UTILIZATION OF TRADITIONAL MEDICINE IN NAIROBI, KENYA: A CASE STUDY OF KIBERA SLUM

BY

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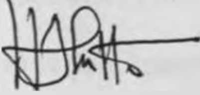
(2005)

Declaration

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



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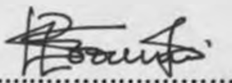

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Dr. W. Onyango-Ouma **Date**

Dedication

This thesis is dedicated to my late grandfather Mr. Mosonik who never lived to see me go to the "city" to acquire knowledge, and to my parents, Ernest and Josephine Rutto, who played a big role in my long journey to attaining one of our independence goals; 'freedom from ignorance'!

Kongoi missing' ak koperupok Jehovah!

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List of abbreviations

AMREF	African Medical and Research Foundation
APHRC	African Population and Research Centre
CBS	Central Bureau of Statistics
EM	Explanatory Model
GOK	Government of Kenya
HBM	Health Belief Model
KPHC	Kenya Population and Housing Census
MOH	Ministry of Health
PHC	Primary Health Care
SAP	Structural Adjustment Programmes
SPSS	Statistical Package for Social Sciences
TBA	Traditional Birth Attendant
TRM	Traditional Medicine
USSR	Union of the Soviet Socialist Republic
WHA	World Health Assembly
WHO	World Health Organisation

Abstract

This study was designed to investigate the "pull" and "push" factors that influence utilization of traditional medicine in Nairobi, Kenya, with a specific focus on the Kibera informal settlement.

The respondents were selected using the non-probability sampling techniques including purposive, snowball, and convenient sampling methods. Data were collected using both qualitative and quantitative methods. The quantitative data were collected using the questionnaire while qualitative data was generated by the use of case histories, and direct observation. The data were analysed using both qualitative and quantitative techniques.

The study findings revealed that the socio-economic status of the respondents does not determine utilization of traditional medicine in Kibera slum. Perceived efficacy was found to play an important role in the use of traditional medicine. Lay perceptions about disease aetiology were also found to have an influence on the use of traditional medicine. Equally important was the aspect of availability of traditional medicine.

This study concludes that patients choose different treatment options as influenced by perceived efficacy, availability and aetiological beliefs. It is recommended that effective and positive traditional healing practices be integrated in the official healthcare system in order to give patients different options to choose from. We also recommend that a socio-cultural dimension be incorporated into the process of healthcare delivery as a way of improving understanding and addressing the unmet needs of patients.

CHAPTER ONE

Introduction

This chapter presents the background to the study, statement of the problem, and research questions. In addition, the objectives and justification of the study are presented.

1.1 Background Information

The World Health Organisation (WHO) estimates that, at least 80 per cent of the population in most developing countries rely on traditional medicine to satisfy their primary health care needs (Bodeker *et al*. 1997:1). This shows that traditional health care system has played/and continues to play a significant role in healthcare delivery. The WHO primary health care[1] conference held in Alma Ata (the former U.S.S.R) in 1979 recommended, among many other things, the use of traditional medicine in health care delivery as a strategy of achieving "health for all" (WHO and UNICEF, 1978).

The concept of traditional medicine is synonymously used with terms such as ethnomedicine, alternative medicine, and indigenous or non-conventional medicine. The WHO defines traditional medicine as:

> the totality of knowledge and practices, whether applicable or not used in diagnosing, preventing or eliminating physical, mental or social dis-equilibrium and which is exclusively based on past

[1] Primary health care concept emerged because of disenchantment with traditional approaches to health care. Rather it meant that fundamental changes were needed in the way health was perceived, promoted, protected and provided. It adopted five basic principles, which provided a framework for its approach i.e. equitable distribution, community involvement, and focus on prevention, appropriate technology, and multi-sectoral approach. "Health for all" by the year 2000 was a vision founded on social equity; on the urgent need to reduce the gross inequality in the health status of the people in the world, in developed and developing countries, and within countries. Health for all meant healthcare was to be brought within the reach of everyone in a given country. The approach shifted from vertical approach to a bottom-up approach. (WHO-UNICEF, 1978:1).

experiences and observation handed down from generation to generation, verbally or in writing (WHO, 1983:25).

An ethno-medical approach to health problems is based on the notion that each cultural group handles its medical problems in a particular way. Through time, these communities have developed their own worldviews, traditions, values, and institutions to help them handle disease and illness (Fabrega, 1975 cited in Sindiga, 1995). Moreover, every cultural group has its own disease aetiologies, medical technologies and classification, medical practices and a whole range of pharmacopoeia (Sindiga, 1995).

In most African communities, the concept of health is bound up with the whole interpretation of life. Considerations such as peaceful coexistence, abiding by the laid down norms and values in society are just as essential for a healthy life as the essence of malfunction of the physical body. This means that health is a state of "social wholeness"[2] (Kimani and Good, 1981:303; Mbiti, 1969:167; Ngubane, 1977: 27-28; Swantz, 1979: 169-170).

Traditional health practitioners employ a number of methods to prevent misfortunes and/or illness (Wandibba, 1995:121). These include isolation of the sick, use of charms and medicines such as preventive magic, and use of herbal remedies, among others. Studies done in both urban and rural areas in Kenya indicate that traditional healing is the most widely available form of health care. It is functionally interconnected with modern medicine through patient's joint use (Kimani and Good 1981: 301).

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[2] Social wholeness- in most African communities, to be a social being is to belong to the whole community. This not only entails being physically fit but also being in perfect harmony with your environment and social life. The society expects an individual to share beliefs, participate in ceremonies, rituals, and festivals of the community (Mbiti, 1969; Ochieng-Odhiambo, 1997:55).

According to Nyamwaya (1992), indigenous and modern medicine interacts in four main ways: sequential, zigzag, supplementary, and complementary. This clearly shows that, traditional medicine continues to play a significant, though somewhat, changing role in healthcare delivery. Kimani (1977) postulates that,

> as traditional medicine spreads from rural to the complex social environment of urban centres, practitioners tend to be generalists. In this sense, their expertise is extended to accommodate illness, socio-economic problems, habits, and aspirations of heterogeneous urban populations. In the rural arcas, a traditional healer is more often a specialist in one or two areas (Kimani, 1977:47).

Indeed, patients still consult traditional medical practitioners even in urban centres where western medicine is reasonably accessible and available as compared to rural areas (Kimani, 1977:47). Furthermore, a large number of women in the city still use indigenous forms of therapy when faced with fertility problems (Kimani, 1995). She attributes the popularity of traditional healers in both urban and rural areas to personal attention they accord their clients. The WHO defines a traditional healer as:

> a person who is recognised by the community in which he lives as competent enough to provide health care by using vegetable, animal and mineral substances and certain methodologies based on cultural beliefs, that are prevalent in that community (WHO,1983:1).

Traditional health care providers vary from diviners, herbalists, magicians, traditional birth attendants (TBAs), to bonesetters. The Government of Kenya, in its 1979-83 development plan, gave due recognition to the role-played by traditional medicine men/women in the promotion of healthcare (GOK, 1983). This was in line with a call by

the WHO in 1978[3] during the primary health conference for incorporation and integration of traditional health care system in the formal health care delivery.

1.2 Statement of the problem

The health care situation in developing countries, described in terms of both facilities (supply) and access (demand), clearly indicates that services are inadequate (Ofware, 2000). Even where facilities exist, they suffer from shortages of trained personnel, inadequate supplies and poor facilities, all translating into non-availability of services. The problem of disease and health cannot be solved by modern health care alone. This therefore calls for the exploitation of all available resources in the un-ending quest for health. The rising cost of living and that of modern health puts majority of urban dwellers, particularly the lower income group at a disadvantage and thus subject to most infectious diseases. Similarly, the inability of modern medicine to treat some diseases has driven many to seek alternative therapy. The Kenya government in this respect has continued to articulate the need for increased coverage and access to health in its development plans. This is in recognition of the fact that, the health of her population is vital if any meaningful development is to take place. Kenya's health problems stem partly from lack of access to modern health facilities by a section of the population to non-availability of services in healthcare facilities (GOK, 2002). Despite the realization, it

[3] The international conference on primary health, organized jointly by UNICEF, WHO, and the government of the former USSR now Russia, took place between 6th and 12th September 1978 in Alma-Ata the capital of Kazakhstan (Coulan, Q.A.A, 1985). During this conference, the Alma Ata Declaration built the historical basis for the official politics of the Traditional Medicine Programme thus opening a dialogue between two distinct systems of medical assistance: traditional and modern medicine. However support to traditional medicine, healers and remedies is to be given only to those practices that, on the basis of medical-scientific testing, are proved to be safe and effective (Consgliere, S.2000)

has been quite difficult to meet the healthcare needs of the first growing population because of socio-economic crisis dating back to the early 80's and subsequent implementation of Structural Adjustment Programme (SAPs)[4] in the 90's that required reduction of state spending in the health sector.

The WHO has documented that the global demand for herbal medicine has tremendously expanded for the past 15 years (WHO, 2001). Similarly, there has been an influx of traditional healthcare providers from rural to urban areas (Kimani, 1995). This partially indicates that demand for their services exist both in urban and rural areas due to its perceived efficacy and failure of modern medicine to meet the healthcare needs of the population.

Therefore, there is a need to explore the extent in which traditional medicine is used in urban centres in terms of its popularity, quality, perceived efficacy and reasons why individuals and communities in urban areas continue to use it despite the fact that modern health care is generally considered to be superior and fairly distributed in urban centres as compared to rural areas.

The study sought to answer the following research questions:

- Do people's beliefs about disease causation determine their choice of therapy?
- What impact does perceived efficacy have on utilization of traditional medicine?
- What is the effect of cost on the use of traditional medicine in Nairobi?

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[4] Also referred to as economic adjustment is usually used synonymously with stabilization programme to denote the set measures aimed at achieving the long-term objective of a programme aim at accelerating economic growth-chiefly by restructuring the economy and reducing excessive or inefficient government intervention (WHO, 1994: 83)

- What role does availability play in health care choice?

1.3 Objectives of the study

1.3.1 Overall objective

The overall objective of the study was to investigate the 'pull' and 'push' factors influencing utilization of traditional medicine in Kibera informal settlement in Nairobi, Kenya.

1.3. 2 Specific objectives

- To explore the traditional beliefs and practices about health and illness causation and their influence on therapeutic choice.
- To asses the influence of perceived efficacy of traditional medicine on its utilization.
- To determine whether cost (ability to pay) influences the demand for traditional health care in Kibera.
- To determine the influence of availability of traditional medicine in Kibera slum on demand and utilization.

1.4 Justification

The performance of any health care facility is determined by its utilization rates. The increase in utilization of traditional medicine has been documented by the World Health Organization (WHO, 2000)-a clear indication that utilization of traditional medicine exists. This is because utilization rates are the complex interaction between availability of services, and the terms in which they are available. The fact that populations do not behave homogeneously in the use of health facilities depending on both the socio-cultural

and economic status of individuals is a clear indication of differences in taste and preferences, which presents a somewhat unique and challenging situation for policy makers and planners.

Additionally, this study aimed at generating data which will inform policy makers and development planners to design and develop appropriate strategies and programs that can help address the unique behavioural patterns in utilization of healthcare services. In so doing, the health care needs of all citizens can be adequately addressed both by policy makers and health care providers

1.5 Scope and limitations of the study

The study focused on patients seeking treatment care at the traditional healers' clinics. This was achieved by carrying out exit interviews with an aim of capturing the views of patients who were at that moment consulting traditional healers. The study mainly focuses on the Kibera informal settlement in Nairobi. This study is, therefore, limited in the sense that other informal settlement and other areas within Nairobi such as the affluent residential areas were not covered thus rendering generalization impossible. The study is also limited in the sense that patients visiting traditional healers were the only respondents interviewed. These limitations might, therefore, be a contributory factor to a skewed perspective in relation to patients' perception in terms of the efficacy of traditional medicine. The study would have benefited much if views of patients visiting conventional health care providers were captured.

1.6 Summary

This chapter presented the background information to the study, an outline of the objectives of the study as well as justification for carrying out the study. In this section a detailed description of the topic of study is presented as well as definition of concepts and terminologies used in the study. The problem statement states the main variables as well as the specific relationships between these variables. The rationale or justification of the study points out the specific significance of carrying out the study. Lastly, the chapter described at length the scope of the study and its limitations.

CHAPTER TWO

Literature Review and Theoretical Framework

2.1 Introduction

This chapter presents a review of literature from existing studies. The review focuses on traditional healthcare sector, people's beliefs, perceived efficacy, cost of health care, government policy, and the healthcare situation in Kenya.

2.2 Traditional health care sector

Every human population, through space and time, builds a specific "view of the world" in the context of its own culture. Furthermore, peculiar perceptions of the body, anatomy, physiology, and the position of human beings within the world are present in all cultures. Accordingly, every culture reproduces and passes on indigenous knowledge (e.g. knowledge about illness), which is put into practice both in everyday life and in institutional circumstances (Consigliere, 2000).

Indigenous knowledge (on perception of the body, anatomy, physiology among others) provides definition of what is, and what is not, pathological; the different hypothesis on the causes of illnesses; and the description of illnesses themselves. It is, therefore, suffice to say that, every community has responded to the challenges of health and illness by developing a medical system defined as 'the pattern of social institutions and cultural traditions that evolve from deliberate behaviour to enhance health' (WHO, 1983:17). Therapies found in these communities largely stem from prevailing causal beliefs, which

form the rationale for treatment. Such beliefs and practices associate the cause of illness with the mode of treatment deemed appropriate.

The positive acts and the avoidance that constitute preventive medicine in traditional African societies are often quite different from those of conventional medicine (WHO, 1983). Studies conducted among three African communities have revealed that, diseases and misfortunes associated with religious experiences, call for a religious approach when dealing with them (AMREF, 1985). Some of the activities involved in treatment are psychologically vital and no doubt play a great role.

The all-embracing attitude of traditional medicine (TRM) cannot be separated from religious concepts. This also applies to the knowledge possessed by traditional healers on the cause, classification, diagnosis, and treatment of diseases. These also include knowledge on the anatomy and physiology of the human body. All these are linked together and nothing is easily explained independently outside the religious circles (Koumare, 1983:28; Turyahikayo-Rugyema, 1983:7; Wandibba, 1995).

In most African societies, to be a social being is to belong to the whole community. This entails participating in the beliefs, ceremonies, rituals, and festivals of the community. Failure to do so amounts to disturbance of harmony, leading to ill health at both the community and individual level (Mbiti, 1969). In this context, one mode of existence presupposes the rest, and a balance must be found so that these modes neither drift too far apart from one another nor too close to each other (Ochieng-Odhiambo, 1997).

Traditional medicine, therefore, is deeply rooted in people's culture; it is an "omnipresent reality" of life for both rural and urban folk-an indigenous resource still serving most parts of Africa and the rest of the world. Its therapies have a holistic and ecological adaptation, which provides the means for maintaining health, and in ameliorating disease and injury among its members (Owuor, 1999).

Apparently, traditional medicine does not only concern itself with curative practices, but also preventive measures. These measures involve behavioural patterns such as immunisation, wearing of objects such as charms and armlets to prevent affliction, observance of prohibitions and taboos, among others (Koumare, 1983; Wandibba, 1995).

Admittedly, some of these preventive measures are difficult to positively and objectively verify, but here again the underlying concept of "intangible forces" deserves some consideration. These 'intangible forces' that may be termed as protective and restorative, are as difficult to generate as, the "force" of hypnosis. The latter and other similar forces have been called "direct forces". The rest have been classified as "indirect forces" as they need to be sustained by the "inductive power" of a *mganga*[4] (Chavunduka, 1994; Koumare, 1983; Mbiti, 1969; Tempels, 1969).

