

HEALTH SEEKING BEHAVIOUR IN A RURAL  
SETTING:  
THE CASE OF UKWALA DIVISION IN SIAYA  
DISTRICT.

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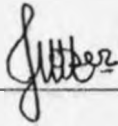
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OCTOBER 1990

**DECLARATION**

This thesis is my original work and has not been presented for a degree in any other university.



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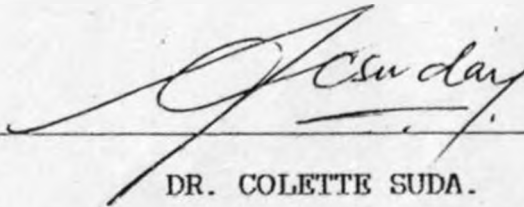


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TO THE MEMORY OF MY GRAND PARENTS OKENDO AND SULWE, WHO DESERVED  
SOMETHING BETTER.

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## A B S T R A C T

Of late there has been a growing interest in understanding the social aspect of medicine. Research is being conducted in this area in an attempt to understand how social and cultural factors affect the health of people. This study is an attempt to identify possible socio-cultural factors related to the health seeking behaviour among the people of Ukwala in Siaya District.

Analysis of the findings indicate that a number of factors influence the choice of therapeutic options. These factors include the perceived etiology of the disease in question which is hereby classified into two broad categories, namely, the natural and supernatural realms. Diseases which fall under the natural realm are mostly seen to be treated by modern medicine while those under the supernatural realm are seen to be delegated to the area of traditional and faith healing. Together with these are the herbal remedies and non-prescribed patent medicine which are self administered. The domains of these forms of therapy often overlap, especially when the first mode, based on an etiological concept, fails to provide satisfactory results. This occurs mainly where chronic diseases are concerned.

A model hierarchy of decision-making in healthcare is seen to be non-existent. What pertains are individual or 'lay group' and situational decision-making hierarchies which are ever changing. The decision making steps appear to supercede though they are actually linked to economic considerations. Other factors include the way the symptoms of the disease in question are interpreted, level of education and general awareness.

A major conclusion of the study is that traditional healing like faith healing is to some extent, based on faith. Both systems have become part of the Luo culture although unlike traditional healing, Christian faith healing is an adaption of traditional thought to the religious plane. A kind of ideological transformation has taken place such that christians can still believe in mystical forces but in a different context from the secular ones. Whereas people traditionally talked of evil spirits in witchcraft therapies, christians talk of revelation by Angels in a christian social therapy of spirit exorcism. In the final analysis, traditional and faith healing are both seen to be more effective in dealing with psychosomatic diseases because of their focus on the "whole person" rather than specific symptoms.

## CHAPTER ONE

### INTRODUCTION:

Disease is a universal phenomenon which was rife in this planet before man came into existence, and it has continued ever since. Disease affects all people every where, but not always to the same degree or in the same way. Because diseases are neither uniform nor random in their occurrence, they are usually observed to be more or less common among various social groupings. consequently the study of this differential distribution of diseases in terms of our knowledge of the social structure and the different life styles it imposes on people frequently provides clues about the nature and causes of disease. People view the event of disease from the perspectives of their particular culture and hence they tend to respond to diseases in predictable ways. Arrays of institutions are therefore developed by the people to treat diseases which appear in their group.

In the preamble to the constitution of the World Health Organization [WHO 1963] health is defined as:

*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity [Ibid pp 1].*

Dubos [1977] argues that health so defined is utopian state. He perceives health from what he considers a practical point of view as:

*a modus vivendi enabling imperfect men to achieve a rewarding and not too painful existence while they cope with an imperfect world... [Ibid pp 31]*

From this perspective, it appears that it is very difficult for one to be in a state of total health. The definition of the negation of health, disease, further complicates the issue. The term disease, which means "not being at ease", encompasses so many different kinds of disturbances. There are so many states which can make a person not feel at ease and lead one to seek the aid of a specialist. Generally, especially among the lay public, disease implies some serious organic or psychic malady such as tuberculosis or mental illness. The concept of disease is being broadened by modern medicine to refer to any state, real or imaginary that disturbs a person's sense of well-being. In this sense disease may threaten life or simply interfere with its enjoyment; it may prevent the sick person from functioning as a normal human being or simply from reaching his self selected goals.

#### Social aspects of ill health.

The study of the ill human being assumes that each individual lives with both the symptoms and the consequences of disease in its physical, mental, medical and social aspects, While attempting to alleviate disease, the ill become involved in a variety of specific or non specific internal and external problem solving processes. The social aspect of illness like the physical, mental and medical aspects, represents a time sequence. Many times during the course of illness, medical and social decisions must be made; roles must be re-adjusted, and attitudes changed to conform to the reality of the situation. Medical sociologists have coined the term "illness

behaviour" to describe the actions which are manifested in the sequence. They have further developed role models-the "sick role" and the "patient role" to aid them in their analyses.

Illness behaviour has been defined as:

*The way in which symptoms are perceived, evaluated and acted upon by a person who recognises some pain, discomfort or other sign of malfunction [Mechanic and Volkhart 1961: 52].*

Illness behaviour may occur independent of patient roles and sick roles. A person who wakes up with a sore throat engages in illness behaviour in that he has to decide whether to take a pain killer and hope for the best or consult a specialist. However, this is not a sick role behaviour; it is only when illness is defined as sufficiently serious to remove a person from his normal role, thus altering and placing extra demands on the role behaviour of those around him, that a person assumes the sick role.

*When behaviour related to illness is organised into a social role, the sick role becomes a meaningful mode of reacting to and coping with the existence and potential hazards of sickness by a society [Jaco, 1972:93].*

The concept of patient role is more restricted than that of sick role. If a person with a sore throat decides to spend the day resting in bed with the expectation that other family members will look after him, the sick role has been assumed. But it is only if a specialist is consulted and the individual acts on his instruction that the patient role comes into being. The patient role is thus an extension of the sick role. The larger society can validate the sick role whereas the therapeutic and organisational setting in which the sick person obtains care and treatment sets up

a criterion for his role as patient in that social system.

Illness behaviour and the sick and patient roles are strongly influenced by factors such as social class and ethnic and cultural differences. Consequently, the same health threat (clinically defined) may, depending on these variables, produce widely differing reactions among patients.

Most of us prefer health over illness. Yet the uncritical acceptance of this assumption blinds us to some of the most vital aspects of health behaviour. Like other desired things in life, good health takes its place in every ones personal priority scale. For some, it is near the top, for others it is further down the scale. In other words few if any people want good health at all costs and particularly if enjoyment of good health may seriously curtail other aspirations. It must be remembered that good health competes as a priority with all non health priorities. Hence individual health behaviour can be understood only in its wider context of life goals.

#### Corrective measures:

The concept of health among the Luo in siaya is that of complete well being. Traditionally, illness or disease was attributed to various sources depending on their duration and severity. For example, a case of illness was expected to respond to treatment within a reasonable span of time, and severe cases were cause for concern and speculation as far as their etiologies were concerned. The more severe and prolonged illness were and are still

attributed to "Chira"(taboo) or even spirits "chien". Epidemic or transmissible diseases were recognised as transmissible but because of their rapid spread and being cause of many deaths, they were attributed to moving spirits or curse. Some diseases were thought to come from bad weather water, food, etc. Others were thought to be contracted from animals, especially poultry, dogs or cats.

Today there is knowledge about causes of certain diseases. For example, malaria is known to be caused by mosquitoes while diarrhoea is recognised as a water-borne disease. However, if these diseases occur in unusually large epidemics, then they are attributed to spirits. The treatment of some diseases is a household knowledge which is available to every mother. If the illness becomes difficult to control, a traditional healer is consulted. The healer usually comes to treat within the home. As far as abdominal disorders, diarrhoea and vomiting are concerned, there is still widespread belief in *the evil eye*.

#### PROBLEM STATEMENT:

Health problems in the developing countries have generally been attributed to poverty and ignorance, among other factors. The former is especially evident in the rural areas where traditional health care is most widespread and quite often the only form of health care which is accessible. In some areas there is an alternative form of healthcare in religious healing. Some religious sects have large followings and advocate for faith healing as a priority. This is more so in syncretic religions such

as the Akorino in Central Province and Legio Maria in Siaya District.

According to Foster [1976] in the non-western medical systems, the kinds of curers, the mode of diagnosis, curing techniques, etc. derive from beliefs about illness causality. However, this argument cannot explain the use of multiple therapy or *healer shopping* evident in Siaya. A variety of therapeutic options are open to the people and can all be resorted to at different points on the same case of illness. The range includes:

- i) Self-treatment with herbs,
- ii) Self-treatment with patent medicine easily obtained over the counter,
- iii) Traditional healing,
- iv) Modern medicine,
- v) Faith healing: This is an aspect of health seeking behaviour which has not been given due attention as one of the alternatives in plural medical systems which exist in Kenya. Some religious sects which practise faith healing have been known to preach against the use of any other form of treatment for their members. Siaya District is an example of a locality where faith healing exists side by side with traditional medicine and modern medicine.

There appears to be a possible hierarchy of decision-making processes in health care through which decisions are made as to



which alternative is to be used when a member of the group falls ill, depending on the situation at hand. Other intervening factors include economic [financial] status, accessibility of health care facilities and perception of the seriousness of the condition.

Several studies [Zborowski 1952; Koos 1960; Zola 1966] have established that there are differences in the perception and interpretation of symptoms across cultures. This is a function of variant environmental and cultural factors but essentially the dangers posed by disease to an organism are uniform. It is probable that as people go through the process of decision making, some disease states are likely to be overlooked and ignored. This is possibly judged by considering the extent to which symptoms of a particular state disrupts family work and other social activities. These reasons call for more knowledge of the social and psychological factors which help determine the hierarchy of decision making in therapeutic choice.

#### OBJECTIVES OF THE STUDY

The major research objectives are:

1. To examine the range of therapeutic options open to people in Siaya District.
2. To determine the distribution of therapy preference within the community and reasons behind these preferences.
3. Identify the variables that underlie decision making process in therapeutic choice.

4. Determine the possible range of aberrations which are widespread in the area and hence become perceived as normal or *asymptomatic*.

#### SIGNIFICANCE OF THE STUDY:

The general health status of people in Siaya is at the moment poor. Using basic health population statistics, Siaya has one of the highest infant mortality rates in Kenya. The death rate for children under two years of age is 211 out of every 1,000 [District Socio-cultural Profile 1987]. There are only 47 Medical and Health-care institutions within the district to cater for a population of 474,516 people. This situation could lead to the emergence of certain characteristics in the health seeking behaviour of the people which would be worth knowing. Considering that there is a wide range of therapeutic options to choose from, people make different choices all the time. In the process of shifting from one alternative to the next, the impact of the illness is greatly increased. An understanding of the factors which affect therapy preference in the rural areas and their implications provides information which can be used by policy makers to design appropriate structures which will be in line with the actual needs of the people. Once the reasons for preference have been understood, it is possible to point out the health problems that are ignored as "normal states" in the process of decision making. Any condition that causes disturbance to the body however minor, weakens it and even if it does not have serious consequences in the

short run, it could make the body vulnerable to other maladies which can have fatal consequences.

An examination of the range of therapeutic options also helps determine their attractiveness in terms of their benefits to the recipients. The different forms of therapy serve different functions in maintaining the health of people. It is therefore enlightening to know how they function and the merits and demerits of their contributions to the general health status of people.

The need to understand peoples knowledge, attitudes and practices in relation to aspects of the health seeking process is not merely of academic interest, but can be seen as relevant questions of social policy and can assist the state in designing appropriate programmes to elevate the health status of the rural population.

## CHAPTER TWO

### LITERATURE REVIEW AND THEORETICAL FRAMEWORK

Literature on health seeking behaviour indicates that the perception of illness and disease varies and cannot be determined by any general criteria. Several studies have shown that people have their own views and beliefs about disease and illness which seem to determine the action to be taken in the event of an illness [Thomas 1970; Kennedy 1973; Staiano 1981]. Specific cultural idioms determine the classification of diseases, the cause, the weight of their seriousness, the type of treatment required and the healer to be consulted [Reed 1966]. For example, it has been reported that among the Egyptian peasants bilharziasis and other parasitic infections that weaken an individual but do not cause overt pain are not attended [ibid]. While many of these symptoms people experience are recognized as indicating disease process, it is not necessarily the case that treatment is sought. There is an indication to the fact that what, when and if action to resolve any problem is undertaken often depends upon a number of factors. [Zola 1973] has looked at the timing of decisions to seek medical care. He found that most people tolerated their symptoms for quite a time before they went to a doctor and that the symptoms themselves were not sufficient to precipitate a consultation; something else had to happen to bring this about. He identified five types of *triggers*

- (i) The occurrence of an interpersonal crisis (eg, death in the family).

- (ii) Perceived interference with social or personal relations.
- (iii) Sanctioning pressure from others to consult.
- (iv) A kind of *temporalizing of symptomatology*, the setting of a deadline [ eg if I feel the same on Tuesday", "if I have another turn.....][1973: 679]

The decision to seek medical care is then very much bound up with the individuals' personal and social circumstances. Zola also found that when a doctor paid insufficient attention to the specific trigger which prompted the individual to seek help, there was a greater chance that the patient would eventually break off treatment.

Epson [1978] carried out an investigation of the health status of a sample of adults using a mobile health clinic. Of the 1360 people investigated, 57 per cent were referred to their general practitioners for further tests and possible treatment. A follow up study of those referred to their general practitioners indicated that 38 per cent of the findings that had not previously been known to the general practitioners for the first time were judged serious enough to warrant hospital referrals. This study was an indication that a clinical iceberg exists: The professional health services treat only the tip of the sum total of ill health, with the result that many people, adults and children alike, are enduring avoidable pain, discomfort and handicap. As a result of various social and psychological factors only *untypical* cases are presented for diagnosis and treatment. For instance, it was discovered with some surprise that a considerable proportion of the population outside the consulting room manifested the signs of high

blood pressure without any complaint or ill effect [Friedson 1970].

Foster [1976] observes that non-western medical systems possessed two categories of disease causation, personalistic and naturalistic. Correlated with the personalistic category is the belief that diseases are due to the active purposeful intervention of an agent who may be human, that is, witch or sorcerer, non human, that is ghost, spirits or ancestors or a deity. Diseases under this category include uncommon conditions which members of the community cannot comprehend or explain, such as conditions that lead to deriliams, malignant growth and elephantiasis. Under the naturalistic category, diseases are believed to stem from such natural forces or conditions as colds, heat, winds and dampness. These diseases include everyday complaints such as the diseases of children , common cold, diseases of the aged and expectant mothers.

### Disease classification systems

In other parts of the world there are examples of disease classification systems which have been in existence for a long time. Some examples are: humoral pathology (found today in Latin America), Ayuverdic medicine (found in India and adjacent countries), and traditional chinese medicine. Humoral pathology is based on the concept of bodily *humors*. Its roots are found in the Greek theory of the four elements (earth, water, air and fire). This theory has been augmented by the parallel concept of four qualities - hot, cold, dry, moist - which, when integrated with the

original theory, produced the concept of the four *humors* with their associated qualities: blood (hot and moist), phlegm (cold and moist), black bile, also called *melancholy* (cold and dry), and yellow bile, or *cholera* (hot and dry). In contemporary Latin American humoral pathology, illness is ascribed to invasion of the body by excessive heat or cold. In this theory illnesses believed to have hot causes are treated with cold herbal remedies and foods and with cold treatments (such as some kinds of skin plasters). Illnesses believed to come from cold causes are treated with hot herbal remedies and foods and hot treatments (such as mustard plasters and cupping). Most remedies are mixtures of a number of elements in which a hot or cold balance predominate [Foster and Anderson 1978].

According to Ayurvedic theory, the universe is composed of the same four elements recognized by the Greeks (earth, water, fire, air), plus a fifth, ether. The arrangement of these elements in the body, each of which possesses five *subtle* and five *material* forms, is a microcosm of the universe. The human body also has three humors or dosha: Phlegm, or mucus; bile, or gall; and wind, or flatulence. Good health exists when the three dosha are in equilibrium; ill health manifests itself when one or more of the dosha are not functioning properly. [ibid 1978]

Traditional Chinese medicine represents a special case of the central concept of Chinese cosmology,

*the dual forces of Yin and Yang, whose continuous interaction lies behind all natural phenomena, including the constitution and functioning of the human body* [Croizier, 1968:17].

The proper balance within the body of Yin and Yang is essential for good health. Since Yin and Yang are thought to be the primordial elements from which the universe evolved, they are endowed with innumerable qualities. Their earliest meanings - cloudy and sunny - have been expanded to produce a philosophical duality that can accommodate almost any concept. Thus, Yang represents heaven, sun, fire, heat dryness, light, the male principle, the exterior, the right side, life, high, noble, good, beautiful, virtue, order, joy, wealth - all positive elements. Yin represents the opposite: earth, moon, water, cold, dampness, darkness, the female principle, the interior, the left side, death, low, ignoble, bad, ugly, vice, confusion and poverty - all the negative elements. Because of its heat, excessive Yang causes fever; because of its coldness, excessive Yin produces chills. Diseases believed to be caused by external forces are Yang diseases while those believed to be caused by internal forces are Yin diseases. Yet Yin and Yang have always been conceived of as a single entity combining, in any being or situation, both positive and negative elements.

### Socio-medical health care research in developing countries

Most of the socio-medical health care research in developing countries has addressed the question of how people enter the sick-role and make choices regarding the use or non-use of different kinds of health services [Kroeger 1983]. In transitional societies of the developing world, the network of integrating explanatory



variables for the use of health services seems to be complex. This complexity is brought about by the fact that there exists a wide range of health services which are different in quality. Kroeger [1983] has identified two main categories of models which have been used by researchers in an attempt to order the mass of possible interacting variables.

### Models of socio medical health care research in developing countries

1. Pathway models: These describe different steps in decision-making in the process of illness behaviour
2. Determinants models: Focus on a set of explanatory variables which are associated with the choice of different forms of health services.

### Pathway models

Suchman [1965] described the stages of illness experience. According to this scholar, when individuals perceive themselves becoming sick they can pass through as many as five different response stages, depending on their interpretation of their particular illness. These stages are:

1. Symptom experience,
2. Assumption of the sick role,
3. Medical care contact,
4. The dependent patient role,
5. Recovery and rehabilitation.

Illness experience begins with the symptoms stage in which the individual is confronted with a decision about whether or not something is wrong. The decision of the person involved may be to deny the symptoms as not needing attention, to delay making a decision until the symptoms are more obvious, or to accept the symptoms as evidence of a health disorder. If the decision is made to accept the symptoms experience as indicative of an illness, the person is likely to enter the sick role. Here the person is allowed to relinquish normal social obligations provided permission is obtained from the persons lay referral system. This includes members of the family, friends and neighbours with whom the sick person interacts on a daily basis, ie, the social network.

