HEALTH CARE CHOICE: OPTIONS AND FACTORS INFLUENCING HEALTH SEEKING BEHAVIOUR IN KHWISERO DIVISION OF BUTERE/MUMIAS DISTRICT
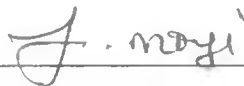
UNIVERSITY OF NAIROBI

BY

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A THESIS SUBMITTED TO THE INSTITUTE OF AFRICAN STUDIES IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF ARTS IN ANTHROPOLOGY OF THE UNIVERSITY OF NAIROBI

DECLARATION

THIS THESIS IS MY ORIGINAL WORK AND HAS NOT BEEN PRESENTED FOR
ACADEMIC AWARD IN ANY OTHER UNIVERSITY

_____
FERDINAND MOYI OKWARO

DATE:____15/11/99____

THIS THESIS HAS BEEN SUBMITTED WITH MY APPROVAL AS THE
UNIVERSITY SUPERVISOR.

_____
PROFESSOR OSAGA ODAK, Ph.D

Professor of Anthropology

DATE:____15/11/99_____

DEDICATION

This thesis is dedicated to my Mother

for her sacrifices in the course of my education

and to the memory of my Father (RIP)

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3.1 Khwisero Division

LIST OF ACRONYMS

ACRONYM:

C.B.D:	Community Based Distributor
C. H.A.K:	Christian Health Association of Kenya
C. H. W:	Community Health Worker
F.I.F:	Facility Improvement Fund
G.O.K:	Government of Kenya
H.B.M:	Health Belief Model
K.E.N.A.FIA:	Kenya-Finland Primary Health Care Programme
K. P.A.R:	Kenya Poverty Assessment Report
U.N.I.C.E.F	United Nations Children Education Fund
W.H.O	World Health Organisation

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ABSTRACT:

This study examines the influence of socio-economic and cultural factors in the choice of healthcare in a rural setting. The focus is on a rural community [area] since these areas have suffered inadequate modern medical facilities - a process initiated in the colonial era, but which has continued unabated in the post-independence period. To be able to investigate these factors, it was considered prudent to initially explore the range of therapeutic options available to the rural residents of Khwisero.

The rationale of this study is to examine why people follow the medical care consumption patterns that can be observed [identified] within their socio-economic and cultural setting. This information can then be used to make national policies on the improvement of healthcare facilities more effective.

This study used both qualitative and quantitative methods of data collection and analysis. Ethnographic methods such as in-depth interviews direct observation and focus group discussion were used. Secondary data which was also used and comprised library materials i.e books, journals and articles, that identified gaps of knowledge and helped shape up this research.

A wide range of therapeutic options was found to be prevalent in the study area. This can be broadly classified as falling either in the indigenous medical realm or in the modern medical system. Factors such as aetiological beliefs, economic resources available to a household, the severity of an illness and a patients' social matrix are investigated and found to excercise a deterministic role in the choice of healthcare. Aetiological beliefs for instance constrained the utilization of modern medical facilities for illnesses believed to be supernaturally caused. The adoption of in-kind, credit and property payment procedures endeared rural cash-strapped households to private medical facilities and traditional healers.

This study concludes that both traditional and modern medical systems play a complimentary and vital role in the fight against illnesses in rural areas. It is hereby

recommended that there is a need to impose checks in the provision of modern healthcare services provided by community health workers and drug stores to guard against their penetration by unscrupulous drug merchants. The role of traditional medicine in rural areas is already obviated. There is however a need to institute a deliberate and practical process to rediscover this lost heritage and to rid it of the obscurantist elements that have crept in following the many years of official and subtle neglect.

CHAPTER ONE

1.1 INTRODUCTION

Illness is a recurrent problem with which all groups and at one time or another, most individuals must deal. Because it is recurrent, and since the consequences of wrong decisions may at times be severe, people usually develop and come to rely upon specific standards for making choices involving the treatment of illness. The basis of decision making and the emergent health seeking strategies constitute the subjects of this investigation. Undeniably, the absence of disease is not the only measure of health. [W.H.O 1963]. However, success in eradicating diseases is a useful measure of how far or near a society is in terms of attaining good health.

Good health is both a basic need and a prerequsite for rapid socio-economic development, a healthy nation is sine-qua-non for successful industrialization. The Government recognizes this fact and has invested heavily in both the expansion of health Personnel and infrastructure [G.O.K 1997].

Wang'ombe [1989] indentifies five sub-sectors in Kenya's healthcare system. These are the ministry of health, local authority, for profit private sector, religious groups and missions and the traditional medicine centre. The government encourages the plural system of healthcare services in Kenya. This can be attributed to the fact as Foster and Anderson [1978] underscore that no scientific medical system completely satisfies all health needs of a nation. Even in countries with highly developed modern healthcare systems, many people under certain circumstances will turn to non-establishment forms of medical care such as chiropractors, faith healers and herbal doctors.

The ministry of health and local authorities are the only groups of healthcare providers who are by law required to undertake public healthcare activities which are financed with public funds. In Kenya, as in most third world countries such a system follows a pyramidal structure. This comprises few major hospitals at the top, a second tier of

regional hospitals and dispensaries, a third level of rural health centres and maternal child health clinics and a final layer of rural sub-centres served by resident or itinerant para-professional health workers.

The "for profit" private hospitals and missions, naturally do not provide systematic geographical coverage. However, where they exist, they usually provide services which would not otherwise be available. There are also parastatals and private companies that maintain healthcare facilities for their employees.

Currently there is an increasing recognition of the indigenous healthcare sector. Accordingly, the government allows for the registration of officially known herbalists [G.O.K 1997].

The advent of a pluralistic healthcare system in Kenya can be traced from the conquest and consequent assumption of State power by the Europeans. Modern healthcare [Western or Ordhodox] was thus introduced in contrast to the pre-existing indigenous healthcare systems that served the pre-colonized populations.

When new forms of medical care such as scientific medicine are made available to people whose health problems have previously been met by indigenous systems, the basic decision they have to make is not whether to accept the new or adhere to the old. Instead, they have a variety of options open to them which can be and almost always are excercised on a situational basis. McDonald [1981] observed one characteristic of modernising societies to be the co-existence of modern and traditional medical professions that claim to perform the same functions.

This study aims at identifying the socio-cultural and socio-economic factors that influence the choice of healthcare in Khwisero division. This study focuses on Khwisero division, because, like all other rural settings, it [Khwisero division] has suffered inadequate modern healthcare facilities. The genesis of this discrepancy is in the colonial era, but the process has continued unabated in the post colonial period. This

rural areas has been occasioned by lack of resources such as drugs, personnel and physical infrastructure. The problem is further excercabated by a poor transport and communication network which inhibits the movement of essential drugs and equipment from the metropolis.

The inability of the government to provide adequate modern healthcare facilities to its citizenry, especially those in the rural areas, has increased the adoption of a variety of therapeutic options. This study seeks to identify the pattern of healthcare choice in the face of a wide range of therapeutic options in Khwisero division. It will also examine the role played by social networks in health seeking behaviour. The latter preoccupation is inspired by what Foster and Anderson [1978] described as erroneous assumptions about decision making. This is the tendency by medical personnel and agencies to ignore the role of relatives and friends of the the patient in making decisions concerning choice of healthcare.

This study also looks at the criteria that people use in selecting among those alternatives i.e what information do they consider? The principles by which this information is manipulated in making a choice are investigated. People characteristically seek the advise of others and communicate with them about these decisions. Consequently, the process through which they are made are likely to be available through verbal elicitation.

1.2 PROBLEM STATEMENT

The preamble to the world health organization [W.H.O] constitution states that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, political belief, economic or social condition. [W.H.O 1963]. However, the cost of modern healthcare is rising very rapidly and serious challenges have arisen as to its iatrogenicity and overall effectiveness. This situation has put pressure on societies to search for more inexpensive but effective ways of providing effective healthcare to all segments of the population.

According to the Kenya poverty assessment report, [K.P.A.R] by the world bank [1995], the public sector provides about 70% of Kenya's hospital beds [KPAR, 1995:74], making it an important player in the provision of healthcare. The poor and the less educated use public facilities.

As a developing country, Kenya cannot afford to provide all modern medical facilities needed by the population. As a result of this constraint, many people, especially in the rural areas, have little access to modern healthcare facilities and have to contend with other options. This study investigates what these options are and how they affect the pattern of health seeking behaviour.

Fiedler [1993] has observed that the ministries of health of most developing countries have been plagued by persistent resource deficiencies since the early 1990s. The root cause of these deficiencies has been faltering economies, accompanied by declining relative shares of funding for the health sector. The constraint imposed by insufficient economic resources for health development is further accentuated by a high rate of population growth, which in Kenya stands at 3.2 [G.O.K 1997].

Developing countries therefore cannot maintain their historical per capita levels of service provision either quantitatively or qualitatively. The result of this in Kenya has been inadequate funding and shortages in key inputs required to maintain adequate standards of healthcare. The ministry is today faced with a crisis where available resources cannot match the demand for services.

The Kenya government's commitment to implementing the structural adjustment policy recommended by the International Monetary Fund and the World Bank has led to the introduction of cost sharing arrangements in a number of services sectors. In 1989, the ministry of health introduced a cost recovery programme called the facility improvement fund [F.I.F]. This programme included in-patient and out-patient fees for all hospitals and health centres. All the revenues so raised were to be used locally.

Since 1992, an outpatient treatment fee has been in place and a graduated scale of charges exist. The charges depend on the type of service and facility where it is offered. As the programme gains acceptability the charges are being increased [KPAR 1995].

The implications of cost sharing for the well being of the poor members of the Kenyan society, however, remain an empirical question. Little or no evidence exists regarding the way in which cost sharing will affect poor households' access to the basic needs such as health care.

The government's argument for instituting a graduated user charge scheme in healthcare is that it would facilitate health recovery, generate additional revenue, improve equity and discourage frivolous demand. However, cost sharing like any other well conceived and well intended project, may have devastating effects on some segments of the population. This is because of it's potential to erode the purchasing power of those populations. The rate of erosion is a function of the frequency a person uses services affected by cost sharing.

The government observes that cost sharing is being appreciated by the hospital users. This study tests the truth of this statement especially in the rural areas. It is hypothesized that users fees over and above other expenses may keep away patients in need of medical care. How does cost sharing for instance, affect a person's choice of modern public healthcare facilities? How able are rural inhabitants to consult hospital services at any point of their illness? How do user charges impact on the health seeking behaviour of the people?

The government has devised a system of waivers for patients who cannot afford to pay the medical fees. It is however, still unclear how the system of waivers works in practice. Recent estimates by KPAR [1995] suggest that very few exemptions have been granted. Further, are the poor attending health services aware of the system of waivers in the event

of financial difficulty? Who determines those who cannot afford, to pay and what is their judgement criteria?.

Besides user's fees, rural inhabitants experience other costs in order to access modern health care such as transportation costs. Khwisero is the poorest division in Butere/Mumias district. [GOK 1997]. It is inhabited by small scale farmers, [owning less than 2ha of land] and with no other source of income apart from occasional food supplies sold at the local market. Transport network is very poor as the division is served by earth surfaced roads only and experiences a severe shortage of motor vehicles. How do such factors therefore affect access to the one government health centre at Khwisero divisional headquarters?

This study also seeks to test the significance of cognitive dissonance in the process of decision making. Are modern healthcare facilities perceived as inappropriate in the local system for a particular category of illness?

The following questions have been used as guidelines:-
[1] What alternatives do members view as open to them in regard to the particular problem at hand?
[2] What is the pattern of health seeking behaviour?
[3] What role do social networks play in health seeking behaviour?
[4] What are the criteria that people use in selecting among available alternatives?
[5] What is the decision making process - the principles by which this information is manipulated in making a choice?

1.3 OBJECTIVES OF THE STUDY.
The main objective of this study is to investigate the cultural and socio-economic factors that influence the choice of healthcare in Khwisero division.

Specific Objectives:
1] To identify the range of therapeutic options available to the people of Khwisero
2] To identify social networks and their role in health seeking behaviour.
3] To describe the economic costs in the pattern of healthcare choice

4] To identify cultural factors in the decision making process at the family level

5] To examine the role of the gravity of an illness in the choice of healthcare.

1.4 RATIONALE OF THE STUDY

Most people in Africa are rural, economically deprived and illiterate [Mburu et al 1981]. Communicable diseases among them are rife. In such communities, the study of health behaviour, community needs and perceived priorities, values, and attitudes would be a contribution towards an evaluation of the dynamics of the society and the processes within it. This study intends to make some contribution to the substantive material in socio-economic and cultural aspects of health and illnesses in developing countries. It will also serve to illustrate the complex processes of cognitive and behavioural changes resulting from contact between non-industrial societies and western technology.

Foster and Anderson [1978] observe that there are various contemporary trends that have not been fully appreciated and their implications for health planning have largely been ignored. Among these trends are, on the one hand, the growing success of Western medicine in winning acceptances and, on the other hand, the rapid growth of alternate medical systems in the rural and urban areas. Therefore the problem is no longer that of Western versus traditional medicine. Instead the question has become one of the roles or possible roles for Western, and traditional medical systems in meeting health needs. The needs are as defined not only by health personnel but also as perceived by consumers. By examining the factors that influence the choice of healthcare, this study in essence investigates the role played by various healthcare systems.

The findings from such a decision making study will be formalized in a model that specifies the different ways in which specific considerations lead to the choice of each alternative. The discovery and modelling of such natural decision making processes have generally resulted in accurate explanations of the behaviour in question. According to Goodenough [1957] studies of this kind hold considerable promise for demonstrating the link between cultural knowledge and purposive action. The accomplishment of this task

has remained elusive despite the ethnoscience goal of describing what one needs to know to act appropriately in a given cultural context.

Foster and Anderson [1978] observe that unquestionably public healthcare programmes designed with an awareness of cultural factors and the beliefs and attitudes of the target group have been more successful. This is in contrast to those based only on the assumption that Western medicine is best and only a peoples stupidity prevents their acceptance and adoption of it. Apparently many of the resistance encountered in the promotion of western medicine are rooted in the medical profession as in the target group. A decision making study such as this one will identify the basis of preference and rejection of particular options. Such anomalies will be identified and recommendations made on how balances can be struck.

This study investigates the implications of the programme of cost sharing on the poor households access to basic needs such as healthcare. Odada [1989] observed that the ramifications of cost sharing on the well being of the poor members of the Kenyan society remained an empirical question. Yet, a thorough understanding of the socio-economic conditions of the people, as this study endeavours to undertake, should form the basis for rational cost sharing measures.

Banerji [1981] observes that, the central premise for any health care service system should be people centred. Instead of fitting people into a predetermined framework of health services, a framework should be designed to form a healthcare service which is tailored to suit the requirements of the people. All the technological innovations should be in consonance with the pre-existing healthcare delivery agencies of the community. Efforts should be made to ensure that they fit in with the cultural and social setting. In other words, people should not be educated to discard health measures that they have previously adopted, unless a convincing case can be made to show that it is possible to have an alternative technology which will yield greater benefits in terms of alleviating suffering caused by health problems.

This research hopes to come up with information that will enable the various health care agencies working in the rural areas to design healthcare schemes tailored to the needs of the people. Such a scheme will serve the people better by ensuring that it is in consonance with pre-existing health behaviour, pre-existing health institutions and healthcare delivery agencies of the community.

The analytical interest here is to examine why people follow the medical care consumption patterns that can be identified and how knowledge of these behavioural traits can make national policies more effective

CHAPTER TWO

2.0 LITERATURE REVIEW AND THEORETICAL FRAMEWORK.

In this section, relevant literature is reviewed under six subheadings.

a] Pattern of health care choice and availability of options

b] The stages in health seeking

c] Social networks in health care decisions

d] Cultural factors

e] Socio-economic factors

f] Gravity of illness

2.1 PATTERN OF HEALTHCARE CHOICE AND AVAILABILITY OF OPTIONS

Kasl and Cobb [1966] identify illness behaviour as any activity undertaken by a person who feels ill for the purpose of identifying that illness and seeking relief from it. An examination of the factors that influence the choice of healthcare falls within the purview of illness behaviour. This study investigates the decision making process that precipitates choice of healthcare and the resultant pattern of health seeking in a period of illness.

Mwabu [1984] Igun [1981] and Nyamwaya [1982] have observed that in a given period of illness, patients or their next of kin make health care decisions in stages. At the awareness of an illness, decisions have to be made as to whether to seek treatment or not. If the decision to seek treatment is made, the choice of health care amongst the existing therapeutic alternatives ensues. As Mwabu [1984] recognised, a visit to a health facility is assumed to be the result of a patients health care decision making process.

A patient, having visited a health care facility continues to monitor the effects of the administered treatment regimen. In the light of these effects, the patient further decides whether or not, to continue to seek further treatment. Should the patient decide to seek further treatment, she/he has to choose amongst the alternatives once again.

It is expected that not all patients come back to this stage, as some feel well and drop out of the sick role category. Others though sick may stop seeking further assistance for

reasons such as lack of resources   Therefore, underlying the observed visits [or lack of them] in the event of an illness to a health facility is an iterative and sequential decision making process which patients often repeat.

The introduction of Western style healthcare facilities by missionaries and colonialists precipitated a wide range of therapeutic options to Kenyans.   These options were superimposed on the indigenous medical system often referred to as traditional medicine [Sofowora 1982, Nyamwaya 1982].

Sofowora [1982] looks at the indigenous medical system as the total combination of knowledge and practices, whether explicable or not used in diagnosing, preventing or eliminating a physical, mental or social disease. Such a system may rely exclusively on past experiences and observation handed down from one generation to another verbally or in writing For Africa, Sofowora [1982] observes that such a system incorporates their original concept of nature.   This includes the material world, the sociological environment [whether living or dead] and the metaphysical forces of the universe.

The essential features of the indigenous health practices is that they were mostly evolved by the communities themselves in response to the health problems encountered by them [Banerji 1981]. Medical personnel in this system can be described as persons who are recognized by the community in which they live as competent to provide health care [Sofowora. 1982]. Elling [1981] however observes that this medicine tends to be built upon accumulated understandings and is more generally known to everyone with less concentration on the hands of specialists.

Western style medicine traces it's birth to western Europe in the late 18th century
Foucault [1973, cited in Cockerham 1992:4] noted the emergence at this time of
medicine of the species and medicine of the social spaces. Medicine of the species
concentrated upon classifying diseases, diagnosing and treating patients and finding
cures The human body became an object of study and observation in order that
physiological processes could be demystified and brought under medical control
[Cockerham 1992]. The medicine of social spaces was concerned with preventing
diseases.

Falola and Ityavyar [1992] observe that western medicine had benefited from the
discovery of the germ theory before it's introduction to Africa. The success of Robert
Koch, Louis Pasteur and others in bacteriological research led to the conceptualization of
the germ theory of disease [Cockerham 1992]. This went along with tremendous
progress in the development of internal medicine, anaesthesiology, pathology,
immunology and surgical techniques. [Cockerham 1992, Falola and Ityavyar 1992].
Physicians therefore concentrated exclusively upon a clinical medicine grounded in
scientific laboratory procedures. The practice of medicine thus rested upon a premise
that every disease had a specific pathogenic cause whose treatment could best be
accomplished by removing or controlling the cause within a bio-medical framework.

Dubos [1959, cited in Cockerham 1992:6] has pointed out that modern medical thinking
has been dominated by a search for drugs as magic bullets that can be shot in the body to
control or kill the health disorders.

Both the manner of introduction and the heritage of western medicine brought new
features and distortions to Africa. [Falola and Ityavyar 1992]. This included, emphasis
on curative care which stressed the building of hospitals and medical schools, an
expensive curative approach for patients involving their travelling to hospitals paying
hefty bills and purchasing drugs, a diminished role for the community and difficult access
to health care. Although there were cases of improvement in some aspects

[UNICEF 1981], there were at the same time problems generated by the penetration of western capitalism.

The entrenchment of the western medical system was a direct attempt to suppress traditional systems of health care. [Mburu 1992]. Missionaries and colonialists were highly ethnocentric and assumed the superiority of their own civilization over non western societies was obvious. Western medical personnel have been, if anything, even more ethnocentric about the superiority of western medicine. [Foster and Anderson 1978]. They find it difficult, despite evidence to the contrary ,that
given the opportunity all peoples will not accept a new medical system in it's totality.

Research has however established that, the introduction of another medical system to a people whose health problems previously have been met by an indigenous system opens up a dazzling array of alternatives. In Lusaka for instance Frankenberg and Leason [1976: cited in Foster and Anderson 1978:249] found the choices open to the sick to be of bewildering complexity. They include dyadic consultation with kin, with White Indian, and with fellow African employer, with neighbours and with friends, with western style doctors operating privately, or through government hospitals, all in addition to traditional healers - the *"nganga's"*. Lasker [1981] in cote d'voure lists therapeutic options as herbal medicine, diviners, [Feiticheurs] religious rites, prophets [christian] marabouts [Moslem], self treatment [either European or traditional] and western medical services.

Studies by Young [1980] Osero [1990] Mwabu [1984] Van Luijk [1981] and Nyamwaya [1982] have demonstrated a wide range of therapeutic options. They include:-
a] Self treatment using herbs [indigenous medicine]
b] Self treatment using patent drugs from pharmacies or retail shops
c] Indigenous medicine requiring a visit to a traditional healer
d] Modern medical treatment requiring a visit to a facility employing western medicine procedures and equipment
e] Faith healing
f] No treatment at all i.e expecting illnesses to go away on their own .

These options can be resorted to for different illnesses or at different points for the same illness.

2.2 STAGES IN HEALTH SEEKING.

Researches conducted on the stages in health seeking have adopted a wide range of methods and approaches. In most of these approaches, however, a number of inadequacies can be observed. According to Igun [1981] the most important shortcoming is the limiting nature of the popular method of correlating selected factors with reported utilization behaviour. This does a lot of damage through unnecessary fragmentation to a phenomenon which is largely an unfolding process. Igun [1981] observes that such methods make it difficult to explore in depth the influence of the relevant factors in empirical on going health seeking situations.

Freidson [1960] Frankenberg [1968] Suchman [1965] and Fabrega [1973] have attempted to provide models that might be useful in explaining health seeking behaviour. Igun [1981] points out several limitations inherent in these models. A glimpse at two of these models reveals some of the weaknesses. Suchman's [1965] model for instance assumes a single system of medicine and healthcare. Consequently, this makes it's value rather limited when it comes to explaining health seeking in societies where there are two or more well defined health care systems from which patients select a source of care.

Fabrega's [1973] model includes alternative sources of treatment. However, as Igun [1981] observes, the model is unnecessarily mathematical and ends up mystifying what it sought to explain. Because of the above limitations, Igun [1981] advocates the building of an eclectic model from those available. His model, thus, is an amalgam of the processes listed in the earlier models. Stages are made up of sequences of events which represent major transition points involving new decisions about future medical care. The stages, however, should be seen mainly as logical possibilities since not all occurrences of illnesses may go through the stages.

These stages vary in duration and may be simultaneous or so closely combined as to be only analytically distinguishable.

The first stage in health seeking is the symptoms experience stage. Igun [1981] analytically distinguishes four aspects of this stage. First is the physical experience which depicts the actual physical pain, discomfort or debility. The cue process is second and represents a series of events that lead to the awareness that something could be wrong with someone's health. Third is the cognitive aspect which refers to the interpretation and derived meaning which a person gives to the chain of symptomatic events. The emotional response is the final aspect representing the fear and anxiety that accompanies the above three stages.

