SELF-CARE HEALTH SEEKING BEHAVIOUR OF THE PIAVE COMMUNITY IN NAKURU DISTRICT, KENYA

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Submitted in accordance with the requirements for the degree of

DOCTOR OF LITERATURE AND PHILOSOPHY

in the subject of

HEALTH STUDIES

at the

UNIVERSITY OF SOUTH AFRICA

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JULY 2010

DECLARATION

I declare that **SELF-CARE HEALTH SEEKING BEHAVIOUR OF THE PIAVE COMMUNITY IN NAKURU DISTRICT, KENYA** is my work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

Signature:_____   Date: 5th March 2010

Consolata Wambui Mureithi

DEDICATION

To my dad, Duncan Wanjohi Wambugu, you laid the foundation for my academic work by constantly supporting me and encouraging me to carry on no matter what. Dad, I dedicate this thesis to you. Rest in peace.

ACKNOWLEDGEMENT

CHAPTER 1

Orientation to the study

COUNTRY OF STUDY: REPUBLIC OF KENYA

Figure 1.1   Map of Kenya with the Nakuru district indicated with an arrow
Source: http://www.internatonalministries.org/read/12585

This study took place at Piave in the Njoro division, Nakuru district

1.1   INTRODUCTION

The study is about exploring and describing the self-care health seeking behaviours of the Piave community in the Njoro division in Kenya and developing a guide which could serve as a leverage point to integrate self-care health-seeking behaviours with professional health care. This is in keeping with the ideals of Leininger who regards community health care as culture congruent care; meaning care that fits with the general values, beliefs, and lifeways of clients for beneficial and satisfying health care (Leininger 2001:46). She advocates a combination of generic care with professional care, both blending into the desired integrated care (Leininger & McFarland 2002:150).

Generic care refers to the oldest or first folk, lay, naturalistic, and traditional cultural ways of assisting, helping, facilitating the healing or curing process of human beings (Leininger & McFarland 2002:147). The two authors explain further that different groups of people have their local or emic (insiders') views and knowledge about their culture that are extremely important for health care professionals to discover and understand for meaningful care practice. They point out that emic ideas and beliefs are often regarded as *secrets* and may not be willingly shared with cultural strangers such as nurses and doctors (Leininger & McFarland 2002:48). The self-care health seeking behaviours of the Piave people is within generic care as its operational definition is the treatment prescribed by self or rather self-medication. Informal care given by significant others in the family to siblings or other members of the family also falls under self-care health-seeking behaviours. Included also in this group is the care sought from the informal sector, for instance, pharmacists, drug vendors and traditional healers such as divine healers, herbalists and witchdoctors.

The current health care reform in Kenya, the National Health Strategic Sector Plan II (NHSSP 11) advocates that communities take active participation in their health care. This notion has been the main agenda in health care reforms in many countries (African Health Strategy 2007-2015; Barry, Diarra-Nama, Kirigia, Bakeera & Somanje 2009:25-32; Cavagnero 2008:88-99; Sekwat 2003:67-78; Gilson & Mills 1995:251-243). NHSSP 11 addresses two aspects of community involvement, health-related matters and community development, both leading directly and/or indirectly to a healthy community (NHSSP 11 2005-2010). According to the reforms, individual households and communities at large are regarded as consumers of health care

(NHSSP 11 2005-2010:xi) and are supposed to participate in the management of their own health. This calls for a wellness-based approach rather than disease-oriented approach so that the focus of attention is health maintenance and promotion for all community members regardless of their status quo within their respective communities. Individuals, families and communities should, therefore, be empowered to plan and implement health care activities related to their identified needs and problems. Health systems should as a result expand beyond the bounds of hospitals, clinics, traditional public health facilities and consider all other avenues that contribute to people's health. More details on NHSSP 11 are given later on in this chapter.

1.2 BACKGROUND TO THE PROBLEM

1.2.1 Description of Kenya's health system

The health sector comprises the Ministry of Health (MoH), with other major players being parastatal organisations and the private sector. The private sector health facilities include private for-profit, non-governmental organisations (NGOs), and faith-based organisations (FBOs).

Health services are provided through a network of over 4700 health facilities countrywide, with the public sector system accounting for about 51% of these facilities. Distribution of government health facilities is indicated in table 1.1 below:

Table 1.1 Distribution of government health facilities by province in Kenya

FACILITY NAME	CENTRAL	COAST	EASTERN	NAIROBI	N/EASTERN	NYANZA	R/VALLEY	WESTERN	TOTAL
Dispensaries	205	144	325	18	43	180	540	81	1,536
Health Centres	57	33	58	8	6	80	136	62	440
District Hospitals	12	11	26	1	10	24	21	13	128
Provincial Hospitals	1	1	2	-	1	1	1	1	8
National & Specialised Hospital	1	-	-	2	-	-	-	-	3
Rural Health Training and Demonstration Centres	1	15	7	-	5	6	12	7	53
Total Facilities	**227**	**204**	**418**	**29**	**65**	**291**	**710**	**164**	**2,158**
Facilities %	12.8	9.5	19.4	1.3	3.0	13.5	32.9	7.6	100.0
Population	**3,918,538**	**2,860,649**	**5,180,139**	**2,656,997**	**1,235,592**	**4,868,010**	**8,077,517**	**3,954,081**	**32,751,523**
Population per facility	14,095	14,022	12,393	91,620	19,009	16,728	11,376	23,964	15,176
Facilities per 100,000 population	**7.0**	**7.0**	**8.0**	**1.0**	**5.0**	**6.0**	**9.0**	**4.0**	**7.0**

Government of Kenya, Human resource mapping and verification exercise (2005)

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As can be inferred from the distribution of health facilities in table 1.1 above, the number of big hospitals available is very low. There are only eight provincial hospitals and three national and specialised hospitals. This causes a lot of congestion because of high demand from the big population served. It is very common to find patients sharing beds while others are sleeping on the floor.

Table 1.2 below shows the number of registered health professionals (HP) in Kenya from 2003 to 2006.

Table 1.2   Number of health professionals registered from 2003 to 2006

Personnel	2003 No of HP	No of HP	2004 No of HP	No of HP	2005 No. of HP	No of HP	2006 No of HP.	No of HP
Doctors	4,813	15	5,016	16	5,446	15	5,889	16
Dentists	772	3	814	3	871	3	898	2
Pharmacists	1,881	6	2,570	8	2,637	7	2,697	7
Pharmacists & Pharmacy Technologists	1,405	4	1,620	5	1,656	5	1,680	5
Bachelor of Science in Nursing (BScN)	-	-	280	1	367	1	429	1
Diploma Nurses (RN)	9,869	33	10,210	32	10,657	30	10,905	30
Enrolled Nurses	30,212	100	30,562	96	31,895	90	31,917	88
Clinical Officers	4,804	16	4,953	16	5,059	14	5,285	15
Public Health Officers	1,216	4	1,314	4	1,388	4	1,457	4
Public Health Technicians	5,627	19	5,861	18	5,938	17	5,969	17
Total	60,509	192	63,227	198	65,914	186	67,126	186

Source: Health Management Information System, Ministry of Health (2007)

As can be inferred from table 1.2 above, the number of health professionals is too small compared with Kenya's population estimated to be 36.1 million in 2007 (Kenya population guide 2007). Since independence in 1963, Kenya has effortlessly tried to improve the health status of its people as reflected in various government policy documents such as sessional papers and development plans. In spite of the efforts made, by 1980 there was virtually no change in the living standards of the Kenyan people and the welfare of the citizens had declined (National Development Plan 1997 to 2001:1). This decline continued with the economy showing a negative growth of 0.3% in the year 2000. In addition to the declining trend in economic growth, the economy has been characterised by poverty, unemployment, and widening income inequalities

(National Development Plan 1999:23). A recent economic survey indicates that the poverty level is still very high; 16.5 million of the 36.1 million population live below the poverty line surviving on less than a dollar per day (*Daily Nation*: April 27, 2007:1).

Recognising that good health is both a basic right and a prerequisite for rapid socio-economic development and that a healthy population is a basic requirement for successful industrialisation, the government of Kenya invested heavily both in expansion of health personnel and infrastructure. The health reform agenda was thus initiated as an alternative strategy for improving the health sector systems.

1.2.1.1 Kenya Health Policy Framework (KHPF) of 1994

The Kenya Health Policy Framework (1994-2010) is a document based on how to deliver health services to the Kenyan population for the next 16 years. The overall goal of the policy is to promote and improve the health of all Kenyans through a deliberate restructuring of the health sector to make health services more effective, accessible and affordable (KHPF 1994-2010:27). Some of the critical problems addressed by the policy were the capacity of the public health care systems to meet the health needs of the people and laws to accommodate changes emanating from the health reform agenda (KHPF 1994:2). It was later established that despite the institutional arrangement in place arising from Kenya's Health Policy Framework, implementation of what was stated in the policy was slow. Poor health still prevailed and many Kenyans lacked access to basic health care, safe drinking water, proper sanitation, and adequate nutrition. Diseases that were treatable and could be prevented were still persistent (NHSSP 1:1999-2004:ix). As a result the NSSP1 was instituted.

1.2.1.2 The National Health Sector Strategic Plan (NHSSP 1) 1, 1999-2004

The NHSSP 1, 1999-2004 was designed to address the downward trend of the health status of Kenyan citizens. Some of the objectives of the plan were to reduce disparities in health resources; enhance the regulatory role of the government in all aspects of health care provision; create an enabling environment for increased private sector and community involvement in health service provision and finance; and increase and diversify per capita financial flows to the health sector (NHSSP 1, 1999-2004:ix). This plan failed as well; there was a downward trend – an increase in infant, under-five and

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maternal mortality rates as indicated in Table 1.3. The poverty level also increased from 47% in 1999 to 56% in 2002 respectively (NHSSP 11, 2005-2010:2).

Table 1.3   Infant, under-five (per 1000 life births) and maternal mortality (per 100 000 life births) rates

	Infant mortality rates per 1000 live births	Under five mortality rate per 1000 live births	Maternal mortality rates per 100 000 live births
1993	Infant mortality rate 64		
1998	Infant mortality rate 72		Maternal mortality rate, 590
2000	Infant mortality rate 74		
2002			Maternal mortality rate, 414
2003	Infant mortality rate 77	Under five mortality rate, 115	
2005	Infant mortality rate 79	Under five mortality rate, 120 X	Maternal mortality rate, 1000 X

Source: MoH (2006:2) and the data with x is derived from Africa development indicators (2007)

The downward trend is noted in infant mortality rates which were 64, 72, 74, 77 and 79 in 1993, 1998, 2000, 2003 and 2005 respectively; under five mortality rates which were 115 and 120 in 2003 and 2005 respectively and the maternal mortality rate from 590 in 1998 to 414 (slightly improved) in 2002 and 1000 in 2005.

As a result of the failure, the National Health Sector Strategic Plan 11 (NHSSP 11, 2005-2010) was initiated by the MoH after wide consultations with stakeholders from both public and private sectors.

1.2.1.3   *The National Health Sector Strategic Plan 11: 2005-2010*

NHSSP 11 is aimed at reducing inequalities in health care and reversing the downward trend in health-related impact and outcome indicators (NHSSP 11, 2005-2010:1). It places a lot of emphasis on the importance of the achievement of Millennium Development Goals. In her speech at the launching of the Strategic Plan, the minister for health underscored the commitment of the MoH in providing accessible and quality care to all Kenyans. She said that it was imperative to revitalise the health sector through improving service delivery, ensuring community participation and enhancing cooperation, collaboration and teamwork among the various departments (NHSSP 11, 2005-2010:iii).

NHSSP 11 moves from the burden of diseases to the promotion of the health of individuals and communities. A gradual but steady shift is taking place from emphasis on hospital-based care which is usually focused on very expensive technology, towards a focus on community health care-led services. However, community health care should be achieved without the neglect of the acute care services. The health reform is, therefore, changing the health care delivery system from disease-oriented to people-centred with a focus on positive health as a part of human development. It has put at its centre stage the Kenya Essential Package for Health (KEPH). The KEPH is a package that groups people together according to their life cycles: namely, pregnancy, delivery and newborn child (up to two weeks of age); early childhood (three weeks to five years); late childhood (six to twelve years); adolescence (thirteen to twenty-four years); adults (twenty-five to fifty-nine years); and elderly (sixty years and over). The NHSSP 11 recognises that each group has its unique health problems that need to be addressed in a professional manner. For the KEPH to work, an appropriate mix of inputs, human resources, infrastructure and commodities will have to be realised through integration of all health programmes into a single package. The emphasis of the package is to improve the health of the population across the lifespan.

The NHSSP 11 is composed of six health service delivery levels as indicated in table 1.4 below:

Table 1.4   Levels of health care facilities

Level 6	Tertiary or referral hospitals. Same functions as level 5 below but deal with complicated disease conditions level 5 is not able to treat. Training of health care professionals at undergraduate and postgraduate degree levels is done at this level. It also serves as an internship centre for health care professionals and research especially clinical research.
Level 5	Secondary or provincial hospitals. This level has a bigger coverage of specialised referral curative services. Training for nurses and paramedics is conducted at this level. It also serves as an internship facility for health care professionals.
Level 4	Primary or district and sub-district hospitals. Primarily deal with curative and rehabilitative activities. To a limited extent, also address preventive and promotive services. Handle fewer complicated disease conditions than level 5 and 6 above. Act as a referral facility for level 3
Level 3	This level provides all the services specified in level 2. In addition, it provides outpatient care which is largely limited to minor surgery on an outpatient basis; limited emergency inpatient services and emergency inpatient awaiting referral, 12 hour observation; limited oral health services; individual health education; specific laboratory tests (routine laboratory including malaria; smear tests for tuberculosis); and HIV testing. Other activities offered at this level provide logistic support to level 2 facilities.

Level 2	This is regarded as an interface between the community and other health facilities. Its work is to organise and coordinate structured permanent dialogue and interaction with the population at the community level while at the same time ensuring provision of curative, rehabilitative, preventive and promotive care. It predominantly deals with promotive and preventive services and also less complicated curative services. Health facilities here are dispensaries and clinics.
Level 1	*Community level: The health care supposed to be given at this level is for community members who are in this research being studied for their self-care health seeking behaviours. The health care strategy will therefore be explained in more details.*

Source: NHSSP 11 (2005-2010:17)

Level 1: Community level

Level 1 is regarded as the foundation of the service delivery priorities. The NHSSP 11 strategies take health care to the community by mobilising people toward their active and dynamic involvement in planning and implementing the interventions that contribute to their own health and socio-economic development. This is likely to release them from the vicious cycle of poverty and ill health (MoH 2006:6). In his address, Dr Nyikal, Director of Medical Services (MoH 2006:i), pointed out that the implementation of health services at the community level is the top priority of the MoH and sector partners. Communities must play a big role in determining their own health today and in the future. They are, therefore, expected to produce their local vision of a healthy society.

The main services at this level are promotive and preventive chiefly provided by the Community's Own Resource Persons (CORPs). CORPs will be supervised by Community Health Extension Workers (CHEWs). The latter group is derived from Kenya Enrolled Community Health Nurses (KECHN) and Public Health Technicians (PHT) with clinical, coaching and supervisory skills. Village Health Committees (VHCs) will be organised in each community to act as avenues where households and individuals can participate and contribute to their own health including that of their people (NHSSP 11, 2005-2010:17). Tables 1.5 and 1.6 below indicate the functions of CORPS and CHEWS respectively as specified by NHSSP 11, Norms and standards (2006:24-30).

Table 1.5   Functions of CORPs

Area of activity	Interventions
Control of communicable diseases	*Malaria*: appropriate referral and health education *Leprosy*: Act as a Daily Observed Treatment (DOT) focal point
Sexual and reproductive health rights	***Care during labour and delivery***: ensure referral systems in place ***Postnatal care***: encouraging breast-feeding & other infant feeding choices ***Family planning services***: Health promotion and family planning including provision of condoms and pills ***Adolescent reproductive health***: Provision of integrated reproductive health services (FP, STI/HIV/AIDS) that involve counselling, prevention and treatment, antenatal care, administration of tetanus toxoid, etc. ***Gender-based violence and reproductive rights***: Management of survivors of gender-based violence (emergency contraception, post exposure prophylaxis, counselling and referral)
Public health	***Environmental health***: Promotion of hygiene practices in households, institutions and public places and control of mosquito breeding sites and other vectors ***Epidemic management***: Ensure provision of adequate logistic supplies to management of epidemics and disasters, and provision of reports to local administrative officials on prevailing local health problems ***Intervention against diseases targeted for eradication***: Health education for prevention and control of targeted diseases and community mobilisation for preventive measures
Mental health	Follow-up treatment of identified mental health patients in the community and give health education and raise awareness on mental health in the community
Clinical work	**Care of injuries and other common conditions including non-communicable diseases**: Treatment of common diseases (communicable and non-communicable) following standard treatment guidelines Health education on common diseases, injuries in the community and appropriate referral where indicated
Administration	Provision of reports to local administrative officials on prevailing local health problems

Table 1.6   Functions of CHEWS

Support integrated outreaches on monthly basis	***Epidemic and disaster prevention, preparedness and response***: Timely recording of records summary to higher levels and ensuring that surveillance systems are in place
Improving nutrition	Establish demonstration gardens Do demonstration on preparation of nutritious meals
Referral	Oral health
Administrative work	Coordination and supervision support, reporting and monitoring of health programmes

As can be inferred from tables 1.5.and 1.6 above, CORPs are involved in carrying out most of the work at this level while CHEWS do supervisory work. This is because the level is supposed to be manned by 50 CORPs and two CHEWS for each 5000 people, making a ration of 1:25. There are no existing physical structures at the moment. Equipment and commodities are supposed to be provided by the MoH to support CORPs and CHEWs in their activities (NHSSP 11, 2005-2010:14).

The emphasis of level 1 health strategies for implementation is more on information, education and communication (IEC) and prevention strategies; CORPs is the main group conducting these activities. The strategies directed towards each group as defined by KEHP are as follows:

Pregnancy, delivery and new born (first two weeks of life)
Providing IEC on practice and positive attitudes on safe pregnancy and delivery of healthy newborns among pregnant women and the community at large; promoting safe delivery through monitoring of pregnancy; advocating for exclusive breast feeding; and establishing timely referrals.

Early childhood (two weeks to five years)
Promotion of community level integrated management of childhood illnesses; de-worming; disseminating key early child development (ECD) health messages and monitoring their growth and development; supporting nutrition awareness especially among orphans and vulnerable children (OVC); promoting food and nutrition security; promoting gender responsive school health activities; training teachers and orienting parents in school health services; and promoting a child-to-child approach to healthy lifestyles.

Adolescence and youth (13–24 years)
Equipping youth (in and out of school) with knowledge and skills in life skills such as family life education; facilitating a supportive environment to enhance adoption of healthy lifestyle for themselves and the community at large; initiating comprehensive community-based youth-friendly centres in collaboration with other arms of government, NGOs and other related organisations; and raising awareness on disease causation, control and prevention in particular STI/HIV/AIDS.

Adults (25–59 years)
Conducting community directly observed treatment, short course activities and defaulter tracing on tuberculosis patients; raising awareness of non-communicable disease control; caring for chronically ill; empowering adults with knowledge and skills for health and key health messages; promoting adoption of healthy lifestyle and care-seeking behaviours; assisting with ensuring household food security; and promoting participation in actions for health.

Elderly persons (over 60 years)

Empowering elderly persons, community and health professionals with relevant knowledge about common old-age diseases, impairments and disabilities; giving IEC on how to improve quality of life and sources of care; advocating for the development of social support systems for the elderly; and advocating the developing community home-based care for elderly persons with chronic illnesses.

To be able to implement the recommended services, a number of results are expected such as development and implementation of guidelines including the training manual and consolidation of information, education and education materials; definition and packaging of CORPs kits; countrywide dissemination of community strategy; training trainers from the District Health Management Teams and Public Health Management Teams; training of 5000 CORPs and village health committees out of which 30% will be women; retraining 200 health extension workers from the existing cadres of health workers; and development of service charter and capacity building of communities to know their rights and make them accountable for their health care as well as that of the community within their catchment area (NHSSP 11: Annual operational plan 2, 2006/07:18).

1.2.2 Declarations for improving health care

Added to health reforms agendas are declarations made to improve the health care of citizens.

1.2.2.1 *Alma-Ata Declaration*

The Alma-Ata Declaration expressed the need for urgent action by all government, all health development workers, and the world community to protect and promote the health of all the people of the world. The declaration also emphasised the rights of people to participate individually and collectively in the planning and implementation of their health care. It stated that governments are responsible for the health of their citizens which can only be met through provision of adequate health and social measures (Alma-Ata Declaration 1978).

1.2.2.2   The Bamako Initiative

The Bamako Initiative was adopted by African Health Ministers in 1987. The main agenda was on community participation in the financing of health services. (Health System Resource guide 2006:1). A decade later, research initiatives conducted in Kenya , Mali, Uganda, and later in Burkina Faso, indicated that the policy had done very little to improve or increase access to health care among the most deprived and excluded vulnerable population. It only served to marginalise certain population groups already vulnerable owing to emphasis on financial sustainability and viability of health care organisations. Exemption mechanisms for alleviating the burden of payment and financial barriers for the poorest were not socially advocated.

1.2.2.3   Millennium Development Goals (MDGs)

The current emphasis now is meeting the MDGs. They were drawn from the actions and targets contained in the Millennium Declaration adopted by 189 nations and signed by 147 heads of state and governments during the United Nations Millennium Summit in September 2000 (UN MDGs 1989).

The goals advocate a more holistic approach which encompasses nearly all facets of what it takes to ensure a healthy population regardless of one's economic status. This is well summarised by the words of the United National Secretary General who asserted:

> We will have to reach the Millennium Development Goals – worldwide and in most, or even all, individual countries – but only if we break with business as usual. We cannot win overnight. Success will require sustained actions across the entire decade between now and the deadline … (UN MDGs 1989).

The MDGs are as follows: eradicate poverty and hunger; achieve universal primary education; promote gender equality and empower women; reduce child mortality (directly health related); improve maternal health (directly health related); combat HIV/AIDS, and malaria and other diseases (directly health related); ensure environmental sustainability; and develop a global partnership for development (UN MDGs 1989). All the goals are interrelated and although only three of them are directly

related to health, the others are integral to health and cannot be separated from it. There is no health without holistic development of the community and nations at large. A report from the United Nations (2009) indicates that the goals are not being met effectively. The progress towards the goals is now threatened by sluggish and negative economic growth, diminished resources, fewer trade opportunities for the developing countries, and possible reductions in aid flows from donor nations.

Apparently, not a single reform or declarations document has mentioned the importance of finding out the self-care health seeking behaviours of the community people since this could be one of the contributing failures to the success of the reforms and declarations. It is estimated that between 80 to 85% of the population of Sub-Saharan Africa receives its health education and health care from practitioners of traditional medicine (WHO 2002-2005). In the same tune, Ampofo and Johnson-Romauld (1978) point out that traditional medicine is thriving in Africa where it is estimated that 75% of the population use this approach. The use of traditional medicine is recommended especially in developing countries (Akerele 1987:117-181; Pillsbury 1979). This is because the formal health sector is unable to deal with the heavy burden of mortality and morbidity. Most of the causes of mortality and morbidity are conditions that can be prevented through promotive and preventive care. Pillsbury (1979) argues that if the majority of people in the rural areas are to be reached by health care systems, efforts have to be made to use the local resources. She points out that some people in the developing countries hardly utilise the formal facilities because they are suspicious of Western medicine for the reason that it does not tolerate local beliefs and behaviours related to health matters.

Leininger and McFarland (2002:48) explain that cultures have their emic views and knowledge about these views are extremely important for meaningful care practices. Tjale (2004:1) further asserts that the need to be well conversant with cultural differences is imperative as the patient's view of physical and mental health is usually informed by cultural beliefs and values. Benjamin and Spacek (2001:4) commenting on the same issue point out that when culture is not considered as a dominant feature in the care of individuals, families or communities at large, the situation can negatively impact on the compliance of the formal treatment. Therefore, health professionals need to understand the customs and belief systems of the communities they serve.

Studies done in the past based on health seeking behaviours of the local communities catered for specific conditions such as malaria, tuberculosis and sexually transmitted diseases among many others (Malik, Hanafi, Ali, Sali & Mohamed 2006:60; Liefooghe, Baliddawa, Kipruto, Vermeire & De Munynck 1997:809). The researcher has therefore found it necessary to investigate the self-care health seeking behaviours of an identified community, with the intention of gaining a good picture of the community's self-care health seeking behaviours. It is hoped that the health professionals will subsequently consider the identified behaviours while planning the delivery of health care in their respective areas of operations by deciding which self-care health seeking behaviours to discourage, reshape, accommodate or maintain within their health care delivery functions. This will advance the ideals of the current health strategic plan whose vision is to have an 'efficient, high quality care system that is accessible, equitable and affordable to every Kenyan household' (National Health Strategic Sector Plan 11, 2005-2010:xi).

1.2.3 Studies in health seeking behaviours

Dunnel and Cartwright (1972) in Helman (2000:69), report on a study done in the United Kingdom which established that self-prescribed medication was twice as common as the use of prescribed medicines. It was used as an alternative to consulting the doctor who was expected to deal with more serious cases. A study on 'barriers and bridges to care: voices of homeless female adolescent youth in Seattle, Washington, USA' demonstrated that women seek health advice from other women, including their mothers. They first try self-care interventions and only go to clinics when it has failed (Liefooghe et al 1997).

Ngo, Ratliff, McCurdy, Ross, Markham and Pham (2007:878-887) did a qualitative study to explore health-seeking behaviour for sexually transmitted infections (STIs) and HIV testing among female sex workers in Vietnam. Results indicated that women's decisions to seek STI treatment and HIV testing were influenced by the complex interplay of personal risk perceptions, social relationships and community discourse. They demonstrated high-risk perceptions of HIV testing but showed little concern for STIs. Most women sought treatment at pharmacies when they noticed symptoms of the genital tract.

Some studies done in Africa have shown various approaches to health-seeking behaviours. A study done in Zambia indicated that the majority of the participants believed that when a child was sick, the practice was to use traditional treatment before looking for professional help. A traditional healer could take three to four days before contacting a community health worker (Kaona & Tuba 2004). The researchers pointed out that improvement in early referral and appropriate care would only occur when traditional healers were integrated into primary health care and hospital-based systems.

Mesfin, Newell, Walley, Gessessew and Madeley (2009:53) conducted a study among pulmonary tuberculosis patients in Ethiopia and found that prior to their first consultation at a public health facility, they received treatment from a variety of informal sources: the Orthodox Church, where they were treated with holy water (24%); private practitioners (13%); rural drug vendors (7%); and traditional healers (3%). The overall median patient delay was 30 days (mean = 60 days).

Kamatenesi and Oryem (2007:1-9) conducted a study on traditional medicine among a rural Ugandan population and found that for day-to-day health care needs, the usage was close to 90%. Women and children formed the bulk of the people dependent on herbal medicine.

Sumba, Wong, Kanzaria, Johnson and John. (2008:245) did a study on malarial treatment in Kenya and results indicated that the most frequent initial sources of treatment for malaria in adults and children were medical facilities (66.0% and 66.7%) and local shops (19.0% and 30.3%) respectively.

Njoroge and Bushmann (2007:303-307) conducted a study in Central Province, Kenya on the use of traditional remedies in managing various skin conditions and found that 57 plant species in 31 families were identified as regularly utilised.

All the above studies testify to the popularity of the use of informal types of treatment. It is, therefore, pertinent to acquire adequate knowledge on self-care health seeking behaviours if culturally congruent health care to any given community has to be realised.

1.3   STATEMENT OF THE RESEARCH PROBLEM

One of the key innovations of NHSSP 11 has been the recognition and introduction of Level 1 health care services aimed at empowering Kenyan households and communities to take charge of improving their own health (MoH 2006:i). The community-based approach as set in the National Health Strategic Sector Plan 11 is said to lay down mechanisms in which individuals, families and communities will play active roles in health and community development initiatives. They are hence expected to produce their local vision of a healthy society (MoH 2006:i). CORPs and CHEWs will be the main health-care providers working with communities with the aim of assisting them to realise their health care vision (Norms and Standards 2006:24-30).

One of the researcher's assumptions is that to effectively bring the community members into playing active roles in health and community development initiatives, understanding of self-care health seeking behaviours could play a big role in this regard. Hopefully, through the research findings, health professionals working in Piave will have deeper understanding of the self-care health seeking behaviours practiced by the community that could lead to less utilisation of health services and community's participation in delivery of their health care most likely leading to poor health.

Currently, Level 1 health care services are not yet implemented within Piave community. The findings of this research could reveal cultural knowledge related to health practices and therefore assist with implementation of Level 1 health services. With the review of the literature and study results, a journey towards an understanding of how community and health professionals can effectively work together to achieve health care for the targeted community will be explored. It is the researcher's belief that though the debate on self-care health seeking behaviours is largely stagnant at present, it is possible to make progress by turning the self-care health seeking behaviours into something more dynamic, useful and applicable in the development of health systems. Hopefully, this study will be a breakthrough in adopting culturally congruent care in Kenya. The study question is, therefore: What are the self-care health seeking behaviours of the Piave community in the Njoro division, Nakuru district?

1.4 THE DOMAIN OF INQUIRY AND PURPOSE OF THE STUDY

The Domain of inquiry and the purpose of the study

The domain of inquiry was the emic (insider) cultural expressions of self-care health seeking behaviours of the Piave community in Njoro division, Kenya.

The purpose of the study was to explore and describe the self-care health seeking behaviours of the Piave community in Njoro division, Kenya and to develop a guide (guidelines) which could serve as a leverage point to integrate self-care health seeking behaviours with professional health care.

1.5 RESEARCH QUESTIONS

The research questions for this study were:

1. What are the self-care health seeking behaviours of the Piave community?
2. How can the community's self-care health seeking behaviours and professional health care as delivered by health professionals be integrated to deliver more culturally congruent care?

1.6 SIGNIFICANCE OF THE STUDY

It is at the individual, family and community levels that self-care health seeking behaviours, health service utilisation, risk perception, decision-making and family expenditures for health are likely to be made or changed. Therefore, the self-care health seeking behaviours of individuals, families and communities at large are likely to influence the nature of the health care delivery processes and subsequently affect the delivery of developed health-care operational plans of the MoH in Kenya positively or negatively.

The study findings will inform the MoH and related stakeholders, the self-care health seeking behaviours of the Piave community. Subsequently, the stakeholders the main ones being health professionals and community members, will be in a better position to discuss the best ways to integrate both generic and professional care through the

use of three theoretical modes of care actions and decisions described by Leininger and McFarland (2002:570) as follows:

Care maintenance and/or preservation: what needs to be preserved and maintained within administrative organisations or consultation work? A good example here would preserve the practice of community members visiting the sick and praying for them.

Care accommodation and/or negotiation: what needs to be accommodated or negotiated in administration or consultation? Discussion with the community, for example, the importance of going to a health facility for treatment early enough before the sickness becomes worse.

Care restructuring or repatterning: what needs to be re-organised, repatterned or restructured to make changes? A good example is finding out alternative ways of initiating girls into adulthood instead of practising female genital mutilation.

The researcher's reckoning is that this will be a good starting point for collaborative health care planning and implementation between the community, MoH and other stakeholders, aiming at coming up with "*Desired Attributes for Integrative Care*"; a combination of formal and informal care (Leininger & McFarland 2002:150). The study results can, therefore, be used as a basis for health care planning and policy formulation within the identified community and the same results, with some modification, are likely to be used in other community settings in Kenya.

1.7   DEFINITION OF CONCEPTS

1.7.1 Health

Health is 'the state of complete physical, mental and social well-being and not merely absence of disease or disability' (WHO 1988). According to Leininger and McFarland (2002:84), health is said to refer to a state of well-being or a restorative situation that is culturally constituted, defined, valued, and practised by individuals or groups that enables them to function in their daily lives. Basavanthappa (2008) defines health at the community level as the state of well-being of the community. At this level, health

refers to various objective measures of health, health status or indices like incidence of prevalence of disease in relation to different segments of the population.

1.7.2 Illness

Illness is an unhealthy condition or an abnormal process in which aspects of the social, physical, emotional, or intellectual condition and function of a person are diminished or impaired compared with that of the person's previous condition (Mosby's Medical Dictionary 2009). The Collins English Dictionary (2006) defines illness in almost the same way as a disease or indisposition or a state of ill health.

1.7.3 Behaviour

Dorland's Medical Dictionary for Health Consumers (2007) defines 'behaviour' as deportment or conduct; any or all of a person's total activity especially that which is externally observable. Using almost the same definition, Mosby's Medical Dictionary (2009) defines behaviour as all of the activities of a person, including physical actions which are observed directly and mental activities which are inferred and interpreted. Kinds of behaviour according to Mosby's Dictionary include abnormal, automatic, invariable and variable.

1.7.4 Health seeking behaviour

Health seeking behaviours are personal actions to promote optimal wellness, recovery, and rehabilitation (Mosby's Medical Dictionary 2009).

1.7.5 Care

According to the Collins English Dictionary (2006) 'care' is to like to do something while 'care for' is to look after or provide for. The Oxford Dictionary (2000) defines it as a process of providing to people what they need for their health or protection.

1.7.6 Self-care

According to Mosby's Medical Dictionary (2009), self-care is the personal and medical care performed by the patient, usually in collaboration with and after instruction by a health care professional. Another definition given by the same dictionary is health care by laypeople of their families, their friends, and themselves, including identification and evaluation of symptoms, medication, and treatment. The dictionary further elaborates that self-care is self-limited, voluntary, and wholly outside professional health care systems but may include consultation with a physician or other health care provider as a resource.

1.7.7 Informal health care: orientational definition

Informal health care is the care sought from other channels of health care delivery systems such as traditional healers apart from formal health care facilities where the health care is given by health care professionals or other trained health professionals such as community health workers.

1.7.8 Self-care health seeking behaviours: orientational definition

In this research, the researcher's operational definition of self-care health seeking behaviours is treatment prescribed by self or rather self-medication. Informal care given by significant others in the family to siblings or other members of the family also falls under self-care health seeking behaviours. Included also in this group is the care sought from the informal sector, for instance, pharmacists, drug vendors and traditional healers such as divine healers, herbalists and witchdoctors. The informal health care is, therefore, being used in this study to mean self-care health seeking behaviours.

1.7.9   Community

A community is a collection of people who interact with one another and whose common interest or characteristic form the basis for a sense of unity or belonging (Allender and Spradley 2005:6).

1.7.10   Community development

Community development is the processes of helping a community strengthen itself and develop towards its full potential (SIL International 2010). According to Wilkinson (1991:8) community development is purposely directed towards altering local conditions in a positive manner. When specific projects are followed with an emphasis on building social relationships and communication networks, community development has ensued. Community and community development are based on the assumption that they add to the social well-being and the self-actualisation of community members. Community is improved when residents work together to address common issues (Wilkinson 1991:8).

1.7.11   Community health workers

In general, community health workers are community members that act as agents of health promotion and development. They provide local health services and links between communities and formal health services. Included in this group in Kenya are:

1.7.11.1 *Community health extension workers (CHEWs)*

CHEWs are public health technicians and enrolled community health nurses recruited and paid by the health system and working through the Corps. They supervise the work done by CORPs and also carry out some of the activities that are not within the scope of CORPS (MoH 2006:4).

1.7.11.2 *CORPs*

CORPs are a community's own resource persons who work as volunteers within their respective neighbourhood. They are trained by trainers within the health systems (registered nurses and public health officers) for a period of two to six weeks and progressively go on short-term training depending on the needs of the community they serve (MoH 2006:4).

1.7.11.3 Health professionals: orientational definition

All the health care providers who have undergone a specified period of training and are registered or enrolled by their respective statutory bodies.

1.7.11.4 Traditional healers

Traditional healers are persons recognised by the community in which they live as competent to provide health care by using vegetables, animals, mineral substances and certain other methods based on the social, cultural, and religious background as well as on knowledge, attitudes, and beliefs that are prevalent in the community regarding physical, mental and social well-being and the causation of disease and disability (Ampofo & Johnson-Ramauld 1987:39).

1.7.11.5 Herbalists

Herbalists are traditional healers who employ a variety of tonics, herbal treatments and dietary regulations to try to maintain balance (Kirkland, Mathews, Sullivan & Baldne 1992:73).

1.7.11.6 Pharmacists

Pharmacists are people qualified to prepare and dispense drugs (Collins English Dictionary 2006).

1.8 FOUNDATION OF THE STUDY

The study is based on the following assumptions and is guided by Leininger's theory of Culture Care Diversity and Universality (Leininger & McFarland 2006:2).

1.8.1 Assumptions

Assumptions are statements based on logic or reason, accepted as true without proof (Polit & Beck 2008:748). Assumptions for this study are derived from the meta-theory of science, anti-positivism, and relate to naturalism and interpretivism. Philosophical

assumptions refer to the role of the value in the inquiry (Polit & Beck 2008:13; Guba & Lincoln 1985:38). The following theoretical-conceptual, methodological-technical and ontological assumptions were posited for this study.

Theoretical-conceptual assumptions

Theoretical-conceptual assumptions pertain to the truth of the theories and laws of a particular paradigm (Mouton & Marais 1994:147). Epistemologically, the naturalistic paradigm assumes that knowledge is more valid when the distance between the researcher and respondents is minimised. This is because the researcher has to try to capture the emic (insiders' view) and subjective experiences of informants. It is assumed that

- the naturalistic inquiry sets the stage for exploring self-care health seeking behaviours as they are created by a specific community
- the voices and interpretation of the members of a specific community are crucial to the understanding of their self-care health behaviours

Methodological-technical assumptions

Methodological-technical assumptions refer to the criteria, methods and instrumentation used to realise that which is scientific and valid (Mouton & Marais 1994:147). In this regard it is assumed that

- the implementation of naturalistic inquiry and the use of the ethno-nursing method are imperative for the study of self-care health behaviours of a specific cultural group
- semi-structured interview guides used on key and general informants through individual and focus groups interviews and participant observation will elicit the required information on self-care health behaviours of a given community

1.8.2 Theoretical framework

The theory of Culture Care Diversity and Universality is built on the assumptions that culture care differences (diversity) and similarities (universality) exist and that culturally

based care is essential for well-being, health and growth (Leininger & McFarland 2002:71, 79).Through discovering of care differences and similarities, new knowledge can be generated to guide professional care to provide culturally congruent care. Leininger's theory of Culture Care Diversity and Universality with its accompanying Sunrise Model are discussed in more details in chapter 2.

The theory guided the researcher to view the population under study holistically and findings of the study are conceptualised within Leininger's Sunrise Model in chapter 7 of this thesis.

Leininger's ethnonursing research method was used in this study (see chapter 3).

Ontological assumptions

Ontological assumptions address the nature of reality for the researcher. A philosophical question to ask is 'What is the nature of reality?' (Polit & Beck 2008:13). Multiple realities are constructed by those involved in the research setting. The researcher takes charge of reporting such realities and advancing evidence of each theme. Reality in this research is self-care health behaviours among a specific community. It is assumed that

- individuals within any given community engage in self-care health behaviours which are influenced by the health care beliefs of the community
- self-care health behaviours take place within the cultural boundaries of the group to which the individual belongs and is in communication with
- community members co-create the social environment in which they interact and this gives meaning to their self-care health behaviours through language
- qualitative researchers can report truthfully on the voices and interpretations of community members on their self-care health behaviours

1.9   RESEARCH METHODOLOGY

1.9.1   Research design

The study has been based on qualitative research design, ethnonursing in nature. The term 'ethnonursing' was borrowed from anthropology and, therefore, relates to ethnography which is the primary method of inquiry in anthropology and the concept of culture is said to be central to it (Leininger & McFarland 2002:75-76). 'Ethnos' is a Greek word for 'a people' or cultural group. The study of ethnos or ethnography centres on describing ways of life of human kind (Patton 2002:81). Ethnography takes into account that any groups of people interacting together for a period of time will evolve a culture. 'Among health care researchers, ethnography provides an access to health beliefs and practices of a culture or subculture' (Polit & Beck 2008:252). The importance of understanding culture particularly in the change efforts of all kinds is the cornerstone of 'applied ethnography' (Patton 2002:81). Ethnographic inquiry assists in facilitating comprehension of the behaviour affecting health and illness; however, it is more of a social science research field method while the ethnonursing research method is more related to a professional practice field with societal obligations to care for people (Leininger & McFarland 2002:22). In emphasising the importance of nurses using ethnonursing methods in their cultural bound inquiries, Leininger asserts: 'Over the last several decades I have found that the ethnonursing research method is fully adequate to replace ethnographies and to get the heart of nurses' research interest' (Leininger & McFarland 2002:86). Thus, the reason for the researcher's choice of this method.

1.9.2   Setting, population and samplin*g*

1.9.2.1   Setting

This study was conducted at Piave situated in the Njoro division of the Nakuru district. More details will be given in chapter three.

1.9.2.2   Sample and sampling techniques

A sample is a small part of anything taken as being a representative of a whole (Collins English Dictionary 2006).

Sampling according to the American Heritage Dictionary (2006) is an act or a process of taking a small portion, piece or segment that is representative of a whole. Purposeful and snowballing techniques were used for this study. The two methods will be discussed in detail in chapter 3.

1.9.2.3   Study population

'Population' refers to the entire collection of individuals, objects or events having common characteristics that the researcher is interested in studying (Babbie & Mouton 2002:134). Included in the study are key and general informants from Piave as well as other general informants; health professionals and traditional healers from Piave and adjacent areas: namely, Njoro and Nakuru. More details on the study population will be given in chapter 3.

1.9.3   Method of data collection

Several data collection tools were used: namely, semi-structured interview guides, focus groups, participant observations, field notes and the researcher as a data collection tool. More details on data collection will be given in chapter 3.

1.10   METHOD OF DATA ANALYSIS

The mechanics of handling large quantities of qualitative data can range from physically sorting and storing slips of paper to using one of the several computer software programs that have been designed to aid in this task (Patton 2002:157). Coding and categorising are generally initiated as soon as data collection begins (Brink 2003:192).

The data analysis in a qualitative study is in the form of written words, videotape, audiotapes and photographs (Brink 2003:192). Analysis, therefore, involves

examination of words rather than numbers as in quantitative studies. The most widely used procedure is to develop a category scheme and then code the data according to these categories (Polit & Hungler 1999:522). This can be done through the use of a computer or manually. NVivo software was used to assist data coding although the researcher had to go back to the data at a later stage and do manual coding of some of the data that had not been picked up at the initial coding. More details of data analysis will be given in chapters 3 and 4.

1.11 METHODS TO ENSURE TRUSTWORTHINESS

Researchers want their findings to reflect the truth. They cannot contribute evidence to direct clinical practice if their research findings are incorrect, biased, do not represent the experiences of the target group sufficiently, or are based on misinterpretation of data (Pilot & Beck 2008:196). Leininger identifies six major criteria that can be used in evaluating quantitative research (Leininger & McFarland 2002:88). They are listed and defined below according to her specifications.

1.11.1 Credibility

'Credibility' refers to direct sources of evidence from the people within their environmental context of their 'truth' held firmly as believable to them.

1.11.2 Confirmability

'Confirmability' refers to documented verbatim statements and direct observational evidence from informants and situations; other community members firmly and knowingly confirm and substantiate the data or findings.

1.11.3 Meaning in context

'Meaning in context' refers to understandable findings that are known and held relevant to the people within their familiar and natural living environmental context and culture.

1.11.4   Recurrent patterning

'Recurrent patterning' refers to documented evidence of repeated patterns, themes, and acts over time reflecting consistency in lifeways of patterned behaviours.

1.11.5   Saturation

'Saturation' refers to in-depth information of all that is or can be known by the informants about phenomena related to a domain of inquiry under study.

1.11.6   Transferability

'Transferability' refers to whether the findings of the study have familiar (not necessarily identical) meanings and relevance to be transferred to another similar situation, context, or culture. Detailed discussion on the techniques of trustworthiness is presented in chapter 3.

1.12   ETHICAL CONSIDERATIONS IN QUALITATIVE STUDIES

Any research must not only generate or refine knowledge, but also ensure that the development and implementation of research is ethically acceptable to the population under study and other stakeholders (Uys & Basson 2000:96). Since the researchers are people concerned about other people's lives, they should be persons of integrity who will not undertake research for personal gains or research that will have a negative effect on the subjects under study or other related people. The researcher must, therefore, abide by the rights of the research informant by adhering to conceptualised ethical position models based on 'mutual respect, non-coercion and non-manipulation, the support of democratic values and institutions, and belief that every research act implies moral and ethical considerations that are contextual' (Denzin & Lincoln 2000:2). Rights of the institutions need to be respected too by seeking permission to conduct research within the identified place and research population. Included also is scientific integrity on the part of the researcher. The researcher has to acknowledge the sources for the data used.

The researcher adhered to the model described above by Denzin and Lincoln. She sought permission to conduct the research from the medical officer of health, Nakuru District Hospital (see annexure A: a letter requesting for permission to conduct the study and another one giving the consent). More information on ethical considerations will be given in chapter 3.

1.13   OUTLINE OF THE STUDY

Chapter 1: Orientation to the study

Chapter 2: Literature review

Chapter 3: Research design and methods

Chapter 4: Qualitative data analysis

Chapter 5: Phase 1: Data analysis and presentation: key and general informants, Piave community

Chapter 6: Phase 11: Data analysis and presentation: additional informants, health professionals and traditional healers

Chapter 7: Conceptualisation: major themes related to Leininger's theory of Culture Care Diversity and Universality

Chapter 8: Conclusions, limitations, recommendations and guidelines

CHAPTER 2

Literature review

2.1   INTRODUCTION

This chapter discusses the literature review undertaken for the study. The purpose of a literature review is to provide a rationale for a study, put it into the context of what is known about the topic and provide an overview of research conducted on the same or similar topics (Parahoo 2006:128). The literature review provides a framework for establishing the importance of a study as well as a benchmark for comparing the results of the study with those of other studies (Creswell 2009:30). According to Polit and Hungler (1999:88), the literature review facilitates the identification of a research problem and development and refining of research questions or hypotheses. It orientates the researcher to what is known about an area of inquiry in order to ascertain what research can best make a contribution to the existing base of evidence. It helps to determine gaps or inconsistencies in a body of research. Through a literature review, it becomes possible to identify or develop new or refined clinical interventions which can be tested through empirical research. A literature review also assists in interpreting findings and in indicating implications and formulating recommendations.

Prior to writing the proposal, the researcher reviewed the literature on data collection and analysis in order to relate the study to what has been found and reported by others. However, it is argued that a qualitative research literature review should not be done to avoid suppositions or biases about the topic under consideration (Patton 2002:226; Speziale & Carpenter 2009:21). In support of a literature review, Creswell (2009:30) asserts that the use of literature in qualitative research varies considerably. Nevertheless, in qualitative research such as ethnographies, the literature on a cultural concept is introduced early in the study by a researcher as an orientation framework. With the gained knowledge after the literature review, the researchers should avoid imposing their ideas by bracketing their thoughts, feelings and perceptions about a phenomenon.