If professional assistance is sought, the person enters the third stage of medical care contact. At this stage the person attempts to obtain legitimation of his or her sick role status and negotiate the treatment procedure. If both the patient and practitioner agree that treatment is necessary the person passes into the dependent patient stage. Here the person undergoes the prescribed treatment, but still has the option to either terminate or continue the treatment. Others who have described the different steps in the process of illness behaviour are Fabrega [1972], who described nine stages from *illness recognition* to *set up for recycling*. He stressed the importance of different illness concepts and medical orientations in non western cultures. Geertsen R. [1975] found social norms and ethnic ties to be important as well as past medical experiences and individual orientations. Chrisman [1977]

identified the following components of health seeking: *symptoms definitions, illness related shift in role behaviour, lay consultation and referral, treatment actions and adherence*. In his framework the integration of cultural and social factors plays an important role. Igun [1979] demarcated ten stages from *symptom experience to recovery and rehabilitation*.

### Determinants models

Ludwig and Gibson [1969] stated that recognition and significance attached to symptoms, degree of difficulty in seeking care and faith in medical care system determine utilization of services. Unschuld [1975] held economic factors, communication gaps and structural conceptual differences as being important for health seeking behaviour.

Zola [1966], upon surveying many cross cultural comparisons of morbidity, concluded that there are at least two ways in which signs ordinarily defined as indicating problems in one population may be ignored in others. The first is related to the actual prevalence of the sign and the second is its congruence with dominant or major value orientations. In the first instance, when the aberration is fairly widespread, this in itself might constitute a reason for its not being considered symptomatic or unusual. This condition is perceived as the normal state. This, however, does not mean that it is considered good but rather that it is natural and inevitable and thus to be ignored as being of no consequence. Koos [1960:13] reports of a housewife respondent who

said:

*There's a lot of these things I know you're supposed to do something about, but there's a lot of reasons why you don't, I'd look silly, wouldn't I, going to see a doctor for a backache. My mother always had a backache, as long as I can remember, and didn't do anything about it. It didn't kill her either... if I went to the doctor for that my friends would hoot me out of town. That's just something you have, I guess why let it get you down? [1960:13].*

In the second process it is the fit of certain signs with societies' major values which accounts for the degree of attention they receive. In this case the extent to which the symptoms are perceived as serious or dangerous and the extent to which symptoms disrupt family work and other social activities will be taken into account. Foster and Anderson [1978] distinguish between disease, a pathological concept and illness a cultural concept. Illness is culturally defined and human diseases become socially significant only when they are identified as illness, a physiological malfunctioning that is seen to threaten the individual and his society.

### Factors influencing health seeking behaviour

A number of variables have been related to health seeking behaviour of people in non-western societies. They include ethnicity, level of education, socio-economic status, geographical accessibility, appeal of services and characteristics of disorders.

#### Ethnicity:

Several studies have attempted to relate a person's utilization of

health care services to his or her cultural background. Suchman [1965] studied the extent of belief in and acceptance of modern medicine among several ethnic groups in New York City. He sought to relate individual medical orientations and behaviours to specific types of social relationships and their corresponding group structures. He believed that the interplay of group relationships with an individual's personal orientation towards medicine affected his or her health seeking behaviour. Suchman felt that individual medical orientations and group structures were related in that members of cosmopolitan groups would hold scientific attitudes and parochial group members would hold popular and non-scientific beliefs. Members of parochial groups did appear to subscribe to popular beliefs about medicine instead of scientific views. Persons in a parochial group were also found to have close and exclusive relationships with family friends and members of their ethnic group. They displayed limited knowledge of disease, skepticism of medical care, and high dependency in illness. They were more likely than the cosmopolitan group to delay in seeking medical care, and more likely to rely upon a *lay referral system*. A lay referral system consists of non-professionals - family members, friends, neighbours, etc, who assist an individual in interpreting his or her symptoms and in recommending a course of action. The concept of the lay referral system originated with Eliot Freidson [1960], who described the process of seeking medical help as involving a group of potential consultants, beginning in the nuclear family and extending outwards to more

select, authoritative lay persons, until the *professional* practitioner is reached.

By contrast the cosmopolitan group demonstrated low ethnic exclusivity, less limited friendship systems, and fewer authoritarian family relationships. Additionally, they were more likely than the parochial group to know something about disease, to trust health professionals, and to be less dependent upon others while sick.

The role of cultural differences in illness behaviour was described by Zborowski [1952] who, in a study of ethnic reactions to pain in a New York City Hospital, observed that while Jewish and Italian patients responded to pain in an emotional fashion, tending to exaggerate pain experiences, *old Americans* tended to be more stoical and *objective*, and Irish more frequently denied pain. Zborowski also noted a difference in the attitude underlying Italian and Jewish concern about pain. While the Italian subjects primarily sought relief from pain and were relatively satisfied when such relief was obtained, the Jewish subjects were mainly concerned with the meaning and significance of their pain, and the consequences of pain for their future welfare. In trying to explain these cultural differences, Zborowski reports that Jewish and Italian patients related how their mothers showed over-protective and over-concerned attitudes about the child's health, and participation in sports, and how they were constantly warned of the advisability of avoiding colds, fights and other threatening situations [Mechanic 1968]. Zborowski's observations concerning

ethnic differences in illness behaviour have been supported in a variety of other studies [Croog 1961; Mechanic 1963].

### Education:

Education has been viewed as a severe means of exposure to Western culture. In Taiwan [Kleinmann 1980], Korea [Rhi 1973], Thailand [Hinderling 1973], rural Mexico [Fromm and Maccoby 1970], Tunisia [Benyoussef and Wessen 1974] and Iran [Mohsemi 1979], formal education turned villagers away from traditional healing. In rural Nigeria, however, no evidence was found that educational status influenced the pattern of utilization of health services [Ademuwagun 1975], although in urban Nigeria an influence was evident [Tumwasi 1975]. In rural Ecuador the patterns of care use varied considerably between those having received secondary education and those without education. Primary education, however, had no significant effect.

### Socio-Economic Status:

Another major approach to the study of health seeking behaviour has been in relation to socio-economic status. Until recently it was generally believed that lower-class persons tended to under utilize health services because of the financial cost and /or a subculture of poverty that failed to emphasize the importance of good health. The seminal study in this regard was Koos' [1960] "The health of Regionville". Koos conducted his study in a small community in New York where he found it possible to rank the local

residents into three distinct socio-economic classes. Class I consisted of the most successful people in town in terms of financial assets. Class II represented middle class wage earners who were the majority of citizens, while Class III represented the least skilled workers and poorest members of the community.

Class I respondents demonstrated a much higher level of recognition of the importance of symptoms than either class II or class III. Only two of the symptoms, loss of appetite and backache, were reported by less than three-fourths of class I as needing medical attention. Otherwise, almost all Class I respondents were prepared to go to a physician if a symptom appeared. For only one symptom, persistent coughing, did class I respondents not rank highest percentage wise and this difference was negligible.

Class III respondents on the other hand, showed a marked indifference to most symptoms. Seventy five percent of the lower-class respondents considered ten of the seventeen symptoms not serious enough to warrant medication. Thus, in Regionville at the time of Koos' study in the early 1950's symptoms did not necessarily lead to seeking medical treatment, especially among the lower class. In addition Class III persons were also inhibited from seeking treatment because of cost, fear and relative need as related to age and the role of the sick person. The very young, the elderly, and breadwinners were most likely to receive medical attention among the poor. Another important factor in health seeking behaviour for Class III persons was group expectations about symptoms, further suggesting the importance of the social



network.

Several studies [Bice, Eichhorn and Fox 1972; Sparer and Okada 1974] have, however, confirmed that it can no longer be assumed that low-income persons under utilize physician services. Lois Mointerio [1973] did an extensive comparison of the 1968 national health survey and a sample of Rhode Island residents. She concluded that:

- i) When an illness is present, there is an equal tendency among all income groups to see a physician.
- ii) When illness is not present, lower income residents tend to report higher physician utilization if *free* care is available; otherwise, lower income persons show about the same level of use as upper income persons who have no *free* care available.
- iii) Therefore, higher rates of demand for physicians and the availability of publicly financed care resulted in an increased use of health services by the poor.

In rural Nigeria [Gesler 1979] and in Mexico [Heller Chalfant, Queseda, Rivera-Worley 1981] higher socio-economic status was related to a higher level of effort to seek modern health care. In rural India, social class and education were positively correlated with the use of allopathic practitioners [Djurfeld and Lindberg 1975]. In urban Columbia, social classes differed in their pattern of use of care [Press 1969]. Among Puerto Ricans in New York, the rich resorted more than the poor to spiritualist temples [Garrison 1977], while in urban Argentina poor people had the highest rates

of non-consultation of physicians [Andisio O, G. Cignacco, M.A Santhua and I. Rosa 1972].

### Appeal and Acceptability of care:

This has to do with the communication between the patient and the practitioner. As in all culturally molded social interactions both patient and physician have clear ideas as to how they should behave in the therapeutic setting, and they have equally clear ideas as to how the other person should behave. When these expectations are essentially congruent, the doctor patient interview is much more apt to be mutually rewarding and therapeutically successful than when expectations are quite different. When the expectations are less congruent as when patients differ from their physicians in social class, ethnic affiliation, or cultural identification, the doctor patient relationship has been found to be less satisfying and successful [Foster and Anderson 1978].

In the western setting, the physician asks the patient a multitude of questions that aid in diagnosis, examine the patient, etc. On the contrary, in the non-western setting an important element of the curing process is the act of naming what is wrong with the patient. Naming the illness or its source implies defining, circumscribing, taming and weakening it. The anxiety of the patient is reduced because of the confidence built around the healer who is capable of knowing what is wrong. This is a very important curative process because it tends to redirect the

patient's psychic process towards a favourable curative direction. The ability to identify the offending illness activates a set of associations which may produce a relief of neurotic state by relating an experience of strong emotional character which had undergone some depression [Uyanga 1979].

A patient who comes from such a cultural background is likely to lack confidence in the western practitioner who asks questions instead of naming the disease. Even when the diagnosis has been done, certain information relevant to it or the diagnosis itself is withheld from the patient. This leaves the patient with the task of interpreting his or her ambiguous status and its projected consequences as best as he/she can. At times the doctor, while certain of the diagnosis, seems uncertain about the origin of the state, leaving the patient with an ambiguous situation which provides simultaneously for hope and frustration [Zola 1966].

#### Characteristics of disorder:

Gould [1957] studied the north Indian village of Sherupur. He distinguished between *country medicine and doctor medicine*. Gould found that folk medical practices were being employed whenever the persons complaint was classifiable as chronic non-incapacitating dysfunction. Doctors were being sought for the complaints classifiable as critical incapacitating dysfunctions, though the citizen of Sherupur was unaware of this distinction. Chronic non-incapacitating dysfunctions are conditions manifesting drawn-out periods of suffering, sometimes cyclical in character, usually not

fatal or fatal by slow degrees and only partially debilitating, thus enabling the sufferer to maintain a semblance of his daily routine. Critical incapacitating dysfunctions are ailments involving sudden and often violent onset, and rather complete debilitation with respect to some aspects of the individuals routine.

Gould concluded that the limited utility of scientific medicine leaves open a relatively permanent area of chronic non-incapacitating dysfunctions within which a primitive system of medical therapy may thrive and continue in a complementary structural position in the folk setting. Other findings have supported this assertion in rural Nigeria [Uyanga 1979], in Zambia [Frankenberg and Leeson 1976], in the Admiralty Islands [Schwartz 1969] and in Kenya [Thomas 1970].

### Faith healing

Anthropological and psychiatric research has generated a considerable body of descriptive data on the emotional impact of participation in religious ritual. These researches have pointed to the proposition that intense religious participation often has long lasting effects on emotional integration.

Glik [1986] did an exploratory comparison group study of participants in spiritual healing practices carried over a two year period [1981-1983] in Baltimore, Maryland. In the study, participation in such forms of healing, which generally occur in small groups, is related to various measures of psycho-social

wellness defined as the emic construct of *subjective health*. Interview data from regular participants in two types of healing groups. First charismatic: healing groups whose members espouse a Christian fundamentalist pentecostal or neo-pentecostal orientation healing practices observed in these groups are expressive; participants engage in singing, gross bodily movements, praying, testimonials, the laying on of hands which sometimes leads to fainting, or being *slain in the spirit* and rituals which often take place in church settings. The second was metaphysical healing groups. These espouse a universalistic *new age* or Eastern religious orientation, whose members represent the current movement known as the *new religions*. Healing practices encountered in these groups include meditation, touch healing, occasional chanting, occasional affirmations and, generally, a minimum of verbal or motor activity among participants. Members of these two groups were compared with regular utilisers of primary care using the same data collection procedures. Members of the two types of healing groups differed on some social attribute data. Members of charismatic healing groups tended to be of slightly lower socio-economic status overall than the members of metaphysical healing groups. Members of both types of healing groups, however had significantly more positive scores on wellness measures than primary care patients, even when sex, age, marital status, illness severity and religiosity were controlled statistically. Glik's findings suggest that such groups play a social support function among regular participants, and that participation in specific healing systems can be seen as a

contextual variable which has an effect on subjective self-reports of health or wellness.

Pattison M, Nikolajs A. Lapins and Hans A. Doerr [1973] did a study of 43 fundamentalist pentecostal persons who experienced 71 faith healings. The study was aimed at finding out:-

- (i) Whether there is a typical personality among those claiming faith healing.
- (ii) Why people participate in faith healing rituals
- (iii) Whether faith healing results in alternate symptom formation.
- (iv) Whether faith healing results in significant changes in the person's life style.

A sample of persons claiming faith healing experiences was sought from an area where churches were known to emphasize and practise faith healing (such as pentecostal sects, assemblies of God, etc.). Each person was interviewed following a structured format to assess:-

- (i) Life pattern prior to faith healing.
- (ii) Life pattern subsequent to faith healing.
- (iii) Medical history prior to and subsequent to faith healing.
- (iv) Perceived function of faith healing.

There was one major change noted by all respondents. They all reported that their certainty in their belief in God and in their religious convictions was markedly increased after their faith

healing experience. However it was found that faith healing does not result in alternate symptom formation nor does it produce significant changes in lifestyle. It was therefore concluded that faith healing in contemporary America is part of a continuum of magical belief system ranging from witchcraft to christian science. The psychodynamics are similar in all such systems, the variation is in the abstractness of the magical belief system. Within the framework of the assumptive world view in which faith healing subjects live, their personality structure and magical belief systems are not abnormal but are part of a coping system that provides ego integration for the individual and social integration for the sub-culture.

In Africa, Daneel [1970] observes that the overall impression which zionist faith healing as practised in Rhodesia (Zimbabwe) makes on a person, is one of a remarkable confluence of old and new; of traditional divination and a confirmations of God's sovereignty over the evil powers in a typical African way.

### Occupation and Health

Health problems have always been linked with political, social and economic conditions of particular groups of people. Observations are available from antiquity; occupation and health are connected in an Egyptian papyrus which comments on the hard life of the people. The influence of certain occupations on health was also noted by physicians and laymen in the Greco-Roman world [Freeman 1963].

In the "Republic", Plato has Socrates say:

*When a carpenter is ill he asks the physician for a rough and ready care. An emetic, a purge, or the knife that is the remedy for him. But if someone prescribes for him a course of dietetics or tells him to wrap his head up keep himself warm, he replies at once that he has no time to be ill, that he sees no good in a life that is spent in nursing his disease to the neglect of his customary employment. [Freeman: 1963 pp. 18].*

The best kind of medical care required time and circumstances favourable to such attention. Very few people, however, could afford to submit to medical care under these conditions. Indeed the writer of hippocratic work "on diet" agreed that the mass of the people:

*by necessity must lead a haphazard life and ... neglecting all cannot take care of their health. [Freeman 1963 pp. 18-19].*

Similarly, some time over five hundred years later Plutarch, in an essay on how to keep well, emphasized that he was writing for scholars and for:

*men in public life and not for men who engaged in the toilsome business of harvesting and caring for their crops [Freeman: 1963 pp. 19].*

#### THEORETICAL FRAMEWORK:

For this dissertation, the health belief model [HBM] was adopted as a frame of reference because it seemed best in explaining health behaviour. This model has also received a wide theoretical and research attention. The model was formulated by Kasl S. and S. Cobb [1966]. In this model, health behaviour is



perceived as :

*any activity undertaken by a person believing himself to be healthy for the purposes of preventing disease or detecting it in an asymptomatic stage. [Kasl S, and Cobb 1966: 246].*

The health belief model also includes illness and sick-role behaviours, where, according to Kasl and Cobb, illness behaviour includes:

*any activity undertaken by a person who feels ill, to define the state of his health and to discover suitable remedy [Kasl and Cobb]*

While the sick role behaviour is seen to include:

*Any activity undertaken by those who consider themselves ill, for the purpose of getting well. [Kasl and Cobb].*

Illness and sick-role behaviours are seen as situations where one defines oneself as having an ailment, or having it diagnosed by someone else then acts appropriately by either going for treatment or administering self treatment. According to the HBM, an individual's engagement in a particular kind of health, illness or sick role behaviour depends on certain conditions, namely, the perceived amount of threat and the attractiveness or value of the behaviour. The amount of threat further depends on other factors, namely:-

- (i) The importance of health matters to the individual.
- (ii) The perceived susceptibility and vulnerability to the disease in question.
- (iii) The perceived seriousness of the disease.

This means that for a person to define his condition as illness and

thus go for treatment, the person has to know about its seriousness and its being a threat to life. However, according to the HBM the choice of action taken to prevent oneself depends not only on whether the person knows them, but also on :-

- (i) The perceived probability that the actions will lead to desirable preventive or ameliorative results,
- (ii) and, the unpleasantness or cost of taking or not taking such action.

As such a person will only take a certain course of action if he thinks that it will help him alleviate his state of illness.

Another model which is used in this dissertation is the situational approach theory propounded by Thomas and Znaniecki [1974]. The basic assumptions of this theory which bear relevance to this study are:-

- i) The idea of what to do when faced with a crisis.
- ii) The redefinition of the situation; socialization and acquisition of new attitudes to avoid social and psychological disorganization.

The situational approach theory holds that human behaviour occurs only under certain conditions. It further holds that there is nothing to define when people act as anticipated, but that when new influences appear to disrupt existing habits, when new stimuli demand attention, when the habitual situation is altered or when a group is unprepared for an experience [e.g. disease], then the phenomenon assumes the aspect of *crisis*, where a crisis is seen as a threat, a challenge, a strain on the attention there is a call to

new action [Volkart 1951]. What may, however, appear as a crisis to the observer may go unnoticed by the participants. In this theory, *crisis* is seen as the most significant of human experiences affecting the definition of individuals and groups, their behaviour and, finally, influencing the content of culture and personality as well as direction of social change.