In Igun's [1981] model the second stage is self treatment. However Mwabu [1984] observes that there are situations where a patient[s] may opt not to initiate any treatment for a variety of reasons. He [Mwabu] argues that the first decision concerns whether or not to seek treatment . It should therefore be anticipated that there is a no treatment stage which antecedes the self treatment one.

The self treatment stage depends on two major factors [Igun 1981]. These are:- [1] that a patient believes he understands and can attach a label to the symptoms and [2] that a patient perceives the symptoms as not serious and capable of being removed by self treatment. Young [1980] adds another important consideration to the above two. This is the knowledge of a home remedy which represents a very significant constraint to self treatment. Therefore, a person will move from this stage to the next when four factors obtain. These are, one, that the patient does not understand the symptoms and is unable to attach a label, two, that the patient sees the symptoms as grave and not capable of being removed by self treatment; three, that he/she has no knowledge of a home remedy; and four, that self treatment has failed to remove the symptoms.

The self treatment is followed by the communication to significant others [Igun, 1981]. This may be voluntary or involuntary. For example, a person with a persistent headache

will intentionally inform members of his immediate family. Conversely a close kin or a friend may notice the constant staying in bed, loss of appetite or the failure to participate in daily activities and draw the attention of the members of his immediate family to it. This stage may lead to or proceed simultaneously with the assessment of the symptoms stage [Igun 1981].

Two things are determined at the assessment of symptoms. [Igun 1981]. These are whether a person should legitimately assume the sick role and the statement of a tentative diagnosis. At the end of this stage a person may legitimately be an incumbent of the sick role [Igun 1981].

At the assumption of the sick role, the person is socially recognised for the first time as a legitimate incumbent of the sick role. His/her sick role has become socially legitimate and he becomes entitled to the privileges as well as the duties of a sick person [Frankenberg 1968, Igun 1981].

The expression of concern stage by kin, close friend and even neighbours follows the assumption of the sick role. [Igun 1981]. This expression of concern offers expressive and instrumental support. Of major concern in decision making is the instrumental support. This is because close friends and kin offer diagnosis and/or recommend treatment.

The above stage may lead to or proceed simultaneously with the statement about an assessment of the probable efficacy or aptness of sources of treatment [Igun 1981]. Every society has a taxonomy or language of illness which is made up of illness categories and labels. [Young, 1980]. These labels also contain ideas and recommendations about appropriate source of treatment or actions for various illnesses. [Igun 1981]. For instance, Young [1980] identified illness types that are widely regarded as treatable only with traditional curing methods.

The selection of treatment follows the assessment of probable efficacy. The former is the stage when particular sources of treatment or treatment action is opted for [Mwabu, 1984: Igun, 1981]. Here, the selected treatment plan is implemented. Mwabu [1984] states that at any one given moment, each of these decisions is discrete in the sense that a patient either chooses to seek medical care from a particular clinic, and not from any others. This stage may lead on to death and so terminate the process, or lead to the next stage where the effect of treatment on the symptoms is assessed. This often goes on with treatment.

As the treatment proceeds, the patient, his relatives, close friends and the practitioner whose services are being utilized constantly monitor the progress being made. [Igun 1981; Mwabu 1984]. This is to see whether or not the treatment is producing the desired effects on the symptoms. If so, the stages of recovery and rehabilitation commence. If it is not, the case then returns to the stage of assessment of symptoms with the aim of following the subsequent stages once more [Igun 1981].

It must be emphasized that these stages are not necessarily present in every case of illness; but they will often be found even in a condensed form. It is however necessary to examine the entire length of health seeking stages so as to analyse all instances and directions of decision making.

2.3 SOCIAL NETWORKS IN HEALTH CARE

According to Foster and Anderson [1978] a continuing problem in the doctor-patient and health educator - client relationship in the developing world is the assumption that patients or potential patients make decisions about what kind of medical help to seek. Lasker [1981] makes the same observation. In her research, she cites MC Kinlays' findings in the United States and Great Britain that social networks is a useful concept not fully explored [Lasker 1981:164].

The notion of social networks is similar to what Freidson [1960] referred to as the "lay referral system". It consists of non professionals, family members, relatives, friends or neighbours who assist individuals in recommending a course of action [Cockerham 1992]. Freidson [1960] described the process of health seeking as involving a group of potential consultants which begin in the nuclear family and extending outward to more select authoritative lay persons until the professional practitioner is reached.

The role of social networks commences at the point where an illness assumes both personal and social significance [Igun 1981]. According to Frankenberg [1968] the idea of disease is a social concept. The society is concerned about the illness of individual members because the illness of an individual member may disrupt equilibrium in social relations. Societal members therefore act to restore the previous equilibrium or to achieve a new one [Frankenberg 1968]. Societal members through instrumental responses help to diagnose and recommend initial and subsequent treatment alternatives.

The role of social networks should be examined within the society in which they operate. In all cases men may be cosmopolitanly or locally oriented [Frankenberg 1968]. Freidson [1960; cited in Cockerham 1992;99] suggests that when cultural definitions of illness contradict professional ones, the referral process will often not lead to the professional practitioner. The highest degree of resistance to using medical services in a lay referral structure lies in low class neighbourhoods. These are characterised by strong ethnic identification and extended family relationships [Freidson 1960].

Cosmopolitan action by contrast is to be found in societies with low ethnic exclusivity, less limited friendship and fewer authoritarian family relationship. These are more likely than authoritarian groups to know something about the disease and to trust health professionals.

Studies by Freidson [1960] Frankenberg [1968] and studies of low income blacks and Mexican Americans by Cockerham [1992] suggest that under certain conditions close and ethnically exclusive social relations tend to channel health seeking behaviour initially to the group. This is as opposed to professional health care deliveries.

However, Geertson et al [1975; cited in Cockerham 1992:104] found an opposite trend. They observed that the Momon community in Salt Lake city had a strong value of good health, education and an emphasis upon family authority and tradition. Their research demonstrated that group closeness and exclusivity can increase rather than decrease the likelihood of an individual responding to professional health services. They concluded that people who belong to close and exclusive groups, especially tradition and authority oriented families, will seek professional care if it is consistent with their beliefs and cultural practices. They will, however, decline to seek professional care if their beliefs support scepticism and distrust of professionals.

Similar processes were observed by Salloway [1973; cited in Cockerham 1992: 105] in the Gypsy community. Although semi-literate, poor and ethnically distinct, Gypsies operated an extensive communication network in the community. They informed each other on a regular basis about who was sick, where they were being treated and how pleased or displeased the patients and other interested parties were with the treatment.

Salloway [1973 in Cockerham 1992: 107] points to the existence of an accumulation of data among family members and friends concerning past diagnostic treating agencies, the prescription, prognosis for specific disorders and differences in the quality of service, including specialities offered in specific facilities. These enabled them to extensively utilize the available health care providers.

In view of such contradictory research findings, this study endeavours to establish the role played by social networks in health care choice for Khwisero. In the case of health care choice, social networks and it's specific values, opinions and attitudes act to suggest, advice or coerce an individual into particular courses of action. The role of social networks in meeting the costs of medical care in the event of financial difficulties will be examined.

2.4 CULTURAL FACTORS:

The importance of socio-cultural factors in differential choice and consequent utility of healthcare options has been underscored in a number of studies. This is because, as Kleinmann [1980] observed, health, illness and health care related aspects are articulated as-constituent parts of cultural systems. Such parts are, like other parts [e.g kinship and religion], symbolic parts, built out of meanings, values and behavioural norms. The health care system articulates illness as a cultural idiom. This further links to the beliefs about disease causation, the experience of symptoms, specific patterns of illness behaviour, decisions concerning treatment alternatives, actual therapeutic alternatives and evaluation of therapeutic outcomes.

Health, illness and health care are therefore part of a cultural system and need to be understood in relation to one another. As Kleinmann [1980] rightly posits, to examine one in isolation, distorts our knowledge of the nature of each and how they function in the context of specific cross cultural systems.

Foster and Anderson [1978] state that non-Western peoples, in their values and belief systems, exhibit forms that sometimes inhibit their acceptance of Western medicine. All people are ethnocentric. They are attached to their traditional ways and beliefs and they assume that these ways are equal to if not superior to the ways of others. The health and illness views of every people are part of their innermost being [Kleinmann 1980] and cannot be cast aside lightly.

Anthropologists have made use of the "adversary model" [Foster and Anderson 1978] which articulates the conflict between "primitive and folk medical systems" on the one hand and scientific medicine on the other. This model states that when western medicine is availed to peoples whose previous experience has been with traditional systems, therapeutic practices that are interpreted to be in direct conflict with traditional etiologic beliefs will encounter most resistance [Foster and Anderson 1978].

Young and Garro [1981] have expounded on the work of Freidson [1960] concerning the effect of adherence to folk illness beliefs in rural third world healthcare decisions. Freidson [1960; cited in Young et al 1981: 1453] suggests that the degree of congruence between lay conceptions of illness and symptoms and those of modern medicine is a primary determinant of whether or not people believing themselves to be ill will consult a physician. He asserts that the primary reason as to why people in non-western societies are less likely to resort to physicians than people in western societies is because they believe that certain illnesses cannot be treated by western medical procedures.

In cross-cultural literature explanations on the use and non-use of physicians services and support for this conceptual incompatibility hypotheses are variable. Research in Latin America, for example, has reported the operation of folk cognitive dichotomies in the choice of treatment [Young 1980]. Indigenous folk etiological beliefs led to the classification of some illness types as incurable by physicians. Young [1980] identified Mollera Caida [fallen fontanelle], maide ojo [evil eye] and illnesses where witchcraft was implicated as a cause to be treatable only by indigenous curing methods in Mexico.

Chen [1981] demonstrated that the clients ascribed cause was the single most powerful factor accounting for whether Malay villagers used medical treatment. In India Gould [1957 in Foster and Anderson 1978: 134] found that critical incapacitating dysfunctions were taken to the physician, while chronic non-incapacitating dysfunctions tended to be treated in the village.

Benyousef and Wessen [1974] report on the role of traditional healer attitudes as an important barrier to overcome in bringing about improvement in medical services of rural Tunisia.

In Kenya, Nyamwaya [1982] asserts that children with measles among the Pokot may sometimes be kept away from the hospital. This is because it is feared that an injection might kill them. In the same society, mental illness, sterility, impotence, fractures and constipation are usually treated by indigenous healers. [Nyamwaya 1982]. Other cases in Kenya include tuberculosis, among the Akamba [Ndeti 1972] leprosy and functional disorders among the luo. [Whissen 1964; Van Luijk 1971].

This study examines whether or not this dichotomy exists in Khwisero. The study seeks to determine the significance and implications of this dichotomy.

Other socio-cultural variables found to exert influence on the choice of health care are religion, age and sex. Cockerham [1992] states that the use of health services is greater for females than for males and more so for the elderly. Mwabu's [1984] studies had two observations:- one, that as a patients age increases, his/her probability of seeking treatment from a traditional healer decreases; and two, that a household finds it easier to allocate the time and money resources for health care of it's older members than for younger members. Members of a household, particularly those under five years of age, do not receive as much attention as the older members of the household. This is inspite of the well known fact that younger members medical needs are much greater than those for adult members. It will be worthwhile to find out whether the same results apply for Khwisero division.

Religion has also been found to influence the choice of health facility. Osero [1990] found that faith healing was a prominent feature in health seeking behaviour of the residents of Ukwala division in Siaya district. According to his findings the basic philosophical assumptions behind faith healing is that disease or illness is a manifestation of forces from outside the human body. Mwabu [1984] observed that Christians had higher probabilities of choosing modern health care facilities over traditional healers than households belonging to the indigenous religious system.

Religious influences together with other socio-cultural variables constitute one facet of this study.

2.5 SOCIO-ECONOMIC FACTORS

Socio-economic factors have been identified by various studies as income, education and/or occupation. Cockerham [1992] states that the higher or lower one's income education and or prestige are, the higher or lower will be their socio-economic class position. The socio-economic class endow or constrain accessibility to various health care options both at national and household levels.

It has already been observed that at national levels, many developing countries cannot afford to provide all the Western health care services required by their populations [Nyamwaya 1982]. This can be attributed to lack of resources. Pearce [1992] writes that in Africa, there is a deepening crisis and that global recession is felt more intensely than in other regions of the world.

Most people in Africa are still farmers. However, there have been crop declines, an exodus of people from neglected rural areas and an increased importation of food items. Just as there are growing inequalities in health between western and non-western countries, there also exists inequalities within Africa [Pearce 1992]. This is between rural and urban populations.

Western style health care in Kenya primarily provided by the state is almost exclusively in major urban areas, having been inherited largely without modification from former colonial powers [Mburu 1992]. The inequalities between the urban and the rural areas is in the differential allocation of such facilities as water, industries and health care [pearce 1992].

Some 85% of Kenya's population live in the rural areas. [Cockerham 1992: 282]. Ironically, this is where dispensaries and clinics are very few. If and where such facilities exist, they are poorly equipped and understaffed [G.O.K 1997].

Another major problem that rural residents face is that they must often travel great distances to reach a health clinic. [Mburu 1992; Osero 1990; Mwabu 1984]. Travel expenses, lack of transportation due to poor road networks in rural areas and delays are major impediments to the utilization of certain health care options. They consequently constitute decision making criteria.

The above conditions, prompted Lasker [1981] to conclude that choice of western medicine is inhibited not by "unscientific" attitudes but rather by political and economic factors. These factors, apart from limiting the usefulness of these services, increase the attractiveness of available alternatives. Accessibility of health services is the key factor in what are essentially rational decisions by rural inhabitants [Lasker 1981].

Availability of resources at household level is a factor that affects accessibility to various health care alternatives. According to Lasker [1981], the notion of accessibility includes such factors as the actual location of facilities, cost of facilities, communication breakdown and time delay. These are pertinent, especially as they relate to household characteristics.

According to the Kenya Poverty Assessment Report [KPAR 1995] the pattern of response to the occurrence of sickness in the household depends on several factors.

Among these are the household characteristics which include the location of the household and it's income. However, facility use also depends critically on the characteristics of the facilities themselves [KPAR 1995]. These are the characteristics which affect the price of the services provided [including the transport expenses and fees that are charged at the facility] and those that affect the quality of the service itself.

The availability of resources at the household level is a crucial factor as most forms of healing options involve some payment. Young [1980] observed that in Mexico, the cost of treatment ranged from very little [as in the case of self herbal treatment] to investments of quite substantial proportions of household resources for a physician's treatment. Households from lower economic classes may be constrained from utilizing options that involve colossal amounts of money. It is generally believed that people from lower socio-economic classes tend to under-utilize health services because of the financial cost and/or the culture of poverty [Cockerham 1992].

The culture of poverty is a phenomenon in which poverty over time influences the adoption and development of certain socio-psychological traits among those trapped in it. [Ruuder and Wheeler, 1978: cited in Cockerham, 1992; 106]. These behavioural traits which include dependence, fatalism and a lower value placed on health, tend to reinforce a person's disadvantaged position. The culture of poverty affects a people's perception of illnesses that warrant medical attention and those that do not [Cockerham 1992].

This study investigates the role of income and availability of resources at the household level in the choice of health care. It is hypothesized that the low socio-economic status of the residents of Khwisero constrains their use of modern health care facilities. Further, it increases, the attractiveness of other cheaper options.

The introduction of cost sharing in Kenya's public sector hospitals and the user charges in a private and mission hospitals are quite high for rural residents. The government, cognisant of this, has introduced a system of waivers for the poor [KPAR 1995].

However, the complex nature of the system of waivers inhibits their implementation. The KPAR [1995] reports that very few exceptions from payment have been made. Furthermore, the poor are not aware of such a system in Kenya's public sector hospitals.

The level of education is a socio-economic factor that influences the choice of health care. According to Mwabu [1984], education had no significant effect on the choice of health care. It only increased the likelihood of utilization of modern health care services. Lasker [1981] observed that education and income increased accessibility of both western and non-western therapies. Respondents with higher levels of education readily admitted utilizing both systems of medicine. This study will seek to establish the role played by education in view of these contrasting observations.

2.6 GRAVITY OF THE ILLNESS
The Judged gravity of an illness is a factor that determines the choice of health care. Igun [1981] states that the seriousness of an illness is one of the two conditions that may make a patient embark on, or omit the self treatment. Mwabu's [1984] research found that as the severity of an illness increases patients seek treatment from high quality government hospitals, private and mission health facilities.

Young [1980] identifies three levels of the gravity of an illness that may affect the choice of health care. At the first level is the non-serious category. This refers to an illness episode that allows normal activities, or that does not involve an interruption in the daily routines for more than a day or two. [Young 1980]. At this level, patients are known to either ignore the problem or to embark on a self treatment regimen. Lasker [1981] found that self treatment was used for fever and for less serious ailments. Mwabu [1984] found that pharmacies or drug stores were important sources of treatment at the early stages of an illness. However, as an illness period protracts their significance as sources of treatment declines rapidly.

The second level of gravity is the moderately serious category. [Young 1980]. It consists of illnesses that pose substantial interruption of daily activities by requiring one

to remain in bed. The diseases usually lasts longer than two days and resist initial treatment. Leavitt [1979] states that an individual's belief about the severity of his own illness, defined in terms of physical harm or interference with his own social functioning is a cue to action in health care utilization. At such a level specialized forms of diagnosis and treatment may require consultations with a curer or a visit to a hospital. Illnesses at this level are not regarded as posing a threat to life although they may become such a threat if left unattended to [Young 1980].

At the final level of gravity are illnesses that constitute potential threats to life. [Young 1980]. They may involve excessive pain or discomfort as well as considerable functional impairment. Such illness may be described as grave, dangerous or heavy [Young 1980].

Gravity assessments take into consideration the interaction between the severity of an illness and the resistance of the victim. The very old, young children and especially infants are regarded in most societies as lacking in resistance. Their illnesses, therefore, almost always evoke considerable concern. Cockerham [1992] observes that one of the reasons as to why older people reportedly utilized the services of physicians more frequently is because they were most likely to be disabled.

Certain constitutional factors are thought to be related to resistance. Young [1980] found that in Mexico, some people are said to have damaged blood which lowers their resistance, or to have blood that easily carries illnesses. Thus, what is objectively the same illness may be judged as representing different levels of gravity in two different persons. Cockerham [1992] also observes that some people will recognise particular physical symptoms and seek out a physician for treatment. Others with similar symptoms may attempt self medication or dismiss the symptoms as not needing attention.

The gravity of an illness does not only affect the initial choice of health care but subsequent patterns also. In the event that a particular therapeutic option is initially tried and a cure is not obtained, the seriousness of the "new" condition determines the choice of the new provider. In this study, the perceived gravity of an illness is considered as a choice factor and the manner in which it affects choices will be examined.

2.7 THE HEALTH BELIEF MODEL

This study will employ the health belief model as it's theoretical framework. As first conceived the health belief model hypothesized that persons generally do not seek preventive care or health screening unless three conditions are met. [Becker 1979]. These are that, [1] they must possess minimal levels of relevant health and knowledge [2] they view themselves as vulnerable and the condition is threatening. [3] they are convinced of the efficiency of intervention and see few difficulties in undertaking the recommended action [Rosenstock 1974]

The health belief model is derived to a great extent from the theories of psychologist Lewin [1935]. He suggested that people exist in a life space composed of regions with both negative and positive valences [Cockerham 1992]. An illness is a negative valence. While people are pushed away from regions with negative valences, they are attracted towards regions with positive valences. Therefore a person's behaviour might be viewed as the result of seeking regions which offer the most attractive values.

Specifically the health belief model contains the following elements:-
[a] The individual's readiness to take action as determined by both perceived likelihood of susceptibility to the probable illness and probable severity of it's consequences.
[b] The individual's evaluation of the feasibility and efficaciousness of the advocated health behaviour, weighed perceptions of physical, psychological, financial and other costs or barriers involved in the proposed action.

[c] A cue to action triggering the appropriate health behaviour. This stimulus can be either internal [e.g symptoms] or external, such as interpersonal interaction and mass media communication.

The assumption in the model is that taking a particular action would reduce susceptibility [Cockerham 1992]. The perception of all threat posed by a disease, however, is affected by other modifying factors. These are demographic, socio-psychological and structural variables that can influence both perception and corresponding cues necessary to instigate action. Action cues are required because while an individual may perceive that a given action will be effective in reducing disease, action may not be taken if it is further defined as too expensive, too unpleasant, too inconveniencing or perhaps traumatic [Cockerham 1992].

Various studies that have employed the health belief model [Becker 1979; Leavitt 1979; Rosenstock 1974] observe that health seeking behaviour is based upon the value of the perceived outcome [avoidance of personal vulnerability]. It is also contingent on the expectation that preventive action would result in that outcome.

This framework [H.B.M], has been chosen as an organizing rubric for a variety of reasons. As Cockerham [1992] observes, this model has demonstrated considerable utility in the study of health behaviour. The merit of the model is that even though an individual recognises personal susceptibility, he/she may not take action, unless the individual also perceives that being ill will result in serious difficulty. Therefore an individual's subjective assessment of the health situation becomes the critical variable in the utilization of health services. Infact, Cockerham [1992] observes that a person's subjective assessment may be more important than an objective medical diagnosis.

The health belief model has received the widest theoretical and research attention and the model seems to satisfactorily describe the majority of findings on health behaviour [Becker 1979]. The aptness of this model to this study stems from the fact that it

proposes specific linking mechanisms between socio-demographic variables and individual health action.

2.8 HYPOTHESES:

The following hypotheses have been derived for this study.

1. Social networks determine the choice of health care

2. Costs involved in accessing modern health care facilities increase the attractiveness of alternative health care facilities for low income households.

3. The choice of health care is influenced by cultural attitudes and beliefs pertaining to aetiology and efficacy of therapeutic options.

4. The judged gravity of an illness influences the choice of health care.

2.9 OPERATIONALIZATION OF VARIABLES,

a] Dependent Variable:

Choice of Health care:

The selection and consequent utilization of a health facility based on a specific criteria of judgement.

b] Independent Variables:

1] Social network

A social network refers to the social relationships a person has during day or day interaction which serves as a normal avenue for the exchange of opinion, information and affection. It is typically composed of family, relatives and friends that comprise the individuals immediate social world.

2. INCOME

It is the total of all cash income and other resources available to the household that can facilitate access to health care. It includes wages, proceeds from sale of farm produce and shop keeping.

3. CULTURAL ATTITUDES AND BELIEFS

These are a people's cognitive perceptions of their lives especially as pertains to health. They include their notions of health, illness and illness causation as well as the aptness and efficacy of therapeutic options as dictated by aetiological beliefs.

4. GRAVITY OF ILLNESS

It refers to the severity or seriousness of the condition of ill-being.

CHAPTER THREE

3.0 SITE SELECTION AND METHODOLOGY:

3.1 SITE SELECTION AND DESCRIPTION

3.1.1 LOCATION AND SIZE.

This study was carried out in Khwisero division of Butere/Mumias district in Western province. Khwisero is one of the administrative divisions that form Butere/Mumias district. When grouped with other divisions in the district, it is positioned between longitudes 34'20 and 35E and latitudes 0'15 and 1.0'N of the equator. It has a total surface area of 143 square kilometres [G.O.K 1997].