Literature reviews vary in scope and depth (Polit & Hungler 1999:110; Neuman 2006:111). The researcher in this study confined the review within the parameters of her field of study; *the self-care health seeking behaviours* and addressed the concepts of professional and generic health care. The community studied was from the Kikuyu tribe. The description of the culture of the Kikuyu people is given in the next section.

2.2   CULTURE AND HISTORY OF THE KIKUYU PEOPLE

2.2.1 Culture

Culture means shared norms, values, assumptions, and perceptions (both explicit and implicit). It refers to social conventions which enable members of a group, community or nation to function in a cohesive manner (Schott & Henley 1999:3). The culture of a given group or community virtually affects every aspect of the daily lives of the people: how they live, think and behave and how they view and analyse the world. Culture is all around any given group in many instances from birth and is unconsciously adapted without much realisation. Most aspects of culture are invisible and intangible while some are apparent (Schott & Henley 1999:3).

2.2.2 Kikuyu people: Historical overview

The Kikuyu people are an ethnic group in Kenya that make up a large percentage of the population. It is estimated that there are around 5.3 million Kikuyu in Kenya. It is generally accepted by academics and scholars that the Kikuyu people originated from West Africa, probably modern-day Nigeria. They migrated to Kenya when their society was displaced by another. Their coming to Kenya also led to the displacement of the Mukogodo people in the area around Mount Kenya (Cronk 2005:34).

The Kikuyu people believed in one god who lived in the sky and only came to earth to do an inspection and reward or punish the good-doers or wrongdoers respectively. When he came to earth, he lived on top of Mt Kenya (Kiri-Nyaga), which was said to be a mountain of brightness. This is why Kikuyu people prayed to their god facing Mount Kenya. They also believed that their god could not be seen by naked eyes but he always took an interest when people were faced with a crisis. He, however, took little interest when individuals were faced with their daily problems. Praying was also meant

to be done when there was a crisis or something bad happened. God was not supposed to be disturbed during other times (Kenyatta 1965:225).

Clark (1989:385) explains the work of Louis Leakey, the ethnographer who in the early 20th century recorded that central to the culture of the Kikuyu people was a system of attitudes and values that indicated the image of society as an integrated organic community characterised by stability and harmony. Any change was viewed as disruptive unless it took the form of steady organic evolution that preserved necessary continuity and order. These ideas were coupled with an emphasis on the value of tradition, a well admired image of rural society, and persistence in loyalty and a sense of duty toward the community. When colonial administrators arrived and settled in Kenya, they deeply distrusted economic individualism, urbanisation and industrialisation as threats to the organic unity of society (Clark 1989:385).

Louis Leakey's ethnography is centred on Kikuyu rites of passage, stressing those which bestowed power on males as warriors and as elders. Throughout the three volumes of his ethnography, Leakey documents the various ceremonies and rituals performed by the participation of elders, and the fees and fines to be paid to them. The many ceremonies, rituals, fees and fines show Kikuyu society as particularly rule-governed and having a systematic culture. Few activities took place without the consent, supervision, or participation of the elders. The many rules recorded in the ethnography were not infrequently broken in the course of everyday life, bringing ritual impurity to the perpetrator and his or her family. The elders possessed the knowledge and paraphernalia necessary to remove the impurity and restore order (Clark 1989:387).

A further historic perspective of Kikuyu history states that the Kikuyu tribe was originally founded by a man named Gikuyu. The Kikuyu God, Ngai, took Gikuyu to the top of Mt Kenya (local name: Kirinyaga) and told him to stay and build his home there. He was also given his wife, Mumbi. Together, Mumbi and Gikuyu had nine daughters: namely, Wanjiku, Wanjiru, Wanjeri, Wambui, Wangari, Wacera, Waithera, Wairimu, and Nyambura. (Traditionally all Kikuyu girls should be given one of these names.) There was also a tenth daughter but the Kikuyu considered counting up to number ten bad luck. When counting, they said 'full nine' instead of ten. It was from the nine daughters that the nine Kikuyu clans arose: namely, Achera, Agachiku, Airimu, Ambui, Angare,

Anjiru, Angui, Aithaga and Aitherandu were formed. Below is a picture of a Kikuyu woman dressed in traditional Kikuyu attire.

Kikuyu woman in traditional attire
Kikuyu images. [s.a.].

The Kikuyu people depend heavily on agriculture. They grow bananas, sugarcane, arum lilies, yams, beans, millet, maize, black beans and a variety of other vegetables. They also raise cattle, sheep, and goats for purification, sacrifice and consumption. The sacrifice of a goat beneath a fig tree is still considered a way to call for rain in times of drought.

The Kikuyu people have a reputation for being hard-working; most of them these days live on small family plots but some have taken opportunities in business and moved to cities and other various areas to work. They value knowledge and believe that all children should receive a good education. They have a remarkable reputation for money management and it is common for them to manage several enterprises at one time. They have also been politically active and the first president of Kenya, Mzee Jomo Kenyatta, was a Kikuyu. He was a major figure in Kenya's fight for independence (The Kikuyu People of Kenya 2000). Below is a picture of late President Mzee Jomo Kenyatta (State House. [s.a.].)

Mzee Jomo Kenyatta, 1st President of the Republic of Kenya

Since the land they settled in was fertile, the people prospered greatly. As a result, they believed that God was smiling on them from Mt Kenya, the largest mountain in Kenya. The mountain, visible from the ridges, has a white patch which the Kikuyu people once believed to be a sign that God was watching them. A few people climb up to the mountain top to pray as they still hold on to the same belief. Below is a picture of Mt Kenya. The ice is melting owing to changes in the climatic conditions (Mount Kenya. [s.a.] Safina Group).

Mount Kenya

The mountain and country (Kenya) got their name because, when speaking to colonists, the Kikuyu pronounced 'Kiri Nyaga' ('the white patch' in Kikuyu) as Kiinyaa (the people did not pronounce r's clearly, a situation common to many Kikuyu people up to the present day). The settlers (white men), therefore, thought it was Kenya, thus the birth of the name of Kenya as the country and Mt Kenya. As a result of the fertile soil of the ridges, the Kikuyu people had very good fortune. They came to believe that God favoured them and they developed their culture around their religion. They also quickly formed a belief that those who were poor were poor because they were lazy. They also believed that one could not talk directly to God; as a result, a religious chain of

command fell into place. When communicating with God, one spoke through those higher up in the hierarchy. The following, from most to least in importance, formed the hierarchy: God, spirits, elders, parents, individuals. Religion influenced all aspects of Kikuyu culture.

The Kikuyu governmental system also developed as a result of the ridge settlement pattern. Prior to colonisation, the Kikuyu were very democratic. If a person experienced problems, these were solved within his/her own place in the hierarchy. If that did not work, he/she would go one-step higher, and so on. The hierarchy, from most to least in importance, was as follows: community, ridge, inter-family, family. The family unit was the most basic political unit.

To become a member of the community, one had to be initiated. Initiation included a period away from home where a socialisation process into Kikuyu culture took place and, finally, circumcision. The warriors, elders, or statesmen led the different political units respectively. The hierarchy of warriors was as follows: junior warrior, senior warrior, junior elder, senior elder, elder, and statesman. The elders were in charge of justice, religion and administration. Every group had a spokesperson chosen on merit or performance. When men were initiated, they were taught to control one another and solve problems at their own level.

Although religion and government developed into a relatively formal structure, education remained informal. Education was based on hands-on experience. Fathers taught their sons and mothers taught their daughters. Children learned how to do the necessary household chores and how to behave themselves. The other socialisation that occurred was during initiation, away from home, where the children were taught how to behave and about issues related to culture.

Kikuyu people learned to read and write as they realised that much of what the missionaries were saying was not contained in the book they preached from, the Bible. A number of them did not believe in Christian teaching and this brought about serious clashes between tribal beliefs/customs and Christianity. This resulted in Kikuyu people establishing their own churches and schools. Formal education gradually led to the end of the Kikuyu practice of female circumcision although some segments of the community are still practising it up to the present day.

From the 1920s onward, the Kikuyu people led the anti-colonial struggle. It was from among them that the Mau warriors that led the struggle for independence from Britain came into being. Below is a picture of a Mau Mau warrior called General Dedan Kimathi (Kimathi 2007).

Dedan Kimathi: A Mau Mau Warrior

In 1962, the struggle for independence succeeded and Kenya rule returned to the hands of the natives. Despite general rebellion against colonial ways, colonisation left a large impression on Kenya. The cultures of the natives were shattered through the forced introduction of new people and new ways of life. The impact of colonisation on Kikuyu society is blamed for the current imbalance of division of labour between the sexes. Prior to colonisation, Kikuyu men and women had a relatively equal set of jobs around the home. The men worked in the fields with certain types of crops, while the women cooked. When money was introduced into the economy, the men had to leave home and find jobs to pay taxes. While the men were away, the women had to do the men's jobs in addition to their own. With so many men going to the city, unemployment was created and this has persisted to today. The men never picked up doing the chores they had left to the women when they went away. This has resulted in the women often working much harder than the men. The inequality in regard to the workload of women versus men is not, therefore, a native aspect of the Kikuyu culture but partly as a result of colonisation. Today the Kikuyu culture is a combination of colonisation, new customs, and newly revived pre-colonial culture (Kikuyu culture. [s.a.]).

2.3   HEALTH CARE SEEKING BEHAVIOURS

The term 'health care seeking behaviour' is often used in the literature referring to the routes people take to seek care. The two routes are formal and informal health care. The researcher's operation definition of the formal route in this study refers to the health facilities legalised by government while the informal route refers to traditional health facilities not yet legalised by government such as traditional healers.

2.3.1   Models of health care seeking behaviours

According to Nyamongo (2002:157-167), beginning with recognition of symptoms, health care seeking behaviours centre on the path that people follow until they choose different health services (home treatment, traditional healer or other forms of medication). People also move from one sector to another. Sindiga et al (1995:33-34) explain how people use formal and informal health care services interchangeably depending on how they feel. At times they use both formal and informal care interchangeably for the treatment of their children; take traditional medicine and when it fails, go to the formal health facility; also use both formal and informal health care in a complementary way such as formal treatment for a certain condition while going to a traditional healer for the treatment of psychological problems caused by the same illness.

Some of the studies use pathway models to investigate the path until the first contact with a health facility. Sahn, Younger and Genico (2003:241-249) have come up with a descriptive model (see figure 2.1) illustrating the sequences people follow in their pursuit of health care services. Sahn has referred to it as an 'Estimated Nesting Structure'.
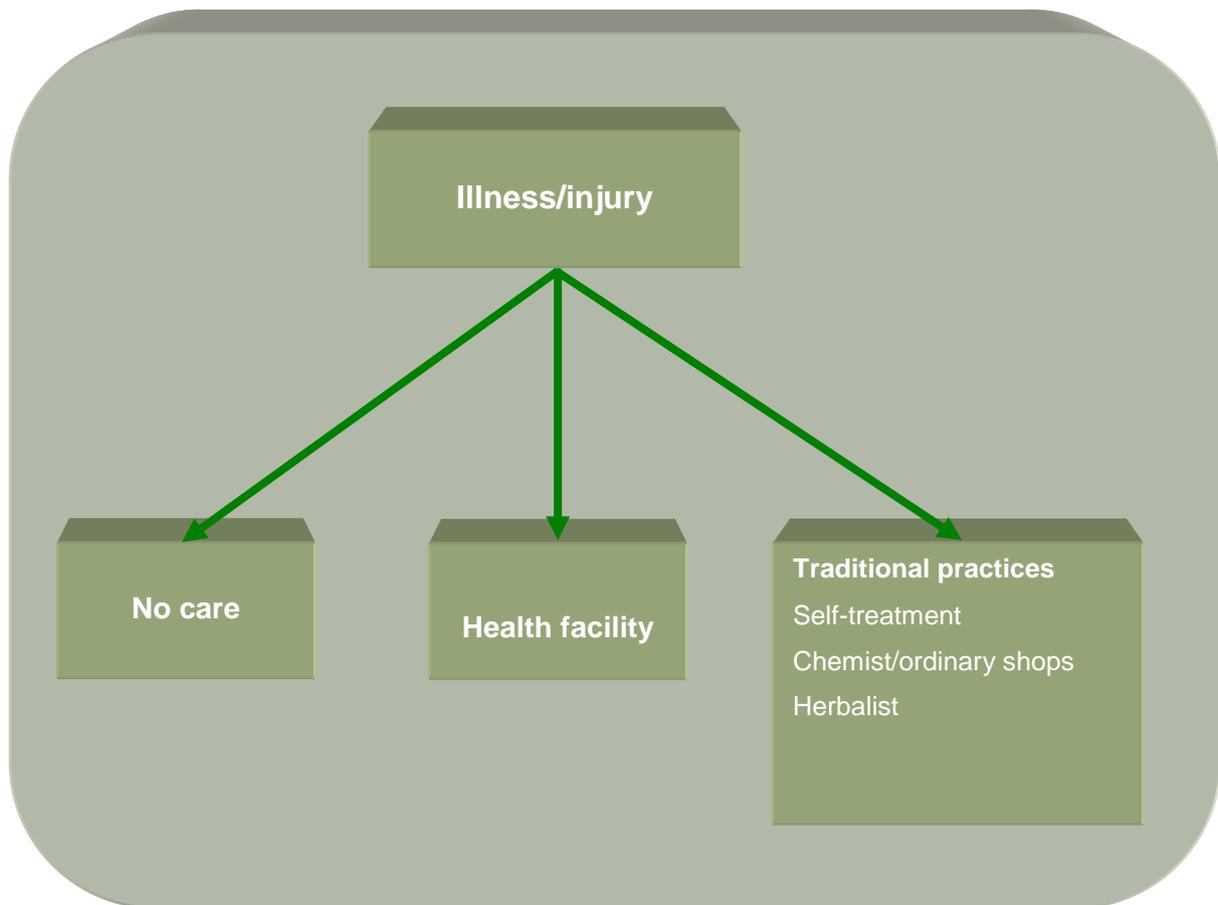
Figure 2.1   Estimated nesting structure
Source: Sahn et al (2003:241-249)

The central idea is that persons follow predefined patterns (do not act randomly), both in their first therapeutic selections and when they move from one treatment modality to the next. Ryan (1998) conducted a study in Kenya and established that two general principles enable people to understand therapy choice. They start with less costly treatments (home treatment) and only opt for more costly alternatives if the first treatments fail or if they do not know the treatment for the problem. When the illness is considered serious, the cost of care is secondary and treatment selection primarily depends on 'probability of cure'; normally persons opt for a physician. On the other hand, Nyamongo (2002:157-167) conducted a study in Kenya and found that for common illnesses, which people recognise well, waiting seems to be their strategy.

The Health Belief Model gives a comprehensive view of why people take different routes. Rosenstock (1971) in Basavanthappa (2008:29-33) proposes a health belief model intended to predict which way individuals would or would not employ preventive measures in vetting for early recognition of cancer. The health belief model is based on

positive health motivation and points out a number of factors: namely, individual perception, perceived seriousness and threat of an illness. It also reveals that factors that modify one's perception also influence one's outlook on health. Such factors are demographic variables, for instance, age, sex, race, and ethnicity; socio-psychological variables such as social pressure or influence from peers or other community groups; structural variables such as knowledge about a disease and prior contact with it. Becker (1974) in Basavanthappa (2008:29) finds greater adherence rates with prescribed treatment among mothers whose children suffer from recurrent ear infection and occurrences of asthma.

2.3.2 Factors Influencing health seeking behaviours

2.3.2.1 Economic factors

Many factors influence choice of treatment. A study done in Nepal found that irrational drug use is common and is also seen in prescriptions for children less than five years of age. According to the researchers, since many patients cannot afford tests, doctors recommend that sick people or patients in places where there are no doctors consult the nearest pharmacist. In this aspect, it was found that mothers likely to seek appropriate care for their child when the child has more than one symptom are those with a secondary level or higher education and higher family income (International Network for Rational Use of Drugs 2005).

Neumark, Palti, Donchin and Ellencheig (1992:271-82) identify economic status as the determining factor in the number of visits to medical facilities while Pillai et al (2003:783-90) identify contrary results. Their study from Kerala Southern India indicates that families with a higher economic status may seek care less often, particularly for milder illnesses, because they have the resources needed to obtain care later in the illness if it does not resolve.

Geissler, Nakes, Prince, Odhiambo, Aagaard-Hassen, and Ouma (2000) conducted a study in Kisumu, Kenya and established that the percentage of Western medicines used for self-treatment increased with age from 44% in the youngest age group to 63% in the oldest. There were differences between boys and girls. Among the youngest age group, boys were twice more likely to use Western medicine than girls (62 versus 32% of the self-treatments, respectively) and in the oldest age group, again males were nearly

three times more likely (75 versus 25%, respectively) to use the medicines. The researchers commented that the probability of males using more self-treatment than females was that males are likely to be more economically able than females.

2.4   STUDIES ON FORMAL AND INFORMAL HEALTH CARE

2.4.1   Studies on formal health care

A study done in India has shown that unqualified or indigenous medical practitioners practise allopathic systems of medicine (Bhatia, Bharamvir & Timmappaya 1975). Allopathic systems are the formal health care systems that provide Western medicine (The American Heritage Medical Dictionary 2006). There are also very high levels of the use of injections by both private and public practitioners as patients expect and have faith in injections. Since the placebo effect of an injection is very high, doctors consider it worth giving rather that losing a patient.

The researcher has also observed that the practice is the same as that in her country. In Kenya, many patients – the majority being the elderly – prefer injections as a mode of treatment and if not administered, they feel there is no justification for the treatment given. A number of doctors give injections to satisfy them. She has also witnessed placebos being given in the form of injections and some of the recipients (patients) say they feel better after the injections.

2.4.2   Studies on informal health care

Home treatment continues to be very popular among many communities. Weller et al (1997:224-245) conducted a study in Guatemala which indicated that up to 90% of the initial treatment actions taking place at home involved the use of home remedies or remedies obtained from a pharmacy. In the remaining 8-10%, the initial actions involved seeing a physician or a nurse while about 2% of the people visited a traditional healer.

Ryan (1998:47-57) found that in a Kom village of Cameroon, 83% of the illnesses were treated at home, with 22.5% of the 454 illness episodes seeking treatment outside the home. Kroeger (1983:147-161) reported that 80% of illnesses in developing countries

were managed within the household, further pointing to the importance of looking at the home as a major player in the management of health problems.

Other studies done in Nepal indicated that most often formal treatment was sought only after home remedies had failed; women were the primary care givers at home and a large proportion of the population (42%) did not visit modern health facilities; instead they sought the assistance of traditional healers (Niraula 1994:151-66).

A fairly recent study done in Nepal reported that 69% of households sought either formal or informal health services when sick; 26% visited traditional healers while 19% first visited formal health care institutions (Jimba, Poudyal, Wakai 2003 34:462-3).

In Kenya, as is the case in most other countries, all types of drugs, including those prohibited from being sold over the counter, can be obtained without prescription. Molyneux, Mung'ala-Odero, Harplan and Show (1999:1-15) conducted a study on maternal responses to childhood fevers. A comparison of rural and urban residents in coastal Kenya, found that despite marked differences in rural and urban study areas in demographic structures and physical access to biomedical services, mothers' self-care health seeking behaviour patterns were the same. Most mothers (88%) used biomedical treatment in which 68% of the medicines were bought from shops while 49% of the mothers contacted government or private clinics. It was found that a high proportion of urban informal drug vendors stocked medications.

Ahmed, Chowdhury and Bhiya (2001:1957-1966) pointed out that self-care visits to traditional healers and unofficial medical channels were often seen largely as something which should be prevented, with the emphasis on encouraging people to opt for formal channels. Nevertheless, individual families and communities at large continue in large numbers to seek health care from the informal health care sector (WHO 2002). Studies done in Kenya and other parts of the world demonstrate the tendency of self-care health seeking behaviours in many parts of the world.

2.5 SELF-CARE SEEKING BEHAVIOURS WITH REGARD TO THE TYPE OF ILLNESSES

2.5.1 Febrile conditions and malaria

Ruebush, Kern, Campbell and Aloo (1999) conducted a study in Kisumu, Kenya and found that self-treatment is extremely common. Out of 138 episodes of febrile illness, 60% are treated at home with herbal remedies or medicines purchased at local shops, while only 18% obtain treatment at a health centre or hospital; no treatment is sought by the remainder. Chloroquine preparations available in the shops are perceived as more effective than either antipyretics or herbal remedies for the treatment of malaria, and injections are regarded as more effective than oral medication.

A study done by Abuga, Mutemi, Karisa, Ochola, Fegan and Marsh (2007) in Kenya on childhood and adult patterns of over-the-counter-medicine (OTC), established that children use multidose antimalarial drugs appropriately. However, the majority of children and adults seek no further treatment. Self-referral to a health facility within 72 hours of illness onset is the commonest pattern amongst those seeking further help. It was also found that OTC medicines are the popular first choice of treatments for fever in children or acute illnesses in adults. The proportions using OTC antimalarials are similar in areas of high and low malaria endemicity. In all districts, adults are more likely to self-treat themselves with OTC antimalarial medicines and less likely to use them in recommended ways.

2.5.2 Tuberculosis (TB)

Auer, Sarol, Tanner, and Weiss (2000:648) followed a group of patients in Kenya and found that only 29% of the patients went first to a health centre, with 53% consulting a private doctor initially. They found 69% of patients had been told by a member of the household to seek medical advice for their symptoms, and that those who felt ostracised because of their TB delayed seeking medical help longer. The authors claimed that effective health seeking and case finding are influenced by the health system, effective community, family, and other personal issues. The TB patients choose private instead of public doctors, as they believe their service to be more polite, more effective, more sympathetic and respectful of privacy.

A study done on TB patients in Botswana repeatedly demonstrated that patients do not always choose a public health care facility; they delay diagnosis and often do not complete the lengthy course of treatment necessary. Steen and Mazonde (1999:170) found that 95% of patients in Botswana visit a 'modern' health care facility as a first step. However, after initiating modern treatment, 47% go on to visit a traditional or faith healer as well. They emphasise the importance of social and cultural factors in contributing to the outcome of TB control. For these patients, TB is seen as a 'European disease' that will respond well to Western medicine. However, a traditional healer is also consulted to explain the 'meaning' of the disease for that particular person. There is an increasing tendency to use modern medicine as a 'quick fix' solution, whereas traditional medicine is utilised for providing answers that may be asked about the meaning of the misfortune, and to deal with the 'real' causes of the illness.

In Malawi, care seeking behaviours and diagnostic processes in patients with smear-positive pulmonary tuberculosis demonstrated that 57% of patients visit traditional healers, grocery shops or vendors and 57% of those who visit health facilities say they do so because of proximity to their homes (Salaniponi, Harries, Banda, Kagombe, Mphasa, Mwale, Upini, Nyrinda, Banerjee & Boeree 2001:327-332).

In Kenya, a study on a community's perception of TB by Liefooghe et al (1997:809) illustrated that disease is attributed to causes such as smoking, alcohol, hard work, exposure to cold, and sharing with tuberculosis patients. Many other participants believe that the disease is hereditary. It was noted that prolonged self-treatment and consultation with formal health sectors as well as the social stigma associated with the disease, increase patients' delay in going for treatment in health facilities.

2.5.3 Sexually transmitted diseases

Some diseases especially those affecting private parts pose some problems to individuals in terms of where to go for treatment.

A study done on health seeking behaviours of patients with sexually transmitted diseases in Malawi found that of the 498 new sexually transmitted disease clients, 53% had taken some form of medication before coming to the clinic and 37% of the

treatment was given by traditional healers (Zacharia, Nkhoma, Harries, Arend, Chantulo, Spielmann, Mbereko & Buhendwa 2002:127-129).

Walker, Muyinda, Foster, Kengeya-Kayondo and Whitworth (2001:35-40) indicate that patients with sexually transmitted diseases (STDs) prefer to go to private practitioners who are said to provide more convenient and confidential care than public health facilities. However, treatment given by the private sector is expensive and often results in partial courses of antibiotics. Another study done by Evans and Lambert (1997:1227-1235) indicates that symptoms such as vaginal discharge or menstrual disorders may not need medication because they are attributed to dietary or other life-style factors.

2.6   GENERIC OR FOLK CARE

> When we refer to living a good life, we are talking about our way of life. The Aboriginal (indigenous – existing in a land at the dawn of history: Oxford English Dictionary) way of life promotes good health throughout life's journey. Through traditional healers, elders and medicine people, our songs, dances, stories, prayers and ceremonies, we are introduced to many dimensions of healing, growth and development. As we pursue our Aboriginal way of life, to live in balance and harmony with all of creation, we reclaim who we are – our Aboriginality. Our sacred path becomes one of healing, reconnecting us to the wisdom and traditions of the past and generations of the future (Anishnawbe Health Toronto 2005).

The above words provide an excellent summary of what generic or folk healing is about. However, the researcher's literature review in generic or folk healing does not purport to be a range of treatment practices by traditional healers. The perusal of various literatures on traditional healing practices revealed that the subject is very complex and wide in scope. Nevertheless, the researcher has attempted to cover issues of generic healing in general. More information on various types of traditional healers is provided below.

2.6.1 Traditional healers

According to Mbithi (1990:179), traditional healers have various specialisations: herbalists, divine healers, spiritualists, traditional surgeons, witchdoctors or shaman and birth attendants, among other categories. WHO (2000-2005) estimates that up to 80% of the population in Africa makes use of traditional medicine. In Sub-Saharan Africa, the ratio of traditional healers to the population is approximately 1:500, while medical

doctors have a 1:40 000 ratio in the rest of the population. It is clear that traditional healers play an influential role in the lives of African people and have the potential to serve as crucial components of a comprehensive health care strategy.

2.6.2 Traditional surgeons

According to Miles and Ololo (2003:505-508), traditional surgeons work throughout Sub-Saharan Africa and perform many procedures including tooth extraction, abortion, injections, incising and draining abscesses, uvulectomy, circumcision, inguinal hernia surgery, non-invasive cataract, and surgery on closed and open fractures. Cutting and injection equipment are not cleaned and are used on a rapid succession of up to 10 patients in a single clinic session. These procedures often cause haemorrhage, septicaemia, tetanus, gangrene, contractures, abscesses, airway obstruction, keloids, iatrogenic fistulae, lacerations of vital organs, loss of limbs, and even death.

2.6.3 Herbal treatment

According to Lietava (1992:263-266), people from the continent have used hundreds of indigenous plants for treatment of ailments since prehistoric times. There is evidence from the Shanidat Cave in Iraq, which suggests that Neanderthals living 60 000 years ago used medicinal plants. A body unearthed there had been buried with eight species of plants which are still being used in ethnomedicine around the world. The accepted use of plants as a healing agent was found in a cave painting discovered in Lascaux in France which has been radiocarbon dated to between 13 000-25 000 BCE. Medicinal plants were found in the body of an iceman and seemed to have been used to treat parasites which were found in his intestines (Capasso 1998:1864).

Herbalism as can be inferred from the above is a traditional medicinal or folk medicine practice based on the use of plants and plant extracts. Herbalism is also known as botanical medicine, medicinal botany, medical herbalism, herbal medicine, herbology, and phytotherapy (Sechagirirao 2007). Many of the herbs and spices used by humans to season food are said to yield useful medicinal compounds. Some of these plants are garlic, black cumin, cloves, cinnamon, thyme, allspices, bay leaves, mustard and rosemary. Other spices such as saffron, food colourants such as turmeric, tea either green or black, and flaxseed contain potent phytochemicals, including carotenoids,

curcumas, catechism and lignan, which are said to provide significant protection against cancer (Lai and Rov 20061451-60).

According to Dorin (2006:564-565), with only a few exceptions, most herbal treatments have not been tested for safety and efficacy utilising scientific studies or clinical trials. The scientific and medical communities state that herbal treatments may risk the well-being or life of the patient when used in lieu of standard medical treatments There is a danger that herbal remedies may be used in place of medical treatments which have been scientifically tested for safety and efficacy, resulting in the development of worsening of the medical condition which could have been prevented or treated. There is also a danger that a herbal remedy may itself cause harm which is unanticipated owing to a lack of a full understanding of its composition and biochemical effects.

A common misconception about herbalism and the use of 'natural' products in general, is that 'natural' equals safe. However, many plants have chemical defence mechanisms against predators that can have adverse or lethal effects on humans. Herbs can also have undesirable side-effects just as pharmaceutical products can. These problems are exacerbated by different controls over purity and inconsistent information on dosage. Furthermore, if given in conjunction with drugs, there is danger of 'summation', where the herb and the drug have similar actions and added together can cause an 'overdose' or reduction in the effects (Overdose or drug reaction [s.a.].)

2.6.4 Witchdoctors or Shamans

According to traditional medicine [s.a.], the term 'witchdoctor' often refers to a healer in primitive regions of the world where traditional healing is used rather than Western medicine. It is usually used with negative connotations since it is meant to imply that the person attempting to heal has little or no expertise or ability in healthcare. However, the term is used colloquially to mean a shamanistic healer, particularly among African people.

Traditional Medicine [s.a.] giving further detail of a witchdoctor explains that the etymology of the word 'shaman' is 'one who knows'. The shamans or witchdoctors are persons who are experts in keeping together the multiple codes through which complex belief systems appear, and have comprehensive views in their minds with certainty of

knowledge. They use multiple codes and express meanings in many ways: verbally, musically, artistically, and in dance. Meanings may be manifested in objects, such as amulets. The witchdoctors know the culture of their community well and act accordingly.

2.6.5 Traditional birth attendants

Traditional birth attendants (TBA), also known as traditional midwives (TM), are primary pregnancy and childbirth care providers. Traditional birth attendants provide most of the primary maternity care in developing countries especially in rural and isolated communities. They usually learn their trade through apprenticeship, although some may be wholly self-taught. They are not certified or licenced.

In a number of countries, efforts have been made to upgrade their work skills and they are, therefore, recognised by the formal health systems. Most training programmes have focused on training them to assist in deliveries and in environmental hygiene. They are also made aware of the conditions for referrals and how to do them, the importance of adequate transportation, and other related issues (Traditional Birth Attendant 2009).

2.6.6 Spiritualism

Ruth (1983) explains that spiritualism is the belief that the human personality survives death and can communicate with the living through a sensitive medium. The term spiritualism has, therefore, been frequently used to denote the belief in the possibility of communication with mystical spirits. In spiritualism, spirits are believed to lie on higher planes of existence than humans and are, therefore, capable of providing people with guidance in both worldly and spiritual matters. Spiritualism is a religion in which the believers accept that life continues after the physical body is deceased. Most spiritualists are said to be happy and cheerful people and do not fear death, for spiritualism is not about death but about life.

2.6.7 Divine healers

According to Booth (2003), divine healers are faith healers who practise divine healing; this is the use of supernatural or spiritual intervention to cure disease. They claim that

their techniques or special spiritual insights can summon supernatural interventions on behalf of the ill. Divine healing or faith healing is said to use divine energy for healing. The vital source of the divine is said to be from God. Divine healing is practised in various religions: Christianity, Buddhism, Islam, Taoism, Baha'i, Judaism, Hinduism, and others.

Booth explains further that before healing, the healer prays silently. The prayers can be directed to an individual or a group of people. It is generally claimed that a powerful healer can heal patients en mass with divine energy. Mass healing is very popular in many parts of the world.

The term 'faith healing' is sometimes used in reference to the belief of some Christians who hold that God heals people through the power of the Holy Spirit and the practice usually involves the laying on of hands. The four Gospels in the Christian bible relate how Jesus performed healings through divine power and indirectly acknowledges the role of the doctor, for example, in saying: 'It is not the healthy who need a doctor, but the sick' (Mark 2:17). Jesus endorsed the use of the medical assistance of the time (used medicines of oil and wine) when he praised the fictitious Good Samaritan for acting as a physician, telling his disciples to copy the Samaritan's behaviour in the parable. The healing in the gospels is referred to as a sign (John 2:2) to prove Jesus' divinity and to foster belief in him as the Christ (Booth 2003).

According to Parsons (1989:1-14), people from Samoa Island in the South Pacific Ocean have diverse traditional medicine. There are priests who communicate with gods to seek divine intervention when a member of the family is sick; priests who are said to be 'anchors of spirits'– they predict who the offenders are and curse them for wrongdoing. There are also healers who are not priests; they use massage and herbal medicine for treatment of minor illnesses such as headache and muscular pains. This is very similar to the Kikuyu form of traditional treatment mostly practised in the past. The practice of the Kikuyu ethnic group's traditional healing will be discussed later in this chapter.

2.7   TRADITIONAL HEALERS IN AFRICA

Individuals who become ill are often faced with a number of choices of health care providers. In most parts of Sub-Saharan Africa, the choice usually includes traditional healers since they are the biggest health manpower force and at times the only source of health services in some remotes areas (WHO 2002-2005). To show the magnitude of the situation, WHO points out that in Kenya the ratio of one medical doctor to patients is 7142 whereas the traditional healer has 987 patients. Similarly, there is one medical doctor to 25 000 patients in Uganda as opposed to one traditional healer to 700 patients. In the Kwahu district in Ghana, for every traditional practitioner there are 224 patients contrasting with one doctor for nearly 21 000 patients. In Swaziland, there are 110 patients for every traditional healer and 10 000 patients for every doctor. With this very large number of patients to one doctor in nearly all African countries, particularly in rural areas, reliance on traditional medicine to improve the health of many people cannot be disputed. WHO could be on the right track when it asserts that traditional practice is one of the surest means to achieve total health care coverage of the world's population WHO (2002-2005).

Surprisingly, even though the majority of the African population utilises traditional medicine services, in many African nations traditional medicine technically remains illegal. The World Health Organization's 2001 survey of the legal status of traditional and complementary/alternative medicine reveals that of the 44 African nations surveyed, 61% had legal statutes regarding traditional medicine (WHO 2001). However, even with legal statutes in place, national policies have not always been implemented. The certifying or authorisation mandate is often assigned to a local governmental authority without national uniformity. No African nation surveyed provided insurance or financial reimbursement for traditional medicine services (WHO 2001).

WHO (2001) classifies the collaboration between national health care and traditional medicine systems as integrative, inclusive or tolerant. However, many of the national health care systems in African countries are based entirely on Western medicine although some traditional practices are tolerated by law. As a legacy of the long history and remnants of European colonisation, outdated laws remain on the books prohibiting the practice of traditional medicine. Pressure from organised Western medicine also

helps to marginalise traditional healers. In spite of the law prohibiting the practice of traditional medicine, the practice is accepted and tolerated throughout the continent.

2.8   TRADITIONAL HEALERS IN KENYA

The spiritual and medicinal healing arts of the traditional societies in Kenya are ancient cultural practices that have adapted to societal and environmental changes. Traditional healing provides remedies for a variety of health problems such as fever, diarrhoea, toothache, sore throats, sinus problems, intestinal worms, respiratory problems, earaches, skin conditions, menstrual problems, infertility, broken bones, wounds and burns. Treatments usually involve a mixture of ritual and herbal remedies using locally available ingredients such as tree bark, sap, leaves, roots, plant stems, flowers, minerals, and various animal products. These healing practices provide remedies for common ailments (Mangum [s.a.].

In 1975, the United Nations Children's Fund (UNICEF) and WHO began to emphasise a primary health care approach that would utilise local human and material resources available in the community to provide the under-deserved population in developing countries (Akerele 1987:117-181). This approach was also meant to include traditional healers. The programme involved immunisation, maternal and child health, family planning, nutrition, curative services, health education, environmental health (clean water supply and sanitation), and early diagnosis and treatment of diseases. Other declarations such as MDGs and Kenya's current Health strategic Sector Plan (Ministry of Health 2005-2010) have advocated the same move but so far the practice has hardly taken route.

From the WHO and UNICEF statement on inclusion of traditional medicine in the health care delivery system, it is clear that in spite of the Western medicine trusted so much by health care professionals, the traditional healing methods occupy a big place in the healing systems of the indigenous peoples

In Kenya, the government is looking at ways to bring some practices used in traditional medicine into mainstream healthcare. Health officials say that the goal is to combine mainstream and traditional healing to provide better health care for people across the

country (Nunan 2004).   Nunan narrates some information on one of the traditional healers as follows:

> The home of Michael Nzau, a traditional healer, is in a narrow lane of a slum in the Kibera district outside Nairobi. The tiny, two-room mud house has no electricity, but Mr Nzau says he doesn't need it to heal the sick. My patients, he says, have been in hospitals taking medicine for two to three years without being cured. But when they come to me, he says, I cure them between one and two months.

According to Yoder (1997:1-20), until the 1970s, most studies concerning traditional healers in Africa were linked with beliefs, religion and ritual. Mbithi (1990:198) explains that traditional healers serve to neutralise the harmful power of sorcerers or witches and also treat other conditions such as what is referred to as the 'diseases of the air' or natural diseases. Understanding of the significance of disease and illness is the key to comprehending traditional medicine (Wisner 1976:82). Ampofo & Johnson-Romauld (1978:40) expound more on traditional medicine by defining a disease in relation to an African context as follows:

> Disease is not merely something that results from malfunctioning in this or that organ or a lesion therein, but essentially a rupture of life's harmony, to be imputed either to a material cause instinct with some 'intangible force' or directly to that intangible force itself. It is necessary in traditional medicine to confront the symptomatology and aetiology of disease not only in the material but also in the immaterial world.

The definition given above carries a lot of meaning in the African context. According to Mechanic (1968:19-20), when some people get sick, they attribute their sickness to some unforeseen forces coming their way because they have done something wrong or somebody out there is unhappy with them and has brought about the sickness. As a result, diseases and bad luck are considered in some circles as having social causes. He further points out that medical practice even within the most scientific context continues to be largely a social art rather than rigorous science.

Mbithi (1990:169-170) explains that diseases and misfortune are regarded as having a socio-religious foundation. The treatment should, therefore, go beyond addressing the symptomatology of disease to discovering its deep-seated cause and at the same time a way of treating and preventing it from recurring. Mbithi further explains that natural diseases (God-given) such as skin rash in children, rheumatism in older people, may be

treated either by modern or traditional medicine. Unnatural diseases (human induced illness) such as tuberculosis and typhoid may be a result of sorcery, witchcraft, spirit disturbances, or breaching socio-religious obligation and taboos especially with regard to ancestors. Diseases originating from such taboos are referred to traditional healers.

2.9 TRADITIONAL HEALERS IN KIKUYU LAND

Kikuyu traditional healers are the most respected persons within their respective communities. Normally, only men become traditional healers, while women became seers or prophetesses if they happen to be possessed by magic powers. Men healers go through an elaborate initiation ceremony in order to become recognised as healers. Women do not take part in all the important ceremonies for initiation, and they have to have the ability to prophesy accurately, and have a reputation for being in close contact with the deity so as to receive messages from him directly (Leakey 1977:1152).

Leakey (1977:11240) explains that Kikuyu traditional healers are known by other names such as healer, diviner, seer, magician and workers in witchcraft, just as in other parts of the world. Individuals are invited to join the healing mostly by relatives such as a father inviting his son. At times, it is said that a child is born clutching magic pebbles (mbugu – smooth pebbles) in his fist and that child is destined to join the healing art. In other cases, a person may be attacked by a serious illness such as hallucination, fits or vision difficulties or have a misfortune in the family such as the death of a child, all these being attempts for him to realise he was chosen by his ancestors to join the healing practice.

According to Kenyatta (1965:291), traditional healers are both generalists and specialists although some combine several specialties. Specialisation includes divination, identifying witches and sorcerers, prophecy, herbalism, anti-witchcraft processes, purification, infertility among women, mental illness, conjuring, hypnosis, fracture, wound suturing and performing simple operations such as removal of uvulae. Their duties range from healing, blessing and purifying those defiled and appeasing ancestral spirits. They also work as counsellors and ritual experts.

General practitioners conduct purification rights and ceremonies in normal social life. They also cure disease and prepare and give charms to prevent illness and bring good

fortune particularly while on a journey (Leakey 1977:146). In cases of severe drought, crop failure or warriors preparing for a battle with Masaai (Kikuyu people and Maasai were known to have serious conflicts which resulted in ethnic battles), specialist diviners were consulted (Leakey 1977:1150-151).

When the country was colonised by the British government, traditional healing was discouraged. Various denominations also came into Kikuyu land and discouraged the practice of traditional healing (Sindiga 1990:134). A Witchcraft Act meant to protect Kenyans from harassment by witchdoctors was constituted (Sindiga 1990:1380). She elaborates further that despite the act, traditional healing continued. Some form of ritual performance and purification to exorcise spirits was needed. However, people started concealing their visits to traditional healers in order to avoid problems with either their fellow Christians or the colonial government and some started going for the traditional treatment in far places such as Ukambani in Eastern Province.

2.10   KIKUYU TRADITIONAL MEDICINE

Kenyatta (1965:222-258) talks of the daily life of Kikuyu people as influenced by beliefs in supernatural powers. Kikuyu people have two types of worship: deity and ancestral worship.

2.10.1   Deity

People pray to God (Ngai or Mwene-Nyaga) when they are faced with a crisis such as disease outbreak or drought. In such a case, they involve the whole clan and conduct ceremonies such as the brewing of traditional alcohol and slaughtering animals all meant as a sacrifice to God. They carry out specific rituals for different ceremonies. A good example is when there is a threat of drought; a cow is slaughtered under a sacred tree meant to be used only for such occasions. They then recite some prayers to request God to bring rain.

2.10.2   Ancestral worship

People pray together with ancestors who are invited for the occasion and asked to intervene by removing the sickness. The sickness could have been brought about by

breaking a taboo and the medicine man has failed to take it away. It is said that where the problem concerns an individual, there is no need to involve ancestral spirits. The medicine man is called in to treat the person but if the cure is not forthcoming, ancestral spirits are involved, perhaps one or two depending on the nature of the offence.

Kikuyu people have several ceremonies in which they ask for divine intervention. Such ceremonies include seed-planting in which the elders bless the seeds in order to ensure good crops; ceremony of purifying the crop, done after the planting of the seeds; harvesting ceremony to thank God for bringing the gift to the land; and the ceremony of fighting and chasing away spirits. Drums and sticks are used to chase away the evil spirits and they are ceremoniously drowned in a river.

Kenyatta (1965:271-296) reports on two varieties of herbs – those used for medical purposes and those for magic. The herbs used for magic are classified as charms or protective magic (githitu); hate or dispensing magic (monuunga or roruto); love magic (monyenye or moreria); destructive magic, witchcraft (urogi); healing magic (kihonia githitu gia kuhuuha murimu); enticing and attracting magic (rothuko); silencing and surprising magic (ngiria, itwanda); fertilising magic (muthaiga wa unoru); and purifying magic (mokora, mohoki, or ndahekio).

2.11 COMPARISON OF BOTH FORMAL AND INFORMAL HEALTH CARE

The formal and informal health care systems are referred to by Andrews and Boyles (2008:76-77) as scientific (biomedical health paradigm) and holistic health paradigm (similar to magico-religious worldview) respectively. Table 2.1 below outlines some of the differences of the two modalities.

Table 2.1   Comparison of formal and informal health care services

Biomedical health paradigm	Holistic health paradigm
Life is controlled by physical and biomedical process that can be studied and manipulated by humans	Life is controlled by forces of nature which must be kept in balance if one has to remain healthy
Cause-and-effect relationship exists for all natural phenomena	The cause of health and illness is mystical. Health is given by God for doing good or ill health for punishment. However, sometimes as God's special favour it is seen as good if it gives the affected person an opportunity to become good or be aligned with God
It is possible to control life processes through mechanical and other engineered interventions	Forces of nature are balanced to produce harmony. Imbalance of forces creates illness. Disharmony may come from seasonal changes, emotional imbalance, or any other pattern of events

Source: Andrews and Boyles (2008:76-77)

Prinsloo (2001:58) also has a view in connection with African (ubuntu) and Western philosophy in relation to treatment and provides some comparisons between the two. The comparisons are very similar to what Andrews and Boyles stated in table 2.1 above.

Table 2.2   Comparison of African and Western philosophy

African philosophy on holistic health paradigm	Western philosophy on biomedical health paradigm
Medical care should focus on the whole person in relation to interpersonal relationships not just the body. The whole human being is considered either well or in a state of disease not merely some part of it. A traditional healer is therefore concerned with the patient's background in socio-cultural and in divine/supernatural relations	Medical care focuses on parts of the body and or the body. The focus is on a disease as a physical matter that can be treated with drugs. Holistic care is hardly considered by a western doctor.
Sickness is regarded as a disturbed relationship among one's fellow people, offending the ancestors or breaking a taboo	In western thinking, sickness comes from physical causes such as germs or wear and tear of some body parts
A supernatural healer may attribute disease to a scientific/natural cause and also consider that the same disease is caused by supernatural forces	Western medicine attributes disease to a scientific cause most of the time.
Cause of stress is usually due to a strained relationship either with one's spiritual agent or with other persons within the community	Stress is regarded as having come from a person's problem such as failure of a business plan or business itself
Anxiety is thought to be a result of bewitchment leading to phobia. Treatment would mean addressing the bewitchment	Anxiety may be as a result of some coming event examination or a wedding
For healing to be considered complete after an illness, some observable measures are taken to integrate the patient socially, emotionally, psychologically, spiritually and ritually or religiously. This is done through a process which synthesises people's sociocultural beliefs, values and practices in matters of birth, life, health, diseases, death and health practices.	Once the person is considered cured, there are no other formalities conducted.
Diagnosis of ailments takes into consideration the ecological complex of the total environmental setting of men; biological, social, psychological, spiritual, and supernatural causal evidences are usually involved. A good example is getting sick as a result of breaking what is considered taboo such as committing incest	Diagnosis is done through laboratory tests or history-taking or presentation of symptoms similar to a certain disease. It is rare that doctors think of psychological attributes of a disease

Just like the comparison given above on both Western and traditional methods of healing, Leininger has extended the explanation further to include desired attributes for integrated care (professional care blended with folk or generic care). Table 2.3 below describes three modes of care, scientific or Western, holistic or non-Western and desired integrated care.

Table 2.3   Treatment modalities according to Leininger

Western (Etic) professional providers' practices	Non-Western (Emic) folk provider practices	Desired attributes for integrated care
Relies mainly on biomedical knowledge of diseases, symptoms and practices	Relies mainly on emic generic (folk) care healing, values and beliefs	Desires trust and mutual respect in caring, healing, curing and well-being
Uses partial body mind meanings, practices, and research	Seeks holistic culturally-based meanings, beliefs and lifeways for healing	Desires collaborative decision-making using the best of emic and etic practices
Uses action-oriented modes and largely 'scientific' medical facts but sceptical of folk practices	Uses listening and watching about professional ideas and practices but often sceptical of them	Seeks etic and emic care-cure practices that are congruent, safe and meaningful
Defends etic professional knowledge and practices	Uses and defends emic folk lifeways, values and experiences, especially in home context	Seeks holistic care perspectives to ensure safe and congruent generic practices
Relies heavily on medical, nursing, and other treatment modes as 'scientific' and best	Relies on folk healers and carers as safe, reliable and trustworthy	Seeks beneficial care or healing practice that incorporates one's values, beliefs, lifeways within one's living environment
Focuses on individual curing and symptom management relief for curing outcome	Focuses on caring modes and lifeway experiences in community context	Seeks competent, creative and compass-sionate practitioners

Source: Leininger and McFarland (2002:150)

The tables 2.1 and 2.2 are similar while table 2.3 has an added advantage of inclusion of desired integrated care which is an outcome of blending both professional and generic/folk care.