On the basis that disease and misfortune in ethno-medical systems have a socio-religious bearing, the treatment process goes beyond addressing the "symptomatology" of disease to discovering its deep-rooted causes and subsequent ways of preventing it. from

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[4] The *mganga* (medicine man) is considered a strong and powerful man of the spirit. With such powers (protective and restorative) he can ascertain who caused the illness and why. He can also offer protection so that it does not happen again (Chavunduka, 1994).

recurring. Treatment of a particular disease is based on every society's explanatory model (EM)[5]. This involves classification of diseases into either naturally or supernaturally caused (Mbiti, 1969; Wandibba, 1995). In most cases, diseases are considered to be having multiple causes such as the human factor, transgression against taboo, the spiritual factor, and environmental pollution (Wandibba, 1995)

In general, traditional medicine in Africa and other parts of the world is an established part of every culture. In contrast, the African system of cure is not as developed as traditional health care systems in other regions such as China and India (Owuor, 1999). The slow process in developing African traditional medicine into a fully-fledged form of health care system is attributed to the stigma attached to it. The post-colonial government and the church adopted a negative attitude towards it. They associated traditional medicine with witchcraft and sorcery. Through evangelisation, converts were encouraged to adopt the western mode of healing. This agenda was reinforced through integration of physical and spiritual healing.

Most health officials find the non-recognition of indigenous health practices to be the easiest option. Cosmopolitan health practitioners wish to be seen as the only officially recognised healthcare providers (Nyamwaya, 1992). The two conflicting worldviews are nothing but a question of "role bargaining"[6]. Even though the role of traditional medicine

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[5] Kleinman (1978) asserts that a useful way of looking at the process by which illness is patterned, interpreted and treated is through what he calls "explanatory model". He defines EMs as the notion about an episode of sickness and its treatments employed by all those engaged in the clinical processes. Both the patients and the practitioners hold EMs, and they explain sickness and treatment to guide choice among available therapies and therapists.

[6] The use of the 'role' concept in Social Science has been primarily structural-functionalism. In the case of role change in response to stimulus of competing values and technology of another, economically more potent culture, the question has seldom been handled except in terms of conflict and strain seen inevitably arising from culture contact. There is a frequent dissension and heated debate between what is regarded as 'unorthodox' and the so-called 'orthodox' medicine.

and its potential contribution to health care has been viewed with scepticism for a long time, a large proportion of the population still rely on its practitioners to satisfy their primary health care needs. The WHO estimates that traditional birth attendants (TBAs) assist up to 95 per cent of all rural births and 70 percent of all urban births in developing countries (WHO, 2000).

2.3 Efficacy of traditional medicine

The perception of health and illness within the context of traditional medicine is not distant from the WHO definition. The WHO defines health as "a state of complete physical, mental, and social well being and not mere absence of disease and infirmity" (WHO, 2002:173). In this context, the traditional medical approach to health care is holistic in nature. Traditional medicine is said to have pharmacological, sociological, and psychological efficacy (WHO, 2000). Studies done on the efficacy of traditional medicine indicate that, patients are attracted to traditional healers not only because they are effective but also due to the personal attention given by the healers.

According to Giddens (2001), several reasons motivate individuals to seek services from an alternative practitioner. He points out that some people perceive orthodox medicine to be deficient, or incapable of relieving chronic illness. He further asserts that, some patients are dissatisfied by the way the modern health care system functions. He goes a head to postulate that the asymmetrical power relationship between patients and doctors is at the heart of some people's choice to avail themselves for alternative medicine.

It should be clear that although there are certain principles upon which the two schools agree in theory, it is the attitude of the mind in practice that is the main theme of variation between the two (Sharma, 1975:6)

Onwuanibe (1978) observe that traditional medicine could lay claim to a number of varied and powerful therapeutic effects geared towards restoring and protecting human health. On the other hand, Mbiti (1975:172) asserts that "whether traditional medicine functions in every case or not need not matter, belief in the efficacy of such a medicine which inspires hope on the sick and others is important". Githae (1995) observes that to the individual patient, herbal medicine has greater advantages than conventional medicine. Herbal medicine is cheaper and readily available and since they are natural, they are less toxic. Furthermore, herbal medicine is wholesome by virtue of its curative aspect. Essentially its ability to provide the patient with nutrients such as carbohydrates, proteins, minerals, vitamins, and hormones required in times of sickness to speed up recovery is vital (Githae, 1995: 55-56).

Traditionally, healing ceremonies are geared towards inspiring confidence, reassurance and do not ignore the psychotherapeutic value of suggestions as well as confession (Ngubane, 1977). The international conference on primary health care held in Alma Ata in 1978 recommended, the accommodation of traditional remedies in the quest to achieve health for all"[7]. In other words, traditional medicine plays a crucial role in primary health care (PHC) delivery.

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[7] Health for all strategy, through Primary Health Care, calls for a dramatic shift in health resources towards a more equitable distribution for the benefit of disadvantaged groups in the world. This support must come from individuals, families, communities, the private sector, non-governmental sectors and, of course, government sources (WHO-UNICEF, 1978)

2.4 Government policy on traditional medicine

The WHO has continued to advocate for the recognition, promotion, and integration of traditional medicine in national health care policies (WHO, 2000). However, a few countries have developed national policies, legal frameworks, and codes of conduct for the practice of traditional medicine.

The 2001-2010 period has been declared the Decade for African Traditional Medicine by the African Union (WHO, 2001:8). Several initiatives have been made as a response to the declaration, including espousing guidelines by the WHO on how to incorporate traditional medicine into Africa's national health care systems. The Kenya government in the 1979/83 development plan gave due emphasis to the use of traditional medicine as exemplified by these words:

> Traditional medicine is an important part of the life of the people... considerations will be given to the manpower aspects of the traditional sector. Practitioners such as midwives might be encouraged to serve in government health facilities...the government therefore, has decided to promote and encourage investigations into different fields of traditional healing (GOK, 1979: 136)

However, Kenya has no clear-cut policy or legislation on the use of traditional/or alternative medicine unlike in countries such as Zimbabwe where traditional medicine is well established and "professionalized" (WHO, 2001). Even though the government has called for the integration of traditional medicine and modern medicine, the bill on integration is yet to be debated in parliament. Nonetheless, the proposition received mixed reactions from members of conventional medicine who questioned the rationale

and practicability of such a scheme. This resistance indicates some intolerance to traditional medicine (Nyamwaya, 1992).

Overall, traditional healers continues to face discrimination and non-recognition because of non-commitment, and imprecise government policy and legislation on its use and practice except the TBAs' who have received some training and recognition from modern healthcare system. This dilemma is partly attributed to the missionary and past colonial legacy, which led the crusade of condemning traditional medicine as witchcraft. After more than forty years of independence, traditional medicine has not attained a clear official status as compared to allopathic medicine in Kenya.

2.5 Cost of health care and therapeutic choice

In most developing countries, about 80% of the population do not have access to modern health facilities and rely on alternative forms of health care (Maitai, 1986). This trend continues to deteriorate with time as the global economic conditions continue to nose-dive, specifically in Third World countries. In both rural and urban environments, the major impediment in accessing modern health care by a majority of the population is the cost of such services.

The cost of medical services has skyrocketed the world over, yet more and more people are suffering from chronic and degenerative diseases associated with modern lifestyles and environmental degradation (WHO, 2001). Most developing countries are experiencing budget deficits leading to reduction in government spending especially in the most crucial sectors such as health and other healthcare related activities.

The general outcry has been that the lives of many people in developing countries have been severely affected by the desolate economic situation experienced in this part of the world. As in other sectors such as education, health indicators improved dramatically after independence. Life expectancy improved from 42 years to 58 years while the crude mortality rate declined from more than 200 to 110 per thousand live births (World Bank, 1994). However, this positive trend has been reversed by economic recession and HIV/AIDS (GOK, 2002). As a matter of fact, the 2003 KDHS revealed that the infant mortality rate has increased by 30% from 60 deaths per 1000 in 1989 to 78 per 1000 in 2003 (see also UNDP, 2003). This shows a declining trend in our healthcare delivery.

Historically, the bulk of the Ministry of health budget was allocated to secondary and tertiary hospital services, leaving meagre funds for rural health facilities. The share of recurrent expenditure devoted to non-wage expenses such as medical supplies has also declined steadily from about 28 per cent in the 1970s to 20 percent in the late 80s and worse enough in the 90s (World Bank, 1994). This is a clear indication that material resources devoted to healthcare delivery have been declining steadily with time and are now short of the needs, while the demographic pressure and the changing structure of the population drives them steadily upwards.

To meet the increasing demand in the face of a tight budget, the government resorted to mobilisation of additional resources and ensured that the facilities available are used more efficiently. In the 1989/93 Development Plan, the Government of Kenya introduced user-fee charges in public hospitals with the aim of increasing the government

financial capacity to provide good and quality healthcare (GOK, 1989). This came to be popularly known as "cost-sharing"[8] in government controlled health facilities.

Despite the renewed effort by the government to provide healthcare to the increasing population, nothing seemed to be forthcoming and things moved from better to worse. With the introduction of user charges, attendance at the facilities declined, but soon returned to the previous levels with one important exception; attendance increased at the dispensaries and declined at hospitals (World Bank, 1994).

The decline in healthcare use led to dropping of user fees by 50 per cent and in 1992 user fees charges were re-introduced progressively from the national referral hospital (Kenyatta National Hospital) in Nairobi to district hospitals and health centres (World Bank, 1994). With the re-introduction of user-charges, health care situation in the country worsened especially among the urban poor and their rural counterparts.

The introduction of user fees resulted in many people not affording to pay, especially those with low incomes and those without income at all. According to the 2001-2004 Poverty Reduction Strategy Paper–PRSP (GOK, 2001), cost sharing in health facilities is said to have "lost meaning". This statement is vindicated by the fact that the situation in most public healthcare facilities has become worse as reflected by lack of drugs, collapse of maternal and child healthcare, absence of personnel, increased cost of drugs and

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[8] Cost sharing refers to a method of financing health care that involves some portion of the expenditure falling directly on the user. The cost is then shared between user and employer, government, donor, taxpayer, insurance agency, e.t.c (WHO, 1994). This was introduced in 1989 in government health facilities in order to supplement the government's provision of healthcare.

general insensitivity and unfriendliness of the staff, coupled with corruption (GOK, 2001:15).

The 2002-2008 Kenya government development plan indicates that, the health targets attained in the past have been reversed by the impact of HIV/AIDS coupled with poor economic performance (GOK, 2002). Even where facilities exist, they suffer from shortages of trained personnel, inadequate supplies and poor management, all translating into non-availability of services. The high cost of western pharmaceuticals puts health care services out of reach of a big proportion of African population especially the poor (AMREF, 1985). Lack of good health facilities in hospitals is a major indicator of the health care situation in the country.

2.6 Utility factor in health care practices

Anderson (1963), among others, attempt to explain utilization of health care services through development of a theoretical framework involving the relationships between predisposing, enabling need factors and health service use. He further asserts that the propensity for some families to use more health services may be attributed to predisposing factors such family composition, health beliefs, and social structure. Family discretion appears to be the lowest in the case of hospitalisation or the use of health services generally as opposed to the purchase of most consumer goods (Anderson, 1963).

Statistics on utilisation of health services are important indicators of a populations' health seeking behaviour. They reveal how much health services are expected to cost under certain circumstances, from the standing point of medical care (Anderson, 1963:349). In

other words, utilisation of health services reveals varying patterns of significance to a wider range of interests. It is reasonable to assume that the pattern of utilisation is not quixotic.

In different contexts, utilisation depends on factors such as illness levels, sex and age composition of the population. Other factors include presence or absence of health facilities, family income, residence, and the perception of providers and recipients of health services (Anderson, 1963). Similarly, socio-psychological factors such as peoples' perception of health and health services, general life values, and the priorities families place on how they spend their incomes, knowledge of disease, among others influence utilization of health care services.

Use of health services is also said to be a function of age and sex. Anderson (1963:353-354) observes that, "utilisation of healthcare is lower in males than females and increases with age. In instances where use varies, the difference is a function of the contexts in which health services are used". Kimani and Good have postulated, people use a health facility not so much because they need it but just because the facility is accessible to them (Kimani and Good 1981:17).

Other scholars have also observed that, even when accessibility factors are favourable, acceptance and utilization of the facility depends on whether it is attractive or not (Kimani, 1995). Attractiveness of a service plays a bigger role in influencing people to use a health facility. In some cases, a health facility may be equipped with drugs and

other needed resources but the health personnel might be hostile to patients. In such a case, people may decide to look for alternatives.

Previous studies have shown that there is a relationship between utilization of health care services and cultural beliefs, and practices. Cultural beliefs determine people's knowledge of disease and recognition of health problems because the basis for health services utilization lies with it. According to Kimani (1995), knowledge of disease could come because of recognised health problems or accumulation of medical experiences, which is also a result of utilization of health facilities.

In spite of availability and accessibility of modern medicine and health facilities in both rural and urban centres people also use traditional medicine. A study carried out by Kimani and Good (1981) among three Kenyan rural and urban communities shows that the services of traditional healers, (herbal and other remedies) are believed to be therapeutic. Their study also revealed that, "the use of such indigenous therapies shows no barrier as influenced by the user religious background, economic status or level of education" (Kimani and Good, 1981:45).

A Study by Bailey and Philips (1986) suggest that, "a low household income is a barrier to utilization of modern health facilities even when they are publicly provided" (p54). The relatively well to do, use the services of a trained physician more and spend more on those services than the poor. Mechanic (1969) and Mohtieri (1973), postulate that socio-cultural differences in utilization greatly diminish with the capacity to pay. This clearly

indicates that the ability to pay is one of the main determining variables in utilization of health services.

2.7 Theoretical framework

2.7.1 Actor-oriented approach

The main proponents of actor-oriented approach are Long and Long (1992). The actor-oriented approach states that individuals are social actors who are knowledgeable and capable of processing social experience (Long and Long, 1992: 21). It further states that human beings are not passive recipients of change, but active participants who process information and lay out strategies on how to deal with both "internal" and "external" forces (Long and Long. 1992).

Long and Long's argument is in agreement with Onyango-Ouma's view that "children and adults are actors who engage with health knowledge and skills in their own right as actors and not merely recipients of interventions" (Onyango-Ouma 2000:6). The actor-oriented approach appreciates individuals' capacities as social actors by virtue of being skilled and knowledgeable in so far as they tap society's stocks of knowledge in the interpretation of new experiences in their life world. Therefore, they should not be considered as dupes of the (social) system or mere reflections or bearers of its demands and requirements (Giddens 1979).

This theoretical approach emphasizes the importance of human agency in analysing the capacity of actors in the formulation of decisions, acting upon them and innovating or

experimenting (Onyango-Ouma, 2000: 6). The central role played by human action is in line with Long and Long's argument, which says that:

> the notion of human agency attributes to the individual actor the capacity to process social experience and device ways of coping with life, even under the most extreme forms of coercion, within the limits of information, uncertainty and other constraints (e.g. physical, normative or politico-economic) that exists, social actors are knowledgeable and capable (Long and Long, 1992: 22-23).

In line with Long and Long's view, being social actors, patients are not compelled by external forces to act contrary to their own feelings and motivation. They rather reflect on their own behaviour and circumstances in making decisions. They are in many ways capable to some degree, of resisting constraints imposed on them by society, therefore influencing and transforming their social situations.