According to the 1997-2000 District Development Plan, Khwisero division has four locations. These are Kisa East, Kisa West, Kisa North and Kisa Central. However in the course of the research, Kisa central was split to create Kisa South. Two other locations were also created, increasing the total number to seven. It was, however, difficult to establish the names and boundaries of the 'new' locations. Fourteen sub-locations make up Khwisero division. They are Emasatsi, Munjiti, Mwikalikha, Mundobelwa, Eshibinga, Mushiangumbu, Mulwanda, Wambulishe, Doho, Eshirombe, Mundeku, Muliaka Ituti and Khushiku [see map 3.1].

3.1.2 CLIMATE

Khwisero lies within the equatorial belt and has an equatorial climate. The movement of air masses between the two temperate belts in the northern and southern hemispheres within the inter-tropical convergence zone provides two rainy seasons. These are the short rains and the long rains. The short rains commence in July and end in September with a peak in August. Generally, rainfall varies from 1000mm to 2.400mm [G.O.K 1997].

Lying in the southern parts of Butere/Mumias district Khwisero division has no distinct dry period. Consequently it has two cropping seasons per year. Temperatures vary between maxima of 26° and 32°C. This climate is good for the cultivation of bananas, napier grass, beans, maize, sweet potatoes, cassava, sorghum and horticultural crops. But there are also adverse effects caused by this type of climate [G.O.K.1997]. These include
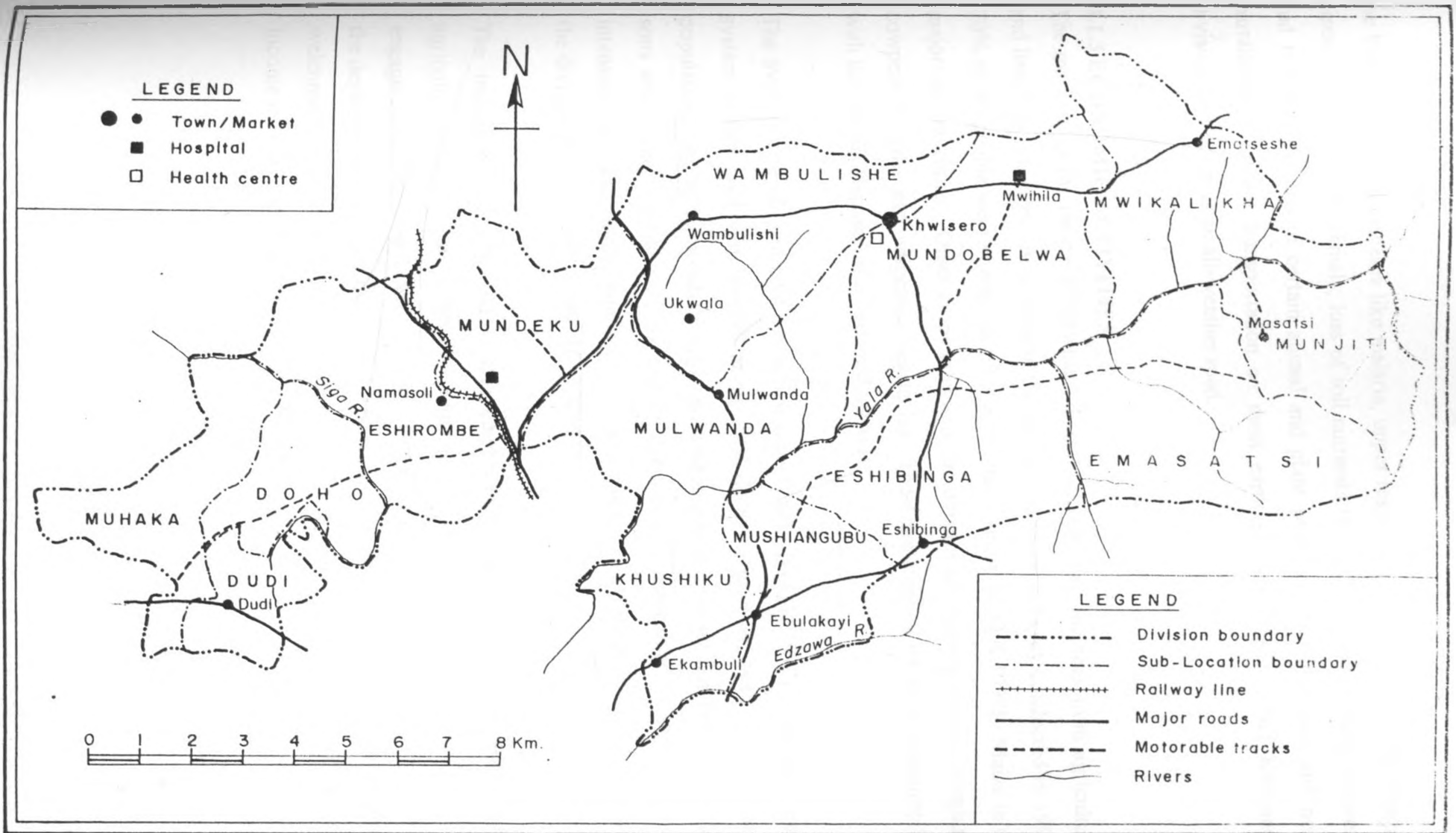
Map 3.1 Khwisero Division

the high incidence of diseases like malaria, upper respiratory tract infections and fungal diseases in plants and animals; loss of soil nutrients through continuous heavy showers and run off; breeding of certain animal and plant pests, and the high cost and near curtailment of motor transportation on most earth surfaced roads; infact Khwisero division does not have an all-weather road.

3.1.3 ECONOMIC ACTIVITIES

The majority of the people in Khwisero division derive their incomes from agriculture and livestock activities. According to the welfare monitoring survey conducted in 1994, 70% of the people were employed in the agricultural sector [G.O.K.1997]. Maize is the major income earner. Other crops grown in the division are cassava, millet, sorghum, cowpeas, bananas and indigenous vegetables. These are cropped for home consumption with the surplus disposed of in the local markets.

The average size of farm holdings is five acres [2ha]. [G.O.K 1997]. The land tenure system is free hold with owners having title deeds. However, with the increase in population, land is being sub-divided into uneconomical units by families as grown up sons seek ownership rights. This land fragmentation, accompanied by the adoption of intensive and inappropriate land use techniques has led to a decline in crop production in the division between 1991 - 1995 [G.O.K.1997].

The import of the aforesaid is that employment opportunities and incomes from agricultural activities are gradually reducing since small scale farm holdings usually engage casual and unpaid family labour. This situation has contributed to the increase in the depth of poverty in the division. The recent introduction of sugarcane production is welcome as an attempt to improve the economic capacity of a division with the lowest income in Butere/Mumias district [G.O.K 1997].

Labourers in the agricultural sector are paid according to the seasons of the year. This is because there are certain seasons when demand for farm labour is high and hence the wages are usually adjusted upwards. Labourers are paid Ksh50 per day [G.O.K 1997].

The informal sector employment contributes about 18.4% of the total employment of Khwisero division. The majority in this sector are employed in repair workshops, e.g in bicycle repair, carpentry and other jua-kali workshops, while others are self employed as barbers, shoe-shiners, repairers, market stall attendants and bicycle transporters which is popularly known as "*boda boda*".

The division also receives some money in the from of remittances form those working outside of it. Such remittances may be regular or for specific purposes, such as for paying school fees and medical expenses. The money is usually from husbands to their wives or working sons to daughters sending money to their parents.

However, it is important to note that:-

1] most of the incomes of the division is generated from the agricultural sector and only little comes from non-agricultural activities.

2] the people employed in the formal and commercial sectors are few and, thus, their proportion of income is not significantly as high as compared with incomes from agricultural activities.

3.1.4 HEALTH FACILITIES

As per the Ministry of Health records, Khwisero has seven health care points. [G.O.K 1997]. These are Khwisero government healthcentre, Muhaka dispensary, Namasoli mission health centre, Mulwanda clinic, Mwihila hospital and Ukwala mission hospital.

However, these official records might be misleading as they do not reflect the exact number of health care points in the division. For instance, the only mission hospital in Khwisero [Mwihila] was not operational due to administrative and financial constraints. At the same time the researcher stumbled across numerous private clinics that have been operational for over five years.

Kisa East location, for example, has Mundaha health clinic, Enanga Baptist dispensary and St. Mary's maternity and nursing. It is instructive to note that the ministry of health unequivocally states that Khwisero lacks a maternity and nursing home. One common feature of the private clinics is that they are temporary in nature. They appear, operate for some time, then disappear, only to reappear later. One explanation for the precarious nature of the private clinics was found to be a preoccupation with pecuniary benefits. A private clinic will operate only when it can raise money enough to cover for it's running costs. Some private clinics are also said to have closed down when the proprietors had amassed "enough" income.

It is probably for the above reasons as well as the fact that ministry of health records are contingent on the clinics that send their reports to the headquarters, that many of them are not on official records.

Several traditional medical specialists operate in the division. Since many of them are not registered it was not possible to establish their exact number. Some were even jittery when approached for fear that they would be arrested.

3.2 METHODOLOGY

3.2.1 STUDY POPULATION

This study focussed on household heads as the unit of analysis. This was in recognition of the fact that the household was the basic unit where decisions are made or disputed, and particular courses of action adopted. At every household the researcher interviewed either father or mother depending on their availability and how knowledgeable they were, on the households health seeking strategies. Generally, women appeared to be more conversant, especially on child illnesses.

Health care personnel in both modern and traditional medical domains, government administrators and other community leaders formed part of the study population.

This study was carried out in Khwisero division which is inhabited mainly by the Abashisa. Abashisa is a tribe of the Abaluyia, the majority of who live in the western province of Kenya. The Abaluyia is composed of 18 tribes, all whom speak dialects that are mutually intelligible. There is a general homogeneity prevailing among Abaluyia in all essential aspects of culture [Wagner 1970]. This [homogeneity] is however broken only by certain local differences.

3.2.2 STUDY DESIGN

This study was designed to initially investigate the range of therapeutic options that the people consider as open to them in the event of an illness episode. The researcher further investigated the cultural and socio-economic factors that influence the choice of health care facilities. The aim was to try to isolate the factors to determine in which direction they tilted or channelled the utilization of therapeutic options.

Data was collected in two categories. The first one involved interviews with household heads while the second one involved community key informants.

Key informants such as health personnel from both modern and traditional medical orientations are vital as they are the final executors of decisions made by potential patients. Others, such as the chiefs, and village elders [Likuru] were interviewed on account of their subsumed knowledge of the social, political and economic problems afflicting subjects under their jurisdiction.

Actual observation involving visits to health centres, traditional healers' clinics or homes that double as clinics was done. This was to enable the capturing of specific cases in the patterns of health care choice.

3.2.3 SAMPLE SELECTION

This study employed both probabilistic and non-probabilistic sampling techniques. These are multi stage-cluster sampling to obtain household respondents and purposive sampling to obtain key informants.

A cluster sample is a simple random sample in which each sampling unit is a collection or cluster of elements. [Menden Hall et al 1971: in Bailey 1987; 91]. Cluster sampling, also referred to as area sampling selects among clusters or areas.

Before embarking on the research, the researcher hoped to draw the clusters from the three administrative locations in Khwisero division. However, on arrival in the field, the researcher could neither ascertain locations nor their boundaries. This was due to the on-going process of subdividing and creating new locations.

The researcher, therefore, opted to sample from the sub-locational level due to the latters' relative stability. This was the first step in the multi-stage cluster sampling. From the fourteen [14] sub-locations, seven clusters were identified through simple random sampling. These were Mundobelwa, Mwikalikha, Eshibinga, Mushiangumbu, Khushiku, Munjiti and Emasatsi.

The second step was to cluster sample within the sub-location. The number of households falling under each village headman [Likuru] were clustered. From each sub-location two headmen were sampled randomly. Households falling under each sampled headman were listed and numbered.

The third step was to select a sample of between 20 and 25 households from the cluster of headmen. The lottery method was used here and a sample size of 150 households was obtained.

It was, however, not possible to interview respondents from all the households. A total of 122 household heads were therefore interviewed.

Purposive sampling was used to obtain key informants as well as members of focus group discussion. The researcher employed this technique as it enabled him to evaluate and pick only those respondents capable of meeting the objectives of the study. They comprised of village elders, chiefs, healthcare personnel, private clinic proprietors and other leaders from the division.

3.3 DATA COLLECTION METHODS:

The researcher employed the following data collection techniques to obtain the necessary qualitative and quantitative data.

1] A basic interview schedule administered to the entire population
2] Focus group discussion
3] In-depth interviews for key informants
4] Direct observation
5] Use of secondary data [documentary materials]

3.3.1 BASIC INTERVIEW SCHEDULE.

This method was used to obtain information from the 122 household heads. A structured interview schedule in the form of questionnaire was administered to the respondents by the researcher. Although it was anticipated that literate respondents would be allowed to fill the questionnaires, complications in the field disqualified the use of this technique. This is because the initial self administered questionnaires were found to be filled defectively. At the same time some respondents found certain questions to be irrelevant and left them blank.

The researcher also preferred to administer questionnaires as this would enable him to maximize the accuracy of information. For instance, when respondents were asked what their first course of action was in a particular illness, they would say "we went to a private hospital". However, on further questioning the respondents admitted that they had used herbs or called in a "bush doctor" prior to going to the hospital.

A standard questionnaire containing both open ended and closed ended questions was prepared before the fieldwork. It was important to use standard questionnaires whose wording and sequence was fixed and identical for every respondent. Such a method enhanced reliability. This is because the variation between responses could be attributed to the actual differences between respondents as opposed to differences that could accrue from the wording or sequencing of interview questions.

Fieldwork was conducted between January and March 1998. This corresponds to the land preparation season which is usually dry. Respondents went to their farms early, retired at 10.00 am and resumed at 5.00 pm. This arrangement worked to the convenience of the researcher because he could access the respondents between 10.00 am and 5.00 pm daily.

3.3.2 FOCUS GROUP DISCUSSIONS

Three focus group discussions were organized in the form of mini-symposia, where a group of between 6-8 respondents discussed among themselves. Issues discussed ranged from the availability of therapeutic alternatives and the criteria of health care decision making. A focus group discussion check list was prepared to ensure an exhaustive coverage of all relevant areas as well as to minimize digressions.

Membership of a particular focus group discussion comprised respondents from similar backgrounds or experience; caution was taken to ensure that age and gender did not stifle free discussions.

One focus group discussion comprised six [6] village elders. These were two women and four men. The village elders were selected with the assistance of the chief in Kisa East location. This focus group discussion was conducted at the chief's office.

The second focus group discussion was made up of six community health workers who abound in the division. These have been trained by various non-governmental organizations such as the Red-cross, Kenya-Finland primary health care programme [KENAFIA] and Christian Health Association of Kenya. [CHAK]. Two men and four women were included here. The researcher selected these members from a list of CHWs availed by the Divisional Medical Officer of Health. Each of these CHWs were visited and requested to participate in the focus group discussion to be held at Khwisero government health centre.

The final group was made up of young men between age 18-26 years of age. The researcher constituted this group for evaluation of inter-generational difference in the attitudes and health seeking behaviour. Eight young men were recruited.

It was not possible to constitute a fourth focus group discussion comprising nurses. This was because the nurses were on strike at the beginning [of the research] and for a good part of the field work duration.

A focus group discussion was facilitated by this researcher with the help of two research assistants. The researcher used the focus group discussion check list to set the agenda and moderate the scope while the research assistants took notes.

Focus group discussions were found to contain deep and valuable information especially on attitudinal variables. It was possible to compare each therapeutic alternative against the other[s] and obtain a consensus on preferential utility. Such see-saw questions were inappropriate to individual respondents. Information from focus group discussions was also utilized to authenticate data obtained through other methods.

3.3.3 IN-DEPTH INTERVIEWS

In-depth interviews were conducted with key informants. Included in this category were a chief, two clinical officers from Khwisero government health centre, two proprietors of private clinics, an administrator of a mission health centre, two community health workers, the divisional K.A.N.U women's leader and a traditional healer. These were selected on account of their vast knowledge on health matters and other societal social, economic, and political processes.

Community health workers, for instance, were found to be conversant with the peoples' attitudes and health care practices. This is because, in most cases, they were the first to be consulted by potential patients. As people who lived in the village, they were privy to both subtle and arcane information especially with regard to illnesses that respondents preferred not to treat using modern medical technology.

Health care personnel, especially the proprietors of private clinics, were very conversant with the illness categories, as well as the cultural and socio-economic constraints facing their clients. Herbalists were able to yield information on the characteristics of their practice as well as the categories of their clientele.

This category of informants provided an invaluable plethora of qualitative information. A question guide containing a list of questions to be covered was prepared. However, relevant information yielded by informants outside the question guide was also incorporated.

3.3.4 DIRECT OBSERVATION

Under this method, the researcher hoped to identify long term illness episodes at household levels. This would enable him to get specific information about the duration of that illness and to sequentially document all alternatives employed in each case. However, financial and temporal impediments constrained this objective.

In the face of limited time and financial resources, it was not possible to trace and follow up specific illness episodes. Instead, the researcher opted for retrospective accounts of long term illnesses from respondents.

The researcher also opted to observe instantaneous utilization of health care alternatives by visiting the health care facilities. Under this technique, the researcher would visit a health facility, and stay there for between 2-3 days.

He would observe the actual interaction between health care personnel and their patients, dignosis and dispensation of therapies. Relevant information about the illnesses and processes involved in accessing health care from both the clinicians and patients perspectives was thus obtained. The researcher for example spent three days at Khwisero government health centre and observed patients being treated. Informal mini-interviews were conducted with such respondents.

3. 3. 5 SECONDARY DATA REVIEW
The researcher reviewed secondary literature on health seeking behaviour, as well as on the culture of the Abashisa people under study. This information was obtained from books, journals, papers and articles. From this literature, pertinent information on the range of therapeutic options, as well as on the factors that relate to choice of health care, were examined. It is from this information that the researcher was able to obtain background information, put the study in proper perspective, as well as to develop and operationalize hypotheses.

3.4 THE PRE-TEST
The aim of pre-testing was to enable the qualitative evaluation of all aspects of the questionnaire. This includes the wordings, order, inappropriate, missing, redundant, unclear and confusing questions or response categories.

To achieve this objective, rough draft questionnaires were administered to a few selected respondents during the first week of fieldwork. Both self administered and researcher administered questionnaires were used to make the necessary amendments.

At this stage the researcher identified several inadequacies of the questionnaire. Questions were reformulated while the redundant ones were expunged altogether. In this way, the researcher ended up with a refined questionnaire that facilitated a smooth field work.

3.5 METHODS OF DATA ANALYSIS
Both qualitative and quantitative techniques of data analysis have been used in this study, in line with the nature of the data generated which was both qualitative and quantitative.

Quantitative techniques involved condensing raw data from the field and quantifying it into meaningful and readily discernible patterns. The main descriptive tools employed include percentages, frequencies and range. With the help of frequency tables, relationships between the variables are presented and explained.

Qualitative data was initially organised in the field. At the formal analysis stage the researcher drew from the evaluation questions generated during the conceptual and design phase of the research, as well as analytic insights and interpretation that emerged during data collection. Detailed descriptions, in-depth quotations and case histories are employed in presenting these data.

3.6 PROBLEMS ENCOUNTERED IN THE FIELD
The researcher encountered several problems in the course of his fieldwork. Transport in Khwisero division constituted a major handicap. It has already been observed that the entire division is served only by earth surfaced roads. Very few vehicles operate within the division. The researcher, for instance, found that no vehicles operated from the divisional headquarters to any of the sub-locations. It was thus initially quite difficult to

access respondents. The researcher was thus forced to use bicycle transport [*boda boda*]. Although it was possible to obtain *boda boda* transport in the morning, the return journey to the researchers abode was hectic. This was because, most *boda boda* operators retire in the evenings. The researcher was thus forced to buy a bicycle and ride it himself.

The researcher could not establish the exact number of locations in Khwisero because of the on-going process of creating "new locations". The boundaries of the "new locations" could not be discretely established. This made it difficult to sample at the locational level. The researcher was, therefore, forced to sample from the sub-locational level as these were relatively stable.

Health care issues are a vital concern of all members of a population. It is, therefore, expected that people would be eager to volunteer information on health matters. Informants were, however, quite suspicious of the true identity and intentions of the researcher. Nevertheless, in most cases, the researcher was welcome in the households, and the informants were eager to ascertain his ethnicity , the reason for visit and the expected benefits the community could get from the research.

Informants thought that the researcher was either a government agent [doctor] or a spy. Those who thought that the researcher was a government doctor, conspicuously exaggerated their plight so as to evoke the governments sympathy. Others who saw the researcher as a government spy were very jittery. As a result many traditional birth attendants and healers concealed their identity. Apart from promptly identifying himself, the researcher enlisted the services of the chiefs and village elders, to impress the informants on his genuity.

Cattle theft was found to be quite rampant in Khwisero division. The presence of strangers was, therefore, highly suspicious. Some informants thought that the researcher was a disguised cattle thief. This made it quite difficult to obtain information on socio-economic variables, such as ownership of livestock. Informants denied ever owning cattle even in situations where the researcher could see livestock tethered outside the

homestead. In such instances the researcher would deliberately stare at the tethered livestock. In most cases the respondents clarified the status of the animals tethered.

This research was also hampered by the nurses' strike, that occurred prior to and in the course of the fieldwork. The researcher was forced to cancel a scheduled focus group discussion comprising nurses.

The researcher was constantly warned of the possibility of being bewitched. When the researcher probed into who was most likely to be a victim of sorcery or evil eyes, informants retorted: *"kata eyiwe unyala khulokwa"* [even you, can be bewitched]. The researcher also remembers one woman's shock when she was informed that the researcher intended to visit all households. Her response was unequivocal: *"eyiwe ulafwa"* [you will definitely die]". As a young man with university education and erroneously thought of as being a government officer the researcher was informed that he was an obvious target for witchcraft.

Such "warnings" and "advice" affected the manner in which fieldwork was carried out, especially in areas reputed to be saturated by witches. The researcher was advised to walk around with herbs on his hair or in his pockets.

CHAPTER FOUR

4.0 PRESENTATION, ANALYSIS AND INTERPRETATION OF RESEARCH FINDINGS

This chapter analytically presents the research findings. The aim is to describe and show the relationship between various cultural and socio-economic factors and the choice of particular healthcare facilities.

The data presented here was obtained from a sample population of 153 informants. When disaggregated, this comprised of 122 household heads, 11 key informants and 20 members of focus group discussions. A total of 200 illness episodes were elicited from the households. Specific illness cases obtained through direct observation at health centres are also incorporated and analysed. These episodes are presented as illness case histories that assisted in making more concrete several features of the decision making process at the household level.

These data focus on five major areas. These are the range of therapeutic options and health status; the socio-economic characteristics of the households and the utilisation of therapeutic options; the influence of social networks; cultural factors and illness treatment; and the gravity of the illness vis a vis health care options. These five focal points should not be misconstrued as sub-headings for this chapter since the data is neither, strictly pigeon-holed into these categories, nor chronologically presented under the same.

4.1 RANGE OF THERAPEUTIC OPTIONS

Several therapeutic options were established in the study area. They include:-

4.1.1 Self treatment [traditional medicine]

4.1.2 Traditional medical specialists

4.1.3 Self treatment using Western medicine

4.1.4 Visit to modern health care facilities be they government, private or mission health care facilities.

4.1.5 Village health workers

4.1.6 Faith healing

4.1.1 Self treatment using traditional medicine

Knowledge of a herbal home remedy is an important determinant as to whether a patient will embark on a self treatment regime. Informants were asked to indicate whether they had some knowledge of traditional herbs. This information is presented in table 4.1

Table 4.1 INFORMANTS' KNOWLEDGE ON HERBS

RESPONSE	FREQUENCY	PERCENTAGE
YES	97	79.5
NO	25	20.5
TOTAL	**122**	**100**

From table 4.1 above it emerges that 79.5% of the informants had knowledge on medicinal herbs and, they consequently embarked on self treatment using herbal remedies. The other 20.5% of the informants never utilized herbs due to lack of knowledge on their presence and efficacy. Those informants who treated themselves using herbs were asked to explain how and where they obtained the herbs. Their responses are shown in table 4.2.