2.12   COMMUNITY HEALTH WORKERS

According to the National Human Services Assembly (2006), community health workers mostly perform preventative and promotive services, monitor the community's health, identify patients at particular risk, act as liaisons between the community and the health system, interpret the social climate, as well as provide basic curative services. Community health workers are currently providing at least the following types of services in different parts of the world: first aid; surgery assistance; operating room technician and equipment sterilisation; treatment of minor illnesses; dispensing drugs;

delivering babies ; giving pre- and postnatal advice; giving child care advice; nutritional education, monitoring and feeding; health education on immunisation, monitoring, and dispensing; family planning services; sanitation and hygiene promotion; screening of communicable diseases, monitoring and follow-up and medication provision; assisting in health centre activities; making health care referrals; performing school health activities; collecting vital statistics; maintaining records, composing reports; carrying out home visits; and participating in community meetings. Studies related to community health workers have reviewed a number of useful findings. Some of them are discussed below.

2.12.1 Studies on community health workers (CHWs)

According to Rosenthal, Wiggs, Brownstein, Johnson, Borbon and Rael (1998), a National Community Health Advisor Study conducted in America provided a practice-based examination of the major roles of CHWs in public health. It found that CHWs help create and improve linkages between individuals in need and community health and support services. These outreach and education services are particularly helpful for vulnerable groups. Yet, CHWs are not a cure-all for the health problems facing low-income families and their communities. The authors concluded emphasised that

> CHWs, with their unique wisdom and skills resulting from shared experiences with the community they serve and complemented by quality training, can be a linking piece ensuring that all remain connected to, and enjoy the benefits of the health care system.

Rosenthal et al (1998) in a study done in the USA refers to CHWs as paraprofessionals who reach out to families and communities facing major barriers to accessing health and human services. CHWs link clients to services, improve clients' ability to manage their health and work to create conditions so that community members can be healthy. Health professionals and systems rely on CHWs' generalist skills to help families with multiple health problems. Much of CHWs' hands-on work is in homes, the streets and other community settings. A wide range of organisations use CHWs, among them public health agencies, Medicaid and other public insurance programmes, managed care organisations, community health centres, faith-based agencies, community-based organisations and human service agencies. CHWs work with individuals and families; some also strive to improve health on a community-wide basis. Specific duties often reflect the availability of health resources and community needs. CHWs create bridges

to close the gaps in families' health resources and overall community access to health care (Rosenthal et al 1998; Love et al 2004:32).

A growing body of research is confirming what practitioners have known for years that CHWs are effective in improving access to and use of health care, including preventive health and chronic disease management, increasing health knowledge and improving health indicators. However, these results are not consistently achieved in all CHW programmes. The most effective services appear to be in improving access to health care (Swider 2002:11-20).

Rosenthal et al (1998) and Richmond (2005) report that CHW programmes can achieve other results: namely, an increased enrolment in health insurance programmes, initiate service development or expansion in underserved communities, increase clients' use of community resources, and collect data to inform for policy. In Minnesota, nearly four in five organisations using CHWs rate them as highly effective, and over 75% of all health and human service agencies indicate they are likely to .expand the number of CHW positions in the future (Eagan 2003).

CHWs have also been proved to be cost-effective. A CHWs' programme that helped Maryland Medicaid patients manage their diabetes generated a savings of more than $2,200 per patient per year. Related programme impacts included a 40% reduction in emergency-room visits and a 33% drop in total hospital admissions, and patients reported improved quality of life (Fedder, Chang, Curry and Nicholas 2003:22-27).

2.12.2   Models on delivery of community health care

Studies done on the delivery of health care at the community level have given a number of interesting results. A study carried out at Alamenda County Council (USA), reviewed that the existence and quantity of contacts and relatives have been found to relate cross-sectionally, retrospectively, and prospectively to lower rates of psychological and physical disorders and mortality (House & Kahn 1985:89).

From several qualitative anthropological studies, Wilkinson (1996:139) showed that prior to a monetary economy, food sharing and gift exchange were dominant forms of social practice in most societies, with a resultant equity of access to basic human

necessities. This is a tradition that could be practised today by individuals, families and communities at large in order to foster a sense of cohesion within their environment. The same can be said of local, regional and international partners who could share their resources for the sake of humanity and create a positive environment within their target groups.

Contrary to these early forms of mutual giving, the latter half of 20th as given rise to a sense that a person's worth is tied intrinsically to his/her market value. Wilkinson cites Cobb's study which shows that the most profound effect of the relatively low position of manual labourers is their belief that they are inherently less capable than those above them (Wilkinson 1996:144). What Wilkinson advocates is a re-ordering of priorities so that social commodities such as love and respect receive more recognition than the size of one's pocket.

A study was carried out at a private care sector by the American Association and its Health Research and Educational Trust jointly with the Catholic Health Association in a community care network-demonstrating project in 1994 in hospitals at the centre. Operating on 49 sites, the initiatives reviewed suggested that health system reform is vital to confronting the rising health care costs, the rising number of uninsured clients, and quality issues. The reform was to be achieved through a focus on the health status of the community, a seamless continuum of care, management within fixed resources, and community accountability (Weiner & Alexander 1998:48-66).

A research conducted on distribution of health in Japan, established that equitable distribution of health coincided with some of the best health status indicators in the world, with the conclusion that, 'it is not the wealthiest countries which on average have the best health status of their population, but rather the countries with the smallest income gaps between the rich and the poor' (Federal, Provincial and Territorial Advisory Committee on Population Health 1994:13). Rather than point to the physical and material dimensions of poverty leading to ill-health, the study furthers the social dimension that must be considered in understanding the effects of material poverty and health social support.

2.12.3 Community involvement

The Institute of Medicine (IOM) in Washington DC recommended that health professionals take up the role of convening partners in an effort to improve community health (Institute of Medicine 2002:187). IOM recommended this role after conducting a study on the 'future of the public's health in the 21st century'. The local health departments were urged to work as facilitators and supporters of a strong local public health system that was informed by community voices, responsive to community needs, and linked to community assets. It was pointed out that the reason for most schemes of community organisations not accomplishing much was that outsiders such as foreign organisations and top management within the respective countries tried to do the organisation with the result that the communities themselves had little or no part to play and, therefore, failed to make any substantial response.

Rothman (1976:8) further assert that for a community to develop self-expression as a process goal it needs to seek to foster collaboration, cooperation and citizen participation in self-help community projects. This is contrary to a task-oriented goal which seeks to complete a concrete task or to solve a community problem predetermined by community organisers and pertaining to the functioning of the community social system. Rubin and Rubin (1995) commenting on the same subject, point out that marginal communities are most in need of collective actions to solve shared problems and are the most difficult but not impossible to organise. He asserts that developing social networks is a way to combat helplessness and disempowerment. However, 'empowerment' being a term often associated with community development, the rational aspect of the terminology is that in order for power to be gained by some, it must be given by others. Professionals, therefore, should include an analysis of how well they are going to facilitate a relationship so that power can be taken by the individuals and communities with whom they are working.

Labonte (1997:520) cautions that instead of stating that professionals need to empower this or that group, they should recognise empowerment as the act of gaining or assuming power. He points out that continually stating we need to empower community members creates and reinforces a world of professionals that believe that non-professional groups are incapable of acting independently on health and other related matters.

The sentiments that Srinivas (1993:284-285) expounds in relation to peasants in India hold true of a community's involvement. He states that peasants are shrewd and rational in the context of culture which has been built into their experience and wisdom for centuries. Even the poorest peasants have a great amount of knowledge of every aspect encompassing the environment gathered as a result of centuries of observation and experience. These people should, therefore, be viewed as gifted individuals who have much to offer in relation to others. By seeking to make explicit the resources, gifts and abilities within a community, and to promote the value of these gifts, a first step needs to be taken in enabling groups to develop the sustainable dynamism of mutual giving and receiving that has characterised socially cohesive societies throughout time (Wilkinson 1996:638-648).

2.13   CHAPTER SUMMARY

This chapter has covered several aspects of the literature related to self-care health seeking behaviours, the domain of inquiry of this research. Major areas covered are the literature review, the culture and history of the Kikuyu people, health seeking behaviours, informal and formal health care, traditional healers (generic/folk) and lastly community health care workers, who they are, and what they do. The next chapter will present the research design and methodology.

CHAPTER 3

Research design and methodology

3.1   INTRODUCTION

This chapter provides a detailed description of the research design, methodology and procedures. A qualitative exploratory research design using the ethnonursing research method was employed. Leininger and McFarland (2002:85) describe ethnonursing research as a qualitative research method focused on naturalistic, open discovery, and mainly inductive mode. They further point out that the ethnonursing research method encompasses documenting, describing, explaining, and interpreting the worldview, meanings, symbols, and life experiences as they affect actual or potential health care phenomena. The primary reason for the use of this approach is that the qualitative research method is used for describing and understanding rather than explaining human behaviour (Babbie & Mouton 2002:270). Kvale (1996) in Babbie and Mouton (2002:289) use a metaphor in which they compare a qualitative researcher to a traveller or a miner. The traveller or a minor explores many domains of the country as known territory or with maps, roaming freely around the territory. He wanders along with local inhabitants, asking questions that lead the subjects to tell their own stories. The miner's job is to dig out precious stones. The precious stones in this essence can be compared to the lived experiences of the informants.

3.1.1   Domain of inquiry and purpose of the study

The domain of inquiry was the emic (insider) cultural expressions of self-care health seeking behaviours of the Piave community in Njoro division, Kenya.

The purpose of the study is to explore and describe the self-care health seeking behaviours of the Piave community in Njoro division, Kenya and to develop a guide (guidelines) which could serve as a leverage point to integrate self-care health seeking behaviours with professional health care.

3.1.2   Research questions

Research questions emerge from the need and rationale of the proposed study. The answers to research questions, therefore, help to fulfill the purpose and objectives of the study (Neuman 2006:291). According to Neuman (2006: 153-154) and Creswell (2009:105), qualitative researchers often begin with vague or unclear research questions as the topic emerges slowly during the study process. This is because the qualitative style is flexible and encourages focusing on the topic throughout the study. Focusing or refining continues after gathering some data and doing preliminary analysis. The research questions for this study as reported in chapter 1 are as follows:

1. What are the self-care health seeking behaviours of the Piave community?
2. How can the community's self-care health seeking behaviours and professional health care as delivered by health professionals be integrated to deliver more culturally congruent care

According to Leininger, researches questions are guides to the inquiry techniques and do not necessarily have to be analysed separately at the end of the study. Additional questions may also be raised during the process of data collection (Leininger & McFarland 2002:93).

3.2   RESEARCH DESIGN

Attig and Winichagoon (1993) in Liamputtong and Ezzy (2005:293) indicate that research design is the logical and systematic planning and directing of a piece of research. According to Parahoo (2006:183), the research design is a plan that describes how, when, and where data is to be collected and analysed. It comprises the approach (qualitative, quantitative or both, with and without a conceptual framework); the methods(s) of data collection and ethical considerations; the time, place and source of the data; and the method of data analysis. Parahoo (2006:183) further asserts that a design does not only specify the steps and actions to be taken but also represents the thinking, beliefs and strategies of the researcher and the logic of the inquiry. It incorporates some of the most important methodological decisions that a researcher makes. In the qualitative approach, the research design is often referred to

as an emergent design, a design that emerges during the course of data collection (Polit & Beck 2008:56; Creswell 2009:180).

The primary goal of qualitative research is describing and understanding phenomena or a group of people living together as community members (Babbie & Mouton 2002:53). Thus, the philosophical underpinning of qualitative research is deeply rooted in the descriptive modes of science. In this research, the ethnonursing method, a form of qualitative paradigm was used to explore and describe the self-care health seeking behaviours of the Piave community. In carrying out this research, the researcher understood that meanings and practices are usually embedded or tucked into the social structural factors, cultural beliefs, language, environment and artefacts (Leininger & McFarland 2002:82).
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Miles (1992) in Hardiman (1993:1024) emphasises that the qualitative research methodology favours understanding rather than predicting behaviours. In the same tone, Morse and Field (1995:152), point out that qualitative research is concerned with people's perception of their presence in the world. They further explain that perception presents with evidence of the world, not as it is thought, but as it is lived. It, therefore, represents a diverse set of philosophies that underpin research practice in human science. The selected approach may, therefore, be adopted if it is in keeping with the research question asked (Maggs-Rapport 2000:375). The researcher used this method since her domain of inquiry is based on understanding the self-care health seeking behaviours of the Piave community.

3.2.1 Analytical methods in qualitative research

For this study, the ethnonursing four phases of qualitative data analysis were used. The first two phases include the recording of all grounded data together with specific code indicators. The third phase is for sorting out recurrent themes or categories while the fourth phase is for identification of major themes (Leininger & McFarland 2002:95). The four phases of data analysis are described in more detail in chapter 4.

3.2.2 Philosophical basis

Researchers approach their studies from a specific philosophical paradigm. A paradigm is a world view, a general perspective of the complexities of the real world (Polit & Beck 2008:13). Old paradigms are sometimes overtaken by new ones depending on the school of thought at any given time. Kuhn (1970) in Parahoo (2006:39) points out that in any era, one paradigm is likely to dominate and that a scientific evaluation takes place in which the dominant paradigm is replaced by a new science, which in turn becomes the preferred paradigm and replaces the previous one.

Paradigms are useful in the research process in relation to guidelines and principles to direct a research study. According to Campbell and Rasso (1999) in Patton (2002:92), knowledge is inherently entrenched historically in a specific paradigm and therefore relative rather than obsolete, and that all methods are imperfect, meaning multiple methods, both quantitative and qualitative, are needed to create and test theory, advance perception over time of how the world operates, and support informed policy making and social models of decision making.

3.2.2.1 *Interpretivist research*

Milburn et al (1995) in Parahoo (2006:42) point out that Interpretivistism is put forward as an alternative to positivism. It looks at the social world as actively constructed by human beings and those human beings are continuously involved in making sense of, or interpreting their social environment. They believe that human behaviour can only be understood when a qualitative, descriptive, exploratory and contextual research design takes place and the thinking process that gives rise to it is studied. The approach also recognises that researchers have preconceptions that must either be bracketed or discussed in relation to their implication in the data being collected or analysed. Another way that interpretive rigour can be ensured is by demonstrating clearly how the interpretation was arrived at. Plenty of direct quotes and complete interviews provide the leader with a clearer sense of evidence on which analysis is based (Parahoo 2006:39; Liamputtong & Ezzy 2005:380). However, Atkinson et al (1991) in Parahoo (2006:39) state that knowledge is legitimised when external peers, the people studied and other relevant audiences agree that interpretation and conclusions are accurate reflections of the aspects of the study under scrutiny. In this study, the researcher

looked into the social and cultural world of a specific community using the ethnonursing method.

3.2.2.2 *Naturalistic paradigm*

According to Polit and Beck (2008:15), the naturalistic paradigm (sometimes referred to as constructivist paradigm), started as a countermovement to positivism. Naturalism was the outgrowth of cultural transformation, called postmodernism. The naturalistic paradigm represents an alternative way to conduct disciplined research in nursing. The naturalistic inquirer does not view reality as a fixed entity; there are always multiple interpretations of reality existing in people's minds. Naturalists believe that reality exists within a context and many constructions of reality are possible. They take the position that there is no process through which the ultimate truth or falsity of the constructions can be established.

Qualitative researches are naturalistic to the extent that the research takes place in the real world setting and the researcher does not attempt to manipulate the phenomena of interest. The phenomena of interest unfold naturally. This means that no predetermined course is established by the researcher such as would be in a laboratory or other controlled setting (Patton 2002:39). Guba (1978) in Patton (2002:39) defines naturalistic inquiry as a 'discovery-oriented' approach that minimises investigator manipulation of the study setting and places no prior constraints on what the outcome of the result will be. The naturalistic method of inquiry attempts to deal with the issue of human complexities by exploring it directly. It emphasises the inherent complexity of human beings, their ability to shape and create their own experiences and that truth is a combination of realities. It places a lot of emphasis on understanding human experience as it is lived through collection of and analysis of qualitative materials that are narrative and subjective (Polit & Beck 2008:16).

Naturalistic thinking emphasises the value of deconstruction of meaning taking apart old ideas and structures (this comprises the ideographic level of data analysis through open coding), and reconstructing them in new ways (referring to nomothetic analysis by using axial coding). For a naturalistic inquirer, reality is not a fixed entity but rather a construction of research findings. This is supported by Young, Taylor and McLaughlin-Renpinning (2001:20) who point out that, 'knowledge grows through a more

sophisticated and informed world view acquired when more information becomes known'. The findings from a naturalistic inquiry are the product of the interaction between the researcher and the informants. Inquiry is conducted in less-controlled settings. Unstructured Interview guides and observations are the main methods of data collection.

Epistemologically, the naturalistic paradigm assumes that knowledge is maximised when the distance between the inquirer and informants in the study is minimised. The voices and interpretation of the informants are crucial to understanding the phenomena of interest. The findings in a naturalistic inquiry are the product of the interaction between the researcher and the informants (Polit & Beck 2008:14).

3.3   RESEARCH METHODOLOGY

Research method encompasses, research setting, sampling, data collection, data analysis and interpretation.

3.3.1   Research setting

Below is a map of the Nakuru district. The research was conducted at Piave situated in the Njoro division of the Nakuru district. The site where the research was conducted is highlighted in figure 3.1.
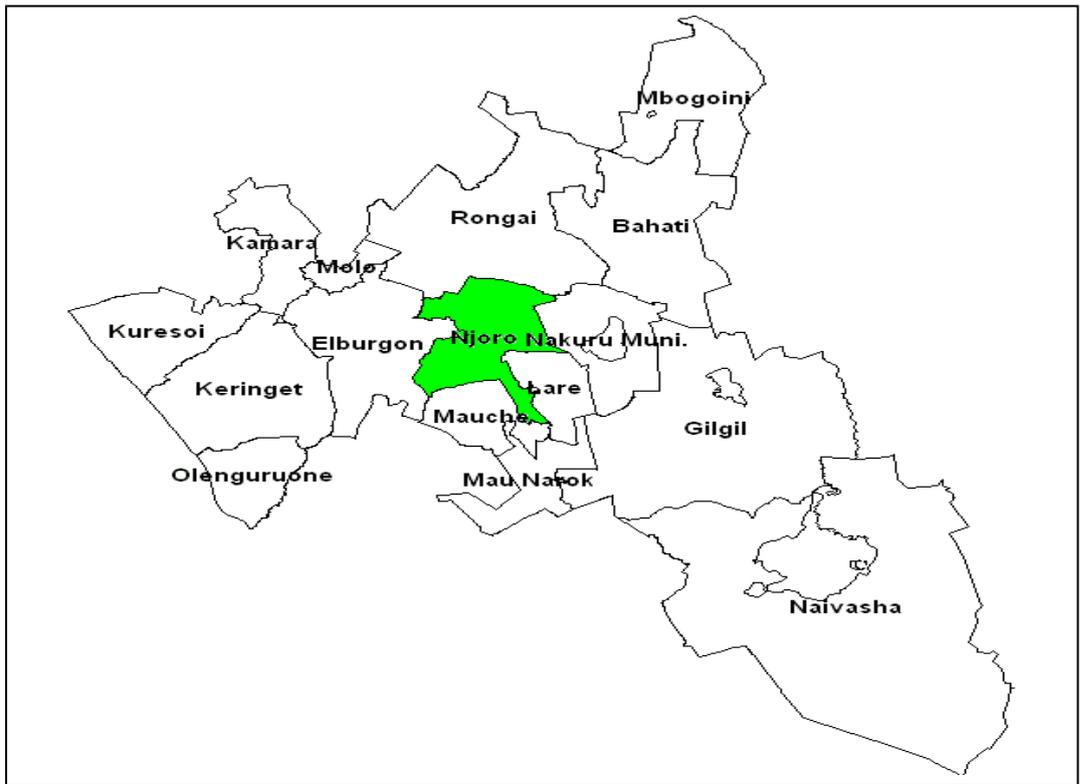
Figure 3.1   The map of the Nakuru district where the research was conducted

Source: ArcView software (mapping software)

3.3.1.1 Njoro division

The Njoro division situated 18 kilometres southwest of the town, Nakuru, is an agricultural area. Njoro is populated by people from all ethnic groups in Kenya. However, the Kikuyu are the predominant people and thus have greatly influenced the culture of the area. It covers an area of 774 kilometres, and has a population of 160 607 people (Njoro [s.a.])

The exact place where the research took place was at Piave within the Njoro division. The reasons for selecting this study area are varied and are as follows:

- The community is lagging behind in terms of health care delivery systems and community development according to the Society for Women and AIDS in Kenya (SWAK).
- The researcher comes from a Kikuyu community and it was, therefore, easy for her to obtain information from the selected population especially because of the language.
- She was familiar with the community because a society she is affiliated to (Society for Women and AIDS, Kenya Chapter) has done some community work within this area in which she has partially participated. She, therefore, realised that being accepted into the community would be easy as she had established very good rapport with some of SWAK's community health workers.
- She had talked to the national coordinator of SWAK about her doing research in Nakuru and both had identified Piave as a good area since SWAK had not yet done community diagnosis there and her results if on time might be helpful in community work.
- SWAK's national coordinator had requested that the Nakuru branch coordinator (SWAK) give the researcher any required assistance. She promised to allocate two field community health workers to accompany the researcher when it was necessary. The researcher, therefore, envisioned that getting into the community was going to be easier with this kind of assistance. The field workers were familiar with not only the area but also with the people in the community because of SWAK's presence there.

3.3.2 Sample and sampling procedures

Purposeful and snowballing sampling was used.

Maxwell (1997:87) defines 'purposive sampling' as a type of sampling in which 'particular settings, persons, or events are deliberately selected for the important information they can provide that cannot be gotten as well from other choices'. Purposive sampling involves taking a sample of a small number of units from a much larger target population. However, there are no rules for sample size. Sampling depends on what the researcher wants to know; the purpose of the inquiry; what is at stake; what will be useful; what will have credibility, and what can be done with the available time and resources (Patton 2002:244). According to Patton (2002:245) and Rice and Ezzy (2001:42), the aim of sampling in qualitative research is to describe a process involved in a phenomenon, rather than in its distribution. A sample aims to identify the cases that will provide a full and a clear understanding of all aspects of a phenomenon. The authors go further and point out that the target of selecting a sample is, therefore, to aim at information-rich cases for studying in depth.

3.3.2.1 Snowballing or networking sampling

A state in which informants refer someone they know has knowledge of the phenomena under study, to be included in the inquiry (Parahoo 2006:473). It is another informant selection strategy in which the initial informants identify others whose perspectives are important to the domain of inquiry. According to Giacomini and Cook (2000:359), the exploratory nature of qualitative research typically requires investigators not to pre-specify a study population in strict terms, in case an important person, variable, or unit of analysis is overlooked. Sampling aims to cover a range of potentially relevant social phenomena and perspectives from an appropriate array of data sources. Selection criteria often evolve over the course of analysis, and investigators return repeatedly to the data to explore new cases or new angles.

With regard to purposeful sampling, the researcher requested the community members to assist her in selecting the study population. As the fieldwork progressed,

she used both community members and key informants in assisting her to enlist more key informants through snowballing sampling. The researcher also came across other potentially useful informants and enlisted them as she continued with the study. The reason for this is that the number of informants is not decided upon in advance; interviews go on until saturation of the data is reached (Patton 2002:245).

3.3.3 Study population

Various groups of informants were selected for the study from among the community members of Piave. These were key and general informants. The informants' demographic data is given in chapter 5.

Two additional groups of general informants (health care providers and traditional healers) were interviewed to gain information pertaining to their work and likely information they might have pertaining to the domain of inquiry. The biographic data included a public health nurse in charge of public health in the Nakuru district; health care providers from the Njoro Health Centre comprising two clinical officers, two Kenya registered health nurses and one Kenya enrolled community health nurse, all interviewed in one focus group. Another group of health care providers from the Piave Dispensary made up of two nurses, one a Kenya community health nurse and the other a Kenya enrolled community health nurse, was interviewed. Traditional healers comprised a woman witchdoctor cum-traditional birth attendant cum-circumciser of girls about 90 years old; five male herbalists whose ages ranged from 30 to 73; a woman herbalist cum-traditional birth attendant aged 42 and a male divine healer 60 years old. The reason for their inclusion was that being health care providers close to the Piave community, they were likely to be able to provide information on the health seeking behaviours of the Piave community and the respective roles played by each group with regard to giving formal or informal health care to Piave community members.

3.3.3.1 *Criteria for selection of key and general informants within the Piave location*

All the key informants were supposed to have lived in the study area for at least 15 years while 10 years were expected from the old men and women interviewed in the focus groups. The general informants comprising the young women and men were

expected to have been born, brought up and have lived in Piave. The reason for selection of the informants who had lived in Piave for the stated period was based on their likelihood of being well conversant with the aspects of the domain of inquiry.

3.3.3.2 Description of the key and general informants

Key informants

According to Leininger (1991:110), key informants are described as 'people who have been thoroughly and purposely chosen for the knowledge they have about the culture under study'. They are, therefore, studied in-depth (Leininger & McFarland 2002:93). According to Parahoo (2006:275), key informants are people whom the researcher relies on for providing information, insights, access to other people, events, and artefacts. They are people who are particularly knowledgeable about the domain of inquiry and articulate about their knowledge. Their insight can be useful in helping a researcher know what is happening and why (Patton 2002:321). Key informants should be clearly told the reason for the inquiry; they are more useful if they understand it and the kinds of information needed. Patton (2002:331) asserts that they should be selected wisely and used carefully. The researcher is advised to draw on the wisdom of their informed perspectives, but at the same time to keep in mind that their perspectives may be selective (Patton 2002:331).

General informants

Leininger and McFarland (2002:93) explain that 'General informants are studied for reflection and for representation in the wider community'. In this research, general informants were placed into focus groups. Carey (1994) in Streubert and Carpenter (2009:28) explains that a focus group is a semi-structured group session, moderated by a group leader, held in an informal setting with the purpose of collecting information. Patton (2002:385) reports that focus group interviews originated from market researchers in the 1950s as a way of simulating consumers' group processes for gathering more information about their preferences in products. On the academic side, it was started by sociologist Robert K. Merton and associates who wrote seminar work on research-oriented focus group interviews in 1956.

Streubert and Carpenter (2009:28) go further to say that, although the focus group method did not originate from the qualitative study method, it is very useful particularly

in sensitive cases. Focus groups are more particularly suited to data collection of the qualitative method because they are inexpensive, flexible, stimulating, cumulative, elaborate, assistive in information recall, and capable of rich data (Patton 2002:386).

Focus group interviews are comprised of about 5-15 people whose opinions and experiences are required simultaneously (Brink 2003:159). Interviewing several people at the same time is used to allow informants to share their thoughts with one another. The sharing is likely to generate new ideas and also consider a range of other existing ideas before the researcher's questions are answered. Focus groups are useful in participatory and action research particularly where the topic of the research is a community concern (Brink 2003:159). The hallmark of focus groups is their explicit use of group interaction to produce data and insight that would be less accessible without the interaction found in a group (Morgan 1997:2). The facilitator can ensure that any confusion about a particular item is clarified and encourages informants to go on with the interview. In this research, the focus groups which are made up of general informants were selected for their representation in the wider community.

3.3.3.3 Selection of key and general informants

Key informants

In this study, the researcher told the coordinator of the branch of the Society for Women and AIDS in the district of Nakuru her intention regarding the data collection in the Njoro division at Piave. The coordinator in turn talked to a community health worker (belonging to the Society for Women and AIDS) well known to the community selected for the study, and requested her to identify some community individuals who were well conversant with the culture aspects of Piave people. To assist her was also the chief of the Piave location. This was done two weeks prior to the researcher's visit to Piave for data collection. When she went there, she again discussed what was required from the key informants and had to choose some from the list of those suggested. By becoming acquainted with the community members of Piave, the researcher with the aid of informants was able to identify other useful key informants. She, therefore, used the snowball technique by enlisting other informants as she found fit.

General informants

Purposeful and snowballing techniques were used for this group. Some of the key informants were requested to assist in identifying the general informants after the researcher explained the criteria to be used in the selection process. Those selected were willing to enter into the interview process and were very participative.

Selection of the additional general informants

The researcher was assisted by the community members in looking for traditional healers. As for the health care providers, she visited the health care facilities where they worked and asked to interview them after receiving permission from the respective heads of the health units visited. She had earlier received a letter of authority to do the research from the medical officer of health at the Nakuru District Hospital and as such there was no objection from the health care providers selected for interview. Table 3.1 below indicates the number and groups of both key and general informants interviewed for the study in Piave.

Table 3.1   Sample: Key and general informants from Piave

Key informants	Eight informants interviewed individually
General informants: Women's group	Eight interviewed in one group
General informants: Men's group	Five interviewed in one group
General informants: Young men	Eight interviewed in one group
General informants: Young women	Seven interviewed in one group

Table 3.2 below indicates the health care providers and traditional healers interviewed.

Table 3.2   Sample: Additional groups of general informants

Divine healer cum witchdoctor (individual interview)	1
Herbalist cum traditional birth attendant, cum girls' circumciser (individual interview)	1
Herbalist (individual interview)	6
Health care provider at Njoro Health Centre (5 general informants in one focus group interview)	1
Health care providers at Piave Dispensary (2 general informants in one focus group interview)	1
Public health nurse in charge of Nakuru district (individual interview)	1

3.3.4 Data collection

In this study, the researcher tried to capture data on the perception of the informants from an 'inside or emic' view through the process of deep attentiveness and empathetic understanding. The researcher respected the views of the informants by using 'bracketing', a cognitive process of putting aside one's own beliefs, not making judgment about what one has observed or heard, and remaining open to data as they are observed (Streubert & Carpenter 2009:22). Ahern (1999) in Streubert and Carpenter (2009:22) states that the process of bracketing is iterative and a part of a reflexive journey. Introspection or reflexivity, whereby biases, values and own interests are acknowledged by the researcher, is very important during qualitative studies. The struggle for objectivity during data collection and analysis while being so intimately involved with the cultural group is a characteristic unique to this paradigm (Streubert & Carpenter 2009:159). To aid in unbiasness, the researcher kept a diary of personal thoughts and feelings to explicate her feelings and beliefs. This meant constantly being aware of what she believed in and trying to keep it separate from the information that was being shared by the informants (Streubert & Carpenter 2009:22).

Data collection was guided by the ethnonursing research method developed to reveal embedded and undiscovered phenomena (Leininger 1991:75). Ethnonursing requires open discovery, active listening and a genuine learning attitude (Leininger 1991:107). It encourages the informants to share their knowledge with the researcher freely while at the same time encouraging the researcher to become actively involved in interviewing the informants and keenly observing them and what is going on in the surrounding area. During data collection, the Domain of Inquiry Enabler (Leininger & McFarland 2006:26) of the ethnonursing research method was used:

Domain of Inquiry Enabler (DOI)

According to Leininger and McFarland (2006:26) researchers develop their own Domain of Inquiry (in this study the DOI was self-care health seeking behaviours of the Piave community) which acts as an enabler to keep focused during data collection. The

researcher kept the DOI and research questions in mind during the data collection to stay focused.

To allow open-ended discussions, semi-structured interview guides were used. They comprised of three different types of interview guides; one type for key and general informants from Piave, another type for health professionals and another one for traditional healers (see annexure C for the three types of interviews guides). The interviews followed the following trend:

- Welcome the informant (s) to the session

- Discuss the purpose of the study

- Obtain informed consent

- Articulate a brief overview of the process, duration, and explanation of the ground rules

- Open with a compelling introductory question to open the discussion

- End with a summary question or statement to close the discussion

- Debrief informant (s) and

- Thank the informant (s) for participating in the discussion

3.3.4.1 Semi-structured interview guides

Qualitative researchers utilise open-ended interviews that allow for individual variations. Polit and Hungler (1999:272-273) point out that a semi-structured interview guide or 'schedule' is given. This contains a list of questions or general topics that the interviewer wants to explore during each interview. Although the guide is prepared to ensure the same information is obtained from each person, there are no predetermined responses, and in semi-structured interviews, the interviewer is free to probe and explore within these predetermined inquiry areas. Semi-structured interview guides ensure good use of limited interview time; they make interviewing multiple subjects more systematic and comprehensive and help to keep interactions focused. In keeping with the flexible nature of qualitative research designs, interview guides can be modified over time to focus attention on areas of particular importance, or to exclude questions the researcher has found to be unproductive for the goals of the interview (Patton 2002:517).

The conversational nature of a semi-structured interview allows informants to tell their stories in a natural way without constraints. In a way, the informants determine the flow of the discussion with the researcher following up their answers (Polit & Hungler 1999:256). Probing questions are asked to explore what is said and is not clear or to gain more information where deemed necessary by the researcher. As the informant speaks, the researcher looks at the interview guide to ensure that all the areas are being covered. She subsequently uses the principle of data saturation and stops the exercise when no new data emerges (Polit & Hungler 1999:43). This occurs when themes and categories become repetitive and no more new information seems to come by.

The interviews were done through two to three interview sessions lasting one to two hours each for key informants and two interview sessions for general informants lasting 30-45 minutes for each group.

3.3.4.2   Focus group interviews

Kreuger (1988:18) defines a focus group as a 'carefully planned discussion designed to obtain perceptions in a defined area of interest in a permissive, non-threatening environment'. As data collection tools, the researcher used general informants in the form of focus groups. The group members were familiar with one another, and shared common interests in the domain of inquiry under exploration.

Interview venues

Semi-structured interviews were conducted at facilities suitable to the key and general informants and in an environment that was conducive to private, non-threatening and non-interrupted conversion. In a qualitative research, the conduct of inquiry is done in a way that limits disruption of the natural context of the phenomena of interest. For the key informants, interviews were done in naturalistic settings; in their homes while those of the general informants were done at the offices of SWAK, a venue that was conducive to interviews. It was spacious enough to accommodate the various groups and quiet with no interruptions coming from within or outside. The seating arrangement

was fairly good; some wooden benches were used and arranged in a way that facilitated the discussions that were taking place.

As for the other general informants, health care workers' and traditional healers' interviews were done in different venues as follows: the public health nurse in charge of the Nakuru District Hospital was interviewed in her office within the hospital setting while the health care workers from the Njoro Health Centre were interviewed in the centre's boardroom and those from the Piave Dispensary in the treatment room of the dispensary. Some of the traditional healers were interviewed in their places of work which comprised homes and herbal clinics. The researcher had to look for quiet places within nearby hotels to use as interview venues for those working at bus terminals. She requested permission from the hotel owners or managers to carry out the interviews within the identified premises.

3.3.4.3 *Participant observation*

Marshall and Rossman (2006:98) define observation as the systematic description of events, behaviours, and artefacts in the social setting chosen for study. Participant observation is the process that enables researchers to learn about the activities of the people under study in the natural setting through observing and participating in those activities. Schensul, Schensul and LeCompte (1999:91) define participant observation as 'the process of learning through exposure to or involvement in the day-to-day or routine activities of informants in the researcher setting'. They point out that participant observation is characterised by such actions as having an open, non-judgmental attitude; being interested in learning more about others; being aware of the propensity for feeling culture shock and for making mistakes, the majority of which can be overcome; being a careful observer and a good listener, open to the unexpected in what is learned. Bernard (1995: 259-300), expounding on the same understanding, indicates that participant observation requires a certain amount of deception and impression management. Researchers, he notes, need to maintain a sense of objectivity through distance.

According to deMunck and Sobo (1998:41), for the participant observation to gain more mileage, a practice referred to as 'hanging out' is necessary. They state that, 'only through hanging out do a majority of villagers get an opportunity to watch, meet, and get to know you outside your professional role'. They point out that hanging out involves

meeting and conversing with people to develop relationships over an extended period of time. The researcher in this study spent a lot of time hanging out with the community members. She visited drinking dens and participated in general and specific discussions related to the domain of inquiry mainly in self-care health seeking behaviours. She also visited homes and took walks within the community surroundings with the aim of observing the general outlook of the environment and the community's ways of life. On three occasions, she participated in community workshops led by the Society for Women and AIDS in Kenya mapping out health and socioeconomic issues ailing the community while at the same time discussing how to address them.

3.3.4.4   Field notes

With ethnonursing, the researchers are supposed to document their experiences after completion of each observation in any given social situation. A social situation refers to the behaviour or activities carried out by people as actors in a particular location (Spradley 1980:86). The analysis of the situation leads to the cultural scene. In an ethnonursing study, a cultural scene refers to the culture being studied (Spradley 1980:86). The documents generated after each observation are referred to as field notes (Streubert & Carpenter 2009:166). The researcher entered the filed notes in a notebook and later transferred them to her computer in Microsoft Word.

3.3.4.5   Researcher as an instrument

In qualitative inquiry, the investigator is a research instrument. This is in line with the epistemological assumptions of the inquiry paradigm, which specify mutual and simultaneous shaping between the investigator and the informants. Because the goal is to understand the social world from the informants' point of view (the emic perspective), it is necessary to be able to experience the subjective world of the performer, or to take the role of the other, to the extent possible. This requires sensitivity, flexibility, and openness. The investigator must be aware of, and guard against, personal prejudices and preconceptions in data gathering and interpretation. He or she must also have a high tolerance for ambiguity, be an astute observer and listener, and have the tenacity to continue probing a social phenomenon until it is thoroughly understood.

Spradley (1980:58-62) describes the various roles the researcher may take as a research instrument. The roles range from non-participation (activities are observed from outside the research setting; to passive participation (activities are observed in the setting but without participation in the activities); to moderate participation (activities are observed in the setting with almost complete participation in the activities); to complete participation (activities are observed in the setting with complete participation in the culture). They further explain that the range of membership roles includes peripheral membership, active membership, and full membership. Those serving in a peripheral membership role observe in the setting but do not participate in activities, while active membership roles denote the researcher's participation in certain or all activities, and full membership is reflected by fully participating in the culture.

The researcher followed similar trends described by Spradley above. However, she used the role of a 'stranger to trusted friend enabler' (Leininger & McFarland 2002:89).

The following section is a description of the roles the researcher took in the interview and participant observations in this research: the role of a 'Stranger to Trusted Friend Enabler' (Leininger & McFarland 2002:89). The roles are described below:

Leininger's stranger to trusted friend enabler'

According to Leininger and McFarland (2006:26), the enabler guides the researcher while working with informants to become a trusted friend and is used from the beginning to the end of the research.

As the researcher started an in-depth interview, she was initially a stranger but slowly became a trusted friend. This was enabled by her gaining trust among the informants for the simple reason that they liked and trusted her especially because she belonged to their ethnic group, the Kikuyu people.

The observation-participation-reflection enabler

According to Leininger and McFarland (2006:26), the researcher gradually moves from observation of the informants to participation phase and still later to full reflection and confirmation of data collected with informants.

The epistemological view of the researcher in this study was that she had to be close to the people she was researching. She placed herself in the role of 'the observation-Participation-reflection Enabler' – a role described by Leininger and McFarland (2002:89) as moving from an observer and listener role to progressively taking an informant and reflector position with the informants or with the phenomena under study. She at the same time ensured that she did not impose her knowledge and experiences on the field under study. By being with the informants and gaining their confidence, she shifted from an etic (outsider's role) to an emic role in her field research.

3.3.5 Data analysis

The Collins English Dictionary (2006) defines the word 'analysis' as separation of a whole into its parts for study or interpretation while to 'analyse data' means to examine something in detail in order to discover meaning or essential features.

3.3.5.1 *Qualitative data analysis*

Miles and Huberman (1994:10) define qualitative data analysis as consisting of three concurrent flows of activity: data reduction, data display and verification. Data reduction refers to the process of selecting, focusing, simplifying, abstracting and transforming the data that is in the field notes. Qualitative data can be reduced and transformed in many ways: through selection, summary or paraphrase or subsumed in a larger pattern. Data display is an organised, compressed assembly of information that permits conclusion-drawing and action. Perusing through display helps the researcher to understand what is happening and analyse further. Conclusion-drawing and verification are done as the researchers proceed with data collection and analysis until they come up with the final results. The research in this study being ethnonursing in design used the four stages of data analysis described by Leininger and McFarland (2002:95). They are similar to what Miles and Huberman have described above. The process of analysis will be described in detail in chapter 4, the data analysis chapter.

3.4 METHODS TO ENSURE TRUSTWORTHINESS

In qualitative data, methods of establishing reliability and validity differ from those in quantitative research. Qualitative researchers use different criteria from those used by quantitative ones and frequently avoid using reliability and validity (Brink 2003:124). The question to ask at times is 'Does the data collected by the researcher reflect the truth?' (Polit & Hungler 1999:361). Lincoln and Guba (1985) in Polit and Hungler (1999:362) have listed a number of ways qualitative researchers can establish the trustworthiness of qualitative data. These are credibility, transferability, dependability and confirmability. The authors are also supported by Leininger who points out similar ways with an additional few: namely, meaning in-context and saturation (Leininger & McFarland 2002:88). Whittermore, Chase and Mandle (2001) in Polit and Beck (2008:436) have added authenticity to the means of establishing trustworthiness to qualitative research inquiry. Below are the explanations of the ways the researcher established trustworthiness in her ethnonursing inquiry.

3.4.1 Authenticity

Authenticity is regarded as a unique feature in naturalistic inquiry; it refers to fairness. It is demonstrated if the researcher can show a range of different realities. The question to ask here is 'Has the researcher adequately represented the multiple realities of those being studied? Has an emic perspective been accurately portrayed?' (Polit & Beck 2008:437). The pertinent question is: 'Are all voices represented?'

In this study, multiple realities were presented through key and general informants from a cross section of the Piave community: namely, women, men, young women and young men. Others included were health care providers and traditional healers from areas adjacent to Piave. In addition, informants' and field trip observations were included and involved interacting with community members either in social places such as drinking dens and Piave shopping premises or within their respective homes to hear their stories in relation to the domain of inquiry and related perspectives.

The voices of the informants were heard through preventing marginalisation and acting affirmatively with respect to inclusion. The voices of the informants were included in the inquiry and represented in the text through direct quotes.

3.4.2 Credibility

According to Parahoo (2006:466), credibility refers to the extent to which the findings of a study reflect the experiences and perceptions of informants. They must also be credible to the readers of the report. The researcher used triangulation to ensure credibility. According to Lincoln and Guba (1985:305), triangulation refers to the use of a combination of methodologies in the study of the same phenomenon. Triangulation may involve multiple investigators, multiple theories, multiple data collections, multiple measures, multiple analysis methods, or any combination of these methods. The assumption underlying this pluralism is that each type of research methodology, whether quantitative or qualitative, has an inherent bias or weakness; however, the biases or weaknesses of research methods are not identical. Consequently, when several methods are used conjointly, the bias inherent in one method may be cancelled out by the bias introduced by another. That is, the weaknesses or limitations of one method may be compensated for by the strengths of the other. This balancing will be likely if different approach methods are chosen because they do not share the same biases or weaknesses. In addition, with triangulation, the strengths of one method add to or even enhance the strengths of the other, thus providing complementary information that gives a more complete and comprehensive explanation or picture of the phenomenon under study.

To establish the credibility of the study results, various sources were used for data collection. These included key and general informants from Piave and additional general informants mainly from adjacent areas, health care providers and traditional healers. Included were multiple methods of data collection: semi-structured interviews, focus group discussions, participant observation and field notes. Prolonged engagement was established through building trust with the informants via establishing rapport, spending time with them before and during the interview in order to become acquainted with them. Before the interview, the researcher on two occasions visited the community with Society for Women and AIDS official members. On the first occasion, she took part in a workshop organised by SWAK on post-abortal care. She had a

chance during this time to meet many women and a few men from the community and also to see the infrastructure of the Piave location. On the second occasion, she accompanied an official from USAID who took a tour of the area to inspect the activities of SWAK that the organisation had funded on post-abortal care.

During the interview process, the researcher was open and honest and honoured confidentiality. She also ensured prolonged engagement by doing 'member checking' through continuously reaffirming or confirming information, restating the informants' statements to clarify the distinctive and accurate meaning and expression of their responses. The researcher also took the data back to the informants for them to determine whether they felt it was accurate in relation to what they had expressed during the interview. She narrated the data to the informants, both key and general informants, and thankfully all that had been recorded was correct; perhaps because she also used member debriefing at the end of every interview to clarify whether the data collected was a true reflection of what had been said during the interview process. She had more than one interview session with both key and general informants for member checking and obtaining more data to fill in identified gaps from the initial interviews. With the informants' permission, the researcher used a digital voice recorder and made notes of each interview session through listening to the recorded information. Translation from the Kikuyu Language to English was done immediately by the researcher who is well conversant with both languages, Kikuyu being her mother tongue. The results of the study were open for scrutiny by the researcher's promoter and co-promoter and any other interested reader.

3.4.3 Persistent observations

'Persistent observations' refers to the researcher's focus on the characteristics or aspects of a situation or a conversation relevant to the phenomena under study (Polit & Beck 2008:430). The observations provide in-depth understanding of the domain of inquiry (Lincoln & Guba 1985:304). The researcher engaged in persistent observation by taking a keen interest in how people interacted and went on with their respective work routines including noting any issues on environmental situations such as infrastructure and the socioeconomic status of the community during her field visits. This gave her in-depth understanding of the lifeways of the community being studied.

3.4.4 Peer debriefing

Three colleagues were requested to peruse the results and give their personal comments. The data was also presented three times to a group of other colleagues at the workplace during the initial data collection, halfway in the data collection and at the completion of the collection. Debriefing sessions provided the researcher with an opportunity for catharsis, thereby clearing the mind of emotions and feelings that might be clouding good judgment or preventing the emergence of prudent ideas. The process of debriefing enhanced the accuracy of the study materials (Creswell 2009:196; Polit & Beck 2008:430).

3.4.5 Transferability

'Transferability' refers to the extent to which qualitative findings can be transferred to other settings (Polit & Beck 2008:41). Lincoln and Guba (1985:316) note that the responsibility of a researcher is to provide sufficient descriptive data in the research report so that those who might want to use it have sufficient data that can be used to evaluate applicability to other similar situations. According to Cronbach (1975:125), 'when we give proper weight to local conditions, any generalisation is a working hypothesis, not a conclusion'. However, as Guba and Lincoln (1985:316) point out, the responsibility of the researcher is to provide sufficient descriptive data in a research report so that the readers can evaluate the applicability of the data to other situations. Rich descriptions allow comparison by other researchers while purposeful sampling aids in transferability. Thick descriptions refer to rich and thorough descriptions of research settings or context and of transaction and processes observed during inquiry (Polit & Beck 2008:436).