Individuals being social actors always act inter-subjectively in relation to others (who are also actors) by virtue of sharing common 'stocks of knowledge"[9]. It is therefore important to note just like Long, that the concept of agency must not be equated with decision-making capacity but it should be seen to compose relations, in which decisions made are effected through (Long, 1992:23).

2.7.2 Relevance of the theory to the study

The actor-oriented approach is appropriate in explaining health-seeking behaviour. It tells us that when human beings are faced with life threatening conditions, being

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[9] 'Stocks of knowledge' is used by Schutz to refer to all the bits of information and knowledge that we have accumulated throughout our lives. It allows us 'typify' things and people (Layder, 2000).

knowledgeable and capable, they engage their "life world"[10] by manipulating their environment.

In their quest for therapy, patients typically seek for a healthcare system that they consider suitable in managing their illness. They always move from one healthcare system to another so long as they believe it will solve their problems. People do not just succumb to the vagaries of disease by sticking to one healthcare system that is acceptable or sanctioned by society. As actors, they are always knowledgeable and capable of manoeuvring their way out of problems even if it means going against the laid down norms in society.

2.7.3 Assumption of the theory

1. When confronted with illness, individuals try out all options available to them in order to achieve better health as influenced by cost, availability, beliefs, and perceived efficacy.
2. People who become ill make choices about whom to consult in either the popular, folk, or professional health sector.

2.8 Definition of key terms

Aetiology: means the root cause of a disease/or illness.

Cultural beliefs: refers to people's cognitive view of their life as governed by supernatural forces (e.g., ancestral spirits, deified beings). This was measured

[10] Habermas uses the word "life world" or "public sphere" to mean the general background/context in which issues of general concerns can be discussed and opinions formed (Giddens, 2001).

by among other things, ideas on disease causation such as mystical powers, and efficacy.

Efficacy: The state or quality of producing desired results/being effective.

Utilization: The number or proportion of a population actually using a service.

Illness: Disvalued change in the adaptation or functioning of an individual that gives rise to need for correction.

Dichotomization: In this study dichotomization refers to classification of diseases either as natural or supernatural.

Pull and push factors: these are the internal and external forces believed to influence health-seeking behaviour. Push factors refer to dynamics within a health care system that drives people away from it. On the other hand, pull factors describes features of destination (health care provider) such as efficacy, affordability, and cultural compatibility.

Informal settlement/slum: these are complex, and dynamic social systems, which experience continual change. In occupying land informally, residents are often prepared to flout the law in the hope of improving their economic position.

2.9 Summary

This chapter presented a detailed literature review and the theoretical framework used to inform and guide the study. The literature is reviewed in terms of traditional healthcare sector, its efficacy, cost of accessing healthcare both traditional and modern, government policy on traditional medicine; therapeutic choices and utility factor in healthcare

practices. The use of actor-oriented framework is described in details and its relevance in addressing the problem at hand is illustrated. Conceptual definitions of terms used in the study are also provided and illustrated. And lastly, the chapter presented the theoretical assumption based on the theoretical framework and objectives of the study.

CHAPTER THREE

Methodology

3.1 Introduction

This chapter sets the context within which the study was done. It presents the description of the study area in terms of physical location, history and its development, and population size. The chapter also describes the study design, study population, sampling techniques, and methods of data collection and analysis. The chapter concludes by noting the problems encountered in the field and what was done to solve them.

3.2 Research Site

3.2.1 Location

Nairobi is the main urban town and the capital city of Kenya. It is located 480 kilometres inland northwest of the Indian Ocean. Nairobi's elevation is between 5,500 and 6,000 feet (about 1,500-2,000 metres) above the sea level. It stands almost at the heart of the country. From north to south it stretches from 2^0 10^0 south and from east to west, it stretches from 37^0 10^0E to 36^0 40^0E (APHRC, 2002). Kibera is one of the six slum dwellings in Nairobi, Kenya. It is situated about five kilometres from Nairobi city centre.

3.2.2 History and its development

Nairobi was founded in 1901 along the Mombasa-Kampala railway (Kenya Uganda Railway). It grew in an organized way, like almost all the colonial cities characterized by

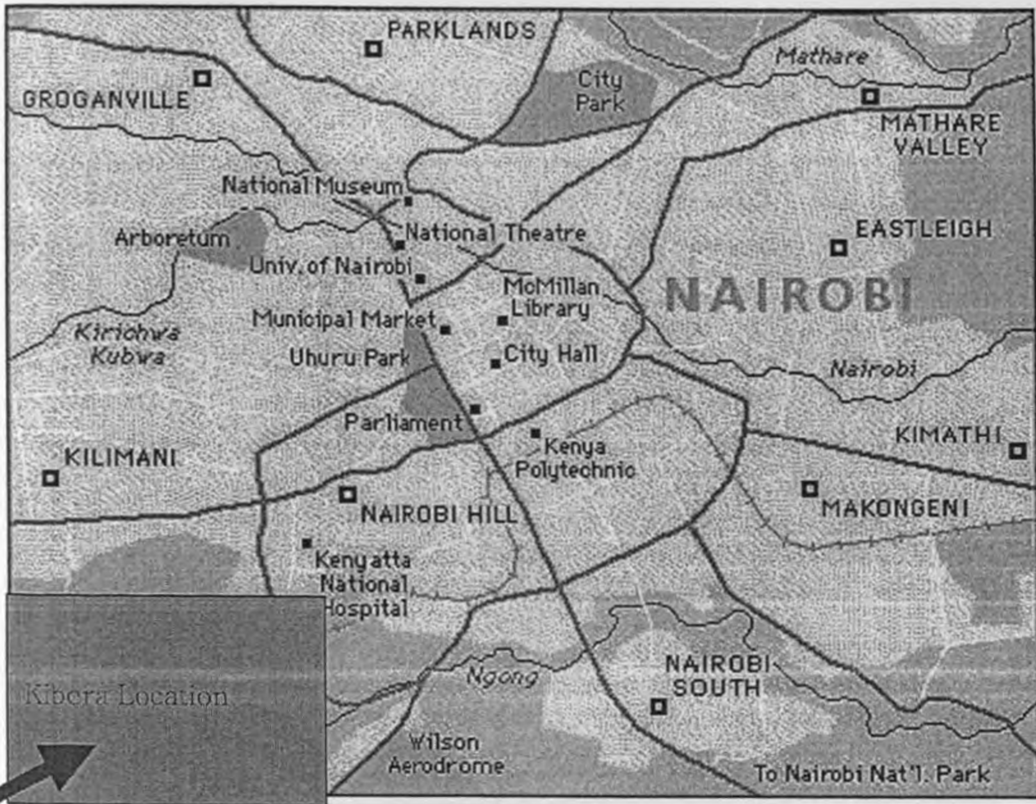
large avenues and well planned, it was considered one of the most modern cities in Africa (APHRC, 2002)

Like any other city in the continent, the population has grown quickly, reaching more than two million people in less than 50 years due to in-migration and natural increase. In recent times, large areas of the city, where access to land was easier, have literally been "occupied" by low-income immigrants. The in-migrants had no choice other than to organize themselves in an informal way to cope with lack of infrastructure. Everything had a tendency to become informal-accommodation, employment, transport and even industrial activities (Nembrini, et al 2002). In these areas of town and in Nairobi, the informal population growth has resulted in environmental degradation, overgrowing, poor housing, limited access to water and sanitation. Since 1993, informal settlements have grown in density per inhabitants per hectare and in size, with an estimated growth rate of 10% per year, with a city population growth rate decreasing from 7% in 1963 to less than 5% in 1989 (Nembrini, et al 2002). Kibera like any other informal settlement in Nairobi grew in almost the same manner.

3.2.3 Population size and density

Kibera is the largest informal settlement in Nairobi and most probably the all of sub-Saharan Africa (Nembrini, et al 2002). With a given total surface of 229 hectares it hosts an estimated population of about 500,000 people or more (See pictures of Kibera in the appendices). The number of inhabitants per hectare was close to 1,100 with a mean surface per dwelling unit of $9m^2$.

Figure 3. 1: The Map of Nairobi showing the Study Site

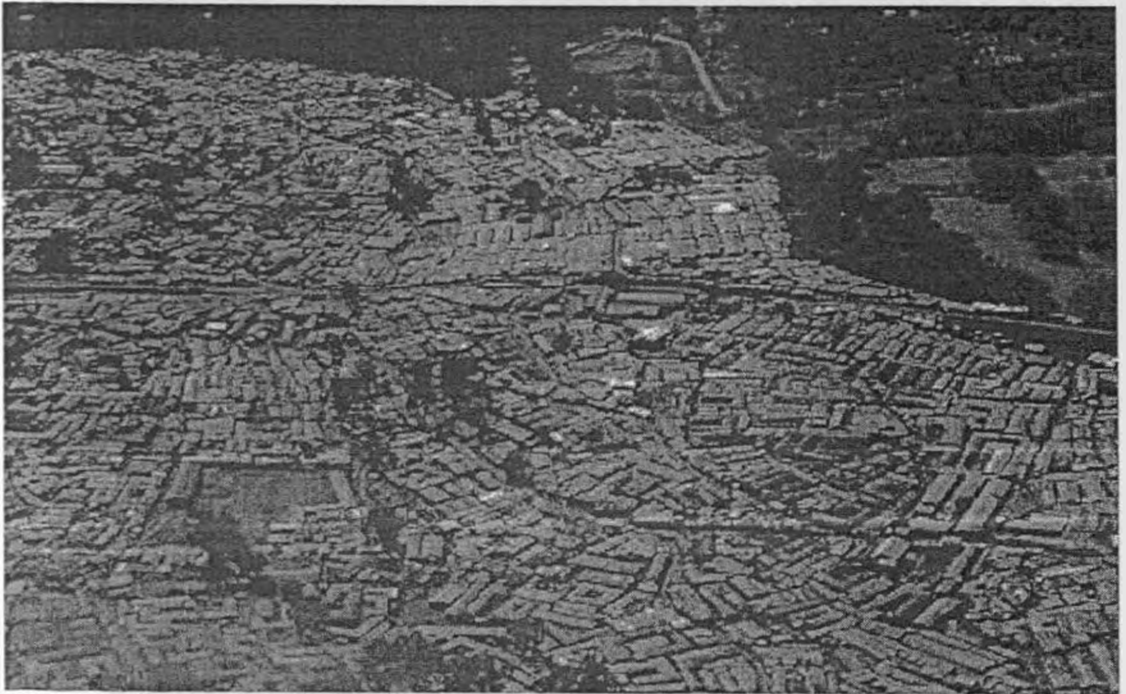


Source: http://www.lonelyplanet.com/destinations/africa/nairobi

As far as density is concerned, data from the Physical Planning Department during the 2001 shows a mean value of 3-5.5 people/dwelling units with a mean surface of the dwelling unit being 9m² (Nembrini, et al 2002). Despite the fact the surface area has not changed since 1993 the density per hectare has more than doubled, increasing from 1,096 inhabitants/ha in 1993 to 2,333 in 2001 if the value of 3.5 people/9m², and to 2,000 if the value of 3 people/9m² is used (Nembrini, et al, 2002). Since Kibera is completely surrounded by well-defined residential boundaries, its expansion is not possible. The total surface of the 21,112 structures can be easily computed and is close to 133,3834 hectares.

Based on these figures the total population of Kibera is now estimated at 500,0000 (Nembrini, et al 2002).

Figure 3.2: Aerial view of the expansive Kibera slum



Courtesy of Nembrini, G.P, 2002

3.3 Study design

This was a cross-sectional study aimed at collecting both quantitative and qualitative data. The study design used a two stage sampling process. At the initial stage of the study, 20 traditional healers operating within the study site were located/identified using snowball method. This was done to enable the researcher schedule interviews in a way that will allow capturing of patients has they exited from the traditional healers clinics. This was subsequently followed by the selection of units of observation using convenient sampling method.

Data collection was done in two stages using a combination of data collection techniques in line with triangulation rule[11]. The first stage of data collection employed survey research method with the aid of a semi-structured questionnaire administered to all the 114 respondents. Finally, anthropological inquiry was carried out using case stories and direct observation. The case study method was used to document patients 'biographies', their 'lived experience'[12] and dynamics surrounding illness and health-seeking behaviour. Direct observation was used to collect and supplement information that could not be captured using the questionnaire and case study methods. Lastly, data collected were processed and analysed using both the quantitative and qualitative methods.

3.4 Study population and unit of analysis

The population universe for this study comprised patients seeking health care services from traditional healers in Kibera location. A convenient sample of 114 respondents were purposively selected and interviewed as they exited from the healers' clinic. The study focused on an individual patient as the unit of observation and analysis to make inferences, deduction and conclusion.

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[11] Triangulation rule refers to the use of multiple research methods as a way of producing more reliable empirical data than is available from any single method (Giddens, 2002:652).

[12] Sociologists have applied symbolic interactionsm in the realm of health and illness in order to understand how the sick experience and perceive their illness and that of others or what Giddens (2001) calls 'lived experience'. In their "biographical work" ill persons are involve in activities that help them build or reconstruct their personal narratives. It is the process of incorporating the illness into one's life, making sense of it and developing ways of explaining it to others.

3.5 Sampling techniques

The study employed purposive sampling techniques.The methods used included snowball, and convenient sampling methods. Each method was used at a different stage of fieldwork. The Purposive sampling technique was primarily used at the initial stage to select the location where the units of observation were drawn. The Snowball method was used to locate traditional healers operating within the study area, while convenient sampling method was used to select respondents for the study.

3.5.1 Purposive sampling

Purposive sampling entailed hand picking of the study site. Kibera Division consists of seven administrative locations. Kibera location was selected using purposive sampling technique owing to its large population as compared to other locations and a large concentration of traditional healers. Information obtained from the people on the ground indicated that Kibera location had a large number of traditional healers as compared to the other locations.

3.5.2 Snow-ball sampling

After selecting the study site purposively, snowball technique was employed to locate traditional healers operating within the study area. These entailed identifying one traditional healer (a subject with desired characteristic) followed by the selected subject helping in locating other traditional healers operating within the locality. This method proved useful bearing in mind the fact that location of traditional healers in the study area is very haphazard due to the poor planning of residential areas and a high concentration

of population and dwelling units. About twenty traditional health care providers were identified and visited. It was important to first identify traditional healers prior to identifying units of observation since the respondents (patients) were to be drawn here.

3.5.4 Convenience sampling

This technique was used in selecting patients exiting from the traditional healers' clinics. It involved selecting cases or units of observation as they became available. In order to understand therapy-seeking behaviour among patients, a client-based inquiry was conducted using exit interviews. The main advantage of using this method is that subjects are easily and conveniently available and at the same time accessible (Mugenda and Mugenda, 1999). All the respondents in the survey were selected using convenient sampling method. A sub-population from the survey respondents was selected and included for in-depth interviews, and conducted in their respective homes.

3.6 Methods of data collection and analysis

The survey method, using a semi-structured questionnaire, was supported by the use of other data collection techniques such as, case stories, and direct observation. According to Warwick and Osherson (1973), "every method of data collection is only an approximation of knowledge". Each method of data collection provides different and usually valid glimpse of reality about the phenomenon being investigated, and it is, therefore, limited in one way or another when used alone.