Table 4.2 MODE OF HERB ACQUISITION

MODE OF HERB ACQUISITION	FREQUENCY	PERCENTAGE
Planted in the homestead	6	4.9
From traditional healer	2ౖ	16.4
From roadsides, river valleys, hills and bushes	28	23.4
From neighbours and friends	8	6.6
Buy from the market	2	1.6
Around homestead and roadsides, river valleys hills & bushes	29	23.8
Around homestead and traditional healer	3	2.5
Not applicable	25	20.5
TOTAL	122	100

From table 4.2 it can be deduced that 28.3% of the informants obtained herbal remedies from their homesteads as well as from the roadsides, bushes, hills and river valleys. One such famous hill is the misango hills. The banks of river Yala that criss cross the division are also famous as herbal reservoirs. Most of the informants who had planted herbs in their homesteads proudly exhibited them to this researcher.

Traditional healers constituted another source of herbs for about 16.4% of the informants. Some 23.8% obtained herbs both by themselves as well as by consulting a traditional healer for illnesses whose diagnosis was unknown to them. The rest of the informants [9.0%] obtained herbs from their neighbours and friends, as well as at the market place. The utilization of herbs did not apply for 20.5% of the population, who, as tables 4.1 and 4.2 show, have never utilized herbs.

From tables 4.1 and 4.2: therefore we can conclude that the greater percentage of the population [i.e 56.7%] self-treated themselves by home made herbal remedies. However, 23.8% required the assistance of a traditional healer.

4.1.2 Traditional medical experts

Several traditional medical specialists exist in the study area. When asked about their knowledge of the presence of traditional healers, 94.3% of the informants knew at least one healer, while only 5.7% were unaware of their presence. Informants were requested to approximate the distance from their households to the nearest traditional healer. Their responses are summarised in table 4.3 below.

Table 4.3 ESTIMATED DISTANCE TO TRADITIONAL HEALER

DISTANCE IN KMS	FREQUENCY	PERCENTAGE
0 - 5 KMS	27	22.1
OVER 0.5 - 1KM	28	23.0
OVER 1KM - 2KM	34	27.9
2 - 3KMS	14	11.5
3 - 4KMS	4	3.3
4 - 5KMS	7	5.7
OVER 5KMS	1	0.8
NOT APPLICABLE	7	5.7
TOTAL	122	100%

Results from table 4.3 indicate that 84.3% of the informants had traditional healers within a 3km radius from their homesteads. Apart from being a pointer to the large number of traditional healers within the study population this data confirms that traditional healers are more proximate to patients than any other group of health care providers.

It was difficult to establish the exact number of traditional medical specialists because most of them were un-registered and feared that this researcher would arrest them. Besides, many informants identified themselves as traditional healers and beckoned the researcher to assist them in getting permits.

In most African communities traditional medical experts are classified according to their fields of specialization. However, such distinctions were found to have vanished in the study area. Traditional medical specialists are all known as *"Abhasirishi bhi shimali"* [Doctors using traditional herbs]. The type of illnesses they treat, as well their methods of treatment, are known to their clientele through past experience, social networks and public barazas where they are invited and given a chance to advertise themselves.

It emerged from focus group discussions as well as from in-depth interviews especially with traditional medical specialists that traditional doctors are fully paid only after successful treatment. However, an initial payment known as *"Olume"* is paid at the onset of treatment. *"Olume"* is a term that is derived from *"Liime"*. which means morning dew. Therefore, *Olume*, is the payment made to a traditional healer to help him fight the morning dew in his/her search for herbs from the bush, hills or river valleys. It is believed that, if a patient failed to pay *"Olume"* the treatment would not be effective at all.

Informants were asked to indicate whether they thought traditional medicine was effective as a treatment alternative. Whereas 85.2% believed that it worked, 14.8% opined that traditional medicine was not effective. On whether traditional medicine should be encouraged, an even higher percent of 95.9% averred. Only 5 informants i.e 4.1% thought that traditional medicine should be discouraged.

4.1.3 Drug shops, pharmacies and market place

Self treatment by means of patent drugs obtained from shops, pharmacies and markets was found to be a common resort in the event of an illness. Informants agreed to having utilised drug shops, especially for minor or less severe illnesses. The presence of community based distributors [C.B.Ds] has increased the accessibility of patent drugs. C.B.Ds constitute a category of community health workers who sell drugs from their homes and at the market place. Patients or potential patients buy drugs from them for both immediate and future use.

Initially, community based distributors were supplied with drugs by the non-governmental organizations that trained them. These are C.H.A.K, K.E.N.A.F.I A and the Red cross. However, these organizations ceased operating in the study area. C.B.Ds are therefore forced to buy drugs and sell to their clients. Consequently, only those who can afford to buy drugs continue to operate. For easy identification at the market place, C.B.Ds wear a green uniform.

4.1.4 Government, mission and private health facilities

According to the medical officer of health in Kakamega district, Khwisero division has eight modern health care points. These are the government owned Khwisero health centre and Namasoli dispensary, Mwihila mission hospital, Ukwala mission hospital, Namasoli health centre, Mundoli mission health centre, Mulwanda clinic and Red-cross clinic.

This information however, was proved to be inaccurate. Mwihila mission hospital, for instance, had ceased it's operation over 1 year prior to this research. The Red cross clinic could not be traced. Informants, however, disclosed that the Red cross society used to operate mobile clinics in the division but had not been seen for the last 3 years or so. Moreover, several private clinics were operational in the division but were not reflected in the ministry's records. Included in this category are St. Mary's Maternity and Nursing Home, Enanga Baptist Dispensary and Mundaha Private clinic. Other private clinics do operate and are only known by the name of the proprietors.

The above discrepancy could be partly explained by the fact that ministry of health records reflect only those health care points that submit their health records to the district headquarters. Consequently, those that do not send their records are subsumed to have wound up.

Informants did not maintain a strict distinction between private and mission health facilities, but they did so as far as private and government health facilities are concerned.

A common feature of the "private" medical facilities [both private and mission] was their temporary nature, a private clinic would operate for some time, wind up, only for it to reopen or re-locate to some other village or sub-location. This could also explain why maintaining records for such facilities becomes difficult.

Most private clinics are run by retired public physicians, nurses and mid-wives. This is in line with the governments policy of allowing and encouraging this cadre of professionals to supplement their incomes by maintaining private practices.

4.1.5 Community health workers [village health workers]

Community health workers [C.H.W], another therapeutic option, have been trained by various non-governmental organizations and they offer services at village level.

According to the Divisional Medical Officer of health [M.O.H], this category of workers is trained in basic treatment of simple illnesses, such as malaria, diarrhoea, worms, dressing small wounds and in basic primary health care services. Traditional birth attendants are also included in this category. Whereas these paramedics are trained in basic treatment procedures, they are, however, expected to refer complicated cases to health care facilities for specialised attention, as they are viewed as the first point in a referral net work.

C.H.Ws are trained for a period of between 3 weeks and three months after which they are issued with a certificate commensurate to the level of training they received. Initially they were supplied with basic equipment such as gumboots, uniform, drugs syringes, spotlight, gloves and surgical blades. Currently, since most of the training non-governmental organizations no longer operate in the study area, these paramedics have got to buy drugs and equipment. Consequently, only those C.H.Ws who can afford these expenses offer the services.

4.1.6 Faith healing

Although no faith healers resided in the study area, informants gave accounts of instances where they witnessed or heard that faith healing had been adopted as a curing option . Such faith healers were hired from neighbouring divisions. They were mostly concerned or are consulted in case of illnesses caused by witchcraft, sorcery, or magic.

The provincial administration informed this researcher that faith healers were banned from operating in the location on security grounds. This is because they exposed witches who faced the wrath of the aggrieved parties as well as the entire community. The chief of Kisa East location gave this researcher an account of an incident where a faith healer exposed a witch. This witch was lynched immediately the faith healer left the division. Such acts led to the proscribing of faith healing.

Informants however indicated through public barazas that they were in favour of faith healers. Others confided in this researcher that they would consult them if and when the situation demanded.

4.2 HEALTH STATUS AT DIVISIONAL LEVEL

4.2.1 Infant Mortality

The infant mortality rate of Khwisero division stands at 82/1000 live births. [G.O.K 1997]. This is above the national average of 60/1000 live births [G.O.K 1997]. This high rate can be attributed to the high incidence of diseases, especially malaria, pneumonia, anaemia, diarrhoeal diseases, acute respiratory infection and malnutrition [G.O.K.1997].

This information was corroborated by majority of the informants. They all agreed that diseases contributed to the high infant mortality rate. Table 4.4 shows the kind of diseases that informants felt were responsible for infant mortality.

Table 4.4 CAUSES OF INFANT MORTALITY

DISEASE	FREQUENCY	PERCENTAGE
Malaria	59	48.4
Measles [*Muyaka mukali*]	3	2.5
Diarrhoea, stomach ache, vomiting	9	7.4
Malaria, Pneumonia, Diarrhoea	6	4.9
Witchcraft/evil eye	19	15.6
Malaria and Measles	3	2.5
Malaria, Measles, diarrhoea	13	10.7
Malaria, Diarrhoea, worms	10	8.2
TOTAL	122	100

In order of importance, 48.4% of the informants opined that malaria was the major cause of infant mortality. Another 15.6% indicated that the cluster of illnesses caused by evil eyes accounted for the high infant mortality, while the rest, 37% felt that a combination of malaria, anaemia, diarrhoea vomiting and measles caused the high infant mortality.

4.2.2 DISEASE INCIDENCE

The top five diseases in the study population in order of prevalence are malaria, acute respiratory infections, STDs/HIV/AIDS, skin infections and diarrhoeal diseases [G.O.K 1997]. Although the division is in the malaria zone, the high prevalence can be attributed to poor environmental management such as stagnant water, and over grown vegetation near residences due to high rainfall. Acute respiratory infection is mainly caused by poor housing, congestion [as a result of high population density], poor economic status and bad weather conditions [G.O.K.1997].

Informants confirmed this. A large percentage of the sample i.e 87.7% agreed that malaria caused most adult deaths. A further 7.3% thought that witchcraft was responsible, while 4.9% indicated that AIDS caused more deaths than any other disease.

According to the chief, Kisa East, the rate of deaths increases every year. The chief attributes this situation to lack of adequate health facilities, absence of vehicles to transport patients, rampant poverty and lack of basic primary health care.

On the mode of treatment for illnesses, 73.8% of the informants suggested that people will normally buy drugs before going to a private clinic. Another 20.1% thought that patients consulted health centres first. The rest 6.1% opined that people used herbs either by self treatment or by visiting traditional medical experts.

Informants were asked whether the mode of treatment was uniform or different across the population. While 88.5% thought that the mode of treatment was different, 11.5% felt that it was uniform. Factors that accounted for the differences are shown in table 4.5.

Table 4.5. REASONS FOR DIFFERENCE

REASON FOR DIFFERENCE	FREQUENCY	%
Money determines	76	62.3
Severity of illness	6	4.9
Both money and severity	24	19.7
Cultural factors	2	1.6
Not applicable	14	11.5
TOTAL	122	100

It is evident that while 62.3% felt that the presence or absence of money caused the difference, only 4.9 thought severity of illness was a determining factor.

For 19.7% of the population, a combination of money and severity of the illness accounted for the difference. Only 1.6% were of the opinion that cultural factors explained the difference.

Key informants in the health sector while agreeing with the above statistics, attributed the high death rate to the health seeking behaviour of the people, as well as the high presence of quacks in both the traditional and modern medicine. The proprietor of one private clinic explained that people went to the health facilities as a third or fourth resort. According to him,

"when a Kisa falls ill, he/she first tries herbs at home. If this fails
to work he/she will buy drugs from the shops or market.
Should this option fail, the patient will consult a bush doctor[quack].
This one will most likely administer under doses and injections that could be harmful.
Only if these fail will the patient go to a health facility. In most cases the
disease is at an advanced stage and the patient often dies".

4.3.0 HOUSEHOLD CHARACTERISTICS

Standard questionnaires were administered to a sample of 122 household heads. A look at their sexual disaggregation reveals that 38.5% were male while 61.5% were female. This sex ratio is more symptomatic of the phenomenon of male outward migration in search of jobs than of the national population sex ratio.

4.3.1 Characteristics of household heads by age

Table 4.6. CHARACTERISTICS OF HOUSEHOLD HEADS BY AGE

Age [in years]	Frequency	Percentage
20 – 30	22	18.0
31 – 40	28	23.0
41 – 50	23	18.9
51 – 60	24	19.6
60 and above	25	20.5
TOTAL	**122**	**100**

From table 4.6 it is possible to conclude that 79.5% of the population fell bellow 60years of age while 20.5% were aged above 60 years. The mean age of the respondents is 45 years.

4.3.2 Groups of household heads by occupation

Table 4.7 GROUPS OF HOUSEHOLD HEADS BY OCCUPATION

OCCUPATION	FREQUENCY	PERCENTAGE
Small scale farmers	108	88.5
Teacher	4	3.3
Trader	2	1.6
Other [specify]	8	6.6
TOTAL	**122**	**100**

Table 4.7 indicates that 88.5% of the respondents were small scale farmers. Teachers and traders comprised 3.3% and 1.6% respectively. The remaining 6.6% comprised of people involved in other occupations such as tailors, bicycle transporters and repairers and shop keepers.

A caveat is however quite in order here. It is important to realise that informants often combined these occupations. For instance, a small scale farmer doubled as a small scale trader after the harvesting season. A teacher would also engage in farming during the school holidays.

4.3.3 Income of household heads

An attempt to quantify the incomes of the informants proved problematic because they could not give exact figures of their income. Most peasant farmers do not keep a record of their revenues and expenditures in monetary terms that would enable a discrete computation of their incomes. What is presented in table 4.8 below should therefore be treated as a rough estimation.

Table 4.8. INCOME OF HOUSEHOLD HEADS

INCOME [IN KSH/MONTH]	FREQUENCY	%
Below 1,000	100	82.0
1000 – 2000	6	4.9
2000 – 3000	4	3.3
3000 – 4000	5	3.3
4000 – 5000	3	4.1
5000 and above	3	2.5
TOTAL	122	100

Table 4.8 shows that majority of the informants [i.e 82%] earned below Ksh1,000 per month, while only 2.5% earned incomes above Ksh5,000 per month. The rest [15.6%] earned between Ksh 2000 and Ksh 5000 per month.

These income results significantly correlate with the occupations of the informants. It has already been shown in table 4.7. that the study population predominantly comprises small scale farmers. Subsistence farming rarely yields high incomes as most of the produce is meant for home consumption. Only in the event of a surplus does this occupation yield incomes. Sugarcane, the only cash crop recently introduced in the division, is done by very few people and on small scale land holdings.

The average land holdings for Khwisero division [and the entire Butere/Mumias district] is 5 acres [2ha]. [G.O.K.1997]. Data collected in the field, as can be seen from table 4.9, corroborates this estimation.

Table 4.9 FARM SIZE

FARM SIZE [IN HA]	FREQUENCY	PERCENTAGE
0 – 1	34	27.9
1 – 2	27	22.1
2 – 3	25	20.5
3 – 4	20	16.4
4 – 5	8	6.6
Above 5	8	6.6
TOTAL	**122**	**100**

Table 4.9 shows that 50% of the informants owned less than 2ha of land. Another 36.9% owned between 2ha and 4ha of land while 13.2% had over 4ha of land. The average [mean] land holding is 2.21ha.

Informants practised mixed farming, growing crops such as maize, millet, cassava, sorghum, cow peas, bananas and indigenous vegetables. All households were found to be rearing livestock of one kind or another. Livestock kept included cattle, sheep, goats and poultry. It was established that 27% of the study population reared chicken alone. The rest of the informants reared a combination of cattle, sheep, goats and chicken in varying numbers.

The data on income, occupation, land holdings and livestock ownership have been used here as an index of the economic status of the households. Education level-data, [which is] a socio-economic variable, is presented in table 4.10 below.

Table 4.10 LEVEL OF EDUCATION OF INFORMANTS

LEVEL OF EDUCATION	FREQUENCY	%
Not gone to school	17	13.9
Primary level	75	61.5
Secondary level	21	17.2
Post secondary level	9	7.4
TOTAL	122	100

The larger percentage of informants [i.e 61.5%] has attained primary school level of education, while 17.2% had received up to secondary school level. Only 7.4% had gone beyond secondary school level and 13.9% never went to school at all.

4.4. ILLNESS DATA AT HOUSEHOLD LEVEL.

A total of 200 illness episodes from 122 households is presented here. At the time of this research, 76 households [62.3%] had sick family members, while 46 [37.7%] had no sick members. Of the latter, 9.8% had had sick members less than a week prior to the researcher's visit, 6.6% had sick members between 1 and 3 weeks ago, while 18% reportedly had a sick member between 1 and 3 months ago. The remainder [3.3%] had a sick member over 3 months prior to this researcher's visit.

The number of steps taken in the treatment of the 200 illness episodes was computed and the results are shown in table 4.11.

Table 4.11 NO OF ALTERNATIVES IN ILLNESS TREATMENT

NO OF ALTERNATIVES	FREQUENCY	%
No treatment at all	8	4
1 treatment alternative	151	75.5
2 treatment alternatives	25	12.5
3 treatment alternatives	16	8.0
TOTAL	200	100

From table 4.11, it is evident that majority of the illnesses [75.5%] were treated successfully by one treatment option. Whereas 12.5% were treated by two treatment options but, 8.0% required three treatment alternatives. A final 4% were not taken to any health facility.

4.4.1 Severity of the illnesses
Informants were asked to state what they thought about the seriousness or severity of the illnesses. While 16.4% felt that the illnesses were grave [very serious], 82% opined that the illnesses were either moderately serious or less serious. The last 1.6% were unaware of the degree of severity.

4.4.2 First course of action
Informants were asked to explain what their first course of action was for the above illnesses. Their responses are shown in table 4.12 below.

Table 4.12 FIRST COURSE OF ACTION

ACTION TAKEN	FREQUENCY	PERCENTAGE
Did nothing	8	4
Self treatment [herbal medicine]	23	11.5
Self treatment [patent drugs]	58	29
Private clinic	31	15.5
Government health centre	21	10.5
Community health worker	36	18
Traditional healer	8	4
Mission hospital	15	7.5
TOTAL	**200**	**100**

Table 4.12 shows that a larger proportion of the illnesses were treated at home. The treatment options in order of utilization were: self treatment using patent drugs which accounted for 58 of the cases or 29%; community health workers who treated 18% of the cases; private clinics that were employed for 15.5% of the illnesses; self treatment by means of herbal medicine for 11.5% of the cases; the government health centre opted for in 10.5% of the cases; mission hospitals accounted for 7.5% of the cases and traditional doctors treated 4% of the cases. In 8 cases [i.e 4%] no treatment option was initiated.

4.4.3 Reason for choice of therapy

Table 4.13 REASON FOR CHOICE OF THERAPY

REASON FOR CHOICE	FREQUENCY	%
It was the nearest health facility	60	30
It is affordable [i.e other options are too expensive]	18	9
Disease was not serious	21	10.5
I had no money to go to hospital	21	10.5
Disease was quite serious	19	9.5
Offer good treatment [often have drugs]	10	5
Disease is best treated by herbal means	12	6
Medicine was available at home	14	7
Nearest health facility that was affordable	25	12.5
TOTAL	200	100

From Table 4.13 it is evident that 30% of the respondents opted for the nearest health facility. And since from table 4.12 self treatment option was the most commonly preferred alternative, we can conclude that, the drug shop appeared to be the most accessible health facility due to distance. For 9.0% of the informants, the treatment alternative utilized was due to it's being affordable. Another 12.5% opted for a particular alternative on account of it's being the nearest and most affordable option. Therefore, the cumulative frequency for affordability was 103 cases [i.e 51.5%]. This means that 51.5% of the informants identified treatment costs and distance as criteria for choice of therapeutic options. They will consequently adopt or consult the nearest affordable therapeutic option in the event of an illness. Seriousness or severity of an illness was also cited as a discriminating factor. While 10.5% stated that the illness was not serious. 9.5% indicated that the disease was serious and hence the choice of that particular option.

not serious. 9.5% indicated that the disease was serious and hence the choice of that particular option. Another cost related factor was lack of money to go to a health facility, which accounted for 10.5% of the informants' actions. For 7% of the informants self treatment was adopted due to the availability of medicine at home. Only 6% of the cases were treated on the basis of aetiological beliefs.

4.4.4 Distance travelled to health facility

The data collected on the distance covered to the health facilities utilized shows that, 63% of the options involved distances of between 0 and 5kms. For 12.5% of the cases the distance covered was not applicable since the treatment was obtained within the homestead. The rest of the illnesses were referred to the facilities that were between 5 and 40kms away. That is, 14% of the illnesses treated in facilities that were between 5 and 10kms away, 6% between 10 and 30kms away, and only 4.5% of the cases treated in the facilities that were over 30kms away.

This data shows that, since most options involved drug shops and community health workers, for reasons of proximity, then these two options are quite obviously very near the informants in the study population.

4.4.5 Time taken to travel

The time taken to travel to a health facility is a measure of it's accessibility, inter-alia. Data collected indicated that in 43.3% of the informants' choices, the time spent was between half an hour and one hour, whereas for 11.5%, time taken to travel to a facility did not apply since the options were within the homestead. The rest of the illnesses [i.e 18.5%] involved times between 1 hour and 3 hours.

4.4.6 Mode of transportation and its costs

Data on the distance travelled to health facilities has already been shown to be largely below 5kms. It is, therefore, not surprising that 70.5% of the informants walked to the

health facilities. Whereas 6% used vehiclar transportation, 7.5% used bicycles. The rest [15.5%] used a combination of walking, bicycle and motor vehicles to the nearest health facility.

The cost of transport to the health facility is contingent on the mode of transportation. In 81.5% of the cases no monetary expenditure was involved. This correlates to those options that involved the bicycle and walking. For 7.5% of the cases, transport costs involved were less than Ksh50. But for 9% it was between Ksh100 and Ksh200, while only 2% spent over Ksh200 on this item.

4.4.7 Cost of treatment
The cost of treatment is summarised in table 4.14 below.

Table 4.14 COST OF TREATMENT

COSTS IN KSH	FREQUENCY	PERCENTAGE
Payment in kind [no money costs incurred]	34	17
0 – 50	45	22.5
50 – 100	24	12
100 – 150	18	9
150 – 200	25	12.5
200 – 250	9	4.5
250 – 300	6	3
300 – 400	6	3
Over 400	33	16.5
TOTAL	**200**	**100**

It is evident, from table 4.14 above, that 17% of the treatment options involved no payment at all. These are illnesses that were treated by the self or family members who did not charge the informants. Whereas 22.5% incurred treatment costs below Ksh50, 12% utilized facilities that charged between Ksh50 and Ksh 100. Another 21.5% were charged between Ksh100 and Ksh200, while 10.5% incurred costs between Ksh200 and

Ksh400. Treatment options whose costs went beyond Ksh400 had a cumulative percentage of 16.5%.