On the event of a *crisis* [for example, an illness] the decision to seek medical attention and who to consult may well depend on this perceived *crisis*. A major argument in the situational approach theory is that behaviour is situationally determined. The human situation and definition of the situation is perceived to depend on :

- (i) Psychological
- (ii) Biological
- (iii) Social + Economic
- (v) Cultural factors.

These singly or collectively determine subsequent behaviour. The human situation is also seen to include factors which are common to the observer and the actor, for example, the physical environment, the relevant social norms and the behaviour of others. It also consists of factors which only exist to the actors:

- (i) How they perceive the situation
- (ii) What it means to them
- (iii) What their definition of the situation is.

The theory holds that the defining of the situation is begun by parents through the process of socialization and is continued by

the community. Through socialization the group endeavors to have the individual internalize its own definitions and make them part of his habitual self. However, as Thomas and Znaniecki [1974] note, the personality development through socialization is not a "bundle of traits" but rather unique and dynamic revealing itself in adjustive efforts in various situations which are determined by a complex of internal and external factors. In this theory, group definitions are seen as only one element in the situation which confronts the individual and the efficiency of these definitions depends on other factors like, for example, unlearned psychological endowments. While psychological and biological endowments may be difficult to determine, factors like education, age, sex, and travelling exposure, may influence one's definition of the situation, especially a disease situation.

A certain culture may demand the consultation of a traditional healer with regard to specific symptoms. However, with time people may come to the realization that the traditional healer cannot cure the disease but modern medicine can. This knowledge is most likely to lead to a redefinition of the situation such that if the same disease is suspected, the sick person is taken to hospital for treatment. The situational approach theory perceives human behaviour as malleable and that people are always trying to come to terms with or adjust to the situation in which they find themselves. The theory, however, holds that adjustment is not a smooth and uniform process in which cause and effect can be isolated simply by knowing the objective condition and then

observing the objective behaviour. When a member of a group falls ill, the action to be taken does not necessarily emanate from the known scientific aspect of the condition. Though the action taken may be illogical to the observer, it does make sense to the actors. This is because the course of action to be taken is not reached at random, rather various factors are weighed which lead to the most suitable action.

Working hypotheses:

The following hypotheses guided the research process accordingly.

- (i) Forms of healthcare are hierarchical and hospital treatment is probably a last resort for most people.
- (ii) People with limited knowledge about causes of certain diseases are more likely to dismiss their symptoms or delay taking action at their onset.
- (iii) Low socio-economic status tends to push people towards alternative health care systems other than hospital treatment.
- iv) Modern religious affiliations, on the one hand, and traditional beliefs, on the other, influence the strategy of relief a person chooses to take.

## CHAPTER THREE

### STUDY SITE AND METHODOLOGY

Siaya District was established in 1966 following the sub division of Central Nyanza into Kisumu and Siaya Districts. It extends from 0° 13' south to 0° 18' north. Longitudinally, it is from 33° 58' east to 34° 33' west. Bordered by Busia and Kakamega Districts in the north and north-east respectively, it forms a boundary in the south-east with Kisumu district. It has an area of 5528 km<sup>2</sup> with 1005 km<sup>2</sup> under Lakes Sore and Kanyaboli, both of which adjoin the Yala swamp, plus a portion which is part of Lake Victoria. Siaya is administratively divided into six divisions, each of which is, in turn, sub-divided into a number of locations and sub-locations.

The District is traversed by two main rivers, namely, Nzoia and Yala rivers. These rivers flow from the north-eastern direction of the district and both enter Lake Victoria via Yala swamp. Rainfall amounts and distribution are determined to a large extent by altitude and wind direction. Moving from north to south within the district, rainfall decreases progressively from an average of 1450 mm annually in Ukwala and Yala Divisions to about 1000 mm in parts of Boro, Rarieda, and Bondo Divisions. The 1979 census reported a population of 474,516 inhabitants [215,058 males and 259,458 females], with a density of about 202-277 persons per square kilometre [Kenya population Census 1979].

The economic activities of the Lake shore areas have largely been confined to fishing and, to a smaller extent, crop farming

both of which have been practised mainly at subsistence level but with the latter within a predominantly bushy environment. Where bush clearing has been intensified, the southern portion has had substantial agricultural potential especially in cotton growing.

### Area of study

This study was done in Ukwala Division, Siaya District. The division covers North Ugenya, East Ugenya, West Ugenya and Ukwala Locations. The 1979 census reported a population of 122,417 people with a density of 233 persons per square kilometre [Kenya Population Census: 1979]. The main occupation of the inhabitants is peasant farming; subsistence food crops like maize cassava millet sorghum and sweet potatoes are grown.

### Health Facilities:

Health facilities in Siaya District are quite poor. The District is covered by 8 doctors, paramedical staff of various cadres working within one hospital, 23 health centres and dispensaries, several private clinics and a few NGO operated facilities. The distribution of these facilities is, however, uneven, poorly staffed and equipped, and the facilities are mostly over utilized. [District Socio-Cultural Profile]

Ukwala Division has two government health institutions and one NGO facility. The staff in these institutions amounts to 21 people out of which there are only 2 clinical officers and no doctor. The vastness of the division and the size of the population makes these

health facilities grossly inadequate.

### Research Design

The study adopted the survey research design within which the basic tool for data collection was the structured interview. A multistage stratified sampling method was used in drawing the sample. All the administrative divisions in Siaya were listed and one was selected by simple random sampling. Following the same procedure, all the locations of the selected division were listed. All the sub-locations in these locations were also listed and by simple random sampling, a sub-location was selected from each location. It was not possible to confine the research to one village in a sub location as had been proposed because there were no marked boundaries. Moreover, the sampling method used, i.e, selecting directions and visiting homes along the directional lines could not allow for the confinement. Since the household was the sampling unit, initially it was proposed that the village heads in each selected village be requested to help in compiling a list of household heads in their respective villages. If this had been feasible, the use of simple random sampling method in drawing a household sample would have been simple. However, it was not possible due to the large number of households involved. Thus unless a house to house census were done, one could not possibly come up with a complete list of households in any village. Because of the difficulty inherent in trying to get a list of households, the study adopted the WHO [1978] recommended cluster sampling



technique. Following is the method recommended for rural areas where household lists are not available and it is not feasible to number each household in the village:-

- i) Define precisely the limits of the village.
- ii) Select a central location in the village such as a market, mosque or church. The location should be near the approximate geographical centre of the village or area.
- iii) Randomly select the direction in which the first household would be located: single digits were allocated to each direction [eg. 1 = North, 2 = West 3 = East, 4 = South]. The directions were selected with the aid of a random number table. This was done in each of the sub-locations.
- iv) Once the direction was selected, the number of households existing along the directional lines from the central locations were listed.
- v) The second random numbers between one and the total number of households along the directional lines selected were drawn from each sub-location. The numbers which were selected identified the first houses to be visited.

According to the WHO this cluster sampling technique meets the following standards of reliability:

- a) The data which result from the survey will have a level of accuracy of plus or minus 10 per-cent.

- b) Nineteen out of twenty times the data which results from the survey will be within the stated level of accuracy.

Ninety household heads were interviewed in total with an equal proportion from each sub location in the sample except for one location which had more sub locations than the rest.

### Data collection procedures

Several data collection techniques were used. The survey study using a structured questionnaire was supported with the use of other data collection techniques, viz, participant observation and informal interviews.

### Questionnaire

A structured interview schedule was administered to all the respondents. The questionnaire was composed of open-ended questions to enable the respondents to give as much information as possible. It was also composed of closed ended questions. The questionnaire was standardised to ensure that questions were presented in exactly the same wordings and the same order to all the respondents. The open ended questions were designed to permit free responses from all the respondents without providing or suggesting any structure for the replies. The respondents were encouraged to talk freely and fully in response to these questions and verbatim recording of these replies made. All the responses that emerged from the open ended questions were suggested by the

respondents themselves and only coded when the research process was over.

### Participant observation

During the course of the research, simple observation techniques were used. Of particular interest to the researcher were activities going on in faith healing congregations, the activities of the members during prayer sessions and how they generally conducted themselves as a group. Through visits during prayer sessions a lot was learnt, especially on the faith healing rites. Health institutions were also visited and selected patients were interviewed concerning the histories of their illness.

### Key Informants:

Unfocused in-depth interviews were carried out with elder members of the community and medical personnel. Though no formal questionnaire was formulated for this purpose, questions arising from the use of the standardized questionnaire were carried further with selected informants. Medicine men/women and officials of the faith healing sects were also consulted informally.

The use of key informants can be very illuminating if the right people are selected. This method can be disastrous if the informant selected is an "outcast" or a marginal member of the community. Such an informant would prevent the researcher from reaching other informants because of his association with somebody who is not respected. To overcome this, an attempt was made at

careful scrutiny of the informants such that the people who were selected in the long run could qualify to be termed socially recognized personalities. Informants have also been known to lie; for this reason the information obtained was thoroughly cross-checked by relating it to the known facts about the people and any inconsistencies ironed out.

#### Procedures for data analysis:

Data was adapted for analysis using statistical package for social scientists (SPSS). The data was presented in terms of percentages, tables and cross tabulations.

Statistical tests of association and significance, namely, gamma and Chi square ( $X^2$ ) were used. The gamma measure of association illustrates the principle behind table statistics, and it is comparatively easier to compute and interpret than other table statistics. The gamma measure shows the direction and strength of association between two cross tabulated variables. It varies between -1.00 (indicating a perfect negative relationship) and +1.00 (indicating a perfect positive relationship). A gamma of 0.00 or near 0.00 indicates the lack of any relationship between variables. The gamma measures the extent to which cases are concentrated in one diagonal minus the extent to which they are concentrated in the opposite diagonal. If the cases are equally distributed in each diagonal, then the gamma measure would show 0.00 relationship. The computational formula for the gamma is

$$\text{Gamma} = \frac{(A \times D) - (B \times C)}{(A \times B) + (B \times C)}$$

Chi square tests of significance were done using the formula:

$$\chi^2 = \sum \frac{(f_o - f_e)^2}{f_e}$$

#### Problems Encountered:

Several problems were encountered in the process of field work. The study came in immediately after the 1989 National population census. Since the census also sought to find out certain aspects of people's lifestyles, like income and family size, quite a number of respondents tended to associate this study with the census. It was a very time consuming undertaking to explain the difference between the research and the census. This resulted in slowing down the speed of the interviews.

The areas which were studied in most cases fell far from the major roads. This, consequently, led to the problem of transport. At times reaching the respondents entailed walking over long distances. It therefore became difficult to make fast progress because of the minimal number of interviews carried out in a day. Considering the time factor and the limited finances at hand it became logical to cut down the number of interviews to a manageable size.

The question of how the respondents would benefit from the research was very persistent. The respondents often related their experiences with past researches and complained that despite pouring out their problems nothing had been done to change their conditions. On such an event the respondent would digress and start

expounding on what he thought was important and therefore needed changing. However, on the whole most of the respondents and the administration were very co operative.

### Operational Definitions:

#### **Health care**

This term was generally used for any practice related to the restoration of health or prevention of ill health.

#### **Modern Health Facilities**

Was used to denote practices and institutions based on scientific medicine.

#### **Knowledge**

Was measured in terms of one's conception of causes of disease. Those who subscribed to scientific explanations were considered knowledgeable while those who subscribed to other forms of explanation were considered less knowledgeable.

#### **Socio-economic status**

Was measured in terms of occupation and incomes.

#### **Low socio-economic status**

A position of low income coupled with low status.

### **Religion**

Was used to denote one's affiliation to a religious denomination or sect. Since there were no other religions mentioned apart from Christianity and traditional religion, the term merely differentiates the various sects of Christianity.

### **Traditional beliefs**

Popular beliefs held by members of a society and which are based on cultural practises.

### **Household**

Was used to mean any unit which comprises a person or a group of persons generally bound by ties of kinship and residing together under a single roof or several roofs within a single compound and who share community life in that they are answerable to the same head and share a common source of food.

### **Education**

Was measured in terms of the years spent in formal schooling and the ability to read and write at the very basic level.

### **Occupation**

What people basically do for their livelihood, ie, how they occupy themselves in the process of earning a means of livelihood.

## **Income**

The actual amount of goods that people have at their disposal at a given time. This was measured either in terms of monies earned from business, salaries, wages, etc, and in terms of agricultural produce. Maize was taken as a standard yard stick as far as farm produce was concerned. Almost every household in the area grows maize and it is the product most liable to be sold as a cash crop when the need arises.

## **Faith healing**

The act of subscribing to religious rite as source of help in combating ill health. This includes the belief that these rites, just like any other form of therapy, can result in the restoration of good health.

## **Strategy of resort or relief**

Any action resorted to in the event of ill health. This entails the decision on one's part as to whether to go to hospital, buy patent medicine from the shops, visit a traditional healer or a faith healer.

## **Culture**

Was seen as people's way of life; their beliefs, customs and socially accepted ways of behaviour.



### **Symptoms**

Used to denote any noticeable changes in the body or its functioning to indicate the presence of disease.

### **Psychosomatic diseases**

Illnesses resulting from the effects of excessive or repressed emotions upon bodily function or structure.

### **Pathogen**

A term applied to bacteria capable of causing disease.

### **Religious affiliation**

Membership to a particular religion, denomination or sect.

### **Drug**

The generic name for any substance used for prevention, diagnosis and treatment of diagnosed disease and also for the relief of symptoms.

### **Medicine**

The word usually preferred for therapeutic drugs to distinguish them from addictive drugs which are used illegally.

### **Therapy**

A term used to denote treatment.

### **Patent Medicine**

Used to denote "over - the counter" medicine, ie, any remedy which does not require a medical prescription.

### **Forms of healthcare**

Refers to the different modes of therapy e.g faith healing and traditional healing are two different forms of healthcare.

### **Hospital treatment**

Any therapeutic services offered at modern health facilities like clinics, dispensaries, etc.

### **Dismiss symptoms of disease**

To ignore symptoms completely and take no corrective measures.

### **Delayed action**

The act of postponing medical consultation or any other ameliorative measures.

### **Alternative healthcare systems**

Any other medical systems outside the modern health facilities.

## CHAPTER FOUR

### PERCEPTION OF ILLNESS AND THE CHOICE OF THERAPY

A casual survey of illness episodes in different societies reveals that each society's definition of illness becomes institutionalized within its cultural patterns. Some individuals recognize particular physical symptoms such as pain, a fever or nausea and seek out a physician for treatment; others with similar symptoms may attempt self-medication or dismiss the symptoms as not needing attention. Sigerist [1960] found that among the Kuba people of Sumatra, skin diseases and injuries to the skin were quite common because of a difficult jungle environment. A person suffering from a skin disease would not be considered to be sick among the Kuba because the condition, while unhealthy, is not considered abnormal. Examples such as these have led to the realization that an essentially unhealthy state may not always be equated with illness when the persons involved are able to function effectively and the presence of the disorder does not affect the normal rhythm of daily life.

There are different kinds of medicinemen/women in the Luo community. The general name for these practitioners is "ajuoga", though they differ in their fields of specialization.

**Sorcerers:** are bad people who are greatly feared. They are considered evil, greedy and selfish. They do not like other people being more successful than themselves. When a sorcerer wants to cause someones death, he goes to *ajuoga* to determine how best the

person could be killed. The medicineman gives prescriptions on what should be done. He may ask the sorcerer to look for a snake of whatever kind that is specified, chicken egg, cowrie shells and many other things like pieces of rags from the victim to be's clothes, bones of human beings, etc.

The medicineman then specifies to the sorcerer where to place the evil charms. These are mostly placed at the victim's gate, roof, door, farm, on the road or any other place where he is likely to be found. As the sorcerer places the charms on the prescribed place, he prays for the death of the person whom he wants to finish.

When the victim encounters the destructive charms, he gets shocked and henceforth lives in fear. He eventually becomes sick and dies. When one gets a sorcerer's charms, a special medicineman should be called. This medicineman is a specialist in neutralizing and countering destructive charms. His charms have the effect of rendering the sorcerer's charms ineffective and causing the latter's death. When this type of medicineman is called in a village, all the villagers are informed of what is going to take place. When the sorcerer hears this, he is fear-ridden and either reveals himself to the persons he wanted to kill so that his destructive charm is not countered or goes to the medicineman who is to do the countering to beg for forgiveness and asks him not to act.

The Luo do not like people who come to the home and idly break pieces of wood or sticks from the gate or those who take grass from

the roof, soil from the farm or pick cow-dung for no apparent reason. This kind of behaviour is feared because these acts can be carried out for purposes of witchcraft.

The Eye Witch : These are usually women who look at children or adults when they are eating and make the food clot in the stomach causing stomach disorder and related illness. It is then said that an eye witch has bewitched one with food. The eye witch is especially dangerous if they look at babies while suckling.

When someone is bewitched with food, he goes to a surgical expert *jatak* who suckles out the bewitched food which had refused to be digested and is causing trouble. The surgical expert gives medicine to be chewed after which he also chews and puts it on the place that is hurting. He then cuts that place with a blade and licks it with his tongue removing the offensive object.

Some people take precautionary measures against the evil eye. A special medicineman for eye witchcraft *wuon yath rongo* is called to put preventive medicine in the home. Once this is done, an attempt by the eye witch to cause harm to any member of the home bounces back on her causing her eyebrows and eyelashes to come off or even blinds her.

#### Dispensers of evil charms *janawi*

*Janawi* is a person who possesses (evil) destructive charms. His charms are open to the service of people who want to destroy others. Some of this category of medicinemen direct their harmful charms to a person then they go to the same person pretending to help so that they can be paid. It is unacceptable to a Luo that

one can have severe headaches, fever, backache, vomit blood, Suffer from long illness, etc, without a cause. It is believed that most likely such a person is being *tied* down with medicine.

### Exorcist *Jadil*

It is believed that if there was somebody in a home who was evil and for example died outside the home or committed suicide because of his crime, when serious problems face members of the home, they are attributed to the dead relative's ghost *Jachien*. When this happens a medicineman is consulted to establish the fact that the home is actually haunted by a ghost. When it has been established as true, a special kind of medicineman called *jadil* is brought. The duty of *jadil* is to expel the ghost. The methods of expelling offensive ghosts vary from one specialist to another. While some just slaughter either a ram or a goat and use the parts of the animal in performing intricate rites, others go as far as exhuming the bones of the dead person and burning them.

### Smellers *Jamrieri*: *Janguecho*:

This category of medicinemen are of several kinds. Some treat by smelling out with medicine in their noses while others boil medicine in a pot to find out things about the body that have been used by somebody else for witchcraft.

In most cases these medicinemen attend to people who have been ill for long and who may wish to have the hidden evil things afflicting them *smelled* or *washed* out. When *Janguecho* puts medicine in his nose, it directs him to where the destructive charm is hidden. The medicineman runs with a spear as people follow him.