To ensure transferability in this study, the researcher described the results in-depth with direct quotations from the interviews. The results were also recontextualised in the literature. In addition, she has given thorough descriptions of the informants and their research settings so that the utility of the evidence for others can be assessed.

3.4.6 Meaning in-context

According to Leininger and McFarland (2002:88), 'meaning in-context' refers to understandable and meaningful findings that are known and held relevant to the people within their familiar and natural living environmental context and culture.

3.4.7 Saturation

Leininger and McFarland (2002:88) explain that 'saturation' refers to in-depth information of all that is or can be known by the informants about a phenomenon related to a domain of inquiry being studied.

3.4.8 Recurrent patterning

'Recurrent patterning' is said by Leininger and McFarland (2002:88) to refer to documented evidence of repeated patterns, themes, and acts over time reflecting consistency in lifeways or patterned behaviours.

3.4.9 Dependability

'Dependability' refers to the stability and consistency of data over time and over conditions (Polit & Beck 2008:434). Dependability can be established through triangulation methods similar to those used in 'credibility' such as audit to be done to establish the dependability of the study. Therefore, demonstration of credibility is sufficient to establish dependability. In this research, all the aspects of the study are fully described. These include methodology, characteristics of the sample and the process, and data analysis. Data quality checks were done through peer review.

3.4.10 Confirmability

Confirmability guarantees that the findings, conclusions and recommendations are supported by the data and that there is an internal agreement between the investigator's interpretation and the actual evidence (Brink 2003:125). Several strategies can be used

in confirmability of the report. Some of the methods are similar to those used for trustworthiness under the headings 'credibility' and 'dependability'. Polit and Beck (2008:435) list them as 'inquiry audit' in which the researcher develops an audit trial; this is a systematic collection of materials and orderly documentation that allows an independent auditor to do an effective audit. Six classes of audit are recommended and these are raw data; data reduction and analysis products (theoretical notes and documentation on the work); process notes; material relating to researcher's intention and dispositions (e.g. reflective notes); instrument development information, and data reconstruction (e.g. draft of the final report).These materials are available if needed at any time and some will be included as annexures (see annexure E for a sample of field notes and D for samples of interview proceedings.

3.5   ETHICAL CONSIDERATIONS IN QUALITATIVE STUDIES

There are ethical considerations at every stage of the research process, including the choice of research topic, the selection of the design, and the publication of the findings (Creswell 2009:63-68). Through discussion with her promoter, deliberate thinking and perusal of the literature and studies done on the whole research process, the researcher was convinced that this was the research of her choice and selection of the design was appropriate to the domain of inquiry.

3.5.1 Ethical issues in research development

In deciding the subject of the domain of inquiry, researchers have to consider how their chosen field will benefit the intended informants or community. They should also ensure that informants are respected and at no time should they be marginalised or disempowered. The researcher adhered to a conceptualised ethical position, a model from Guba and Lincoln (1985:21). She respected the informants and this led to the development of mutual respect on both sides, the researcher's and the informants'. She described her research objectives and process with the informants and informed them that there would be no coercion and manipulation. What would prevail was the support of democratic values, and a belief that every research act would employ moral and ethical decisions that were contextual.

3.5.2 Ethical issues in purpose, statement and research questions

The purpose of the study should be developed and described to research informants. Both parties – researcher and informants – should understand the purpose in the same way which means that the researcher should never hold back information from the informants or deceive them. The informants in this study were thoroughly informed about the purpose of the study and any fears were dealt with right from the beginning of the study. Allaying of fears was done through constantly reminding them of the purpose of the study and that confidentiality of the informants would be adhered to. Initially, there were a few informants who were concerned about the study. They thought it was a ploy to get them involved in politics as the Kenyan national elections were to be held in about six months' time. They wondered whether the researcher was campaigning for a candidate using the study as an excuse. The researcher realised the situation promptly because some informants were open with her. She openly discussed the issue and disassociated herself from politics. They felt at ease after this discussion.

3.5.3 Ethical issues in data collection

During data collection, many ethical issues arise such as: researchers should avoid putting people at risk and respect the vulnerable population. They should get permission from individuals in authority to provide access to informants at the study site.

The researcher in this study received written permission from the district officer of health at the Nakuru District Hospital to conduct the research. The chief of the study site gave verbal permission after being informed that the district officer of health had allowed the researcher to conduct the study in the Njoro division at Piave. Informants were given consent forms to sign after the following was explained:

- The right to participate voluntarily and the right to withdraw at any time if individuals so wished

- The purpose of the study for them to understand the nature of the study and its likely impact on the individuals and community at large

- The procedure of the study so that individuals were able to anticipate what was expected of them

- The right to ask questions and have their privacy respected

- Signatures of both informants and researcher agreeing to these requirements were obtained and each one kept a copy of the signed consent forms (see annexure B for a sample of a consent form).

3.5.4 Ethical Issues in data analysis and interpretation

A number of matters should be considered in data analysis and interpretation. One of the considerations is how the study will protect the anonymity of the individual. In the interpretation of data, researchers need to provide accurate accounts of the information. According to Streubert and Carpenter (2009:196), the methods of validation of data are triangulating different data sources of information by examining evidence from various data sources and using it to build a coherent justification for themes; using member checking to determine the accuracy of the findings; using thick descriptions to convey the findings; clarifying the bias the researcher brings to the study; presenting negative information that is against the themes; spending prolonged time in the field in order to develop a better understanding of the situation; using peer debriefing to enhance the accuracy of the account, and using an external editor to review the entire project.

In this study, the researcher used a coding system to protect the identity of individuals. The data was also stored in a safe place to protect it from falling into the wrong hands. Different sources were used for methods of triangulation such as member checking. The researcher carried out informal member checking during interviews through summarising data collected and clarifying it with the informants after every interview. After the initial data analysis, she went back to the field to verify with the informants whether what had been documented was the correct information. She also discussed her study with colleagues almost on a continuous basis. Coupled with this were the thick descriptions used to describe the data, spending a good amount of time on field trips and socialising with informants and other community members to learn more

about their lifeways. Data collection also came from different sources as already indicated.

The researcher has an obligation to respect the rights, needs, values, and wishes of informants (Creswell 2009:201). Spradley (1980) in Creswell (2009:202) points out that in a qualitative research design, participant observations invade the lives of the informant and sensitive information is revealed. To safeguard the informant's rights, Streubert and Carpenter (2009:202) point out some ways to handle the situation: articulating the research objectives verbally and in writing to the informants and also thoroughly explaining how the results will be used. Informants are told about all the data collection devices and activities and verbatim transcriptions. Written interpretations and reports are made available to them. Their rights, interests and wishes are considered first when making choices regarding reporting of the data. They are also given an opportunity to make their final decision involving anonymity. Owing to the nature of qualitative research, anticipated ethical issues can materialise from time to time. The ethical dilemmas inherent in issues surrounding informed consent, anonymity, and confidentiality, data collection, treatment, publication, and informant research relationships are reviewed in the light of unique issues that emerge in the design and conduct of qualitative investigations.

Certain principles must be observed while conducting research: namely, any research must not only generate or refine knowledge, but also ensure that the development and implementation of research is ethically acceptable to the population under study and other stakeholders (Uys & Bason 2000:96). The researchers should, therefore, adhere to the laws and regulations pertaining to research undertakings. To guard informants from harm, there are six ethical principles the researcher should observe. According to Parahoo (2006:111-112), they are: beneficence; the study should benefit the participating individuals and society in general by contributing to the pool of human knowledge; non-maleficence, which means the research should not cause any harm to informants either physically or psychologically; fidelity, meaning building of trust between the researcher and informants and safeguarding their rights; justice, which involves being fair to informants by not giving better treatment to some and depriving others of the care and attention they deserve. In this research, purposeful sampling was done and that meant excluding some community members. However, justice was followed in the sense that purposive sampling requires looking for specific informants

who are knowledgeable about the domain of inquiry; building trust between informants and researchers; veracity – the researcher must tell the truth, even if it causes the informant to withdraw from the study; and confidentiality – the information gathered should be held in confidence. The identity of the informants should not be revealed.

The researcher was able to observe the ethical principles stated above. She was able to build trust within the group through explaining the nature of the research and being fair to all. The researcher remained open to any anticipated ethical issue that could arise at any time while conducting the research (Streubert & Carpenter 2009:314). Fortunately, she did not encounter any problems on ethical issues as she adhered to the principles of ethical considerations at all times.

With regard to the domain of inquiry, the research will benefit individuals, families and community members if desired integrated health care comes into being within the health services delivery systems.

3.5.5 Other ethical issues in field research

The direct personal involvement in social research raises a number of issues which are likely to arise when the researcher is alone in the field and may have little time to make moral judgments (Neuman 2006:412-414). These are explained below.

Deception

The researcher may be converting, or assuming a false role, name, or identity. Convert research is never preferred. However, Lofland and Lofland (1999) in Neuman (2006:413) point out that, as in all other ethical dilemmas of naturalistic research, an ethically sensitive, thoughtful and knowledgeable researcher should be in a position to judge whether covert research is justified. However, this feature did not apply to this study.

Involvement with a deviant

The researcher may conduct field research on people who are deviant and engage in illegal, immoral, and unethical behaviour such as using illegal drugs. Such researchers face an ethical dilemma and have to find a solution to the problem. In this study, the researcher visited drinking dens which were not licensed to sell alcoholic drinks and

some of the customers were very drunk. She was also told about some of the community members who engaged in illicit drugs. However, she did not come across any of them knowingly. Nevertheless, her mission was different and, therefore, she would not have taken any extensive measures (unless an informant's health was heavily compromised) at this stage because of the issue of confidentiality. This is supported by Streubert and Carpenter (2009:159) who assert that the naturalistic paradigm in which ethnographic research is carried out supplies the researcher with the view of the world as it is but not what they wish it to be.

Publishing the report

Members of the group which has been researched may sometimes need to check the report for correct documentation. However, the researcher does not have to contact members of the group all the time; it is for the researcher to decide whether to publish or not depending on the nature of the report. In this study, the researcher does not feel bound to contact the informants prior to publishing the report since the nature of the research is for their own good and publishing it would not affect any one of them in an adverse manner.

Individual researcher

A researchers' personal moral code is the best defence against unethical behaviour before, during and after conducting a study. Researchers should reflect on the research and consult their conscience. Ethical research depends on the integrity of the researcher (Neuman 2006:130).

The privacy of all interviewed informants was protected: No names were disclosed. However, it is hard to protect the privacy of the interviewees completely in the sense that there were focused group discussions. On the other hand, privacy may not be a major issue since what was being discussed was for the good of all the community people. The data in the final stage has been presented in such a way that it captures the general discussion and decisions of the group, while attempting to ensure that individual identities are protected.

3.6   SUMMARY OF THE CHAPTER

This chapter discussed the research design and methodology used in the study. All the relevant areas pertaining to qualitative research ranging from the philosophical foundation, study design, methodology, establishment of trustworthiness and ethical considerations were covered. The next chapter presents the methods of qualitative data analysis.

CHAPTER 4

Qualitative data analysis

4.1   INTRODUCTION TO DATA ANALYSIS

Data analysis comprises the systematic organisation and synthesis of research data (Polit & Beck 2008:751). Data analysis is the process of bringing order, structures and meaning to the enormous amount of collected data. According to De Vos et al (2002:339-340), the process of data analysis is messy, time consuming, creative and fascinating as well. This is supported by Creswell (2009:139) who asserts that qualitative data analysis means searching for general relationships among categories of data. It is said to present a formidable task to researchers because of the large amount of data. However, many computer packages developed since 1970s have contributed a lot to speeding up the process.

The data analysis during this study was through semi-structured interviews with individual informants and focus groups (discussed in chapter 3). The data resulted from the following research question:

- What are the self-care health seeking behaviours of the Piave community?

4.2   QUALITATIVE DATA ANALYSIS

Data analysis starts at the proposal stage in which the decision is made on the study design (Miles and Huberman 1994:16). It covers a spectrum of techniques, the main ones being; observations, interviewing and documenting (Denzin & Lincoln 2002:84). In data analysis, researchers scrutinise their data carefully, reading it over and over again in search for meaning and deeper understanding. Insight only emerges when researchers become completely familiar with their data (Polit & Beck 2008:571). In the same tone, Morse and Field (1999:126) emphasise that data analysis is a process of fitting data together, of making the invisible obvious, and of linking and attributing

consequences to experience. It also means reducing data to a small, manageable set of themes (Creswell 2009:144).

Data analysis involves two approaches; the first one is analysis at the site during data collection. This is supported by Polit and Beck (2008:570), Marshall and Rossman (2006:113) who explain that in qualitative studies, data analysis usually occurs at the same time with data collection, rather than after all of it has been collected. The researcher, therefore, finds and makes sense of data at the same time. The second data analysis is done between site visits before the completion of the data collection (Erlandson et al 1993:113). As data is gathered, it is analysed and this might necessitate revision in data collection procedures. The revision generates new data that is subjected to new analysis. As a result, effective collection of rich data that provides a good basis of construction of reality or lifeworld of the community under investigation is done (De Vos et al 2002:344).

4.3   THE PROCESS OF DATA ANALYSIS

Creswell (2009:142) comments that qualitative data analysis can be presented in a spiral rather than using a fixed linear mode. However, for convenience of the description, the researcher has presented the data in a linear form although the steps move in circles. The following are the various stages the data has gone through.

4.3.1 Data collection, entry, coding, and analysis

In data collection, the researcher maintained perspective of open discovery, active listening, and genuine learning in the total context of the informant's world. She was active and curious about the 'why' of whatever was seen, heard, or experienced. She was also appreciative of the information the informants shared with her. She recorded whatever data was shared with her in a careful and conscientious manner in order to perceive full meanings and informants' ideas. The interviews were done in a Kikuyu language which the informants were comfortable in speaking as it is their mother tongue. The major Enablers used in this study were Leininger's *Stranger to Trusted Friend* to facilitate obtaining data as the researcher moved from a Distrusted Stranger to Trusted Friend. Leininger's *Observation-Participation-Reflection Enabler* was also used

to facilitate and guide the researcher to gain in-depth knowledge of the culture on the self-care health seeking behaviours of the Piave community. A semi-structured guide developed by the researcher to obtain culture-specific data related to the domain of inquiry and research questions was used. This was supported by De Vos et al (2002:340) who points out that in data collection, the researcher uses interview guides to ensure that data is collected in a systematic way.

Data obtained from this ethnonursing qualitative study was entered and managed through Digital Voice Recorder software which had already been stored in the researcher's computer. Data entry included a wealth of detailed raw emic data from all the informants that included verbatim statements and many hours of observational data collection. The researcher's insights, theoretical speculations, feelings, and environmental contextual data was also included for a full and detailed account.

The researcher read and re-read the data many times and also listened to a CD the same data had been stored in. This aided listening to it repeatedly and through this the researcher became immersed in the data. When categories and groupings began to emerge, descriptive codes were assigned to data groupings based on the domain of inquiry and research questions. Codes were continuously compared to determine patterns. Patterns were the researcher's best statements that reflected the meanings and experiences of the informants. Patterns were scrutinised to discover saturations of ideas and to identify similar or different meanings, experiences, structural forms, interpretations, or explanations related to the domain of inquiry. Informants were asked to clarify and explicate findings at all stages in the analysis. In this way, patterns of self-care health seeking behaviours were confirmed in the context of the informants' experiences.

The coding of the data that reflected categories and subcategories related to the domain of inquiry and research questions was done by the use of both NVivo software and manual manoeuvres. This was done after the researcher had re-visited the data, organised it along the line of the semi-structured questions on the interview guide and compiled it. A document that included all the informants' data in a single document was produced as a result. After coding by means of NVivo software, the researcher re-

visited the data, read it many times and also listened to the taped data through a CD in which it had been entered and was able to come up with more data that had been missed during the initial coding. This data was then coded manually, another process that took many hours to accomplish. Additional codes distinctive to this study were also added as new data was collected from the informants during the member-checking exercises. The final data was analysed using Leininger's four phases of Ethnonursing Nursing Data Analysis guide (Leininger & McFarland 2002:95).

The interviews can be retrieved as the researcher used a digital voice recorder and saved the interviews later on a CD and in 'my documents' and also in an audio form (in her computer) to leave an audit trial. A field journal log was used to process data immediately and store important observations. Note pads were used for storing the researcher's observations and participatory experiences along with the researcher's reflections. All the records were stored in a safe place for retrieval when necessary. This is in line with De Vos et al (2002:340) who point out that the data collected should be safely stored. Data entries included a wealth of detailed raw emic data that included verbatim statements and many hours of observational data collection.

4.3.2 Transcribing and translating

Transcribing and translating entail judgment and interpretation. According to Wengraf (2001:7), once the data has been transcribed or translated, it is no longer raw data; it is processed data.

4.3.2.1 Transcribing

The visual cues that we rely on to interpret another's meaning are lost when we listen to a tape as the transcriber no longer has access to those important paralinguistic clues about meaning (Marshall & Rossman 2006:110). The researcher noted some cues during the interviews and was, therefore, able to insert them in the respective sections while translating and transcribing the data into verbatim. The researcher did all the translation since she comes from the Kikuyu community and is well conversant with the Kikuyu language.

4.3.2.2 *Translating*

Issues associated with translating from one language into another are much more complex than transcribing as they involve more subtle issues of connotations and meaning. Esposito (2001:570) defines translation as 'the transfer of meaning from a source language … to a target language'. The translator in this case is regarded as an interpreter who has the vocabulary and grammatical structure of the spoken words while at the same time considering the individual situation and the overall cultural context. This means that the exactness of producing accurate and meaningful data through translation is crucial. Marshall and Rossman (2006:122) believe that since the translation entails the construction of meaning, the analysis is happening whether acknowledged or not. Rossman and Rallis (2003:260) pose three questions related to translating as follows:

- If you are translating from one language to another, which language constitutes the direct quotes?
- Can you translate words as direct quotes?
- How do you signal that a translation is accurate and captures the subtle meanings of the original language?

They explain that there are no simple blueprints for addressing the issues associated with translation. The important thing is that the reader of the research knows that the researcher understands the issues at hand, takes an ethical standpoint in translating and clearly describes what she has done in the final report. The researcher did all the translation of the data and found it easy since she belongs to the same community and is well conversant with the language.

4.3.3 Preparation of data

Collection of data was done in the Kikuyu language after which it was transcribed in English. It took an enormous number of hours to do this – one informant's or focus group's interview took an average of six hours to put into verbatim. The transcribing was

done in plain text as indicated in the example below:

INTERVIEW: YOUTH GROUP (BOYS)
Interviewer: When you look at a person and say that person is healthy, what does he/she look like?   **Interviewee:** He does his work, he is not in pain, does his chores well, eating well, does his/her own work and does not send a person for anything, moves from place to place and does not complain after eating   **Interviewer:** What else?   **Interviewee:** If you are not healthy you cannot go for a walk, you cannot play but talking abusive language is not being healthy, if you are unhealthy you cannot go from place to place   **Interviewer:** If you say a person is good, what do you mean?   **Interviewee**: Behaviour wise, that person , he talks to people well, he is not abusive, takes things lightly, forgives and will always talk to you even if you do not respond   **Interviewer:** Is there anything else?   **Interviewee:** One does not engage in bad behaviours like smoking, drinking and bad company, is active and does good things   (This is an illustration of how interviews were transcribed).

4.4 DATA ANALYSIS AND INTERPRETATION

According to De Vos et al (2002:345), interpretation means making sense of data from the 'lessons learnt'. Interpretation is based on insights and intuition plus a combination of personal views. Intuition describes the manner in which information is received through hunches. It comes through one of the senses, images, sensations, sounds, tastes, or smells. It is perceived either with only one sense or a combination of the senses (Rea 2001:97-106). In interpretation, alternative views emerge which means ways exist and the researcher must search for, identify and describe them and then explain how and why the explanation given is the most plausible of all (Marshall & Rossman 2006:116-117). Transcriptions of participants' interviews were analysed, using an 'emic' frame of analysis. That is, the data was first coded using words given by participants, thus representing the participants' perspectives. The coded data was examined for similarities and differences and then sorted by topic. Codes that related to each other were grouped into categories that represented the various themes. Relationships in the data were sought, and a taxonomy was developed to describe the knowledge, beliefs, values, and behaviours with regard to the self-care health seeking behaviours of the Piave community (Atkinson & Hammersley 1994:248-259).

4.4.1 Analysis by the use of computer-aided software

Many computer packages developed since 1970s have contributed to speeding up the process of qualitative data analysis. Weitzman and Miles (1995:5) point out that using computer for qualitative research can give studies more credibility and status because of their association with 'hard' data. The software can also help the researcher to analyse data that is too bulky for manual analysis. Computers greatly speed up the process of retrieving, exploring and organising data. Before choosing software for a qualitative study, researchers should not only be familiar with the types of software available, but should also be well versed in the particular program functions and features. Flexibility and user friendliness are two additional considerations addressed by Weitzman and Miles (1995:5). They also explain that before choosing software, researchers should find out if the software is designed to do what they need to do.

The researcher used computer software for transcribing, editing and revising field notes; coding by attaching text to permit later retrieval; storing data by keeping text in an organised database, searching, retrieving and locating relevant segments of texts and making these available for inspection; linking data by connecting relevant data segments to each other; and forming categories, clusters, or networks of information.

4.4.2 Analysis using the ethnonursing method

The researcher applied Leininger's four phases of ethnonursing data analysis (Leininger & McFarland 2002:95):

4.4.2.1 First phase: collecting, describing, and documenting raw data

The researcher collected and recorded data from interviews with key and general informants; made observations; identified contextual meanings, made preliminary interpretations and identified. Data was transcribed according to the emic perspective but at the same time the etic was considered. The data from the field journals was processed directly into the computer. The transcriptions were translated into English by

the researcher. The data was typed into Microsoft word from the Digital Voice Recorder after which it was copied to the NVivo software program.

Data analysis was done continuously as the interviews and participants' observations went on. Gaps in the data were noted and where necessary, the researcher went back to the field for more clarification or to ask more questions to fill the identified gaps. Following data collection, member checking consisted of reporting back findings and interpretations to the key and general informants and asking for critical commentary on the findings to confirm that the researcher's interpretation represented their beliefs and practices. This was done through restating, summarising, or paraphrasing the information received from informants to ensure that what had been heard or written down was in fact correct.

4.4.2.2 Second phase: identification and categorisation of descriptors and components

The data collected was coded and classified by using the NVivo computer programme. Emic and etic descriptors were studied within the context for similarities and differences. Components that recurred were studied for their meaning (Leininger & McFarland 2002:95).

In order to ensure familiarity with the thick descriptions in this study, the researcher read the data repeatedly and listened to the taped material frequently. This enabled her to use different methods in accessing it, thus using different senses for better understanding. For further preparation of data analysis, the researcher repeatedly perused the data from key and general informants, participants' observations and field trips to a point where she became immersed in the data. She then organised it according to the research questions and finally generated categories and subcategories.

4.4.2.3 Third phase: patterns and contextual analysis

Data was scrutinised to discover saturated ideas and recurrent patterns of similar and

different meanings, expressions, structural forms and interpretations related to the domain of inquiry. Data was examined to show patterns in relation to the meaning in context along with credibility and confirmation of findings (Leininger & McFarland 2002:95). This is referred to as 'member checking' by Guba and Lincoln (1985:314). Streubert and Carpenter (2009:38) explain that the purpose of member checking is to have those people who have lived the described experiences validate that the reported findings represent their experiences.

The researcher scrutinised the data further to discover saturated ideas and recurrent patterns. She combined some categories because they were found to be similar and continued with analysis and interpretation of the data. She completed the work during this phase by analysing categories and sub-categories to discover the inherent meaning. The researcher described the observations made during data collection and analysed her field notes to obtain contextual meanings. The meanings which emerged were incorporated into the research findings.

4.4.2.4 Fourth phase: major themes, research findings, theoretical formulations, and recommendations

This final stage requires synthesis of thinking, configurations, analysis, interpretation of findings, and creative formulation of data from the previous phases. The researcher's task is to abstract major themes, research findings, recommendations, and theoretical formulations (Leininger & MacFarland 2002:95).

During this final stage of the ethnonursing data analysis, the researcher critically perused and reflected on the analysed data from chapters 5 and 6 and finally came up with substantive concepts, or major themes. The major themes depict what self-care health seeking behaviours mean among the members of the Piave community. Table 7.1 presents the major themes derived from categories and subcategories of data discussed in chapters 5 and 6.

The researcher subsequently discussed the major themes in chapter 7 using the three modes of care actions and decision-making identified by Leininger (Leininger &

McFarland (2002:570) and finally applied the research findings to the Theory of Culture Care Diversity and Universality with the aid of the Sunrise Model Enabler.

4.4   SUMMARY

The process of data analysis followed during this study was discussed with reference to the NVivo computer program used for the analysis. The four phases of Leininger's ethnonursing method for data analysis were explicated and it was indicated how these phases were implemented during the study. Chapters 5 and 6 represent data analysis phases one, two and three whereas the fourth data analysis phase culminates in chapter 7.

The next chapter presents the phase 1: data analysis and presentation of the key and general informants from Piave community.

CHAPTER 5

Phase 1: Data analysis and presentation: key and general informants, Piave community

5.1   INTRODUCTION

This chapter provides phase 1 of the analysis and presentation of the data collected for the study; it is from the key and general informants of the Piave community.

The domain of inquiry was the emic (insider) cultural expressions of self-care health seeking behaviours of the Piave community in Njoro division, Kenya.

The purpose of the study was to explore and describe the self-care health seeking behaviours of the Piave community in Njoro division, Kenya and to develop a guide (guidelines) which could serve as a leverage point to integrate self-care health seeking behaviours with professional health care.

The research questions are:

1.   What are the self-care health seeking behaviours of the Piave community?
2.   How can the community's self-care health seeking behaviours and professional health care as delivered by health professionals be integrated to deliver more culturally congruent care?

Six categories with several subcategories emerged from the data (table 5.1). These are discussed in detail in this chapter. Data from the additional informants (tables 6.4 and 6.7) is presented in chapter 6. The major themes which emerged from the entire study are discussed in chapter seven.

A few vignettes, brief interpreted descriptions, of some of the key and general informants are provided before the data presentation to reveal interesting background information on community members.

5.2 DATA ANALYSIS STRATEGY

The four phases of the ethnonursing qualitative data analysis strategy as described in chapter 4 of this thesis were used. The first three phases of data analysis were applied to present the data in this chapter.

5.3 VIGNETTES

An important aspect of aiding understanding the culture and other ways of life is to provide brief descriptions of some of the community members interviewed in the form of vignettes. A vignette is like a photo with blurred edges, and provides an example or small illustrative story which can clarify a particular point or perspective in relation to some findings in the data. Vignettes can originate from the researcher or from the informants and can come from compressed data or from consolidation of different data sources (Grbich 2007:214). According to Miller, Velleman, Rigby, Orford, Tod, Copello and Bennett (1997), very few studies have used vignettes to summarise and reveal interesting points about a specific client population, rather than the traditional function of composed vignettes written to aid a particular investigation. The following are a few vignettes of some of the key and general informants

5.3.1 Key Informant: a woman

This 43-year-old woman has been trained by the Society for Women and AIDS as a community health counsellor dealing with post-abortal care. She is married with five children (three died through an unidentified sickness). The remaining two are 20 and 25 years old respectively. She has lived in Piave for 15 years. The informant's husband works in Nairobi and hardly goes to his rural home where she lives.

 She is one of the community health workers and has been involved in counselling girls and women on post-abortal care. She is very keen and interested in giving health education to the community and is well respected by the members of the community who usually consult her on health matters.

5.3.2 General Informants: young men in a focus group

These were young men aged from 18 to 30 years. They were all primary school leavers having reached standard eight and dropped out of school because of lack of fees. Only one was in the fourth form but was not attending school because of lack of fees.

The young men were very much interested in telling their stories and from the researcher's observation and reflections after interacting with them, they were willing to make some changes in their lives if they have the means. Though not well educated, most of them appeared intelligent and had visions of what they would like to be. What they need is for Piave to have a better infrastructure so that they can get involved in self-employment such as welding and in agriculture. The future for them looked doomed unless Piave is developed to promote better ways of living for the community.

5.3.3 General informants: young women in a focus group

The interviewed young women were seven in number, their ages ranging from 18 to 25. They were all primary school leavers (eighth form) except one who was currently in high school. Like the young men, they were not well educated and were looking forward to better days a head.

They wished Piave had better opportunities so that young people would not get into prostitution and drugs. They asserted that their generation was different. They had fewer children and communicated openly with them telling them how to avoid diseases like HIV/AIDS. The situation was, therefore, better. They expressed the wish to be invited to participate in health related workshops because at the moment, only those who are well known by the community health workers are selected and they may not be the best candidates for the workshops. They do not cascade what they have learnt to the rest of the community members. They also said it would be better if workshop participants are not given money when they attend the workshops as this encourages favoritism, those conducting the workshops select mostly their friends only.

5.4   DATA PRESENTATION

According to Miles and Huberman (1994:302), data may be organised in two ways; text or organised displays such as matrices. Visual displays may be constructed as a single case or two or more cases at a time known as cross-case display (Onwuegbuzie & Dickson 2008:208). The findings of this research are presented in mixed mode. Table 5.1 displays the categories and sub-categories generated from the data of key and general informants in response to the domain of inquiry and research questions. The key informants were interviewed individually while the general informants were interviewed through focus group interviews to supplement the information given by the key informants. This is supported by Morgan (1997:3) who states that general informants can serve to supplement another primary method of data collection. The data from both groups were similar.

Table 5.1   Data display of categories and sub-categories which emerged from the data collected from key and general informants of the Piave community

Category	Sub-categories
5.3.1 Health and illness	**5.3.1.1 Health** • Strong • No pain • Ability to work • Well nourished • Well behaved **5.3.1.2 Illness** • Body pain • Inability to do daily work • Bad behaviour • Mentally ill

Category	Sub-categories
5.4.2 Factors predisposing to ill-health	**5.4.2.1 Supernatural beliefs** • Religion • Witchcraft • Curse **5.4.2.2 Social factors** • Poverty • Infidelity • Prostitution • Alcohol and drug abuse **5.4.2.3 Environmental factors** • Cold weather • Rainy seasons • Dust and smoke • Inadequate and dirty water • Inadequate personal hygiene • Germ infection • Diet
5.4.3 Self-care health seeking behaviours	**5.4.3.1 Herbal treatment** • Self-treatment with herbs • Treatment by herbalists **5.4.3.2 Drugs** **5.4.3. 3 Supernatural interventions** • Prayers • Divine healers • Witchdoctors
5.4.4 Influences on self-care health seeking behaviours	**5.4.4.1 Family** • Elderly women • Other family members **5.4.4.2 Community influence** • Community health workers • Community members • The chief • Neighbours • Self-help groups • Church members **5.4.4.3 Previous experience with formal health care** • Unsuccessful treatment • Lack of trust in medical doctors **5.4.4.4 Access to health services** • Transport • Cost
5.4.5 Assistance required from health pro-fesssionals	**5.4.5.1 Health education** **5.4.5.2 Home visits**
5.4.6 Community development initiatives	**5.4.6.1 Water** **5.4.6.2 Roads** **5.4.6.3 Electricity** **5.4.6.4 Entrepreneurship** **5.4.6.5 Farming** **5.4.6.6 Employment and education**

5.4.1 Health and illness

The health and illness category contains the community members' insights on health and illness. There was agreement between the key and general informants' views.

Binder (2008) in defining health contends that much depends on the point of view. The average man considers himself healthy when he is not ill. Some people suffering from endemic diseases, e.g., malaria or hookworm, regard themselves well since they are not seriously ill. Ardell's [s.a.] explanation of health supports the above definitions. According to Ardell, health involves the spiritual, the body, the mind, and the concept dimensions. Leininger and McFarland (2002:84) view health as a culturally constituted phenomenon. They define it as a state of well-being or restorative state that is culturally constituted, defined, valued, and practised by individuals or groups that enable them to function in their daily lives.

The data shows that the Piave community's perception of health and illness is holistic – both include the physical, spiritual, psychological and social dimensions of health.

5.4.1.1 Health

Strong

The Piave community members' expression of being healthy or ill includes reference to physical as well as psycho-sociological factors. For them, the concept of '*strong*' includes both body strength and a healthy mind. A key informant pointed out that, "*To be healthy means that you are fit, even the brain; you look after your family well because you are strong and healthy*". A general informant said: "*Even if you are old, you can work because you are strong whilst even the young people who are not healthy cannot work*". A key informant remarked: "*When one is healthy one feels he or she is strong*".

Basavanthappa (2008:680) emphasises physical fitness as one of five dimensions of health whereas the definition of health by WHO (1958) in Basavanthappa (2008:680), refers to complete physical well-being as one of the dimensions.

From the researcher's observation, Piave people rely mostly on gardening for their daily food and consequently need to be physically fit or strong to do their gardening. The researcher noted that most of the men and women in Piave are of medium stature, neither too tall nor too thin although a few women have quite a bit of weight compared to their stature.

No pain

The informants said that a healthy person has no pain. A key informant commented: "*When one is healthy, there are no body aches*" while another said, "*A healthy body has no problems physically*". A general informant asserted, "*A fit body has no pain*".

Smith (1999) in Lundberg (1999:32) mentioned lack of pain as one of the four models of health, a symptom based on a medical perspective. Rosenbaum (1991) in Lundberg (1999:32) explored the meaning of health through older Greek Canadian widows and found the avoidance of pain to be one of the three categories.

Ability to work

The informants perceived able to work as an indication of being health. A key informant said: "*A healthy person is seen as a person who is able to function in her/his own role in order to meet the basic needs not only of herself/himself but also those of her/his family members*". Another key informant commented: "*Being healthy means being able to work, wake up in the morning and do one's daily chores*". According to her, work included going to the garden, milking the cows, cooking for the children and families. A key informant said: "*You feel you are able to work and even the parts of the body operate well, for example, in the morning you are able to wake up; when you are not feeling well you cannot wake up*". A general informant stated: "*A healthy person can farm, can walk for a long distance and even jump when asked to*".

Leininger's (2001:48) reference to health explains that it is the ability of individuals to do their daily activities in culturally expressed, beneficial and patterned lifeways. In Piave, farming is the community's preoccupation and men and women also work in their gardens. When they do not have sufficient food, they leave Piave for casual work in search of food. A general informant remarked: "*Some men working to get food for their families* stay away from their homes sometimes for a year". Work according to their view was crucial to their health and survival.

Well-nourished

Both key and general informants said that a healthy person ate well. A key informant asserted: "…*the diet is balanced enough to help the body in the proper way*". Basavanthappa (2008:680) and Ardell (1986:324) also mention nutritional awareness as one of five dimensions of health.

Well behaved

The data from the informants emphasised a bright appearance and good behaviour as indicators of good health. Both key and general Informants asserted that when one is healthy one's skin shines. A key informant pointed out; "*A healthy person is bright in the face and the heart; the person looks undisturbed"*, while a general informant pointed out that: "*A healthy person has a good body and the skin shines*".

When the skin shines or looks bright, it is generally perceived that one is free from stressful situations. This is affirmed by Smith (1999) in Lundberg (1999:32) when he refers to the eudemonistic model which emphasises health as characterised by exuberant well-being. The implication here is the importance of being sound in body (shiny skin) and mind (looking bright from the heart).

A general informant asserted: "*A healthy person behaves well; he does not drink alcohol, does not smoke or mix with bad company*". He also said: *"Behaviour-wise, that person talks to people well, is not abusive, takes things lightly, forgives and will always talk to you even if you do not respond'.* A key informant remarked: "*Many people seem mature physically but their behaviour shows they are not mature*".

 George (2002:116) defines health as a state of self-awareness with conscious selection of behaviours that are optimal for an individual. His definition expresses almost similar sentiments described by the informants in this sub-category. King (1989:152) points out that health is the dynamic life experience of an individual employing continuous adjustment to stressors in the internal and external environment through optimal use of one's own resources to reach to maximum potential for daily living. Healthy persons are seen as people who are able to function in their own roles.

The following quotation given by one of the key informants illustrates what is regarded as good behaviour:

When you are normal for example me, I cooperate with my wife, if anything comes along, we handle situation together in a peaceful manner and if it's my child who has a problem we discuss with her and find out how we can help and solve the problem. We discuss how we want to be living and how our life is supposed to be. That is what I do in my family. For example, my son went to Kisumu and stayed for eight years without coming home, I went for him and we talked to him with my wife and told him that he was our first born boy child and had left home without any reason. He said he was sorry and had behaved like the prodigal son and asked for forgiveness. I was happy because he read the bible and said he was lost but he was found and wanted our advice. We advised him and told him that we would inform the sisters and brothers to advise him too so that we can all be together again. He is still here and I want to look for an alternative job for him.

5.4.1.2 Illness

Body pain

Body pain was perceived as a sign of illness. One of the key informants commented: "*You find a lot of sick people in the community who complain of body aches nearly all the time*", while another key informant lamented: "*… my body is weak and sometimes aching …*" Yet another one pointed out: "*I feel ill and often have a lot of pain …*". Pain is, therefore, regarded as one of the attributes of ill health

Inability to do daily work

The informants' insight on illness is inability to do daily work in relation to one's sphere of work or life involvement. Three different key informants commented: "*If it is cooking, one cannot do it*". "*You cannot work because you are sic*". "*You are unable to carry on with your daily work*". A fourth key informant elaborated further:

When I am sick, my life is miserable. I cannot do the actual work I do on daily basis. My wife has to do everything including taking care of me. I like moving around particularly in my garden and I feel miserable if sickness can confine me in the house or bed.

Another key informant said: *"There is illness when somebody is unable to do anything and cannot carry out his usual activities. However, some people work but may be sick in their bodies"*. A general informant pointed out: "*A disease is inability to work; your body aches and you are unable to attend to your daily duties because the body has a problem*".

Downie et al (1939) in Peattie and Walker (1995:53) point out that ill health or the negative dimension of health may refer to illness, disease, disability or handicap either as a single entity or a combination of several of them. In this study's context, being *unable to work is a handicap.*

Bad behaviour

The Informants' view was that feeling miserable and having problems (pointing to psycho-social problems) meant being unhealthy. They regarded bad behaviour as a sign of illness. The problems which they referred to included use of abusive language, conflict between husbands and wives, drinking alcohol, being promiscuous, smoking and taking illegal drugs. A general informant also stated: "*Girls who have children out of marriage get diseases through stress because they live in poverty*". Another general informant said: "*Talking in abusive language is a sign of unhealthiness*". Another general informant commented: "*The behaviour of a person who smokes and takes illicit drugs is generally not good*". Yet another general informant stressed:

> *Some girls smoke, take drugs and beer as well. These are not many but a number do it in hiding but when you meet them, one can notice their habits are bad. Bad habits are not just prostitution. Their health is not good because they are using things that damage their health.*

Another general informant lamented:

> *Many problems can result to bad behaviour and also bring misery to the kids. Children may be troubling you too. The same children you have brought up acquire bad habits (meaning behaviours such as smoking, drinking alcohol, taking illicit drugs and using abusive words) and this brings misery to the parents especially mothers.*

From the field observation and informants' data, many men of all ages smoked and took illicit drugs. A general informant commented: "*Problems come from husbands who might be drinking a lot. It is terrible when he comes home and throws away the food you have given him. This can make you unable to eat and can become sick*". Another general informant said: "*Because of lack of rain, sometimes there is no food, people get hungry and children get malnutrition; there is also no peace in families due to hunger*". Another general informant said: "*There are different types of diseases, some make one unable to work and some make one to change behaviour …*"

According to the information from the members of the community talked to, conflict arose between husbands and wives as the women expected men to provide enough food and fetch firewood and water for their families. Men complained that if they did not meet women's expectations, they were mistreated. A general informant complained: "*If you have a bicycle and don't go to get water or fetch firewood, your wife won't give you water to bathe in the evening*".

The researcher learned from listening to the community members during the field trips that some of the married couples quarreled a great deal and that wife beating was common. One of the SWAK's community health workers, who was apparently very good at settling family conflicts, was called on to quell these fights. According to the community members talked to, the fights originated mostly from women who did not respect their husbands particularly when they were not able to provide for their families; this led to disharmony in their homes. There was a lot of promiscuity among married couples too because of the low economic status. Women as well as men went in search of food outside Piave and some of them became promiscuous while away. All these factors led to disagreements between couples and resulted in broken marriages.

Mentally ill

A key informant pointed out: "*Somebody miserable is not healthy, has something troubling her/him, can even talk to herself/himself due to misery or problems*". Another key informant said: "*You can look at a person and wonder; a healthy person you will just see from the appearance and a person with a problem you will also know*". Another comment from a general informant was: "*Others are genuinely sick either mentally, psychologically or both. Many Piave people are not well*". A key informant commented: "*Some people when stressed, at times talk to themselves and people in the community think they are becoming crazy*".

5.4.2 Factors predisposing to ill health as viewed by informants

The factors predisposing ill-health as viewed by the informants comprise supernatural beliefs (referring to religion, beliefs in witchcraft and curses), social and environment factors.

5.4.2.1 Supernatural beliefs

Religion

There are two mainstream churches; the Roman Catholic and Anglican churches while others are small churches of different denominations. The researcher came across 23 of them: Solid Rock Disciples Church, House of Prayer, Pentecostal Church of East Africa (P.C.E.A.), Independent Church, Seventh Day Adventist, Assemblies of God, Apostolic Faith, Apostolic Original, Full Gospel Church, Coptic Church, African Inland Church, Wakorino Church, Wakorino Original Church, Barabas Church, Elimu Victory Church, Paper Church, Pentecostal Assembly of God, Orthodox Church, Israel Church, Kanitha wa Ngai (Church of God), Miracle Restoration and Miracle Celebration Churches. Most of them have semi-permanent buildings with mud walls and iron roofs.

Pastors were thought to be above ordinary Christians or parishioners. They prayed for their parishioners when unwell or when affected by social problems. They believed that physical healing could be effected through prayer. Some of the denominations like Kanitha wa Ngai (Church of God) do not believe in seeking formal treatment for their people as explained above; they pray for God's intervention. A key informant explained:

> I am a pastor and I pray for my family or encourage them to pray for themselves when sick. My wife and children live in Nairobi and I know my wife takes the small children to the hospital while the big ones take themselves. She also goes there when seriously sick. If not seriously sick they do not go to the hospital because the power of prayer is great.

Another key informant stated:

> We also have churches with a lot of influence on their parishioners. Some pray for the sick instead of telling them to go to the hospital and tell them to trust in God. Some of those prayed for end by becoming very sick and die or go to the hospital at the terminal stage and have to be admitted if money is available.

A key informant (a community health worker) gave some information of a young man at the Piave Centre who did not go to the hospital. She narrated:

> *At one time his children were sick and he did not take them to hospital. One of the community health workers was told and she went there only to find that the house was very filthy because the whole family except the father had diarrhoea and vomiting. The man had to be forced to take his children to the hospital but did not do so until the police intervened. There was also another case of the same church where two children died of measles. One died when a community health worker was taking her to hospital. Some people expect they are going to get well without going to the hospital. For a period of two years, two women have died thinking that they were going to give birth at home without any problems but things got worse and they died.*

Another key informant pointed out:

> *As religious people, we counsel the sick against going to herbalists and consulting witchdoctors. We also pray for them and since they believe, they get well. God mercy descends down on them. Those who do not believe are taken to the hospital including those who are seriously sick. The church wants people to get well. That is why I told you education is important so that people can prevent diseases.*

A key informant commented:

> *We also have churches with a lot of influence on their parishioners. Some pray for the sick and tell them to trust in God instead of telling them to go to the hospital. Some of those prayed for end by becoming very sick and dying or being admitted to hospital in the terminal stage and if money is available.*

Witchcraft

Witchcraft is an act of casting a spell over someone or something or to put a hex on someone or something. It refers to sorcery, and the use of magic (Oxford Dictionary 1989). Some Piave people believe in witchcraft.

A key informant said: There was a woman who was suspected to be a witch and we also know some people who keep snakes and extraordinary big cats in their homesteads but due to fear of being bewitched, we do not report them to the authorities. A key Informant said: "*Some people go to the hospital and when they do not get well, they believe they are bewitched and turn to the witchdoctors for cure*". A general informant stated: "*One person told me he was removed a sleeper from his ribs.*

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I went to visit him; we prayed and I was told he got well. Unfortunately, the sick use money to consult witchdoctors or divine prayers …" Another general informant lamented: "*When people get money, they go to witchdoctors (muganga) and spend a lot of it. Many people have died thinking they are bewitched particularly when there was no hospital around here*".

A key informant stated:

> *There was a woman who was sick and we took her to the hospital by force. Her private parts were sick and she was given herbs and used to wash herself with the medicine and was saying that since she was bewitched, black soil which she was bewitched with was coming from her private parts. We took a step and approached her since she was getting no better and asked her to go to the hospital because if she failed to go her condition would become worse. By that time she was very seriously sick and had a boil on her private parts. She told us she had taken drugs and was to revisit the witchdoctor after a few days. She had been told that the people who had bewitched her were her neighbours. She was told by the witchdoctor that there was a pint of blood under her bed and they came to her house and showed her where it was.*

The woman who had a vaginal discharge had been convinced that it was as a result of soil matter which had been inserted there by one of her neighbours. Ashforth (2001) relates a story of a mother whose son died of HIV/AIDS in South Africa. He states that as the mother conceded the possibility of AIDS, her view was that it must have been sent by someone. Someone poisoned her son by using witchcraft to send AIDS. Ashforth explains, as an epidemic of AIDS sweeps through South Africa, isidliso is the name that springs to mind amongst many people in the epidemic's track. They know about isidliso or 'black poison,' an evil work of the people they call witches.

Ashforth (2001) further points out that the interpretation of AIDS in terms of the witchcraft paradigm by no means precludes the notion of a sexually transmitted infection. He explains that while it may be accepted that the disease is transmitted through sex with an infected partner, it is does not necessarily mean the source of the misfortune comes from that particular person, meaning that while the virus might be contracted from a man's illegitimate love affairs, the witchcraft responsible for his infection could have been sent to him by his mother-in-law, or a jealous neighbour, his wife, or a person in any one of the different relationships that might have been motivated by jealousy and hatred to malicious occult action. In retrospect, AIDS awareness campaigns also highlight the harmful effects of exchanging bodily fluids.

Anyone conscious of the hazards of witchcraft and sorcery being wrought with blood, hair, nail clippings, or other bodily excretions might equate harmful bodily fluid with witchcraft. AIDS therefore becomes interpreted as sexually transmitted witchcraft, and curing the disease (which usually means expelling the witchcraft) can also be interpreted as requiring a sexual release of the witchcraft agent.