From the above data, it is clear that the majority of the informants [i.e 73.3%] spent less than Ksh200 for treatment. Out of the 73%, 39.5% utilized below Ksh50 for treatment at the first stage. This does not mean that the treatment costs are generally low. Rather, it demonstrates the attractiveness of cheaper options of treatment over the more costly ones. It also shows the propensity of informants towards utilizing cheaper options due largely to poverty, which prevents them from using costly therapeutic alternatives.

This finding confirms the hypothesis that costs involved in accessing modern health care facilities has increased the attractiveness of cheaper options. Data on the distance covered, mode of transportation, transportation costs and treatment were generally below Ksh100. Informants, therefore, demanded health care services that cost less in terms of transport and treatment.

When they were asked as to whether they were required to do other things at the health facility besides paying for treatment, 22% stated that they were needed to provide writing material, [such as, pens and paper], bottles or to buy syringes. It is important to note that the majority of those in this category were treated at government facilities. Focus group discussants were in agreement that private health facilities did not require a patient to buy, when treated, the syringes and bottles.

4.4.8: Relationship between producer and consumer of health service as it affects utilization pattern

Most of the informants claimed that the treatment received, especially from private and mission health care facilities, was good. Good treatment was evaluated in terms of availability of drugs and facilities, as well as the likelihood of a cure. Informants also

appraised the qualification, conduct, manner of speech and time spent with them by the health care personnel as adequate.

However, 23.8% felt that the treatment, manner of speech and qualification of health care personnel was below their expectations. They explained that the nurses and clinicians, especially from government facilities, were harsh, impolite and occasionally abusive. For that reason, many avoided government health facilities.

Health care personnel from government health facilities, however, denied that patients were mistreated. The medical officer in-charge of Khwisero government health centre emphasised that they never acted in a manner that would stigmatise the patients or potential patients. For example, he maintained that patients suffering from venereal diseases were treated alone in the clinician's room. He further stated that any drugs dispensed or injections given were administered by the clinician. As a result, the patients' illnesses were known only to the physician. According to him, the above procedures were, adopted when it was discovered that patients never went for drugs or injections after the diagnosis. They feared that the pharmacist and nurses who administer injections will know their illnesses and either chastise them or tell it to their friends. The precondition that one comes with his or her sexual partner to the health centre has also been relaxed. Patients are however advised to compel their sexual partners to visit a health facility for treatment. This researcher verified this through observations at government health facilities. More details are provided in the next chapter.

This research intuitively observes that, it is possible, some medical personnel may occasionally abuse patients. These cases are however, isolated. In many instances medical personnel in government and private facilities were, humble and polite to the patients. Patients may hold the unsubstantiated belief that personnel in government facilities were uncaring.

4.5 SECOND COURSE OF ACTION FOR ILLNESSES ADVANCED FROM FIRST COURSE OF ACTION

Out of the 200 illness episodes collected at household level 41 required a second source of treatment. The different courses of action adopted, conditional on the outcome of the first choice are shown in table 4.15 below.

Table 4.15 COURSE OF ACTION AT SECOND STAGE OF ILLNESS

COURSE OF ACTION	FREQUENCY	PERCENTAGE
Did nothing	9	21.95
Drug shop [self treatment]	4	9.8
Self treatment [herbs]	1	2.44
Mission hospital	4	9.80
Private clinic	6	14.6
Traditional healer	10	24.4
Government health centre	3	7.3
Community health worker	4	9.8
TOTAL	**41**	**100**

It is evident from table 4.15 that the majority of the patients [i.e 24.4%] visited the traditional doctor as the second alternative resorted to after the first course of action has been attempted. This is the second stage of the illness which could be attributed to an instantaneous faith judgement concerning the efficacy of modern and traditional medical systems for this particular case. While modern medical facilities, were believed capable of producing a cure at the first stage, their failure to provide one must have led to their disqualification at the second stage.

This does not, however, imply that modern medicine has been rejected in totality, or would be rejected in the event of the same illness occurring on a different member of the household. Some 22% of the patients did nothing even after confirming that the first source of treatment had failed to provide a cure. Most of them attributed it to lack of resources, while only one of them stated that he did not want to go to another hospital. The other facilities utilized at this stage were private clinics [14.6%], community health workers [9.8%], drug shops [9.8%], mission hospitals [9.8%]. government health centre [7.3%] and self treatment by means of herbs [2.44%].

A comparison between the first course of action [table 4.12] and second course of action [table 4.15] does not yield a specific pattern of choice of health care. This implies that we cannot confidently predict the second course of action from the first one. Table 4.16 below compares choices made at the onset of the illness [first stage]. and the subsequent choices made for the 41 illness episodes. A total of 22 different pathways emerge.

Table 4.16 PATHWAYS TO SECOND SOURCE OF TREATMENT

ACTION	FREQUENCY	%
Government health centre – Mission H.C	2	4.9
Government health centre – private clinic	2	4.9
C.H.W - C.H.W	4	9.8
Private clinic – private clinic	3	7.3
Private clinic – traditional healer	2	4.9
Drug shop – traditional healer	1	2.4
Mission hospital – traditional healer	2	4.9
Drug shop – government H.C	2	4.9
Self treatment [herbs] – Government H.C	1	2.4
Drug shop - private clinic	4	9.8
Government H. C - drug shop	2	4.9
Self treatment [patent drugs] - self treatment [herbs]	1	2.4
Private clinic – drug shop	1	2.4
Mission H.C – government H.C	1	2.4
Drug shop - no further treatment	4	9.8
Government H.C - no further treatment	1	2.4
Mission H.C - no further treatment	2	4.9
Self treatment - no further treatment	1	2.4
Private clinic - no further treatment	2	4.9
Traditional healer - drug shop	1	2.4
Drug shop - drug shop	1	2.4
Drug shop – mission H. C	1	2.4
TOTAL	41	100

Key:

H.C - Health Centre

C.H.W - Community Health Worker

From table 4.16, a wide range of actions in subsequent treatment emerges. It is thus difficult to predict the course of action at the second stage based on the initial choice.

We can however, deduce from this, that, it is unlikely that a patient would use the same facility at the second stage except for follow-up cases. Out of the 41 cases examined in table 4.16, only 8 of them went back to the initial facility.

4.6 THIRD STAGE OF ILLNESS

A total of 16 illnesses were not successfully treated at the second stage. This advanced to the 3rd stage. While three [3] of these patients passed away, 5 visited a traditional healer. The government health centre was utilized by 2 patients. The rest [6] did not do anything to their illnesses though they were still ill.

Therefore, when we compare the first, second and third stages, we can conclude that as the illness period gets protracted, the proportion of patients doing nothing about their illnesses rises. This could be attributed to such reasons as a lack of money, waiting to see the effect of treatment and fatalism. At the later stages of an illness, patients may run short of funds and so could not afford further treatment. Alternatively, patients may resign to fate and accept their ill condition as God-given. As one respondent aptly put it,

> "I've now left it to God. I'm not going to any other
> health facility [hospital]".

Another observation to be made is the relative importance of traditional curing mechanisms at the second and third stages of illness treatment. It has been observed that traditional medicine accounted for the majority of the cases treated at these later stages. This is attributed to faith judgement pertaining to the efficacy of modern and traditional medicine. While patients may initially prefer modern medicine for a particular illness, a failure by the same to produce a cure leads to a change in faith. Similar modern health facilities will be by-passed and a traditional medical specialist would be consulted.

Monetary reasons may also endear patients towards traditional medical experts. Patients may have exhausted funds for further modern medical treatment. The advantage of traditional medicine here stems from the fact that payment is made only after a patient is fully recovered. The patient only gives the initial payment "[*Olume]*", for enabling the medicine to work.

While no specific hierarchy of health care choice clearly emerges between the various stages, it suffices here to conclude that patients tend to use different health care providers. This can be variously explained. One obvious explanation is in the case of one health

care provider referring a patient to another health care institution for specialised treatment. It emerged from in-depth interviews and focus group discussions that instances abound where modern medical personnel referred patients to traditional healers for particular illnesses [see section on cultural factors]. They, however, advised patients to go back to their facilities after treatment by traditional medical experts. This was because of the belief that the successful treatment of certain illnesses required the consultation of both medical systems.

Other cases of referral involved a movement from a government health facility to a private health centre or from a private clinic to a mission hospital. Utilization of different health care providers could also be attributed to the learning process of patients and their relatives about particular health care facilities. Initially, patients, or their next of kin, may generally be unable to tell the provider who will cure their illnesses. They, therefore, search among health care providers for a method [or information about a method] of treatment that will cure them. And since they cannot visit all of them at the same time, only one of them is visited at a time.

Lack of financial resources featured prominently in the utilization patterns of different health facilities. It was established that 95.1% of the respondents had, at one point or another, failed to visit a health facility due to lack of money. In such circumstances 15.6% admitted to having used herbs, while 24.6% stayed at home until they got money. Some 9% stayed at home and got cured in the process. Pharmacies were used by 10.7% of the informants. 7.4% loaned money from friends, while the rest of the patients [2.5%] passed away.

Government facilities were reported to persistently suffer from lack of drugs and other essential equipment. A total of 90.2% of the informants had failed to obtain drugs in government health centres. These patients adopted a variety of alternatives that are shown in table 4.17 below.

Table 4.17 COURSE OF ACTION FOR FAILURE TO OBTAIN DRUGS FROM HOSPITAL

COURSE OF ACTION	FREQUENCY	%
Went home and waited for drugs to be supplied	65	53.3
Bought drugs from the chemist	26	21.3
Used herbs	9	7.4
Loans of drugs from C.H.W	10	8.2
N/A	10	8.2
Other courses of action	2	1.6
TOTAL	122	100

It is evident from table 4.17 that the majority of informants [53.3%] simply went home and waited for the drugs to be supplied to the health facility. While 21.3% were able to buy drugs from the chemist, 8.2% got loan of drugs from community health workers. Only 7.4% opted for herbal medicine.

Most of the informants claimed that the absence of drugs was most pronounced in government health facilities. Private and mission health facilities were preferred since they always had drugs required by the patients. Government health facilities were accused of charging fees even when drugs were not available.

Informants were asked to explain whether they were aware that they could be exempted from paying fees at government health facilities in the event of genuine inability to pay. Only 3 out of 122 informants [i.e only 2.5%] were aware that they could be exempted. The rest [97.5%] were unaware of the fee waiver. Consequently, very few informants [only 2] had been exempted from paying fees at government health facilities. Therefore, since 97.5% of the informants were unaware of the fee waive scheme, and since an even greater percentage [98.4%] had not been exempted, it is impossible to conclude that these scheme was operational in the study area.

Key informants and a focus discussion with the community health workers however, gave a different opinion. The medical officer in-charge of Khwisero health centre stated that he was empowered to waive fees for needy [poor] patients. This researcher witnessed such a waive through direct observation. However, this informant could not explain his criterion for judging who was poor. Community health workers in a group discussion explained that they initially were given powers to recommend needy cases to the hospitals. Such cases were treated free of charge. They were, however, quick to point out that of late, they are no longer given forms to recommend needy cases and consequently they do not recommend.

4.7 PREFERENCE FOR HEALTH FACILITY

In view of the above conditions at particular health facilities, informants were asked to indicate the facilities that they preferred and the rationale of their preference. The highest percentage, [i.e 53.3%] preferred private health facilities, while 13.1% preferred community health workers. Self treatment by modern medicine and by traditional medicine was preferred by 12.3% and 8.2% of the informants respectively. The government health facility was preferred by 11.5% and only 1.6% preferred traditional healers.

The rationale for preference is varied but quality and monetary factors emerge prominently. Most informants preferred private health facilities because of their flexibility on the mode of payment. These facilities could treat on credit, and could accept all manner of payment such as farm produce [e.g maize and beans], livestock [such as goats, sheep and cattle]or even shoes, clothes and chair cushions. Alternatively, patients could mortgage items such as bicycles, cushions and shoes in return for treatment Patients were also allowed to leave their identity card numbers so that the provincial administration, through the chiefs, would assist in ensuring that patients paid at a later day.

Community health workers were particularly very flexible in their kind and manner of payment. Government health facilities were chastised for taking payment even before treating. These facilities were also accused of having in place a confusing and complicated system of payment.

Therefore, while private hospitals might in the long run charge more than government health facilities, they are preferred for being simple and flexible. Informants stated that private hospitals never turn away patients who were in financial difficulties and the quality of treatment is also another factor that was in favour of private facilities over government ones.

Quality was measured by availability of drugs, personnel and the possibility of cure. Private facilities always had drugs, the personnel were warm, friendly to patients and understood the patients' maladies [qualified]. Those in the government facilities were judged as being uncaring, harsh, lazy and hostile.

This researcher intuitively observed the operation of cultural factors in the preference of private health facilities. Most proprietors of private clinics were members of the same culture with the patients and shared the same cultural values. Their perceptions on illnesses especially those treatable best by traditional practices was congruent to that of their patients. One key informant from a private health facility openly admitted to this researcher that he sent patients to traditional doctors for certain illnesses. [see section on cultural factors]. This was because like the informants, he felt that the illness was only treatable by traditional means. Such a sharing of values put patients or potential patients at ease with such facilities.

4.8 CULTURAL FACTORS IN THE CHOICE OF HEALTH CARE

Informants were asked to state whether there were illnesses which they believed could only be cured by traditional remedies. Only 1 informant felt that there were no such illnesses. The other 99.2% believed that there was a particular category of illnesses that could only be treated by traditional medical procedures.

Asked what would happen, if such patients were taken to modern hospitals the informants were unequivocal in saying that they would die. Injections were particularly feared for such illnesses. Informants said that while drugs would exacerbate the illness, injections would surely kill patients suffering from such illnesses.

These illnesses include *Ebhikhokho*, [servere bodily pains] *Obhuhindi*, or *Obhusula*, [severe pains in the neck region] *Ebhikumba* [bones] *and Tsishira*. Except for *Tsishira*, the other illnesses are caused by evil eyes. *Tsishira* is a condition of illness that afflicts people who have broken the taboos such as incest.

Other conditions requiring treatment by traditional medicine are situations in which witchcraft, magic or sorcery is implicated. *"Okhulokwa"* is the term given to the act of having been bewitched or being a victim of sorcery, witchcraft or magical activities.

All informants were familiar with traditional medical specialists who treated such illnesses. Illnesses caused by evil eyes [*Ebhikhokho, Obhuhindi, obhusula, Ebhikumba*] are characterised by extreme pain in the affect parts. Informants believed that the evil eye dispatches substances into the body of the victim by merely looking at the latter. The victim will experience extreme pain in the head, or stomach - a pain that does not respond to modern drugs. *Obhuhindi* is especially common in young children. It affects the buccal cavity and the neck region.

Such illnesses are treated using herbal remedies administered by traditional medical experts. Where the buccal cavity of a child is affected, traditional healers burn herbs whose ashes are licked by children. Alternatively, the traditional doctor may rub the buccal cavity with herbal remedies based on ashes to extract the harmful substances.

If it is the stomach or head which is affected, the same treatment procedures are procured. Patients are given concoctions and decoctions of herbs to drink while other medicines in the form of ashes are provided for licking. Children may also be bathed in herbal remedies.

Serious evil eye attacks may be treated by minor operations on the affected sections. Minor slits are made on either the head or stomach of the victim using a razor. An instrument known as "*Eshilumukho*" [a kind of horn] is used to suck blood from the slits, in an operation known as "*Okhulumikha*" [removal of evil eye]. Blood sucked from these patients is put in a basin with water. The shape that the blood conjures as it clots is used to determine whether bones [*Ebhikumba*], frogs [*Amashere*] or snakes [*Thinzokha*] had been magically introduced into the patient. After the blood is sucked, herbs are rubbed into the open slits and the patient recovers within 3 hours of operation.

This researcher observed one such treatment procedure and attended the burial of a child said to have died of an evil eye attack. While the modern medical practitioner identified the cause of death as pneumonia, the child's parents, next of kin and other mourners informed this researcher that it was evil eye. They even pointed an accusing finger to a known evil eye. They further maintained that injections at a modern medical facility killed the child.

According to one doctor, a number of preventive mechanisms exist. One involves small slits made on some parts of a new born baby [usually the stomach or back] and traditional medicines are rubbed into them. These act as a prophylactic against evil eye attacks for a life time. Other preventive mechanisms involve the application of a pigs' fat on the body or licking it, [pigs' fat], sticking herbs such as *Lukohe* [black jack - biden pillosa] and *zindalandalwa* [sodoms apple solanam incanum] on the hair or carrying them [the herbs] in the pocket so as to distract the evil eye from afflicting the victim. In-depth interviews as well as focus group discussions, agreed that such prophylactics could indeed protect a person from evil eye attacks.

Tsishira, which has been referred to is another illness that is believed to be treatable only by traditional medicine. One famous traditional doctor explained to this researcher that *Tsishira* was caused by breaking incest and other taboos. For instance, the pair involved in an incestuous relationship develop a rapid loss of appetite and weight.

According to him, if not treated such patients die within a few months. However, shortly before dying, a patient grows healthy and even becomes fat.

Traditional doctors explained that treatment for *Tsishira* involves ritual cleansing and administration of herbs. This ceremony is performed far away from the village and near a stream. A sheep is slaughtered and it's ovals ["*busee bwi likondi*"] are used to cleanse the victim.

A curse is spelt on the evil forces believed to have made the patients commit incest. A herb is then administered by a traditional doctor and the pair bathe in the stream or river. This is believed to be the final symbolic cleansing where the evil forces are swept away by the stream waters.

Boils [*amabhimba*] mumps [*tsindeindei*] and measles [*muyaka mukali*] are other diseases commonly treated by traditional means. However, informants were quick to point out that modern medicine also treats such illnesses. Measles will be given extra attention here as it exemplifies a dynamic case of a mix between traditional and modern medical procedures.

This disease is a highly communicable disease of childhood which is caused by the measles virus. There are prodromal symptoms of coryza, cough, fever and conjuctivitis. Kopliks spots appear on the buccal mucosa between the 3rd and 4th day of illness which is then followed by a final slightly raised rashes starting on the face and extending all over the body and lasting 4-6 days. This rash frequently stains the skin and is usually followed by desquemation [Hayden 1982].

This researcher established that certain local beliefs are associated with measles. Parents believed that a child should not be taken to hospital until the rashes had come out completely and were over. In the meantime, herbal concoctions and ashes are applied to the skin to help bring out the rash.

The child will not be bathed for fear that this may hinder the development of the rash. Since the rash may take up to the 6th day, children suffering from measles may not be taken to the hospital until then.

Therefore, measles treatment is successfully done by either traditional medicine, modern medicine, or a combination of both.

This section has observed illnesses treated only by traditional medical procedures and techniques. A vital feature of such illnesses is a strong belief that such patients should not be taken to modern medical facilities as this would result in death. Such illnesses are contrasted from those treated by traditional remedies only after failing to be cured by modern medical procedures.

4.8.1 Choice of health care by religion

The majority of the informants were Christians. Only 1.6% profess the Muslim faith. They were asked whether they were constrained by their faith and religious affiliation against the utilization of any health facility. All Muslim informants stated that their religion did not advocate against any treatment option. But 63.9% of the informants explained that Christianity objected to the utilization of particular kinds of treatment. Of the 63.9%, 27.9% said that herbal treatment was discouraged, while 35.2% opined that their religious affiliation would not allow them to consult diviner or any treatment procedures that involved divination.

Religious constraints did not apply to 35.2% of the informants. They stated that illnesses and their mode of treatment was an individual affair. Any health facility that would produce a cure whether modern or traditional could therefore be utilized as and when the situation demanded. It emerged from focus group discussions that Traditional African Religion did not constrain the utilization of any system of medicine.

4.8.2   Age and utilization of health facilities

Age has been identified as one of the factors that influenced the utilization of health facilities.   Informants were interviewed on whom they regarded as needing constant health care in the household.   Some 58.2% of the informants were of the opinion that children were mostly in need and actually consumed more resources on health care.

Only 1 informant [or 0.8%] felt that adults should be preferred in the allocation in health care. This was because as bread winners, it was important for them to be healthy so as to cater for the family.   The rest of the informants [41%] stated that the age of a patient did not account for any difference in health care choice.   This is because they considered everyone to be vulnerable and in need of medication in the event of an illness.

4.8.3   Social networks and choice of health care

The role of social networks in the health seeking behaviour was elicited through in-depth interviews, focus group discussions as well as questionnaire administration.   However, apart from direct questioning, a careful recording and analysis of the informants accounts of the health seeking stages yielded enormously invaluable qualitative data. For instance, rather than ask an informant whether or not social networks contributed to a decision made, the researcher would identify social networks from the illness account.

An informant, when asked what he/she did would respond, thus:-

"I first called my mother-in-law to see my child"
A supplementary probe would be:-
"What transpired between you and your mother in law; or what did you discuss? or simply urge the informant to continue with the account.

It emerged from focus group discussions and in-depth interviews, that health care decisions were arrived at by discussing among the household members. From the survey data, 86.9% of the informants admitted that they discussed illnesses, especially, those at the moderately serious and grave levels.   However, illness decisions at the less severe category were mostly decided upon unilaterally.

Members of the social matrix consulted included parents, spouses, in-laws, brothers and sisters and select neighbours. Households that had health care personnel usually depended on them on determining the most appropriate course of action. Such households constituted 30.3% of the sample. Of these 26.2% indicated that in the event of an illness, they fully relied on these relatives. However, 4.1% did not depend on the health care personnel in their households since they worked far away.

It was observed at the beginning of this chapter that informants obtained herbs through the assistance of other family members, neighbours and friends. At household level, where herbs were grown, members would have to consult those who were knowledgeable on the herbs' aptness to that particular case.

The most crucial role played by social networks is in the understanding of illnesses and the dichotomy of those treatable by modern treatment methods and those by traditional techniques. This is very vital because of the belief that certain illnesses can only be treated traditionally and that it would be dangerous if patients were taken to modern medical facilities.

Therefore, in the event of an attack by such illness [or any illness], especially on children, parents would first consult other family members. Their duty is to qualify or disqualify treatment options based on the symptoms exhibited. Where a traditional medical specialist is opted, then, this will definitely be accompanied by a suggestion on the particular specialist to be consulted. Where modern medicine is qualified, various available options are examined and an appropriate one decided upon.

Social networks thus assist in pooling together ideas about an appropriate therapeutic option in view of the cultural and socio-economic conditions in a particular case. Whereas the socio-economic conditions may vary with time and, therefore, with the choices made, the beliefs pertaining to illnesses may remain relatively stable. Once an illness is determined as treatable by modern medicine, the various options available are

examined and one of them picked upon. However, where traditional remedies are appropriate, modern medical options are out of question.

4.9 SEVERITY OF ILLNESS AND CHOICE OF THERAPY

The severity of the illness was found to be a prominent consideration in the choice of therapeutic option. Informants gave the level of severity or seriousness of an illness as a factor that determined their health seeking strategies. From table 4.13 it is evident that severity factors accounted for 20% of the informants' rationale for the course of action embarked on at the onset of illness. Thus, whereas 10.5% stated that the illness was very serious, 9.5% indicated that it was less severe.

4.9.1 Course of action for grave illnesses

Informants recognised different levels of severity and were consequently requested to explain their course of action based on these levels. For very serious or grave illnesses, 52.5% of the respondents would go to big hospitals, such as Mukumu and Mwihila mission hospitals or Kakamega district government hospital. All these, save for Mwihila, are located out of Khwisero. The other 47.5% indicated that they would visit any health facility in the division [whether government or private] where the severity would be determined and a referral advised. The latter group recognized severity levels, but opined that the medical personnel would be in a better position to determine the degree.