When he strikes a place with the spear, the place is dug and whatever a sorcerer might have buried is removed.

#### Washers Joluoko

These put water in a pot with medicine which is then covered. When the water has boiled, they pour it out and all the property of the patient which had been lost should come out of the pot with the water. They are thus *pulled* by the medicine. After this the patient should have some peace of mind for what had been taken for witchcraft purposes is recovered and there is no cause for fear.

#### Fumigator Jafwagro

This medicineman gives patients medicine for steaming and bathing.

The medical view of illness is that of deviance from a biological norm of health and feelings of well being. This view involves the presence of a pathogenic mechanism within the body that can be objectively documented. The diagnosis of a disease results from a correlation of observable symptoms with knowledge about the physiological functioning of the human being. It is against this view that the hypothesis on knowledge about symptoms of disease and the decision to take action at a particular point in time or not to do so at all is tested in this Chapter.

A variety of symptoms were used in testing this hypothesis with a view of examining how they fitted into the respondents concept of illness.

**Table 4.1 Etiology of backache**

Etiology	n	%
Abortion	1	1.1
Heavy work	33	36.7
Don't know	50	55.6
Blood shortage	1	1.1
Witchcraft	2	2.2
Bad blood	1	1.1
Evil eye	1	1.1
Stomachache	1	1.1
<b>TOTAL</b>	<b>90</b>	<b>100.0</b>

Table 4.1 is an illustration of the respondents views on the etiology of backache. 36.7 per cent of the respondents attributed backache to heavy work especially work that involves much bending of the back. As indicated on Table 6.8, most of the respondents in this study were peasant farmers. Most of these people are always working on their subsistence plots for virtually almost all the year round. Breaking the ground, planting and weeding are done using the hoe.

There are very few exceptions where ox ploughing comes in as a substitute. This is a pointer to the fact that most of the work is done in a bending position. The views of the respondents in this regard and the evident conditions tally with the assertion by Susser and Watson [1962] that man's economic and social environment is part of this natural environment and helps to determine the incidence and prognosis of diseases. Medicine has come to recognize that many diseases are not natural calamities that strike in a haphazard way, but are injuries inflicted on people by the



nature of their daily occupations and their customary modes of life.

When asked about the best mode of treatment for backache, most of the respondents said they were not aware of any way out of the condition. Thus most of the respondents seemed to have taken the condition as inevitable since they see it as not responding to any form of treatment. Backache as a disease condition can be classified as a chronic non-incapacitating dysfunction because it manifests drawn out periods of suffering which are sometimes cyclical in nature and in a way enables the sufferer to maintain a semblance of his daily routine. The respondents views on the etiology of coughing were also sought.

Table 4.2 illustrates that 30 per cent of respondents attributed coughing to dust, 55.6 per cent did not know its cause while the remaining 14.4 per cent gave various other responses. Though the respondents were not aware of the biological basis for attributing coughing to dust, this explanation is valid. It is true that if a person inhales dust it irritates the lungs and coughing ensues. Though there are many other causes of coughs, at least 30 per cent of the respondents were aware that the condition is caused by the intrusion of a foreign body into an organism. This knowledge called for an examination of the modes of treatment prescribed by the respondents for coughing.

Table 4.2 : Etiology of Coughing

Etiology	n	%
Worms	1	1.1
Overworking	2	2.2
Don't know	50	56.6
Malaria	2	2.2
Dust	27	30.0
Genetic inheritance	1	1.1
Bad chest	3	3.3
Drinking dirty water	3	3.3
Overgrown uvula	1	1.1
TOTAL	90	100.0

Table 4.3 shows the respondents preferred modes of treatment for coughing. It was assumed that those who classified diseases as naturally caused would be more prompt in taking modern medicine oriented action than those who ascribe diseases to the supernatural realm or knew nothing about them. The finding in Table 4.3 indicates that 78.9 per cent of the respondents would prefer to take their coughing patients to modern health facilities while 14.4 per cent preferred patent medicine for the same symptom. This concentration of responses around modern health facilities and patent medicine is an indication that owing to the knowledge that some of the respondents had about the coughing condition, it was much easier for them to make their minds about the exact mode of treatment to be resorted to. When such knowledge is available to the people, it is very unusual to have the sick among them delaying to take appropriate action. However, according to Alonzo [1984] the seekers of medical care and other forms of social and psychological assistance represent the minority of all ill and troubled

individuals.

Table 4.3 : Preferred Mode of treatment for Coughing

Mode of treatment	n	%
Self treatment with herbs	8	8.9
Self treatment with patent medicine	13	14.4
Modern medicine	71	78.9
Faith healing	2	2.2
Cutting overgrown uvula	1	1.1
Others	2	2.2

Elsewhere the same author argues that individuals who do not seek medical care for biophysical signs and symptoms are able to contain them within their situation set. [Alonzo 1979]. These individuals are able to attend to bodily deviations within their situation set without them becoming the dominant focus of attention within the situation. To be able to contain a situation means keeping signs and symptoms at the level of a side - involvement by suppressing them, disattending them, concealing or shielding them, so that they may be integrated into activities, role demands and obligations of the situation. The concept of containment is the primary adaptive process involved in everyday illness behaviour (EIB).

Containment can be said to occur if body state deviations and normal processes can be kept at the level of a side involvement, in order to sustain the definitional and participatory integrity of the situation for the individual and others. The most typically contained signs and symptoms from illness, self medication and epidemiologic studies are: cough, cold, flu symptoms; aches,

stiffness, swelling or pains in joints or muscles; headache, indigestion and stomachache, breathlessness, rashes, itches or other skin troubles; diarrhoea, faintness or dizziness; backache, burns, bruises, cuts or other accidental trauma, feeling and appearing fatigued; "female complaints", nausea, chest pain, ear and hearing trouble, teeth gums and jaw pain problems; fever and eye trouble. Dunnel and Cartwright [1972]; W.H.O. [1976].

Table 4.4: Etiology of joint and muscle pains

Cause	n	%
Overworking	4	4.4
Don't know	74	82.2
Blood shortage	2	2.2
Stomach problems	1	1.1
Malnutrition	2	2.2
Spirits	2	2.2
Witchcraft	1	1.1
Malaria	2	2.2
Old age	2	2.2
<b>TOTAL</b>	<b>90</b>	<b>100</b>

Pain in joints is one of the symptoms mentioned by Dunnel as containable. Table 4.4 is an indication of the respondents' perception of this symptom. The table illustrates that the majority of the respondents i.e. 82.2 per cent said they did not know what causes joint and muscle pain. This has the implication that according to the respondents experiences, there is no specific attribute that can be accorded to the symptom. This being the case, an examination of the way the symptom is dealt with would enhance the view on the perception of the symptom by the

respondents. Table 4.5 shows how the respondents thought the symptom is best dealt with.

Table 4.5 indicates that 7.8 per cent of the respondents did not know the best cure for muscle and joint pains. Most of the respondents reported the prevalence of the symptom though none of them had confidence in the answer given. What actually appears in Table 4.5 is what the respondents thought could be done about the symptom.

Table 4.5: Mode of Treatment for joint and Muscle pains

Mode of treatment	n	%
Self treatment with herbs	4	4.4
Self treatment with patene medicine	2	2.2
Traditional medicine	2	2.2
Modern medicine	74	82.2
Don't know	7	7.8
Faith healing	2	2.2
Do nothing	1	1.1

Of particular interest are those who mentioned herbal remedies and traditional medicine. This category of respondents instead of saying that the symptom could be treated in such a way, said *If it were the old days, I would use herbs* or *I would visit a medicineman*. Such answers seemed to delegate herbal remedies and traditional medicine only to the past yet they still exist in the area of study. When asked what they could do at present, most of these respondents answered that *nowadays we just go to the doctor.* This answer left a lot to be desired since it appeared non-committal. On the one hand it would seem to suggest that the

doctor is the only alternative available or that going to see the doctor is some kind of routine. Indeed some of the respondents implied that visits to the doctor had yielded no response and so they have had to stay with the symptoms.

In a study of the mortality and morbidity situation in Siaya, Koyugi [1982] noted that the majority of the patients who were admitted in health institutions as in-patients suffered from Rickettsiosis and other arthropod-borne diseases. Viral diseases came second followed by intestinal infections diseases. However, according to the 1980 out-patient morbidity data, the main causes of illness were malaria, acute respiratory infections, intestinal worms, diarrhoeal disease and diseases of the skin in that descending order of importance. Koyugi's study points out the major causes of illness in Siaya but does not address the victim's perception of the causal factors.

Health problems in the current study area could be said to stem mainly from environmental conditions namely: the inadequacy of clean water, unsanitary food preservation methods especially during large gatherings like funerals and diet content. According to Koyugi's findings based on 1979 in-patient mortality data, the major causes of death in Siaya were viral diseases followed by intestinal infectious diseases.

Against Koyugi's findings this study sought to find out the respondents knowledge about the causes of some of the fatal diseases and how they attempt to cope when afflicted.

Table 4.6 is an illustration of what the respondents mentioned as

the cause of blood in stool. The table illustrates that the majority of the respondents did not know what caused blood in stool while a significant number attributed the condition to stomach problems. When asked further what could be the cause of stomach problems that necessitated the appearance of blood in stool, the answers varied from eating poor food, food poisoning and constipation.

Table 4.6: Etiology of blood stool.

Etiology	n	%
Worms	2	2.2
Dont know	51	56.7
Stomach problems	13	14.4
Malnutrition	3	3.3
Koko or Orianyanja *	18	20.0
Bad wind	2	2.2
Bilharzia	1	1.1
<b>TOTAL</b>	<b>90</b>	<b>100.0</b>

\* Cultural terms for conditions which manifest blood in stool

Another significant response was *Orianyanja* or *Koko*. This is a traditional (Cultural) explanation for blood in stool. According to the respondents this condition is more common among children. This view is similar to the UNEP [1981] assertion that water related diseases, especially those transmitted through faecal contamination and malnutrition are responsible for the majority of deaths among children under five years of age in developing countries. *Bilharzia* is an example of the vector-borne parasitic diseases which plague Africa. The worm parasite of this disease

causes much damage in the intestine, bladder and the urinary system. A common indication of their presence is the passage of blood in the urine and stool, the enlargement of the spleen and liver, and the collection of fluids in the abdomen to produce a bloated belly. Bilharzia is a most debilitating disease, not only responsible for the loss of many man-months of work but also the cause of unnecessary pain and misery. Because bilharzia is a slow-killer and does not cause spectacular epidemics and mass death, it generally fails to attract the concentrated attention it deserves.

It is evident from Table 4.6 that ninety eight per cent of the respondents gave responses which were nowhere near the cause of the symptom blood in stool. When the symptom is seen from the cultural point of view herbal remedies are prescribed and administered to the patients. The list of perceived causes of the symptoms suggest that the respondents are actually unaware of the causal factors. This is the reason why consultation with modern personnel may be limited. If a person perceives a condition as being caused by worms the most logical action would be to look for worm-killer medication. On the other hand if the perceived cause is stomach problem which might have occurred as a result of constipation or eating contaminated food, it might be assumed that it will "pass" with time. Owing to such perceptions, if the patient is taken to a modern health facility at all, it might be too late and the damage already done.

Table 4.7 is an illustration of what the respondents in the study proposed as treatment for blood in stool. The table



illustrates that though the highest number of the respondents i.e. 67.8 per cent mentioned going to modern health facilities for the treatment of blood in stool, a percentage considerably high mentioned other modes of treatment. This is an indication that the respondents have had to face incidents of the symptom for a long time but have not yet developed the awareness about its actual cause.

Table 4.7: Mode of treatment for blood in stool.

Mode of treatment	n	%
Modern medicine	61	67.8
Herbs	22	24.4
Don't know	8	8.9
Patent medicine	3	3.3
Faith healing	3	3.3
Traditional healing	3	3.3
Others	2	2.2

Whether the symptom can be managed by herbal medicines or the other modes of treatment mentioned is beyond the scope of this study. It would also be important to mention that the other modes of treatment mentioned in connection with the symptom include eating "well" and eating pieces of leopard meat.

Since intestinal infectious diseases featured prominently in Koyugi's study as a major cause of death in the study area, it was deemed necessary to test the respondents perception with regard to the cause of diarrhoea.

**Table 4.8: Cause of diarrhoea**

Cause	n	%
Worms	4	4.4
Don't know	43	47.8
Stomach problem	11	12.2
Contaminated food and water	30	33.3
Spirits	2	2.2
<b>TOTAL</b>	<b>90</b>	<b>100.0</b>

Table 4.8 illustrates that a majority of the respondents gave an objective answer with regard to the cause of diarrhoea. This implies that when a person suffers from diarrhoea most of the people in the study area would attribute the illness to an organism in the elementary canal. Within our definition of knowledge in this study it can then be said that a good number of the respondents appeared knowledgeable about the cause of diarrhoea. This knowledge however had great limitations. The respondents who mentioned worms as a cause for diarrhoea could not for example say what could have brought about the worms or the specific family of worms in question. On the other hand those who said that diarrhoea was a result of eating contaminated food were in most cases talking about food that had gone bad.

Bennet serwadda, and Jeliffe [1972] did a study on Kiganda concepts of diarrhoeal disease and came to the conclusion that the Baganda had two sets of beliefs about diarrhoea which could be held simultaneously. The consequences of the older traditional set were found to be important in that if they were held exclusively by a family then there would be no measures taken to stop the spread of

the disease as it was not considered communicable. In this regard among the causes given for diarrhoea in children included teething, sitting too early and being tied to the mother's back too early. When such is the case, no attempt would be made for corrective measures of protecting food, milk and water from contamination by excreta, a delay in seeking modern medical treatment and no endeavour to restore fluids lost by diarrhoea.

**Table 4.9: Mode of treatment for diarrhoea**

Treatment	n	%
Herbs	10	11.1
Patent medicine	3	3.3
Don't know	1	1.1
Modern medicine	77	85.6
Faith healing	1	1.1
Others	2	2.2

Table 4.9 illustrates the modes of treatment that were mentioned with regard to diarrhoea. A majority of the respondents preferred to go to modern health facilities in case of a diarrhoea outbreak. This preference for modern health facilities is significant in the sense that the respondents' attitudes towards diarrhoea is based on objective notions. Whether diarrhoea is caused by poorly cooked food or food that has gone bad or some virus, the point remains that some organism which is foreign to the body has entered it and the body mechanisms are reacting against it.

The preceding discussion presents some of the findings on knowledge relating to a group of selected symptoms. These findings indicate that symptoms of disease as brought out by the study can

be said to fall under two broad categories. In the first category there are symptoms which are widespread and do not have any single explanation for their causes. These symptoms prevail in people's everyday lives, do not prove instantly fatal and are to some extent containable. These symptoms which also happen to be chronic in most cases do not elicit immediate consultation of modern medical specialists. This attitude is due to the fact that even with prolonged duration of treatment there is no guarantee of a cure. These symptoms are also brought about by the socio-economic conditions of the people. Backache is cited as an example of a symptom which is brought about by the nature of economic activities that the respondents engage in.

The second category of symptoms is also related to the socio-economic condition of the respondents though these are not as explicit to them as those ones in the first category. This category is seen to consist of symptoms whose causes are related to what is consumed in form of food and drink. Here the respondents knowledge was divided; while some were able to identify the objective causes of the symptoms (though in vague terms), others were completely ignorant. Consultation in this category is much higher because some of the symptoms here were known to be acute and fatal. Although some of the symptoms in this category are here termed as fatal, the necessity to take prompt and relevant action was not uniformly noted among the respondents. It was noted that known symptoms for a disease like Kwashiorkor which is a function of malnutrition, is associated with *chira* or taboo. Since

Kwashiorkor is common among young children, the associated breach of taboo has to do with sexual purity. The people of Ukwala believe that if any of the parents gets involved in extra-marital sexual relations then holds the children before bathing, the child is most likely to develop the symptoms of what is medically known as Kwashiorkor. Where such beliefs are adhered to when a child falls victim to Kwashiorkor, some purification rituals are performed instead of consulting modern medical personnel. Since the diet content in this rural area lends children susceptible to Kwashiorkor, great losses of life could result from the condition if such beliefs are adhered to.

Measles is another disease which has not been given proper definition by the residents of Ukwala. It was learnt from Segha Mission Hospital that an attack of measles is frequently misinterpreted to imply that a child has been attacked by demons which need to be exorcised. Certain intricate rites are performed for this purpose as the condition grows worse. Some people have even been known to follow measles patients to the hospital beds and demand to have their sick back or alternatively excorsise the alledged demons in bed as the patient continues getting medication.

Due to limited knowledge about the actual causes of disease, even a disease which is easy to cure at the early stages could develop into a critical condition as people still grope around for a cure.

## CHAPTER FIVE

### RELIGIOUS FACTORS IN THERAPY CHOICE

In this chapter the hypothesis on the influence of religious affiliation and traditional beliefs on the choice of therapy is tested. The two major themes used in discussing this hypothesis are ethnicity and characteristics of disorder. Two of the therapeutic options open to the people of Ukwala, namely, faith healing and traditional healing, are examined and their major areas of influence noted. The two are then compared to determine any common grounds. Faith healing is further analyzed and compared with other methods of non-scientific healing.

According to Durkheim, all religious beliefs, whether simple or complex, have common characteristics in that they presuppose a classification of all things of which men think. These things, real and ideal, are classified into two opposed groups, namely, the profane (secular) and the sacred. He defines religion as:

*A unified system of beliefs and practices relative to sacred things, that is to say, things set apart and forbidden - beliefs and practices which unite into one single moral community called a church, all those who adhere to them. [ Durkheim 1972: 30]*

In the light of this definition, religion is seen to subsume all areas of life that are sacred or mystical which include aspects such as witchcraft and sorcery. However, Durkheim makes a distinction between the belief in magic and belief in God. He sees the belief in magic as being more or less general and very frequently diffused in large masses of the population. However,

magic does not result in binding together those who adhere to it, nor in uniting them into a group leading a common life, hence there is no church of magic. There are no lasting bonds between the magician and his clients as there are none between the clients themselves which make them members of the same moral community, comparable to that formed by believers of the same God or observers of the same cult.

Indeed, the Luo concept of God is consistent with Durkheim's definition of religion. The Luo idea of God was interwoven with every aspect of religious and secular life. For instance the Luo believed in the world of spirits, which manifested themselves in various ways. Spirit possession among the Luo is a phenomenon where the spirit of a dead person or thing possesses and manifests itself in a living person by speaking through him and giving him some supernatural power or charisma and influence in the community. The possessed person is thus raised to the medium status. The charisma one gained as a result of being spirit possessed was regarded as a gift from God which was strictly to be used for the well being of the community.

When the study was designed, it was hypothesized that religious and cultural factors influence therapy choice. The percentage of membership in the various religious sects was sought. Membership to the groups is shown in table 5.1 .