3.6.1 Survey interview method

A standard survey questionnaire with identical questions was administered to all respondents in the form of a semi-structured interview. The questionnaire was divided into two sections. Part I of the survey questionnaire enabled the interviewer to explore the socio-economic dynamics, and the patient's ethno-cultural background, in a structured way. Part II of the survey questionnaire explored in an open-ended way, how the patient dealt with the present or most recent illness in terms of steps undertaken in seeking treatment. Eliciting information about previous or parallel treatment allowed the researcher to have a longitudinal perspective of their illness.

A series of more specific questions regarding the therapeutic landscape, classification of illness, exploratory models, culture sensitive diagnostic and aetiological discourse and peoples perception of the two health care approaches. Standardization of the questionnaire was aimed at achieving reliability and validity. Open-ended questions were designed to permit free responses from the respondents and to give room for probing while closed-ended questions were aimed at obtaining specific information. Interviews were conducted with a non-random sample of 114 patients.

3.6.2 Case Study

Drawing on the information obtained in the survey questionnaire, a series of questions were added in the in-depth interview guide to investigate the patients' narratives or what Giddens (2001:160) calls the patient's 'lived experience' and dynamics around the

illness. It addressed issues to do with diseases and illnesses they were suffering from, measures they employed to arrest the problem and the reason why they opted to consult a traditional healer rather than modern healthcare provider. Case history became handy in documenting health seeking behaviour process and tracing pertinent events particularly the recent actions undertaken by the patient in the quest to get well.

3.6.3 Direct observation

During the course of this study, simple observation technique was used to capture events and activities going on at the traditional healers clinic/home. The researcher was also interested in establishing whether members of the community do actually consult traditional healers and in what magnitude. The researcher visited 20 traditional healers' clinics operating within the study area. Direct observation also yielded pertinent data on the general picture of the socio-economic conditions of the study population.

3.6.4 Data analysis

Analysis of data involved coding open-ended questions, data cleaning and entry. Both quantitative and qualitative methods were used to analyse the raw data. Data obtained using a questionnaire was analysed using Statistical Package for Social Scientists (SPSS) 10.0 software package. Descriptive analysis was carried out to assess the difference in proportions of responses. This package was chosen because it is faster, reliable and efficient. Qualitative data obtained using case histories, and direct observation, were reviewed and analysed using the main themes. In essence, content analysis was used to look for themes and patterns in the text.

3.7 Ethical considerations

Ethical issues are very important aspects in any kind of research. The study adhered to the code of conduct laid down for carrying out anthropological studies. First and foremost, the researcher obtained a permit from the government to enable him conduct the study. Informed consent was obtained from the informants before interviewing them and lastly the researcher assured respondents that their participation would remain anonymous and information obtained from them would be treated confidentially.

3.8 Problems encountered and solutions

Several problems were encountered in the process of carrying out fieldwork. Kibera being an informal settlement is very congested rendering access and interviewing problematic. As such, finding my way in and out of the slum was difficult and I had to hire a field guide to take me round the field and serve as my security.

At the same time, the question of how the respondents were going to benefit from the study arose. The respondents often related their experience with previous research activities undertaken in the area, and complained that despite giving out information nothing has been done about their situation. Similarly, it was learned that some researchers who have previously carried out their studies in this area have been giving out tokens to persuade informants to participate in their studies or as a sign of appreciation.

The issue of payment became problematic since there was no money to offer to the informants in this study and hence affecting the response rate. This was countered by informing them that their participation was voluntary and that the study was not only for the benefit of the researcher but also for the country at large.

3.9 Summary

In this chapter, the description of the study area and population, research design and methods are provided. The research design is described as a cross-sectional study applying multiple methods in line with the rule of triangulation. Description of the sampling and data collection procedures are also provided together with methods used to analyze raw data. The chapter goes on to highlight problems encountered while undertaking the study and possible solutions provided. The chapter also describes application of ethical procedures as a way of concealing the identity of the respondents and an assurance of confidentiality in the manner in which their responses were to be handled.

CHAPTER FOUR

Utilization of Traditional Medicine in Kibera Slum

4.1 Introduction

This chapter presents the research findings from the survey, in-depth interviews, direct observation, and case stories. Data is presented using, tables, figures, and graphs.

4.2 Basic characteristics of the study population

This section presents a description of the socio-demographics of the 114 respondents interviewed in the survey. See table 4.1 below.

Table 4.1 Demographic characteristics of the respondents

Characteristics		N (%)
Ethnicity	Luo	37(32.5)
	Gikuyu	28(24.6)
	Luyia	19(16.7)
	Kamba	11(9.6)
	Nubi	10(8.8)
	Kisii	5(4.4)
	Others	4(3.4)
	Total	114 (100)
Sex	Male	62(54.4)
	Female	52(45.6)
	Total	114 (100)
Marital status	Single	26(22.8)
	Married	77(67.5)
	Divorced	11(9.7)
	Total	114 (100)
Age	20-30	34(29.8)
	30-40	30(26.3)
	49 and above	50(43.9)
	Total	114(100)

Source: survey data, 2003. N=114

Table 4.1 above presents the distribution of respondents by socio-demographic indicators. The results show that about a third (32.5%) of the respondents were from the Luo community followed by the Agikuyu (24.6%). Those from the Luyia and the Akamba communities accounted for 16.7% and 9.6% respectively. The Nubi (8.8%) and the Abagusii (4.4%) formed a small percentage. This shows that traditional medicine is used by a diverse group of the population of Kibera and that the Luo, the Agikuyu and the Akamba are highly represented in the study area.

The proportion of respondents who reported to be currently married accounted for 67.5% of the sampled population while 22.8% reported that they were single. A small percentage (9.7%) of the respondents reported that they were divorced or separated. On the whole, more than a half (54.4%) of the patients visiting traditional healers were men the majority (43.9%)of whom were in their forties or older. About 26% of the sampled population was aged between 30 to 40 years old. The youngest group (20-30 years) accounted for 29.8% of the sample. These findings capture categories of people from all socio-cultural backgrounds implying that traditional medicine is widely used across spectrum irrespective of ethnic affiliation, marital status, gender, and age.

Table 4.2 below presents the distribution of respondents based on their socio-economic characteristics. Data on the respondents' level of education, income level, employment status and religious affiliation are presented.

Table 4.2: Socio-economic profile of the respondents

Characteristics	N (%)
Education Level	
None	8(7)
Primary incomplete	6(5.3)
Primary complete	18(15.8)
Secondary incomplete	32(28)
Secondary complete and above	50(43.9)
Total	114(100)
Income Level (In Kshs)	
None	53(46.5)
<2000	3(2.7)
2000-4000	16(14)
4000 and above	42(36.8)
Total	114 (100)
Employment Status	
Formal	56(49.1)
Informal	58(50.9)
Total	114 (100)
Religious Affiliation	
Christians	102(89.5)
Muslims	10(8.8)
Others	2(1.7)
Total	114(100)

Source: Survey data, 2003. N=114

At the time of collecting data, table 4.2 above shows that, about a half (43.9%) of the respondents had completed secondary and above level of education, while 28.1% did not complete at all. Those who had completed primary level of education accounted for 15.8% while 5.3% never completed their primary education. The above findings show that people consult traditional healers irrespective of their level of education. This is not

to say that a significant percentage of respondents with secondary and above level education highly use traditional medicine as opposed to the rest. The above observation might be a reflection of the general level of education in the study site as observed in the 1999 Kenya Population and Housing Census (KPHC) in which more than a half (52%) of the population in Kibera had secondary and above level of education (GOK, 2001).

In regard to employment status, 50.9% of the respondents derived their livelihoods from the informal sector. Those working in the formal sector accounted for about a similar percentage (49.1%) of the respondent's. Data gathered through informal interviews and direct observation indicate that most of the people who work in the informal[13] sector engage themselves in manual/casual tasks and small businesses such as selling vegetables, welding, selling clothes, house help, brewing local beer, hawking, among others. Those in the formal sector worked as security guards, plumbers, electricians, and clerks. These jobs are usually characterised by low wages. The above findings show that people use traditional medicine regardless of their economic status.

Interval level measurement was used to categorize income status of the respondents into four scales (None, <2000, 2000 and 4000, 4000 and above) to enable the respondents' give an estimate of their income. Table 4.2 (page 38 above) indicates that, slightly less than a half (46%) of the respondents did not earn any income at all while 36.8% of the respondents earned an income of between 4000 and 10000 ($51-128)[14] Kenya shillings (an average of 7,000 shillings) per month. About 17% of the respondents earned an

[13] Informal sector in this study is used to mean those who do not receive any salary or wage, while formal sector is used to mean those who at least earn a wage at the end of the week or a salary at the end of the month.
[14] One dollar in this case is taken to be an equivalent of 78 Kenya Shillings

income of less than 4000 (>$51) Kenya shillings. This shows that more than a half (63%) of the population live on less than a dollar[15] a day, a phenomena characterising many slum areas in the world.

In regard to religious affiliation, table 4.2 above shows that the majority (89.5%) of the respondents were Christians as compared to 8.8% of the respondents who supposedly professed Islamic faith. The least (1.8%) were not inclined to any religious faith making Christians the majority.

The above findings show that utilization of traditional medicine is popularly used regardless of religious affiliation, education level, and economic status among others. All said and done, the findings indicate that, traditional medicine remains a very vital element in healthcare delivery both in urban and rural settings.

4.3 Health seeking behaviour

In order to find out patients' health seeking behaviour, respondents were asked whether it was there first time to seek health care and what was their first healthcare choice. Figure 4.1 below shows the respondents' first choice of therapy. More than a half (53%) of the respondents had previously visited a modern health clinic before opting for traditional medicine. About a half (43%) of the respondents opted for traditional medicine as their first choice of therapy. A small proportion (4%) engaged the services of prayer healers.

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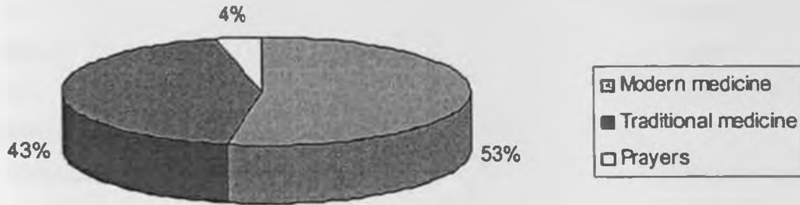
[15] The poverty line adopted in Kenya is US$ 17 and US$ 36 per month per adult in rural and urban areas respectively (GOK and UNDP, 2003)

Figure 4. 1: First choice of therapy



Source: Survey data, 2003

The study findings show that when people become ill, they first seek care from modern healthcare providers as opposed to traditional healthcare and prayer healers. Traditional medicine and prayer healers were relegated to the second level of therapy.

4.4 Factors influencing therapeutic choice

The reasons for choice of traditional medicine over other health care services ranged from perceived efficacy, cost of healthcare, cultural factors, and availability of healthcare services. Table 4.3 below presents a summary of the push and pull factors (determinants) found to influence therapeutic choice in Kibera slums.

Table 4.3: Determinants of therapeutic choice

Determining factor	N (%)
Perceived efficacy	
Yes	81(71)
No	31(27.2)
None	2(1.8)
Total	114 (100)
Cultural factors (cause of illness)	
Natural cause	74(64.9)
Supernatural cause	22(19.3)
Don't know	18(15.8)
Total	114 (100)
Belief that certain illnesses can only be treated by traditional healers	
Yes	59(51.8)
No	55(48.2)
Total	114 (100)
Cost of healthcare	
Yes	29(25.4)
No	85(74.6)
Total	114 (100)
Availability	
Traditional medicine is readily available	113(99.1)
Traditional medicine not readily available	1(0.9)
Total	114 (100)
Side effects of modern drugs	
Yes	12(10.5)
No	102(89.5)
Total	114 (100)
Staff attitude	
Yes	6(5.3)
No	108(94.7)
Total	114 (100)
Long queue	
Yes	2(1.8)
No	112(98.2)
Total	114 (100)

Source: Survey data, 2003. N=114

4.4.1 Perceived efficacy and choice of therapy

This study endeavoured to find out whether the perceived efficacy of traditional medicine influenced its use. Respondents were asked if they believed traditional medicine was capable of solving their health problems effectively. Table 4.3 below indicates that majority (71%) of the respondents had a strong belief in the efficacy of traditional medicine.

When asked whether they believed some illnesses could only be treated well by traditional healers, table 4.3 above shows that more than a half (51.8%) of the respondents answered in affirmation while 48.2% did not share the same view. According to one respondent:

> When a child is suffering from *ang'iew* (measles) and you take her/her to the hospital and is given an injection the child will die…this disease is not compatible with injections. You should only give the child *yadh agulu*[16] (Source: {Survey data (open-ended questions), 2003}.

Table 4.4 below present distribution of illnesses believed to be treated well by traditional healers. Over 26% of the respondents stated that asthma could be treated well using traditional medicine while 13.2% mentioned cancer and lastly infertility (12.3%). The findings indicate that respondents believe that certain diseases can be handled well by traditional healers. We also note that illnesses such as HIV/AIDS, which do not have a cure yet was mentioned.

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[16] Literally translates to herbs/medicine prepared by boiling in a pot and is used to treat measles.

Figure 4.4: Diseases believed to be treated well by traditional healers

Condition	N (%)
Asthma	30 (26.3)
Cancer	15 (13.2)
STDs	3 (2.6)
Infertility	14 (12.3)
HIV/AIDS	18 (15.8)
Diabetes	5 (4.4)
Stomach problems	5 (4.4)
Chira	7 (6.1)
Skin diseases	2 (1.8)
Epilepsy	8 (7)
Tuberculosis	7 (6.2)
Total	**114 (100)**

Source: Survey data, 2003, N=114

The above findings show that patients visit traditional healers because they believe that; they can handle certain healthcare issues better than modern healthcare.

4.4.2 The cost of healthcare and therapeutic choice

One of the main objectives of this study was to find out whether cost had an influence on their choice of therapy. The findings show that the cost of healthcare has no substantial influence on choice of therapy. Only 25 per cent of the respondents mentioned cost of modern health care as a barrier to their utilization (page 44). The findings indicate that most respondents utilizing traditional medicine were doing so not because they considered it cheaper as compared to modern medicine. These findings can be explained by the fact that at the initial stage of health seeking, more than a half (53%) of the respondents had consulted modern healthcare providers (Fig. 4.1).

4.4.3 Availability of health care services and choice of therapy

Table 4.5 below presents respondents' perception about the services provided by both modern and traditional health care systems. This was achieved by asking respondents to rate the two health care systems in terms of doctors/healers presence, and availability of medicine.

Table 4.5: Respondents evaluation of modern and traditional medicine

Variable Name	Traditional medicine N (%)	Modern medicine N (%)
Drugs/herbs available	113 (99.1)	36 (31.6)
No opinion	1 (0.9)	78 (68)
Doctors/healers always present	113 (99.1)	47 (42)
No opinion	1 (0.9)	67 (58.8)
Total	**114 (100)**	**114 (100)**

Source: Survey data, 2003. N=114

Table 4.5 above indicates that 31.6% of the respondents confirmed that drugs were readily available in public hospitals while more than a half (68.4%) did not share the same view. In terms of healthcare provider presence, about a half (47%) of the total responses received, indicate that health care personnel in modern public hospitals are always available.