It emerged conspicuously from focus group discussion and in-depth interviews that, at this level, the role or possible role of evil eyes attack or witchcraft was carefully deliberated. This was because, illnesses, particularly those caused by evil eyes were very severe and would produce deaths within a short time. Therefore, where a disease is initially very severe, and where evil eyes are deemed responsible, the patient is taken to a traditional medical expert. As already described under cultural factors, such a person would not be taken to a hospital as injections would kill him/her. This fear is intense, especially, where the affected patient is below 5years of age.

At this grave level, therefore, cultural factors feature prominently since the ramifications of a 'wrong' decision may be fatal. Informants characterised it with excessive body pains, excessive bleeding, fractures, diarrhoea and vomiting, restlessness and loud cries by children.

4.9.2 Moderately serious illnesses

The course of action that would be adopted for moderately serious illnesses is shown in figure 4.18 below.

Table 4.18 COURSE OF ACTION FOR MODERATELY SERIOUS ILLNESSES

ACTION	FREQUENCY	%
Go to any hospital	58	47.5
Buy drugs from pharmacy	23	18.9
Use traditional medicine	7	5.7
Go to any hospital or buy drugs from chemist	6	5.7
Call a community health worker, nurse or private doctor	28	23
TOTAL	**122**	**100**

It is clear from table 4.18 that the greater percentage of informants [47.5%] went to any health facility for treatment in the event of a moderately serious illnesses. Community health workers, who are not usually consulted in the event of grave illnesses gain prominence here.

They are the second most frequently opted for alternative as 23% of the informants indicated. Whereas 18.9% bought drugs from the pharmacy or shop, only 3.7% opted for herbal self treatment. The rest [5.7%] iteratively combined the above options depending on their accessibility at that point in time.

4.9.3 Less serious illnesses

As table 4.19 below indicates, self treatment by means of patent drugs and herbs is the most preferred course of action at this level of severity.

Table 4.19 COURSE OF ACTION FOR LESS SERIOUS ILLNESS

ACTION	FREQUENCY	%
Go to hospital	1	0.8
Use herbs	27	22.1
Buy drugs [chemist or shop]	43	35.2
Just stay at home	17	13.9
Call in community health worker	3	2.4
Buy drugs or use herbs	31	25.4
TOTAL	122	100

At this level the larger percentage of informants [35.2%] opted to buy patent drugs from the chemist, shop or community health worker. Others in this category would have drugs bought and kept in the house for use at any time. Another 22.1% would treat themselves by traditional medicine obtained by them, or through social networks while a further 25.4% would combine the above two options. The cumulative percentage for self treatment is thus 82.7%.

It is worth nothing that only at this level do we encounter patients who would ignore such illnesses and just stay at home. This constituted 13.9% of the informants. Such patients expect the illnesses to go away by themselves. Only 3.2% would go to a hospital or call in a community health worker.

Key informants and focus group discussants agreed that such illnesses were either treated at home or ignored. They mentioned minor headaches, stomach aches, joint pains, small cuts, flu and common cold as some of the illnesses that fell in this category.

CHAPTER FIVE

5.0 DECISION MAKING

5.1 DECISION MAKING AT HOUSEHOLD LEVEL

This chapter discusses the research findings in view of the objectives and the hypotheses advanced for this study. It also compares the findings with other studies carried out. Several cases of illness episodes are highlighted in detail to concretise certain aspects of health care choice at household level. The choice of health care is a complex process that involves a delicate interaction of household characteristics [i.e their location, and economic resources etc] as well as the characteristics of the health care facilities themselves. Thus, in the event of an illness, the choices made are not only contingent on either the severity of the illness or the resources at the disposal of the household, but also on the availability and nature of the alternatives. Akin et al [1985], for instance, observes that a sick individual in a third world country may face the decision of treating himself using a free public clinic, or using a traditional doctor.

In this study, it is established that self treatment by means of herbal remedies was not an option for a section of the sample as they had no knowledge of its availability and utility value. The absence of electricity in the division's health facilities constrained their utilisation for illnesses requiring urgent attention at night. These and other factors as Lasker [1981] also observed, lead to the conclusion that illness behaviour is [and should actually be seen as] a rational response to the nature of one's options. This is because individualistic explanations most often used for health behaviour is constrained by structural factors.

It is for the above and other reasons that this study first sought to identify the range of therapeutic options existing in the study population. These options, as well as their nature especially as they affect the proclivity of their utilization, are examined later in this chapter.

At this juncture, it is also important to note that although four factors are identified in the hypotheses as influencing choice of health care, these never operate in absolute independence of each other. A decision made for the utilization of an alternative was in most cases found to be sensitive to more than one consideration.

The seriousness of an illness, for example, was identified as a major factor that overwhelmingly determined the choice of health care. Serious or grave illnesses were taken to district or provincial hospitals. Informants were however, aware that even when taken to local health centres, such cases would be referred to district hospitals for special treatment

Studies by Mukolwe [1989], Akin et al [1985] and Young [1980] have remarked that the seriousness of the illness was the most important factor in the choice of health care. Akin et al [1985], for instance, observed that, the overwhelmingly important explanatory variable was seriousness of the illness which cut across the socio-economic lines and forced the poor and the rich to act in the same way. They tended to utilise private Western health care facilities.

This study agrees with the findings cited above. However, it cautions on the danger inherent in identifying one variable and elevating it to the level of the single most important determining factor in the choice of health care. Severity factors were found to be modified by cultural and economic factors that would have to be held constant. Three points can be observed here regarding the role played by severity at the serious level.

1] This study established that, for very severe illnesses, cultural factors pertaining to their aetiology were prominent. This was because certain illnesses were believed to be curable only by traditional herbal remedies. For instance, an instantly severe headache, believed to be caused by evil eyes was treatable only by traditional remedies.

Such illnesses are said to be undetectable by western practitioners and that western medicine gravely excercabate them. The interaction of severity and aetiological beliefs thus lead to the choice of a traditional medical expert.

2] Illnesses that are protracted and fail to respond to modern medicine also attract the attention of cultural factors. Thus, while modern medical procedures may be adopted at the initial stage, lack of relief and the new level of severity leads to a change in treatment. The preference for traditional doctors when illnesses fail to respond to modern medical treatment [and thus are perceived to be serious] was also observed by Cosminsky [1972]. She suggests that people have come to expect quick relief from modern medicine. So when prompt relief is not forth-coming the patient may sense failure and change to the traditional doctor.

Cosminsky [1972] also considers another determinant of this behaviour to be rooted in the realm of aetiological beliefs. As the illness is perceived to be more serious and more tenacious, the question of "why me?" becomes relevant. The answer to the question of ultimate causation lies in the supernatural and moral domains of local belief systems.

3] Third, as the illness period gets protracted and the illness assumes new levels of severity, some action may not be taken at all. This is because the patient may have exhausted all the resources at his/her disposal. The patient may thus opt for a C.H.W, a private clinic or any other group of providers who will treat on credit. Such a decision, while being prompted by severity factors, is sanctioned by financial constraints. The ultimate decision is thus more sensitive to economic factors than severity.

At the moderate and non-serious levels of illness, informants utilized any health facility, be it government , private or C.H.W. Self treatment by means of patent medicine obtained from a pharmacy, a drug shop or a C.B.D was very prominently initiated. This decision may superficially appear to be guided by faith judgements in the ability of these sources to contain the illnesses. However as Mwabu [1984] and Young [1980] also observed the choice of health facility is an outcome of patients cost minimizing behaviour.

Young [1980] for instance comes up with a 'cost ordered' resort to health care. He argues that, for non-serious illnesses, the alternatives are ordered on the basis of

estimated cost and the action is to avoid as much expense as possible by trying the least costly alternatives.

This section, therefore concludes that, as hypothesized, the judged gravity of an illness influences the choice of health facility. However, in some instances, severity factors per-se may not be the only explanatory variable in the choices made. Thus, the popular method of correlating a single factor with reported utilization may be unsatisfactory, which thus calls for a need to integrate all the factors involved.

In the following section specific illness episodes are presented and a brief discussion of circumstances under which the decisions were made is provided. The illness cases are [save for the real names of informants which are withheld] reproduced as accurately as possible from direct observation and accounts of the sick or their next of kin.

5.2 ILLNESS EPISODES AT HOUSEHOLD LEVEL.

Case 1

This involved an eight months old baby boy who had fever, high temperature and stomach pains. The first course of action taken by the mother was to prepare herbal concoctions and give them to the baby. The baby however, did not show any improvement and on the third day he was taken to a nearby private clinic where medicine in tablet and syrup form was administered. This child did not respond to this medicine either. After another two days, the grandmother to the child was informed and asked to observe the child. She looked at the child's oral cavity and diagnosed it as suffering from an evil eye caused malady known as *obhufira*. Since she has the knowledge of traditional curing techniques, she went ahead and prepared a herbal remedy and administered it to the child. This consisted of herbs that were burnt and their ashes given to the child. The child diarrhoead and got relieved within a day.

Before discussing the above case, another similar illness episode is presented.

Case 2

This case involved a young boy $3^{1/2}$ years of age called Isaji. Isaji complained of a sharp pain in the head and neck region. He was

crying as a result of the pain. On seeing this, his mother called
in Isaji's grandmother who observed his oral tract. She diagnosed
the illness as *obhuhindi*. They [parent and grand parent] sent for a
traditional healer who lived at about half an hours walking distance.
She came and observed the child and concurred with the grandmothers'
observation. She requested for *olume* which was paid [Ksh 50], before
she could go to Misango hills to look for herbs. She came back
an hour later with herbs that she burnt to be licked by the boy. She also
came back with *eshilumukho* and a razor blade which she used to make
two slits on the head of the boy. Using *eshilumukho*, she sucked blood
from the head of Isaji and declared that a bone [*ebhikumba*] had been
thrown to the boys' head by an evil eye. Some of the ashes were
rubbed into the slits made. The child recovered the same day. A final
payment of Ksh200 was paid the next day. The healer was also given
some sweet potatoes.

The above cases contain illnesses that perfectly exemplify the operation of a cognitive dichotomy between illnesses that are believed to be treated by traditional medicine and those treated by modern medicine. While in case one the illness was treated by a traditional medical practitioner at the third stage, in the second case, the first option was traditional and it certainly produced a cure.

Besides the cognitive dichotomy, these two cases illustrate the role played by social networks in illness identification and recommendation of treatment option. In both instances it is the older women who helped identify and recommend the source of health. In the first instance, a failure to seek opinion led to two unsuccessful treatment options before a third effective one was recommended. Thus, social networks reinforce the cognitive dichotomy for diseases whose aetiology is determined by cultural factors.

Economic factors exemplify themselves in the form of the payment procedures. In traditional medicine, payment is done at two stages. The second payment is done only if a cure is effective.

Case 3

Involved here was a 16 years old girl called Agnes. Agnes complained
of joint pains, chest pains and a persistent cough. The first option taken
was to call a nurse from a public health centre who was their neighbour.
She administered an injection and gave tablets. Agnes, next of kin paid

Ksh 400 for this treatment. Three days later, Agnes had not recovered and they opted for another nurse from the same public health facility. The second nurse [a female] administered yet another injection and gave different tablets. The payment was done in two ways. There was a cash payment of Ksh200 and an additional pair of shoes. This was to cover for the extra cost since they did not have cash money. After this the illness subsided but recurred again after three weeks. The same [second] nurse was consulted. As the family did not have money, they requested her to treat on credit. Only after this did Agnes fully recover.

This case demonstrates people's preference for nurses or clinicians treating at home. This case had three options both attended to by nurses i.e nurse [1] - nurse [2] - nurse [2]. However, what clearly emerges in this case was the development of payment practices rampant and well adapted to the local economy. These includes not only the lack of fee for service billings but also a greater willingness to accept payment in property, or even more, to forgo money transactions altogether unitl the patient or next of kin can afford to pay.

Case 4

This case involved a 26 year old female patient who had swollen legs. The first option was Kakamega district hospital. The decision was taken for Kakamega district hospital since her aunt worked at that facility.
Transport was accomplished by bicycle and vehicle at a cost of Ksh120. Treatment was free of charge and consisted of tablets.
Two weeks later the illness recurred and after consultations between the patient and her parents, [father and mother], a decision was arrived at to consult traditional doctor. A traditional doctor situated some 3kms away was consulted. He prepared a herbal concoction which he gave to the patient to drink. They initially paid *olume* of Ksh300. The patient recovered fully after a week and a final payment of Ksh800 was made.

This case illustrates an instance of system shifting in the choice of health care. While the initial choice was to consult a modern medical practitioner or facility, a traditional healer is consulted in the second. However, this does not reflect an aetiological shift. It is more reflective of a pragmatic shift pertaining to the efficacy of the traditional system as a result of the failure of the modern system. It should be noted that all other modern medical facilities are lumped together and by-passed as they are judged to be ineffective.

The two-part system of payment and the role of social networks also emerge. The system of payment endears traditional practitioners to their clientele since they are seen as earning their incomes genuinely. This contrasts the deprecated view of modern practitioners as people who charge even when their medicine do not cure. It was not clear whether lack of payment at the district hospital was a factor of the systems of waiver, or an extension of social network privileges.

Case 5

This case involved a 21 year old man who reported to Khwisero government health facility with a sexually transmitted disease. The STD had affected him for three months. I reproduce here part of my conversation with him at Khwisero health centre.

I=== interviewee
R========researcher

R. What made you not seek treatment from a modern facility for so long?

I. I had no money to pay for hospital treatment

R. Have you used other sources of treatment?

I. Yes

R. I would like you to tell them to me. So what did you do first?

I. I went to a traditional doctor who gave me herbal concoctions in two tree top bottles. He advised me to drink half a cup daily.

R. Did you pay the traditional doctor?

I. Yes, I gave him *olume* of 2 kg tin of maize.

R. Did you feel better?

I. No

R. Did you do anything else?

I. Yes. I went to another traditional doctor who also administered a herbal concoction in two treetop bottles. He advised me to avoid milk or tea with milk.

R. What was the cost of treatment?

I. I gave him *olume;* some two 2kg tins of maize.

R. After taking the herbal concoction did you recover?

I. No, the pain initially subsided only to recur after two weeks. That is when I decided to come to hospital.

R. And now do you intend to meet the hospital fees?

I. I borrowed some money from my sister in-law.

R. And couldn't you have borrowed this money at the onset of the illness?

I. I did not want her to know that I was suffering from an STD.

This case was treated at Khwisero health facility free of charge. It demonstrates an instance where a patient benefited from the government proposed waiver for a patient who could not afford hospital fees.

This case also enabled the researcher to observe the treatment of STDs at government health facilities. STDs were solely treated by a clinician. All injections and tablets were administered by the same person in the same room. This was aimed at alleviating fear or stigmatising the patient.

While appreciating this instance of free government health service for the poor, it is important to note that this patient had failed to obtain treatment from a modern health facility in the first 2 stages. This was because of financial hardship. He was not aware that he could be exempted from hospital charges. He opted for a cheaper option, in this case a traditional doctor. Traditional doctors may occasionally charge more than modern medical practitioners. However, the staggered nature of payment enables a patient to meet the costs over a protracted period. It also instils confidence on the doctors' abilities since the doctor demands full payment only if a person is cured. In the above cases, full payment of traditional doctors' fee was not effected since the patient did not get cured.

Case 6

This case involved a 28 year old man who had been assaulted by thugs the previous night. He came to the health centre as the first resort. When further probed he stated that he had used vicks to try and alleviate the pain. He also swallowed panadols only for pain relief. This patient was treated at the health centre and went home.

Case 7

This case involved a form 3 secondary school student. She complained of headache and joint pains. Laboratory tests confirmed that she had malaria. When asked whether she had used other sources of treatment, I established that she had used chloroquine and panadol tablets given by the school's matron. She came to the hospital as a second option. This was after two days.

Case 8

This involved yet another secondary school student from the same school [as in case 7]. She had been sick for four days and admitted that she had used aspirin and panadol tablets prior to visiting the health centre.

R. Where did you obtain the medicine?

I. At the beginning of the term, my mother bought them from a C.H.W and asked me to carry them to school.

These three cases, 6, 7 and 8 have been lumped together because of their similarities. They all demonstrate the proclivity of patients to embark on self treatment at the onset of an illness. While the young man in case 6 used drugs to contain the pain, the two girls used drugs as a form of treatment. For the three cases, drugs appear to have been bought and stored by the patients.

It is noteworthy that these three patients stayed within a 100metres radius from the government health facility. Their action reinforce the often stated observation that self treatment was the first course of action in the event of an illness.

These cases illustrate a hierarchical resort in health care facility utilization. After the failure of self treatment, a health facility is visited. This is because it is perceived as having a higher probability of a cure than self treatment.

Case 9

This involved a mother who brought her 3 year old daughter to the health facility. The child had been reportedly ill for close to 4 weeks and was consequently anaemic.

R. Have you given any medication to your daughter for the last 4 weeks?

I. Yes. My mother-in-law is a traditional healer and has been treating her with herbal concoction.

R. Why did you decide to use traditional healing method?

I. We thought that the illness was *obhufira*. Such illnesses are not treatable in hospitals since injections kill the patient.

R. What kind of medicine did your mother-in-law administer?

I. This constituted herbal concoctions from leaves and ashes burnt from the very same leaves which the child licked: This has been going on intermittently for the last 3 or 4 weeks.

R. So what made you visit this facility?

I. The illness refused to heal.

This case was judged to be severe anaemia and the child was referred to Kakamega district hospital.

The case exemplifies a situation where an incongruence between modern and traditional illness beliefs influence the choice of health care. However, such a dichotomy of illnesses may have adverse effects in the event of erroneous judgements. In the case above, there appears to be a judgmental error since the traditional techniques failed to produce a cure, and a modern medical facility was opted for. At this time, the severity of the illness has escalated to a level that it could not be handled effectively by a health centre. Consequently, the child was referred to a higher facility - namely a district hospital.

It has been stated earlier that the belief in exclusive traditional remedies for particular illnesses is severely reinforced by an opposite fear of grave consequences should a different alternative be opted for. The flip side of this belief also holds true. In the event that an illness episode is erroneously thought of as treatable only by herbal medicine, the period in which herbal concoctions are unsuccessfully tried may strangle the possibility of a cure by modern medicine. This is because a lot of time is wasted on ineffective traditional medicine as the severity level rises.

Case 10

This case involved an 18 months old child. [Alice] brought to the health facility by her mother. The child had diarrhoea, fever and was vomiting. According to her mother, Alice had been sick for 4 days. At the onset of the illness her mother bought panadol tablets from a community health worker and administered them to Alice. When the illness failed to subside, she brought her to the health centre. Laboratory tests carried out on Alice confirmed that she had severe malaria. She consequently had to be admitted. Children below 5 years of age are usually admitted together with their parents or caretaker. This parent however, objected to being admitted and demanded that she be allowed to go back home and inform the husband. Fearing that she might not come back, the clinician declined to let her go. At this point the mother went to the corner of the examination room and cried there. She however, later agreed to be admitted.

Besides confirming the case for self treatment, this case highlights some of the social costs that accompany the consumption of modern medicine. The parent to the child declined to be admitted in the hospital without the husband permission and also because there would be no one left at home to cater for the husband during her admission. The clinician realised that the woman would not come back which would jeopardise the treatment of the child. He consequently declined to let her go home.

These ten illness cases have been highlighted to illustrate some of the factors and situational determinants in specific health care decisions. Some of the situational conditions are quite specific to those illness cases and cannot be generalised for all

illnesses. They, however, give insights into the decision making processes at household level.

5.3 CHARACTERISTICS OF THERAPEUTIC OPTIONS AS THEY AFFECT UTILIZATION

Several therapeutic alternatives were identified in the previous chapter as available to a household faced by an illness episode. All these have attributes that endear them to the sick as well as those that discourage their utilization. These are examined in the following section.

5.3.1 Traditional medicine

The two major ways in which traditional medicine was procured was found to be by self-treatment or a visit to a traditional healer. Markets also acted as sources, but in very infrequent circumstances.

Self treatment was contingent on the knowledge of traditional remedies either by the sick persons, their next of kin, friends or neighbours. Thus, in the event of an illness episode where traditional medicines are thought to be efficacious, the patient or next of kin prepares herbal medicine. Informants appreciated indigenous medicine and the majority of them had herbs planted in their homesteads. Alternatively, herbs could be obtained from the hills, roadsides or river sides.

Traditional medicine could also be obtained by consulting a traditional doctor. In this case, the doctor is either visited by a patient or is called to attend to the patient. As already observed, traditional doctors are the most proximate and accessible [by distance] group of practitioners. Almost every village had one or more traditional doctors.

Akin et.al [1985] observe there is still an abundance of traditional doctors in non western societies. They further argue that traditional doctors are used by necessity where other alternatives do not exist, and voluntarily in cases where other practitioners are available

but the patient considers the traditional doctor to be more appropriate for economic or other reasons.

These reasons, therefore, produce two pathways or patterns of resort to a traditional doctor. One, where a patient considers the traditional doctor as appropriate and opts for him/her as a first resort; two, where a patient first resorts to other options and only opts for traditional medicine when the cure is not achieved in the first options. This is normally at the second, or 3rd stage of an illness treatment strategy.

An investigation into the training of three traditional doctors with whom this researcher frequently interacted reinforced the contention that a lack of formal medical training in a body of collected scientific knowledge usually distinguishes traditional practitioners from their western medical counterparts. One of the doctors learned his skills in the neighbouring Siaya, while another claimed to have travelled widely in Kenya and Tanzania and acquired knowledge in traditional medicine. He learned the treatment techniques and even imported several medicinal herbs from these lands that he has planted in the homestead. The third doctor stated that he was a Red Cross' trained traditional doctor and even had a certificate to that effect. Other doctors especially the female traditional birth attendants and experts on child diseases undergo apprenticeship according to local system of training or carry on their parents' work. In most cases an individual becomes known as a doctor over a number of years and is called on increasingly to perform medical duties by patients.

The effectiveness of traditional doctors and the entire traditional medical realm is contingent on the accuracy of diagnosis, the power of traditional medications and the extent to which an illness is believed to be caused by a physical or mental disorder the physician is believed to be able to treat. A doctor gains reputation on the basis of his/her proven effectiveness in either producing cures or making diseases understandable as outcomes of certain life events that have importance in the local belief system. Thus, a doctor who can diagnose an illness such as *tsishira* [incest produced illness] or *obhuhindi* [evil eye] and cure it effectively [or propose a cure/curer] will be repeatedly consulted

under seemingly similar circumstances. The reputation is also enhanced by his/her ability to link evil eyes and/or incestuous interactions with the illnesses observed.

One important factor that has endeared traditional healers to their potential clientele is that they have developed payment practices well adapted to the local economy. Traditional healers have divided their fee into two parts and demand the second only if the patient is cured. The initial payment known as *olume* is both morally and medically reinforced by a belief that medicine will not work unless it is paid. It is seen only as a motivator for the healer and his/her medicine.

Ngubane [1981] observed an analogous situation among the Zulu of South Africa. Here indigenous practitioners charged fixed fees divided into two parts. There is an initial payment when consultants begin and a later one [cash and/or cow, chicken] depending on the practitioner after a cure is effected.

The fee for indigenous practitioners may be high but since the charges are known in advance and the payments may be made in cash or property, household can budget for them. A final economic advantage of this sector of medicine stems from the willingness of healers to forgo money transactions as well as to carry the patient until the next harvest, or until patients get remittances from working relatives in town.