Table 5.1 shows that a majority of the respondents reported membership of the conventional christian churches with most of them being Catholics. A combination of the percentage of Catholics and

anglicans adds upto 73 per cent membership.

Table 5.1: Religious Affiliation

Group	n	%
African traditional	3	3.3
Legio Maria	4	4.4
Catholic	52	57.8
Anglican	14	15.6
Pentecost	9	10.0
Others	8	8.9
<b>TOTAL</b>	<b>90</b>	<b>100.0</b>

The first preference in healthcare contact was then sought to establish the modes of treatment most utilized. Table 5.2 shows the preference level by percentage.

Table 5.2 First source of therapeutic help.

Source	n	%
Used herbs at home	13	18.3
Used patent medicine	29	40.8
Visited traditional healer	3	4.2
Private clinic	9	12.7
Health centre	8	11.3
Hospital	6	8.5
Others	3	4.2
<b>TOTAL</b>	<b>71</b>	<b>100.0</b>

It was found that the use of patent medicine from the shops was a first preference for the majority of the respondents. 40.8 per cent of the respondents who reported sickness in the family



within a period of the preceding four weeks indicated that the first course of action taken in seeking relief was the use of patent medicine. Second in the preference list was self treatment with herbs, 18.3 per cent. This suggests that selfcare and, especially, self medication with non-prescribed medicines is widespread in Ukwala.

A  $X^2$  test was computed to find if religion influenced the first course of action one takes in the event of an illness. The null hypothesis being that religion does not significantly influence the course of therapeutic action taken when one falls ill.

Table 5.3 Religion by first source of therapeutic help.

	Herbs	Patent medicine	Trad Healer	Private Clinic	Health centre	Hospital	Others	TOTAL
African traditional	0	0	2(2.8)	1(1.4)	0	0	0	3(4.2)
Legio maria	1(1.4)	2(2.8)	0	1(1.4)	0	0	0	4(5.6)
Catholic	5(7.0)	19(26.8)	1(1.4)	4(5.6)	7(9.9)	1(1.4)	3(4.2)	40(56.3)
Anglican	4(5.6)	5(7.0)	0	1(1.4)	0	1(1.4)	0	11(15.5)
Pentecost	1(1.4)	2(2.8)	0	2(2.8)	1(1.4)	1(1.4)	0	7(9.9)
Others	2(2.8)	1(1.4)	0	0	0	3(4.2)	0	6(8.5)
<b>TOTAL</b>	<b>13(18.3)</b>	<b>29(40.8)</b>	<b>3(4.2)</b>	<b>9(12.7)</b>	<b>8(11.3)</b>	<b>6(8.5)</b>	<b>3(4.2)</b>	<b>71(100)</b>

df = 30

$X^2$  (calc) = 61.4

Probability level = 0.05

where  $X^2$  Critical = 43.7

Gamma = -0.04

At a probability level of 0.05, the  $X^2$  (calc) on religion and course of therapeutic action taken indicates that religion significantly influences the decision as to which course of action is taken on the event of an illness. The  $X^2$  (calc) is not only significant at 95 per cent probability level but it is even significant at 100 per cent level showing that there is no probability that the result will occur by chance. What this suggests is a strong significant relationship between religious affiliation and the decision making process in therapeutic choice. The gamma measure of association of -0.04 shows no association between the two (Religious affiliation and decision making in choice of therapy).

Since all the people of Ukwala division were considered homogenous to some extent with regard to culture and ethnic affiliation, it was deemed necessary to find out their opinion regarding the efficacy of traditional medicine. The statement *traditional healing is outdated*, was read out to the respondents to elicit their reactions. These reactions were recorded in the form of level of agreement or disagreement by opinion.

Table 5.4 shows that 47.8 per cent of the respondents expressed the opinion that traditional healing is not outdated. This, in effect, indicates that even though the respondents have taken up the use of other forms of therapy, the belief in traditional medicine is still dominant.

The respondents who expressed belief in the efficacy of traditional medicine explained that there are some diseases which

cannot be cured by modern medicine.

Table 5.4: Opinion on the outdatedness of Traditional Healing.

Opinion	n	%
Strongly agree	10	11.1
Agree	19	21.1
Uncertain	18	20.0
Disagree	43	47.8
TOTAL	90	100.0

Similar trends were found by Gould [1957] in India, Uyanga [1979] in Nigeria and Thomas [1970] in Machakos, Kenya. This implies that the characteristic of the disorder in question plays a vital role in the use of traditional healing. The preceding studies also came to the conclusion that chronic diseases are usually treated by traditional and other healing methods. Another crucial factor in the delegation of some disease conditions to either traditional healing or faith healing is the concept of etiology. The perceived etiology of a disease condition can be said to be a vital determinant of the mode of therapy to be adopted. Tables 5.5a and 5.5b illustrate the perceived etiology of hysteria and the proposed mode of treatment, respectively.

Table 5.5a illustrates that the highest percentage, 62.2, of the respondents attributed hysterical symptoms to evil spirits. 26.7 per cent of the respondents did not know what to attribute the symptom to. These two categories constituted 88.9 per cent of the respondents. The remaining 11.1 per cent attributed the symptom

hysteria to witchcraft 1.1 per cent, stress 2.2 per cent, malaria 3.3per cent, chira (taboo) 1.1 per cent, genetic inheritance 1 per cent, excess blood in brain 1 percent, fear of the unknown 1.1 per cent.

Table 5.5a Perceived cause of hysteria.

Etiology	n	%
Don't know	24	26.7
Spirits	56	62.2
Witchcraft	1	1.1
stress	2	2.2
Malaria	3	3.3
Genetic inheritance	1	1.1
Fear of the unknown	1	1.1
Taboo	1	1.1
Excess blood in brain	1	1.1
TOTAL	90	100.0

Table 5.5b: Proposed mode of treatment for hysteria.

Mode of treatment	n	%
Traditional healing	22	24.4
Modern medicine	14	15.6
Faith healing	41	45.6
Don't know	15	16.7
Not curable	2	2.2

Table 5.5b illustrates the responses for the proposed mode of treatment for hysteria as reported by the respondents. Out of the total number of responses, 45.6 per cent proposed faith healing as the best mode of treatment for hysteria; 16.7 per cent had no idea; 24.4 per cent proposed traditional medicine; 15.6 per cent proposed

modern medicine. As per these findings, it is evident that a good number of respondents attributed hysteria related conditions to spirits while an almost equally significant number showed uncertainty about the etiology of hysteria.

In table 5.5a, if we add the responses of those who mentioned spirits to those who did not know the cause of hysteria, the statistic, 88.9 per cent, overwhelmingly points to forces not known or clearly understood by humans or those not under human control. This last point (not under human control) is confirmed in table 5.5b by the therapies prescribed. This means that when symptoms are not known or thought to be caused by mystical forces, therapy is mystical, ie, traditional healing or faith healing.

Among the Luo the reality of spirits is markedly clear, these can broadly be placed under two categories. First, there are *Yambe*. These are spirits whose abode and intentions are not known. It is believed that some of them were initially spirits of dead people which had lost contact with their living kin and were, therefore, floating in the air. Some of them were believed to have temporary abodes in bushes, caves and hills. People hardly moved close to places where such spirits were believed to live. However, if they were not interfered with, they remained peaceful spirits until they were employed by malignant spirits to cause trouble to living people. Secondly, there were spirits which the Luo believed were close to man and either lived with people in their homes or bushes around the homes or in shrines. These included spirits of the ancestors (*Juok kwere*), spirits of persons born abnormally (*Juogi*

*magath*), and spirits of relatives who had died with a grudge and which are believed to be malignant spirits (*Jochiende*)

Traditional systems exist everywhere in the world (see chapter 2) and they always comprise the fundament of knowledge, beliefs and practices even where alternatives have developed [Fosu 1981]. The very nature of hysteria manifesting conditions lend them wide open to multiple explanations. According to the Luo of Siaya, conditions whose etiology could not be rationally explained were delegated to the work of evil spirits.

Traditionally there were experts (*Jodilo*) who dealt with such cases in culturally prescribed ways. With the introduction of modern medicine, many diseases can now be diagnosed and cured. However, medical science has not provided answers to some of the problems that face the people in a way they can accurately interpret and understand. Where such a situation arises, people fall back to seek answers and remedies from their traditional systems.

Religious or any other set of beliefs concerning supernatural powers and forces do not die out with social change and an increased sophistication in science and technology. They change and develop new forms and concepts. In Siaya, this state of affairs is manifest in the syncretic sects of Christianity. Christianity as was introduced in Africa bore elements of the western culture which was not compatible with the African cultures. The convertees were therefore expected to assimilate some aspects of western culture in the name of faith. While the African accepted

the faith, it was not easy to cast off part of the very basic pillars which he believed were part of his existence, thus the formation of the break away sects. An example of such a sect which exists in Siaya is Legio maria. It is interesting to note that even though this particular religion denounces traditional healing and stresses greater reliance on the works of the Holy Spirit, they practise divination, a practise which is as old as the Luo tradition. The difference is that this divination has taken on a new form in that the diviner is said to speak to the Holy Spirit by invoking the names of the angels and saints. Thus, divination and exorcism are old forms in the traditional settings which have been given new concepts. Lessa [1965] argues that:

*The actual cultural content found in the religions of different societies may vary enormously, but underlying this diversity there may be impressive similarities in basic functions, involving the culturally prescribed solutions of human social and psychological problems and the ways of expressing and reaffirming the central values of a society. Viewed in this light, religion appears to be an essential ingredient of society [1965:88].*

No wonder the African religious formations are, in the words of Welbourn and Ogot [1966] *A place to feel at home* where the Africans can find free expression in worship. One, if not the main reason why the phenomenon of break away churches came about was that the missionary churches paid little or no attention to the African world view in religious expression. According to a story current in Legio Maria, when Jesus expelled the demons from the Gerasene demoniac and sent them into the pigs, these threw themselves into the lake but did not drown. They swam as far as

Africa with demons from which Jesus had delivered the Europeans. That is why the western missionaries do not understand the sufferings of the Africans. When Africans complained in confession of being tormented by an evil spirit, the missionaries answered that the spirit torments the body and not the soul so there is no reason to be upset! The Africans saw the gospel as being clear on the point that Jesus did give his disciples the power to expel the demons. If the missionaries do not use it, they are either refusing to put it at the service of Africans or they have lost it [Perrin-Jassy 1973]. Similarly, Daneel [1970] observes that the Zionist movement in Rhodesia (Zimbabwe) developed under circumstances in which the individual was searching for an own identity. According to this position, the centrality and near deification of the main leader result from efforts to relate the Christian message to the African world of thought and belief, in a manner the white missionary was not capable of.

Uyanga's [1979] study among the Efik - Ibibio speaking people of south - eastern Nigeria revealed that patients who felt that something unusual was going on, ie, involvement of super natural forces got tied down to either spiritual or traditional treatment. According to Uyanga, these conditions demand for causative explanation which modern medicine is mostly unable to meet at the level sought by the patient while, in contrast, both the spiritual and traditional consultation has explanation as the main ingredients. For purposes of comparison, the modes of treatment preferred for a common symptom headache was sought from the



respondents, and the results are shown in table 5.6.

Table 5.6: Proposed mode of treatment for headache

Mode of treatment	n	%
Herbs	7	7.8
Patent medicine	11	12.2
Do nothing	2	2.2
Modern medicine	68	75.6
Don't know	3	3.3
Faith healing	3	3.3

Table 5.6 illustrates that out of a total of 90 respondents, 75.6 per cent preferred to visit modern health facilities for treatment with regard to headache. Patent medicine fell second, with 12.2 per cent of the respondents. From these findings it can be said that the respondents have discovered that modern medicine prove more effective in dealing with headache.

For comparative purposes, the respondents were asked to name the symptoms which, in their opinion, could be cured by faith healing and the results are shown in table 5.7. Table 5.7 illustrates that 40 per cent of the respondents had no idea about diseases that could be cured by faith healing. While 44.4 per cent mentioned conditions whose etiology are attributed to evil spirits, another 11.1 per cent mentioned any disease.

In the process of this study, it came out quite clearly that the diseases which are claimed to be curable by faith healing are the same ones that are said to be cured by traditional healing.

Table 5.7: Diseases likely to be cured by faith healing

Disease	n	%
Stomachache	6	6.7
Coughs	1	1.1
Body pains (Muscles)	1	1.1
Spirits	40	44.4
Hysteria	3	3.3
Taboo	2	2.2
Mental illness	4	4.4
Any disease	10	11.1
Witchcraft	2	2.2
Backache	1	1.1
Vaginal bleeding	2	2.2
Don't Know	36	40.0

Among all the medicine men/women who were interviewed informally, there was consistency in their view of the areas which fall under the influence of traditional medicine. They all claimed that they could cure diseases related to spirits, the evil eye, witchcraft, barrenness, vaginal bleeding and mentally related cases. These observations raised a complex question regarding the relationship between these two systems (traditional healing and faith healing) which are strongly opposed to each other. Another fact which was evident in the course of the interviews is that quite a number of people did not wish to discuss their experiences with traditional healers and some even feigned ignorance on obvious matters. It seemed as if some of the respondents were trying to deny any knowledge of the traditional system of healing. At least some of the convertees of the break away (syncretic) sects were honest enough to declare that they used to believe in that system some time back and since they were now saved (in their faith), they had

nothing to do with such practices any more. Table 5.4 illustrated that only 47.8 per cent of the respondents accepted the existence and efficacy of traditional healing methods. This figure could have been much higher given the facts known about the respondents if presumably there had been more honest people among them. One of the traditional healers, a Mr. Francis Otieno, who was interviewed, started his profession in 1935. According to him, the introduction of modern medicine has drastically reduced the number of clients but all the same he said that for some specific diseases people still go to him in great numbers. On the question of as to who, ie, what category of people his clients were composed of, the answer was *people from all walks of life, even the learned and the rich*. He further observed that although his clientele cut through a wide cross section of the society, there is a stigma associated with traditional healing. He lamented the fact that the British had termed African traditional healing systems backward and made the Africans themselves shy of what they had been practising for a very long time. Being shy of the system does not mean that they do not use it. When such a person wants to consult a traditional healer, he visits one who operates very far away from his home area to avoid being noticed by friends and neighbours. Alternatively, if there is a rite that is supposed to be performed in the client's home, the healer is instructed to pay his visit late in the night and leave very early in the morning.

Religious affiliation was cross-tabulated with diseases perceived as likely to be cured by faith healing to find out the

existence of any relationship.

Table 5.8 Religion by diseases likely to be cured by faith healing

diseases Religion	Don't know	Any disease	Spirits	Stomach ache	Back ache	Mental illness	others	Total
African traditional	1(1.1)	0	2(2.2)	0	0	0	0	3(3.3)
Anglo maria	0	0	2(2.2)	0	0	2(2.2)	0	4(4.4)
Catholic	26(28.9)	0	17(18.9)	1(1.1)	1(1.1)	4(4.4)	3(3.3)	52(57.8)
Anglican	5(5.6)	2(2.2)	4(4.4)	0	0	0	3(3.3)	14(15.6)
Pentecost	1(1.1)	2(2.2)	6(6.7)	0	0	0	0	9(10.0)
Others	3(3.3)	2(2.2)	2(2.2)	0	0	1(1.1)	0	8(8.8)
<b>TOTAL</b>	<b>36(40.0)</b>	<b>6(6.7)</b>	<b>33(36.7)</b>	<b>1(1.1)</b>	<b>1(1.1)</b>	<b>7(7.8)</b>	<b>6(6.7)</b>	<b>90(100)</b>

df = 30

$X^2$  (calc) = 40.3

probability level = 0.05

where  $X^2$  critical = 43.7

Gamma = 0.02

A  $X^2$  test was computed to find if there was any relationship between one's religious affiliation and the diseases the person believed faith healing could cure. At a probability level of 0.05 the Chi-square calculated is less than the Chi-square critical. this is an indication that religion has no influence at all on people's views about the diseases that can be cured by faith healing. This suggests that there is no relationship at all between religious affiliation and people's views on the diseases that can be cured by faith-healing. The gamma measure of association of 0.02 shows no association between religious affiliation and the views on the diseases that can be cured by faith-healing. This finding

enhances the assertion that faith healing has gained an acceptance in Ukwala which supercedes religious boundaries.

When the research was designed, it was hypothesised that members of the syncretic Christian religious sects, other than the Catholics and the Anglicans, would subscribe more to faith-healing (ie, resort to faith-healing for a wider range of diseases). However, the findings cannot be wholly relied upon for any conclusive claim since there are other factors to be accounted for. The belief in the efficacy of faith healing is not only confined to the boundaries of the particular sects which practise faith healing. It has already been noted that even members of the conventional Christian churches resort to the practice of faith healing when occasion demands. Unlike Christians in other parts of the world, for instance Britain or America, religious groups are not so distinct and there are no religious traditions to be adhered to.

There is a kind of a free mix and the difference in affiliation only comes in on Sundays when people go to church. An example of the prevailing state of affairs is when one claims to be a Catholic, either because one was baptized in that church when one was young but does not know very basic things about it, or because some members of the family belonged to that particular church. In fact, some of the respondents who claimed to be Catholics were not sure whether the said church practised faith healing or not. The syncretic religious sects have institutionalized faith-healing, making it an integral part of their faith. While some religious

affiliations do not practise faith healing as it were, they find this aspect attractive and resort to it during a crisis. In any case, all the religious affiliations have nothing against praying for the sick contrary to the way consultation with traditional healers is viewed. Table 5.9 is an illustration of people's reaction to the statement that faith healing works only on believers (and specifically members of the faith-healing sects).

Table 5.9 Opinion on the efficacy of Faith-healing

Response	n	%
Strongly agree	2	2.2
Agree	8	8.9
Uncertain	20	22.2
Disagree	60	66.7
TOTAL	90	100

Table 5.9 shows that out of a total of 90 respondents, 66.7 per cent disagreed with the statement (faith healing works only on believers). This has the implication that it is not only members of the syncretic religions who believe in faith healing but most of the people recognise the fact that it is a reality.

In the history of health, methods of healing which do not correspond to the science of medicine as it is known to us today are numerous. Doctor Braid's work on hypnotism is an example.

In 1841, Braid found that by fixing his eyes on those of a relaxed patient, or getting the patient to gaze at some bright

object until the eye muscles tired, he could induce a condition that looked like sleep. He further discovered that in this state of induced sleep the patient exhibited characteristics that made his sleep different from the natural type. The patient was extremely suggestible to anything the hypnotist said but oblivious of all else. Ideas suggested by another person were apparently unheard, unless the hypnotist told the patient to hear and heed them. If paralysis of a certain limb were suggested to the patient, then he appeared paralysed in that limb, but more usefully, symptoms of diseases from which he was suffering when he came to Braid were diminished and often removed during the hypnotic state.