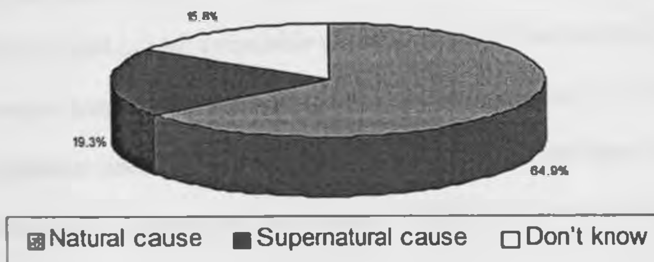
Traditional medicine was rated highly in terms of availability of health providers. Almost all respondents (99.1%) reported that whenever they visited a traditional healer they always find him in his clinic and that they always got drugs. They also reported that one

could hardly miss a traditional healer in his clinic, as is the case with modern doctors. These findings indicate that traditional medicine is readily available as compared to modern health care.

4.4.4 Cultural beliefs and choice of therapy

One of the objectives of the study was to find out the respondents perception about the cause of their illness. Figure 4.2 below indicates that about 65% of the respondents believed that their illness was naturally caused as opposed to 19.3% who believed that their illness was supernaturally caused.

Figure 4.2: Perceived cause of illness



Source: Survey data, 2003

Breaking taboos, witchcraft, curse, and sorcery were factors mentioned in relation to supernatural causes. Factors such as being rained on, mosquito bites, eating bad food, and pollution were among natural causes mentioned. Those who could not tell the cause of their illness accounted for about 16% of the respondents.

4.4.5 Illness narratives as "lived experience"

To confirm findings obtained using the survey questionnaire, case stories were obtained from the respondents' who were visiting traditional healers. This was also aimed at getting a deeper understanding of what Giddens calls patients 'lived experiences' (Giddens, 2001:160). Below are brief descriptions of respondents lived experiences.

Case story 1

Catherine, a 42-year-old businessperson, completed her secondary school and is a Christian by faith. In 1984, she began suffering from chest problems. She visited Thika District Hospital for treatment as a first recourse. She continued consulting the hospital but the problem persisted. The doctor referred her to Kenyatta National Hospital for further check up and treatment.

Even after consulting modern doctors at the Kenyatta National Hospital severally, her health condition did not improve either. She decided to visit a reputable private hospital in Nairobi but all was futile. After 10 years of consulting modern hospitals and not getting well, a friend suggested to her that she tries traditional medicine. She did not hesitate since she had been tormented for ten good years by a disease that had proved to be incurable. Neither did her frequent visit to a famous traditional healer near her home area improved her health condition.

One day she was relaxing at home listening to a radio program on traditional medicine. The presenter was interviewing a renowned herbalist based in Nairobi. As the interview progressed, the healer mentioned illnesses that he has been treating effectively. The symptoms for one of the illnesses he was describing matched hers. She decided to try her luck by visiting the healer. After making several visits for about 3 years, she noticed a big difference and her condition improved tremendously. Since 1986, she has continued consulting traditional healers for any form of ailment before going to a modern hospital. In her own words, she prefers visiting a traditional healer because, "when you have a problem and you don't have

any money, they (traditional healers) will always treat you and you agree when to settle the bill or you can pay in kind and not necessarily with money".

Case story 2

Jane (not her real name) is 35 years old. She completed her college education and is currently employed. She is a Christian by faith. She started suffering from a myriad problems including pain all over her body. Her body was laden with rashes that were so itchy. She had visited four modern hospitals in the city but whenever she was through with her medication the problem would recur again and again. A friend suggested to her that she tries traditional medicine. At the time of this interview, Catherine was visiting the healer for the first time and therefore she could not say much about her experience with traditional healers.

Case story 3

Born 41 years ago in a small village in Butsotso in Kakamega, Muyila is a Christian by faith. He did not manage to complete his Secondary education due to his deteriorating health condition. So much was being spent on his medical bills that his parents could not afford to raise his school fees. Muyila, a shop attendant, after having tried what he calls 'expensive but less effective' modern medication for a period of seven years, opted for a relatively cheaper way of treatment (alternative medicine).

A close friend to his brother floated this idea to him. Initially, he never appreciated the efficacy of traditional medicine since at that time he considered traditional medicine 'dirty' and 'backward'. However, the desire to get well down played his pride and thus decided to visit a traditional healer. With continuous use of herbal drugs, Muyila became once more an active and charming man he used to be. At the time of the interview, Muyila was married and a proud father of two boys. Muyila commented that, "I have been saved from the jaws of death, and I am happy to be back to life again, thanks to traditional medicine".

Case story 4

In one Herbal Clinic in Kibera, I met Wanjiku who is 48 years old. She was born and brought up in Nairobi. She went to school up to form two. She happened to have had a sexual relation with a man whom she conceived a baby girl with. Coming from a strict Christian family, she feared their wrath. She decided to have an abortion, which developed into complications at the age of eighteen. This was to avoid being rejected by her family. This became the onset of her ordeal. She dropped out of school, and went to leave with her aunt in Kariokor.

She later on got married, but six years down the line, she had not conceived. Her husband became worried about the situation. He advised her to go for a medical check up in order to ascertain what her problem was. Wanjiku agreed to go for a medical check up. At the hospital, the doctor realised that she was having complications with her uterus because of an abortion she had carried out.

The doctor therefore recommended that she undergo an operation to correct the anomaly. After undergoing the operation, she was not able to conceive either. Her husband decided to abandon her because he could not stand the stigma of staying with a woman who could not give birth. After separating from her husband, she vowed never to bear the pain of marrying again and therefore decided to stay single. She continued seeking help and at one point in time, a friend suggested to her that she tries traditional medicine. Being desperate for help she did not hesitate, and heeded her advice.

For starters, she visited a famous traditional healer in Kariokor. The healer began administering herbs, which, according to him, were capable of reversing the situation, which will enable her in the long to conceive. After taking the herbs for some time, to her bewilderment she started experiencing her menstrual flow again after more than 10 years of agony. She decided to break the news to her ex-husband. She nonetheless continued taking herbal medicine. At the time of the interview, Wanjiku was a proud mother of a baby boy and at the same time expectant. At Wamirithu, she had come to pick some medicine to ease her back pains. For her this was not her first time to use traditional medicine.

Case story 5

Mary is a standard 3 pupil suffering from brain tumour. She is 9 years old. Her parents are Christians by faith and come from a low-income family. Her mother (who narrated the story) informed the researcher that her daughter begun suffering from an epileptic kind of disorder in 1998. The problem started affecting her by suffocating her. She could collapse several times in a day. Her mother took her to a local clinic for treatment. However, her problem worsened with time and the Clinician referred her to a specialist at Kenyatta National Hospital for further check up and treatment.

At Kenyatta, she was diagnosed with a brain tumour. After several attempts to suppress the tumour, the doctors recommended that the child undergo radiotherapy. Being lay on the procedure and having heard incidents where patients develop complications after exposure to X-ray substances, she refused to let her daughter undergo radiotherapy. After consultation with other family members, they decided to take her to a traditional healer in 2002. During the time of carrying out fieldwork, I met her with her daughter at the traditional healer's clinic. Her mother said that since she started consulting the herbalist, her situation has improved and she does not experience frequent seizures anymore.

Case story 6

Karanja was born 53 years ago and went to school up to standard two. He is a father of six; two of who are sons and the rest are daughters. Ten years ago, he started suffering from epilepsy. At the initial stage of his problem, he started panting, sweating, and was so hypersensitive to shocking news or events. His children started worrying about his condition since he was their sole breadwinner.

He visited all kinds of modern hospitals, including Melkizeden in Dagoreti. He spent over 5000 Kenya shillings (KShs) but his condition did not improve at all. Being sympathetic to his family, one of his friends advised him to try traditional medicine. Being a strong believer in Christianity, he was hesitant to go against his faith for what he termed as" dirty" traditional methods of healing. His health deteriorated further

with time and he had nowhere else to go after consulting almost all kinds of conventional doctors. He decided to heed his friend's advice.

Being desperate for cure, he consulted all forms of traditional healers, both in the rural and urban areas. After six years of consulting traditional healers, his health has improved tremendously. He says that compared to traditional medicine, modern medical facilities at times is very expensive especially when it comes to complicated diseases such as blood pressure, asthma among others. He however said that, "modern medicine is still superior in treatment of many forms of illnesses".

Case story 7

James is 58 years old and hails from Mbale, Vihiga District. He went to school during the colonial days but never went beyond standard three. He is employed as a watchman in Nairobi and at times sells *tumbaku* (tobacco) to supplement his income.

He began suffering from stomach problems two years ago. His first action in an attempt to solve his problem was to buy over the counter drugs but his condition did not improve. He then decided to take a further step by visiting a modern hospital in Kibera. His problem became no better and he was referred to Kenyatta National Hospital for further consultation and treatment. At KNH, the diagnosis revealed that he was allergic to protein foods. He was advised not to eat meat, eggs, fish, and chicken if he wanted to get well. The doctor's verdict was so disappointing to him for the listed foodstuffs were among his favourite dishes. To make it worse the drugs that the doctor prescribed to him were so expensive that he could not afford to buy them. His wife advised him to try alternative medicine. Being a committed Christian, he declined. His religion teaches against the use of *miti shamba* (herbs). Herbs are associated with demonic powers.

His situation worsened with time. Being desperate to get well, he decided to heed his wife's advice and consulted the healer secretly. Two months down the line, his situation improved but even after using the herbs for about six months he was still not convinced of its efficacy. However, when his situation improved, his attitude and perception towards traditional medicine changed. At the time of this interview,

James is now a full subscriber to traditional medicine. In his own words, he said "these drugs have saved me from a very grave situation and now my digestive system is back to normal"

From the case materials presented above, one can observe that although in deciding to consult a traditional healer, patients do not choose traditional medicine in comparison with allopathic medicine, it is not automatic either. Choosing a particular health care system may be due to religion, stigma, one's lifestyle, among other things, implying that they go through an elaborate decision making process.

It is equally important to note that patients follow a hierarchy of resort in their quest to get well. The case of Nyambura (Case story 1) show that patients move from one healthcare to another depending on whether they get well or not. More often, the hierarchy of choice or strategies are sequential or progressive, as the patients try out one therapist after the other in the hope of finding a cure. As observed from the above case materials, patients who have been healed will at times revisit the same healer in the future and in addition become publicity agent for such healers that they patronise.

As far as hierarchy of choice is concerned, it is evident from the case stories that medical pluralism or therapy choice fits within the multiplicity of the urban ecology. A close examination of the case materials shows that patients do not find the two forms of care incompatible; on the contrary, they see them as complementary to one another. It is apparent that, by moving from one healthcare system to another, patients submit their various experiences of illnesses to several tests: besides seeking to restore their physical health. We also observe from case stories 1,3,4,6 and 7 that the belief in the efficacy of

traditional medicine at times is not universal but patients try it out of desperation and when they are healed, it gains popularity and acceptance even with subsequent illnesses.

It is also equally important to mention that, health-seeking strategies may originate with the individual health-seeker or with his or her lay therapy management group (support network) as illustrated in case stories 2, 5, and 6. The case materials show that when confronted with illness or disease, an individual takes his/her own initiative to seek care. But when disillusioned due to unsuccessful treatment, the health seeker turns to another medical practitioner or seeks alternative therapy. The longer the illness resists cure, the more the health seeker opens up to other suggestions. This is an opportunity for the therapy management group to come into play and give suggestions and at times make decisions on available options such as traditional medicine. In brief, it appears that therapeutic pathways are shaped by the patients and their families in connection with the interlocking network of mutually supportive and dependency relationships or neighbourhoods.

In conclusion, the above case materials illustrates the fact that individuals are knowledgeable and capable actors who engage their agency by analysing their health situation alongside availability of healthcare options in order to get well. In the process of doing so, they engage their agency in formulating decisions, acting upon them and experimenting on all available options. It tells us that individuals do not give up even if they are in the brink of death.

4.6 Summary of the findings

This chapter presented findings in relation to factors which people put into consideration when seeking therapy. Findings from the study have revealed that therapy seeking and therapy-selecting behaviour is quite pragmatic. A majority of respondents interviewed opted for modern healthcare as their first choice of therapy as opposed to those who opted for traditional medicine. Patient's resorted to traditional medicine as an alternative when modern medicine failed to cure their illness. Those who opted for traditional medicine as their first choice of therapy cited perceived efficacy, aetiology, and availability as motivating factors.

The findings also showed that traditional medicine is readily available in terms of drugs and healthcare providers. A big promotion of the respondents pointed out that it has become a common phenomenon, especially in public health facilities, not to be given drugs or if you are lucky, you will be given painkillers. Similarly, it was revealed that failure to get drugs is not the only frustration but also finding the health care provider.

Socio-cultural beliefs in terms of disease aetiology were found to play an important role in influencing therapeutic choice. Respondents categorized the causes of their illnesses into natural or supernatural depending on what they perceive to be the agent of causation. When an illness is perceived to lie within the supernatural domain, the appropriate recourse is to seek the services of a traditional healer. On the other hand, when an illness was associated with natural cause, therapy was sought either from a traditional healer or modern doctor. In some instances, patients jointly utilize the services of traditional and

modern medicine. Another reason mentioned for using the services of a traditional healer by an overwhelming majority of respondents was perceived efficacy. We found that people use traditional medicine because they believe it is effective.

CHAPTER FIVE

Discussion, Conclusions and Recommendations

5.1 Introduction

This chapter presents an analytical discussion of the findings in the preceding chapter. Results pertaining to objectives of the study are comprehensively discussed based on the actor-oriented approach. In essence, factors that were found to influence utilization of traditional medicine in the study area are explored further.

5.2 The influence of cultural beliefs on therapeutic choice

The knowledge and socio-cultural dynamics that inform therapy choice may depend, partially or wholly, on the aetiology of an illness offered by agents in the community. This study intended to find out whether cultural beliefs regarding illness causation influence health seeking behaviour in Kibera. The findings have shown that cultural beliefs about illness play a very important role in healthcare choice. In some societies misfortunes afflicting society are blamed on supernatural forces, or on divine retribution, or on malevolence of a "witch" or sorcerer. This therefore shows that cultural background has an important influence on many aspects of people's lives, including beliefs, perceptions, behaviour, and attitude towards illness.

In all human societies, beliefs and practices relating to ill-health are abound and central feature of the culture. According to the Parsonian school of thought (in Layder, 2000), human interaction over a long period of time creates what Bourdieu calls "cultural

products"[17] (Layder, 2000). Humans being cultural beings have over time developed social institutions, aetiological theories, and therapeutic techniques to enable them cope with the social and other problems occasioned by illness-induced disability.

During the process of socialization, the agents of culture (parents and other significant people in society) inculcate in their children the cultural knowledge and practices that influence their behaviour. The cultural system serves as a "store house" which Bourdieu calls *habitus*[18] (Layder, 2000: 156). In this "storehouse" or *habitus,* cultural forms and human products such as belief systems, healing practices and definition of illness, are found. These structures provide the social context or a predisposition under which people act in relation to health seeking behaviour.

Aetiological beliefs, that is, concepts or models of disease causation are part and parcel of these "stocks of knowledge". The cultural beliefs surrounding illness create a distinction between "naturalistic" and "personalistic"[19] aetiologies in medical systems resulting into "dichotomization" of diseases and illness. Classification of illnesses into natural or supernatural is a product of cultural explanatory models. This forms part of a people's worldview, and hence, any treatment offered must "make sense" to the patient in relation to the two dualism. Conventional healers in Kenya and other parts of the world today are

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[17] 'Cultural product' is a consequence of human interaction that represents the history and traditions of particular society. According to Bourdieu, the society reproduces itself through the process of socialization in which the *habitus*, which is the conduit of cultural products, is reproduced (Layder, 2000:156).