In Kenya very little work has been done on the relationship between HIV/AIDS and witchcraft. IRN/PlusNews (2008) gives some comments in relation to HIV/AIDS and witchcraft in Ijara, a district in Kenya's North Eastern Province which has recorded the lowest number of people living with HIV in the province although the stigma associated with it is very strong. HIV/AIDS is associated with magic, witchcraft and evil spirits by many people in the region, leading them to seek ritualistic help instead of medical treatment. The voluntary HIV counselling and testing centre in Ijara remains idle because the local community believe they cannot contract the disease.

Curse

Dictionary.com has different approaches to the definition of a curse; it defines it as: "*To curse somebody is to bring great evil upon that person; to be the cause of serious harm or unhappiness to; to furnish with that which will be a cause of deep trouble; to afflict or injure grievously; to harass or torment".* The Oxford Dictionary (1989:233) defines a curse as an '*utterance of deity, or of person invoking deity, consigning person or thing to destruction, divine vengeance*'.

Being sick because of a curse came up frequently during interviews. Apparently many community members believed in curses that occurred for doing something wrong to a person particularly a relative or for being disobedient to God. They also believed that the problem could not be treated unless one corrected the wrongdoing. One of the key informants said:

> *If a person is sick and believes it is an inherited disease or a curse they say if they go to the hospital they will die as a result of the drugs interacting with curses. One refuses to go. If one is sick but does not know where he/she is suffering from, that person might refuse to go to hospital. I do not know whether it is custom but they seek herbalists first. You find in a home many people are sick but they do not go to the hospital.*

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He further said:

> *As for me, if the problem is brought by a curse, I would seek traditional help because I know the hospital will not be of any assistance. I may have been cursed by a relative for wrong doing and therefore I would rather try to amend the curse by doing what might be dictated to me by a traditional person. This could be an elder or any other person who knows what should be done.*

Another key informant stated:

> *Unless it is due to something wrong I have done to other people, I would go to the hospital but if I have offended a close relative, like a grandmother I would get sick immediately, then I would know it is the wrong doing that has caused the illness.*

The informants pointed out that some people who believed they were cursed changed their minds when counselled and went to the hospital for treatment while others did not.. The informants further pointed out that they were becoming more enlightened through community health workers and their chief and now knew it was better to go to the hospital. However, they stated that they would still correct the wrongdoing so that the medicine could work.

Yronwode (2004) has given very good examples of how she thinks removing a curse works. She says:

> *I have met some people into Wicca who believe that one should not take a spell off of another person without a request from him/her. Assuming your friend has requested help -- or that you are an atypical Wiccan (a religious practice involving nature worship and witchcraft: Encarta dictionary: English North America) who will perform a curse removal without specific request -- the best I can say is that removing curses from others, in my tradition of folk magic comes in two forms: either you work directly on the person (who is called a client, whether or not he or she is paying you, is a family member, or just a friend) or you work indirectly for the client.*

She further explains that removing a curse from a client especially if one has the client's cooperation and has a magical link donated by the client, for example, a piece of hair or name-paper, is fairly effective. Another method is removal of the curse directly in the form of bathing or rubbing the client's skin or prescribing baths or teas to drink, or smoking of a herb.

5.4.2.2 Social factors

Poverty

A key informant commenting on poverty stated: "*Poverty to the extent that one cannot get enough food for herself and family*". The informants explaining further stated: "*There are people with a lot of problems that make them become miserable. People have not had their title deeds for their land and cannot afford them due to poverty*".

As observed by the researcher during the field trips and participant observations, the Piave community is generally poor. People within the community have very small pieces of land for cultivation in spite of the community relying on food produced from their gardens to meet most of their needs. According to a general informant:

> *They mainly grow maize and beans and hardly anything else. They have no cash crops and that means they rely on the food they produce for feeding and selling to meet their other daily needs such as buying sugar, soap, and clothing. To make it worse the food grown is stolen either from their granaries or while still growing and before harvest, mostly by their husbands or sons who sell it to meet some of their needs. They usually use the money for alcoholic drinks, cigarettes and clothes.*

Another problem brought about by poverty was voiced by a general informant who lamented:

> *Men complain of harassment from their wives, mothers or grandmothers due to the fact that they have no land of their own. The land belongs to the old women. It was given to them by the former first president of the Republic of Kenya, Mzee Njomo Kenyatta, as a gift after singing for him. These women hold the land dear to their hearts and refuse to have their offspring make any improvement. However, some women have divided the land among their children but again due to large families which many families have, the pieces of land are too small for any meaningful cultivation.*

A general informant referring to the elderly women commented:

> *They even go as far as telling you that the farm is theirs… The children also run away from their homes because the mothers are very insulting and instead of coming back home after getting money to develop their home, they don't come back.*

A general informant lamented: "*Men here are led by women. You cannot advise them on their farm, they tell men to buy their own farm*". Another general informant lamented:

> *Development can only come when the landlords are dead (loud laughter). By good luck, a number of them are dead and nearly all of them could die soon since they are very old. Most of us will then have a breathing space'.*

All these factors increased the poverty level. They also thought that the poverty problem was made worse by lack of electricity, lack of good roads, education and lack of rain. A key Informant lamented: "*There is lack of business, communication and transport".* Another one commented, "*Subsistence gardening is the only means of livelihood in Piave and when it does not rain there is no food'*.

Infidelity

Infidelity refers to marital disloyalty/unfaithfulness (Oxford Dictionary 1989). A general informant indicated that HIV/AIDS was common owing to infidelity within marriages. He commented:

> *Men are not able to satisfy their wives because they are usually away from home looking for food for their families and also there is a lot of drinking of alcohol and that also make men weak sexually. Women look for alternative means for sexual satisfaction.*

According to some community members talked to during the field trips, men used bicycles because they travelled far almost on a daily basis to look for food for their families. They lamented that sometimes men went away from their homes for days at a time and two problems arose as a result: one, the man had limited sexual contact with the wife and two he was likely to have problems with sex as a result of riding on a bicycle for long periods of time. Women grumbled that men had problems with erection because of the pressure of the bicycle pressing on their private parts. This phenomenon was said to cause broken marriages and infidelity among their wives. They also said that when men went away for long periods, they at times married and did not come back home. Even where the marriage did not take place, there were increased numbers of unfaithfulness leading to increased HIV/AIDS. On the other hand, if men remained at home and thus did not provide for their families, women looked for greener pastures leading to infidelity or separation. They usually went away from their homes to look for food and since they were not able of cycling for long distances or cycling at all, coupled with insecurity problems (afraid of coming back at night), they went away for days at a time and only returned during the weekend where possible, leaving their children with

their husbands. Men on the whole did not look after the children since they were more inclined to drinking and engaging in sex with other women. The group pointed out that the whole scenario did not appear promising for stable marriages and family relationships.

Prostitution

Prostitution refers to the practice of engaging in sexual intercourse for money (Oxford Dictionary). As pointed out by a general informant from the young men group, one of the causes of prostitution was due to having many sexual partners, He pointed out: "*Girls when they leave the village and go to town, they dress smartly and when they come back, they look different and we all want them sexually. You will see that if she is positive, she infects around ten young men".* The general informants (young men) pointed out that even men bring diseases but the biggest percentage is girls because they move a lot. One of the group members asserted: "*If a man goes to town, he is unable to practice prostitution because he has no money but a girl will rent a house and then do prostitution as a way of living".*

According to the youth focus group (general informants-young men), young people are also involved in prostitution because Piave is near Nakuru Town. When they go there they practice prostitution and then come back. One of the group members explained: "*If those who are coming from town are tested for HIV, we think they are positive".* He went further to say, **"***You will see that after coming back they fall sick often. There was Voluntary, Testing and Counselling (VCT) here and they refused to go and that is why we think we are mixed".* Being mixed according to him meant those with and without HIV/AIDS were found within the community.

Another cause of prostitution according to the general informants (young men) was many children were unable to go to school because of poverty and as a result, a number of them became street children. They prostituted themselves so as to have a better life. One of the general informants lamented: "*Our parents have not been able to do much because of poverty*". The young men (general informants) believed that the young people have to be kept busy to avoid becoming involved with sex. A general informant (young man) stressed, "*If one is tired, he will not get involved with a girl coming from town".* He continued*:*

There is no work now. We have finished harvesting the beans and there is hardly anything else to be done. When you look at some facts, idleness and poverty increase population. People mostly think about sex when idle and poor because there is nothing else available.

A key informant pointed out: "*People here have very loose morals particularly when it comes to sex. Women, men and worse the young people move from one person to another; having multiple partners is bad and HIV/AIDS can spread very fast*".

Girls admitted to having sex outside marriage because of poverty and inadequate knowledge of reproductive processes. To make it worse, some men pretending to be very religious, seduced innocent girls and once they had succeeded, returned to their former lifestyle. When the girls became pregnant, most men did not accept any responsibility and some girls turned to abortion through illegal means.

Alcohol and drug abuse

As noted previously from the field visits, people were observed to be drinking alcohol a great deal, mostly because of idleness. A few people grew bhang and sold it to the community people while others bought from the surrounding areas. Also a lot of people brewed alcoholic drinks and this led to excessive drinking. One of the general informants from the young men's group explained:

> *Some young persons have left home and are staying for some days where the alcoholic drinks are being sold. They use their money for drinking; at times they are bought alcohol by their friends and other times borrow from those who are selling it ... In the long run, they work there to pay their debts. They are sent for errands to get alcohol from where it is sold and when they come back, they are likely to be given some more alcohol to drink for the work done. It becomes a vicious circle.*

Another informant lamented:

> *You find a retired man misbehaving, drinking and mixing (meant socialising) with children as well. Sometimes, they drink and pass urine on themselves and also a lot of saliva. The women become miserable and get stressed. The children start abusing their parents leading to more misery. When young people get money, they go to drink and buy cigarettes. Their food is moonshine (very strong distilled traditional drink). Our husbands and young people mainly boys drink a lot because of idleness particularly those who reach standard 8 and parents are not able to pay for their school fees for further education. They take illicit drugs too, abuse their parents and make them miserable to an extent that they can easily get sick. Also some women including the old ones drink a*

lot too and cause a lot of chaos. One might even find some old women staggering and falling down due to alcohol intoxication. If there is less drinking, peace would prevail in our community.

Piave has many drinking dens. The researcher visited some of them and made the following observations:

The dens were within the main houses and that meant within sight of all the members of the family. The areas preserved for people to drink were very small often leading to overcrowding. They were fairly dirty and untidy. The containers in which the drinks were served were dirty and were shared in turn by a number of people.

People – mainly men – included all ages, some very young (as young as 15). Adolescents were said to indulge in alcoholic drinks at an early age because their parents were not able to look after them. They dropped out of school and did not become involved in any meaningful work. The researcher saw many of them loitering aimlessly or in groups playing games.

The rate of drinking was immense and it was not unusual to find mostly men and a few women staggering about, noisy and abusive to one another. On one occasion that the researcher visited a drinking den for field observation, some drinkers were rude to her. This might have been because she was accompanied by one woman and two men from the local community and her mode of dressing was very simple; they thought she was one of them. In another drinking den, the chief of the area who was also among the group drinking knew her and she explained to him that she was doing field observation. The researcher bought some alcohol for those drinking to demonstrate her willingness to be a temporary member of the group during that drinking episode. She drank some soda, again to demonstrate that she was with them. It was during this time that she was given most of the information on herbal treatment and was shown some of the herbs the community used for self-treatment (see table 5.2 under category 5.4.3; list of herbs used by Piave community).

Moonshine (chang'aa) was very common in the dens visited. This is a drink made from distilled Busaa (fermented millet flour) and was the second commonest, while standard beers were very scarce as people were not able to afford them. Moonshine and busaa make their consumers very intoxicated within a short time. According to a key informant:

"*Some people have no alternative but just sleep where they are until morning as they become extremely weak to walk due to being drunk*". According to a general informant: "*Due to drinking, people misbehave and do all sorts of bad things such as abusing others, fighting sometimes for nothing, and even going as far as raping women*".

The researcher noticed that women had a lot of concerns and seemed to carry a lot of problems caused by their husbands and children. They were also the main care- takers of their homes and everything around those homes, thereby increasing their social responsibilities and problems.

5.4.2.3   Environmental factors

Cold weather

The community associated cold weather with sickness. One of the key informants said: "*Bad cold can also come from exposure to cold weather*". Another key informant commented: "*Young people do not take care. They sometimes wear a vest only*". Sickness caused by exposure to cold or cold weather featured a great deal and informants' comments were very explicit.

Rainy seasons

A general informant lamented: "*A disease like malaria you can prevent by removing water pods and clearing the bushes. The mosquitoes will have no place to breed and thus prevent malaria*". Another general informant stressed:

> *You have seen a lot of stagnant water on the road and if you tell people that the water will bring mosquitoes; they will say they do not have cars, why am I digging the road? The mosquitoes are so many and the grass should be cut.*

He complained that people thought they had been requested to clear stagnant water from the road so that cars could move safely but not because of minimising the places mosquitoes were likely to breed in.. He said: "*When it rains, water collects in holes caused by soil erosion making the roads impassable especially with regard to cars*".

Dust and smoke

As per the researcher's field trip observations, the majority of Piave people lack permanent houses. They mostly live in two-roomed semi-permanent houses, the whole house having a space of about 15 by 30 feet. The houses have dirt rather than concrete

floors. They become very dusty when the floor is not sprinkled with water. Because of water shortages, people do not consider damping the floors. This makes the houses very dusty inside. Household items such as bedding and personal clothing are rarely cleaned due to water shortages. As a whole, home cleanliness is hardly observed in many homes. To illustrate this, in figure 5.1 below is a picture of a house in Piave. It is a semi-permanent house belonging to a witchdoctor-cum-circumciser–cum-traditional birth attendant. Many houses in Piave are similar to it with little or no compound. Foodstuffs are planted almost at the door steps.

A general pointed out that in Piave there were no all-weather roads, that is gravelled surfaces that protected cars from sliding even during the rainy season. Another general informant commented: *"We have very dusty places including roads and worse when there is no rain for a long time. People get asthma and other ailments due to dust and smoke from industries"*. Basavanthappa (2008:289-347) explains that some environmental hazards such as air pollution emanates from industries emitting large amounts of pollutants in the atmosphere. He points out that ill-ventilated, dirty and overcrowded houses are responsible for respiratory infections.

Basavanthappa (2008:288) explains that according to WHO, environmental sanitation is said to be the control of the factors in one's physical environment which can bring about harmful effects on the person's physical development, health and survival. These factors include food, water, housing, clothing and cleanliness. He points out that environmental sanitation is the science of safeguarding health. According to him, the health status of an individual, family, community or nation is determined by the interaction of the internal and external environment of a person.

Inadequate personal hygiene

Inadequate personal hygiene was seen as a sign of sickness. According to the Oxford Dictionary (1989), hygiene refers to principles of maintaining health for instance cleanliness.

Data obtained during the interviews and field trips, revealed that lack of toilet facilities and availability of water were major predisposing factors to health problems among the Piave people. A general Informant said:

> *Also the toilets we use are dirty. They are not covered and when it rains, they are very dirty and we use them without wearing shoes. Children have no shoes or slippers. That is why we get a lot of diseases. If we can be clean, diseases can be lessened.*

The informants said that people as a result of dirty toilets were likely to get infection of their feet. Flies were attracted to dirty toilets and might cause diarrhoea and other diseases. A general Informant lamented: "*Many homes have no toilets and if you go into their houses, you will find a lot of health problems*". According to the field trip observations, because of shortage of water and ignorance, people in Piave did not wash their hands after visiting toilets which means they could contaminate food and get diarrhoea.

The Piave community obtained its water from the Ndaragwa River which was polluted by drainage from a canning factory, domestic animals which drank from it and people who washed their dirty linen and threw rubbish into it. According to information from the Piave people talked to during the field visits, foetuses were sometimes thrown into the river by women performing illegal abortions. Information gathered from workshops on post-abortal care attended by the researcher in Piave, there were quite a number of young as well as old women who were said to perform abortions using crude means: namely, herbs for example Ajuga Remota and drugs such as quinine resulting in infected reproductive organs, sterility and at times death.

Inadequate and dirty water

The poor water supply was a source of lack of personal hygiene as well. Information from the field trips and interaction with the community members revealed that Piave people had to walk for about six kilometres to get water for their domestic use. Owing to the distance, some individuals relied on water for sale which could be very expensive (one jerican cost 12 Kenya shillings). However, whether they bought or fetched water from the river, the supply was inadequate, hardly enough for cooking and washing their bodies. Personal and environmental hygiene were compromised as a result. The researcher witnessed poor personal hygiene by the old and dirty clothes people wore, in particular the elderly and young children. Most of the homes visited were dirty as well.

Dirty water was a major source of contamination in Piave. A key informant said, "…*People drink it because they have no alternative and have also no time to boil it*". A general informant also pointed out: "*Some people store water in uncovered tanks and use it for cooking and drinking"*. One of the key informants stressed: "*Roads are necessary but not as much as water"*. The informants also commented: "*It is important to teach people how to prevent diseases like disinfecting water, what disinfectant to use and the dosage".*

From the researcher's field trip observations, personal hygiene was limited, although a few community members were fairly clean. Some of the community members tried to maintain personal hygiene as much as possible through getting more water for their domestic needs by either buying or sending some casual workers to fetch it from the river. A key informant asserted: "*To maintain health one needs to be clean. When I was in school I was told cleanliness is next to godliness*". A general informant reported:

> *Personally, I wash hands and take care of what I am eating. I have to know how the food is cooked and use clean utensils. Also, I have to know where I am going like visiting the toilet; I have to take care of myself. My family takes the same preventive measures.*

Another general informant pointed out: "*People do not know preventive measures. They do not know they have to boil water before drinking and wash hands before eating. However, I do not know whether people do not know preventive measures or what?"*

To be able to observe personal hygiene, a lot of emphasis was placed on health education. Both key and general informants on several occasions said that Piave people were ignorant on many health-related issues including lifestyle and preventive measures.

Health education is "*any combination of learning experiences designed to facilitate adaptation of behaviour conducive to health*" (Basavanthappa 2008:1061). Basavanthappa views health education as an essential part of community health as it aids in understanding health issues which are likely to impact on the health of individuals, families and communities as a whole. It is concerned with changes in knowledge, feelings and behaviour of people. The knowledge enables people to make informed choices so as to assume responsibility for their own health

Germ infection

A general informant commented: "*Germs attack the body and spread through blood and one feels weak uncomfortable and unable to work*". Germ infection is a common phenomenon in a dirty environment. A key informant said: "*Germs come from food or dirty water and also surroundings if not clean*". A general informant commented: "*Alcohol is cooked with dirty water and utensils. Also not washing fruits because they are touched by many people in the market can cause germ contamination*". Another general informant said:

> *Unfortunately some people also believe that water does not have to be boiled because there is a strainer in the stomach that strains the germs thereby preventing one from getting sick. Skin diseases were also common due to dirty environment and lack of water.*

A general informant pointed out: "*Water which is not treated causes cholera*".

5.4.2.4 Diet

Contaminated food

The informants talked of food hygiene: namely, storing food in clean containers. One of the key informants said: "*I wash my hands and take care of what I am eating*". From the field observation, washing hands before eating was rarely done, and so was warming cold food. Food was usually stored in containers on the floor and very few people covered it. Those who covered it used dirty lids most of the time. One of the key

informants lamented, "*Firewood and water are rare commodities and we have to get them from very far. As a result, some families sleep hungry while others eat food which is not properly cooked getting stomach ache at times"*. It was observed during the field trips that there were hardly any available trees for firewood in the Piave area and people had to go for long distances to find it. Few people sold firewood to the community and when available it was at a price many could not afford. The major means of firewood according to the community people talked to and field trips observations were stalks from the maize and beans which were used within a short time after harvesting of the crops. The stalks burned very fast and also made very weak fires.

Food was also contaminated by chemicals from fertilisers used to make the soil more productive. One of the key informants lamented: "*Many years ago, people ate nutritious diet but nowadays we have food that is no good, fertilisers affect the soil"*. As per the researcher's observation during the field trip, farmers used fertilisers bought from the shops. The fertilisers were used repeatedly on the same areas of land as no land left fallow at any time because of the shortage of foodstuffs.

According to WHO (2001) it is estimated that 1.8 million people, the majority of whom are children, die annually from food-borne and water-borne diarrhoeal diseases in the developing countries. In 2001, WHO came up with five keys to safe food: namely, keep clean; separate raw and cooked food; cook food thoroughly; keep food at a safe temperature; and use safe water and raw materials (WHO, 2005 in Stanhope & Lancaster 2004:880). Protecting food from contamination is multifaceted; most of food-borne illnesses regardless of casual organism can easily be prevented through simple changes in food preparation, handling and storage (Stanhope & Lancaster 2004:880). According to the two authors, causes of food contamination occur as a result of cross-contamination of it during preparation; insufficient cooking or reheating temperatures; storing food at temperatures that promote the growth of pathogens; formation of toxins and poor personal hygiene.

Uninspected meat

Contaminated meat was another problem in Piave. One of the key informants said: "*People also get sick from eating meat which is not inspected by a health officer*"**.** According to the informants, meat inspectors were not available in Piave. People ate meat which was not inspected and were, therefore, likely to become sick if it was

diseased or rather if the slaughtered animal had some kind of sickness that could be transmitted to human beings. The community viewed this as a threat to their health.

Imbalanced diet

Inadequate nutrition or imbalanced food was likely due to several parameters:

A key informant commented: "*Eating poorly and inadequate food can cause sickness*". Another key informant pointed out: "*Sickness can be lack of nutritious food as well as lack of knowledge on nutritious food*".

According to informants, HIV/AIDS, TB, asthma and malnutrition affect people mainly because of food shortage; at times even children drink black tea without milk. Some informants also complained that a lot of problems resulted in death as a result of lack of water. A key informant grumbled: "*At times there is no rain for a long time and when rain fails to come, we have famine*'. He went further to say:

> *Eating well balanced diet is necessary but we only grow maize and beans and sometimes we have no food because of lack of rain. We have very few trees in this community and people need to be taught the importance of tree planting so that we can have more rain and clean air. I know the land is scarce and nearly all of it is under cultivation, but we can still grow some trees if allowed by our grandmothers who are the landlords.*

Data from the informants and field visits indicated that there was famine when it did not rain and this happened quite often. People relied on rain for food since the only way of getting it was through agricultural produce. As observed during the field visits, there were many cases of malnutrition among the young children, the major one being protein-calorie-malnutrition. Some of the adults looked malnourished too. There were hardly any fruit trees and that meant low or hardly any consumption of fruit. They also lacked a variety of foodstuffs. According to a key informant:

> *People have to be educated in the village about nutrition because they do not know. They think eating well is eating rice and potatoes and such a person thinks is civilised. They grow maize and instead of taking it to the miller, exchange it with flour No.1 (white flour). They also grow wheat and again exchange with white wheat flour instead of taking their whole wheat to the miller to get nutritious flour.*

The same key informant lamented:

> *These are nutritious foodstuffs but we do away with them and buy foodstuffs that are not nutritious. You see people are using foodstuffs that don't help them. They sell the food items that can help them like eggs for sugar which doesn't help. People like tea and it's of no help. People are milking but sell milk because they want sugar and tea leaves. That milk is not helping and the cows belong to them. That's lack of knowledge. If you take porridge, you will help yourself but you would rather take tea because it's easier to cook. People's health deteriorates and diseases attack them especially in Piave.*

From the data, it appears that Piave people have problems in meeting their basic food requirements. There are two reasons given by the informants and community members for lack of nutritious foodstuffs, minimal land to grow nutritious foodstuffs, inadequate know how in farming techniques and lack of knowledge on what comprises nutritious foodstuffs.

Lack of knowledge of agriculture and nutritious diet

According to Basavanthappa (2008:253), nutritious food is one that contains all the essential nutrients - proteins, fats, carbohydrates, vitamins and minerals. A well balanced diet should contain all these in correct proportions and adequate amounts. Proteins, fats and carbohydrates give the energy essential for various activities. Vitamins and minerals play an important role in the regulation of several essential metabolic processes in the body.

From the researcher's observation, very few community members grew nutritious foodstuffs. A key informant commented: "*We have farms here and we do not know farming*", while another one said:

> *To make this community healthy, we need a lot of health education from the hospital people. Eating well balanced diet is necessary but we only grow maize and beans… One should grow everything for example potatoes, oranges, and vegetables. People should be shown farming so that they can grow foodstuffs in their gardens.*

A general informant stated. "*Demonstration gardens can be developed for people to learn farming and take a leaf from them*".

Searles [s.a.] reports on Kenya's subsistence farming by highlighting farmers' ignorance on food production issues. The local subsistence farmers are not educated on the

treatment of the environment, pollution, erosion, soil run-off, method of growing foodstuffs, the types of crops to be grown, how to manage crop growth, use of chemicals, water safety, and proper diet. The challenges are compounded by major barriers to improving food, nutrition, security issues dealing with farming practices, farmers' ignorance of sustainable actions to take, and variations in the weather. Over-cropping takes place, leaving the land degraded and often infertile. Farmers often grow the wrong crops in the wrong places causing low rates of crop production and problems with soil degradation. Droughts cause problems because almost none of the small subsistence farms have ways of irrigating crops other than the rain. Also, in some areas, heavy rainfall drenches fields and farms destroying the crops.

5.4.3   Self-care health Seeking Behaviours

A variety of informal treatment approaches in self-care health seeking behaviours was practised by the Piave community.

5.4.3.1   Herbal treatment

There are two modes of herbal treatments in Piave:

- Self-treatment with herbs found within the home environment
- Treatment by herbalists

Self-treatment with herbs
The researcher, through interaction with various individuals and groups of people (particularly those in drinking dens), drew up table 5.2 that indicates information on the self-treatment use of herbs most of which were found within their home surroundings.

Table 5.2   Herbal remedies associated with self-treatment

Kikuyu name	English and botanical names	Usage
Mugwanugu	Aloe Kedongensis	Malaria, scabies and dandruff
Wanjiru wa weru	(Bugle) Ajuga Remota	Malaria, stomach ache, pneumonia and liver
Mubao	(Blue gum) Eucalyptus Globus and its charcoal	Feverish conditions and chest-related conditions (asthma included) and its charcoal used in cases of ingestion of poison
Mukinduri	Croton Megalocarpus	The liquid from the leaves is used to treat wounds and also prevents tetanus
Mucege	(Black Jack) Bidens Pilosa	Treats wounds – used when dry
Magurukia	(thorn apple, jimson weed, datura) Datura Stramonium	Teeth dislocation and tonsil treatment – seeds mixed with cooking oil (a red hot iron bar and a tin with a hole is used; then the patient sniffs the smoke as it is poisonous to take the seeds orally)
Mboga	(Cabbage, Vegetable) Brassica Oleracea or Capitala	A blood cleanser
Maigoya	Plectranthus Barbatus	Treatment of malaria (leaves boiled)
Gitunguru kia Ngoma	(Devil's onion or wild onion) Liliaceae ornithogalum tenuifolium	Treatment of tonsils (by inhaling smoke from it)
Kitunguru sumu (Swahili word)	(Garlic) Allium Sativum	Teeth treatment, respiratory tract infections especially common colds and digestive problems
Mukuyu	(Syncamore fig) Fiscus Syncomorus	Treatment of teeth (application of the milky liquid)
Mukura utuku	(Mallow) Malva Veticillata	The sap from the leaves is used to treat wounds while the roots are chewed for teeth treatment
Mukorobia	Avocado Pear	Teeth treatment – avocado seed is dried, powdered and the powder applied to the painful tooth which heals immediately
Mutamaiyu	(Brown Olive) Olea Europaea or Olea Africana	Intestinal worms
Muteta	Strychnos Henningsii	Backache and joint pains
Thabai	(Stinging nettle) Urtica Massaca	Backache and joint pains

The English and botanical names have been taken from a Kikuyu botanical dictionary (Gachathi (2007:58-195). English names are in brackets.

A general informant pointed out: "*People trust herbal treatment a lot because according to them, herbs do not have side effects. They also do not like taking a lot of drugs frequently*". Another one noted: "*Many people here say the patient should be taken to the hospital while others use herbs before going to the hospital and only go to the hospital when they are badly off*". Another general informant lamented: "*The only problem with herbal treatment is that one does not know the amount to take when using the treatment but all the same, people get cured*".

Some community members believed that a herb known as Azadirachta Indica (Murubaini) could treat forty diseases and that means nearly all the diseases they contract are within that bracket. One of the general informants said: "*Since they count and find 40 diseases are not yet over, people take stomach pain very lightly. They boil the leaves of Azadirachta Indica and drink it*". People were also told that there are herbs that treat HIV/AIDS and they try them. One of the general informants commented: "*It is common to find a sick person with a line of thermos with all types of herbal medicine. Some of the medicines are made from honey*". Another general informant commented:

"*In the last minute, if you have no money to buy herbs, then you have to go to the hospital and by that time you are very seriously sick*".

A key informant said: "*There are people who go for herbs like Aloe Vera, Sodom's Apple (Dongu) and Stinging Nettle (Thabai) for treating a wound; this wound of mine I treated with Sodom's Apple*". Another general informant commented: "*There are people who might tell you, if you use this herb you will get better. They will tell you that but it's because they are used to treating themselves*". A general informant explained: "*As for the young generation, we also take herbal medicine and go to the hospital when we do not get well*".

There was also another group of people who when sick were told what to do by their elderly parents and one of the general informants commented: "*Here in Piave we are brought up by elderly parents and they get herbs, boil them and then give as medicine*". Another key informant commented:

> *The older people give advice on herbal medicine; they say what works and are listened to. Others go for herbal medicine. If they do not get well, they come back home, become sicker and at times parents might think that one is bewitched. They then go to the witchdoctors but do it secretly'.*

Treatment by herbalists

There were not many herbalists in Piave unless they were visiting. Community members visited them either at Njoro or Nakuru.

Data from informants and field trip observation indicate that some community members believed that some diseases were better managed with herbal medicine. These are asthma, abdominal ulcers, epilepsy, malaria and wounds. According to a key informant: "*People prefer herbal medicine; a good example is my wife who had problems with asthma and was treated by herbalists. Many people are going to herbalists instead of the formal sector*". He further stressed:

> *Yes, just like my wife, I would rather go to a herbalist for asthma than to a hospital. A herbalist will give you almost an instant cure while the hospital does not have a cure. You have to take the medicine throughout your life.*

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A general informant said:

> *For some diseases like abdominal ulcers, epilepsy and asthma, people prefer to go to herbalists if they can afford because they say a cure is almost guaranteed while the hospitals will keep on treating you but no cure for the problem subsides and comes back every now and then. For abdominal ulcers like I have now, I would rather go to a herbalist for the same reason I have given. However, owing to lack of money, I have been attending Nakuru Provincial Hospital. I was told that I need to be operated but I refused. I am now looking for money to go to a herbalist.*

Another general informant said: "*I have also an aching leg and I am not getting better after going to hospital and I am also thinking of going to herbalist and try*". Another general informant said*: "As for asthma, epilepsy and typhoid, we would still try the herbal treatment if we can afford and only go to the hospital if there is no improvement*". The informants further said*: "A common treatment for asthma is dung from an elephant, rolled in a paper and smoked while typhoid is treated with moonshine (chang'aa) and Azadirachta Indica (Murubaini) is commonly used for malaria*".

Several studies done on the use of herbs have demonstrated that they are widely used. In a study done by Tabuti (2008:33-42) in Uganda, 27 species were used for the treatment of malaria. Another study done by Njoroge and Bushmann (2007:303-307) in Central Province, Kenya on the use of traditional remedies in managing various skin conditions, found that 57 plant species in 31 families were identified as regularly utilised. It was found that some of the highly utilised plant species included Croton Megalocarpus, Senna Didymobotrya, Vernonia Lasiopus, Croton Macrostachyus, and Aloe secundifolia.

5.4.3.2   Treatment with drugs

Some community members buy over-the-counter drugs for self-treatment. Four different key informants pointed out: "*They also buy drugs from shops for malaria*". "*We also buy drugs from the shops such as panadols for headache and pain*". "*Many people are used to taking herbal medicine obtained from their surrounding and at times buying drugs from the shops when sick*". "*Some diseases are treated at home with herbal medicine or drugs from the shop*".

Geissler et al (2000) did a study on the use of over-the-counter drugs in a rural area of Western Kenya and found that the community members preferred the use the drugs for headache, fevers or common colds while herbal remedies were preferred for the treatment of abdominal complaints and wounds. The drugs were bought from small shops at low prices.

5.4.3.3 Supernatural interventions

Prayers

Some community members pray for themselves while at the same time are prayed for by community members and pastors.

A general informant stated: "*Some people here go for prayers when sick*". A key informant pointed out: "*My family takes the sick relative to the hospital and also gives moral support. We take care of their needs where found necessary and offer our prayers too*", while a general informant said: "*Mothers are also very good in prayers; they ask the family to pray for the sick and at times call neighbours to do the same*". A key informant explained: "*Women in the family pray for the sick and at times request the church people like pastors to come and pray for them*". Another key informant emphasised: "*We also pray for the sick and since they believe, they get well. God's mercy descends down on them*".

Divine healers

Divine heals are said to pray for people to get well. However, according to a key informant: "*They hide behind religion; they are not genuine Christians because these are people born with magic pebbles in their palm and are later supposed to become witchdoctors. They start their own churches when they become adults*". Another general informant commented:

> *The community thinks that these kind of rituals spread bad omens in the community. Those who go to them take bad omens to their homes and become more affected and also other family members become affected. These disguised divine prayers continue cheating the community.*

According to Andrews and Boyle (2008:67), divine healers come into play in relation to people's beliefs and follow the magico-religious paradigm in which supernatural forces

dominate. According to the two authors, the fate of the world and those in it depends on the actions of God or gods or other supernatural forces that bring good or evil. At times, people are at the mercy of such forces regardless of their respective behaviours and at other times the gods punish people for their sins. Magic involves control of supernatural forces for and against others.

A general informant said:

> *My brother in-law is a saved Christian and has been getting sick because he refused to be consecrated as a witchdoctor. He was born with a magic pebble in his hand. The mother removed and kept it and she is now dead and nobody knows where it was kept.*

Leakey (1977:11240) commenting on the Kikuyu community explains that Kikuyu people have a way of knowing the persons destined to be witchdoctors. Individuals are invited to join the healing practice mostly by relatives such as a father inviting his son. In other cases, a person may be attacked by a serious illness such as hallucination, fits or vision difficulties or have a misfortune in the family such as the death of a child, all these being supernatural attempts for him to realise he was chosen by his ancestors to join the healing practice.

Witchdoctors

Witchdoctors according to the informants were usually found in Nakuru or Njoro towns and were consulted secretly. They said that there were no witchdoctors in Piave except for one elderly woman. Referring to this elderly woman, one of the key informants told the researcher: "*The elderly woman you saw this morning is a witchdoctor*". Through interviewing this elderly woman, the researcher found that she was a witchdoctor-cum–circumciser-cum-traditional birth attendant. She did not admit this initially but did later during member checking, although her actions were a clear indication of her being one. She told the researcher that she could find out what was ailing a person by tossing castor seeds in the air. She threw them in the air for the researcher and told her what was wrong with her in spite of her not complaining of any problem.

On the researcher's second visit meant for member checking, one of the general informants told her that one of the key informants was a witchdoctor and that was how she had managed to become very rich. They were even afraid for the researcher when she went to interview the woman (she was one of the key informants) because they

suspected that she might be bewitched by the informant. Since the researcher was also doing member checking on the same woman, she asked her whether there were witchdoctors within the community but she denied it and stated: "*Those who talk about witchdoctors try to malign the community members who are doing well financially and in other ways*". This notion is confirmed by Ntloedibe-Kuswani [s.a] who did a study in Botswana in which a group of the respondents stated that everyone can be a witch or can be bewitched, whether old or young, male or female, poor or rich, indigenous or foreign. Such people may include the wealthy, because people are jealous of their riches.

Information from the community members indicated that witchdoctors in the community do not talk about it openly because of the fear of being rebuked by the community and arrested by police officers. Talking about the witchdoctors being consulted by some of the Piave community members, one of the key informants commented:

> *Recently, a man who works here (meaning working for the informant in his garden,) consulted a witchdoctor on his sickness and was told to wait until the following day. That was because the witchdoctor wanted to cheat and she didn't know what to say. Come the following day at 2 a.m, I saw a man standing near a tree near my house. I asked the man the following day what he was doing there at night and he told me that his mother (the elderly witchdoctor) had sent him to bury things there so that the person can be told the following day that under the tree were the things that had made him separate with the wife. The man who was consulting was shown nails, hair and other things that had been sent to him by his enemy to cause trouble and he believed, but on my part I knew it was not true.*

Although none of the Piave people admitted consulting witchdoctors; may be because of the stigma behind it, the researcher believed they did because the witchdoctors' places of practice (basically their houses) were busy with clients.

5.4.4 Influence on self-care health seeking behaviours

5.4.4.1 Family influence

Elderly women

The parental influence in this section refers to the elderly women who were the owners of the land. The families from individual households were very much influenced by the elderly women whose decisions at times had to be followed irrespective of other prevailing ideas. A key informant commented: "*In my family, members of the family normally do the same things. They are influenced by the older members within the family like my old mother and follow what they say*".

A general informant further said: "*Yes, our families influence one another a lot*". Another general informant pointed out: "*People also consult the older people in the community in finding out the best herbs to use. The older generation has been using them for years and is very conversant with them*". One of the key informants lamented: "*I can tell somebody something and the person refuses to listen just because an older person told them so*"; referring to not going to the hospital. Many people were said to follow the elderly women's instructions for fear of being sent away from home thereby becoming landless and homeless. A key informant pointed out: "*Sometimes the chief has to intervene for the sick to be taken to the hospital*".

Andrews and Boyle (2008:154) point out that health professionals need to understand how individual families influence health related behaviour among their family members because conceptions of health and illness and reactions to them form during childhood within the family context. They comment that when illness has social and cultural meaning, the issue becomes more complex.

Other family members

Other family members in this study refer to the rest of the family apart from the elderly women. They included fathers or children of these individual households. There was significant influence of the other family members because they lived within the same compound. Information from the informants and field trip observations indicate that family members saw one another almost daily since the land was small and therefore the houses were congregated together. The people tended to buy over-the-counter medicine, use herbs from the environment or visit herbalists for treatment of minor

ailments. They only sought formal treatment (going to the hospital) in the case of serious illness or when their illnesses did not respond to the herbal treatment.

One of the general informants stated:

> *Mostly in our family, we first stay at home hoping the sickness will subside and at the same time taking herbs such as Ajuga Remota (Wanjiru wa Weru), Azadirachta Indica (Murubaini) and others. If the sickness is serious, we go to the hospital and it is fortunate that we now have one within the community (referring to Piave).*

The general informant further said: "*Family members also buy drugs such as panadols for headache and pain from the shops*". Another general informant observed: "*Our families influence one another a lot; the family members who are seriously sick are taken to the hospital immediately while others less seriously sick wait to see the course of the disease and at the same time use herbs from our surroundings*".

A key informant stated:

> *My family listens to me and because I am an advocate of telling people to go to the hospital when sick, that is what they do. Occasionally, we use herbal treatment from the herbs around here for minor ailments like a flu such as Ajuga Remota (Wanjiru wa Weru), lemon and Azadirachta Indica (Murubaini).*

A general informant commented:

> *We mostly go to the hospital unless it is a minor illness like common cold or a bit of diarrhoea. In case of a common cold, my family takes Azadirachta Indica (Murubaini) and for diarrhoea, we wait to see whether it would subside while at the same time treating ourselves with cooked bananas if available.*

A key informant explained:

> *I and my husband believe in seeking medical help through formal health facilities although personally, I prefer to go for herbal medicine but it is too expensive. My family prefers the same. We take herbs around our environment and get well if the problem is not very serious. In serious cases like abdominal ulcers I have been suffering from for a long time, we go to the hospital. At times when we have no money, we just use herbs around here and hope to get better. My family has a lot of influence in self-care health seeking behaviours particularly my grandmother.*

Many families preferred to use herbal medicine picked from their home surroundings and only sought formal treatment when sickness became serious. A few who could afford to consulted herbalists. According to Basavanthappa (2008:126), the way individual families perceive a certain situation, the meaning they attach to things and their way of relating to the outside world, influence the way they react or act to what is happening around them.

In the culture of the Dominican Republic, family members and traditional healthcare providers were influential advisors on initial health-seeking behaviours and self-care practices (Person, Addiss, Bartholomew, Meijer, Pou, & Van den Borne 2006). Skordis-Worall, Mills, Pollit and Hanson (2007) did a study in Cape Town South Africa and found that both women and men tended to depend on a female family member (usually the mother) to guide in health seeking behaviour.

According to Andrews and Boyles (2008:266), mostly family members are the ones who decide on the course of treatment. It is within the family context the individual members learn basic ways to maintain health and to ensure their own wellbeing as well as that of their family members. The family has the primary responsibility for taking care of the health needs of its members. Geissler et al's (2000) study in a rural area in Western Kenya also found that all the medicines taken by children, two thirds were provided or facilitated by adults.

5.4.4.2 Community influence

Community health workers

Community health workers trained by the Society for Women and AIDS in Kenya (SWAK) have been very influential in advising people to seek formal health care for treatment. They give health education specifically on health problems related to post-abortal care and HIV/AIDS. One of the key informants said: "*Our people are sometimes given health education by community health workers particularly those taught by SWAK*". Another key informant commented: "*SWAK community health workers are moving the community ahead in matters of development*". Yet another general informant stated: "*There is one of them who is very influential and has solved a lot of family and community problems here. If she appears in a drinking den, men almost run away; they*

are afraid of her". The informants said that some community members had been taught ways of living well. According to one of the SWAK members interviewed as a key informant: "*People are taught, they understand and change".* In trying to demonstrate some of the good work done by the community health workers, one of the key informants, a community health worker trained by SWAK reported:

> *We had to take a sick woman by force to the hospital. She was found to be HIV positive and was put on treatment. She was almost dying but has greatly improved since then. The child was sick too and was taken by force to the hospital, was HIV positive as well. The mother of the sick woman had instructed the girl not to breast feed but had not given the reason why.*

The researcher's field trip observations established that the community health workers who were all women had been very instrumental in the prevention, health promotion and counselling of the community members. They counselled women and also girls with bleeding disorders because of abortion and other gynaecological problems and infected or affected by HIV/AIDS. They were instrumental in creating an awareness of these conditions and tried to convince the sufferers of the importance of seeking formal treatment. They referred patients to the health facilities: namely, the Piave Dispensary, Njoro Health Centre or Nakuru District Hospital depending on individual case merits. They had established referral relationships with the current health facilities. They followed up their referred patients to ascertain that they had been treated satisfactorily. All this work was done on a voluntary basis. The researcher found them to be very popular among Piave people and were greeted with a lot of respect by men, women and children when she accompanied them during the field visits and also during some of the workshops (three workshops) they held within the Piave and Njoro divisions assisted by official members of SWAK from the Nakuru Branch. The workshops were held on HIV/AIDS and post-abortal care.

Below are a few pictures taken during the workshops

The middle picture comprises SWAK community health workers with one of the SWAK officials and the researcher while the other two pictures on either side show workshop participants (courtesy of the researcher).

Piave community health workers as indicated earlier were trained by SWAK, an organisation that deals with HIV and AIDS. They were very helpful to the community; however, they lacked extensive training since they had been trained on HIV/AIDS and post-abortal counselling. They received hardly any stipends except when they conducted workshops for which they were given some honorary money for workshop facilitation and a few of them were given some money for airtime just in case they needed to ring the health facilities for patient referrals. Community health workers from MoH were seldom seen; the researcher never met any of them during her data collection. On asking the nurses whether they sent any MoH community health workers to the community, they said no, the reason being that curative work took precedence.

Community members

It appears that some community members had some influence on where to go for treatment. One of the key informants commented: "*People do this, if I go to a herbalist and I am given herbs, I will also go and tell other people that a certain person is giving herbs, that person tells another person who will do the same*". Another key informant commented: "*Some people visit the sick and during this time of the visits, they tell the sick where to go such as going to herbalist or a witchdoctor*". In other words, information spread among the community members.

According to Basavanthappa (2008:29), socio-psychological variables such as social pressure or influence from peers or other community groups, influence health seeking behaviors.

The chief

Another influence was the chief of Piave who was very keen on instructing people to go to the hospital when unwell. One of the key informants said:

> *Some don't go to hospital, but many of the ones we know have accepted and are followed up. While we were being taught on how to do counselling, we were told that we inform the Chief and Police so that they can force the sick unwilling to go to the hospital to go.*

Neighbours

Both the key and general informants said that neighbours cared for the sick at times. One of the key informants explained:

> *When one is very sick, we organise a committee, visit the sick person and take some foodstuffs and money. We arrange to take the person to the hospital if one is very sick and depending on financial status of the person, we decide whether to give money or to take the person to the hospital. We also help in house chores and help the children even in farming.*

Another key informant commented: "*The sick are supported by neighbours and family. However, some are left by themselves because the family is not able or is ignored. It is a problem if one does not have money*".

The researcher on her field visit found a lot of interaction among the neighbours and they seemed to support one another although one of the informants lamented that the assistance came very late sometimes when a person was very sick, mostly when the patient was admitted and money was contributed for the hospital bill.

Self-help groups

These groups were established by community members of Piave. There were groups that contributed money for the '*merry-go-round*' (referred to it at times as 'table banking') and any other assistance needed. The money contributed assisted one another in times of need, such as payment of hospital bills and funeral services. One of the key informants said: "*If one is sick we visit, contribute money and ask the person to go to the hospital*".

Church members

Church members pray for their members when the latter are sick. They also visit them in their homes and take food or money to them if they are not able to meet their basic needs. A general informant commented: "*Neighbours take care of their sick and the church members also visit their fellow parishioners*".

Previous studies show that women's decisions regarding health seeking behaviours are strongly influenced by the practices of others in the community, for example, in a community in which a high percentage of women are using health services for childbirth, the practice is likely to be seen as a norm, influencing individual behaviour (Stephenson, Baschieri, Clements, Hennink, & Madise, 2006:84-93).

5.4.4.3 Previous experience with formal health care

Unsuccessful treatment

People, who go to the hospital and do not get well, tend to go to herbalists or witchdoctors. One of the key informants gave the example of her grandmother. She said:

> *My grandmother never went to the hospital because one of her children went to one for a tooth extraction and died thereafter because he developed some complication. Since 1950 when this happened, she has never gone to a hospital for treatment.*

Another key informant commented: "*Yes, there are people who after going to hospital and do not get well, opt for herbalists and they praise them*". A general informant pointed out:

> *You find that some do not go to a hospital and say that they do not take medicine from the hospital as they do not recover and therefore go to herbalists. They go to traditional healers like the ones in the town of Njoro; they are said to be recognised herbalists.*

Lack of trust in medical doctors

According to a key informant:

> *Another situation that keeps Piave people away from going to the hospitals in particular is that some government doctors do not keep secrets. This is more so to those who are aborting unless it is threatened abortion. This is because in Piave it was decided by the chief sometime back that anybody found*

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aborting would be dealt with by the law. Those aborting are taken to police immediately after being taken to the hospital and treated. They are then taken to court because of the criminality of the act. Those aborting do not want to follow suit and do not go to the hospital (including Piave Dispensary) since they know the consequences of abortion; they have to hide.