[Weatherhead 1951]

Psychologists say that one of the great truths about the mind is: if it really accepts an idea as true, and if the idea is reasonable, it tends by means of unconscious processes, to actualise itself or come true. To bring about the entry of an integrating idea into a mind, so that the idea may come true and bring health, is called treatment by suggestion. Weatherhead [1951] defines suggestion as the action by which an idea is introduced into the brain and accepted by it without regard to evidence or proof, or even reasonable grounds.

According to Weatherhead, the early morning when we waken and the evening just as we drop off to sleep, are the best time for suggestions to be made in the mind.

The idea of specific times when suggestions can be made to the mind can be compared with the specific timings of faith healing

rituals. Most of the respondents who were aware of the requirements of faith healing rites pointed out that serious prayers for the sick were carried out at specific times. The hours mentioned in this connection were 9.00 p.m, midnight and 3.00 a.m. in the morning. Though most of the respondents who belonged to the faith healing sects were not sure of the preference for specific hours, a few of them attributed it to the "working hours" of angels.

In a study of the characteristics of patients of spiritual healing homes and traditional doctors in South-Eastern Nigeria, Uyanga [1979] found that there were characteristic differences between patients of spiritual healing homes and native doctors. Children, illiterates and married women, made up the largest proportions of the patients of most native doctors. Educated persons and young women formed the bulk of the patients in the spiritual healing homes. He observed that in both cases the majority of the patients were those suffering from mental symptoms, infertility, childbearing problems and diseases attributed to enemies, witchcraft and supernatural forces. Many of the patients in both cases were those who had failed to obtain any rapid treatment in hospitals or private clinics. Uyanga concluded that such disappointments in many cases had led to a resort in traditional or spiritual healing.

Similarly Katz and Kimani [1982] observed 50 patient /healer encounters in one administrative district of Nairobi (Kenya). Out of these encounters 32 patients were women 18, of whom complained of all or some combination of the following symptoms: Headaches,



stomach pains, loss of appetite and generalised aches and pains. They observed that because the patients of traditional healers are psychologically set to expect relief through confidence built around the healer, it is not surprising that a cure is achieved since many of their symptoms have a psychosomatic component and are related to inter personal tensions.

According to Black's medical dictionary, the three major problems that lead to psychosomatic disorders are: marital relationships; occupation, which includes frustrations, dissapointments and feelings of unfulfilment provoked by the patient's work; and social relationships, the feelings which prevail between friends, neighbours and relations.

This study also aimed at investigating the relationships between level of literacy (education) and belief in faith-healing, on the one hand, and the relationship between literacy (education) and belief in traditional healing, on the other. These relationships are given in tables 5.10 and 5.11, respectively.

A  $X^2$  test was computed to find if there was any relationship between level of education and belief in traditional healing as shown in table 5.10 .

Table 5.10: Education by belief in traditional healing

Level of education	Strongly Agree	Agree	Uncertain	Disagree	TOTAL
Illiterate	3(3.3)	11(12.2)	10(11.1)	24(26.7)	48(53.3)
Literate	3(3.3)	0	2(2.2)	2(2.2)	7(7.8)
Primary	3(3.3)	6(6.7)	2(2.2)	11(12.2)	22(24.4)
Secondary	1(1.1)	2(2.2)	3(3.3)	6(6.7)	12(13.3)
Post secondary	0	0	1(1.1)	0	1(1.1)
<b>TOTAL</b>	<b>10(11.1)</b>	<b>19(21.1)</b>	<b>18(20.0)</b>	<b>43(47.8)</b>	<b>90(100.0)</b>

df = 12

X<sup>2</sup> (calc) = 15.9

Probability level = 0.05

Where X<sup>2</sup> Critical = 21.02

Gamma = -0.05

At a probability level of 0.05, the X<sup>2</sup> (calc) on level of education and belief in traditional healing indicates that the level of education does not significantly influence the belief in traditional healing. The gamma measure of association of -0.05 shows almost no association between level of education and belief in traditional medicine. This could be as a result of the low levels of education reported among the respondents. 53.3 per cent of the respondents were illiterate, 7.8 per cent could read and write, 24.4 per cent were of primary level of education while only 13.3 per cent were of secondary level and above. A X<sup>2</sup> test was also computed to find if the level of education influences belief in faith healing as observed in Table 5.11.

Table 5.11: Level of education by belief in faith healing

Level of education	Strongly agree	Agree	Uncertain	Disagree	TOTAL
Illiterate	3(3.3)	2(2.2)	12(13.3)	31(34.4)	48(53.3)
Literate	0	1(1.1)	1(1.1)	5(5.6)	7(7.8)
Primary	1(1.1)	2(2.2)	3(3.3)	16(17.8)	22(24.4)
Secondary	1(1.1)	3(3.3)	1(1.1)	7(7.8)	12(13.3)
Post secondary	0	0	0	1(1.1)	1(1.1)
<b>TOTAL</b>	<b>5(5.6)</b>	<b>8(8.9)</b>	<b>17(18.9)</b>	<b>60(66.7)</b>	<b>90(100.0)</b>

df= 12

$X^2$  (calc) = 8.43

Probability level = 0.05

Where  $X^2$  Critical = 21.02

Gamma = 0.0

At a probability level of 0.05, the  $X^2$  (calc) on level of education and belief in traditional healing indicates that education does not significantly influence the belief in faith healing. The gamma measure of association of 0.0 shows that there is completely no association between education and belief in faith-healing. It can, therefore, be said that the belief in faith healing overrides factors like education since, in fact, faith involves total acceptance of an idea without question.

From the ensuing discussion, it can be concluded that faith healing like traditional healing, is a widespread practise in Ukwala. Apart from dealing with other diseases, faith-healing is seen to mainly deal with therapy in so far as spirits are concerned. Since the spirit phenomenon existed in Luo society

before the coming of Christianity and was dealt with by traditional methods, the arrival of faith-healing on the scene has divided therapy managing groups into two categories. The religious converts now subscribe to faith-healing while the secular ones still use the traditional healing methods.

The popularity which the techniques of battling with evil have with the local people, particularly prayer for the sick and excorsim, seem out of proportion to the concrete results obtained. If the desire to be cured is one of the principal motives leading people to indulge in faith-healing, it seems that when no real physical relief is forth coming, those affected content themselves with being accepted by the group and being the centre of attention. Certain indefinite complaints and chronic ailments are often a means of securing the attention of those around and of justifying some personal deficiency such as sterility or social failure. However, what matters is the reintergration of the patient in the group, who sympathise with his miseries and provide him at the same time with both explanation of them and compensation for them.

## CHAPTER SIX

### THE HIERARCHY OF RESORT IN HEALTH CARE

In this chapter the different stages of decision making in health care are sought. It was hypothesised that alternatives in health care are hierarchically ordered and that for most people hospital treatment is the last resort. It was also hypothesised that low socio-economic status tends to push people towards alternative health care systems other than hospital treatment. Both hypotheses are tested herein.

The stages of decision making were sought. First the distances from the nearest health facilities were measured. Table 6.1 below shows the distance distribution among the respondents.

Table 6.1 Distance to the nearest health facility

Distance	n	%
2 km and less	38	42.2
3-5 km	41	45.6
6-10 km	11	12.2
TOTAL	90	100.0

42.2 per cent of the respondents stayed within 2 kilometres of a health facility while 45.6 per cent were within 3-5 kilometres of a health facility. Only 12.2 per cent fell in the range of between 6 and 10 kilometres of a health facility.

The WHO recommended distance to the nearest health facility in the developing countries is a 4 km radius. The distances shown in the table are not very long by rural standards or even by the WHO

standards since only a small percentage would seem to be out of the recommended range. This has the implication that the majority of the people in the study area have access to modern health facilities, hence distance would not be a major factor militating on their non use.

To determine the decision making steps, the respondents were asked to mention their first healthcare contact (table 6.2) and other subsequent modes of action taken.

Table 6.2 Modes of treatment adopted chronologically:

Modes of treatment adopted	n	%
Patent medicine to private clinic	6	9
Patent medicine to health centre	2	3
Herbs to patent medicine	2	3
Patent medicine to herbs	2	3
Hospital to patent medicine	1	1.4
Private clinic to hospital	1	1.4
Health centre to faith healer	1	1.4
Patent medicine to private clinic to herbs	1	1.4
Traditional healer to patent medicine	1	1.4
Herbs to patent medicine to traditional healer to faith healer	1	1.4
Health centre to Hospital	1	1.4
Traditional healer to hospital	1	1.4
Herbs to patent medicine to health centre	1	1.4
Patent medicine to Quack	1	1.4
Herbs to private clinic	1	1.4
Herbs to health centre	1	1.4
Did nothing	3	4.2
Used only one therapeutic alternative	43	61.0
<b>TOTAL</b>	<b>71</b>	<b>100.0</b>

Table 6.2 illustrates that most of the respondents who reported a sick member in the family never went beyond two alternatives of

treatment. Of the 71 respondents only 3 reported to have gone beyond the second source of medical care contact. However, as the table shows, there is a wide range of variation in what the respondents chose as subsequent alternatives. This variation is in itself an attribute of human nature. From the way people look at symptoms of disease they are able to decide on what course of therapeutic action to take as a first alternative and if the results are not satisfactory what should follow next.

Table 5.2 established that patent medicine was adopted as a first source of help by a larger number of the respondents. It was therefore deemed necessary to establish the reason for the preference of particular therapeutic modes.

Table 6.3 Why particular therapeutic action was taken

Reason	n	%
Nearest source	25	36.8
Cheapest source	21	30.9
Most appealing source	22	32.4
TOTAL	68	100.0

Table 6.3 illustrates that of the total number of respondents 32.4 per cent resorted to a mode of treatment because they considered it most appealing, 36.8 per cent as being the nearest source and 30 per cent as being the cheapest source. These data suggest that the distribution of the stated alternatives ie, nearest source, cheapest source and most appealing source among the respondents was more or less equal proportionally. On the question

of which was the most appealing source of help, what actually qualified a source as appealing was the patient's previous experiences with services plus those of families and friends as well as factors like waiting time. In most cases the respondents qualified their sentiments about appeal of care by relating how somebody had been attended to at a particular place.

It was observed that the people of Siaya seem generally to value the medications and therapies that they pay for in the countryside more highly than the medications and treatments offered free at the government facilities. Many explanations are given for the priorities attached to therapies offered outside the national medical services. The people seem to have developed the idea that unless one knows an inside person at the hospital, it is not possible to receive adequate and efficacious treatment. This attitude could be explained in terms of the mentality which stems from ideas about traditional healing though unknown to the actors. Traditional healers in the Luo community were very knowledgeable people who were widely travelled in the land and knew most of the chiefs, clan elders and other notable personalities. Before they began their work they usually enquired about the home of the patient and, in most cases would identify with a person related to the patient. A typical remark would be:

*No wonder you resemble your grand father, he was such a great friend of mine we went to music festivals together. I was even there when your father was born.*

After such discourse the patient would gain confidence knowing that he is getting treatment from somebody who would do his best to



restore his health because they had something in common. On the contrary the doctor at the hospital has quite a different approach of detachment which leaves the patient wondering if he is getting the best treatment possible.

It is a widely held opinion of prospective patients that at the Government health facilities, aspirin is prescribed for every ailment, or alternatively, adequate dosages are not given because the drugs are provided free. Many express the view that injections are the medication that should be offered at the health facilities and people feel ill treated if injections are not given.

An attempt was made to establish if the therapy managing group's perception of the situation influenced the mode of treatment that was considered appealing. Table 5.4 gives the finding of the cross tabulation between what was done as the first thing when the illness was sensed and the perceived severity of the condition. A  $X^2$  test was computed to find if there was any relationship between the severity of a condition and the first source of help that was sought (see table 6.4 ).

At a probability level of 0.05 the  $X^2$  (calc) on severity of illness and first course of action taken indicates that the perceived severity of the condition does not significantly influence the mode of therapy to be resorted to. The gamma measure of association of -0.32 shows a mild negative association between severity of the condition and the course of action taken.

Table 6.4 First source of therapeutic help by perceived severity of condition

severity source	VERY SERIOUS	SERIOUS	NOT SERIOUS	TOTAL
Herbs at home	2(2.8)	3(4.2)	8(11.3)	13(18.3)
Patent Medicine	2(2.8)	14(19.7)	13(18.3)	29(40.8)
Traditional Healer	0	1(1.4)	2(2.8)	3(4.2)
Private Clinic	1(1.4)	5(7.0)	3(4.2)	9(12.7)
Health centre ;	2(2.8)	4(5.6)	2(2.8)	8(11.3)
Hospital	3(4.2)	2(2.8)	1(1.4)	6(8.5)
Others	0	2(2.8)	1(1.4)	3(4.2)
<b>TOTAL</b>	<b>10(14.1)</b>	<b>31(43.7)</b>	<b>30(42.3)</b>	<b>71(100)</b>

$$df = 12$$

$$\chi^2 (\text{Calc}) = 13.83$$

$$\text{Probability level} = 0.05$$

Where

$$\chi^2 (\text{critical}) = 21.02$$

$$\text{Gamma} = -0.32$$

This result can be explained by the various ways in which the respondents view diseases. Whereas a respondent could qualify a condition as very serious there is no general rule as to where help could be sought for such a condition. The determining factor would seem to be how the therapy managing group define the condition. This has the implication that a condition could be very serious pathologically or otherwise, but it could be defined as breach of taboo by one group and as intrusion of a pathogen into an organism

by another. Thus, both the groups would take different courses of therapeutic action under the same threatening conditions.

When the research was designed it was hypothesised that people perceive episodes of illness differently. It was further hypothesised that these perceptions would be influenced by factors such as education, social network and religious affiliation. It was also hypothesised that in the event of an illness different alternatives of therapy would be tried at different points in time. The research therefore sought to determine this hierarchy of decision making. The findings indicate that there is indeed a hierarchy of decision making in the use of therapy. However, the stages of decision making are not uniform for all the respondents. i.e there are individual variations in the steps taken. At least each of the existing modes of therapy was given either as a first second or third preference by different people. This has the implication that there are as many different stages in the therapeutic decision making process as there are individuals. The finding rejects the research hypothesis that it is probable that alternatives of health care are hierarchical and hospital treatment is for most people the last resort. The hierarchy is evident but it is not necessarily true that hospital treatment is the last resort for most people. Evidence from the study shows that some health problems can be dealt with without necessarily going to the hospital. Those conditions which warrant hospital attention are likewise accorded due attention without trying other means first. This in effect means that most people have their own criteria

for determining which cases can be dealt with through other alternative modes of treatment and those that require immediate hospital attention. These choices do not necessarily depend on the seriousness or severity of the condition. For instance, it would be wrong to assume that a patient would only be taken to the hospital after all other avenues have been tried without success. When a person falls ill the therapy managing groups, which may include families, kindred friends etc will decide what to do depending on their past experiences with cases of that nature. If known experience dictates that such a case had previously been effectively handled by a hospital, then chances are that the patient will be taken to the hospital first. On the other hand if traditional medicine is known to effect cure then it will be resorted to as a first alternative. Further, the finding indicates that a fine line cannot be drawn between those who subscribe to either traditional methods of healing, faith healing or the modern form of healthcare. Table 6.5 indicates an opinion poll on what people believe about faith-healing as a mode of therapy. It is evident from that table that although some people doubted the efficacy of faith-healing, a considerable number believed in it. This state of affairs makes it difficult to exactly place the different modes of therapy in any organized order of merit.

It is clearly indicated in table 5.3 that people chose to make use of different modes of therapy for different reasons. For instance geographical accessibility to a particular source of help would be enough reason for one to visit a hospital or a health

centre which is closest.

TABLE 6.5: Faith healing results in complete cure

Opinion	n	%
Strongly agree	8	8.9
Agree	24	26.7
Uncertain	18	20.0
Disagree	40	44.4
TOTAL	90	100.0

However other factors also come into play when considering the type of facility that is closest. In Ukwala Division, there are very few options in terms of modern health facilities. When considering Government sponsored facilities there is only one Rural health demonstration centre and one dispensary. the catchment areas of these facilities are much too large for their capacities which in effect means that their ability to cater effectively is grossly minimised. The Ministry of Health has specific kits which are distributed to the various health facilities all over the country. These kits are supplied to health facilities by considering the capacity and the catchment area that is served. There are special kits for health centres, dispensaries, etc. The ministry assumes that the kits are enough to cater for the needs of the facilities for a month so they are supposed to be supplied on a monthly basis.

The method of supply of facilities like drugs has its effect on shaping the general outlook of the institution in the manner in which it offers services to members of the public. Interviews with

officers incharge of the two government run facilities in Ukwala Division revealed that there were problems with regard to the procurement of drugs. One of the facilities (Urenga Dispensary) caters for a very big catchment area with a population which far overstretches its capacity to serve. In fact it is the only government run facility in the whole of East Ugenya Location. Urenga dispensary is supposed to get drug kits once a month from the District hospital in Siaya. A major problem that the dispensary faces is lack of drugs which is chronic. For one its big catchment area makes it impossible to run on the supplies kit meant for a dispensary. Secondly, even if the drugs are available at the district hospital when it is time to collect them the problem of transport is another issue altogether. The dispensary is even known to have gone for over a month without drugs. In such cases the medical personnel just examine their patients and prescribe drugs that they should go and buy.

If a patient happens to visit a health institution twice and on both occasions is told to go and buy drugs, chances are that next time he would find it more convinient to go straight and buy drugs. This is because it is disappointing to wait for long hours for treatment only to get none in the end. It was interesting to note that most of the people who used non prescribed medicines mentioned having bought aspirins from the shops. This drug is so popular that it is almost a household name among the respondents in the study area. People with complaints bearing on any form of ache would in most cases buy aspirin. Even the rise in body temperature

of an infant is an aspirin case. Aspirin is of course a pain killing drug which can reduce the aches manifested by certain diseases but cannot effect cure. This has the implication that if for instance one was suffering from malaria, one would take aspirin which might temporarily clear the accompanying headache and joint pains but allow the plasmodium to continue multiplying in the body unchecked. When this happens people suffer pains which are said to be unresponsive to drugs while the truth remains that they did not take the right medication.

The other health facility in the division is the Ukwala Rural Health Demonstration Centre. Like Urenga dispensary the major problem cited was the erratic distribution of drugs and at times total absence of essential drugs. It is evident from the ensuing discussion that rural health facilities are beset with problems of a complex nature yet the rural people are expected to have faith in them and utilize them to the maximum. The characteristics these facilities exhibit have a very important bearing on the health seeking behaviour of the people. Thus those people in this particular area who would like to visit a government facility as a first preference always have these considerations in mind.