[18] Bourdieu's conception of "*habitus*" refers to the stocks of knowledge that people carry around in their heads because of living in particular culture or sub cultures. It is a cultural resource available to others

[19] "Personalistic" causes refer to an active or purposeful intervention by an agent (human or non-natural or supernatural), whereas naturalistic causes refer to natural forces or conditions such as bad weather, chills (Molsted, 1995:32).

faced in their practice by patients whose health seeking behaviour traverse and transcend the worldviews and systems of modern healthcare.

From the findings, it is evident that in their everyday life, individuals make a clear distinction between illnesses that can be treated by traditional medicine and those that can be treated by modern medicine. The fact that respondents harbour these views implies that people share the social world, which is the basis of their common "stocks of knowledge" and "recipes" which they draw from (Layder, 2000). More often than not, illnesses perceived to fall within the natural domain are mostly referred to the modern healers while those that fall under the supernatural domain are referred to traditional healers.

However, it is important to note that the two domains at times overlap, leading to concurrent utilization of both traditional and modern medicine. No wonder, there have been strident calls in some quarters for the integration or conscious proportion of some sort of collaboration between the two systems. Yet others harbour the feeling that traditional therapeutic regimes should be banned or its use discouraged because it is primitive, bereft of scientific efficacy and inimical to patients' well being. Despite the stigmatisation, a high and increasing rate of dissatisfaction with biomedicine, in contrast to correspondingly high levels of satisfaction with alternative care-in particular traditional medicine is evident.

Giddens (2001) on the other hand offers an alternative explanation to the above observation. According to him, modern medicine follows a reductionist approach and

increasingly focuses less on the actual patient. The modern medical view is based largely on objectively demonstrable physical changes and, in the long run, ignores the social aspect of health that is more emphasised by traditional healers. Feistens' (In Helman, 1994) further affirms this view by pointing out that there has been a shift in recent years in how doctors collect information about the underlying disease process (Feisten cited in Helman, 1994). The traditional method has been listening to patients' symptoms and how they developed the disease but currently they have come to rely on diagnostic technology, a shift from the subjective to an objective form of diagnosis and hence the dissatisfaction with modern medicine.

It has also been observed in other studies (Anderson and Philips, 1963) that socio-economic factors such as education level, income level, social class, and religion, shape peoples' beliefs, tastes, and preferences which in the long run influence their health seeking behaviour. This was not found to be the case in this study. It was observed that patients use traditional medicine irrespective of their socio-economic status. The explanation given for this observation is that, modernisation 'produce and reproduces'[20] values and perceptions that favour modernity. This study assumed that, largely, the non-literate portion of the population forms a big proportion of the patients consulting traditional healers while their counterparts with a school education and a Christian outlook often consult modern healers.

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[20] 'Production' and 'reproduction' are concepts used by Bourdieu to explain how society replicates its cultural products not only in terms of artifacts such as buildings, furniture, but also in terms of different forms of knowledge, literature, art and traditions (Giddens, 1979).

This study also assumed that people whose behaviour is situated in a modern space such as the urban setting (having embraced Christianity and other western values) do not make use of traditional medicine because it is considered demonic and primitive. This argument borrows largely from the collective representation school[21] which analyses human action in terms of group symbols or rules governing an institution such as the church and are supposedly applicable to all individuals subscribing to the rules and principles of the very system (Cohen, 1969:103). An individual is expected to behave according to societal norms. The society on the other hand is expected to act in the best interest of the patient (collective-orientation) and hence the presence of the therapy management group. The followers of a particular religious group are therefore expected to behave and embrace such notion in a collective manner (group behaviour) as dictated by societal values and customs.

The above observation was, however, not found to be the case in Kibera. Findings from this study have shown that people across the religious spectrum use traditional medicine irrespective of their socio-economic status by virtue of being born and brought up within a particular cultural context before entering a secondary social group through secondary socialization. By this, I mean that individuals are predisposed with "common stocks of knowledge"(Layder, 2000:156), which they constantly draw from in their quest for therapy. Before an individual is transformed into a new social/cultural group, he or she grows up in a society with institutions such as belief systems, medical systems, and so on.

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[21] Collective representation school of thought puts more emphasis on the macro (societal level) elements as opposed to the microelements (individual level). This has been expressed as the power of social system to influence the social behaviour of individuals. This underlines the dilemma between acting primarily in terms of one's self interest, or sacrificing ones agency to act independently and embrace societal rules of the game.

In the event that the conventional mode of therapy fails to offer a positive solution to their illnesses, individuals simply revert to familiar cultural resources irrespective of their socio-economic status.

Mbiti (1969) points out that in times of crisis modern values take a backstage and people resort to whatever explanation and help they understand better. Social life is seen as a game involving continuous scheming, struggling, and making decisions at the expense of what systems attest to. The overriding factor in this case is whether the chosen mode of therapy is capable of bringing relief or not.

As far as therapeutic choice is concerned, studies conducted by scholars such as Nyamwaya, (1992) have shown that diseases whose causes cannot be well understood or treated by modern healers are believed to fall within the supernatural domain. Chronic and terminal illnesses such as cancer and asthma are said to respond well to traditional medicine (see table 4.4 p46). Even though illnesses such as HIV/AIDS have no known cure, people still believe they can be treated well using traditional medicine. The perceived cause of illness is used to classify illness and diseases that go beyond human understanding as supernaturally caused thus informing the option(s) that is deemed appropriate and desirable.

Beliefs about illness and health enable people "make sense" of various events that befall them. The way in which people perceive and respond to illness is learned and varies from society to society. The health of a person in traditional societies cannot be improved simply by exporting medical knowledge and understanding, assuming that those in the

recipient group will change their ways to adopt the advocated procedure. This is because culture determines the manner in which persons behave and that is why people consult traditional medicine when they link the cause of their illness to a supernatural force. On the other hand they turn to biomedicine when they perceive their illness to be naturally caused. It is therefore vital to look at lay beliefs about health and illness from a cognitive framework[23]. This is necessary in explaining the nature of illness. It is also imperative in the sense that, even though there is increased knowledge and understanding of disease causation by virtue of scientific advancement in the world today, the view that some diseases are supernaturally caused are still harboured among people who have embraced modernity.

5.2.1 Religious affiliation and health seeking behaviour

Findings from this study have shown that religious affiliation does not deter an individual from using traditional medicine. A majority of those who were found to be using traditional medicine were Christians, a fact that has for a long time not augured well with their doctrinal philosophy. The Christian thinking has for a long time associated traditional medicine with witchcraft, a misconception traced back to the colonial era. The colonial government outlawed the use of traditional medicine by branding it as harmful and dangerous (to be precise witchcraft) practices while on the other hand promoting the use of modern medicine.

Beginning in the 1950s, modernization discourse “reproduced” a model offering “mirrors” for evaluating health and other development issues. This was founded on

optimistic developmental theories inspired by Western evolutionary vision dominated by rationalistic and universalising conceptions propagated by formal education and Christianity. Through these mirrors, the people assimilated new ideals of health and healthcare and later partially rejected them.

However, from our findings, there seems to be a contradiction between religious ideology and the reality of individuals' everyday lived experiences, and interests, which leads to an act of defiance. For instance, visiting a magician instead of a medical doctor or rather a prayer healer has no relation to ones' religious affiliation. Leonard cited in Layder, 2000: 47, confirms that the social order may be resisted in a psychological sense through the rejection of the conventional standards of behaviour and an acceptance of stigmatised and marginal identities (such as using traditional medicine).

Fosu (1995 cited in Ofware, 2000) in his study on women's orientation towards health seeking behaviour for mental health in Ghana affirms the above statement. His study found out that, women who were professing Christian faith or had a higher level of education did not completely abandon traditional medicine. Tempels (1969) reports that the African *evolue*[24] often reverted to their traditions whenever they encountered problems that could not be handled by modern medicine. Additionally, the African Christian "rolls back"[22] to his traditional way of life whenever they are overtaken by moral lassitude, dangers or suffering (Mbiti, 1969). This shows that behaviour can neither be universal nor permanent unless it is grounded on an individual's cultural context.

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[24] By rolling back we mean a situation where an individual reverts back to a conventional mode of behavior

It is important to note that, even though an individual's personality is moulded and shaped by social institutions such as the church, the very individual maintains what Giddens (1979) calls a "dialectical"[25] relation with the social order. In this respect, an individual may actively resist its demands while on the other hand weighs the cost of his actions vis-à-vis his/her quest to get well. This shows that in spite of the rules and norms of a social system an individual has some space for manipulation either through resistance, avoidance, or descent.

This study has, therefore, demonstrated that, unofficial and informal expectations grow up in and around roles and positions in society even in the most routine and seemingly rule-bound activities, such as those involved in work and occupational tasks. For example, when an individual goes to church, he/she is taught to obey Christian teachings (values and doctrines). Besides, he/she is tutored to desist from engaging in "demonic" activities such as visiting *waganga wa miti shamba*[26]. The above notion follows Parsonian school of thought[27] which according to Layder (2000) has created an "over-socialised" image of a human being as a passive conformist.

On the contrary, individuals routinely act in accordance with the informal and unofficial "rules of thumb" by engaging their "agency"[28]. Availability of what Parsons (cited in Layder, 2000:20) calls "pattern variables"[29]enables actors to engage their human agency by choosing options such as traditional medicine that they consider to be compatible with their conditions and beliefs. Layder, (2000:4) attests to the fact that people are actively involved in social relationships by virtue of being 'agents' or "actors" in the social world. In this case, patients in their capacities as actors engage their agency by choosing the

pattern variable they believe will handle the situation affecting their social relationship with other actors as opposed to being passive victims of social pressure and circumstances. This behavioural aspect departs and often contradicts the conventional belief outlined in the Christian world. This thesis consequently points out that, nonetheless, people may indeed internalise norms and values, but at the end of the day not conform to them. In this case, the elemental impulse and motivation to "reproduce" good health constantly jostle with the demand for social conformity, discipline, and often wins out of struggle.

5.2.2 Gender and health care

Gender has been found to play a big role in influencing health-seeking behaviour (Anderson (1963). Women are said to be more likely to seek medical attention more than men, an aspect attributed to their willingness to reveal their feelings more easily than men. In addition, as they accompany their children to health centres they exploit the opportunity by presenting their health situations to the doctor (Helman, 1994). This is contrary to the above observation. More than 50% of the respondents consulting the healers at the time of the study were found to be men (see table 4.1 pp36).

Several aspects of male gender arising out of enculturation can be said to contribute to men's ill health, or the risks of such ill health developing. Helman (1994) asserts that in comparison with women, men are encouraged to be more competitive and, therefore, take more risks in their daily lives. This pattern of behaviour is associated with type A

(TABP) personality[30], which is a kind of competitive and time-obsessed behaviour. It is said to increase the risk of coronary heart disease.

5.3 The effect of cost on therapeutic choice

The client's expectations or economic and family situation may equally influence therapeutic choice. It has been argued that the cost of modern medical services may be an important reason why people turn to traditional medicine (WHO, 2000). The argument is centred on fees and other monies and is used to explain the reason why patients turn to traditional medicine or what has come to be known as alternative care. The use of alternative care has been tied primarily with the socio-economic context within which people operate and yet other factors may be contributing to this observation. This, therefore, indicates that a considerable gap remains in our knowledge concerning patients' health seeking behaviour and health seeking practices.

Findings in our study show that, despite Kibera being a low-income area with about a half of the sampled population earning less than US$51 (2000 KShs) a month, the cost of modern healthcare was not mentioned to be among the primary reasons why they opted to consult a traditional healer. Our findings indicate that, only less than a half (25%) of the respondents felt that cost was an important reason why they turned to a traditional healer for help while a glaring majority (75%) did not harbour the same view (See table 4.3 pp42). This shows that patients don't make comparisons between the cost of modern and traditional forms of care when selecting therapy managers. The above observation might be a consequence of other confounding variables. However, it is important to note just

like Nyamwaya (1992) that the low level of income by a majority of citizens' limits their healthcare choice.

If indeed traditional medicine was perceived to be less costly than modern medicine, the findings would have indicated that majority of the patients consulted traditional medicine as their first choice of therapy, which was not the case in this study. Data obtained from direct observation indicate that both modern hospitals and traditional clinics are located within the same locality in the study area. This means they do not require any additional cost in terms of transport. For instance, within the precincts of Kibera, the major referral and teaching hospital (Kenyatta National Hospital) in the country is located.

This, therefore, indicates that access in terms of transport costs is not a limiting factor to utilization of healthcare in Kibera unlike their rural counterparts who are forced by circumstances to travel long distances in order to be seen by the doctor. Swiderski (1995) observes that in the rural areas, people travel long distances to wait for a doctor who might end up not seeing them at all. If he does, probably he will prescribe aspirin due to shortage of drugs.

As far as cost of delivery is concerned, it was observed that TBA's charge about US $13 per delivery, a similar amount or slightly higher fee charged by some modern clinics such as the City Council clinics and others operating within the area. Respondent's acknowledged that the services offered by TBA's might be of lower quality, yet they find them largely reassuring and positive insofar as attitude is concerned. Some respondents mentioned that nurses working in public hospitals have negative attitudes towards

patients and at times harass and abuse pregnant mothers in public. Additionally, the shortage of dressing facilities in government health facilities aggravates the situation. For a pregnant mother or any other patient for that matter, it serves no purpose to visit a health facility yet one is still required to buy almost everything from surgical gloves to painkillers.

In this regard, delivering at home is preferably cheaper and convenient since one is saved of travelling expenses. This finding is reinforced by an observation documented by the 2003 Kenya Demographic and Health Survey (KDHS). The results showed that more than a half (58%) of deliveries occurred at home with the assistance of non-trained personnel (TBA, relatives and self).

In some instances, reducing the cost of healthcare or even making it free does not translate largely into increased utilization of healthcare services. The quality of care[23] and the manner in which healthcare is delivered is vital. If the quality of care is perceived to be poor, patients will seek alternative care despite the cost. A case in point is when the Kenya government introduced user fee charges in public hospitals in 1989 leading to a decline in attendance at the healthcare facilities (World Bank, 1994). The introduction of user fees to access healthcare was not found to be commensurate with improved quality of services.

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[31]According to Jain (1989:10), quality is much more difficult to define than quantity. He defines quality of care in terms of the way individuals and clients are treated by the system providing services. Quality however has different connotations to many people, and whether a particular service is of quality is a matter of judgement. For some aspects of quality are based on, standards set by International organizations, while others require evolving standards of quality within particular country contexts.

However, it is worthy to mention that the cost of sustaining modern healthcare is way up the sleeve of many people. These ranges from doctor's fees to the cost of maintaining the more elaborate settings for curing. The western form of medicine, unlike traditional medicine, depends much on very expensive medical technology, which requires thorough training and cost of maintaining it is high making it quite expensive in the long run.

Nonetheless, much emphasis has been given to western medicine while locally available herbs and other remedies based on knowledge and traditions built up over generations tend to be ignored. Most drugs used by traditional healers are available locally and mostly taken in their natural form unlike modern drugs, which have to undergo complex processing.

Overall, health care facilities in both urban and rural areas have deteriorated significantly due to poor financing by the exchequer. Non-availability of services and drugs might have forced many to shift to traditional medicine and not cost per se'. The financial status of the respondents does not seem to explain respondent's dissatisfaction with biomedical medicine.