In Kenya abortion is illegal except in cases where the pregnancy is a threat to the life of the mother.

5.4.4.4   Access to health services

The Piave Dispensary is manned by two nurses. The current nurse in charge of the dispensary is a Kenya Enrolled Community Health Nurse while the other one is a Kenya Registered Community Health Nurse who was posted to the dispensary recently. Previously, there was only one nurse, the current one in charge of the place. Only one nurse is present at any given time most of the times; the two nurses work on alternative shifts. Data from the informants indicate that the clinic opens its doors at around midday since the nurses come from Nakuru Town; about ten kilometres from the dispensary and means of transport are poor. There is no direct transport to the dispensary, they take public transport for a distance of about six kilometres and walk the remaining distance as there is no public transport going to the dispensary because of bad roads. They usually reach there by around 10 or 11 a.m. and by the time they have had a cup of tea and prepared their working area, it is already midday. They work until 4 PM and close the dispensary ready to return to their homes. On Saturdays and Sundays, the dispensary is closed.

Transport

According to the key and general informants, Piave community has to look for alternative means of getting treatment when sick since the health care is not accessible on a 24-hour basis. Some revert to herbal treatments or buy over-the counter drugs from the shops for first aid while waiting for the dispensary to open. When very sick at night, weekends, or day time after 4 p.m., they have to look for transportation to take them to the hospital. There are no public vehicles that come to Piave. The only means of transport during the day is bicycles referred to as 'boda boda'. At night, people have to rely on vehicles belonging to their neighbours which are very scarce. They have to

hire them at a rate of Kenya Shillings 2000 to be taken to the Nakuru Provincial Hospital, about 15 kilometres from the town of Piave.

The informants said that some patients are taken to Njoro Health Centre (about 10 kilometres) although their preference is the Nakuru Provincial Hospital because of better medical facilities. When the patients are taken to the Njoro Health Centre, they might be referred to the Nakuru Provincial Hospital if the illness cannot be treated and that is why they prefer to go to the Nakuru Hospital straightaway. Those without the means of transport because there is none available or they cannot afford to pay, wait until morning or until the dispensary is open. Some get health complications or die while waiting. This is common particularly in cases of abortion or any other type of bleeding. Babies die as well because of diarrhoea or chest problems. Some people are said to die too as a result of anxiety or fear.

Cost

The other hindrance to access to health care services is the cost. According to the informants, some community members are very poor and that means they cannot afford the small fee paid for the health care even at the dispensary level. Patients pay Kenya shillings 50 for the card and thereafter the same amount for re-visits. The community is constrained; they do not have money. One key informant commented:

> *We lost a woman recently because she depends on selling charcoal and it is illegal to burn charcoal. She goes to the forest but if forest guards are there, she comes back. Problems are too many and are affecting many things.*

A general informant stated:

> *People do not go to the hospital mostly because of money. Like when there were herbalist here so many people came because they thought it was a free medical camp but were disappointed to find out they had to pay.*

Mbagaya et al (2005:322-327) study in Kenya found that a third (32.4%) of the mothers bought and administered drugs to their sick children without seeking medical help. The most commonly reported reasons for this behaviour were: the government health facilities were at a distance, the services were poor and the mothers were not able to afford the service of the private hospitals and clinics.

5.4.5 Assistance required from health professionals

5.4.5.1 Health education

Key and general informants expressed needs for health education on the following: health problems affecting the community; when to go to hospital; family planning; menopause; vaginal bleeding; HIV/AIDS; first aid; typhoid; snakebites; nutrition; clean environment; personal hygiene; malaria; and prevention of disease..

A general informant emphasised:

> *There are many diseases here that can be prevented such as typhoid and malaria. We need to clear the bushes and stagnant water to prevent mosquitoes from breeding but people do not do that. We need health professionals to tell the people about all this hoping that they would believe what they are taught and practice it as well*

Another general informant pointed out:

> *Nurses and doctors have a lot of knowledge on health matters. I would therefore like to see them getting into our community and giving us health education on health problems that are inflicting us. We need to know how to prevent disease, how to eat well and keep our environment clean. We have a little knowledge on these issues but we want to know more as I find a lot of sick people here. I am one of the community health workers and we teach also about HIV/AIDS but it seems that some people ignore us because they know we are not well educated. We need nurses and doctors to come so that they can reinforce what we teach.*

When to go to hospital

A key informant pointed out: "*We need to know the importance of going to the hospital when sick".* Another key informant remarked:

> *Some of the people refuse to go to the hospital and say they are being prayed for, may be health professionals can convince them to go to the hospital. They have tactics that might convince them to do so. Nurses and doctors should not just wait for sick people at the hospital; they should visit the communities for better health care. Herbalist visit people or go to television and talk about disease they can heal and people get convinced by them. If health professionals really care for the community's health, they should come and explain the implications of the preaching people get from herbalists.*

Family planning

A key informant commented: "*Many women and girls get pregnant because they do not do family planning; they need to be taught by credible people because there are a lot of myths surrounding family planning*". He further elaborated:

> *I have heard many men complain that their women become cold when they use family planning because their sexual desires are diminished. Men therefore refuse to allow their wives go for family planning resulting in a lot of children.*

The same sentiment was echoed by a group of community members undergoing a workshop on post-abortal care that the researcher attended in Piave.

Menopause

A key informant had this to say about menopause:

> *You will find here in the village, they take it to be normal. As for me when I reached menopause, I started sweating very much and when I went to Nakuru Hospital, I was given medicine and they told me not to take sugar, salad, red meat and now its five years and I do not have that problem.*

She elaborated further

> *Lack of knowledge is dangerous. Many women in the village do not know about menopause. I also had that experience and I have a husband who is saved. I did not want to have sex and because he is human we used to talk about it and we sorted it out. Some other women out there go to women's prayers where they are taught about menopause and they say that they are helped.*

Another key informant commented:

> *If a seminar is organised, we would all learn. I know that a person who doesn't know is in darkness. One might say I thought I knew but now I know. People need to know there is nothing unusual about these health problems and should be able to consult a nurse or doctor at any time. When it comes to menopause, people have no idea, they think they are unwell and may be suffering from malaria or other bad diseases. Nurses and doctors have to come out of the health facilities and organise and implement teaching sessions for different community groups or even individuals where necessary.*

Vaginal bleeding

A key informant said: "*… most important is the teaching on post-abortal care and any other forms of vaginal bleeding*". Another one stressed:

> *I think a person might be laughed at by some people in the community; might not even know what to tell the doctor since the problem is affecting the private parts and the doctor might also treat her with disrespect (says this happens at times particularly if the problem is abortion); feels shy exposing the private parts. If the husband notices his wife is bleeding the most likely thing is to send another woman to find out why she is bleeding. By the time the bleeding woman discloses her problem, she might have gone around the bush for many days. Only about 1 in 100 would say immediately that they are bleeding. However, initially many women think the bleeding is heavy monthly period and only come to realise it is abnormal bleeding when it is too late. You will find a woman bleeding even up to eight month of pregnancy and they don't know how dangerous that is and here many women have died because of that.*

HIV and AIDS

A key informant commented: "*HIV/AIDS is finishing us and also many orphaned children are left behind by their parents; we need more awareness and this needs people who will be listened to*".

Nutrition

A key informant stated: "*People have to be educated in the village about nutrition because they do not know*". A general informant also commented:

> *The things we can do are visiting in groups. Lets say our counselling group is invited by community groups and we advice them on good nutrition and way of living as we have been taught and they understand and change. Some have no knowledge but as we teach they understand and change.*

A key informant stated: "*We need to be taught about nutrition so that we eat food sensibly*".

Clean environment

A general informant reflected: "*To improve this community, we need a lot of health education from the hospital people. We also need to keep our environment clean and drink clean water which is unfortunately not available*".

A key informant said: "*We need to know how to keep our environment clean. We have a little knowledge on these issues but we want to know more as there are a lot of people*

sick here". Another key informant asserted: "*We need to be more aware about keeping our environment clean as much as possible and also the importance of clearing stagnant water to keep away mosquitoes".*

Personal hygiene

A general informant pointed out: "*We need to be taught about keeping the home clean and building good pit latrines*".

First aid treatment

The community expressed the wish of learning first aid so that they could take care of snake bites, emergency treatment of pneumonia and dog bites. One of the key informants stressed:

> *Nurses and doctors should go to villages and select a few people and train them on diseases and drugs after which if one becomes sick, the trained people can give the right drugs. If one is sick at night or is bitten by a snake (there are snakes in Piave) the same people can do first aid.*

A key informant commented:

> *What the hospital staff can do, we have four villages Githira, Kahuho, Migaa and Subuku. I think they can go to villages let's say Githira they take a few people and train them on diseases and medicine to give. When a community member becomes sick, these people can give relevant drugs. If one is sick at night the same people can do first aid. The doctors are there but if a person falls sick here people do not know how to do first aid. They can be bitten by snakes and we have snakes here. These trained people can do first aid.*

5.4.5.2 Home visits

The informants expressed the desire that health care personnel visit them. A key informant emphasised:

> *We should have health workers visiting and teaching us how to prevent diseases. We would also like them to visit us once in a while as you are doing (referring to the researcher) so that they can learn about our problems and assist us in solving them or give us some advice on what to do.*

A general informant said:

> *They should take a step and say that they will be visiting such and such a district at such and such a time. If they call people in meetings they will not come. Many cannot sit here and listen to you, they cannot agree. Only visiting sub location can help. If they come to teach people they should go from house to house and this can help a lot.*

To be a good player in the matters of health and related aspects, the roles of health care personnel working in the community have to be diverse. Some of the roles are taking the position of a care finder through visiting the community to establish groups or individuals who need health care and help out through sharing health messages to solve problems or health needs (Basavanthappa 2006:82-84). Nazzar, Adongo, Binka, Phillips, and Debpuur (2006:307-24) did a number of studies in Navrongo, Ghana to determine the demographic and health impact of deploying nurses and volunteers in the community. The conclusions were that health care personnel working in the community where they provide basic curative and preventive care substantially reduce childhood mortality and accelerate progress towards attainment of child survival. It was also found that using community volunteers has no impact on mortality. The research, therefore, demonstrates that affordable and sustainable means of combining health professionals with volunteer work can accelerate attainment of Millennium Development Goals on child survival and family planning. Another study done on fertility rates demonstrated that reducing fertility depended upon combining the presence of nurses with community mobilisation and the involvement of men in family planning.

5.4.6 Community development initiatives

On being asked to propose ways of making the community healthy, key and general informants suggestions were; supply of clean and adequate water, good roads, electricity, availability of entrepreneurship, high-quality farming and employment.

5.4.6.1 Water

Clean and adequate water was hardly available in Piave. A key informant commented: "*We have water problems. We have one river which you saw. Everybody uses this river water. We do not have water boreholes but donors dug a borehole at the hospital. If we had more boreholes this would help*".

A key informant stated: "*If we had more boreholes this would help. When there are water shortages some people who are weak and can't walk, drink dirty water from dams*".

5.4.6.2   Roads

A key informant complained: "*Roads here are good but they are not maintained. That is the problem. You cannot pass in some areas as the road is very rough*" Another key informant stated: "*We have managed to talk to politicians of this constituency on important matters like building of roads and at least tarmarking or making the few we have all- weather roads*".

5.4.6.3   Electricity

A key informant explained: "*Electricity that's what we lack. I use battery (shows me the battery); this is a donation from a group called search of light*". Another key informant pointed out:

> *We have also requested for electricity and will soon be installed as you can see some poles are being put up for that purpose. However, we have no idea as to when this will be done. We have also discussed about water as you know it is very scarce but there are no signs of anything being done about it.*

5.4.6.4   Entrepreneurship

A key informant stated:

> *If we had electricity, we can build houses for renting and keeping cows. The biggest problem here is brokers. The government can support us in our co-operative so that our milk can be taken to Kenya Creameries Corporation (KCC) even if its one litre, instead of selling to brokers who buy it cheaply.*

A general informant stressed:

> *Give some loans, peoples have pin numbers and will not escape from here for that reason. We can keep chickens since we are near town and so can take the eggs to town. The problems might be less as a result.*

5.4.6.5 Farming

A general informant stated, "*Counselling is good. Sometime back we were counselled on the importance of planting tress, keeping compost and a drug that can be used to speed up the composing manures and planting vegetables*". A key informant asserted, "*These people have to be shown how to farm so that they can have more food crops to feed from*".

5.4.6.6 Employment and education

A key informant noted: "*Young men are irresponsible. If they were well educated, they might get jobs and have a life they can manage. There is one secondary school now in Piave and the situation is becoming better*". A general informant stated: "*Generally, poverty is also a problem and therefore jobs are needed so that we can meet our basic needs*".

5.5   SUMMARY OF THE CHAPTER

In this chapter, six categories emerged after data analysis, namely, Piave community perception of health and wellness, factors contributing to ill-health, self-care health seeking behaviours, influence of self-care health seeking behaviours, assistance required from health professionals and initiatives for community developments and improving health. Data was presented in categories and subcategories and discussed with the support of raw data from the voices of the informants. Literature control was added where relevant. Preceding data analysis and presentation, a few vignettes of some of the key and general informants were given to provide background information on the informants.

In the next chapter, data analysis and presentation of the additional informants; health professionals and traditional healers is done.

CHAPTER 6

Phase 11: Data analysis and presentation: additional informants, health professionals and traditional healers

6.1   INTRODUCTION

This chapter provides phase 11 of the analysis and presentation of the data collected for the study from heath professionals and traditional healers. They were included in this study because their close proximity to Piave results in the community consulting them for health care services and they would consequently be aware of the health seeking behaviours practised by the community. Both groups were used as general informants but the interview guides were different as each party provides different care. The interviewing approach was also different as the health professionals were interviewed in two focus groups, one group from the Piave Dispensary and the other from the Njoro Health Centre. Traditional healers were interviewed individually.

As the Piave Dispensary is situated at Piave, it is usually the first place the community members go to for health care. The Njoro Health Centre is about 10 kilometres from Piave and is the nearest health centre that Piave patients are referred to if the illness is too difficult for the dispensary to handle. The Nakuru District Hospital is about 15 kilometres from Piave and some patients are referred there by the Piave Dispensary health professionals if the sickness is serious enough to warrant care at the level of a district hospital. Information gathered from the community health workers indicated that they preferred to send patients suffering from serious health problems such as vaginal bleeding to the Nakuru District Hospital because they were likely to be attended to immediately without referral to other health care facilities.

Traditional healers are also situated close to the Piave community since they are found in the towns of Njoro and Nakuru. Figure 6.1 below is a map of the Nakuru district with the towns of Njoro and Nakuru highlighted.
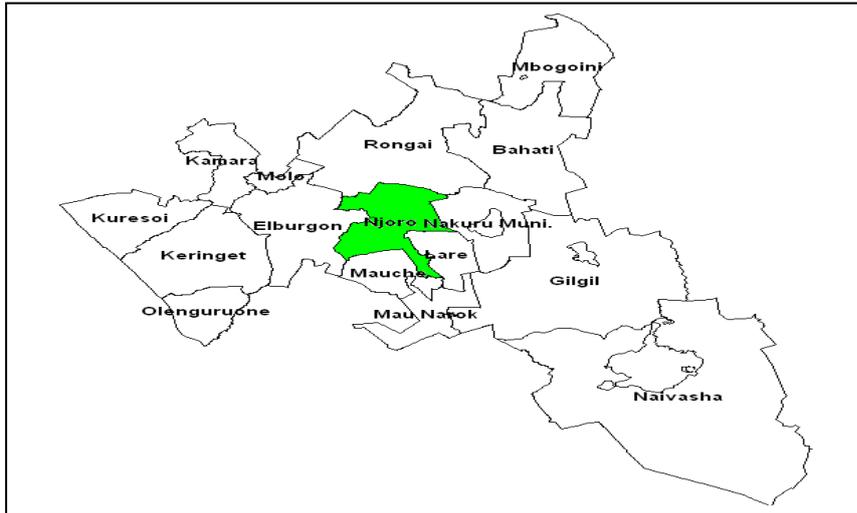
Figure 6.1   Map of Nakuru district with towns of Njoro and Nakuru highlighted
Source: ArcView software (mapping software)

The research questions pertaining to the data presented in this chapter were:

1.   What are the self-care health seeking behaviours of the Piave community?
2.   Has the level 1 health care strategy been implemented within the Piave location?

Some of the questions in the interview schedule for the health professionals included: an average number of patients seen in a day; the type of health care seeking behaviours they are likely to have noted and any awareness of the existence of traditional healers in the community. As for the traditional healers, some of the questions in their interview schedule included diseases treated by traditional healers; means of knowledge acquisition; reasons why the community sought health care from traditional healers and acceptance of traditional healers' practice by health care professionals.

6.2   DATA PRESENTATION: HEALTH PROFESSIONALS

Table 6.1 displays the health professionals interviewed and the venues where the interviews were conducted.

Table 6.1   Venue for the interview and the type of health professionals interviewed

Nakuru District Hospital	The Public Health Nurse in charge of public health in Nakuru district
Njoro Health Centre	Health professionals comprised of two Clinical Officers, two Kenya Registered Community Health Nurses (KRCHN) and one Kenya Enrolled Community Health Nurse (KECHN).
Piave Dispensary	Two nurses; a Kenya Registered Community Health Nurse and a Kenya enrolled Community Health Nurse

6.2.1 Diseases in the location of Piave

Table 6.2 displays informants' data on diseases found at Piave. All the diseases grouped into body systems are in the middle section while the same diseases classified according to the causes are shown at the sides.

Table 6.2   Diseases at Piave grouped according to body systems

(a) Infectious diseases • Brucellosis • Comon cold • HIV/AIDS • STDs • Skin diseases • Tuberculosis • Typhoid	Respiratory system • Asthma • common cold • pneumonia • tuberculosis Digestive system • Stomach ulcers • Stomach ache • Typhoid	**(b) Personal hygiene** • Skin diseases • Stomach ache • Typhoid
	Muscular/Skeletal system • Joint pain • and swollen legs	**(c) Waterborne** • Typhoid • Stomach ache
(d) Environmental hygiene • Skin diseases (dirt) • Asthma attack (dust) • Coughing (dust) • Common cold (dust) • Stomach ache (dirt) • Typhoid (dirty water) • Tuberculosis (overcrowding) • Malaria (stagnant water • Asthma (could be predisposed to dust and exposure to cold	Reproductive • Birth complications • Vaginal bleeding	
	Metabolic and endocrine • Diabetes Mellitus	**(e) Non-communicable diseases** **Cardiovascular** • Hypertension **Endocrine** • Diabetes Mellitus **Alimentary system** • Stomach ulcers
	Cardiovascular • Hypertension	
	Blood • Malaria	
	Neurological • Paralysis • Epilepsy	
	Special senses • Skin	**(f) Neurological conditions** Epilepsy • Paralysis • Headache • Backache (the last section includes symptoms that could originate from neurological problems at times)
	Others • Infectious diseases • HIV/AIDS	
	Symptoms • Headache • Backache	

Table 6.3 shows the Piave Dispensary statistics of various disease conditions treated in the year 2008.

Table 6.3   Various disease conditions seen at Piave Dispensary in 2008

Statistics of seen cases at Piave Dispensary in 2008												
	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct.	Nov.	Dec	Total
Malaria	93	90	90	96	96	4	275	185	178	171	73	62	1413
Intestinal worms	14	18	6	16	9	7	10	7	1	1	2	2	93
Respiratory diseases	116	102	114	105	84	55	339	259	201	107	93	80	1655
Skin diseases	50	43	15	20	65	31	7	2	52	72	55	70	482
Diarrhoea	50	22	15	10	11	16	31	32	20	16	5	48	276
Pneumonia	0	5	12	16	3	16	29	21	6	13	5	2	128
Others (include typhoid, tuberculosis, abdominal ulcers)	3	4	6	11	8	28	39	56	63	44	25	25	312
Family planning	34	36	42	53	55	74	58	50	84	50	52	66	654
Total	**360**	**320**	**300**	**327**	**331**	**231**	**788**	**612**	**605**	**474**	**310**	**355**	**5013**

Source: Piave dispensary

As can be inferred from the information in Tables 6.2 and 6.3, most of the diseases can be prevented. They range from diseases caused by drinking dirty water, poor personal and environmental hygiene and cardiovascular conditions. One of the health informants from Njoro said, "*The common diseases that we have are malaria, respiratory tract infections, diarrhoea, sexually transmitted diseases (STDs), skin disease and diseases related to HIV*". Another one said referring to Piave "… *around those areas we have skin condition, malaria and worm infestation. When you look at Piave area, water is an issue … Water borne diseases are mainly in that area*".

6.2.2 Analysis and interpretation of the health professionals' data

Table 6.4 displays categories and sub-categories generated from health professionals' data

Table 6.4   Health professionals: data display

	Categories	Sub-categories
6.2.1.1	**HEALTH CARE SEEKING BEHAVIOURS OF THE PIAVE COMMUNITY**	• Self-treatment (herbs, drugs) • Herbalists • Traditional birth attendants • Hospital treatment
6.2.1.2	**HEALTH PROFESSIONALS' VIEWS ON INTEGRATION OF TRADITIONAL HEALERS INTO THE FORMAL HEALTH CARE SYSTEM**	• Awareness of traditional healers • Integration and training of traditional healers
6.2.1..3	**CURRENT STATUS ON IMPLEMENTATION OF LEVEL 1 HEALTH CARE FACILITY**	• Shortage of health professionals • Shortage of drugs • Bad roads • Lack of markets • Home visits • Health professionals and community relationships
6.2.1.4	**HEALTH PROFESSIONALS' VIEWS ON INITIATIVES FOR COMMUNITY DEVELOPMENT AND IMPROVING HEALTH CARE**	• Cost sharing • Health education • Outreach programmes • Training other community health workers • Recruitment of nurses • Clean water • Electricity • Good roads

Data analysis and interpretation based on individual categories

6.2.2.1 Health care seeking behaviours of the Piave community

The Piave community practised different ways with respect to health seeking behaviours.

Self-treatment (herbs, drugs)

Self-treatment was found to be a common practice among the community. They used herbs from their home environment. This was voiced by a number of informants. An informant said: "*Some take malaria herbs like Ajuga Remota (Wanjiru wa Weru)".* Another one said: "*I think it is only on weekends that they take their own remedies. Some fear to tell what they have taken thinking it might bring a negative impression on them".*

Over-the-counter drugs

One of the informants said: "*Some enlightened ones will tell you they have treated themselves with drugs for malaria and some pain killers*". Another one commented: "*Some say they buy relieves from the shop or the chemist*". Another informant said that some community members took shop drugs and observed themselves while yet another one commented: "*Most of them treat themselves or buy drugs over the counter*".

Herbalists

Another common practice among the community members was consulting herbalists for treatment after home remedies or hospital treatment had failed. Others preferred to go to herbalists as they believed herbal treatment had no side effects like drugs from the hospitals.

Commenting on the use of herbs, an informant said: "*They don't open up on where they go for herbs and I don't know any herbalists*". On being asked whether they know of the diseases herbalists are consulted for, one of the informants said: "*HIV alone I think*". Another informant pointed out*: "We have these people who go round selling herbal drugs to people. Some people are used to them. You go to the slums and you find these herbalists there and people are using them*". Another one stated: "*We have herbalists even in the market places. They sell herbal medicine in the open*".

Traditional Birth Attendants (TBAs)

The community uses TBAs quite a lot. However, according to the informants, TBAs are not trained by the health care system. They learned the trade through observation. Commenting on the use of TBAs, one of the informants stated: "*With Piave location, Njoro is a bit far, so they would rather go to TBAs*". Another one pointed out while still talking about TBAs: "*They first try to conduct deliveries at home and when they fail, they send mothers to hospitals. We have been getting many cases here*" (the Njoro Health Centre).

Hospital treatment

Some community members sought hospital treatment when herbal treatment failed. One of the health profes*sionals explained: "They say they use herbals and if there is no improvement they come here*" meaning the health facility). Another informant said: "*There are those who will go to the hospital immediately when sick*". Another one

pointed out: "*Also HIV patients come to the hospital later when herbal treatment fails. We tell them the importance of coming to the hospital, the use of ARVs and how hazardous it is to mix those drugs*" (referring to mixing with herbal treatment). Another one commented: "*We have one private clinic at the Piave Centre and some go there*". Another one said: "*We have a maternity in Njoro Health Centre and many mothers go there because they find it has improved and the nurses are willing to assist them*".

6.2.2.2 Health professionals' views on integration of traditional healers into the formal health care system

Awareness of traditional healers

Some of the health professionals were not aware of what traditional healers did. One of the informants commented: "*They do not identify themselves and we are not aware of them and they also think we are against them*". Another informant lamented:"*I don't know what they do, but the best thing is to talk to them so that we find out what they are doing*". Yet another one said: "*I may not know really' (referring to the traditional healers and looked surprised when the question was asked)*". Another one observed:

> *I have never interacted with them. Nurses have not really tried (interacting with traditional healers) because I have found in Njoro Health Centre they don't talk to them. Actually time for talking to them is not there because of the workload. It is not like our time when we used to go to the community, meet them and discuss with them (referring to the researcher's time and hers as the two trained at the same period). This time, we are just around the hospital because you are either two or you are the only one who has reported to work, so you have to rush with time to finish what you have to do.*

Integration and training of traditional healers

Training and integration of traditional healers was recommended by some of the informants. One of them said: "*For us we do not have any plans to train traditional healers, the government should do so*". Another informant emphasised:

> *We need to integrate them into the health service and also train them. We need to add something to them because there are people who are so much into them that we cannot convince them otherwise. We want to ask them to refer patients to us and not to attend to them.*

The same informant added:

> *People have trust in them because before we came (prior to opening a dispensary in Piave) they were there and they were attending to them (the community). They trust them but now we want to integrate them in the health service so that uniform health care standards can be maintained.*

Another informant emphasised: "*We have to integrate them because we have to talk the same language; they should not sit there and tell people not to use condoms*". The informants lamented (looking disgusted): "*You know they talk about very bad things. They talk badly about family planning to common citizen. They brainwash the people. So if we don't incorporate them, we will not be able to penetrate our people*". '*By penetrating the people*' she meant community members accepting the care given at the formal health care facilities. She added:

> *We should bring them closer to us so that we understand those herbs they are trying to sell to people, what they are made of and what they are treating. When you give then health education, they will know what the Ministry is looking for. We have planned to have them brought in as health professionals.*

6.2.2.3 Current status on implementation of Level 1 health care strategy

This refers to the implementation of the ideals of Level 1 health care strategy in which health professionals and community health workers are supposed to provide the community with promotive and preventive services and minimal curative care for minor health problems. They are also supposed to assist the community in coming up with their own vision and mission of health care. Unfortunately, these ideals have not sufficiently taken off as can be inferred from the informants' data on the shortage of health professionals, poor transport because of bad roads and lack of public vehicles among other difficulties.

One of the informants explained:

> *When the community strategy will be implemented, we have identified the volunteers; they are 50 and they know the number of families they are attending to. They have community register. What is remaining is training them. Money is supposed to come to train them.*

The informant added: 'We have a training manual and I had been trained for one week.

Another informant observed: "*When we implement the community strategies, it will be wonderful*". Yet another pointed out:

> *Apparently the time we have been here, it has been hard to go out. The community strategy is in the process being implemented. One of us will remain here and the other one will visit the community to train the community health workers on how to give first aid and refer the patients to us.*

Another commented:

> *We are going to use the community health workers to make sure that every person within the community utilises the facility (the Piave Dispensary). We want to use the community strategy to reach the common citizen on preventive and promotive services and even curative. For curative services, we are going to use the linkage type of system whereby the treatment for minor ailment will link up with the health facility.*

The informant added: "*For promotive services, we will have to use health education; for preventive we have the water treatment sachets and we have already started using them in Piave within Ndaragwa Rive*r". She explained further: "*We are then planning to come to the facility (Piave Dispensary) for immunisation and care of ante-natal mothers*".

According to the informants, the existing deficits in the infrastructure, materials and human resource had hampered the delivery of care to the community. Data analysis and interpretation of the deficits mentioned by the informants follows.

Shortage of health professionals

On this, an informant commented:

> *Nurses have not been able to go to the community and work with community health workers due to shortage of health professionals. The volunteers are there in place but for us to go to the ground (the community), it is not yet in place.*

Shortage of drugs

The drug shortage has been severe but the situation is becoming better these days. One of the informants said:

> *In the recent past, we had not been registered by the Ministry of Health and we were running out of drugs but when we have drugs, all patients come. On*

Thursday, a consignment of drugs will be brought and sometime in October as well.

The researcher thinks that this is an indication that fewer people go to a health facility when they know drugs are not likely to be available.

Bad roads

As echoed by all the categories of the informants both in this chapter and chapter five, roads are in bad condition. An informant said: "*Traveling now is a problem because of the road; they repaired it and is slightly better although cars cannot pass. Most of the time we are handcuffed when referring patients to other health care facilities*".

Lack of markets

Lack of a market is a concern to the community because it causes poverty. An informant lamented: "*I think lack of market is the biggest problem, they (community members) are farming and doing their best*".

Home visits

Curative services are offered at the two facilities with very few outreach visits to the community because of the shortage of health professionals, as noted by the informants. Two hundred patients were seen daily at the Njoro Health Centre including the outpatient department, ante-natal and child welfare clinics The Piave Dispensary treated 25 patients, adults and children.

Health professionals and community relationships

According to the health professionals, relationships between them and the community people were generally good. An informant had this to say: "*Whenever they come here, they tend to talk openly because it depends on how we receive and talk to that*". She added: "*The relationship is good. In addition to that, we have private clinics where they pay a lot of money and they don't have all the drugs but here we give them a lot of services*". Another informant emphasised:

> *I must say it is good from whatever report I get. The hospital committees are our eyes out there and I tell them when they are in the committee to tell us what we are doing so that we can change. The report they give us if they are sincere at heart, I think the community is happy. The community is also happy because of confidentiality; you will never hear about your disease. The discussion is on one-to-one basis and this makes them feel free.*

Another informant stressed: "*The attitude, some say they are harsh but it depends with the individuals. These days' people talk and they will say when they are harassed. The health professionals know that mishandling the community members would not be entertained*".

From the researchers' view, it appeared that most of the Level 1 services are not in place yet.

6.2.2.4 Health professionals' views on initiatives for community development and improving health care

A number of initiatives were being employed in community development and improving the health status of the Piave community.

Cost sharing

An informant excitedly pointed out: "*Government has put something in place and it's very nice. There is some money I am allowed to use here when a woman is bleeding*". The informant meant that there was money set aside for transporting seriously sick patients to other facilities for the treatment that could not be handled at the dispensary level.

Health education

One of the informants asserted:

> *We should have health education. Maybe when they are gathered in groups we give health education and encourage them to come to the hospital. Maybe also with change of attitude of health professionals, they would be more willing to come.*

Another informant emphasised:

> *We empower the community because, sometimes, they come when they have a sick patient who cannot come and they request you to go and see their patient. We assess the situation and we go to see them and teach them.*

Outreach programmes

Asked whether they go to the community to find out what is happening in relation to health care, one of the informants commented:

> *With collaboration from the public health officers and public health technicians, we send them to look for defaulters in order to find out what they are doing at home. We also have home-based care community health workers who visit them and find out what they are doing. They find out the ones taking herbs and try to find out why they opt for herbs.*

Another informant reported:

> *We have home-based-care workers and volunteers who go for HIV training and volunteer to work in the community. We are training them in conjunction with the Family Health International. They are also given some incentives like lunch and transport.*

Training of community health workers

Training of community health workers has been recommended by the health professionals**.** An informant emphasising youth training had this to say:

> *I have recommended two youths to be trained for two weeks by the Ministry of Health so that they can manage that office (pointing to an office at the Piave Dispensary). The youth will be free to come and speak to their fellow youths whatever they want to speak. Theirs is just to give me a report and update me on what is happening.*

Another one said: "*I would suggest more training of community health workers and employment of more staffs so that we can work together with community health workers to reach the community*".

Recruitment of nurses

This has been recommended by the health professionals too. One of the informants emphasised:

> *Get enough staff so that one can easily go to the community without getting stressed and serve them without any worry that my partner is very busy with patient and I am out here or I will find a long line when I go back. If we get enough staff, we are able to put a programme that on such a day one will go to such a place.*

Clean water

There is a serious shortage of water at Piave and that which is available is polluted**.** One of the informants said: **"***But now I think things will improve since we have dug a borehole which is going to serve a bigger area around Piave. We were trying to introduce water treatment in sachets*".

Electricity

An informant stated: "*Electricity is coming and that is a big improvement because when electricity is here, our young girls will open salons and look beautiful. Welding will be done; we will not have to go to town*".

Good roads

On roads, the informant said when they are improved, women in labour could be taken to the hospital to deliver there**.** An informant said: "*We will be having smooth roads that can take you to town. In case of any emergency, it is a bit easier to refer you to the next level"*.

6.3   SUMMARY OF HEALTH PROFESSIONALS' SECTION

After the initial analysis and interpretation of the data of the health professionals, four categories emerged: namely, community's health seeking behaviours; integration and training of traditional healers in the formal health care system; current status of the implementation of Level 1 Health Care Strategy; and initiatives for community development and improvement of health care.

On community health seeking behaviours, it emerged that some members of the community self-treat with herbs or over-the-counter drugs and only go to the hospital when health problems become worse. Others do go to the hospital but if their condition does not improve, they revert to traditional healers who are either herbalists, witchdoctors or divine healers. The same information emerged from both key and general informants from the Piave community, who are the main targets of this study.

On the integration of traditional healers within the formal health care sector, it was found that the health professionals would recommend the move. It was also found that the health professionals had very little knowledge of what the traditional healers did; the

interaction between the two parties had been almost non-existent. With regard to the implementation of Level 1 health care strategy, very little had been done as a result of many constraints such as various short-comings in the existing health facilities and transport. However, they looked forward to outreach health initiatives when the numbers of health professionals and community health workers would be increased. On the way forward for community development, they suggested the building of roads, provision of bore holes, electricity and markets so that the community could sell their produce.

6.4   DATA PRESENTATION: TRADITIONAL HEALERS

6.4.1 Introduction

Apart from one traditional healer interviewed at Piave, data obtained from the informants indicated, generally, that people from Piave consulted traditional healers in the towns of Nakuru or Njoro as there were hardly any traditional healers at Piave

Although the phrase 'traditional healer' is meant to include all the people who use informal treatment to treat their clients, the exact titles in this section have been stated in relation to what one does instead of using a blanket cover – traditional healer (s). In total, eight traditional healers were interviewed.

6.4.1.1   Biographic data of the traditional healers

Table 6.5 below displays biographic data of the traditional healers included in the study.

Table 6.5 Table: Biographic data of the traditional healers

1	2	3	4	5	6	7	8
A witchdoctor-cum-traditional birth attendant-cum-circumciser of girls: A woman about 90 years old. Has lived in Piave since 1977 and is one of the landlords. Had five sons who are now dead except one	Herbalist: 73 years old man He has been practscing herbal medicine for more than 15 years. Married with eight children who are all over 21 years old	Divine healer: 60 years old, previously employed at Egerton University as an officer of Protection Against Cruelty to Animals but left because according to him, he had a calling from God in the healing mission. He now lives in Njoro, Njawatho village where he practises divine healing. Not yet married	Herbalist: 30-year-old man. Works with his father who is a herbalist too. He is not yet married	Herbalist: A 42-year-old woman practising herbal medicine in Nakuru. She is a Luhya by tribe but has been brought up among Kikuyus in Nakuru where her father worked for the Kenya Railways. She is now divorced and has three children who are still in school aged between 7 and 14 years	Herbalist: A 70-year-old man from Njawatho village; has been practising as a herbalist for theplast 20 years. He is married and has six children who are between 25 and 40 years old.	Herbalist: A 45-yea- old Maasai man from Tanzania has been selling herbal medicine in Nakuru for the past eleven years and has been in the trade for 22 years. Prior to coming to Kenya, he was in Tanzania. He is married with four children.	Herbalist: A 30 years old herbalist from NakuruTown married with two children Has been a herbalist for the last 10 years

6.4.1.2 Vignettes

The following vignettes provide background information on some of the traditional healers interviewed.

Witchdoctor-cum-circumciser–cum-traditional birth attendant

One of the general informants was an old woman of approximately 90 years old (did not know her age). Three of her four children had died except one who lived with her in the same compound. She was said to be a girl's circumciser, traditional birth attendant and a witchdoctor. The woman was very interesting and had some good stories which she narrated very disjointedly during the first interview. She talked of various activities she did such as assisting women when delivering, being a witchdoctor but denied being a circumciser of girls and pointed out that the government did not allow it. During the same visit, she told the researcher that a girl who had been circumcised sometime back had bled to death. The chief of the area had come to ask her whether she had been the circumciser but she denied it. The researcher had a feeling that she did not want to disclose her practice on circumcision.

During the interview, she talked randomly about the president of Kenya whose ideals did not support circumcision of girls in spite of this being a Kikuyu tradition; her earlier involvement with the freedom struggle and showed photos of herself with the Mau Mau freedom fighters. She then started singing freedom struggle songs and at one time, stopped what she was doing and threw castor seeds in the air so as to tell the researcher what her home problems were (the researcher had not told her about any problems). She carried out the ritual and told the researcher that a neighbour was the cause of a lot of her family problems and the best thing to do was to confront her and tell her to stop disturbing her family. She was also eager to cook her some eggs she had hidden under her bed.

During the second visit meant for member checking, she became very open to the researcher and admitted that she was a girls' circumciser and even told the researcher that she used goat's oil and white powder bought from the shops to treat the circumcised girls; she applied the medicine on the circumcised area. She said her reluctance to disclose this information to the researcher at the first visit was because she was not sure whether she (the researcher) had been sent by the government to spy on her. She also talked about the herbs she used for treatment and showed the researcher some of them.

The old woman lived in a very small house made of cracked mud walls. There were no seats in the house except a small old box where she stored the articles for her rituals and one bed which seemed to be a store for her belongings as well. She lived in a very unhygienic and untidy environment and appeared dirty and malnourished. Her extended family was living within the same compound with slightly better houses though still semi-permanent. They did not seem to support her. Below is picture of her house and the woman holding the guard with castor seeds she uses for her rituals.
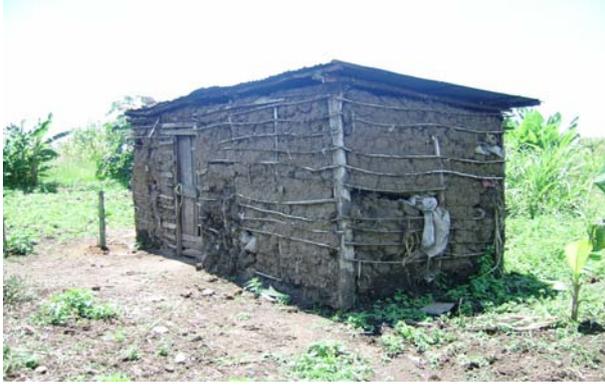
The first photo above is the house of the witchdoctor-cum-circumcise- cum-traditional birth attendant.   In the second photo, the woman is holding a guard and castor oil seeds (her photo is not shown in full to hide her identity). The researcher took the photos with her permission.

Divine healer

The informant was 60 years old, previously employed at Egerton University as an officer of Protection Against Cruelty to Animals but left because according to him, he had a calling from God in the healing mission. He lived in Njoro Njawatho village where he practised divine healing. He was not yet married and told the researcher that it was difficult to find a good wife who was a devoted Christian. He said he did God's work and was a spiritual healer. According to his explanation, he started the practice through God's command. He explained that he had been asleep when at three o'clock one night, he had heard a voice calling him which told him, 'Starting from today, I give you the job of looking after people; pray Our Father who art in heaven …' and he started praying. The following day he claimed to have seen two men outside his house who asked him for some water. When he went inside the house he saw a bright light and was told to take care of the men.

He claimed that through prayer, the patient's guardian angel spoke to his guardian angel and told him what was wrong with her/him. He was not ready to disclose the media of communication between him and the guardian angels. He gave water to the two men to drink and while they were drinking, he was able to diagnose their problems through looking at the remaining water as he had told them not to finish it. He treated; one had a wound on his leg and he prescribed cotton swabs for him for cleaning it. The other one had a stomach ulcer and he prescribed Neem herbs. They were cured according to him. He said mad people mainly came to him. They became mad because they were born holding magic pebbles in their palms and that meant they were destined to be witchdoctors when they grew old. If they failed to become witchdoctors, they

became mad. Also those people who inter-married between two clans one of which was known to be inherently bad, the married couple became sick and he claimed to be able to treat them. Some people also misbehaved and committed deadly sins like adultery, incense or rape. People particularly the youth followed other customs mainly from Europe and America and became misfits in their respective communities. They became ill as a result and he could treat them. The divine healer used conventional medicine such as ampiclox and erythromycin to treat some of the illnesses such as blockage of the tubes among women. He also prescribed nutritious diet for treatment purposes.

Herbalist

One of the herbalists interviewed was a 42-year-old woman from Nakuru Town. She was a widow and had four young children. She lived in a semi-permanent house and at that particular time it was wet because the roof was leaking. She claimed to treat many diseases including cancer of any part of the body. She emphasised the importance of using vegetables for treatment because eating well helped to cure diseases. She said she had suffered from breast cancer and at one time she was blind and she was now completely well after being treated with herbal medicine. She also said she had been warned by her father, who was a herbalist that once she starts practising as a herbalist; she would cease to have babies. She said that was what happened to her. She never became pregnant after involving herself with the practice though she is only 42 years old.

6.4.1.3   Diseases traditional healers treat

Table 6.6 below displays diseases treated by traditional healers. Basically, most of them claimed to be able to treat nearly all the diseases their clients presented except a few who said they could not treat HIV/AIDS and diabetes.

Table 6.6   Diseases traditional healers claim to treat

Respiratory	Cardiovascular	Endocrine	Sexually transmitted	Blood	Reproductive	Alimentary	Skin	Special senses	Nervous System
Asthma	Hypertension	Diabetes	HIV/AIDS	Malaria	Infertility	Hernia	Scabies	Blindness	Epilepsy
Chest pain		Kidney disease	Syphilis	Cancer	Deliveries (babies)	Typhoid	Circumcision	Dental problems	headache
Pneumonia						Stomach ulcers			Mental illness
Coughing						Stomach pains			
						Lack of appetite			

As can be inferred from table 6.6 above, the traditional healers have a wide scope of diseases they claim to treat; they include all the body systems.

6.4.2 Traditional Healers: Data display, analysis and interpretation

Data display

In table 6.7 below is a data display of the final category and sub-categories generated from the traditional healers' data.

Table 6.7   Data display of categories and sub-categories from traditional healers' data

	Categories	Sub-categories
6.4.2.1	**Methods used by traditional healers to treat diseases and improve health of their clients**	**Treatment of disease** • Herbs • Prayers • Drugs • Nutrition **Improving health** • Health education on: Drugs, Nutrition Sexual behaviour Pollution
6.4.2.2	**Traditional healers' training**	• Traditional healers' training received • Traditional healers' need for further training
6.4.2.3	**Traditional healers' view on integration of formal and info-mal health care**	• Networking (sharing knowledge) • Teamwork

6.4.2.1 Methods used by traditional healers to treat diseases and improve health of their clients

Treatment of diseases

Herbs

Treatment using herbs appeared to be diverse. Traditional healers mostly boiled herbs; used the same herbs to treat different diseases; used herbs to treat curses; gave herbs in liquid form and sometimes rubbed them on the body. A general informant who was said to be a witchdoctor-cum-birth-attendant-cum-circumciser explained:

> *For infertility, I mix tea leaves with sugar and Erythrina Abyssinica (red-hot poker tree) back after boiling. I then give one cup start and thereafter half a cup twice a day. The same herbal medicine is applied on the body daily. After about two weeks, the woman becomes pregnant most of the times.*

Another herbalist said she was also a traditional birth attendant and explained the herbal treatment she used for a mother with fetal death: "*If you have a still birth I pour a herbal drug on the stomach and the child comes out*". For delayed delivery, she explained:

> *If the pain disappears, I give her medicine to make the labour start again like they do in hospital. They inject in the hospital but for me I have herbs that I tell them to chew and the pain starts again. I make black tea and give her to drink; it makes her vomit. Vomiting pushes the child down the birth canal. I hold her back and shake her a little so that the child does not become weak and listen to the child heartbeat with my bare ears because I don't have the instruments for checking. If the delivery is normal, I tell her not to take cold water because it can kill her. She has to take hot water or tea.*

A herbalist explained:

> *For HIV/AIDS and other diseases, I use Azadirachta Indica (Murubaini), Sodom's Apple (Mutongu), Scutia Myrtina (Mutenda Mbogo), Teclea Nobilis or Teclea Simplicifolia (Mwinderendu), and Clutia Abyssinica (Muthima Mburi). I boil the roots of the trees and give one cup at once and then half a cup two times per day until the person is cured. The same mixture is applied on the body daily.*

He added:

> For hypertension, I treat the underlying cause as hypertension is not a disease, it is a symptom. I use the same trees as mentioned above. I mix the roots, boil them and give patients 3 cups per day for 10 days. I then get them tested and give more treatment of the same type if one is not cured. For this, I treat the cause of hypertension, asthma and nearly all other diseases that patients come suffering from.

Another herbalist explained:

> I treat diseases like hernia which is that disease that you cannot urinate. I boil herbs for ten minutes or so and then I give that person to take two cups daily for two weeks. Instead of operation, I use that medicine. That person should be taking a lot of water and porridge to make the pipe (meaning urinary tract) not to block.

The same herbalist in the treatment of kidney disease said: "*I use vegetable called Dhania (ndania). It washes the blood. You boil and take that water*".

Another herbalist said:

> *I use different treatment for various types of stomach problems and also give fresh treatment. I give to the patients herbs to boil for themselves with instructions on how to use them. I also treat typhoid; there is herbal medicine for it.*

Another one said: "*Teeth diseases, I do not extract a tooth, I put some medicine (powder mixed with oil) and the patient gets cured*". Another herbalist explained: "*I have a drug that I give and a person can remain without diabetes for two or three years. I use a tree called Muvuvira Nyungu*" (the researcher could not find the English name). Another herbalist explained that there are two types of malaria, one brought by mosquitoes and the other by bad spirits. He treated the latter and explained: "*The bad spirits come out because there are traditional medicines that can treat them. If you know the treatment, the patient will for sure get well. There is one called 'Manyasi'* (the researcher could not find the English name) *and does the treatment*". The researcher thinks the kind of mental illness he says is brought by bad spirits could be cerebral malaria or some type of mental sickness.