5.3.2 Drug shops, pharmacies, community based distributors and market place

Akin et.al [1985] observe that in the medical systems of most third world countries, where the dispensing of drugs is neither highly institutionalized nor easily controlled by governments, the pharmacist plays an active role in diagnosing disease and prescribing drugs. Drug shops, pharmacies and C.B.Ds, were common sources of modern drugs besides health facilities. The local duka [shop] sold drugs as well as other household goods. CBDs sold drugs either from their houses or the market place on market days.

CBDs and shops are quite proximate to the people since almost every village had a shop and a CBD.

This category of health care providers serve both as primary or first level resource [as in case of self treatment] and as a secondary level, in dispensing drugs for physicians and other practitioners. This study has observed that self treatment by means of patent drugs was the most frequently utilized alternative at the initial stages of an illness. In this case the patient sometimes knows the name of a drug that she/he or acquaintances have used previously and asks the pharmacist for that product; in other cases, he seeks the advice of the pharmacist or CBD, thus using them as lay doctors.

Some of the reasons for using these health care alternatives are apparently rooted in economic thinking and in the level of severity. Pharmacies, CBDs and shops are privately operated and are usually more widely dispersed than any other institutions of the modern medical establishment. The training of CBDs in the rural areas is an attempt at bridging the distance between patients or potential patients and health facilities. They are educated in basic treatment techniques of moderate and less severe illnesses that can be handled effectively at home.

Shop are not essentially established to sell drugs, but usually stock medicine alongside other household utilities. Adeya [1997] observes that the shop is a very ready source of medication when the physicians' advice is too far or too costly.
In Mexico, Young, [1981] observed that people often use pharmacies to circumvent pecuniary and non pecuniary costs such as transportation costs, physicians fee, travelling time and waiting time to consult a physician. As Cosminsky [1972] observes in Guatemala, people sometimes go directly to the pharmacist because they can receive an injection there without questions being asked, whereas at the clinic they have to wait, be examined and then may be given pills instead of the injections they prefer.

Shops and CBDs have the advantage of advancing credit facilities to clients. Shops, for instance, often offer credit facilities not only on drugs but on other household items.

These debts are settled when the clientele have sold farm produce or from remittances. It is, however, observed here that there is a need to monitor the activities of these sources of medication. This is because unscrupulous drug dealers may penetrate them and work in tandem with shop owner to dispose off fake, expired or harmful medical products. As Akin et.al [1985] , also observe, pharmacies and drug company retail men are the basis of an underground system of dispensing powerful pharmaceuticals that in high income countries are tightly controlled.

CBDs may also not have adequate and hygienic storage facilities for their drugs. This researcher visited the homes of several CBDs and at their selling stalls at the market place. One notable characteristic feature of the drugs was that their expiry dates could not be ascertained and their genuity or of lack of it could not be established. My suspicions were further raised by the fact that some of the drugs were sold at far below their market price and were wrapped in very unfamiliar casings.

5.3.3 Community health workers.

Community health workers [CHW, who are also referred to as village health workers - VHW] are a vital source of health care in Khwisero. Their training and operation is part of the wider scheme of primary health care [P.H.C] programmes in third world countries. Akin et.al [1985] state that CHWs ought to be the first point of contact between the rural population and the modern medical system.

Certain explicit and implicit assumptions form the intellectual basis of PHC policies and the CHW strategy. Most third world health problems are thought to be susceptible to elementary types of care and simple drugs both of which can be supplied by paraprofessionals. Improving environmental conditions, raising awareness of good health, improving hygiene and promoting preventive care are seen as the most effective means for improving rural health conditions over the long run.

The task of training the CHWs was undertaken by various non-governmental organizations. Like in all PHC strategies, this was characterised by initial co-financing

by an outside agency which uses a third party [CHAK, KENAFIA,etc] to set up the programmes, train the CHWs and have the necessary facilities or structure in place. The goal is to establish an institutional structure, then turn it over to the recipient country for permanent operation. The effect of such PHC programmes is to add a new layer of prevention oriented CHWs to the hospital based system already operating in the 3rd world.

This research observed that, apparently, CHWs neither understood that their trainers [donors] would turn the project to them, nor were they prepared to take on these responsibilities when their donors had decamped. CHWs interviewed complained that the training could no longer operate due to the lack of drug supply and other medical equipment. As a result, only those CHWs who could raise capital to purchase the drugs continued to operate. The existing rural health units have not absorbed them either.

Community health workers were the second most frequented group of health care providers at the onset of an illness. Since CHWs are trained from village, they are the most proximate group of modern health care providers. Their charges are also far below those of modern health care facilities because they offer elementary types of care using simple drugs. However, what appeared to endear them more to their clientele is the flexibility of the mode and manner of payment. Like traditional doctors, CHWs accept all forms of payment including credit treatment arrangements. This is a candid adaptation to a cash strapped rural economy.

CHWs also have a cultural advantage appended to their services. As people who lived in the villages with their patients and potential patients, they shared the same aetiological beliefs on efficacy of modern and traditional therapies.

Thus, when visited by a patient whose illness they perceived as treatable only by traditional curing techniques, they advised aptly. A number of CHWs admitted to have some knowledge of traditional remedies which they advised for or utilized. They thus

operated like a stop gap health care providers between western and traditional medical systems.

Several inadequacies were, however, identified in the use of CHW in rural areas. Patients were occasionally found to consider CHWs as an effective resort *perse*, rather than a first point in the treatment of an illness. Therefore, when a CHWs treatment failed to provide a cure, they concluded that modern medicine had failed and so they turned to traditional medical experts. This exemplifies the failure of the referral system of health care utilization in which the CHW are primarily trained to facilitate.

Alternatively, consultations with CHWs appeared to delay the referral process to a health facility. A patient would visit a CHW and, instead of being referred, the paraprofessional would offer to treat the illness, although unsuccessfully for economic or other reasons. By the time the patient goes to a health facility, the disease may be too severe to be cured.

Since the CHWs are not affiliated to rural clinics, it has become increasingly difficult to monitor their activities. For instance, informants related to this researcher an incident where a CHW injected a patient whose gluteal muscle swelled and later died. Although this CHW was arrested [and later died while in custody], there is a need to put in place a mechanism that would ensure an adherence to medical ethics and professionalism. It should be noted that CHWs were not allowed to inject patients. Their source of drugs and other equipment could not be verified.

The role of CHWs was not fully understood by private medical practitioners. They referred to them as quacks and often discouraged their clients from visiting them.

5.3.3   Private, mission and government health facilities

Private, mission and government health facilities are variably distributed in Khwisero. Informants did not strictly distinguish mission from private facilities. They referred to both as private facilities.

Two government health facilities exist in the division. The exact number of private facilities could not be established. However, it suffices here to state that several private health facilities exist. While others collapse, others get established and operate sometimes under the name of the proprietor only.

The general consensus among the informants was that government facilities were few and far away from the potential users, besides being plagued by lack of drugs and being staffed by impolite personnel. The quality of treatment was judged to be only fair. Such factors discouraged patients from frequenting them. Although the majority of the informants agreed that the charges [fees] in government health facilities were lower than those in private facilities, the complicated system of payment persuaded them to avoid these facilities. The absence of alternative modes of payment in government facilities and the contention that patients paid fees [registration fee] even before being examined by the physician was seen as fraudulent and was thus deprecated.

This study established that the system of waivers for those patients who could not afford to pay hospital fees was not operational. A number of reasons mitigated against such a scheme. The clinician at Khwisero government health centre informed this researcher that he was empowered to exempt needy patients. However, since the physician encounters the patient only at the health facility, it is difficult to understand how he/she would determine their economic capability.

Young [1981] reports that people in his rural Mexican study were aware of private doctors in the neighbouring town susceptible to pleas for reduced charges. Residents were thus familiar enough with the market to know both where to go and what to wear [their most tattered clothing] when making such charity visits. Thus, if the clinician were to judge a patient at the health facility, how immune would he/she be from such manipulation? Alternatively, people in rural areas view a visit to a health facility as a trip to the market centre and may thus choose to dress very smartly. This may obscure an objective assessment of their economic status.

Bennet [1989] observed that in Machakos [Kenya], C.H.Ws assessed the socio-economic conditions of patients and recommended a waiver for the poor ones. CHWs interviewed in Khwisero admitted that they used to recommend needy cases using such criteria as poor housing, small land holdings and a few domestic animals, physical disability and large family size. However, they complained that in the recent past [2 years or so], they have not been supplied with recommendation forms. Consequently, they no longer recommend.

Such a system of waivers is also liable to manipulations as CHWs may end up recommending their friends relatives and leave out the genuine cases.

Another hindrance to the operation of the scheme of waivers is the lack of awareness by patients on the existence of such a scheme. Consequently, most poor patients opted for home prepared herbal remedies. Such a financial handicap situation under close scrutiny reveals a pathetic health scenario than what can superficially be perceived. Social conditions often related to poverty are inextricably intertwined with vulnerability to illness, [a high risk in medical terms], mortality and malnutrition. Thus, it is the poor who fall in the high risk group who cannot pay for health services.

Due to the complex nature of the system of waivers, the poor prefer to use private health facilities. These facilities have been appraised for good quality treatment, a judgement based on a constant supply of drugs and responsive personnel.

Economic factors favour private health facilities. Informants pointed out that, private health facilities never turned away patients who could not afford to pay for medical attention. Instead, they had in place a mechanism of payment that was adapted to the local economic situation. This included payment by farm produce, and household items such as cushions and shoes. Occasionally, patients mortgaged household items such as bicycles, tables and chairs for treatment. The patients repossessed their items on payment of the fee. In extreme cases where clients had nothing to mortgage, they left their identity card numbers with the physician. This would assist in claiming the money and in some instances the chiefs or sub chiefs assisted.

Such payment procedures are common in the rural areas of most 3rd world countries. Akin *et al* [1985] observe that this kind of payment system can work like a sliding fee scale to raise the demand for a providers service through a form of price discrimination that does not show up in the nominal fee structure. The availability of non-cash income in the study population's households increased the proclivity for the use of private forms of care partially because of the ease of payment. Thus, generally, even though the public facilities charged significantly less for their services than private ones, they had no room for payment procedures adapted for the local economy. The cost of using them was thus prohibitively high for cash short households.

Private practitioners were also most likely to be aware of the socio-economic backgrounds of their patients. This enabled them to design a practical and affordable payment systems for each patient. They also stocked most of the drugs required by patients and in peculiar illnesses could arrange to buy drugs for a client and charge them. Payment procedures for private practitioners were commended as simple since the practitioner included the cost of drugs in the fee. This contrasted with public health facilities where registration, prescription, drug costs, injections and blood test fees etc were disaggregated. Informants complained that such payment procedures were herculean and puzzling.

This study has so far examined some of the characterisitics of the available health care facilities especially as they affect utilization. In the following section the hypothesized factors in the choice of health care are discussed. An attempt is made to link them with utilization behaviour.

5.4 CULTURAL FACTORS

5. 4.1 Social networks determined the choice of health care

One of the hypothesis formulated for this study was that social networks determined the source of health care. This research confirmed that the social relationships a person had

during his/her day to day interaction and which served as a normal avenue for the exchange of opinion information and affection influenced the decisions made in the event of an illness. Specifically, at the household level, illness decisions made are consequential to discussions among the available significant members of the social matrix.

It has been observed in the literature review that an examination of the role of social networks would make clear the health seeking process [Foster and Anderson 1978; Lasker 1981]. Freidson [1965] drew attention to the importance of lay referrals in health seeking. He, however, does not discuss the factors which lay referral take into consideration and which therefore inform their recommendations and advice. Frankenberg, [1968] also observed that health seeking was not merely an individual but also a social action which concerns and involves other members of the social unit.

The kind of disease, as well as its severity, determined the level of involvement of social networks. This study established that the involvement of other members of the household was very minimal [almost absent] at the less severe level of an illness. Thus, once an individual developed a simple headache, stomach-ache, a cold, a slight cut, etc, remedial action was unilaterally taken. This illness category involved buying drugs at a chemist or shop or using herbal remedies.
In this case, the sick person would simply walk to the drug store, collect the herbs, or ask a close kin to assist. At moderate or grave levels, social networks feature prominently.

At the grave level of an illness one vital factor that lay referrals consider pertains to the nature of the illness. This involves determining the aetiology and consequent apt source of treatment. Grave illnesses that are believed to be caused by evil eyes, or witchcraft activities are treatable only by traditional techniques.

Therefore, the role of the social networks here is to classify the illness on aetiological grounds and recommend treatment. Their role is vital, since it is strongly held that illnesses with cultural aetiologies would result in death should they be subjected to

modern medical procedures. In the event of such an illness, where the sick member cannot conclusively dichotomise the illness, knowledgeable family members or neighbours are consulted. If aetiological fears are eliminated, then the social network moves further to choose an appropriate alternative in view of the socio-economic or other factors involved in assessing the option.

Cockerham [1992] suggests that under certain conditions close and ethnically exclusive social relations tend to channel health seeking behaviour initially towards the group as opposed to professional health care delivery system. This was due to a distrust of professionals. This study, however, established that social networks channelled illnesses towards traditional treatment methods only in situations where evil eye, magical or witchcraft activities were aetiologically connected. In this case, a traditional medical expert was called to inspect the patient at the initial stages or in the event of a long term illness, where other options had failed. A determination of the cause as cultural definitely eliminates or blocks the thought of other non-traditional remedies in favour of the traditional one.

Where cultural aetiological factors are dismissed, the social network chooses any appropriate facility, be it modern or traditional. The next stage pertains to looking for resources to facilitate the choice.

Like the studies by Salloway [1973; cited in Cockerham 1992: 105] this study found that social networks acted as a data bank among family members and friends as concerns medical decisions. The guiding principle[s] is something like "The last time we had a sick person in this homestead or neighbourhood what did he/she/we do? Where was she/he treated and with what degree of success? What were the charges? How responsive to their needs was the health personnel? etc. Decisions are thus made on the basis of the previous illnesses.

Social networks also acted as a pool or source of economic resources that could facilitate access to health facilities. Informants explained that the choice of a health care facility was often followed by how costs could be footed by family members.

However, what appeared to be important was the mutual confidence that a particular household or a social matrix and a particular health facility had invested in each other. Where a household did not have economic resources, a frequently utilized health facility or practitioner could be approached to treat on credit. This was especially true for private health facilities. Private health facilities [proprietors] in turn had invested confidence on the ability of particular households to pay the fee and readily treated on credit. Some kind of facility patronage was thus established and members of particular households were known to visit specific facilities for advice and treatment.

A social networks association with a specific facility affected the quality of treatment. Cockerham [1992] has observed that low-income people receiving medical care in the public sector are less likely to have a personal physician and must be treated by whichever physician who happens to be on duty in a hospital or clinic. However, having a regular source of care affects the health seeking behaviour. Anderson and Aday [1978] have observed that a variable having great impact on physicians use is the presence of a particular physician who is the person's regular source of care. The patient develops confidence and trusts the physician's skills at diagnosis and treatment.

By patronising particular private facilities, members of a social network build such confidence in a practitioner who in turn offers good quality treatment. This is because, out of a regular interaction with the patients he/she comes to understand their medical conditions.

Therefore, while it would not be entirely true to argue that social networks channelled health seeking to private facilities, it, however, suffices to note that the information accumulated by a social network enabled them to utilize certain facilities more than others. Private health facilities and CHWs [except for 'cultural' illnesses] were in a position to earn the confidence of social networks.

It can thus be concluded that social networks determined the choice of health care at

grave and moderately serious levels of illnesses. Cultural factors, as well as past experience with health facilities, featured as discriminatory factors.

5.4.2   Etiological factors in the choice of health care

Foster and Anderson [1978] observed that "traditional peoples" [quotations mine] felt that illnesses with certain etiologies could be cured or prevented by physicians, so that in spite of initial distrust, they sought such services. Illnesses with other etiologies, however, were felt best treated by home remedies since it was believed that physicians did not recognise them and hence could not be expected to have a cure for them. Illnesses with magical or emotional etiologies, such as the evil eye or *susto* [fright] were the ones most frequently judged to be unsuitable for treatment by the modern physician.

This research established the existence of this dichotomy of illnesses believed to be treated by traditional methods and those treated by modern medical techniques. These illnesses have already been cited in chapter four as those caused by witchcraft, magic, sorcery, evil eye and incest. Of these five categories, evil eye caused diseases were most prevalent. Informants were unequivocal that these illnesses are fearfully regarded since modern practitioners could neither recognise nor treat them. Yet an attempt to treat such illnesses with modern medical procedures put patients in jeopardy.

Children suffering from evil eye attacks were never taken to modern medical facilities for fear that injections would kill them. This practice was also found among Zulu patients in South Africa. Barker [1959], observed a strong belief among the Zulu that their diseases were 'African diseases' which are hidden from foreign eyes. "You wouldn't have been able to help" [Barker 1959: 88]; women would tell Barker while commenting on deaths of their children.

Measles has been mentioned, however, as a disease that shows a complex mix of traditional and modern medical practices. A similar scenario was observed by

Nyamwaya [1982] and Hayden [1982] among the Pokot and other African communities respectively.

Nyamwaya [1982] observed that children with measles may sometimes be kept away from the hospital for fear that injections might kill them. This research established that, while agreeing that measles was treatable by modern medicine, informants would treat using traditional methods or take their children to the hospital only after the rashes were out. This was usually after the sixth and seventh day. Informants believed that treatment by modern medicine before the rashes had come out might result in death for the child.

Such an overlap or mix of beliefs with utilization patterns could work to the detriment of the patient and thus erroneously enforce a false belief. When a child suffering from measles is taken to a modern health facility after a long time and it dies, the hospital is usually blamed for the death and the parents/guardian for taking the child there. However, modern medicine will hold that the true cause/reason for the death could be the delay of treatment or the previous series of ineffectual treatments which allowed the illness to get past the point that the hospital could treat it.

Therefore, this study concluded that when faced by an illness that was believed to be culturally caused households took the decision for traditional curing techniques.

Another issue that raises concern in traditional treatment techniques pertains to operations for evil eye illnesses [okhulumikha]. From this researcher's observations and in-depth interviews, the lack of standard hygiene procedures in the surgical apparatus used was very evident. The blades and horn [eshilumikho] used were rarely sufficiently cleaned nor sterilized. But of a more serious concern was the blood extraction itself. For one, the traditional medical specialist could not establish the quantities of blood in an evil eye attack victim before extracting it. An anaemic patient would be in grave danger after such an operation. Secondly, since the amounts of blood to be extracted was never definite, excessive bleeding could leave the patient in a poorer state of health.

This study thus concluded that cultural factors influenced the choice of health care. It is important to note that judgement on aetiological factors do not depend heavily upon a rigid dichotomy of traditional versus modern medically treatable illnesses. There is however a category of illnesses types that are widely regarded as treatable only with traditional curing techniques. For most other kinds of illnesses including all of the common types, either form of treatment is considered potentially effective.

5.4.3 Age and sex in the choice of health care

The age of a patient is singled out here as a factor in the choice of health care, mainly because the findings in this study appear to contradict those observed by other researches. Mwabu [1984] observed that a household feels or it's head "figures out" that in order for it to survive its adult members must be given first priority in the share of the available resources. Cockerham [1992] observed that people more than 65 years of age are in poorer health and are hospitalized more often than other age groups.

This study however, established that the majority of the informants allocated a disproportionately higher amount of household resources to the health of their children. The second largest proportion of informants did not discriminate health care resources on the basis of age. This group maintained that people of all ages required medical attention. A very insignificant proportion of respondents opined that adults would be given priority in the utilization of medical services.

The reason for the higher premium on health of the children was repeatedly cited to be their vulnerability as well as a perceived low resistance to illnesses. Informants pointed out that adults could persevere illnesses. Children were considered to be weak and in constant need of health care. Households will allocate more resources to children because they had longer to live and were the communities' fore bearers. This accords to the high value placed on children in most African communities. Adults quipped that they had lived for some time, more resources should be allocated to children so that they may live also.

The sex of the patient was not found to exercise any discriminatory role in health care choice. Although Akin *et. al* [1985] observed that the choice of health care may be influenced by sex, informants in this study dismissed all forms of gender discrimination in health care choice. This is because in their view, diseases affected all sexes equally.

5.5 SOCIO-ECONOMIC FACTORS

5.5.1 Costs involved in access to modern medical facilities and the attractiveness of cheaper options.

This study revealed that a feature of the modern medical system was the installation of an expensive curative approach for patients who are supposed to travel to hospitals, pay hefty bills and purchase drugs. Such costs, it is further hypothesized, reduce the accessibility of such facilities and increase the attractiveness of other cheaper options for low incomes households. Such alternatives include self treatment by means of herbal remedies and patent drugs sold in shops and pharmacies.

Akin *et al* [1985] note that the opportunity cost of seeking medical care is approximated by the sum of the price paid to get to the medical installation, the price paid to use the services, and the price paid for any medicines required for treatment. These prices will, in most cases, have two components: a direct pecuniary cost in terms of money and an in direct one in terms of time. For instance, walking to a health facility may not have a pecuniary cost but a non-pecuniary one in terms of time and energy spent. Some of the costs involved in access to a medical facility are examined in the following section i.e transport costs, medical fees and drug costs.

5.5.2 Transport costs

An investigation into the transportation costs considers the distance to the health facility, mode of transportation, time taken, and the actual monies paid. This is because the cash price of a trip is a small part of the real cost of transportation, since a large proportion of

the trips undertaken in the rural areas of non western societies involve no cash outlay at all [cf Akin et al 1985, Mwabu 1984 and Lasker 1981].

Due to the poor state of the roads in Khwisero and the consequent absence of sufficient motor vehicle transportation, travelling to health facilities was usually accomplished on foot or by bicycle. Patients who were unable to walk to the health facilities were either carried on home made stretchers, bicycles or wheel barrows. This researcher frequently observed instances of such modes of transport. While no cash price [in monetary terms] could be attached to it, it is noteworthy that transporting a sick person to a hospital in this manner required a minimum of four adults who would carry the patient in shifts. The availability and opportunity cost on the time of four adults would be quite high

This study established a non-linear, inverse relationship between transportation costs [both pecuniary and non-pecuniary] and use. The more the costs incurred to access a medical facility, the less likely patients and potential patients are to utilise it. Transportation costs as a composite, of both cash outlay and time cost, acted as a deterrent to using long distance health facilities. Where the whole range of therapeutic options are available, transportation costs act as an allocative device determining [i.e when all other factors are considered] which health care alternative is chosen.

Government health facilities and private clinics were the furthest from the informants. Government health facilities were particularly avoided on the basis of distance, inter-alia. The distance to a health facility was persistently mentioned as the reason for the utilization or avoidance of certain facilities. Informants thus frequently used drug shops, herbal remedies and CHWs, whose proximity to their clientele minimized the transport costs.

5.5.3 Medical fees and cost of drugs

Akin et al [1985] observe that the actual cash out-lay for using a health facility should other things being equal, act as a deterrent to use. The introduction of cost sharing in Kenya's public health facilities eliminated the only source of "free" health care facilities for the urban and rural poor.

While instituting cost sharing, the government intended to raise revenue and reduce it's expenditure. Ochoro and Omollo[1989] observed that cost sharing may have devastating effects on some segments of the population due to it's potential to erode their purchasing power.