In table 5.4, it is indicated that people in the area of study still widely believe in the efficacy of traditional medicine. The study reveals that in some cases of disease there are differences between indigenous perception of particular illness with clinical perception of the same illness. In this case there are differences between cultural perceptions of the severity of

the illness and biomedical evidence of severity of disease. Some diseases, for example malaria are known to be endemic during the rainy season when the plasmodium vector the mosquito breeds in large numbers. However when malaria protracts a severe illness it is felt to be operating in conjunction with other factors. In this case, going in line with the traditional cultural beliefs of the people, a traditional healer would be consulted to determine the spiritual basis of the situation and to obtain more powerful herbal preparation and ritualistic directives.

Another factor which affects the use of health services and thus delegating different complaints to different sources of help is the classification of diseases. In this case it was found that the basis of the disease classification system is what is believed to be the cause of a disease. Basically in all cultures there are ways in which people classify diseases (see chapter two). This applies to Ukwala too. The way in which diseases are classified in a way affects the type of medical services sought for its treatment. The use of health care services may depend on whether a disease is considered to be of natural origin (in the domain of scientific medicine) or of supernatural origin (in the domain of traditional and other healers).

Fosu [1981] carried out a study in which he investigated how the people of Berekuso, a rural community in Ghana, classified diseases and examined the extent to which this classification affected the utilization of existing health care facilities. He found that the people of Berekuso distinguished between three main



causes of diseases; natural, super natural and both natural and supernatural. Most supernaturally caused diseases were treated in the context of traditional medicine. It was also found that with the supernaturally caused diseases. there was belief that the clinic remedies were ineffectual and could even aggravate them. However, when such diseases are taken to the clinic, the people do so mainly for symptom relief, and they trust the traditional healer to effect the actual spiritual cure. Fosu observed that to most people of Berekuso, especially the illiterate, a disease was inseparably linked to its cause. He therefore came to the conclusion that even though the symptoms and signs of supernaturally caused diseases may abate with the help of scientific medication the subjective sense of being sick may persist so long as the spiritual cure has not been effected (see chapter one).

The prevailing situation in Siaya is such that it contradicts Foster's [1958] assertion cited by Fosu that

*many people needing medical care do not receive it because folk diagnosis says that the illness is one in native curers not the doctors domain.*

This is because in Siaya the classification of a condition is not permanent and is subject to redefinition which facilitates the change of therapeutic agent.

An example of an ailment which has multiple classification as far as the respondents in the study were concerned is loss of weight. Table 6.6 illustrates the various classifications attributed to loss of weight.

Table 6.6 Classification of loss of weight.

Class	n	%
Natural	30	33.3
Supernatural	18	20.0
Don't know	42	46.7
TOTAL	90	100.0

From this table it can be deduced that in analysing data within two broad based categories of the natural and supernatural each category has its own share of subscribers. The finding also shows that the number of respondents who classified loss of weight in the terminology of natural class were more than those who classified the same symptom with supernatural terminology. The greatest number however went to those who could not classify the symptoms in either category. Most of those who classified loss of weight in the supernatural category attributed the symptoms to *chira*. *Chira* is here defined as the result of breach of taboo which brings leanness and sickness unto death. Among the traditional Luo there was nothing more frightening than the knowledge that had been caught by *chira*. The Luo maintain that *chira* is the primary cause of most suffering and death, wherein rests the root explanation of most forms of misfortunes. Most of the respondents said that *chira* comes in many forms and it can act swiftly or very slowly.

Going by the traditional classification of diseases, the symptoms manifested by the acquired immune deficiency syndrome (AIDS), have been viewed as *chira*. The adherents of this

proposition claim that AIDS has been brought about by the current laxity of sexual mores. It is claimed that AIDS is spreading in big towns because of promiscuity of the type that has never been known in the rural areas. One of the respondents who was convinced that AIDS is actually *chira*, gave an example of a neighbour's son whom it was alleged was suffering from AIDS and the researcher had an opportunity to see.

The account goes that the man (A) aged about 35 worked in Nairobi and lived in the Kibera slums. This man had a neighbour (B) who was a Luo like him from Siaya District. It happened that the victim (A) befriended his neighbour's (B's) wife and had sexual intercourse with her. When (B) discovered what was going on between his wife and his neighbour he sent his wife back home to the rural area. When this happened (A) went ahead and befriended (B's) daughter whose mother he had shared a bed with. A few months later (A) fell seriously ill, he was taken to the hospital but there was no improvement and his health continued to deteriorate. At last it was decided that he goes to a traditional healer who diagnosed his case as *chira*. Since then, (A) lost a lot of weight and he continued doing so. The colour of his hair turned brown and soon he could barely stand on his own. At last (A) died after suffering for four years.

A cross tabulation was done and the Chi-square test worked out to find if there was any relationship between the way the symptom loss of weight was classified and the mode of treatment recommended for the symptom (Table 6.7).

Table 6.7: Classification of loss of weight in relation to mode of treatment

<u>treatment Class</u>	Natural	Super Natural	Do nothing	Natural & super Natural	Don't know-	Total
Natural	26(28.9)	1(1.1)	1(1.1)	1(1.1)	2(2.2)	31(34.4)
Super natural	5(5.6)	11(11.2)	0	1(1.1)	0	17(18.9)
Don't Know	33(36.7)	1(1.1)	0	1(1.1)	7(7.8)	42(46.7)
<b>TOTAL</b>	<b>64(71.2)</b>	<b>13(14.4)</b>	<b>1(1.1)</b>	<b>3(3.3)</b>	<b>9(10.0)</b>	<b>90(100.0)</b>

$$df = 8$$

$$X^2 = (\text{calc}) = 18.9$$

Probability level 0.05

Where

$$X^2 = (\text{critical}) = 15.5$$

$$\text{Gamma} = 0.1$$

At a probability level of 0.05, the  $X^2$  (calc) on symptom classification (loss of weight) and classification of the recommended mode of treatment for it indicates that symptom classification significantly influences the mode of treatment recommended. The  $X^2$  (calc) is not only significant at 0.05 probability level but it is also significant at 0.02 probability level. What this suggests is a strong significant relationship between symptom classification and the recommended mode of treatment for loss of weight. The gamma measure of association of 0.1 shows a very weak association between the two variables. These findings suggest that there is no overall framework for the

classification of disease symptoms among the respondents. In so doing the findings lend credence to the earlier assertion that there are so many different steps in decision making with regard to matters of health as there are individual variations in the perception of symptoms. At this point the research hypothesis that there are probable steps in the decision making process and hospital treatment is for most people the last resort can be modified. As the findings have shown, there are stages in the decision - making process depending on the classification of the symptom, ie, natural vs supernatural. This in effect implies that if a symptom is classified as natural then the first resort would be the modern health facilities while if it is perceived as supernatural other healing methods would be resorted to first.

The frame-work within which one classifies symptoms has been found to hinge on other personal attributes like education, income, contact with other communities e.t.c. Gordon Lloyd Chavunduka, (1972), in a study of therapy management in an African township in Salisbury (Harare). shows that neither the educational accomplishments nor the income of the patient have any impact on the choice of therapy because the therapy managing group includes members at all educational and income levels. Against Chavunduka's findings it was deemed necessary to investigate the corresponding situation in Ukwala. The main purpose was to find out if socio-economic status placed people into different categories in the therapy managing process.

TABLE 6.8 Groups of household heads by their occupation

Occupation	n	%
Teacher	6	6.7
Clerk	1	1.1
Farmer	59	65.6
Artisan	3	3.3
Labourer	1	1.1
Businessman/woman	6	6.7
Other	14	15.5
<b>TOTAL</b>	<b>90</b>	<b>(100.0)</b>

Table 6.8 indicates that most of the respondents, i.e 65.6 per cent were farmers (peasants). Teachers and clerks comprised only 7.8 per cent of the total, while the remaining lot consisted mainly of labourers, people operating petty business and artisans of various sorts. Table 6.9 is an attempt to show the incomes of these occupational groups. An attempt to quantify the incomes of these groups however proved problematic because it was not possible to determine income by converting the value of goods to their exact equivalent in monetary terms. However, estimates were worked out as shown in the said table.

TABLE 6.9: Income levels

Income	n	%
Upto shs 100	66	73.3
Shs 150 - 300	8	8.9
" 400 - 600	4	4.4
" 700 - 1000	4	4.4
" 1500 and Above	8	8.9
<b>TOTAL</b>	<b>90</b>	<b>(100)</b>

The figures in table 6.9 though not an accurate presentation of the

incomes of the respondents, illuminates the fact that in general terms the average income of the respondents was relatively low. This is more so considering the fact that where income was measured in terms of farm produce, the recorded income is not monthly but half yearly because of the two maize growing seasons. Despite the fact that most of the incomes were low, there were differences involved. A cross tabulation was therefore done for the variables income and the first step taken in healthcare in the event of an illness. A  $X^2$  test was then worked out to find out if one's income influenced the strategy of relief resorted to.

Table 6.10. Income by course of therapeutic action

<u>action</u> <u>Income</u>	Herbs	Patent Medicine	Traditional Healer	Private Clinic	Health Centre	Hospital	Others	Total
Upto Shs 100	8(11.3)	23(32.4)	2(2.8)	7(9.9)	6(8.5)	3(4.2)	2(2.8)	51(71.8)
150-300	2(2.8)	2(2.8)	1(1.4)	2(2.8)	0	0	1(1.4)	8(11.3)
400-600	1(1.4)	1(1.4)	0	0	0	1(1.4)	0	3(4.2)
700-1000	0	0	0	0	0	1(1.4)	0	1(1.4)
1500 and above	2(2.8)	3(4.2)	0	0	2(2.8)	1(1.4)	0	8(11.3)
<b>TOTAL</b>	<b>13(18.3)</b>	<b>29(40.8)</b>	<b>3(4.2)</b>	<b>9(12.7)</b>	<b>8(11.3)</b>	<b>6(8.4)</b>	<b>3(4.2)</b>	<b>71(100)</b>

$$df = 24$$

$$X^2 \text{ (calc)} = 24.52$$

$$\text{probability level} = 0.05$$

where

$$X^2 \text{ (critical)} = 36.41$$

$$\text{Gamma} = -0.02$$

The findings in table 6.10 indicate that income does not

significantly influence the course of action taken in the health seeking process. The gamma measure of association of  $-0.02$  shows no association. This finding is consistent with findings from other studies [Bice, Eichhorn and Fox 1972; Sparer and Okada 1974; Galvin and Fan 1975] which disapproved the assumption that low income persons under utilize physician services.

Barinlaw Malinowski [1944] observed that human behaviour, and hence the institutions that organize it into meaningful patterned activities arises in the first instance because of the biological need of humans. Malinowski tried to develop a scientific theory of culture on this premise, explaining all the manifold activities of people as being either directly or indirectly related to their attempts to assure for themselves, the basic needs which they, as organisms, require in order to survive and to thrive. The whole area of health seeking behaviour would seem to fit Malinowski's assertion that human institutions are based upon individual biological needs. This being the case, when an individual finds him or herself in a state of ill health, the best course of action will be taken notwithstanding factors like cost, distance and other socio - demographic factors. Indeed people seem to be acting rationally for maximum gain. Past experience plus knowledge or perception of a condition would determine whether the state of disease can be dealt with by administering patent medicine or other home remedies. Where past experience has shown that such measures have failed and the condition is best treated at the hospital, no matter at what cost



the sick will be taken there. This assertion fits well with the situational adaptation perspective where health is viewed as adaptation and the interactionist conception of the defined social situation. The range is wide; from symptomatic episodes where signs and symptoms are contained in everyday situations without direct medical consultation/everyday illness behaviour, illness experiences where coping necessitates medical consultation, acute illness behaviours, chronic disease where adjustment and long term care are necessary, chronic illness behaviour, emergent life threatening illness behaviour, emergent life threatening illness episodes which require definitive medical care and life threatening illness behaviour. Under the situational adaptation perspective, the image of health expressed by Dubos [1959], is that of a relationship to ones social, psychological and physical environments. The individual is perceived as seeking to establish a relationship with or within his environment, which must be constructed and sustained, and is ever changing and emerging. Health or disease is not an entity but a relationship that emerges within environmental settings. This suggests that culture is an adaptive response to environmental pressure in which man changes his environment, often drastically through the adaptive mechanism of culture.

Signs and symptoms of illness, do not speak for themselves, rather they emerge from the interaction of biophysical sensations and the process of social objectification or selection, interpretation and evaluation. The experiencing of signs and

symptoms by the individual does not occur "In Vacuo". Douglas [1970] in discussing the principle of integrity of the situation," argues that

*..... concrete human events are always to some degree dependent on the situational context in which they occur and can be adequately explained only by taking into consideration that situational context.[1970:37]*

The study also sought to establish the Respondents opinion as to whether lack of alternatives in health care in terms of the unavailability of health facilities or the inability of people to seek help from them (because of limiting factors such as cost, accessibility e.t.c) compelled people to seek alternative forms of healthcare; in this regard faith-healing methods other than modern health facilities. The respondents were requested to respond to the statement "Lack of alternatives in healthcare compels participation in faith healing". Table 6.11 shows the responses. The table gives the indication that 66.7 per cent of the respondents disagreed with the statement.

TABLE 6.11. Faith healing and lack of health care alternatives

Response	n	%
Strongly Agree	5	5.6
Agree	8	8.9
Uncertain	17	18.9
Disagree	60	66.7
TOTAL	90	(100)

In this regard it can be said that the other alternative methods in

healthcare used by the respondents and especially faith healing are not influenced by socio-economic factors but stand in their own right as parts of the larger coping system. This fits well with Malinowski's observation that there is no institution that emerges and persists in existence that has no function. The fact that traditional healers and faith healers exist implies that they serve some purpose.

From the ensuing discussion it can be argued that there are indeed different stages in decision making apparent in the health behaviour of people in Ukwala. These stages however do not appear in any organised order but seem to appear randomly from one person to the other. A host of factors determine these stages hence they are individual specific. This being the case, all the therapeutic options in Ukwala compete on an equal basis an indication that modern medicine is not always a last resort. Some cases which have been tried out in alternative therapeutic systems can be taken to hospital as a last resort in the process of healer shopping yet, on the other hand, some cases which are taken to hospital as a first source of health care contact can be forced to resort to alternative systems. In this respect income does not wholly exert any influence on the choice of therapy because of the actor's world view which places illness episodes in specific realms which supercede economic factors.

## CHAPTER SEVEN

### CONCLUSIONS AND RECOMMENDATIONS

This study sought to establish factors which influence the health seeking behaviour of the residents of Ukwala in Siaya District. The major objectives of the study were to examine the range of therapeutic options open to people in the area, to determine the distribution of therapy preference among them and to identify the variables that underlie the decision-making process in therapeutic choice. The study also sought to elicit information on the possible range of disease symptoms which are viewed as normal because of their widespread and common occurrence.

Findings on the range of therapeutic options show that a wide range of therapeutic options exist. Each of these options are used by different people at one time or another, hence all the therapeutic options were found to be valued by different groups at varying degrees. On the whole, preference for modern medicine was rated highest among the respondents. A section of modern medicine in the form of non-prescribed patent medicines was found to be very popular especially as a first step in medical care contact. Information on the range of medicine to be bought was found to emanate mainly from commercial advertisements in the media. The most common drug in use proved to be aspirin which surprisingly is no longer advertised in commercials. Because of its harmful side-effects aspirin is a drug which is in present times discouraged and

most commercial advertisements of drugs attempt to assure their consumers that their products contain no aspirin. Contrary to this observation, the impression created in the course of the study is that aspirin is the wonder drug relied upon by most people especially when it comes to complaints such as headache, backache, painful joints, and general restlessness in babies particularly when they are seen to have a hot body, "a temperature."

While patent medicine is widely used as a first source of healthcare contact, the use of herbs was found to be of significance too. Herbal remedies were found to play a big part in therapy especially on babies and young children. Cases such as vomiting, diarrhoea and blood in stool among children were found to be a main area of herbal medication influence.

The belief in traditional medicine was found to be widespread in the study area though very few people reported to have sought help from traditional healers. There is a kind of secrecy maintained by the people when it comes to the consultation of traditional healers because of the colonial derogatory propaganda war waged on African healing methods. Because of this people consult traditional healers but do not acknowledge the fact in public. However, judging by the peoples responses in disease causation, belief in mystical causation of diseases and the potency of witchcraft are acknowledged facts. Alongside traditional healing is faith-healing, which is widely acknowledged. Findings from this study show that traditional healing and faithhealing have a common sphere of influence in so far as symptoms they are

believed to cure are concerned.

Members of faithhealing groups and traditional medicinemen claimed that they could cure conditions resulting from the involvement of spirits, the evil eye, witchcraft, barrenness, vaginal bleeding and mental cases. While it was found possible to rationalize some aspects of traditional healing, e.g., the dispensing of herbs to be boiled and taken, making incisions on the patients body and applying medicine, etc, it was not possible to do the same for faithhealing since no medication is provided at all. What pertains in faithhealing is the fact that patients who go there are psychologically set to expect relief mainly because of the reassurance they get from the congregation who make them the centre of attention and concern. While the reassurance alone cannot effect a cure where pathogenic conditions are evident, i.e. where disease causing bacteria are involved, it proves very important in dealing with symptoms involving psychosomatic components which are related to tensions and stressful situations in life. This aspect is shared with traditional healing where the anxiety of the patient is reduced because of the confidence built around the healer who is capable of knowing what is wrong. In turn, this proves to be a very important curative process because it tends to re-direct the patient's psychic process towards a favourable curative direction.

Schwab and Pritchard [1950] classified types of situations they believe may lead to physiological disorders and chronic disease. They formulated 12 specific types of stress, which for

the purposes of this study, include: death of a loved one, fear of an unknown situation, fright, chronic worry, fatigue from overwork, rejection and feeling of isolation, disappointment and conflict. It is clear from existing studies [Mechanic 1968; Moss 1973], however, that the experience of stress is a subjective response on the part of the individual as a result of exposure to certain social experiences. According to Cockerham [1978], before an assessment can be made of the effect of stress upon an individual, it will be necessary to know: The nature of the stress itself; the subjective social environment within which the threat appears; the psychological supports offered by group membership and the duration of the threat. Indeed, these are aspects that can only be brought out by the kind of interaction which pertains between the traditional healer and the patient or the faithhealing congregation and the patients, and, definitely, not between a patient and a doctor in the hospital. In the final analysis faithhealing is seen to be an extension of traditional healing and an adaptation to the changing trends in contemporary society where traditional beliefs are seen to be losing credibility while Christian belief is being embraced. New concepts are being introduced to fit the next context while the basic ideas remain the same.

For most of the respondents in the study, distance to a modern health facility did not pose a problem. However, owing to the fact that the facilities implied included private clinics, the influence of income had to be considered. A Chi-square test to find the significance of income showed that income does not influence the

mode of therapy chosen. The perceived severity of a condition was also found to be no influence on the choice of therapy. A chi-square test on the significance of symptom classification on the choice of therapy showed that there was a significant relationship where  $X^2$  was even significant at the 0.02 probability level. The findings show that the way people classify symptoms influences the mode of therapy adopted.