Another herbalist pointed out: "*If one cannot eat because he/she is not able to go to the toilet, we give herbal treatment per rectum. It takes less than five minutes to treat and*

one gets the appetite immediately". Another herbalist pointed out: *"Some women go for family planning and miss their periods and also start discharging some whitish discharge; I treat them with herbal medicine that cleanses their uterus and they get cured"*.

Another traditional healer pointed out:

> We treat other diseases which are chronic like diabetes and cancer that cannot be treated in a hospital. We use herbs that are powerful than drugs from the hospital. Drugs from the hospital have side effects while our herbs do not have. That is a very important thing.

Another healer stated:

> HIV/AIDS comes in many ways. The patient can have opportunistic diseases such as body rashes, ulcers, pneumonia, tuberculosis and so forth. We give pain killers in relation to where the patient is suffering from. As I told you, we have no cure for the disease just like the hospital as it is a punishment from God. It is written in the bible that people will get incurable diseases. We only give painkillers to make the patient as comfortable as possible.

Another traditional healer stated: 'There is traditional herb called 'manyasi' which I use to wash the children who have been cursed or are unwell due to parents who have misbehaved" (have sex outside marriage). Another one pointed out: *"Nowadays, I can see they prefer herbs than going to the hospital. They are saying that drugs have side effects and the problem does not end"* (meaning the patient is not cured).   Another traditional healer said: *"Majority of patients are the ones who have tried the hospital and have not gotten well, and then they come to me"*.

Prayers

Prayers are also used as a form of treatment. A divine healer explained:

> When people come here they do not tell me their problems. They tell me they have come for prayers. I pray, and I see one's problem and I ask you whether your problem is what I have seen and you say no I pray again and you say yes.

He also stated that an Asian man whose wife had a pseudo-pregnancy consulted him. The wife had gone to a hospital where water from the stomach was removed but it

returned. He explained: "*When he told me I went to his place and put this bible (he shows the researcher the bible) on her chest and I prayed and the woman gave birth to a baby boy later. I have treated five Asians. I don't treat diseases, I pray*".

Drugs

Some traditional healers use drugs for treatment of various diseases. A divine healer explained: "*The diseases I see are like blockage of the fallopian tubes. Mainly this drug I give it a lot*" (he showed the researcher ampiclox capsules among his list of drugs). He further explained:

> *When I find out the disease you have, I prescribe the drug for you. You go and buy. I tell you that the drug is for all diseases, Erythromycin, is for all diseases. Ampiclox is for the chest. Some people ask what type of drug have you given me and I tell them the disease it cures and you will buy from the chemist.*

He went further to say: "*Penicillin is an injection and nowadays they do not use the cream one, they use one which is like liquid. Penicillin cures all diseases. The liquid is applied on the shoulders*".

Nutrition

Some traditional healers use fruits and food rich in protein and vitamins. A traditional healer stated:

> *HIV/AIDS patients come to me but I tell them I cannot treat them. I don't know how to treat HIV/AIDS and there is no person who can cure the disease. Mostly, when people come here, I tell them what food to take. I remember there were two Egerton students who came to see me and I advised them on what to eat I told them to mix beans, the small fish (omena) and other types of food and get flour for cooking porridge, make porridge and take it. I told them that after six months their bodies will change. After using my prescription, they came back later to say they did not have AIDS. They came with confirmation letters from the hospital indicating that they were cured.*

He commented: "*I tell the patients to take nutritious diet. But I am frank. It is the food that I give them that heals*" (referring to HIV/AIDS).

Another herbalist explained:

> *For malaria and typhoid I use fruits, I buy ripe avocado, banana, oranges, lemon, pawpaw, pineapple and mangoes, all fruits with water are good except pears. I cut and mix and put them in water with tea leaves. I then add one bottle of honey and white whisky. The reason for putting whisky is to make the drugs circulate in the body very fast. Honey makes the mixture sweet.*

Another herbalist explained that for diabetes:

> *You are supposed to eat food that will give you strength and vitamins. White maize floor instead of sorghum is good. Sorghum adds strength on bones but it dries your body like sugar. You need food that gives you strength and supplies vitamins in your body. Sorghum does not help. Brown rice, brown wheat floor and sorghum are good but cannot give you strength. If you are taking the herbal medicine, I advise you to eat food that will give you strength and vitamins in your body such as white wheat floor, white maize floor, and your body will be health and blood sugar will go down.*

Her advice seems contrary to what a diabetic diet should constitute: fewer carbohydrates and more protein and vitamins. White wheat and maize flours border more on carbohydrates.

Improving health

Health education on:

The data from traditional healers indicated that they used health education to improve health. According to them, they gave health education on a number of health-related problems stated below.

Drugs

On herbal drugs, the traditional healers had various explanations. One of them said:

> *Like in typhoid, I tell the patients to take the medicine before feeding and they should expect to vomit a lot. I tell them it is normal to vomit or diarrhoea at least once. This helps in cleansing the body and the person becomes well. I also visit them to find out how they are doing.*

One of the herbalists said: "*I instruct my patients on how to apply or take any herbal treatment I have given them. That is all*". Another one stated: "*That stage of giving health education has not reached, the people belong to the government but if I treat someone I would guarantee the disease would not come back*". Yet another one said: "I instruct them on how to take the drugs and also to continue praying for themselves and their families otherwise that is all".

Nutrition

Traditional healers commented on different aspects of food. One of them said: "*I tell them about food because it's not a must that you take drugs*". Another one stressed:

People with stomach ulcers, we tell them to stop using cooking fat that has cholesterol, spices and tea leaves because of nicotine; it thins the veins and shorten intestines. Coffee makes the heart beat fast. Let's say the things made nowadays are not good. Soya and ginger can be used instead of tea leaves. We also have tea from plants and we give them.

Another traditional healer commented: "*Solid oil can also cause stomach pains. I ask people to use very little oil for cooking*". Another one lamented: "*Doctors cheat but they are educated more than me. How can you boil water and you are on a safari?*" Another traditional healer stressed:

Diabetes is like HIV, you lack vitamins in your body. The person does not eat fruits, does not drink milk and does not eat food. There are people who eat meat. A person who eats sukuma daily is healthier than a person who eats meat. Meat does not help at all, you can get malaria easily.

Sexual behaviour

One of the traditional healers emphasised that she instructs her customers: "*Avoid sex if you have HIV but if you can't, you can then have sex once or twice a month and use condoms. Check the condoms thoroughly because some men pierce them, so do it yourself*". For women working in bars she tells them: "*If you are a woman in a bar be very careful and don't drink so that you can remain healthy and look after your children*". Another one explained: "*For gonorrhea, we tell them not to have sex with young girls (asked why young girls, the response was) because one cannot have sex out of wedlock with his age mates*". Another one stated: "*If it is sickness affecting the private parts, I tell them to avoid having sex for at least four days after they are well*".

Pollution

One of the traditional healers pointed out: "*Typhoid is brought by dirty water and people have to avoid that*". Another one lamented: "*Sometimes malaria is brought by mosquitoes if they are many but if your body does not have enough strength, you can get sick at any time*". A comment from another traditional healer was: "*Things like chest pain; you can advice about effects of dust in the house, and smoke and dusty environment*".

6.4.2.2 Traditional healers' training

Traditional healer's training received

Several methods were used for acquisition of knowledge and skills of the traditional healers' practice: namely, inheritance; education by parents/grandparents, observing and attending workshops.

Inherited

For some traditional healers, healing power was given by God (see vignette of the divine prayer on 6.4.1.2). A traditional healer stated: "*I inherited this treatment from my father who was a herbalist. I was born when he was already involved with the practice and he taught me how to do it*".

Observing

A traditional healer commented: "*I used to be keen with circumcision and I learnt a lot during the circumcision procedures*". Another herbalist explained that she was married to a herbalist and had this to say: "*He was a herbalist and I used to see how he was treating people, I used to accompany him when he went to search for herbal treatment. I learnt the trade as a result*".

Educated by parents/grandparents

Another traditional healer commented: "*It is my grandfather who taught me. We used to go together to the forest and he would show me the herb he was using for treatment. I then had little education and when I went to Masaai land, I really learnt a lot*". Another herbalist commented that he was not well qualified and his father who was a herbalist was training him. He explained: "*My father was taught by my grandfather and when he grew up, he started treating people*".

Traditional healers' need for further training

On being asked whether they needed further training, the traditional healers had various responses: Some wanted further training only for their own benefit while others were not willing to be trained and another lot were uncertain.

Wanted further training

Some of the traditional healers wanted training for their own benefit. One of them said: "*Yes, I would like to be trained so that I learn more about herbs and Western treatment*". Another one stressed: "*Yes if I get time, I can learn what they do and also share with them what I do. I will then be able to use Western medicine where I find it necessary*". Yet another one pointed out: "*Yes I would like to learn a lot because everything is helping one another; you show me what you know and I show you what I know*".

Others were not willing

Some traditional healers were not willing to go for further training. One of them lamented: "*No, it is too late for me. I am too old for any training and I am almost giving up in this practice. I am just doing it in order to get some money for my needs because my children do not assist me at all*". Another one (looking very serious) boasted: "*No, I have enough knowledge on herbal treatment. What else do I want?*"

Uncertain

The divine healer was not certain about being trained. He commented:

> *Not exactly because I pray for people and seek divine intervention. Maybe I can learn about some diseases and their treatment so that I can combine prayer with actual treatment. My only problem is lack of time, I like devoting more attention to prayers.*

Another traditional healer explained:

> *I am not well academically qualified and therefore I may not understand about Western medicine. I hear learning there is very difficult. However, if I try and see I can make it, I would like to be trained so that I get more knowledge particularly on Western medicine. I can then use Western medicine at times to treat my patients.*

6.4.2.3 Traditional healers' view on integration of formal and informal health care

Networking (sharing knowledge)

Sharing knowledge among traditional healers and health care professionals was recommended by a good number of traditional healers. One of the traditional healers had this to say:

> *If it's to do with herbals, we can work together because they have knowledge. I can show them what I do and they can show what they know. In Kitale and Bukusu, doctors used to send patients to me for treatment of diabetes. They were also sending patients to me with diseases they could not treat like syphilis.*

Another traditional healer in agreement with networking said: "*I am going to show the trees and the machines for making the herbs. I am the best in looking for the trees*". Another traditional healer pointed out:

> *I would like to treat the diseases they cannot, that mean they refer them to me. One of the diseases is the mental problem I talked about caused by not honouring God's way of being chosen to be a witchdoctor. I can cure that while the doctors cannot. They can also refer patients to me for divine interventions. I pray for the sick and they become well. I personally can refer to them diseases like HIV/AIDS and others that have not responded to prayers.*

Another traditional healer, referring to working with health professionals, said**:** "*I will be happy, my life will change and I will look for all the herbal medications and how they help and if there is a hospital, I can take the medicine there and we give to patients*". Another traditional healer in agreement with networking stated: "*I can tell them what I do and maybe they can at times refer their patients to me. I can also do the same if it is necessary*". Another one commented: "*Is not bad but what I cannot treat I tell patients to go to the hospital. If it is stomach problems, I can network with them but in other illnesses, I do not see how I can join with them*". Another one explained: "*At times, we tell the patients to go to the hospital to be given water intravenously and can come back for treatment*". He also pointed out: "*If you come and I find I cannot treat you, then there is no point of damaging my drugs, I tell one to go to the hospital*".

Teamwork

A bit of teamwork was seen among the traditional healers although not in an organised manner. Some traditional healers felt threatened while other did not and referred patients to the formal health services for various reasons. A traditional healer said: "*When HIV/AIDS becomes very serious, I refer patients to the hospital because they might need to be given water intravenously and we cannot do it here".* Another traditional healer explained: "*We do not have a laboratory here and so we ask them to go to the hospital first to be tested and bring the results to us*". Another traditional healer stated: "*Like the patients suffering from diabetes, HIV, Asthma and TB, a doctor has to do a test and confirm they have the diseases before I start the treatment".* Another one said: "*If a person delivering start bleeding a lot, she should be taken to the hospital for treatment*". Another one explained: "*TB with asthma and also swollen joints (sounds like rheumatism) is hard to treat. I tell people to go to the hospital*". Another one had this to say: "*I get some health professionals coming to inquire about this practice and we tell them what we do*". On the same subject of health workers, another traditional healer reported: "*There were two doctors who used to take medicine from me. I believe they had faith in my treatment. I also have some hospital people who come here for treatment and have been very happy with it; they get well".*

6.5   SUMMARY OF TRADITIONAL HEALERS' DATA

Three categories with various subcategories emerged from the data obtained from the traditional healers. Methods used by traditional healers to treat diseases were mainly herbs, prayers, over-the-counter drugs and nutritious food rich in proteins and vitamin. They improved the health of the community through giving health education. They taught their patients how to take the treatment they prescribed for them. Others gave health education. Some of the traditional healers learned their practices through inheritance from their grandparents and parents while the divine healing power was bestowed on the divine healers by God; according to the divine healer's assertion.

The majority of the traditional healers said they would like to be taught formal ways of treating patients by health professionals while a few disagreed, the reasons being they

were either too old to learn new ways, they were not academically qualified or they did not think they needed to learn at all. With regard to the integration of formal and traditional care, some felt threatened while others thought it was a good idea because the hospitals could assist in diagnosing patients through laboratory services and giving intravenous infusion when necessary. The traditional healers could treat conditions that did not respond to formal treatment and also treat those conditions such as mental illness that could only be treated by them. Their explanations were based on their beliefs related to traditional practices.

6.6 SUMMARY OF THE CHAPTER

This chapter has two sections, one on health professionals and the other on traditional healers' data analysis and interpretation respectively. Categories and subcategories emerged for each group and were discussed respectively. A summary of each section is given under the respective parts.

In the next chapter, the major themes which were identified from the data presented in chapters 5 and 6, are discussed and integrated into Leininger's theory of Culture Care Diversity and Universality and Sunrise Model indicating the way forward to establish culturally congruent care for the Piave community.

CHAPTER 7

Conceptualisation: major themes related to Leininger's theory of culture care diversity and universality

7.1   INTRODUCTION

This chapter presents four major themes which emerged from the research findings presented as categories and subcategories in chapters 5 and 6. The themes will be explicated in relation to Leininger's Theory of Culture Care Diversity and Universality in line with the tenets of the Sunrise Model Enabler. A description of Leininger's theory and the Sunrise Model precedes the discussion on the integration of the major themes in the theory.

7.2   MAJOR THEMES

The researcher applied the fourth phase of the ethnonursing data analysis method to identify the major themes. This is a phase that requires the researcher to use creative reflections, reasoning, intuition, and abstract thinking in order to synthesise the findings into dominant care themes related to the domain of inquiry and research questions (Leininger & McFarland 2002:96). The researcher rechecked and did audit trials of all the analysed categories and sub-categories to be sure they were substantiated with grounded evidence and credibility from the raw data of the informants. Through the process of creative thinking and a high level of abstraction, she came up with four dominant major themes to guide health professionals in providing culturally congruent and relevant health care. The major themes are:

Theme 1:   The Piave community's perception of health and illness

Theme 2:   Different beliefs about interventions in self-care health seeking behaviours as expressed by the informants

Theme 3:   Factors influencing self-care health seeking behaviours

Theme 4:   Informants' views on ways to improve health care to the community

Table 7.1 displays the four major themes and the categories and subcategories derived from phases 1 and 11 of the research. Since the interview guides for the three types of informants (key and general informants from Piave, traditional healers and health professionals) were different, the results from each group of informants may not always correspond. However, the main focus is the lifeworld of the Piave community; the main target of the study and findings from this group will dominate the data from the rest of the informants.

Table 7.1: The major themes, categories and subcategories

1	2	3	4
Chapter 5: Key and general informants from Piave	MAJOR THEMES	Chapter 6: General informants	
		Traditional healers	Health professionals
*Health and illness **Health** *No pain* *Strong* *Ability to work* *Well nourished* *Well behaved* **Illness** *Body pain* *Inability to work* *Bad behaviour* *Mentally ill* *Factors predisposing to ill-health **Supernatural beliefs** *Religion* *Witchcraft* *Curse* **Social** *Poverty* *Infidelity* *Prostitution* *Alcohol and drug abuse* **Environmental** *Cold weather* *Rainy season* *Dust and smoke* *Inadequate and dirty water* *Inadequate personal hygiene* *Germ infection* *Diet*	01: THE PIAVE COMMUNITY'S PERCEPTION OF HEALTH AND ILLNESS		
*Self-care health seeking behaviours **Herbal treatment** *Self treatment with herbs* *Treatment by herbalists* **Drugs** **Supernatural interventions** *Prayers* *Divine healers* *Witchdoctors*	02: DIFFERENT BELIEFS ABOUT INTERVENTIONS IN SELF-CARE HEALTH SEEKING BEHAVIOURS WERE EXPRESSED BY INFORMANTS	*Methods used by traditional healers to treat disease and improve health of their clients **Treatment of diseases** *Herbs* *Prayers* *Drugs* *Nutrition* **Improving health** *Health education on:* *Drugs* *Nutrition* *Sexual behaviour* *Pollution*	*Health care seeking behaviours of the Piave community *Self treatment (herbs, drugs)* *Herbalists* *Traditional birth attendants* *Hospital treatment*

| 1	2	3	4
Chapter 5: Key and general informants from Piave	MAJOR THEMES	Chapter 6: General informants	
		Traditional healers	Health professionals
*Influences on self-care health seeking behaviours **Family** *Elderly women* *Other family members* **Community members** *Community health workers* *Community members* *Chief* *Neighbours* *Self-help groups* *Church* **Previous experience with formal health care** *Unsuccessful treatment* *Lack of trust of medical doctors* **Access to health services** *Transport* *Cost*	**03: FACTORS INFLUENCING SELF-CARE HEALTH SEEKING BEHAVIOURS**		***Current status on implementation of level 1 health care facility** *Shortages of health professionals* *Shortage of drugs* *Bad roads* *Lack of markets* *Home visits* *Health professionals and community relationships*
*Community development initiatives *Water* *Roads* *Electricity* *Entrepreneurship* *Farming* *Employment and education* ***Assistance required from health professionals** *Health education* *Home visits*	**04: INFORMANTS' VIEWS ON WAYS TO IMPROVE HEALTH CARE TO THE COMMUNITY**	***Traditional healers' view on integration of informal and formal health care** *Networking* *Teamwork* ***Traditional healers' training** *Traditional healers' training received* *Traditional healers' need for further training*	***Health professionals' views on integration of traditional healers into the formal health care system** *Awareness of traditional healers* *Integration and training of traditional healers* ***Health professionals' views on initiatives for community development and improving health care** *Cost sharing* *Health education* *Outreach programmes* *Training other community health workers* *Recruitment of nurses* *Clean water* *Electricity* *Good roads*

The second column illustrates the major themes whereas the third and fourth columns display supportive data of the key and general informants from Piave (data presentation chapter 5), traditional healers and health professionals from areas adjacent to Piave (data presentation chapter 6) respectively.

7.3   LEININGER'S THEORY OF CULTURE CARE DIVERSITY AND UNIVERSALITY

According to Grbich (2007:186), a theory is abstract knowledge which has developed as an account concerning a group of facts or phenomena. It is derived from exploration of phenomena, the identification of concepts surrounding phenomena from which an explanatory framework can be developed. Leininger explains that theories that use appropriate research methods are creative ways to discover, explain, and interpret findings of largely unknown or known or vaguely known phenomena or human conditions (Leininger & McFarland 2002:71).

Leininger developed the theory of Culture Care Diversity and Universality to guide health professionals to find new meanings, patterns and expressions, and practices related to culture care that would influence the well-being of different cultures or assist them to face death or disability. Two of the assumptions of the theory among many are as follows. The ethnonursing qualitative research method provides an important means to accurately discover and interpret emic and etic embedded knowledge in the complex and diverse culture care data; and culture care values, knowledge, beliefs and practices are influenced by and tend to be embedded in the worldview, language, philosophy, religion, kinship, social, political, and legal, educational, economic, technological, ethnohistorical, and environmental context of cultures (Leininger & McFarland 2001:79). Figure 7.1 presents the Sunrise Model as Leininger's Enabler for the Theory of Culture Care Diversity and Universality. Culture diversity refers to the variations and differences among cultural groups resulting from differences in lifeways, language, values, norms, and other cultural aspects while universality refers to the nature of human beings that is held as common or universally found in the world as part of humanity (Leininger & McFarland 2002:53).
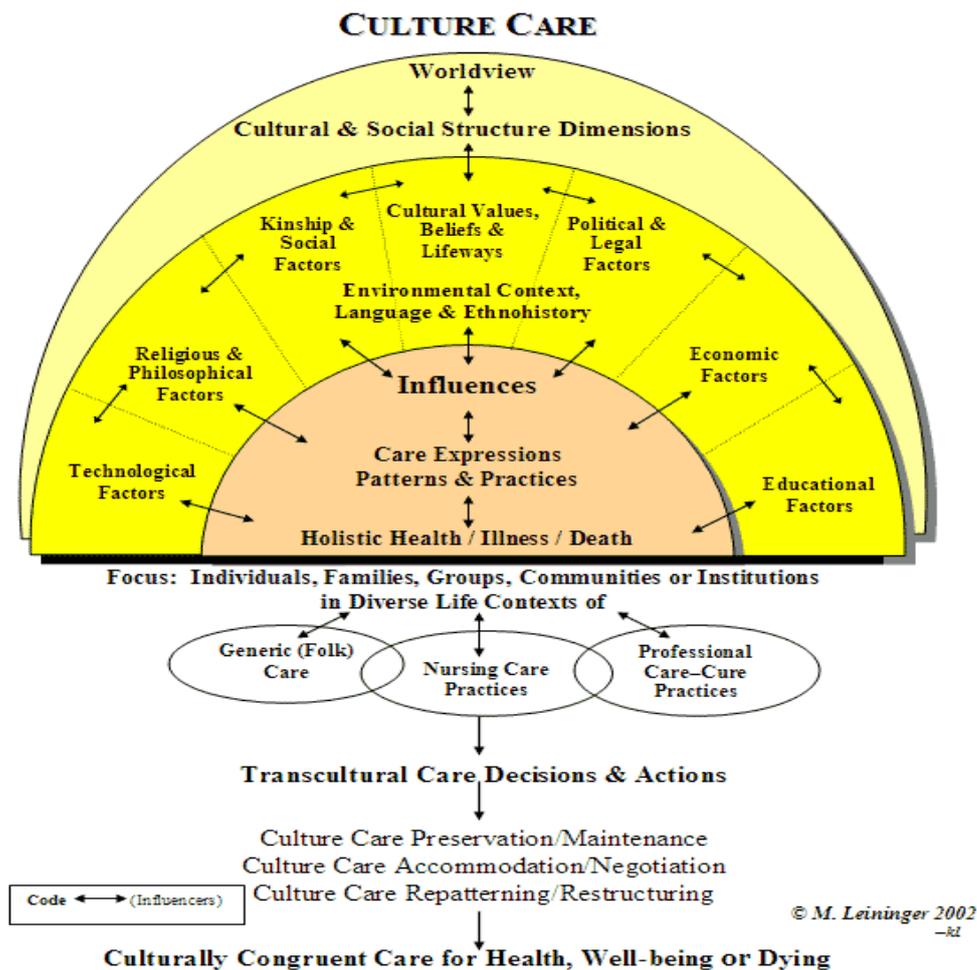
Figure 7.1: Sunrise Model

7.4 THE SUNRISE MODEL

Leininger (2001:23) looked at culture and human care as a holistic and unified perspective that reflects individual' or groups' total caring lifeways or influences on their well-being and as a result, she developed the Sunrise Model.

In conceptualising the Theory of Culture Care Diversity and Universality, the Sunrise Model was developed to guide the health professionals as a concept map that would assist them in remaining sensitive to multiple factors in influencing culture care outcomes (Leininger & McFarland 2002:79). The Sunrise Model is, therefore, a conceptual holistic research guide or enabler to tease out multiple factors that influence people's lifeways. It helps health professionals to initiate dialogue with patients, ask pertinent questions, and suggest health care modes that would facilitate culturally

congruent care. According to Coortis (2004:33), the Model outlines the clients' 'world view' .as the way individuals or groups look at the world to form values related to their lives and the world around them. The clients' cultural and social view is shaped by the environment and language context in which they exist and as a result each cultural group lives differently.

The potential influencers that explain the care phenomena related to different factors shown in the model include educational factors, economic factors, political and legal factors, cultural values, beliefs, and lifeways, kinship and social factors, religion and philosophical factors, and technologic factors (see in figure 7.1).

To provide culturally congruent care for clients, Leininger has identified and described three major care actions and decisions:

- **Culture care preservation and/or maintenance**

Culture care preservation and/or maintenance refers to those assistive, supportive, facilitative, or enabling professional acts or decisions that help cultures to retain, preserve, and or maintain beneficial care beliefs and values or to face handicaps and death.

- **Culture care accommodation and/or negotiation**

Culture care accommodation and/or negotiation refers to those assistive, accommodating, facilitative, or enabling creative provider care actions or decision-making that helps cultures adapt to or negotiate with others for culturally congruent care, safe and effective care for their health, well-being, or to deal with illness or dying.

- **Culture care repatterning and/or restructuring**

Culture care repatterning and/or restructuring refers to those assistive, supportive, facilitative, or enabling professional actions and mutual decisions that help people to reorder, change, modify, or restructure their lifeways and instructions for better (or beneficial) health care patterns, practices, or outcomes.

7.4.1 Application of major themes to the Sunrise Model

Lyons, Orozovi, Davis,and Newman (2000:285-295) point out that many researchers advocate an intellectually engaged form of analysis that goes beyond identifying and describing themes within individual studies to discussing the meaning of data, explaining how the study relates, contests or furthers existing theories. A major purpose of qualitative research is to relate findings to an existing theory. Miles and Huberman (1994:261) point out that while trying to determine what someone's behaviour means, the mental exercise involves connecting a discrete fact with other discrete facts and then grouping them into comprehensive and more abstract patterns. This involves moving up progressively from empirical trenches to a more conceptual overview of the landscape. The researcher deals with observables as well as non-observables. The two authors assert that concepts without corresponding facts are hollow, just as facts without concepts are literally meaningless. The researcher, therefore, relates her research findings to the Theory of Culture Care Diversity and Universality through using the tenets of the Sunrise Model Enabler.

7.4.1.1 Theme 1: The Piave community's perception of health and illness

The Piave community's perception of health and illness is supported by the cultural and social structural dimensions of cultural values, beliefs and lifeways.

The Piave community conceptualises health and illness in terms of physical, spiritual, psychological and social well-being. The informants' perception of a healthy person refers to having a strong body, being able to work, being well nourished and well behaved and experiencing no pain. Their perception of illness was the opposite of health referring to body pain, inability to work, bad behaviour and being mentally ill. Culture maintenance and preservation would be the most fitting care modality to use for this theme.

Maintaining and preserving one's body and soundness of mind implies living healthy lifestyles which include exercising and participating in recreational activities, eating well and doing one's daily cores. This community is encouraged to maintain and preserve these activities. Management of pain can be maintained and preserved through effective treatment of diseases and administration of pain killers through the use of

herbs and/or Western medication. Clients should be told it is acceptable to complain of pain when suffering from it. Although not voiced during data collection, men in Kikuyuland are not supposed to complain of pain even where they suffer excessively. Any complaining is considered a cowardly way of behaving and it is not unusual for other people to laugh and ridicule the victims. This is based on the researcher's observation and culture knowledge which has been passed down from generation to generation. Health professionals should be familiar with pain identification and management so that they are in a better position to assist the sufferers.

Ability to work is extremely useful to Piave people who rely on food produce from their small gardens. If there is no food to put on the table, men as well as women start going outside Piave to look for casual work so as to support their families. It takes a strong man and woman to work well and earn a living for his/her family. The community should be assisted with knowledge on food and good methods of farming and be encouraged to grow enough food for their own needs and possibly for selling to others.

Culture care preservation should be encouraged with regard to food which has been replaced by members of the community with food of little nutritional value. The use of indigenous foodstuffs should be supported if found nutritious so as to maintain good health. Health professionals could teach health education and work with other stakeholders such as agriculturalists who would be more fit to provide information on how to grow nutritious foodstuffs. Demonstration gardens and cookery classes would be of much help to the community members.

Good behaviour should be preserved and maintained. Many complaints were voiced about bad behaviour particularly by young men and to some extent old men. Ways and means should be sought to impart information on character building and good values to both young and old alike. This could be done through health education by health professionals or community workers and also by churches. All the concerned parties, young and old men and women could change their behaviour for the better and all could work in harmony for the maintenance and preservation of health.

Health professionals have a major role to play in the maintenance and preservation of health. They should steer the initiatives while at the same time work with the community members as partners in health care initiatives for long term sustainability.

7.4.1.2 Theme 2: Different beliefs about Interventions in self-care health seeking behaviours as expressed by informants

Beliefs about interventions in self-care health seeking behaviours are supported by cultural and social structure dimensions of religion, education, kinship and cultural beliefs and lifeways.

Self-care health seeking behaviours range from treatment with herbs, drugs, nutritious food, acting on health education and seeking supernatural interventions such as prayer and consultations with divine healers and witchdoctors. Culture care accommodation and negotiation are essential in this theme. This means letting the community members participate in care practices that are not harmful and negotiating for those practices which have the potential for becoming harmful. The following are suggestions on care actions or decisions that could be taken in informal treatment modalities.

The Piave community believes in the value of prayer. Many people in Piave are Christians who worship through different denominations. To date, the mainstream churches are Roman Catholic and Anglican churches while 23 are small churches belonging to different denominations. The priests, pastors and parishioners pray for their church members when sick.

The belief is that God will have mercy and heal the sick. It was said during the interviews that families, neighbours and groups such as self-help groups gather and pray for the sick person; pastors and parishioners pray for their sick church members.

There is one group of Christians that does not take their sick to the hospital but instead prays for them to get well. They believe that the sick are healed through intercessory prayers. Within the same group, some parishioners pray for their sick people and only take them to the hospital when the sickness becomes worse.

Culture care accommodation or negotiations should be used by health professionals to strengthen the cultural values and beliefs of the Piave people in the value of prayer. Health professionals should network with other related disciplines and in this case a pastor or a religious person in particular one who professes the same faith with the community members could be invited to talk about religious aspirations. It is important

to capture the religious or spiritual factors among the Piave people in order to strengthen, maintain, and preserve the community's religious aspirations. Local church groups could be used to promote the cultural care of respect for self and others in the light of biblical teachings. In order to strengthen family and community bonds, church centres could be used and maintained. The maintenance and preservation modes of professional action could be used to ensure that family and church members remained with the sick to give them moral support and assist in other possible ways. The health care professionals' knowledge of the cultural importance of family and religion to the well-being of individual, family and community members should strengthen their ability to teach other colleagues about the importance of cultural care preservation and maintenance.

As for those Christians who do not take their sick to the hospital, accommodation and negotiation form a crucial part of professional actions and decisions to be taken. It would be in the interest of culture-congruent care to preserve the practice of performing cleansing prayers while at the same time taking their sick to a health facility for health care. Health education on the causes of diseases and treatment is very pertinent to this group while at the same time respecting their beliefs and negotiating how they could be accommodated within the prescribed treatment since prayer gives comfort to those who believe in it.

Piave people believe that some illnesses are caused by curses. There are indigenous or culture specific diseases that are said to be caused by the anger of the ancestors, breach of taboos, doing something wrong to a person particularly a relative; the wrath of the offended person or ancestor is directed on to the offender who as a result becomes ill or experiences a misfortune of some kind. There is also a belief that a person can activate a demon or bad spirit to another person causing some bad omen.

As for the affected person or significant others, these beliefs are real because they have been there from time immemorial, having being handed down from generation to generation. Health professionals should not ridicule these beliefs as they may antagonise and send away some clients from the health facilities.

Culture care accommodation and negotiations could be used here. The client could be persuaded to go through the prescribed ritual if harmless and still consult a health care

professional for treatment. The two modes of care, ritualistic practices or other modes of traditional treatment and medical care could be combined if there is no conflict foreseen in combining the two. If harm to the affected persons is likely to occur, then the traditional healers can be pursued to counsel the affected persons to go to the hospital while still maintaining contact with them in the manner of moral support. The reason is that some of the community people believe in traditional cures or the removal of a curse. The traditional healers' presence may, therefore, play a key role in the person's recovery. Giving health education to traditional healers on health and related issues would be of much value since they are likely to impart the knowledge gained to their clients, colleagues, families and the community at large.

Some Piave people believe in bewitchment. They suspect that there are witchdoctors within the community but are afraid of pinpointing the suspects through fear of being bewitched. Some informants pointed out that some people seek the treatment of witchdoctors at the surrounding towns: namely, Njoro and Nakuru, but do so secretly because the practice is condoned by the church members.

There are two types of illnesses according to the African people: natural and unnatural. Natural diseases such as skin rashes in children and rheumatism in older people may be treated either by modern or traditional medicine while unnatural diseases (human-induced illness) such as tuberculosis and typhoid are said to be caused by sorcery, witchcraft, spirit disturbances, or breaching socio-religious obligations and taboos especially with regard to ancestors. The natural illnesses are said to be treated by health professionals while unnatural ones are said to be treated by traditional healers. Some traditional healers use herbs and other types of concoctions while others use ceremonies in their healing practices. When Piave people go to formal health care facilities, they are likely to bring these beliefs with them.

It is, therefore, important for the health professionals to be sure that there is no conflict or incompatibility between the two differing methods given to the sick person. Health professionals and other health care workers should try as much as possible to establish the authenticity of the traditional healers' treatment and advise accordingly. They should be familiar with the herbal medicine commonly used by the Piave community and try to establish where possible the modes of action. Clients using these herbs are often not aware of all the reactions and effects of herbal medicine unless the traditional healer

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has informed them. Based on the health professionals' knowledge of the herbal medicine, discretion should be used to accommodate continued use of the medicine while the client is undergoing hospital treatment if there is no interference with the medicine prescribed at the hospital. In cases where harm is likely to be caused by herbal use, the healing practices should be negotiated or repatterned. Negotiations to stop the practices and repatterning to alter the practices to a harmless activity such as prayer to cast away the evil spirit inflicted on the person through bewitchment are suggested.

Apparently, there is a lot of secrecy behind believing and seeking help from witchdoctors (researcher's observations). Church members are prohibited by their respective denominations from seeking their help. However, the same Christians and pastors who condone the practice in public are said to believe in bewitchment and secretly seek assistance from the witchdoctors. It is, therefore crucial for church members and pastors to encourage community people to talk about the issues openly to allow both parties to find solutions together. This would prevent the dangers of people seeking traditional help secretly while at the same time suffering in silence for a long time until the health problem reaches a   serious level or results in death.

Divine healers' prescriptions may compromise optimal health. Changes must, therefore, be negotiated with divine healers to encourage them to send their sick clients to health institutions for treatment. Accommodation could be employed in relation to divine healing.

Divine healers' prescriptions may compromise optimal health. Changes must therefore be negotiated with divine healers in a way that they would see it fit to send their sick clients to health institutions for treatment. The divine healers do not only pray for the sick but they also give traditional medicine such as herbs and sometimes conventional medicine. They prescribe and then send their clients to buy the drugs from the pharmacy. Unfortunately, many pharmacies in Kenya issue drugs including antibiotics without prescriptions and that implies that they do not establish the authenticity of the person who has prescribed them. Divine healers also perform some rituals such as digging out witchcraft materials they claim have been buried near the victim's home to cause harm to the person. Accommodation and negotiation are the best ways to handle these care modalities. Accommodation can be used on the portions of the practices that

are not harmful such as prayer and negotiation to stop the treatment that is harmful such as giving drugs meant to be prescribed by a qualified doctor because this may impact upon the health of their clients since they may be deprived of essential health care.

Negotiation can also be used with divine healers with respect to referring their clients to the hospital for biomedical treatment instead of prescribing drugs and telling them most of the time that prayer is sufficient to cure their ailments. Health education on the possible effects of giving drugs not prescribed by a qualified doctor should be given to the community as well as to the divine healers. If the divine healers were incorporated into the mainstream health system after some basic training, they could be used in praying for the sick and giving health education since many community members respect them by their virtue of their being divine healers. Some of them are pastors of the African Gospel Churches.

Accommodation and negotiations could be used for self-treatment with herbs and over-the counter drugs. Health professionals could establish the authenticity of the herbs used at home to find out whether they have a healing effect or not. Home treatment should only be done for minor ailments such as in cases where herbs have been tested and found to be reliable for treating health problems such as common colds. In such cases, the treatment could be accommodated. There are currently a number of medical textbooks with information on some of the common herbs used, for example, garlic and Aloe-vera. Over-the-counter drugs should be discouraged through negotiation because people use them without much knowledge of how they work and the possible complications they are likely to cause. Some community members use them repeatedly without ever going for formal treatment resulting in the deterioration of their illnesses and sometimes death. However, the ones with minimal complications could be used for minor symptoms like headache and pain as temporary measures but those taking them should be advised to seek formal treatment if the pain persisted.

Some members of the Piave community seek treatment from herbalists

Negotiation and accommodation could be used*.* Some herbs which have been tested by health care laboratories are effective for particular disease conditions. However, herbalists have hardly any diagnostic methods apart from the clinical signs and symptoms of the patient. In such cases, it is important to give the traditional healers health education on the importance of coming to a correct diagnosis prior to treating their patients. They can be requested to send their patients to the hospital for laboratory tests to aid with diagnosis. They could then treat the patient or refer him/her to a health facility if they were not able to give effective treatment on account of the seriousness of the condition or the nature of the diagnosis. Negotiations to abandon the herbs that have not been scientifically tested should be done and community members, in cases of where home remedies have been used, should be advised to go to the hospital for medical attention.

Herbalists could be encouraged to visit their patients while hospitalised or at home. This is necessary in order to facilitate and secure their cooperation and promote holistic well-being since community members have a lot of trust in them. This would be possible if networking and collaboration between health care professionals and herbalists were initiated and maintained through respect for each other's work. Herbalists could be invited for training in areas identified by both parties such as health education on some disease conditions, and the effects of delayed treatment. They could be effective agents for positive change since many are well known and are respected by many community members within their respective working environments. According to the data from the herbalists and other traditional healers most of them are ready to work with medical people if invited to do so. Only one herbalist said that he would not work with health professionals because they might steal his skills in herbal medicine and then he would have nothing to do except to go home.

Nurses and doctors attending to the patients should find out whether the person is taking herbal or other forms of treatment so that counselling could be done accordingly. Many traditional treatments are likely to conflict and be incompatible with biomedical modes of treatments. Cultural assessment of an individual and family, performed by a nurse or a doctor with adequate knowledge and skill in using the tool could increase awareness of cultural variability that might be prevailing within an individual, family or

the community at large. It is important to note that a number of variations in cultural beliefs, practices and values can exist among individuals, within families and community members even where they belong to the same community. Individual and family assessment is, therefore, pertinent.

In general, the medical fraternity has to adhere to the notion of 'do no harm'" to clients. The notion should prompt them in advocating for quick action in scientific research to find out the authenticity of herbal medicines and other modes of treatment modalities used by the traditional healers. Disclosure on the part of the traditional healers on the treatment they use is not easy because they are suspicious of people who go to see them to enquire about their treatments. They suspect the inquirers to be spies who can have them arrested because the government has not licensed them to carry out treatments. They also think their knowledge and skills could be copied by other people thereby minimising opportunities for their practice. A case in point is, that the traditional healers were unwilling to disclose to the researcher what they do when she first visited them. It was only during the subsequent visits that they were willing to open up after they became less suspicious. They should, therefore, be approached with caution and respect and ways of networking and collaboration established. A reciprocal relationship between the two bodies would have to be well deliberated and executed as traditional healers have a large section of the population behind them in Africa, the Piave community included, and getting to know their world would be beneficial for the future of health system management.

7.4.1.3 Theme 3: factors influencing self-care health seeking behaviours

This theme supports the cultural and social structure dimensions of kinship and social factors, economic, technological and religious factors.

Various factors influence self-care heath seeking behaviours as can be inferred from table 7.1 comprising of family and community members and previous experience with and access to health services.

From the data, self-care health seeking behaviours are influenced by several factors: family members, especially elderly women; community members; previous experience

with unsuccessful treatment; lack of trust of medical doctors; inaccessibility of health services; transport problems and the cost of health care.

The elderly women are said to command a lot of power when it comes to deciding how the sick members of their families are cared for. Many of them believe in herbal treatment and sometimes refuse to allow their family members to seek treatment in formal health care facilities. They prescribe herbs and become annoyed if their commands are not met. They sometimes punish the family members who do not heed their commands by sending them away from their homes.

Accommodation and negotiation are the modes of care action recommended in this aspect. Health professionals could play a pivotal role in giving health education to the community on the causes of various diseases and their treatment. They should also provide health education on healthy lifestyles and the importance of going to a recognised health facility when unwell; the same applies to the members of the households and the community at large. The health practices that cause no harm such as prayer and family cleansing could be encouraged for their psychological comfort.

Negotiation with those community members who do not believe in formal treatment, in particular the elderly women, could be done in order to assist them in making favourable choices for themselves and their families, that is, seeking biomedical care from health facilities in cases of severe illness. They should be approached with respect as old people can be very stubborn and tend to be suspicious of any ideas that are not their own. Examples are their opposition to the building of the Piave Dispensary and their refusal to allow their children to develop their land because they think they are being cheated.

The chief of the Piave community is said to encourage community members to seek formal care. He should be encouraged to continue the good work and at the same time be given counselling skills so that he can approach the community members with respect and counsel them on going to the hospital instead of imposing on them his values and beliefs.

Health professionals should teach community members about diseases found within the Piave area in order to empower them. They would then be in a better position to make

informed choices. With regard to lack of trust of medical doctors, doctors should honour their oaths, keeping patient information confidential at all times. If they need to share a patient's information for educational or treatment purposes, consent should be obtained from the person concerned or a guardian in case of a minor. They need to remain professional at all times.

Negotiations with the relevant bodies such as national and local government on access to health services, shortage of health professionals and shortage of drugs should be done by the health professionals working in the Piave location. Improvement of infrastructure such as bad roads should be negotiated with the government. The MoH should try to address the shortages and attempt to come up with workable solutions. Attempts to improve relations between health professionals and the Piave community are crucial in order to avoid situations in which the community members reject their services. More meaningful interactions between the two parties should be encouraged. Health care professionals need to give more workshops or training sessions on public and interpersonal relationships.

7.4.1.4 *Theme 4: Informants' views on ways to improve health care to the community*

This theme supports the cultural and social structural dimensions of technological, educational, economic, and political and legal factors.

The Piave community indicated that the provision of adequate water, good roads, opportunities for entrepreneurship and education on good farming activities, employment and health education by health professionals could assist in improving the health of the community. They voiced the need for receiving more health education as well as home visits from health professionals. Traditional healers expressed the need for networking and teamwork with health professionals as they thought it might contribute towards a healthier community one complementing the treatment by the other. The health professionals confirmed that they were not against the inclusion and training of traditional healers. They agreed with the Piave community's expressed needs for the improvement of their health but added that they needed more nurses to assist them and that more community health workers needed to be trained (see table 7.1). All the parties concerned need to negotiate for the factors they deem necessary for

development initiatives. They should also play a variety of roles in an effort to contribute to the developmental issues as much as possible without always relying on government, local, regional and international bodies for assistance. However, where deemed pertinent, and allowed by government or the respective authorities, they could negotiate for outside resources such as donor funds to positively impact the ideals of development initiatives.

Networking and team work between traditional healers and health professionals should be encouraged. The need for team work and networking with traditional healers who are not ready to share their practices with health professionals has to be negotiated in such a way that the traditional healers' trust is gained. Traditional healers expressed concerns that the health professionals might cheat them and that once the doctors gained knowledge about their medicines, they would start using them and then they would have to abandon their trade. Negotiation between health professionals and traditional healers who were not ready to share their knowledge and skills related to their practice should be done in such away that both parties gained trust in each other.

7.5 EXPLICATION OF THE STUDY FINDINGS WITH RELATION TO THE CULTURAL AND SOCIAL STRUCTURAL DIMENSIONS OF THE SUNRISE MODEL

7.5.1 Technological Factors

7.5.1.1 Formal and informal health facilities

In the Piave location, health facilities are minimal. There is only one dispensary, a private clinic. However, the community is able to access health care for more serious health problems at the Njoro Health Centre and the Nakuru District Hospital. Other available services are those of traditional healers mainly found in the towns of Njoro and Nakuru. The community also self-treats with herbs found in their surroundings and at times with over-the-counter drugs.

7.5.1.2 Agriculture

The Piave community relies on rain water but this is inconsistent. The people plant mainly maize and beans in their gardens according to their traditional methods of farming as modern farming methods have not been introduced to the community. They now wish for demonstration gardens so that they could learn to garden productively and provide the best and most nutritious foodstuffs for their families.

7.5.1.3 Water

Available water for the community is from Ndaragwa River and is highly polluted. The community is investigating the possibility of more boreholes in the near future. The Public Health Nurse in the Nakuru district said there was a possibility of having the means to disinfect the available water with sachets.

7.5.1.4 Firewood

Because of the scarcity of firewood, stalks from the maize and beans are used for fires for both cooking and warmth but they last for only a short time after the crops are harvested. People have to travel far to find firewood. A few people sell firewood to the community but at a price many cannot afford. At night, many people remain in darkness since they have neither firewood nor paraffin for lighting their houses.

7.5.1.5 Roads

There is a serious lack of good infrastructure. Roads are not tarmacked and are dusty. They are in bad shape and many are impassable because of pot holes and soil erosion. When it rains, vehicles can hardly get through. People, therefore, have to walk long distances to the formal health care facilities..

7.5.1.6 Means of transport

The only means of transport in Piave up to the main road (about six kilometres) is bicycles (boda boda) – either privately owned or available for hire – and mainly used by men .There are hardly any public vehicles because of the bad roads. When people get

sick, they rely on herbal or over-the-counter drugs particularly on weekends, public holidays or evenings when the dispensary is closed. This includes some of the seriously sick because even if the transport were available (very rarely), they usually have no money to pay for it to the Njoro or Nakuru health care facilities.

7.5.1.7 Telephone

Public telephones are not available but a small number of community members have mobile phones.

7.5.1.8 Electricity

There is no electricity and people have to rely on paraffin lamps for lighting their houses at night. Some people are not able to afford the paraffin and, therefore, remain in darkness. This means that school children are not able to do their homework at night. However, there is hope at the end of the tunnel since electrical posts are being erected and this might mean electricity is on the way even if it takes a long time.

7.5.1.9 Industries

There are no industries and that means that almost no development is taking place in Piave.

7.5.2 Social and economic factors

As social and economic problems are interrelated, the researcher has discussed them under one heading. Generally, the economic status is very low for several reasons, lack of adequate land on which to cultivate and grow crops; no cash crops grown within the community; frequent droughts leading to famine; poor infrastructure such as lack of good roads and electricity; lack of markets for the food produce and high levels of unemployment. Self-employment is lacking too. The informants stated that if electricity were available, young men would do welding while the girls would keep salons as good ways of earning a living.

