicine and continue to use it. Their trust in traditional medicine is, therefore, firm and they believe that health care delivery should involve traditional medicine in as far as certain diseases are concerned. The most common disease that the respondents in all classes believe should be treated by traditional means is malaria. The role traditional medicine plays in the treatment of certain diseases to them is enormous and unrivalled. Most of the respondents who hold this view vehemently pointed out the ineffectiveness of modern medicine in tackling malaria. This trend was reinforced in the proportion of the respondents, among the different social classes, who hold the cause of the disease to be some supernatural power. 50.05% of the lower and 72.0% of the upper class respondents held that supernatural forces were behind their last serious illness.

The communities which are clustered around Laikipia consist mainly of Agikuyu population. However, they have settled in varied farms, having been members of different land buying companies. They do, therefore, have their different characteristics. As was shown above Area A and Area B have varied characteristics between them. Special mention of Burguret area, which consist of mainly "saved" Christians was made. They have the biggest number of the low class and the highest proportion of the respondents who are highly devoted and, therefore, few of them use traditional medicine. The relativity of each group of people as they realize their daily life is important. Each of their ideals shapes up their behaviour and, as shown in the presentation and analysis of the data above, this pattern of behaviour is not similar to the patterns in the other areas or sub-communities. The health-seeking behaviour is itself a function of various factors and social economic status is one of them. Social class increases options and sensitises the individual to the various options of medical behaviour that are available. And since their aim is to leave the sick role and return back to normal, the upper class with their increased choices, utilise as many modes of treatment as possible that are readily available to them.

## CHAPTER FIVE

### CONCLUSIONS AND IMPLICATIONS

#### 5.1 Conclusions

The health-seeking patterns and the factors that influence these patterns, the circumstances under which they are realised among the immigrant population of Laikipia District, was the subject of this study. The study set out to explore how the people of Laikipia District seek good health during illness. This was to help identify the alternative ways of treatment that are employed by the people of Laikipia District, and in what way the various modes of treatment function towards maintaining a healthy population in the district in the wake of the enormous increase in the cost of modern medicare. The various attitudinal differences towards western and non-western medicine have been shown as well as the factors that influence such attitudinal differences. What is clear is that there are varied differences that individuals hold towards various modes of treatment both western and traditional.

From the data presentation and analysis in Chapter Four, the role traditional and modern medicine play in the community's day-to-day affairs was shown. A sick person is not able to function positively in the community and does, therefore, strive to return to his/her normal state through well defined and accepted means and both traditional and modern medicine function toward achieving this. Traditional medicine has as much a role to play as modern medicine this concurs with the theory of functionalism (Malinowski 1961). The role traditional medicine plays, as has been shown, is paramount. It is used for treating a variety of diseases that occur in Laikipia District. Due to factors like cost and inaccessibility to modern medicine, traditional medicine has become very useful, indeed, to a majority of the population.

However, the way the use of traditional medicine and modern medicine are realised is very different among the various sub-communities. Each of the areas consists of members who are drawn together by a common goal of acquiring land. For example in Burguret area, people occasionally have a dominant characteristic which might, on the whole, influence their behaviour. This makes their health behaviour to be quite distinct from the other sub-communities. Burguret area consist of a mainly "saved" population and thus its level of belief and practice of

is level of belief and practice of traditional medicine is varied from the rest of the other three areas that were included in this study. The people living in each of the areas have varying ways of handling their health problems such that the level with which traditional medicine is utilised in area A is different from the way it is utilised in area B.

The results do show that the more close a health facility is the more frequently it is used. The dispensary, which is close to area B respondents, is utilised by a majority of the people in this than the proportion of area A respondents who utilise dispensaries. However, where a health institution is of vital importance, like the hospital, more respondents will use it despite the long distances that they have to cover in order to reach it. The disparity in the use of a hospital and a private clinic, which are both far to a majority of the population, is due to the fact that private clinics are expensive and, thus, are out of reach of the average person.

Among the factors influencing accessibility are the cost, the type of treatment that is received and the manner with which it is delivered. More respondents would, therefore, value the capability of treatment being able to achieve results within a limited time and budget. Less cost and high recovery, is their motto. Cost determines how accessible any single health care delivery method is to the population. The introduction of cost sharing does deny the respondents an opportunity of utilising the only means of health care they are able to afford. The peoples attitude toward a given health care delivery system is also greatly influenced by whether the treatment accorded does achieve recovery. And, therefore, the fact that the hospital is far but it is better equipped with more facilities than the dispensary, more people will tend to use the hospital.