On the hierarchy of decision making, the findings show that there exists what could be termed a multilinear hierarchy of decision making in healthcare. While a majority of the respondents who reported a sick member in the family only had a single medical care contact, very few went beyond the second contact. A look at the list of modes of treatment adopted (Table 6.2 page 92) explains why it is difficult to formulate or establish any trend in the adoption of subsequent modes of therapy. This is more so because what appears first in one case may appear second or last in another case and vice versa. This may be explained by the fact that in a plurastic medical setting where there are many options in healthcare, adoption of these depend on the definition of the situation. While a definition can be done, its finality depends on whether or not the threat of disease is arrested. If the threat of disease persists, it may call for a redefinition of the situation and consequently a different strategy to tackle the new situation.

An exception to the foregoing trend which appears to be having a uniform occurrence is patent medicine, which generally appears as



a first alternative in cases where it occurs. This may be explained by referring to man's natural inclination to objectify his goals by weighing and opting for the least involving ways. Patent medicine is easily available, cheap and does not involve the protocol of making appointments or spending long hours waiting to see a specialist. It is, therefore, only when this alternative fails to avert symptoms of disease that people now find it necessary to engage in more elaborate therapeutic processes.

While some diseases were found to be widespread, for example, backache in adults and diarrhoea among children, there was no evidence of any disease which was considered "asymptomatic" because of its widespread or common occurrence.

Findings on health seeking behaviour in the study area indicate that :

- (a) Health behaviour is a manifestation of the social and economic conditions which prevail in a community at a given time. The study reveals that Ukwala is a place which is wanting in medical facilities. This inadequacy of facilities has to some extent led to apathy in seeking help from medical institutions. While people recognise the need to visit hospitals and related institutions when they fall ill, at times they get discouraged by the nature of the services offered especially when there is shortage or total lack of essential drugs. While there is scepticism about the quality of treatment offered free at the government facilities, privately run

facilities prove rather expensive given the low economic status of the people in the study area. Because free treatment at times involves travelling for over long distances waiting to be attended to; which may finally end at the level of prescription without drugs, a compromise has been reached where a heavy reliance on "over the counter" drugs is the result. The situation is further compounded by lack of basic health education knowledge. This factor leads to the perpetuation of practices which are in themselves hazardous to good health like unhygienic food handling and storage especially during large gatherings like funerals, drinking unboiled water from streams and improper disposal of faecal matter. Worse still, in the absence of basic knowledge on matters concerning health, people become vulnerable to interpreting health problems in terms of the involvement of supernatural forces. This in effect makes people resort to mystical therapies.

(b) Faith-healing as a mode of therapy is not a new phenomenon in Ukwala. The findings show that the basic philosophical assumptions behind faith-healing as in traditional healing is the notion that disease or illness is a manifestation of forces from outside the human body. Both tend to locate the etiology of disease in mystical realms, e.g., evil spirits and witchcraft. When it comes to the act of healing both systems have divination and

prophecy as their main ingredients. Faith-healing in the study area incorporates elements of traditional healing in a new context where the converts of Christianity claim to surrender to the works of the Holy Spirit while they continue to deal with the threatening problem of disease and illness in a way that is comprehensible to them, which is based on their traditional-cultural world-view.

### RECOMMENDATIONS

- 1) Since the perception of symptoms of disease is evidently an important fact and the way people interpret the symptoms of disease plays a major influencing role in the actions they decide to take, it is recommended that health educators emphasize on educating people about causes of common diseases. For example, some diseases which result from malnutrition, unhygienic food, water and poor sanitation are sometimes viewed in terms which make it difficult to arrest their spread or recurrence. Motivation of the community through health education is vital in bringing about a desirable change in their knowledge, attitudes and practice. The health educators, while trying to change the people's attitude on the incidence of disease, should pay due attention to the traditional beliefs. For example, while it is

biologically known that Kwashiokor is a direct resultant of malnutrition, traditional belief in the study area explains it in terms of breach of sexual taboo. In such a case while the health educator enlightens the community on the importance of a balanced diet, there would be no harm in allowing the traditionally prescribed purification rites to be carried out alongside the improvement of the diet content.

2)

The study has shown that other methods of healing other than modern medicine are also beneficial to the general well-being of individuals. In the light of this finding an effort should be made to "decolonize" people's minds from the old colonial legacy that traditional healing is evil and un-Christian. It is surprising to find that up-to-date there are many people, the "educated" included who still maintain that there is nothing to traditional healing but without any objective justification. Modern medicine has benefitted a great deal from traditional medicine and could continue doing so if this valuable potential is taken seriously. A programme should be launched where traditional healers should be given the opportunity of airing their views with regard to their work and their medicines subjected to scientific tests with a possibility of having them prescribed in health institutions. Traditional healers should be encouraged

to learn from their colleagues in modern health institutions improved ways of storing medicine.

3) While traditional healing and faith healing are seen as being beneficial to people, their areas of influence and especially the disease they are said to 'cure' should be clearly identified. If done, this would go a long way in helping people to seek help in the right places when they are sick instead of groping around all the time before they stumble on the right therapy. As for faith healing, the reliance on prayer alone to cure disease is rather extreme and can have adverse negative consequences on the health of people if left unchecked. Church leaders, especially those whose dominations practise faith-healing should be advised as a matter of policy to make their followers aware of the importance of going for treatment in health institutions when they are sick. People should clearly be made to understand that prayer for the sick should be complementary to hospital treatment and not the ultimate answer for diseases.

4) The Ministry of Health's drug distribution system should be adjusted and made more efficient in order to facilitate the presence of drugs and essential equipment in the health institutions throughout. To achieve this, it would be advisable for the Ministry to carry out a

morbidity study throughout the republic so as to establish the prevalence of diseases in various parts of the country. If done, this exercise would help alleviate the essential drug shortage problem. Since the incidence of specific diseases is not uniform in the country, a state would arise whereby if, for example, there is a higher incidence of malaria in Siaya District and a very low incidence of malaria in Machakos District while there is a high incidence of Kalaazar in Machakos District and a very low incidence in Siaya, the proportion of drugs and equipment allocated to both Districts should be biased towards an inclination for the drugs which are more in demand for each district.

*alleviate*

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QUESTIONNAIRE

1. Name of Respondent .....

Division ..... Location .....

Sub location .....

Village .....

Sex: 1. Male

2. Female

2. Age

--	--

3. List the people who live in this household.

Name	Sex	Age	Relationship to Respondent

Code Categories:

1. Son

2. daughter

3. Niece

4. Nephew

5. 1st wife

6. 2nd Wife

7. 3rd Wife

8. 4th Wife

9. Grandson

10. Grand daughter

11. Other specify.

4. level of literacy (education)

- |                   |   |
|-------------------|---|
| 1. Illiterate     | 2. Literate (can read and write)          |
| 3. Primary        | 4. secondary <input type="checkbox"/>     |
| 4. Post secondary | 5. Other specify <input type="checkbox"/> |

5. Have you undertaken any practical training skill ?

- |        |                           |                          |
|--------|---------------------------|--------------------------|
| 1. Yes | 2. No ( If 2 Skip to Q 7) | <input type="checkbox"/> |
|--------|---------------------------|--------------------------|

6. What kind of trainig ?

- |              |   |
|--------------|---|
| 1. Masonry   | 2. Capentry                                 |
| 3. Tailoring | 4. Jua Kali <input type="checkbox"/>        |
| 5. College   | 6. Other (specify) <input type="checkbox"/> |

7. What is your main occupation ?

- |                    |                                   |
|--------------------|-----------------------------------|
| 1. Teacher         | 2. Clerk <input type="checkbox"/> |
| 3. Farmer          | 4. Artisan                        |
| 5. Labourer        | 6. Businessman/woman              |
| 7. Other (specify) |                                   |

8. What is your monthly income from this source? .....

9. Do you have other sources of income?

- |        |                             |                          |
|--------|-----------------------------|--------------------------|
| 1. Yes | 2. No ( if no Skip to Q 12) | <input type="checkbox"/> |
|--------|-----------------------------|--------------------------|

10. List the other sources of income .....

.....



.....  
.....

11. What is your total monthly income from all sources  
(don't Ask Compute) .....

12. Which of these assets do you own ?

- |            |                 |
|------------|-----------------|
| 1. Plough  | 2. Bicycle      |
| 3. Radio   | 4. Wheelbarrow  |
| 5. Ox Cart | 6. Two of these |
| 7. None    |                 |

13. How often do you travel out of ..... (Name area)

1. More than once every month
2. At least once every month
3. Once in six month
4. At least once every 12 months
5. Less than once in 12 months
6. Others (specify)

14. What is the nature (purpose) of your travels ?

.....  
.....

Decision making process:

15. Which is the nearest health facility from your home ?

.....  
16. How far is the health facility from your home ?

.....(in Kms)

17. Has anybody in your household fallen sick during the last one Month ? 1. Yes 2. No

if 17 is 2 Skip to Q 32)

18. How severe was the illness ?

1. Very serious 2. Serious  
3. Not serious 4. Dont Know

19. What was done as the first thing to cure the illness ?

1. Used herbs at home  
2. Used patent Medicine  
3. visited traditional healer  
4. Visited faith healer  
5. Private Clinic  
6. Health centre  
7. Hospital  
8. Other (specify) if nothing skip to Q 32)

20. Why did you take this course of action ?

1. It was the nearest source  
2. It was the cheapest source  
3. most appealing source  
4. Don't Know

- 21 For how long had the patient stayed without treatment or Medicine ?

- 1. Less than a week      2. A week      3. 2-3 Weeks
- 4. 4-5 weeks      5. 6 weeks & above

22. What was the distance travelled to the source of help ?  
 .....( Kms)

23. How long did it take to travel to the facility ? (time in  
 minutes, Hours) .....

24. What mode of transport was used ?

- 1. walked
- 2. rode on a bicycle
- 3. rode on a motorcycle
- 4. personal vehicle
- 5. public vehicle
- 6. Other (Specify)

25. How much did the transportation cost ?  
 .....

26. How long did the patient have to wait before treatment ?  
 .....

27. What was the cost of treatment ? (for self, Traditional, and  
 Faith healing, record the non cash resources expended)  
 .....  
 .....

28. How would you evaluate the treatment recieved ?

1. Very good

2. Fair

3. Poor

4. don't know

29. Did the person(s) feel better after treatment

1. Yes

2. No (if no Skip to Q 31)

30. How soon ?

1. Immediately

2. after a week

3. After 3 weeks

4. not sure

31. What else was done ? List all the mode of treatment adopted

Chronologically.....

.....

.....

.....

.....

.....

**Faith healing and traditionalism:**

32. What is your religious affiliation ?

1. African Traditional

2. Legio maria

3. Catholic

4. Anglican

5. Pentecost

6. others (Specify)

33. Have you ever heard of faith healing ?

1. Yes

2. No ( If no Skip to Q 40)

34. Have you ever participated in a faith healing ritual ?

1. Yes

2. No

35. Why did you participate in this ritual ?

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

36. What does it involve ?

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

37. Name the types of illnesses that are likely to be cured by

Faith healing.

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

38. Have you ever witnessed a person cured by faith healing ?

1. Yes

2. No

39. What is the attitude of your religious affiliation toward  
faith healing practices ?

1. Favourable

2. Unfavourable

3. Neutral

4. Dont Know

I Would like to know whether you agree or disagree with the following statements

STATEMENT	CODE CATEGORIES			
	1. Strongly agree	2. Agree	3. Uncertain	4. Disagree
When a person falls ill it is advisable to immediately take the patient to a faith healing congregation				
When a person falls ill it is advisable to take the patient to a traditional healer.				
Faith healing does does not result in complete cure.				
Traditional healing is outdated				
Lack of alternatives in health care compell participation in faith healing rituals				
Faith healing works only on believers and not non believers				

Perception of disease symptoms:

For each of the following symptoms, name the cause and possible mode of treatment.

46. Loss of appetite

- (i) Cause .....
- .....
- (ii) Mode of treatment .....
- .....

47. Eruptions on the skin.

- (i) Cause .....
- .....
- (ii) Mode of treatment .....
- .....

48. Blood in urine

- (i) Cause .....
- .....
- (ii) Mode of treatment .....
- .....

49. Excessive vaginal bleeding.

- (i) Cause .....
- .....
- (ii) Mode of treatment .....



.....  
50. Swelling of ankles.

(i) Cause .....

(ii) Mode of treatment .....

51. Loss of weight

(i) Cause .....

(ii) Mode of treatment .....

52. Bleeding gums

(i) Cause .....

(ii) Mode of treatment .....

53. chronic fatigue.

(i) Cause .....

(ii) Mode of treatment .....

54. Shortness of breath

(i) Cause .....

.....

(ii) Mode of treatment .....

.....

55. Persistent backache

(i) Cause .....

.....

(ii) Mode of treatment .....

.....

56. Fainting spells.

(i) Cause .....

.....

(ii) Mode of treatment .....

.....

57. Pain in chest

(i) Cause .....

.....

(ii) Mode of treatment .....

.....

58. Lump in breast

(i) Cause .....

.....  
(ii) Mode of treatment .....  
.....

59. Lump in abdomen

(i) Cause .....  
.....  
(ii) Mode of treatment .....  
.....

**For each of the following symptoms name the cause and all the modes of treatment you know.**

60. Diarrhoea.

(i) Cause .....  
.....  
(ii) Modes of treatment .....  
.....  
.....  
.....  
.....

61. Hysteria.

(i) Cause.....  
.....  
(ii) Modes of treatment .....

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

62. Persistent headache

(i) Cause.....  
.....

(ii) Modes of treatment .....  
.....  
.....  
.....  
.....

63. Persistent joint and muscle pains

(i) Cause.....  
.....

(ii) Modes of treatment .....  
.....  
.....  
.....  
.....

64. Blood in stool.

(i) Cause.....

.....

(ii) Modes of treatment .....

.....

.....

.....

.....

.....

65. Continued Coughing.

(i) Cause.....

.....

(ii) Modes of treatment .....

.....

.....

.....

.....

.....

APPENDIX :B MAPS.

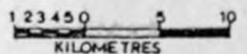
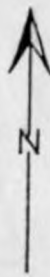
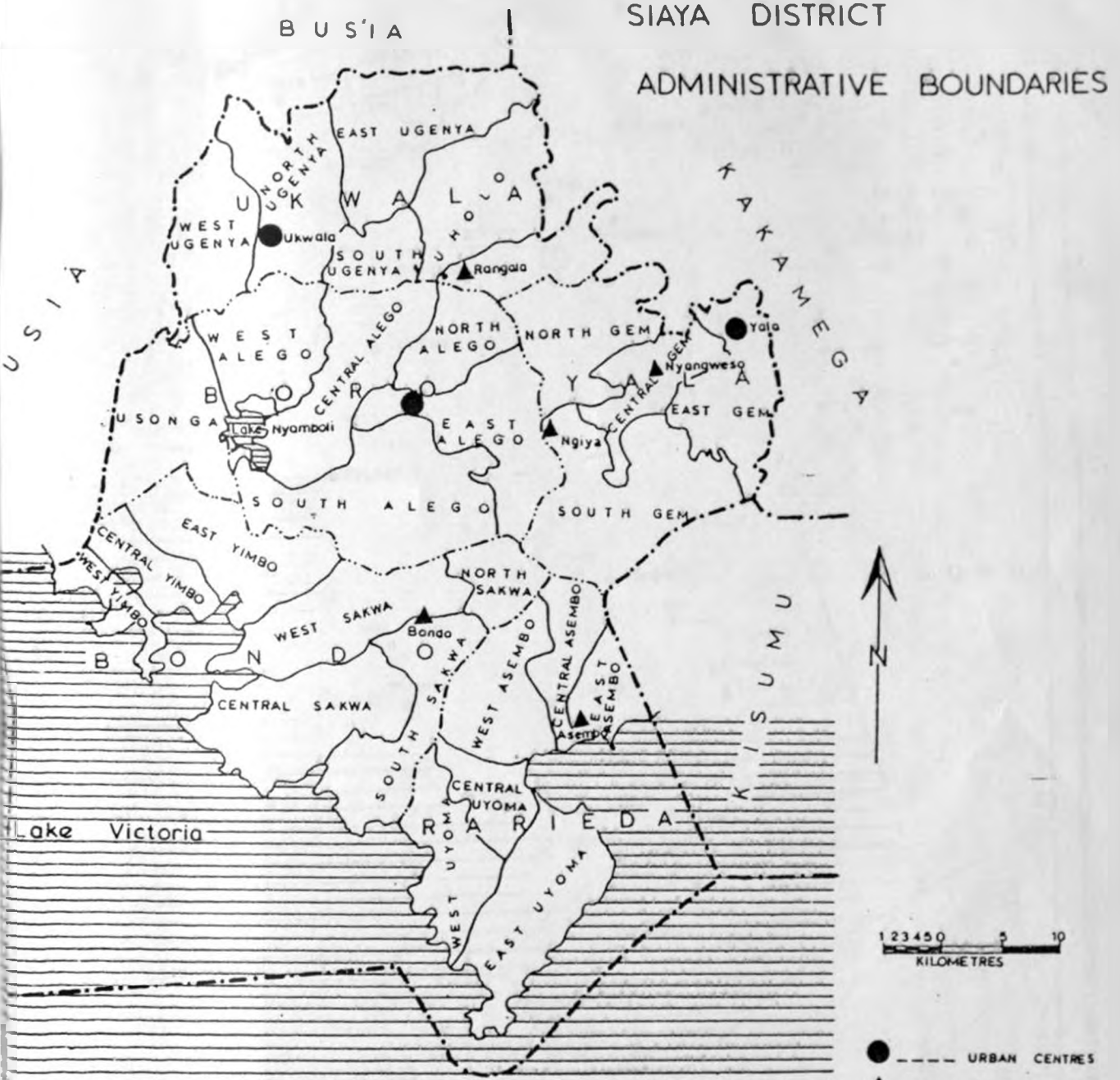
fig 1. Location Of District



Fig. 2

SIAYA DISTRICT

ADMINISTRATIVE BOUNDARIES



- URBAN CENTRES
- ▲ RURAL CENTRES

- DISTRICT BOUNDARY
- - - DIVISION BOUNDARY
- LOCATION BOUNDARY

SOUTH NYANZA



Fig 3 HEALTH UNITS: STUDY AREA SHADED



**LEGEND**

- |  |                       |  |                                 |
|--|-----------------------|--|---------------------------------|
|  | National Boundaries   |  | Local Centres                   |
|  | Provincial Boundaries |  | Siaya District General Hospital |
|  | District Boundaries   |  | Mission Hospital                |
|  | Division Boundaries   |  | Rural Health Centre             |
|  | Urban Centres         |  | Health Centre                   |
|  | Rural Centres         |  | Sub-Health-Centre               |
|  | Market Centres        |  | Dispensary                      |