According to the KPAR [1995] the less educated and the poor use public facilities. The bulk of these patients are to be found in the rural areas. This observation assumes that charges in the public facilities were either absent or lower than those in private facilities. While informants agreed that public health facilities charged less, it cannot be stated unequivocally which facility would charge lower than the other for an identical illness.

In Khwisero, informants cited lack of financial resources as a determinant of the health care facility opted for. Government and private practitioners explained that a large number of patients could not afford to pay hospital bills. Private practitioners exhibited lists of their patient debtors to this researcher.

In the absence of money, patients opted for cheaper alternatives such as self treatment [traditional and modern], CHWs and traditional healers. They came to the hospital only when these alternatives failed.

Heller [1982] found that the total demand for outpatient care from all sources was insensitive to the cash price. However, the decision of which alternative to use was somewhat sensitive to the prices of the other practitioners. Thus patients weighed the costs involved and chose on the one that could be accessed, in view of the resources available at the household level.

This study established that it was not merely the amount of cash and/or other payments made, but also the manner of payment which discriminated between alternative facilities. This distinction was not merely between modern and traditional practitioners, but also within modern health practitioners. While traditional medical specialists divided their fee

into two, modern medical practitioners demanded payment at once, and this payment was independent of whether a patient was healed or not.

As Pielemeier [1975] observed, this kind of payment was alien to the local cultures. As a result, informants felt that the modern medical system was deceptive, since subsequent follow-up treatment was paid for. The traditional medical system had the alternative of no payment where patients were dissatisfied with the treatment. Payment was seen as an element of reciprocity for a service well done.

Private and government health facilities were also distinguished on the basis of payment procedures with private facilities being preferred. The payment system in government health facilities was found to be confusing and a way of camouflaging on otherwise expensive medical system. Government facilities had no provisions for credit treatment. The scheme of waivers introduced by the government was shrouded in mystery and there was little evidence that it was effective.

Private medical facilities, besides accepting credit payment, combined all expenses into one fee. As a result they were preferred by majority of the patients.

Both modern and traditional medical systems are highly dependent on drugs for their treatment. The cost of medicine is thus a major complimentary cost of medical facilities. Prescriptions costs differ systematically with practitioners and this was found to greatly affect utilization behaviour. This is because, as rational people, informants through experience judged which facility charged more for drugs.

As in Ivory Coast [Akin *et.al* 1985] this study found that in rural areas, traditional medicine or self treatment with herbal concoctions [remedies] were reasonable alternatives to modern medical care because herbal treatments can be prepared cheaply or free at home. Therefore, to circumvent drug costs these alternatives were employed.

Shortages of drugs constituted a major set back to the utilization of public health facilities. The bureaucratic system of procuring drugs for public health facilities on many occasions led to discrepancies between demand and supply. This was partly because, at national levels, supply of pharmaceuticals are highly dependent on government budgetary allocations and the actions of donor agencies. Warehouse facilities are often inadequate and record keeping is unreliable. Drugs are thus often unavailable at the local level because of transport problems and the inability to predict demand.

Private health facilities were appraised for constant supply of drugs. The advantage of private facilities over public ones in the procurement of drugs is fairly obvious. For sole proprietorships, decision making at the local level facilitated an easy reading of the local pharmaceutical needs and effective procurement of necessary drugs. Private facilities could allocate resources for specific cases. They were consequently seen and preferred by informants more than public facilities for offering high quality treatment.

Waiting time was another complimentary cost associated with the consumption of modern medical services. The actual cost to the individual waiting to be seen at a clinic is not the time spent *perse*, but the value of the time lost from other activities in order to be at the clinic.

In this research, however, informants did not stress the importance of waiting time in the utilisation of medical facilities. Nevertheless, as illness case no 10 indicated, a situation that required a mother to be admitted in hospital with a sick child could be resisted. Mwabu [1984] observed that lack of someone to leave at home in the event of a hospital visit could hamper the utilization of a facility. The value of the mother's time in case 10 as well as the female marital obligations and respect for the husband, could prevail against utilization of hospitals.

This research, therefore, concludes that the costs mentioned above are prohibitively high for cash strapped rural economies like those of Khwisero. Consequently, sick patients adopt available cheap alternatives. In conformity with studies by Mwabu [1984], Akin

et. al [1985] and Young [1980], this research confirmed that people will pursue self treatment at least until it becomes obvious that the illness is not likely to respond. CHWs are also consulted due to their proximity and low charges. Private medical facilities and traditional healers are economically endearing to their clientele while government facilities were deprecated.

CHAPTER SIX

6.0 SUMMARY AND RECOMMENDATIONS

6.1 Summary

This study set out to examine the influence of cultural and socio-economic factors on the choice of health care. To be able to investigate the choice variables, it was imperative that the choices themselves be isolated and identified. The range of therapeutic options was initially examined and found to include self treatment [herbal remedies], self treatment [patent drugs], traditional doctors, community health workers, private health facilities [mission facilities included], government [public] health facilities, and faith healing.

The utilization of these facilities is contingent on the attributes of the families themselves [proximity, quality of treatment etc] as well as on the characteristics of the patients [their resources, aetiological beliefs and their social matrix etc].

Various studies [Osero 1990 and Mwabu 1984] have noted the inadequate supply of modern medical facilities in the rural areas. Consequently, the rural population has resorted to [and are actually encouraged to resort to] traditional medicine. It is, however, important to understand the status of both modern and traditional medicine in the rural areas.

Modern medical facilities introduced by colonialists and missionaries and inherited by newly independent governments has continued to be biased in favour of urban areas. The result of this has been a neglect of the rural areas in the planning and consequent supply of modern medical facilities. Their planning procedures, primarily concerned with the physiological aspects of health and the supply of governmental medical service, negates or fails to consider the behavioural aspects of medical care consumption. The result has been that as badly as modern rural health services are needed, they are often under used by the target population. As this study observed, private facilities have mushroomed in the rural areas and are utilized more than public ones.

The colonial policy of shifting state patronage from indigenous systems to western system drove the former into a whirlpool of a vicious circle. The indigenous systems very neglect accentuated their decline and their decline in turn made it increasingly difficult for this system to compete with the western system of medicine. Thus, at a time when spectacular developments were taking place in the different branches of western medicine, the professions of indigenous medicine became dominated by persons of very limited competence sometimes even by quacks and impostors. These continue to operate even today and further confound the indigenous medical realm.

After independence, a native ruling elite that took over power made lofty egalitarian pronouncements on health sector development. Regrettably, however, they used essentially the same machinery bequeathed to them by their former rulers. Besides promising a regional redistribution of the benefits of health services, they promised a revival and strengthening of the indigenous system of medicine.

The indigenous system of medicine has been subjected to two contradictory pulls. It's being rooted in the culture of the people evoked considerable admiration and a certain degree of emotional attachment from a large cross section of the population. At the same time long periods of neglect for these systems of medicine had led to a very sharp deterioration in their bodies of knowledge, in their institutions of training and research, in their pharmacopoeia, industry and in their corps of practitioners.

The political leadership paid only lip service to the indigenous system. There has been almost negligible investment in indigenous medicine. As Banerji [1981] also observed, the indigenous medicine was never taken seriously by the political leadership. This same nonchalance has been inculcated into the general population. Consequently, very superficial efforts have been made to rediscover the indigenous medicine's lost heritage, get rid of the obscurantist elements that had crept in and to promote further growth and development of the system.

In the study population, the researcher encountered many informants who claimed to be able to cure many ailments by herbal remedies [i.e herbalists]. Their expertise could, however, not be authenticated except for a few well established, known and registered herbalists. Therefore, while encouraging people to utilize traditional remedies, it would be more important, first of all to examine the present nature of the traditional medical realm. This is where research should be focused namely, the basic research on traditional medicine rather than the popular applied ethnomedical research that ends up strengthening western medicine at the expense of traditional medicine. This includes the quantity and quality of herbal remedies, and the practitioners expertise. Traditional medicine like it's modern counterpart could be infiltrated by quacks and impostors who may be more of a health hazard than a panacea.

Private health facilities appear to be more widespread and more utilized than government ones. Their proximity, quality of treatment and a payment procedure adopted to rural economies continue to be their strong points. Government health facilities are perennially beleaguered by the problem of inadequate supply of facilities, personnel and other pharmaceutical supplies. This has led to their being under utilized.

Community health workers constitute another therapeutic option commonly utilized in the rural areas. Their role is important both for the treatment of simple illnesses as well as in detecting serious illnesses and referring them in higher facilities.

Pharmacies, shops and CBDs are the major sources of patent medicine in the rural areas. Their utilization is a function of their proximity to the potential patients as well as the patients cost-minimizing strategy.

Although faith healing is a therapeutic option in rural communities, the provincial administration in Khwisero has banned its operations on security grounds.
It is possible, however, that patients and potential patients would consult faith healers when they were convinced that they were victims of illnesses with supernatural aetiologies.

This study hypothesized that social networks determined the choice of health care. Data collected and analysed was accordant to this hypothesis, especially at grave and moderately serious levels of illnesses. Except for illnesses with supernatural aetiologies [where social networks unequivocally favoured herbal remedies], they favoured private facilities and CHWs. This was the result of a long period of client-patronage that led to mutual benefits both in the quality of treatment and payment procedures.

Costs [pecuniary and non-pecuniary] involved in accessing modern medical facilities continue to exercise a limiting control towards their utilization. Rural households that are often cash strapped resort to cheaper options such as self treatment and community health workers. Where modern health facilities are utilized, preference appears to be for private medical facilities. Private facilities often charge more than public facilities. Their utilization by poor households instead of the public ones is therefore sensitive to more than simply the cost. This research established that the utilization of modern health facilities was not merely sensitive to the cost but to the manner/nature of payment. Private facilities charge more but the charges may be staggered over a period of time. They are also willing to accept other forms of payment in tune with the local resources.

Beliefs pertaining to the perceived aetiology of an illness affect the choice of health care and decision making at household level. Illnesses caused by evil eyes, witchcraft, sorcery or magic activities are treated by traditional medical specialists. Where supernatural causes are not attributed, either system of medicine is employed depending on economic or other criteria.

The gravity of the illness overwhelmingly affected the choice of health facility. At the grave or serious level of illness only cultural factors modified the illness curing strategy. Where the aetiology was not supernaturally connected the facility with the highest probability if a cure [usually a big hospital] is often opted for. Households will pick on a facility and then raise the resources from among themselves or their friends. The probability of a cure is judged from the patient or patients social network perspective.

At the moderately serious or less serious level, the choices made are sensitive to the availability of resources. Households employ a cost-minimizing strategy where the least costly facility that has a probability of a cure is opted for.

Decisions made at household levels in the event of an illness are, therefore, usually informed by a set of variables. To be able to understand the health seeking strategies, the variables involved should be considered not in isolation but in conjunction with each other.

6.2 Recommendations
The following recommendations have been made from this study.

1. Transportation facilities being very poor in Khwisero constitute a major problem in the access to modern medical facilities. The government should thus concentrate it's resources to reduce the non-pecuniary impediments to using medical facilities. Directing government expenditure to projects that can reduce the indirect costs of medical care can have spill-over effects on other sectors of the economy. For example, government resources spent on roads and public transportation to make Khwisero health care more accessible can simultaneously improve the food distribution system, widen markets and lessen the economic impact of weather. Such an effort, besides increasing accessibility can lead to more opportunities for earning cash incomes that would facilitate accessibility.

2. Khwisero division is, to a large extent a subsistence economy. There is thus a need to encourage the inhabitants to practice cash crop farming that would enable them earn incomes which would provide them with access to modern medical facilities. The introduction of sugarcane farming is hereby lauded as a welcome development.

3. Although the government has instituted scheme of waivers for the poor, it's complicated nature inhibits it's operation in the rural communities. This research found

that most rural residents were unaware of the presence of such a scheme. It is, therefore, important that the government institutes proper policy guidelines that would enable the clinicians or other health care personnel to judge the needy and award waivers. The poor patients ought to be informed on the operations of such a scheme to enable them benefit from it.

4. The role of traditional medicine has been obviated by the inadequate supply of modern medicine and the rural population is encouraged to utilise it. There is, however, a need to decamp from rhetorical support for indigenous medicine and engage practical strategies to revamp/rejuvenate it. It is not just important to romanticise the importance of traditional medicine to the rural population. Efforts aimed at rediscovering it's lost heritage, to rid it of the obscurantist elements and to promote its further development ought to be taken by the rural populations and their leaders. People in the rural areas should be encouraged to arrest further deterioration of traditional medicines' body of knowledge and the associated pharmacopoeia and corps of practitioners.

5. The use of the CHW strategy to deliver simple health services is an approach with universal applicability. There is, however, the need to take into account the diversity of populations or differences in available resources. The CHW strategy is slowly dying out in the research area due to an apparent lack of financial preparedness on the part of the paramedic after the departure of their donors. It is important to prepare the CHW financially and in infrastructure to ensure that their activities are sustained. There is also the need to affiliate them to the rural health facilities so that their activities can be monitored to ensure strict adherence to professional ethics. In the absence of such monitors, the CHW strategy may jeopardise effective treatment by protracting the referral process.

In the same vein, private practitioners should be enlightened on the role of CHW so as to avoid a conflict of interests. As it is now, private practitioners view CHWs as quacks and advise their clients against them.

6. In the medical system of most third world countries, pharmacists, CBDs and drug shops play important roles in diagnosing diseases and prescribing drugs. As a vital source of drugs for rural populations, it is important to monitor their activities or guard against their being penetrated by unscrupulous drug dealers. This is because pharmacies and drug companies retail men may penetrate them and dispose of fake, expired medicine or powerful pharmaceuticals. CBDs should especially be monitored since in the absence of donor supplied drugs, they could be duped by drug companies into buying harmful medical products due to their rudimentary pharmaceutical knowledge.

7. Traditional doctors ought to be encouraged to maintain proper hygiene in their treatment techniques. It is important to impress upon them the dangers inherent in operations involving excessive blood extractions. As much as possible they should avoid such operations as they may jeopardise the life of the patient. Traditional doctors should be made aware of the danger posed by the use of un-sterilised equipment in the spread of the HIV virus. They should, therefore, be advised to maintain acceptable standards of hygiene.

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APPENDIX 1

QUESTIONNAIRE

1.   [a] Name of respondent_____

     [b] Location_____

     [c] Sub location_____   Village_____

2.   Sex   Male:

            Female:

3.   Age_____ [When were you born]?

RANGE OF THERAPEUTIC OPTIONS

4.   How far is the nearest health facility from your home? I would like you to tell me
     its name and distance from your home.

Name of facility	Distance in Km	Time to walk	Time by vehicle

5.   Do you know someone in this area or another village who treats people in
     traditional medicine?

                    Yes

                    No

6.   How far is the nearest one from your home?_____

7   Do you normally treat yourself using traditional medicine?

                    Yes

                    No

8. If yes, how do you obtain them?

_____

_____

SOCIO-ECONOMIC FACTORS

9. What level of education have you attained?_____

10. Are you retired?

        Yes

        No

11. What is your main occupation?

Small scale farmer	
Teacher	
Trader	
Other [specify]	

12. Approximately what is your monthly income from your main occupation?

Below 1,000	
1,000 – 2,000	
3,000 – 4,000	
4,000 – 5,000	
Over 5,000	

13. Do you have any other sources of income besides your salary?

        Yes

        No

If yes

14. Please list the other sources of income

Source	Amount

15. What is your total income then? [Do not ask but compute]

_____

16. Do you own any of the following livestock?

    a] Cattle   c] Goats

    b] Sheep   d] Others [specify]

17. Farm size

    a] Farm acreage_____

    b] How much land is cultivated?_____

    c] What do you grow on the farm?_____

18. Do you own any of the following household assets?

Bicycle	
Motor cycle	
Motor vehicle	
Radio	
Sofa set	
Iron roof	

[Where possible do not ask, just observe and indicate approximately]

19. What do you think is the major cause of death in this area?

Diseases	
Accidents	
Old age	
Famine	
Witchcraft	
Other specify	

20. Which disease accounts for the highest infant mortality in this region?

_____

21. How is it usually treated?

Use of herbs	
Visit to a traditional healer	
At mission hospital	
At government hospital	
At private clinic	
Other specify	

22.   Which is the most prevalent disease for adults here?

_____

23.   How is it normally treated?

_____

24.   Is the way it is treated uniform or different in this region?

          Uniform

          Different

25.   Could you please explain what accounts for the difference?

_____

26.   Is there anyone sick in your home?

          Yes

          No

27.   If yes when did you last have someone sick?

_____ Days/weeks/months ago.

28.   How serious was the illness?

Very serious	
Moderately serious	
Not serious	
Do not know	

29. Who is/was sick?

          Parents information

          a] Name

          b] Period of sickness _____ days/weeks/months

          c] Sex

          d] Age

30. What did you do as the first thing to cure the illness?

_____

Why?_____

31. For how long had the patient stayed without treatment?

_____ days/weeks/months.

32. If the patient did something about the illness ask for the following

a] Name of source

b] Type of source

c] Distance travelled_____kilometres　:

d] Time taken to travel_____minutes

e] Mode of transportation_____

f] Transportation costs _____

g] What was the cost of treatment _____Ksh. [for self treatment and traditional curer, record non cash resources expended]

h] Did you have other things to do at the health facility apart from getting treatment or medicine

                 Yes

                 No

If yes what?_____

33. How would you assess the treatment/medicine received?

    Excellent

    Very good

    Fair

    Poor

34. If treatment was not by self how would you assess the qualification of people who gave you medicine or treatment?

    Excellent

    Very good

    Fair

    Poor

35. How would you assess their behaviour, manner of speaking to you?

    Excellent

    Very good

    Fair

    Poor

36. Did they spend enough time with you?

        Yes

No

37. Did you or the sick person feel better after treatment?

        Yes

        No

If yes

38. How soon after treatment? After _____ days/weeks.

39. Did you do anything else?

        Yes

        No

40. If yes, what did you do?_____

41. After how many days/weeks since last treatment?_____
weeks/days/months.

42. Source of second treatment

    a] Name_____

    b] Type of source_____

    c] Distance travelled in kilometres_____

    d] Time taken to travel in _____min/hours

    e] Mode of transport_____

    f] Transport costs kshs.

    g] Cost treatment Ksh_____ [for self treatment and traditional doctor
       Record non cash resources expended]

    h] Type of treatment given

    i] Did you have any other thing to do at the health facility apart from getting
       treatment?

            Yes

            No

43. If yes what?_____

44. How would you assess the treatment received?

        Excellent

Very good

Fair

Poor

45. If treatment was not by self how would you assess the qualification of the people who gave you the medicine of treatment?

Excellent   Poor

Very good

Fair

46. How would you assess their behaviour, manner of speaking, acting etc?

Excellent

Very good

Fair

Poor

47. Did they spend enough time with you?

Yes

No

48. Did you or the sick person feel better after treatment?

Yes

No

49. If yes, how soon? _____ days/weeks/months

50. Did you do anything else?

Yes

No

51. If no why?_____

52. If yes, what did you do?_____

How long after last treatment?_____ days/weeks/months

NB a] If third option of treatment was used ask the same question for it as 31-39.

b] After 3rd option stop questioning and go to another illness: separate sheets containing questions 31-39 will be provided for other illnesses.

53. Has any member of this house hold ever failed to visit a hospital because of financial disability?

Yes

No

If yes

54. What eventually happened?

Used herbs	
Patient passed away	
Bought drugs from pharmacy	
Patient got cured	
Others [specify]	

55. Has any member of this household ever failed to obtain drugs from hospital?

Yes

No

If yes, which drugs/for what illness?_____

56. What was done in the circumstances?

Went home

Bought drugs

Used herbs

Other [specify]

57. Are you aware that you can be exempted from paying fees at government hospital

If you are poor?

Yes

No

58. Have you ever been exempted?

Yes

No

59. Are there persons known to you who have personal physicians?

Yes

No

60. If yes how do you rate their economic status?

High income

Middle income

Lower income

CULTURAL FACTORS

61. Which health facility do members of this household use most frequently?

       Self treatment [herbs]

       Government health centre/clinic

       Mission health centre

       Private clinic

       Traditional doctor

       Other [specify]

62. Please explain your preference for 61 above

_____

63. When do you consider any member of these household as sick?

_____

64. What is your usual advise after seeing/recognizing such symptoms?

       Chewing herbs

       Visiting traditional doctor

       Going to a government hospital

       Visiting a private hospital

       Buying drugs from chemist

       Other [specify]

65. In your understanding are there diseases that can **only** be cured by traditional medicine?

       Yes

       No

66. If yes, please name some of them?

_____   _____   _____

67. Why can't modern medicine treat such diseases?

_____

68. Are evil eyes/sorcery capable of causing diseases?

       Yes

       No

69. If yes, please name some of them?

70. How are these diseases usually treated?_____

71. Are there experts who attend to illness caused by sorcery/witchcraft/evil eyes?

        Yes

        No

72. To what extent do you think traditional medicine is effective?

    Greater extent

    Great extent

    Lesser extent

    Do not know

73. Please explain your assessment_____

74. To what extent do you think modern medicine is effective?

    Greater extent

    Great extent

    Lesser extent

    Do not know

75. Do you think traditional medicine should be encouraged?

        Yes

        No

        If yes

76. How should it be encouraged?_____

77. What is your religious affiliation?

        Christian

        Muslim

        Other [specify]

78. Does your religion constrain utilization of any health facility?

Yes

No

If yes

79. Which health facility?_____

and why? _____

80. Whom do you regard as needing constant health care in the household?

Children   Aged

Middle aged   All

81. Why is it so?_____

GRAVITY OF ILLNESS FACTORS

82. When do you visit a health facility?

When critically ill

Whenever I fall sick

When previous resorts fail

Other [specify]

83. When do you consider someone to be very ill?_____

_____

84. What do you normally do? [in 83 above]_____

_____

85. In your opinion are there illnesses serious enough as to be treated only in certain facilities?

Yes

No

If yes

86. Which ones and where are they treated?

Disease   **Facility**

87. What do you do for these categories of illnesses?

Grave/serious

Moderately serious

Less serious

SOCIAL NETWORKS

88. Is there anyone who helps you make decisions in health care?

Yes

No

89. How are you related?_____

90. What kind of advice do you elicit?_____

_____

91. Do you have a medical personnel in your household?

Yes

No

If yes

92. Do you depend on his/her advice? Please explain?

_____

APPENDIX 2

QUESTION GUIDE FOR KEY INFORMANTS

NAME_____

SOCIAL POSITION_____

1. What is the range of therapeutic options available to people in this area?

2. How accessible to the people are modern health care facilities?

3. Are there specific problems that people face in their utilization of hospitals/ clinics/health centres?

4. How has cost sharing affected people' access to hospitals?

5. Would you agree that lack of resources has led people to prefer traditional medicine or, what kinds of people prefer traditional doctors medicine?

6. What part does traditional medicine play in the health of the people in this area?

7. Should traditional medicine be encouraged? How do you think this should be done?

8. How do you assess the incomes of the people vis-à-vis utilization of health care options?

APPENDIX 3

AREAS OF DISCUSSION FOR FOCUS GROUPS

1. Population density and availability of modern health care.
2. Problems in utilization of modern health care facilities.
3. Reasons for utilization of traditional medicine.
4. People's attitude towards modern medicine.
5. Social networks in choice of health care.
6. Interplay of traditional and modern medicine
7. Instances of utilization of:
   a] Modern medicine and not traditional medicine.
   b] Traditional medicine and not modern medicine.
   c] Private modern health care providers.
   d] Government health care facilities.
   e] Drugs stores.
8. On improvement of health facilities.