5.4 Perceived efficacy and therapeutic choice

The effectiveness of traditional medicine to treat illnesses is still widely debated but no one disputes its significance. Traditional medicine for a long time has been and continue to be popular among clientele by virtue of its ability to cure a number of illnesses that have proved challenging to modern medicine (see Table 4.5). A classic example of such an illness that people believe can be handled effectively by traditional healers is an illness

known locally as *chira*[12] among the Luo community in Kenya. This depends much on the relationship between the illness and perceived cause. Diseases whose aetiologies are linked to supernatural forces are believed not to respond well to modern medicine. In this case, patients opt to consult traditional healers believed to have relevant powers to suppress and control disease/illness causing agents/powers.

There are occasions where patients feel that there is something wrong with their system but diagnosis fail to identify the problem. This phenomenon, according to Helman (1994) is increasingly becoming common in modern medicine which places due emphasis on diagnostic technologies. The ability of traditional healers to heal such a kind of illnesses (illness without disease) might be attributed to the placebo effect. The patient might be made to believe that the healer has actually cured the illness yet the healers' action served as a placebo. Therefore, patients at times are duped without their knowledge and understanding into believing that they have been healed. This shows that in some occasions, health and illness is a question of the mind and once a patient has been convinced that he has been treated, he goes ahead to believe in its efficacy.

By and large, there are illnesses that respond well to traditional medicine and that is why diseases and illnesses such as asthma and HIV/AIDS were mentioned. Despite HIV/AIDS not having any known cure proofed scientifically, some respondents believed that traditional healers could treat HIV/AIDS. The only valid proof so far observed indicate that traditional medicine is capable of suppressing opportunistic infections but not curing HIV/AIDS (Njoroge, 2003). On the contrary, unscrupulous traditional healers have gone a head and exploited the situation. Fortunately enough, clinical studies done on

herbal therapies have indicated that drugs such as *propolis*[33]a beehive product used by traditional healers has strong antiviral properties that spruce up the body's immune system (Njoroge, 2003). Clinical observations have shown that this substance is capable of inhibiting replication of the virus, which causes HIV and slows down its spread in the body. Another herbal drug, *virakil,* is said to be capable of managing AIDS and related infections.

Herbal medicine, being holistic, is known to contain proteins, vitamins, and carbohydrates such that besides healing, it also helps in nourishing the body and in so doing replace worn-out tissues thus offering speedy recovery (Githae, 1995). Some respondents observed that TRM is very effective in treating childhood diseases such as measles. The psychological/psychosomatic value of TRM is widely recognized by many people.

Inability of conventional doctors to explain some culturally related conditions such as *chira* has popularised the work of magicians who fill this gap by offering an alternative explanation of the cause and treatment to such illness. This is enabled by the fact that in most cases, traditional medicine emphasise the "why" of an ailment rather than the "how" of an illness. The concern of traditional healing process to resolve the "why" of an illness is frequently connected with supernatural explanation. When considering the value of TRM, it should be relative to both pharmacological, psychological or its social value. Mbiti (1969) asserts that, whether traditional medicine works or not, need not matter very much. The belief in its efficacy in inspiring hope to the sick is what matters.

It is therefore apparent that, the decision to consult or not to consult any healer largely depends on whether the available option is capable of arresting the problem or not. In the event of an illness, a patient will first evaluate the available options in terms of availability, accessibility, and perceived efficacy. The overriding factor in this case will be the effectiveness of a particular option in handling the problem. This is what makes patients pragmatic about health care choice through experimentation on anything that affords relief. When one remedy fails, patients try out other options available. A significant proportion of the respondents interviewed in this study had tried other services before ending up at the traditional healer's clinic while others opted for traditional medicine as their first choice of therapy.

However, not everybody who visits traditional healers believes that their medication is effective. Case story 4 shows that some people still consider traditional medicine as "dirty" and "backward" and thus try it out of desperation and not out of the conviction that it is effective. Githae (1995) observes that in his clinic he receives three categories of patients. The first category comprises patients who visit the clinic because they regard herbal clinics as any other clinic and are therefore sure of recovering. The second category, are the patients who visit to try whether herbal medicine works, whilst the third, and the largest category, comprises patients who visit traditional healers as a last resort.

In most cases, traditional medicine is relegated to the second level. However, from our findings it is evident that when the second choice succeeds in alleviating illness it becomes popular with subsequent illnesses and, thus change positions with the initial option in relation to health seeking behaviour as shown by case story 4. It is equally

noticeable from the case materials that traditional medicine is resorted to whether one is educated or not. Additionally, the quest to get well as observed from the case materials seems frustrating to an extent where patients try out anything within their reach to get well. Case 5 is quite unique in the sense that the fear of complication associated with modern forms of therapy forced the patient to stop visiting modern clinics and after consultation with the social network she opted to visit a traditional healer.

Finally, the health-seeking pattern shows that when other forms of healthcare fail, people resort to alternative forms of care either as a last resort or as an option of care besides modern medicine. The actor-oriented approach asserts that individuals are actors who have knowledge and capacity to process social experiences and in so doing design ways of coping with the situation even under extreme pressure from society. This confirms the idea that patients pragmatically seek out anything that promises relief.

5.5 Availability of healthcare

Traditional medicine is known to be readily available in almost every community in Kenya as compared to modern medicine. The almost 100 % (Table 4.5) availability can be attributed to the fact that herbs and other traditional remedies are locally available and more so do not require any sophistication in terms of processing unlike modern medicine. Owing to competition and popularity of modern medicine, traditional healers ensure that they are always available in their clinics in order to attract clientele and popularise their work. Some traditional healers depend on the practice as a main source of livelihood and hence the need to be there at all times.

Inadequacy and scarcity of modern health care services can contribute to the use of traditional health services (WHO, 2000). Public hospitals have been hit by shortage of health personnel and essential drugs forcing doctors in most public hospitals to send their patients to buy drugs from private chemists. A study by the World Bank on the effectiveness of public healthcare facilities reported that there is rampant corruption and laxity of personnel due to poor pay, which has hindered service delivery (World Bank, 1994). It observes that this phenomenon has been a general trend in most developing countries, especially sub-Saharan Africa. Similar findings have been reported in a study carried out on utilization of health services in one village in India (WHO, 2000). The small proportion of trained medical personnel in relation to the population size they serve can explain the inadequacy of services in modern health facilities.

According to the 2002 Kenya statistical abstract, the ratio of doctors to the population is extremely low[34](GOK, 2002). Statistics on medical personnel between 1996 and 2002 show that there were only 3,971 trained doctors in the country. The ratio of doctors to the population was estimated to be 1 doctor to a population of 6536. In the same year, there were 4,235 health institutions in the country, 419 of which were in Nairobi. Statistics from the same source indicate that for every 1 bed available there were 5263 persons. There was no evidence of improvement in subsequent years. The 1994 World Bank report, based on data from 1988 to 1992, gives a similar picture of widespread variation in the supply of medical personnel. In sub-Saharan Africa, for example, there was an average of 0.12 doctors per thousand persons compared to 0.14 in India, Latin America,

and 1.25, China 1.37, 3.07 in industrialised countries, and 4.07 in the former USSR (World Bank, 1994).

Despite the major gains in health care delivery, population growth and HIV/AIDS has outstripped the capacity of the MOH to meet the demand for healthcare services (GOK, 2000). Currently, over 70 percent of the recurrent budget is used to pay staff salaries and benefits to the detriment of expenditures on other essential supplies. Lack of resources has meant that a number of facilities have remained under utilized.

This situation has caused a serious problem in the referral system, resulting in unnecessary congestion in hospitals. Patients who should be treated at a lower cost in health centres and dispensaries are forced to travel long distances to District or Provincial hospitals. This congestion has led to cases of patients dying in long queues as they wait to be seen by a doctor (World Bank, 1994). A good number of patients die at home, because they lack money to consult private clinic/hospitals or even buy over the counter drugs.

The prices of medicine in the retail outlets are way far beyond the reach of most Kenyans. This places a heavy burden on vulnerable groups and poses a serious challenge to the Ministry of Health. In the recent past, reports by the MOH have indicated that the population of patients has overwhelmed our hospital capacities. Statistics from Central Bureau of Statistics (GOK, 2000) shows that the bed capacity is below the required number leading to patients sharing beds. With such a situation, it is possible for patients to infect each other especially if the disease is communicable.

A report by the Ministry of Health (GOK, 2002) indicates that a number of critical problems constrain its ability to legislate for and ensure the delivery of adequate quality health care. These include finances, capacity of the public healthcare unequal distribution of healthcare facilities and, above all corruption and inefficiency in the system. The big disparity between the number of doctors and the size of population attest to the fact that modern health care is inadequate to cater for the increasing number of the population and myriad health problems experienced everyday. A recent survey report by the Society for International Development (SID) and the Kenya Government showed that social inequality in the country is glaringly high. The statistics shows a worrying trend in terms of distribution of social services in Kenya. Such kind of scenario has contributed to the increased demand for traditional medicine (WHO, 2001)

The shortage of health personnel in Third World countries is also exacerbated by brain drain where trained medical personnel and other professionals relocate to the western world in search of greener pastures. In the recent past, we have witnessed a massive exodus of medical personnel from Kenya to the developed countries (GOK, 2002).

It is also worth mentioning that poor performance of our national economy has led to deterioration of both the health and social sector. Corruption and poor governance as also exacerbated the situation culminating in budget deficits that cannot sustain services provided by the government and other stakeholders. These inequities, have forced people to seek alternative therapy. A report by APHRC (2002) indicates that, in the informal settlements healthcare services are poor and as a result, alternative medicine becomes immediate healthcare resort.

5.6 Conclusions

This study concludes that, traditional medicine is still a very significant and relevant aspect in health care delivery. This can be attributed to the "push" and "pull" factors identified in this study. There is every reason to believe that in spite of a wide network of modern medical services, people still use traditional forms of healthcare. Traditional medicine being a key factor in primary health care delivery plays a crucial role in improving individual and community health.

Socio-cultural factors in terms of disease aetiology were found to be substantially present in the management and treatment of illnesses. The argument in this thesis is that, aetiological factors have a bearing on therapeutic choice. The knowledge and socio-cultural dynamics (explanatory models) that informs therapy choice decisions may depend, in part, or wholly on aetiology of illness (explanatory models) offered by agents in the community or individual patient. This, therefore, shows that cultural background has an important influence on many aspects of people's lives, including the way people go about seeking for healthcare.

It is also evident from the study that perceived efficacy of traditional medicine plays an important role in peoples health seeking behaviour in this case the use of traditional medicine. It is therefore clear that the amount of satisfaction a service offers influences an individual choice of therapy. In this case, majority of patients utilizing traditional medicine believe in its efficacy. What matters to the patient is whether a particular health care system can offer relief or not regardless of whether it is approved by society or not.

Availability of health care service was also found to have a big influence on the use of traditional medicine. A majority of the patients visiting traditional healers in Kibera did so because they are sure of finding the healer in his clinic and in addition they are sure of being given drugs. This therefore, means that availability is a very important component in healthcare delivery.

Finally, the study has proved that individuals are knowledgeable and capable actors who engage their agency by analysing their health situation alongside availability of healthcare options in order to get well. In the process of doing so, they engage their agency in formulating decisions, acting upon them and experimenting on all available options.

5.7 Recommendations

From the above findings and conclusions, this study makes the following recommendations:

Due to the vital role played by traditional medicine both in urban and rural areas, there is a need to formalize the use of traditional medicine by promoting collaboration and co-operation with modern health care providers. This will go a long way in addressing the phenomenon of medical pluralism by affording patients with a variety of options they can choose from. In order to achieve the above, a basic and good working relationship between medical health officers and traditional healers should be established

Since most traditional healers put a wider claim on their ability to cure all forms of diseases and illnesses, it is recommended that safety measures should be put in place for the evaluation of traditional medicine and its procedures. This can be done by establishing national testing centres in every district, which will help in verifying the efficacy of traditional medicine in order to ensure that these claims are true and actually fit for human consumption. The centres should be geared towards ascertaining the efficacy of medicinal plants and if possible help in its propagation for future use.

This study further recommends interdisplinary training involving the cultural rationale underlying peoples' health-seeking behaviour for the medical personnel. This will inspire greater sensitivity on the part of medical health care providers to patients' aetiological repertoire, and their rationale in healthcare seeking. This is in view of sustaining both the services of the biomedical curative impact and of helping powerless health-seekers to be understood through developing culture-specific communicational and observational skills. This will go a long way in addressing the diverse healthcare needs of patients has influenced by the patients background.

Lastly, there is need for further research in order to document indigenous knowledge and biodiversity resources and obtain patent rights to avoid the effects of globalisation, which has led to loss of indigenous knowledge through bio-piracy. This will go a long way in ensuring that traditional medical knowledge and biodiversity is protected and equitably shared. We also recommend a research that will focus on the perception and attitude of patients using modern health care on the efficacy of traditional medicine.

Bibliography

Amref, 1985. *Characteristics and Practices of Traditional Birth Attendants: A Study of Three Rural Kenyan Communities*. Nairobi: Amref Publications.

APHRC, 2001. *Population and Health Dynamics in Nairobi's Informal Settlements.* Nairobi: African Population and Research Centre.

Anderson, O.W. 1963. The Utilization of Health Services. In Freeman, H. E, S. Levine, and G. L. Reeder. *Handbook of Medical Sociology*. London: Prentice Hall Inc.

Bailey, W. and Philips D.R. 1986. Spatial Patterns of Use of Health Services in the Kingston Metropolitan area of Jamaica. *Social Science and Medicine,* 23:611-620, 1986.

Bodeker, G. and Parry, Z. (eds) 1997. New Approaches to Traditional Medicine. *Tropical Doctor,* 27 (1), 1997.

Chavunduka, G.L. 1994. *Traditional Medicine in Zimbabwe*. Harare: University of Zimbabwe Publications.

Cohen, Y.A. 1969. *Social Boundary System. Current Anthropology*, 10 (1): 103- 126, 1969.

Consgliere, S. 2000. Ethnomedical database: Internet search. http://www.ethnomedicine.htm.

Coulan, Q.A.A, 1985. Health for All: Leadership Information Materials. Geneva: WHO.

Giddens, A. 2001. *Sociology* 4[edn]. Cambridge: Polity Press.

——— 1979.*Central Problems in Social Theory: Action Structure and Contradiction in Social Analysis*. London: Macmillan.

Githae, J.K. 1995. Ethnomedical Practice in Kenya: The Case of Karati Rural Service Centre. In **Sindiga I, N, Chacha-Nyaigoti, and M.P, Kanunah (eds)** *Traditional Medicine in Africa,* pp. 55-63. Nairobi: East African Educational Publishers.

G.O.K 1979. *National Development Plan, 1979-1983.* Ministry of Planning and National Development. Nairobi: Government Printers.

______ **1989.** *National Development Plan, 198 -93.*Ministry of Planning and National Development. Nairobi: Government Printers.

______ **1989.** *Kenya National Population Census*. Nairobi: Government Printers.

______ **1997.** *National Development Plan, 1997-2001.* Ministry of Planning and National Development. Nairobi: Government Printers.

______**1998.** *Kenya Demographic and Health Survey.* Ministry of Planning and National Development. Nairobi: Government Printers.

_______**2001.** *Poverty Reduction Strategy Paper for the Period 2001-2004*. Ministry of Finance and Planning. Nairobi: Government Printers.

———— **2001.** *The 1999 Population and Housing Census*. Ministry of planning and National Development. Nairobi: Government Printers.

———— **2002.** *National Development Plan, 2002-2008*. Ministry of Planning and National Development. Nairobi: Government Printers.

———— **2003.** *Kenya Demographic and Health Survey.* Ministry of Planning and National Development. Nairobi: Government Printers

GOK and UNDP, 2003. The Millennium Development Goals (MDG): Progress Report. Nairobi: Government of Kenya and United Nations.