The results indicate that more people resort to traditional medicine for treating those ailments which are perceived to be best treated by traditional means and even the other diseases that can be treated by modern medicine. This is due to the strong belief that people have in the effectiveness of traditional medicine. The role played by traditional medicine was shown to be enormous. The role of traditional medicine is of paramount importance in dealing with diseases like malaria which is on the increase despite the concerted efforts to eradicate it. This pointed out the need to emphasize on preventive and not curative measures when dealing with

The type of disease one is afflicted with influences to a great deal the type of action that one is likely to take to combat it and does, on the whole, influence the use of health care services (Koos 1954). There are those diseases that are best cured by traditional medicine like malaria whereas most accidents would be referred for medical treatment in a hospital. Whatever the disease, there is a higher tendency to resort to traditional medicine in combating those diseases whose cause is of a supernatural nature. These are diseases whose cause is not readily deciphered and the people who directly resort to traditional medicine are mainly those who are satisfied that the cause is of a supernatural nature.

Going by the trend in the preferred mode of treatment when afflicted with the various diseases, each disease prompts a different chain of reaction. However, it is not uncommon that two different diseases will prompt the same cause of action from the respondents, or the same diseases two different courses of action.

The results did render support to the hypothesis that the type of disease one is afflicted with influences the type of action that is taken to combat it. As shown in the study, there are those diseases which will primarily be referred to the dispensary or the hospital and there are those diseases where many of the people will resort to traditional medicine. On the other hand, there are those diseases such as common colds which people will treat at home. For these sources of treatment a variety of measures exist and are utilised. This study did also show that the level with which the communities living in areas A and B make choices about the type of disease to take to a modern health institution, or traditional medical specialist or just deal with at home is varied between the sub-communities. Each sub-community has its own unique features that shape the way medicine is sought

In the third hypothesis, the role religion plays in influencing the health seeking behaviour of the people of Laikipia is hypothesised. The evidence in support of this hypothesis was enormous. First, it was revealed that the denomination one belongs to does influence one's likely course of action during sickness. Variations in attitudes towards various modes of treatment does vary between Catholics and the rest of the denominations. The majority of the respondents are Catholics. It was revealed that Catholics use modern health facilities more

frequently than the members of the other denominations while less Catholics use over the counter drugs compared to the non-Catholics. Also there is a higher tendency to seek treatment among the Catholics than the non-Catholics and to achieve this all the means that are at their disposal are utilised. More Catholics will, therefore, use traditional medicine to combat those disease that pose a greater risk like malaria than Upper Respiratory Tract Infection

The mere fact that one frequents one's place of worship does not imply that one will actually frequent the modern health facility more often. However, a high frequency of visits to modern health institutions corresponds to high religious devoutness. Persons who are highly devoted are more likely to frequent the dispensary than those who are not devoted. For example, it was shown that the various sub-communities that were studied have a varied level of religious devoutness. More people who are highly devoted are concentrated in Burguret. The results of the study did indicate that the higher the religious devoutness the lower the likelihood of using traditional medicine. And thus an area like Burguret where most of the respondents are highly devoted less of the respondents use traditional medicine despite the fact that the medicines are capable of treating a number of diseases.

The results did also render support to the hypothesis that socio-economic status influences the practise of both the traditional and modern medicine. The intensity with which the respondents utilise the modern health facilities is higher in the upper class than the lower class. The proportion of informants in the lower class who use traditional medicine is higher than the same proportion in the upper class while the proportion of the middle class who use traditional medicine is lower than the upper class who use traditional medicine. However, over half of the upper class use traditional medicine which is an indication that the use of traditional medicine is rooted among all the different social economic classes. It is further revealed that the upper class have a higher belief in traditional medicine than the lower class which is an indication that while the lower class use traditional medicine because they cannot afford modern medicine this is not the overriding factor among the upper class. The upper class use traditional medicine because of its curative powers, and the trust that they have in traditional medicine. It is a way of procuring treatment that they have faith in and are not ready to let go.

Given the findings in this study the use of traditional medicine is undoubtedly growing and not decreasing. However, there are various factors, such as religion, that affect the level of usage and acceptance. And even the proper use and exploitation of the modern health facilities is hindered by cost, lack of medicine and proper facilities, and the location being too far away from the people who need them. Medical seeking behaviour, as has been shown above, is affected by accessibility, religious devotedness, social economic status and the type of disease one is suffering from. All these factors act, in one way or another, to determine at what stage a member of a community assumes the sick role and at what stage he/she leaves this role.

## **5.2 Implications and Recommendations.**

The function that any social fact might have on the whole society does not always conform to what Malinowski (1954) conceived when he studied the Trobriand islanders. But the functional importance of any social fact should be conceived with the understanding that societies change as they develop. The members of these societies, however, still, on the whole, continue to conform to the community's values and norms. This study, apart from showing the various modes of treatment that are utilised by the people of Laikipia, both modern and traditional, also hoped to avail information and recommendations to policy makers and academicians. This information will help them improve health care delivery in the rural area at a time when the basic health costs have greatly increased while the quality of health care has slumped to very low levels. It is hoped the following recommendations will go a long way in achieving this.

- (i) Traditional medicine is used in its varied forms in Laikipia District. However, the most common form is herbal remedies whose knowledge is mastered by herbalists but universally known to the people. The use of traditional medicine is not decreasing but increasing. There is, therefore, a need to realistically approach traditional medicine so as to not only promote it but to enable it contribute to health care. The vast knowledge that exists in the sphere of traditional medicine should be exploited to promote the integration of proven valuable knowledge and skills in traditional medicine into western medicine.



- (ii) The various modern health facilities that exist within Laikipia District are exploited variedly. The private clinics are the least utilised due to the cost factor. However, the dispensary is frequented by a majority of the respondents, although, lack of medicine, health facilities and experienced staff continue to hamper the effective use of the various health facilities that exist within the district. There is a need to improve the health facilities and also to improve the medicine available in the modern health institutions. Of paramount importance, however, is to increase the personnel at health centres since good medicine and facilities if not properly utilised may be ineffective.
- (iii) Health seeking behaviour is dynamic and is affected by the type of disease one is suffering from, the accessibility of the modern health facilities, religious devoutness and one's socio economic status. The path to health, therefore, is varied. Health workers should put this in mind when dealing with the patients during sickness. This will help in diagnosis and understanding what the patients they are dealing with really think or like about the treatment they are being given and at what stage their illness is.
- (iv) This study has shown that the modern health institutions are not readily accessible due to various factors. Cost is prime and it actually plays a very crucial role in determining the use and non-use of modern health practices. The need to address poverty as a real issue influencing peoples health is paramount. The other major factor is distance. The presence of very few scattered health facilities is not effective in health care delivery. Therefore, There is a need to increase the number of health facilities to the people of Laikipia in order to reduce the distance the people have to trek to the nearest source of treatment.
- (v) Since this study aimed at allowing the people of Laikipia to prioritise their needs, the respondents own views as to the measures the government should take to improve their health was taken into account. Table 5.1 below summarises their suggestions. One distinct aspect is the variability between the recommendations of area A and area B

**Table 5.1: Respondents recommendations as to the action the government should take to improve their health**

Action	Area A	Area B	Total Sample
More Medicine at dispensary	(22.6)19	(24.1)19	(23.3)38
In-patient facility	(3.6)3	(55.7)44	(28.8)47
Construct dispensary	(57.5)50	(2.5)2	(31.9)52
Telephone & Electricity	(1.2)1	(0.0)0	(0.6)1
Increase quality staff	(2.4)2	(1.3)1	(1.8)3
Introduce family planning	(1.2)1	(0.0)0	(0.6)1
None	(9.5)8	(16.5)13	(12.8)21
Total	(100.0)84	(100.0)79	(100.0)163

Note: The percentages are in parentheses

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APPENDIX `1`  
QUESTIONNAIRE

INTRODUCTION

SAMPLE HOUSE HOLD

PLOT NO: ..... DATE: .....

NAME: ..... DURATION: .....

FAMILY TREE

PART 1:RANGE OF FACILITIES

1. What is the closest health facility to you? .....

2. Apart from 1 above what other health facilities are there within Laikipia District?

(i) .....

(ii) .....

iii) .....

(iv) .....

3. Have you ever visited any of the above?

(a) Yes

(b) No

4. If you have, what forms of medicines did you receive?

(a) .....

(b) .....