Helman G. 1994. *Culture Health and Illness*. Oxford: Butter worth-Heinemann, 2nd edn.

Jain, A.K (ed), (1992). *Managing Quality of Care in Population Programs*. Connecticut: Kumarian Press.

Janzen, J.M. 1978. *The Quest for Therapy: Medical Pluralism in Lower Zaire. Comparative Study of Health System and Medical Care*. Berkeley: University of California.

Kimani, V.N 1977. The Role of Traditional Medicine in the Treatment of Female Infertility. *MILA,* 6 (2) p. 47.

——— **1995.** *African Traditional Health Care: The Place of Indigenous Resources in the Delivery of Primary Healthcare in Kenyan Communities*. Unpl PhD Thesis, Department of Community Health, University of Nairobi.

Kimani, V.N. and Good, C. N. 1981. Urban Traditional Medicine: A Nairobi Case Study. *East Africa Medical Journal*, 57(5): 3-01-316.

Koumare, M. 1983. Traditional Medicine and Psychiatry in Africa. In Bannerman R, J. Burton, and C. Wen-Chien, (eds) *Traditional Medicine and Health Coverage: A reader for health Administrators and Practices,* pp. *20-28.*Geneva: WHO.

Schaeffer, R.T, and Lamm, R.P, 1995. *Sociology* 5th edn. New York: McGraw-Hill, Inc.

Layder, R. 2000. *Understanding Social Theory.* London: Sage.

Long, N. and Long, A 1992a. Introduction. In N. Long and A. Long (eds.) *Battlefields of Knowledge: The Interlocking of Theory and Practice in Social Research and Development*, pp. *268-277.* London: Routledge.

Maitai, C.K. 1986. *The Dynamic Interplay Between Man and Medicine: A Historical Perspective.* Nairobi: University of Nairobi Press.

Mbiti, J.S. 1969. *African Religions and Philosophy.* London: Heinemann

——— **1975.** *Introduction to African Religion.* Nairobi: Heinemann, 2nd edn.

Mechanic, D. 1969. Correlates of Physician Utilization: Why do Studies of Physician Utilization find Trivial Psychosocial and Organization Effects? *Journal of Health and Social Behaviour,* 20(1): 387-396.

Mohtieri, L. 1973. Expense is no Objecta: Income and Physician visits reconsidered. *Journal of Health and Social Behaviour* 14: 499-500.

Molested, H. 1995. *Contextualizing vaccination: Balanta Appropriation of Preventive Health measures in Guinea-Bissau.* MA Thesis, Institut for Anthropologi, Kobenhavns Universitet.

Mugenda, O.M. and Mugenda, A.G. 1999. *Research Methods: Quantitative and Qualitative Approaches:* Nairobi Acts Press.

Nachmias, C. and Nachmias, D. 1996. *Research Methods in the Social Science.* London: Arnold Publishers 5th edit.

Nembrini, G.P, G. Sartori, and F. Stauffer, 2002. Monitoring of Urban growth of Informal Settlements (IS) and Population Estimation from Aerial Photography and Satellite Imgaing. Occasional Paper no. 6 July 2002. Geneva Foundation.

Ngubane, H. 1977. *Body Mind in Zulu medicine: Ethnography of Health and Disease in Nyuiswa-Zulu Thought and Practice.* London: Academic Press.

Njoroge, J. 2003. Horizon: AIDS Herbs comes under the Microscope. An article in the *Daily Nation* of July 10, 2003. Nairobi: Published by the Nation Media Group.

Nyamwaya, D. 1992. *African Indigenous Medicine: An Anthropological Perspective for Policy and Primary Health Managers.* Nairobi: Amref Publications.

Ochieng-Odhiambo, F. 1997. *African Philosophy: An Introduction*. Nairobi: Consolata Institute of Philosophy Press.

Ofware, O.B. 2000. *Factors that Influence Utilization of Traditional and ModernMedicine among the Samia of Funyula Division, Busia District.* Unpl MA Thesis, Institute of African Studies, University of Nairobi.

Omare, J.M 1999. *The Role of Indigenous Medicine in National Health Care.* Unpl MA Thesis, Institute of African Studies, University of Nairobi.

Onyango-Ouma, W. 2000. *Children and Health Communication: Learning about Health in Everyday Relations among the Luo of Western Kenya.*Unpl. PhD Thesis, Institute of Anthropology, University of Copenhagen.

Onwuanibe, R.C. 1978. The Philosophy of African Medical Practice. A Paper presented at the 21st Annual Meeting of African Studies Association, Baltimore, Maryland, November 1-4, 1978.

Owuor, C. 1999. The position of Traditional Medicine in Health Care Delivery: The Kenya case. *Mila* (N.S.) Vol.4: 27-33, 1999.

Sindiga, I. 1995. Traditional Medicine in Kenya: An Introduction. In I, Sindiga, N, Chacha-Nyaigotti and M.P, Kanunah (eds). *Traditional Medicine in Africa,* pp.1-12. Nairobi: EAP

Swantz, L. 1979. *The Medicine Men among the Zaramo of Dar-es-Salaam.* Dar-es-Salaam: Dar-es-Salaam University.

Swiderski, N. 1995. Confidence in Traditional Healers. **In I, Sindiga, N. Chacha-Nyaigotti, and M.P Kanunnah, 1995**. *Traditional Medicine in Africa*, PP.40-53. Nairobi: East African Educational Publishers.

Tempels, P. 1969. *Bantu Philosophy.* Paris: Presence Africaine.

Turyahikayo-Rugyema, B. 1983. *Philosophy and Traditional Religion of the Bakiga in Southwest Uganda.* Nairobi: Kenya Literature Bureau.

UNDP, 2003. *Millennium Development Goals.* Nairobi: UNDP

Wandibba, S. 1995. Traditional Medicine among the Abaluyia. In I, Sindiga, N. Chacha-Nyaigotti and M.P, Kanunnah (eds). *Traditional Medicine in Africa*, pp.117-128. Nairobi: EAEP.

Warwick, D.P. and Osherson, D. 1973. *Comparative Research Methods*. Englewood: Prentice-Hall.

WHO 1978. *Promotion* and *Development of Traditional Medicine.* Geneva: WHO Tech. Rep., Series 622.

———**1983.** *Traditional Medicine and Healthcare Coverage*. Geneva: WHO.

———**1994.** *Health Economics: A guide to selected WHO Literature*: Geneva: WHO.

———**2000.** *Traditional Medicine: Better Science, Policy, and Services for Health Development*. Proceedings of a WHO International Symposium Awaji Island, Hyogo Prefecture, Japan, 11-13, September. Geneva: WHO.

———**2001.** *Promoting the Role of Traditional Medicine in Health Systems: A Strategy for African Region.*Geneva: WHO.

———**2001.** *Legal Status of Traditional Medicine and Complementary/Alternative Medicine: A World Review.*Geneva: WHO.

———**2002**. Health and Welfare Systems Development in the 21st Century. *Proceedings of Third Global Symposium on Health* pp.167-174, KOBE-Japan.

WHO/UNICEF 1978. *Alma - Ata Primary Health report of the International Conference on Primary Health Care.* Geneva:WHO.

World Bank 1994 *Adjustment in Africa: Lessons from Countries Case Studies.* Washington: World Bank.

Appendices

Appendix I: Data Collection Tools

Questionnaire For Clients

(To be filled by the interviewer)

Informed Consent

Good morning/afternoon. My name is-------------------------from the Institute of African Studies, University of Nairobi. I am carrying out a study on utilization of traditional medicine in Kenyan urban centres: A case study of Kibera Location. The objective of this study is to determine factors influencing utilization of traditional medicine in urban centres. In this study, your participation is voluntary and you will be interviewed at your convenience. Your responses will be confidential and your identity will not be revealed at any time to anyone. You may withdraw from the study at any time and you may decline to answer any single question if it makes you uncomfortable but I request you to answer the questions truthfully. I will also request you to allow me record your responses by writing down your responses for the sole purpose of capturing your responses.

Thank you very much

Date of interview ________________ Questionnaire No. __________

Location ____________________ Residence __________

BACKGROUND INFORMATION

1. Sex of respondent

1. Male □ 2.Female □

2. Marital Status

1. Single 2.Divorced 3.Married 4.Separated

3. How old are you? ___________

SOCIO-ECONOMIC PROFILE

4. What is your highest level of education?

1. None 2.Uncompleted Primary 3.Completed Primary

4. Uncompleted Secondary 5.Completed Secondary 6.University

5. Are you employed?

1. Yes *(If yes, go to question 7)* 2. No

6. (*If No in QN 5 above)* what do you do for a living? _____________

7. Approximately what is your net monthly income from your employment or other occupation? ______

1. Less than 2,000 2. 2,000-4,000

3. 5,000-10,000 4. More than 10,000

8. Which religious faith do you belong to? _______

1. Christian 2.Islam 3.Hindu 4.None 5. Others (specify) ___________

9. Is this your first time to seek for treatment? 1. Yes 2. No

UTILIZATION OF HEALTH CARE SERVICES

10. [*If yes*] what reasons do you have for choosing to come here instead of going to the hospital? *(Probe on the responses given)*________________________________

11. Do you think there are diseases, which can only be treated by a traditional healer and not a medical doctor?

1. Yes 2. No

12. Name at least one (One only)? ______________________________

13 Why do you think a medical doctor cannot treat the diseases you have mentioned above ______________________________?

14. Does your coming here also have a relationship with the belief about the cause of your illness?

15. What do you think is the cause of your illness? ____________________

16. Besides, coming to a traditional healer, had you tried some other services?

1. Yes 2. No

17. *[If yes]* which ones? *(Name them)*

1. ________ 2. ________ 3. ________ 4. ________

18. Were you treated?

1. Yes 2. No

19. Were you given drugs?

1. Yes 2. No

20. *[If No]* what was the doctor's advice after failing to give you all the drugs?

____

21. Ho much did you pay in total for your treatment? ____________________

23. How far is the hospital from your residence? ________________________

24. How much did you pay for your transport to the hospital? ____________ (Kshs)

25. Generally, what are you opinion about the services provided at the hospital you went in terms of?

1. Availability of drugs
2. Presence of doctors and other personnel
3. Care given by the staff at the hospital
4. Other facilities

26. *[If not treated in Q18.]* why was the doctor unable to treat your case? ________

27. What other steps did you take? ______________________________________

28. Incoming to a traditional healer does you belief he/she will handle your case.

1. Yes 2. No

29. Why do you say so? ______________________________________

30 Before, coming here had you at any time used the services of other traditional healers?

1. Yes 2. No

31. What is your opinion about the services offered by traditional healers' in-terms of?

-Availability of drugs

-Cost of treatment

-Presence of the traditional healer in his clinic

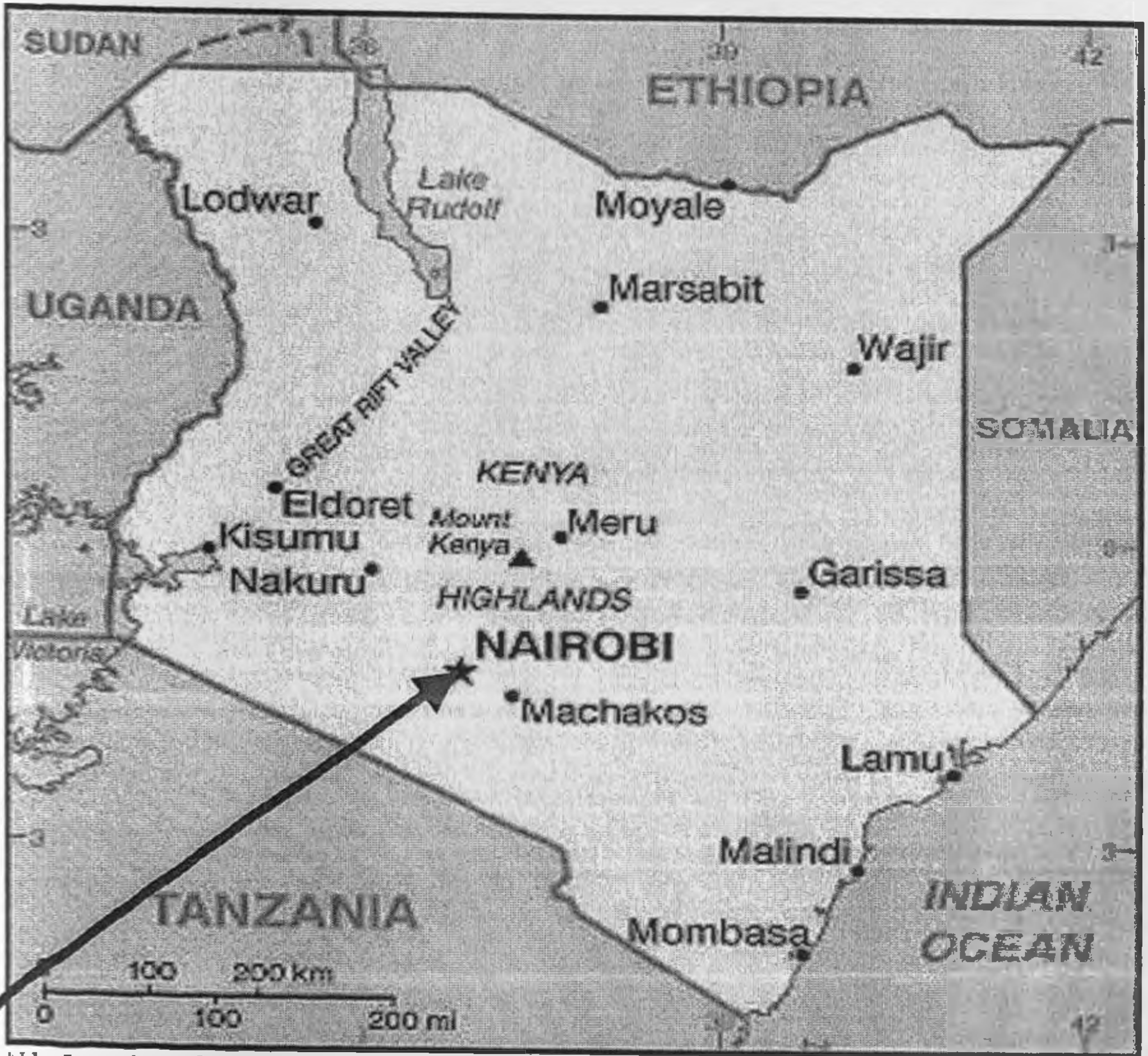
-Other services

Interview Guide

1. Where do you stay in Nairobi? ___________________________
2. How old are you? ___________________________
3. What is the highest level of education completed? __________________
4. What is your religion? ________________________________
5. Are you married?
6. When did you start suffering from this disease?
7. What steps did you take to solve the problem?
8. Which health facilities did you visit?
9. What was your experience in each of them?
10. Did you get well?
11. How did you come to know about this traditional healer?
12. What made you chose to come to a Traditional Healer and not a Medical Doctor?
13. How many times have you used his services?
14. Since you started consulting this traditional healer, how is your situation?

Thank you very much for agreeing to be interviewed by me

Appendix II: The Map of Kenya



N.b. Location of the study site

Source: http://www.lonelyplanet.com/destinations/africa/nairobi

Appendix III: Materials used to construct houses in Kibera

Courtesy of Nembrini, G.P, 2002: Picture 2: A close look of Kibera Slum and the congestion problem, which has an impact on health status of the residents.