(c) .....

(d) .....



5. Apart from hospitals and clinics where else do you get your medicines?

- (a) .....
- (b) .....
- (c) .....
- (d) .....

6. What kind of traditional health practitioner(s) do you know?

- (i) .....
- (ii) .....
- iii) .....
- (iv) .....
- (v) .....

7. What forms of traditional medicines do you know?

- (i) .....
- (ii) .....
- iii) .....
- (iv) .....
- (v) .....

**PART II:USE OF THE HEALTH FACILITIES**

8. How many times have you visited any of the following the last year?

- (i) Clinic .....
- (ii) Hospital .....
- iii) Mobile clinic .....
- (iv) Dispensary .....

10. How do you rate the kind of treatment you received in 9 above?

	(i)	(ii)	(iii)	(iv)
(a) Very good	.....	.....	.....	.....
(b) Satisfactory	.....	.....	.....	.....
(c) Bad	.....	.....	.....	.....
(d) V/bad	.....	.....	.....	.....
(e) No comment	.....	.....	.....	.....

11. How far would you say the following are to you?

	V/FAR	FAR	NEAR	V/NEAR	UNKNOWN
(a) Clinic	1	2	3	4	5
(b) Hospital	6	7	8	9	x
(c) Shop	1	2	3	4	5
(d) Chemist	6	7	8	9	x
(e) Dispensary	1	2	3	4	5
(f) Herbalist					
(Daktari wa miti)	6	7	8	9	x
(g) Medicineman					
(Mundu Mugo)	1	2	3	4	5
(h) Circumciser					
(Muruithia)	6	7	8	9	x
(i) Uvula Specialist					
(Mundu wa Kirimi)	1	2	3	4	5

12. When is the last time you visited a traditional specialist?

13. Please tell us something about him. His name, where he stays and what diseases he is good at treating.

.....  
 .....

14. When was the last time you or a member of your family had a serious illness?  
.....  
.....  
.....

(NB - if the respondent has never had a serious illness ask Q15 otherwise skip to Q16).

15. When is the last time you had a slight illness? .....  
.....  
.....

16. What type of disease were you suffering from? .....  
.....  
.....

17. Why do you think you became very sick? .....  
.....  
.....

18. What action did you take. Describe briefly .....  
.....  
.....  
.....  
.....

19. If you were infected with any of the following diseases, which health specialist, both western and Non-Western are you most likely to visit.

(i) U.R.T.I .....  
.....

(ii) Diarrhoea .....  
.....

(iii) Worm infection .....  
.....

- (iv) Malaria .....
- (v) Skin diseases .....
- (vi) Eye diseases .....
- (vii) Accidents .....

20. Would you say that there are some specific diseases which are best treated by traditional medical practitioners?

- (a) Yes
- (b) No

21. If yes, which are they, and why do you think so? .....

.....

.....

.....

22. Which diseases would you not bother going to a health centre or a traditional practitioner?

- (i) .....
- (ii) .....
- (iii).....

23. What remedies do you employ? .....

.....

.....

**PART III: RESPONDENTS SES AND FINAL EVALUATION**

24. How many heads of cattle do you have? .....

.....

.....

25. How many sheep and goats do you have? .....

.....

26. Do you own any of these?

- (a) Radio
- (b) T.V. and Video
- (c) Bicycle
- (d) Oxen Plough
- (e) Tractor
- (f) Mabati House
- (g) Stone House

27. Highest level of education achieved

- (a) Primary
- (b) Secondary
- (c) Certificate and Diploma College
- (d) University
- (e) Never went to school

28. Did you go to church last sunday?

- (a) Yes
- (b) No

29. When were you baptized? .....
30. If baptized when were you last in church? .....
- .....
31. Which denomination do you belong to? .....
- .....

32. Do you think it would be a good or bad idea for the government to do any of the following?

- |     |   |   |   |   |
|-----|---|---|---|---|
| (a) | Give licences to traditional practitioners to operate legally   | 1 | 2 | 3 |
| (b) | Introduce both western and traditional medicine in health clinic  | 4 | 5 | 6 |
| (c) | Allow traditional medical practitioners to practise on their own bases independently without interference | 7 | 8 | 9 |
| (d) | Launch a campaign to discourage the use of traditional medicine in any form                               | 0 | A | B |

33. Briefly describe what other action the government should take to enhance the health status of the people in this location.

(a) .....

.....

.....

.....

(b) Don't know.

(c) Satisfied with the government's efforts.

34. If you have anything else you would like us to know tell us now.

.....  
.....  
.....

APPENDIX II

KIKUYU NAME	SCIENTIFIC NAME	FORM TAKEN	DISEASES
1. Kererwa	<i>Croton dichogamuc</i>	stems	Stomachache
2. Kiruma	<i>Aloe Lateritia</i>	leaves	Burns, Boils, and wounds
3. Mubau	<i>Eucalyptus globulus</i>	leaves, barks	Malaria, Pneumonia
4. Muchuthi	<i>Caesalpinia volkensii</i>	leaves, fruits	Malaria, syphilis, sore throat
5. Mugayangandu	<i>Clematis hirsata</i>	leaves	Gonorrhoea, syphilis, sore throat
6. Mugegeni	<i>Tragia brevipes</i>	roots, leaves	As apurgative, labour pains, rheumatism
7. Mugere	<i>Hibiscus fuscus</i>	bark	Prolonged menstruation, pregnancy, child birth
8. Mugumo	<i>Ficus thonningii</i>	bark	Liver problems, diarrhoea
9. Muheheti	<i>Pistacia Aethiopica</i>	roots, bark	Liver problems
10. Muhinga	<i>Microglossa pyrifolia</i>	leaves	limb fractures
11. Muhoko	<i>Phytolacca dodecandra</i>	roots	epilepsy
12. Muhuti	<i>Erythrina abyssinica</i>	roots, bark	liver problems, elephantiasis
13. Muirungu	<i>Catha edulis</i>	bark, roots, leaves	Malaria, coughs, influenza, gonorrhoea
14. Mujugairia	<i>Clerodendrum myricoides</i>	roots	prolonged menstruation, childbirth
15. Mukawa	<i>Carisa edulis</i>	roots	chest, indigestion, lower abdominal pains
16. Mukinduri	<i>Croton megalocarpus</i>	bark	severe colds, pneumonia
17. Mukuriundu	<i>Maerua Triphila</i>	roots	Rheumatism
18. Mukuyu	<i>Ficus sycomorus</i>	bark	liver problems, diarrhoea, dysentery
19. Muratina	<i>Kigelia africana</i>	fruit, seeds, bark, leaves	Measles, Headache, Malaria, to enlarge sexual organs
20. Murema	<i>Piliostigma thonningii</i>	leaves, bark	stomach pains, snake bites, coughs, colds



21. Mururue	<i>Toddalia asiatica</i>	roots, leaves	malaria, pneumonia
22. Murute	<i>Erlangea cordifolia</i>	roots, leaves	sore eyes, as anaesthetic
23. Mutarakwa	<i>Juniperus procera</i>	young twigs & buds	intestinal worms
24. Mutati	<i>Polyscias kikuyuensis</i>	stems	malaria
25. Mutero	<i>Olae europaea</i>	stems	backache, painful joints
26. Muteta	<i>Strychnos henningsii</i>	bark, roots	Rheumatism, backache
27. Muthaiti	<i>Ocotea usambarensis</i>	bark	stomachache
28. Muthiga	<i>Warbugia ugandensis</i>	bark	diarrhoea, chest pain, malaria, pneumonia, fevers, toothache
29. Muthigio	<i>Rhus vulgaris</i>	fruits, stems, root, leaves	diarrhoea, wounds, gonorrhoea, Haemorrhoids
30. Muthiriti	<i>Lippia javanica</i>	leaves	stomachache
31. Muthuthi	<i>Maytenus obscura</i>	leaves	Internal injuries, cancer or tumours
32. Mutongu	<i>Solanum incanum</i>	roots, leaves	Abdominal pains, toothache, snakebite, earache
33. Mutuumo	<i>Schrebera alata</i>	bark	Toothache
34. Mwarubaine	<i>Azadirachta indica</i>	leaves, barks	malaria plus many other ailments
35. Mwenu	<i>Cassia spectabilis</i>	leaves	stomachache
36. Njeri wa gana	<i>Ajuga remota</i>	leaves	malaria, pneumonia, stomachache, liver
37. Njogu ya iria	<i>Sphaeranthus suaveolens</i>	leaves, stem	menstruation, childbirth
38. Watha	<i>Synaderium compactum</i>	latex	swollen glands

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