7.5.2.1   Unavailability of land

Land is used as a means of livelihood and is very scarce in Piave. The four-acre plots given to the landlords (women) have been divided into small portions for the offspring to cultivate. Some people who can afford to hire one acre of land for Kenya shillings 2000 per year to grow food do so.

7.5.2.2   Problems brought by land ownership

Added to the existing socioeconomic problems, the majority of the landlords have not subdivided their land for their children to inherit resulting in conflict after their deaths. It is also unfortunate that there are still no title deeds for the land. Several people have cheated the women who have paid for the procurement of the title deeds but with no results. The government is not helping them to obtain the title deeds either.

7.5.2.3   Problems caused by lack of food

The food grown by individual community members is used for different purposes mainly consumption and the sale of some it to obtain money for other requirements such as school fees and a variety of home requirements. Some men and boys steal the food to sell and use the money for alcohol. This results in poor nutrition. There are many cases of malnutrition among the young children. Some of the adults look unhealthy too, most likely owing to inadequate food consumption and the lack of a balanced diet that would include a variety of foodstuffs and fruits. Fruit trees are extremely rare in Piave.

Owing to almost persistent problems regarding lack of food, men go away from their homes in search of food. Some marry while away from their homes and leave their families suffering. According to some informants (women), women also contribute to broken marriages by not allowing intimacy with their husbands and their alcohol abuse and promiscuity.

7.5.2.4   Suicidal tendencies

Some of the community members take rat poison (diasonon) to kill themselves because of poverty as they feel they do not want to see their families suffering. Some youths do

the same particularly after being involved with alcohol and drug abuse. They feel life is not worthy living and want to commit suicide as a result.

7.5.2.5   Alcohol consumption

Piave has many drinking dens. The researcher visited some of them and found that the dens are within the main houses and that means within sight of all the members of the family. The areas preserved for people to sit while drinking are very small and, therefore, muggy depending on the number of customers present. They are also fairly dirty and untidy.

Moonshine (Changaa) and Busaa (made from fermented millet flour) are the commonest drinks while standard beers are very scarce because people cannot afford them.

Adolescents indulge in alcoholic drinks at an early age because of irresponsible parenting. The parents are bad role models and hardly socialise their children into societal norms with guidance and counselling. Young people also complain that their parents misbehave sometimes in their presence by getting drunk. Women who get drunk are at times raped on their way home.

7.5.2.6   Illicit drug abuse

Mostly because of idleness, many women, men and children abuse drugs. A few people grow bhang and sell it to the community members. Other drugs are obtained from surrounding areas. Unfortunately, the community members complain that the administration; chief and police officers have not stamped out the vice, most likely because of corruption. Some of the community members especially women have reported some of the culprits to the chief but no measures have been taken. They have also been threatened by the same culprits and are afraid of reporting them.

7.5.3 Education

There are five primary schools and only one secondary school built three years ago. The majority of the children reach only Std 8. There is no vocational training for the youth either.

Parents complain that because of the poor economic status of the community, children are not well taught. Nursery school teachers are paid so badly that they work in their gardens in the mornings or do anything else to support themselves economically, before going to teach. Children attend nursery school for only one year because of lack of fees. The end result is poor performance when they go to primary school as they lack a sound foundation. There is also child labour which children are prevented from going to school in order to assist their parents in their gardens. This is particularly so where the parents have to go away from home almost on a daily basis to search of daily bread. They rely on paraffin and since it is very expensive, children are not able to study or do their homework at night. Added to this, most of the adults have not been to school and are therefore not able to assist their children with their learning.

7.5.4 Religious and philosophical factors

After interviewing several people about the numerous churches, the researcher learnt that there are many Christian churches with different names all supposedly worshiping the same God, They were started by various people who were apparently looking for power and money. One church sometimes divided into several groups each starting its own church.

7.5.5 Kinship-related social factors

The fertility rate in Piave is high. Many families have more than six children. The main reason for this is lack of family planning knowledge and services. Women have to go to the Njoro Health Centre for the services, which is far for them. Coupled with this, are the men who refuse to allow their wives to go for family planning. They complain that women suffer from diminished libido on account of the family planning medication,

especially injections. Women also reject practising family planning for fear of having marital disharmony possibly leading to separation.

Families live together within the same compounds and that means seeing one another on a daily basis. They tend to do a lot of things in common, mainly gardening as there is hardly any other mode of occupation.

The main stumbling block in the development of Piave is the old women who are the current and original owners of the land. They are very domineering and order their offspring what to grow on the land and at times where to go for treatment when sick. They generally advise their families to get herbs from the home surroundings and administer them for their health problems. If their instructions are not adhered to, they get annoyed and at times ask the offenders to leave their homesteads. Men are more oppressed by them than women and this has made a number of them leave home to look for greener pastures elsewhere. Women especially daughters are said to be closer to their elderly mothers and collude with them in suppressing the men. It was said that the reason why the elderly women were closer to their daughters was that the daughters looked after them better and also took care of them when they were sick.

7.5.6 Girls' pregnancies

As for the girls, pregnancies outside marriage are very common at a very early age. Their parents tolerate them for the first pregnancy. When they become pregnant for the second time, most of them are sent away from their homes or are given a small piece of land to build a shelter for themselves and their children. Because of poverty, they engage in prostitution and trading in illicit brews. It becomes a vicious circle. The young women interviewed complained of lack of parental guidance.

7.5.7 Cultural values, beliefs and lifeways

Beliefs: Some of the Piave people believe in curses and bewitchment. They, therefore, seek the assistance of traditional healers for cures. Others believe in prayer and hope for God's intercession when they are unwell. Community members have various beliefs related to the treatment of disease: some believe that herbal treatment has no side effects and, therefore, prefer it while others believe that some diseases like the ones

caused by human interference (unnatural disease) such as mental illness, typhoid and tuberculosis can only be treated by traditional healers.

7.5.8 Political and legal factors

Piave people consult their member of parliament when necessary or the chief, the assistant chief and some of the established community groups such as the Constituency Development Fund Committee deal with administrative and developmental issues when problems arise. Some of the issues are conflicts within homes or groups; facilitating meetings for the allocation of constituency funds for development and development initiatives such as the installation of electricity and access to clean water. The administration represented by the chief and police try to stamp out vices like excessive drinking and use of illicit drugs through patrolling the places suspected to be involved in this kind of trade.

7.6   SUMMARY OF THE CHAPTER

In this chapter, major themes which derived from the research findings were explicated and applied to Leininger's theory with specific reference to the three modes of major care actions and decisions for arriving at culture congruent care. It was also indicated how the social structure factors in the Piave community influence their cultural care meanings and expressions.

CHAPTER 8

Conclusions, limitations, recommendations and guidelines

8.1   INTRODUCTION

In this chapter, the conclusions, limitations, recommendations and guidelines are presented. The purpose of the study was to explore and describe the self-care health seeking behaviours of the Piave community in the Njoro division of Kenya and to develop a guide (guidelines) which could serve as a leverage point to integrate self-care health seeking behaviours with professional health care. The research questions were as follows:

1.   What are the self-care health seeking behaviours of the Piave community?
2.   How can the community's self-care health seeking behaviours and professional health care as delivered by health professionals be integrated to deliver more culturally congruent health care?

8.2   RESEARCH DESIGN

A qualitative exploratory research design using the ethnonursing research method was employed. The study was conducted in two phases. During phase 1 data was collected from key and general informants from the Piave location. During phase 11 data was collected from additional informants: namely, traditional healers and health professionals who render health care to the Piave community. Data analysis was done by using the NVivo computer programme for qualitative data analysis and by implementing the four phases of the ethnonursing data analysis method. After completion of data analysis and interpretation, four major themes emerged which are displayed in table 7.1.

8.3 CONCLUSIONS

The conclusions are offered according to the major themes (table 7.1) derived from the research findings presented in chapters 5 and 6.

8.3.1 Theme 1: The Piave community's perception of health and illness

The Piave community view health holistically. According to them, health means physical, spiritual, social and psychological well-being. They believe that social factors such as poverty, infidelity, prostitution and alcohol and drug abuse have a negative impact on their well-being. These social problems are mainly caused by poverty and a high rate of unemployment and can be addressed through health education and improvement of the infrastructure of the Piave location.

The community is well aware of the impact of the environment on their health. They seem to understand that cold weather and dust can cause respiratory diseases and that stagnant water invites mosquitoes which cause malaria. They believe that a lack of personal hygiene, dirty water, an inadequate diet and germs cause ill-health. Statistics from the Piave Dispensary show malaria and respiratory diseases as the highest incidence in the area (table 6.3).

8.3.2 Theme 2: Different beliefs about interventions in self-care health seeking behaviour as expressed by informants

The Piave community believes in the healing effects of herbs. They collect herbs growing in the area and appear to know which herbs to use for specific ailments. They also visit herbalists practising in nearby towns to seek treatment from them. The buying of over-the-counter drugs is a common self-care health seeking practice especially over weekends when the Piave Dispensary is closed.

Different treatment modalities are used by traditional healers and there appears to be no consensus on which herbs cure which diseases. A disease like diabetes, for example, is treated by some traditional healers by using herbs and by others through health education on a nutritious diet containing lots of fruit. Some traditional healers believe that they can cure chronic diseases such as AIDS, diabetes, hypertension,

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asthma, typhoid, prostatitis, bladder infections, scabies, pelvic inflammation, venereal diseases and malaria with herbs (see 6.3). Others, however, realise that they cannot cure AIDS and, therefore, send their clients to hospital. Some of them also give health education on various aspects such as how to take prescribed drugs and what their effects are; nutrition; environmental pollution and sexual behaviour. Advice given on nutrition and sexual behaviour is not always directed to improving health and well-being and is sometimes contradictory. These issues need to be addressed by health professionals together with the traditional healers to enable the integration of both formal and informal health care delivery.

The Piave community believes in the power of prayer for curing illness and providing support during illness. Prayer is offered by pastors and parishioners of different denominations as well as by family and community members. These practices should be preserved as they are not harmful and combined through negotiation with formal health care.

The community's beliefs in supernatural forces lead them to seek the help of divine healers and witchdoctors when they are ill, especially when they think that their illness was caused by a curse or witchcraft. The traditional healers who include witchdoctors and divine healers use different rituals to relieve clients of bewitchment and get rid of curses. Very little detail was gathered on these modalities.

Women in the community seek the assistance of traditional birth attendants (also categorised under traditional healers) when in labour. Traditional birth attendants are part of their culture and are more readily available as formal health care facilities are not adequately accessible because of distance and availability of these services on a 24-hour basis in the Piave location. Those community members who can afford transport and service fees go to the Njoro Health Centre or Nakuru District Hospital for delivery of their babies.

8.3.3 Theme 3: Factors influencing self-care health seeking behaviours

The community's self-care health seeking behaviours are influenced by various factors. Elderly women (who are the landlords) strongly influence the self-seeking behaviours of their family members. They compel them to take herbs for treatment and are strongly

opposed to formal health care treatment as they do not believe in formal health care. They threaten to banish family members from home if they ignore their orders.

Mothers tend first to engage in self-treatment such as herbs, over-the-counter drugs and prayer for themselves and their children and only seek formal health care when a disease becomes serious. Community health workers who have been trained by the Society for Women and AIDS (SWAK), a non-governmental organisation, encourage community members to seek formal health care and organise transport for them to the hospital. Other community members including neighbours, self-help groups and church groups visit the sick, pray for them and advise them about where to seek help both formally and informally (herbalists). It appears that the chief is in favour of formal health care as he uses his administrative power to send community members for formal treatment.

Previous experience with formal health care comprising unsuccessful treatment and lack of trust in medical doctors as a result of breach of confidentiality, results in community members seeking the help of traditional healers.

Self-care health seeking behaviours are also influenced by the absence of a 24-hour service by the Piave Dispensary and the distance and lack of transport to the Njoro Health Centre and the Nakuru district hospital. The community is very poor and the majority of the people cannot afford health service fees.

The shortage of health professionals (there are only two nurses working at the Piave Dispensary), shortage of drugs at the dispensary and bad roads result in the nurses not being able to do home visits and the community, therefore, turns to self-care health seeking behaviours.

8.3.4 Theme 4: Informants' views on ways to improve health care to the community

The Piave community is of the opinion that improved infrastructure including adequate and clean water, good roads, electricity and assistance with entrepreneurship and effective ways of farming, would lead to improved development and health. This should result in a decrease in unemployment which could directly influence the social problems

of prostitution, infidelity, alcohol and drug abuse. A definite need for more health education and home visits from health professionals was indicated.

It appears that both the traditional healers and the health professionals are in favour of working towards integration of formal and informal health care through networking and teamwork. The health professionals confirmed the need for better infrastructure and it is apparent that more nurses should be recruited and more community health workers trained for the area.

Some of the Piave community's self-care health seeking behaviours should be preserved (those that are not harmful), whereas others need to be negotiated or repatterned as discussed in 7.4.

Data collected from the health professionals indicates that they have minimal knowledge of the presence and practice of traditional healers in the community, and of the community's self-care health seeking behaviours as there is hardly any interaction between them and the traditional healers. The health professionals have little time to do outreach programmes in the community because of the shortage of staff in their respective working areas, and so they concentrate on curative services (see table 6.4: Data display of health professionals) which is not in line with the policy of the Kenya government for the implementation of Level 1 health care facilities.

8.4   CONTRIBUTION TO THE STUDY

The findings from this study are valuable to health professionals, community members, traditional healers and other interested individuals or groups of people. Below are some of the main contributions of this study emerging from the study findings.

The study will contribute to the body of transcultural knowledge of the perception of health and illness; health has been expressed in a holistic manner rather than merely as the absence of disease or infirmity (theme 1). The study will contribute to the body of the transcultural knowledge of different beliefs contributing to the self-care health seeking behaviours (theme 2). Additional to this are the research findings obtained from the data on traditional healers. They have given valuable insight into the diseases they

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claim to treat (table 6.5), their sources of training and opinions on the integration of formal and informal health care (table 6.6: data display of traditional healers).

Finally, the findings of the study and compiled guidelines will assist the health professionals, community members and related stakeholders to develop a culture-congruent care strategy in order to secure optimal utilisation of health services by the Piave community and at the same time encourage the use of self-care health seeking behaviours which are beneficial to the community.

In chapter 7, using the three modes of care actions and decision-making developed by Leininger, the researcher suggested how informal and formal health care could be combined, thereby blending health care activities into culturally congruent care.

8.5 LIMITATIONS

Although the study of ethnonursing requires the researcher to live with the community where the study is taking place, this was not possible owing to work commitments. However, the researcher tried to spend as much quality time as possible with the informants in their natural surroundings.

The researcher translated the interview raw data from Kikuyu language to English language. Ideally the translation should be done by an independent person but since she had interviewed the informants all by herself, she thought doing the interpretation would be more appropriate to avoid loosing some of the meanings of data embedded in gestures and non-verbal communication.

Artefacts are necessary when describing the cultural aspects of a community. However, there were very few within the community: infrastructures such as ramshackle houses and churches and people's poverty-stricken dress – torn clothing and bare feet. One also noticed the misery on their faces.

8.6 RECOMMENDATIONS AND GUIDELINES

Recommendations pertaining to the integration of self-care health seeking behaviours and formal health care are presented as well as recommendations with regard to further research.

Guidelines for the integration of self-care health seeking behaviours with formal health care have been compiled. These guidelines will be presented to and discussed with all the relevant stakeholders for implementation to facilitate the delivery of more culturally congruent care to the Piave community.

Table 8.1 Recommendations and guidelines for integration of self-care health seeking behaviours with formal health care

Findings	Recommendations	Guidelines for intervention	Persons responsible
The community perceive health as a holistic perspective (major theme 1)	Maintain and preserve perception of health for building a healthy community and support the community to decrease social problems impacting on health Assist with improvement of a healthier environment	• Provide health education on prostitution, alcohol and drug abuse and environmental hygiene • Establish and improved infrastructure as mentioned for major theme 4	• Health professionals • Government • Local council • NGOs Community members
Some community members do not consult the formal health care facilities because of their religion; belief in the power of prayer to cure them (5.4.2.1) (major theme 2)	Preservation and negotiation can be done to assist the community members to accommodate the good elements in prayer and abandon the negative ones such as not taking the sick to the hospital	• Negotiate with and inform the community that prayer is good but that sometimes it may also be beneficial to seek formal health care. • Negotiate with pastors and parishioners to refer clients to formal health services after having prayed for them	• Health professionals • Community health workers • Community members
Some community members believe in witchcraft and curses and that only traditional healers can remove them (5.4.2) (major theme 2)	Discourage harmful elements in the community's supernatural beliefs and maintain the elements that are not harmful and do not conflict with formal treatment	• The cultural pattern of casting away evil spirits or curses through harmless rituals can be preserved • Use negotiation when practices are harmful to convince traditional healers to refer clients to formal care health care facilities	• Health professionals • Community health workers • Members of the community
Community members complain of poverty: there is a high rate of unemployment and the land is too small to cater for their needs (5.4.2.2) (major theme 4)	Diminish poverty and unemployment through development initiatives so that people can get involved in self-employment	• Assist the community to establish a market where they can sell their produce • Improve the infrastructure through building proper roads, providing electricity, and the drilling of boreholes and/or provision of tap	• Government and local council using Development Fund allocated to constituencies • NGOs • Community members

Findings	Recommendations	Guidelines for intervention	Persons responsible
		• water • Provide information and training on entrepreneurship so that people can get involved in self-employment	
Infidelity is common among the married couples, the major reason being poverty. Men and women leave Piave looking for employment elsewhere (5.4.2.2) (major theme 1)	Community development should be initiated to eradicate poverty Health education should be given on the negative ripple effects of infidelity and prostitution	• Community development initiatives could assist in eradication of or decrease in poverty, infidelity and prostitution • Health education should be given on family planning	• National and local government • Health professionals • NGOs • Families and community members
Inadequate personal and environmental hygiene is caused by dirty roads, lack of clean water, contaminated food (5.4.2.3) (major theme 1)	Attend to environmental factors which influence the community's health	• Provide health education on personal and environmental hygiene • Teach the community how to purify water to make it safe for human consumption; how to get rid of dust in houses; how to construct and maintain pit latrines; and how to cook and store food properly	• Health professionals • Community health workers • Community members • National and local government • NGOs
Inadequate nutrition and lack of knowledge of good methods of agriculture(5.4.2.3) (major theme 1)	The community to be taught about a balanced diet and how to grow nutritious food	• Give health education on a balanced diet and preparation of food to avoid the loss of nutrients; and encourage them rather to use the indigenous food which has more nutritional value. • Offer demonstration gardens for people to acquire good practices in agriculture	• Nutritionists • Agricultural technologists • Health professionals • Community health workers • Community members
Self-care health seeking behaviours include using herbs from the environment and over-the-counter drugs for treatment of different diseases and pain management (6.2.1) (theme 2)	The community should be encouraged to use formal health care facilities and be given health education on possible detrimental effects of herbs and over the counter drugs Improvement of formal health care	• Home visits to establish the right kind of self-care health seeking behaviours, counsel accordingly and improve interpersonal relationships • Improvement of formal health care through availability of health care on a 24-hour basis	• Health professionals • Community health workers

Findings	Recommendations	Guidelines for intervention	Persons responsible
	services	• Improved means of transport • Recruitment of more nurses for the Piave location • Provision of adequate drug supplies at the Piave Dispensary	• National and local government • MoH
Some community members prefer herbal treatment and believe in herbalists (6.2.1) (major theme 2)	Community self-seeking behaviours which are not harmful should be preserved	• Health education for community regarding some herbs which may have harmful effects and encourage people to use formal health services also • Negotiate with herbalists to send their clients for formal health care when they do not respond favourably to their treatment	• Health professionals • Community health workers • Community members
Community members visit TBAs to assist them with child birth (6.2.1) (major theme 2)	Networking should be established with TBAs and further training should be offered.	• Since there is a shortage of health professionals, it is crucial to train TBAs to assist women in labour and delivery. This could decrease maternal and infant morbidity rates – one of the MDGs • It should be negotiated with the TBAs to refer complicated pregnancies to formal health services	• MoH • Health professionals
Health professionals expressed willingness to work with traditional healers since many community members go to them and are sometimes given advice that conflicts with that of the health professionals such as nutritious diet and protected sex (6.2.1.2) (major theme 4)	Government and MoH should work towards integration of traditional healers into the formal health system Health professionals should interact more with traditional healers to gain knowledge of what they do and provide health education accordingly Sharing of selected knowledge between health professionals and	• Establish regular interaction between health professionals and traditional healers through seminars and a one-on-one basis • Traditional healers could be trained as community health workers to assist with health education and promotion	• Health professionals • Traditional healers • Community health workers

Findings	Recommendations	Guidelines for intervention	Persons responsible
	traditional healers should be encouraged.		
Family members and community members influence health seeking behaviours (5.4.4) (major theme 3)	Establish whether influences are positive or negative and negotiate either to encourage or discourage the influence (for example, elderly mothers who discourage their offspring from going to formal health services). This should be negotiated in order to encourage abandonment of the practice The good influences such as community health workers counselling people on the use of formal health care facilities should be preserved	• Work with community members and find out how much they are affected by the influence of family and other community members. Give them the relevant health education related to these influences and encourage them also to utilise formal health care	• Health professionals • Community health workers

In addition to the above recommendations and guidelines, implementation of Level 1 Health Care Strategy is included since it is meant to play a significant role in the health care of communities at the grass root level. Below is a brief discussion of the facility.

8.6.1 Level 1 health care facility

The National Health Sector Strategic Plan 11 (2005-2010:xi) emphasises that a wellness-based approach rather than disease-oriented approach is the main goal of the MoH. The focus of attention is health maintenance and promotion for all community members regardless of their status quo within their respective communities. Individuals, families and communities should as a result be empowered to plan and implement health care activities related to their identified needs and problems. Health systems should, therefore, expand beyond the bounds of hospitals, clinics, traditional public health facilities and consider all other avenues that contribute to people's health.

The Level 1 Health Care Facility is the lowest level with no structures (buildings) in place but it is very important for the community and health sector, nevertheless. More efforts are supposed to be directed at this level to minimise the overcrowding of the other levels (see table 1.4: Levels of health care facilities), especially hospitals which suffer from a lot of congestion resulting in patients sharing beds and sometimes sleeping on the floors (researcher's observation). It is believed that if promotive and preventive services were well delivered at this level, the health of the community members would improve, thus lessening the number of people going to the hospitals. More finances should be used at this level and less for curative services and purchasing of expensive technology for patient care, although this does not mean neglect of those patients who need expensive treatment.

 It is crucial to empower community members with adequate knowledge and skills to enable them to develop their own vision and mission of health care and community development. Ways and means should be found to implement suggestions given by the informants on community and health care improvement (major theme 4). Traditional healers are said to influence a large number of people and sometimes their advice conflicts with that given by health professionals such as telling their clients not to use condoms (see sub-category 6-2-3-2: health professionals). Health professionals

suggest that they be integrated into the health service so that all care givers speak in the same language. Traditional healers could be useful in giving health education messages as they are trusted by a large number of people who go to them for treatment. According to WHO (WHO 2002-2005), it is estimated that between 80 - 85% of the population of Sub-Saharan Africa receives its health education and health care from practitioners of traditional medicine. Likewise, in Kenya, the ratio of one medical doctor to patients is 1: 7142 patients whereas the traditional healer ratio is 1 to 987 patients. This is a good demonstration of how useful the traditional healers could be in giving health education to the community if they had the correct message to deliver.

NHSSP 11(2005-2010: x1) points out that the Level 1 Health Care Strategy calls for a wellness-based rather than disease-oriented approach so that the focus of attention is health maintenance and promotion for all community members regardless of their status quo within their respective communities. Consequently, if community development and improvement of health care have to take any significant steps, the Kenya government and Kenyan people should make a conscientious decision and effort on how best to allocate resources and formulate operational plans to provide for the health and well-being of all citizens regardless of their socio-economic status. This ideal coupled with the delivery of culturally congruent care would be the most suitable for the Piave community.

Transculturally prepared and competent health professionals are crucial in the decision-making process on culture-congruent care that works for different groups of communities in Kenya.

The researcher's recommendation after dissemination of the study results and suggestions on the way forward is that a representative number of people from the Piave community together with health professionals come together, discuss the major themes again and generate a final document for possible use in the formal and informal health care facilities. Since they are the end users of the health care, it is imperative that they be involved in the decision-making and action on the integrated care (formal and informal) that will provide culturally congruent care to the community. This will possibly lead to a new era of health care transformation that is inclusive of all regardless of their socio-economic and cultural orientation status.

The researcher is, however, aware that the research findings of this study may not be applicable to other settings but can, nevertheless, provide many facts for the health professionals to draw on in either adjusting the health care operational plans of the health care system or carrying out similar studies to attain the desired integrative health care of the respective communities in Kenya. The researcher's task is, therefore, to present her findings and suggestions on the way forward for using the theoretical modes of care. She will also be available for consultation and if need be, will join in some of the discussions.

8.6.2 Recommendations for further research

Generally, health professionals, educators and researchers need to be more and more involved in qualitative research methods if they want to get to the roots of the health and social problems afflicting communities in their respective environments. Through culture care studies, fundamental scientific and humanistic discipline knowledge offers different ways of knowing and delivering health care that works for individual communities. This goes beyond the current empirical and evidence-based knowledge to a new kind of therapeutic practice.

The following recommendations pertain to further research:

- By means of the ethnonursing research method, more in-depth studies could be undertaken to investigate the care practices derived from this study such as the use of witchdoctors, herbalists, divine healers and home remedies

- A study could be conducted on the impact of the community's influence on the health seeking behaviours of the community

- This study could be replicated in other communities in Kenya as the 42 different tribes living in various parts of the country have different health seeking practices as a result of their respective cultural beliefs

- Research studies on the medicinal effects and side effects of the different herbs used by the community and herbalists should be continued and accelerated

- In-depth research studies could be conducted on the Piave community's supernatural beliefs about diseases which according to them are caused by

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curses or witchcraft and for which they seek treatment from traditional healers. The knowledge generated from such studies might assist with the delivery of culturally congruent care

- A study could be conducted on the Piave community's utilisation of the available formal health care services to explore the interpersonal relationships between health professionals and community members with the aim of ensuring optimal utilisation

- The ways in which traditional healers treat their patients and the health education they give to them should be further investigated. The knowledge generated could be used to reinforce networking between health professionals and traditional healers and contribute towards establishing safe practices

8.7   SUMMARY

Conclusions, recommendations and guidelines have been offered based on the findings and major themes which emerged from the data. The contribution of the study and limitations were discussed.

The researcher is convinced that with this first study based on the ethnonursing research method in Kenya, many other health professionals will do similar studies in different parts of Kenya so as to devise culture congruent care that works for all 42 ethnic groups. The health professionals will probably also appreciate the importance of selecting qualitative study methods especially ethnonursing in studies related to the delivery of health care. This is because the health care of any given community is said to be culturally determined. It is hoped that such research studies will also contribute to implementing Level 1 health care facilities adequately for the benefit of the various communities in Kenya.

LIST OF REFERENCES

Abosede, OA. 1984. Self-medication: an important aspect of primary health care. *Social Science and Medicine* **19**:699-703.

Abuga, TO, Mutemi, W, Karisa, B, Ochola SA, Fegan, G & Marsh, V. 2007. *Kenya Medical Research Institute/Welcome Trust Centre for Geographic Medicine Research-Coast, Kilifi, Kenya.*

Ackerknecht, EH. 1971. On the collecting of data concerning primitive medicine. *American Anthropologist.* (**47**):427-432).

African Development indicators. 2007. *World Bank*

African health strategy. 2007-2015. Third session of the African Union Conference of Ministers of Health, Johannesburg, South Africa 9-13 April 2007.

Ahmed, SA, Chowdhury, M & Bhuiya, A. 2001. Gender, socio-economic development and health-seeking behaviour in Bangladesh. *Social Science and Medicine* **51(3):** 361-371.

Akerele, O. 1987. "The best of both worlds. Traditional medicine up to date". *Social Science and medicine,* **24 (2):**177-181.

Allender, JA and Spradley, BW. 2005. Community health nursing: promoting and protecting public health. 6th ed. Philadelphia: Lippincott & Wilkins.

Alma-Ata. 1978. International Conference of Primary Health Care. USSR. *Public Health Nursing*, **20(3):**6-12.

Ampofo, O & Johnson-Romould, FD. 1987. Traditional medicine and its role in the development of health services in Africa. Brazzaville: *World Health Organisation Regional Office for Africa.*

American Heritage Medical Dictionary. 2006. Houghton Mifflin Company.
The American Medical Student Association Newsletter. 2009. It takes more than medical school to make a physician: cultural competence in medicine. AMSA.
The Kikuyu people. From: http://www.org/Stories/kikuyuhistory.html (accessed 4th April 2008).

Andrews, MM & Boyles, JS. 2008.*Transcultural concepts in nursing care*. London: Lippincott Williams and Wilkins.

Anishnawbe Health Toronto. 2005. *Circle of care.*
From: http://www.aht.ca/circle-of-care (accessed 14/7/2007).

Annual Operational plan 2. 2006/7. Nairobi: Ministry of Health.

Ardell, DB. 1986. *High level wellness: an alternative to doctors, drugs, and disease.* Berkeley: Ten Speed Press.

Ardell. D. [s.a]. From: Living Well Center, University at Buffalo (accessed 6/7/2009).

Ashforth, A. 2001. *AIDS, witchcraft, and the problem of power in post-apartheid South Africa*. From: http://www.sss.ias.edu/publications/papers/paperten.pdf (accessed 27/3/2009).

Atkinson, P & Hammersley, M. 1994. *Ethnographic and participatory observation* in Denzen NK &, Lincoln YS (Eds). Handbook of qualitative research. Thousand Oaks: Sage.

Auer, C, Sarol, J, Tanner, M & Weiss, M. 2000. *Tropical medicine and international health,* **5(9):**648-656.

Babbie, E & Mouton, J. 2002. *The practice of social research*. South African edition. Cape Town: Oxford University Press.

Barry, SP, Diarra-Nama, AJ, Kirigia, JM, Bakeera, S, & Somanje, H. 2009. Monitoring and evaluation of health sector reform in the WHO African Region. Health Policies and Services Delivery Programme, Division of Health Systems and Services Development, WHO Regional Office for Africa, BP 06, Brazzaville, Congo.

Basavanthappa, BT, MK. 2008. *Community health*. Mumbai: Jaypee Brothers.

Benjamin, BJ & Spacek, S. 2001. Multicultural issues in health care. *Journal of multicultural nursing and health,* **7(3):**5.

Bernard, HR. 1995. *Research methods in anthropology. Qualitative and quantitative approaches*. 2nd ed.. California: AltaMira Press.

Bhatia, JC, Bharamvir, CS, & Timmappaya, A. 1975. Traditional healers and modern medicine. *Social Science and Medicine,* **9**:15-21.

Binder, RM [2008]. *Meaning of health*.
From: http://www.healthguidance.org/authors/666/Rudolph-M.-Binder (accessed 13/10/2009).

Booth, C. 2003. *Faith Healing – God's compassion, God's power, and God's sovereignty: is a Christian permitted to seek medical assistance and to use faith healing -- God's compassion, God's power, and God's sovereignty: Is a Christian permitted to seek medical assistance and to use medicine?*
From: http://the faithhealingfulword.org/faithhealing.html (accessed 19th Sept. 2007).

Brink, HI, 2003. *Fundamentals of research methodology for health care professional*. Cape Town: Juta.

Capasso, L. 1998. 5,300 years ago, the ice man used natural laxatives and antibiotics. *Lancet,* **352***:1864.*
From:
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&dub=pubmed&adopt=Abstract&list_uinds=9851424 (accessed 15th Sept. 2007).

Cavagnero, E. 2008. Health sector reforms in Argentina and the performance of the health financing system. Health Policy 2008 *(1): 88-99. Department of Health.*

Clark, CM. 1989. Louis Leakay as ethnographer: on the Southern Kikuyu before 1903. *Canadian Journal of African Studies*, Canadian Association of African Studies. From: http://pittsburg-pennsylvania..helium.com/topic/5023-university-of-pittisburg (accessed 6 Feb. 2010)

Collins English Dictionary [s.a[. From: http://www.collinslanguage.com (accesses 6/10/2008).

Corbin, J & Strauss, A. 2008. *Basics of qualitative research: grounded theory procedures and techniques.* London*:* Sage.

Coortis, J. 2004. Managing society's difference and diversity. *Nursing Standard* 18(14):33.

Creswell JW. 2009. Research design: q*ualitative, quantitative, and mixed methods.* 3r[d] ed. London: Sage.

Cronbach, LJ. 1975. Beyond the two disciplines of scientific psychology. *American Psychologist,* **30(2):**116-127.

Cronk, L. 2005. *From True Dorobo to Mukogodo Maasai: contested ethnicity in Kenya, Ethnology, University of Pittsburgh - the Commonwealth System of Higher Education.* From: http://pittsburg-pennsylvania..helium.com/topic/5023-university-of-pittisburg (accessed 6 Feb. 2010)

Daily Nation: April 27, 2007:1

DeMunck, VC and Sobo, EJ. 1998. *Using methods in the field. A practical introduction and casebook.* Walnut Greek: AltaMira Press.

Denzin, NK & Lincoln, YL (eds.) 2002. *Handbook of qualitative research.* Thousand Oaks, CA: Sage

De Vos, AS, Strydom, H, Fouche, CB. 2002. *In research at grassroots.* Pretoria: Van Schaik Publishers.

Dictionary.com. [s.a]. From: http://www.ardictionary.com/Curse/15881 (accessed 26/3/2009).

Dorin J. 2006. Herbal treatment. *Mt Sinai Journal of Medicine,* **73(2):**565-566. From:http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&dub=pubmed&adopt=Abstract&list_uinds=16685816 (accessed 15th Sept. 2007).

Dorland's Medical Dictionary for Health Consumers. 2007. Elsevier, Inc.

Durant, W. 1939. *The life of Greece.* New York: Simon and Schuster.

Eagan, MN. 2003. *Critical links: study findings and forum highlights on the use of community health workers and interpreters in Minnesota.* Blue Cross and Blue Shield of Minnesota Foundation.

Encarta World English Dictionary (North America).2009. Bloomsbury Publishers.

English M, Marsh V, Amukoye, E, Lowe, B, Murphy, S & Marsh, M. 1996. Chronic salicylate poisoning and severe Malaria. *Lancet*, **347**: 1736-1738.

Erlandson, DA, Harris, EL, Skipper, BL & Allen. SD.1993. *Doing naturalistic inquiry: a guide to methods*. London: Sage.

Esposito, N. 2001. From meaning to meaning: the influence of translation techniques on non-English focus group research. Qualitative health Research, **11 (4)**:568-579.

Evans, C & Lambert, H. 1997. Health seeking strategies and sexual health among female sex workers in urban India. Implications for research and service provision. *Social Science and Medicine,* **44**:1227-1235.

Fedder, DO, Chang, RJ, Curry, S, & Nichols G. 2003. The effectiveness of a community health worker outreach program on healthcare utilization of West Baltimore City Medicaid patients with diabetes, with or without hypertension. *Ethn Dis.* Winter, **13(1):**22-27.

Federal, Provincial and Territorial Advisory Committee on Population Health. 1994. *Distribution of wealth in Japan*. Canada.

Gachathi, M. 2007. Kikuyu botanical dictionary guide to plant names, uses and cultural values. Nairobi: Tropical Botany.

Geissler, PW, Nakes, K, Prince, RJ, Odhiambo, RA, Aagaard-Hassen, J & Ouma, JH. 2000. Children and medicines: self-treatment of common illnesses among Luo schoolchildren in Western Kenya. *Danish Bilharziasis Laboratory, Charlottenlund.*

George, JB. 2002. *Nursing theories: The base for professional nursing practice.* 5th ed. New Jersey: Prentice Hall.

Giacomini, MK, Cook, DJ. 2000. Users' guides to the medical literature: XXIII. Qualitative research in health care. Are the results of the study valid? *JAMA,* **284**:357-362.

Gilson, L & Mills, A. 1995. Health sector reforms in sub-Saharan Africa: lessons of the last 10 years. Health Policy, (**1-3**):215-243. *Health Policy Unit,* London School of Hygiene and Tropical Medicine, UK.

Government of Kenya. 2005. *Human resource mapping and verification exercise.*

Grbich, C. 2007. *Qualitative data analysis: an introduction.* London: Sage Publications.

Hardiman, RB. 1993. Teachers' experience of their role following implications of project 2000. Qualitative approach. *Journal of Advanced Nursing,* **18**:1023-1037.

Health System Resource Guide [s.a]. From:
http://www.eldis.org/healthsystems/userfees/background.htm (accessed 6/4/2007).

Helman, CG. 2000. *Culture, health and illness.* New York: Oxford University Press.

Hjelm K. 2003. Nurses' experience of problematic situation with immigrant's emergency of care in Sweden. *Clinical Effectiveness in Nursing,* **7(2):**84-93.

House, JS & Kahn, RL.1985. Measure and concepts of social change in Cohen, S & Syme, SL (eds*) Social Support and Health*. Orlando: Academic Press.

International Network for Rational Use of Drugs. 2005. *Nepal 18th national training course on rational use of drugs*. <u>In</u> *Training Manual*. Kathmandu

IRN/PlusNews. 2008. *HIV/A/AIDS awareness efforts face difficulties in Northern Kenya, health workers, advocates say*.

Jimba M, Poudyal AK, Wakai S. 2003. The need for linking healthcare-seeking behavior and health policy in rural Nepal. Southeast Asian J Trop Med Public Health, 34(2):462-3.

Kamatenesi-Mugisha, M & Oryem-Origa, H. 2007. Medicinal plants used to induce labour during childbirth in western Uganda. *Journal of ethnopharmacology,* (**109**):1-9.

Kenya Demographic and Health Survey. 2003. Nairobi: *Central Bureau of Statistics.*

Kenya Demographic Health Framework. 1994-2010. Nairobi: Government printers.

Kenyatta, J. 1965. *Facing Mt Kenya with an introduction from B. Malinowski*. New York: Vintage Book Edition.

Kimathi, D. [s.a]. From: http://www.amren.com (accessed 4th March 2008).

Kikuyu images. [s.a.]. From: http//:www.bluegecko.com (accessed 10th Nov. 2008).

King, I. 1989. *King's general systems framework and theory*. In Riehl-Sisca, J (ed.), *Conceptual modes for nursing practice.* 3rd ed. Norwalk: Appleton and Lange.

Kirkland, J, Mathews, F, Sullivan, CW, & Baldin, K. 1977. *Herbal and magical medicine: traditional healing*. London: Duke University Press.

Kroeger, A. 1983. Anthropological and socio-medical health care research in developing countries. *Social Science & Medicine,* **17**:147-161.

Kreuger, RA. 1988. Focus groups: *A practical guide for applied research*. London: Sage.

Labonte, R.1997. Community development and the forming of authentic partnership: some critical reflections. <u>In</u> Minikler, M (ed) *Community organising and community building for health*. Piscataway, NJ: Rutgers University Press.

Lai, PK & Rov, J. 2006. Antimicrobial and chemopreventive properties of herbs and spices. *Curr Med Chem*. 1451-1460. From:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&dub=pubmed&adopt=Abstract&list_uinds=15180577 (accessed 14th Sept. 2997).

Lancaster, J, & Stanhope, M. 2004. *Community and public health nursing.* 4th ed. St Louis: Mosby.

Leakay LSM. 1977. *The Southern Kikuyu before 1903.* London: Oxford Press.

Leininger, M & McFarland, MR. 2002.*Transcultural nursing. Concepts, theories, research & practice.* 3rd ed. New York: McGraw-Hill.

Leininger, M. 2001. *Culture care diversity and universality: a theory of nursing.* London: Jones and Bartlett Publishers.

Leininger, M. 1991. (ed). *Culture care diversity and universality: a theory of nursing.* New York: McGraw-Hill.

Liamputtong, P & Ezzy, D. 2005. *Qualitative research methods.* 2nd ed. New York: Oxford University Press.

Liefooghe, R, Baliddawa, JB, Kipruto, EM, Vermeire, C & De Munynck, OA. 1997. From their own perspective. A Kenyan community's perception of tuberculosis. *Tropical Medicine International Health,* **2 (8):**809.

Lietava, JJ.1992. Medicinal plants in a poleolithic grave Shanidar IV? *Malar J*, **(6)**:106.

Lincoln, YS. and Guba, EG. 1985. *Naturalistic inquiry.* Newburg Park, CA: Sage.

Love, MB, Legion, V, Shim, JK, Tsai, C, Quijano, V, Davis, C. 2004. CHWs get a 10-year history of the first college-credit certificate for community health workers in the United States. *Health Promot Pact,* **5(4)**:418-428

Lundberg, PC. 1999. Meaning and practices of health among married Thai immigrant women in Sweden. *Journal of Transcultural Nursing,* **10 (10)**:32.

Lyons, M, Orozovi, N, Davis, J, Newman, J. 2000. Doing-being-becoming: occupational experience of persons with life-threatening illness. *American Journal of Occupational Health,* **56**:285-295.

Maggs-Rapport, F. 2000. Combining methodological approaches in research, ethnography and interpretive phenomenology. *Journal of Advanced Nursing,* **3(1)**:219-225.

Malik, EM, Hanafi, K, Ali, SH, Salim, A, & Mohamed, KA. 2006. Treatment-seeking behaviour for malaria in children under five years of age: implication for home management in rural areas with high seasonal transmission in Sudan *Malaria Journal,* **(5)**:60.

Mangum, BP. [s.a.]. *Village volunteers. Guide to working with traditional healers*. From: http://www.villagevolunteers.org/PDFs/Travel%20Documents/Projects%20Library/Traditional%20Healers.pdf?PHPSESSID=af9c0e7b8b8580b4201100434792847f (accessed 14/7/2009).

Marshall, C & Rossman, GB. 2006. *Designing qualitative research.* Newbury Park, CA: Sage.

Maxwell, J. 1997*. Designing a qualitative study*. In Bickman, L & Rog, D J (eds.) *Handbook of applied social research methods*. Thousand Oaks, CA: Sage.

Mbagaya, GM, Odhiambo, MO, & Oniang'o, RK. 2005. Mothers' health seeking behaviour during child illness in a rural western Kenya community. *Afr Health Sci.* **5(4)**:322–327.

Mbithi, JS. 1990. *African religions and philosophy*. London: Heinemann.

Mechanic, D. 1968. *Medical sociology: a selective view*. New York: Free Press.

Merriam Webster medical Dictionary. 2009. Sv "*Self treatment*" From: http://www.merriam-webster.com/medical/self-treatment (accessed 26/2/2009).

Mesfin, MM, Newell, JN, Walley, JD, Gessessew, A & Madeley, RJ. 2009. Delayed consultation among pulmonary tuberculosis patients: a cross sectional study of 10 DOTS districts of Ethiopia. *BMC Public Health,* (**9)**:53.

Miles, MB & Huberman, AM. 1994. *Qualitative data analysis*. London: Sage.

Miles, SH & Ololo, H. 2003.Traditional surgeons in sub-Saharan Africa: images from South Sudan. *International Journal of STD and AIDS,* **14(8)**:505-508. Royal Society of Medicine Press*.*

Miller, T, Velleman, R, Rigby, K, Orford, Tod, A, Copello and Bennett, G. 1997. The use of vignettes in the analysis of interview data: Relatives of people with drug problems. In N Hayes (Ed.), *Doing qualitative analysis in Psychology* (pp201-225). UK. Psychology Press.

National Health Strategic Sector Plan1 (NHSSP 1). 1999-2004. Nairobi: Health Sector Secretariat.

National Health Strategic Sector Plan11 (NHSSP 11). 2005-2010. R*eversing the Trend.* Nairobi: Health Sector Secretariat.

Ministry of Health (MoH). 2006. *Taking the Kenya essential package for health to the community: a strategy for the delivery of LEVEL ONE SERVICES*. Nairobi: Afya House.

Molyneux, CS, Mung'ala-Odero, V, Harphan, T. & Snow, RW. 1999. *Maternal responses to childhood: a comparison of rural and urban residents in coastal Kenya.* Kenya Research Institute (KEMRI) Welcome Trust Centre for Geographical Medicine Research, Kilifi, Kenya.

Morgan, DL. 1997. *Focus group as qualitative research*. Thousand Oaks, CA: Sage Publications.

Morse, JM and Field, PA. 1999. *Qualitative research methods*. Thousand oaks: CA Publications.

Mosby's Medical Dictionary, 8th ed. 2009. Elsevier.

Mount Kenya. [s.a]. From: http://www.wildherps.com (accessed 4th April 2008).

Mouton. J & Marais, HC. 1994. *Basic concepts in the methodology and social science*. Pretoria: HSRC Publisher

Mzee Jomo Kenyatta, 1st President of the Republic of Kenya. [s.a]. From: www.statehousekenya.go.ke...profile.htm (accessed 3rd May 2008).

National Development Plan. 1997-2001. Republic of Kenya: Government Printers.

National Human Services Assembly. 2006. Closing gaps in families' health resources. Families' Strengthening Policy Center. An initiative of National Human Service Assembly, *policy* brief 13. From: http://www.nydic.org/fspc/practice/documents/Brief13.pdf (accessed 14 July 2009). Nazzar A, Adongo PB, Binka FN, Phillips JF, Debpuur C.2006. Developing a culturally appropriate family planning programme for the Navrongo experiment. Stud Fam Plann ;26:307-24.

Neuman WL. 2006. *Social research methods. Qualitative and quantitative approaches.* London: Pearson.

Neumark, Y, Palti. H, Donchin, M, Ellencweig, AY. 1992. *Utilization of pediatric health services in Jerusalem. J Community Health* 17(5)**:**271-82.

Ngo, AD, Ratliff, EA, McCurdy, SA, Ross, MW, Markham, C & Pham, HT. 2007. Health-seeking behaviour for sexually transmitted infections and HIV testing among female sex workers in Vietnam. *AIDS Care,* **(7)**: 878-887.

Ngulube, MJ. 1989. Some aspects of growing up in Zambia, Lusaka: Nalinga *Consultancy/Sol-Consult A/S Ltd.*

Njoro. [s.a.]. From: http://en.wikipedia.org/wiki/Njoro (accessed May 2007).

Njoroge NG & Bushmann RN. 2007. Management of skin diseases among Kikuyus of Central province. *Journal of Ethnopharmacology,* **(111)**:303-307.

Ntloedibe-Kuswani,GS. [s.a] witchcraft: a challenge to Botswana ideas of community and relationships. University of Botswana.

Nunan, M. 2004. *Traditional healing and modern medicine join forces in Kenya*. From: http://www.voanews.com/english/archive/2004-06/a-2004-06-18-17-1.cfm?moddate=2004-06-18 (accessed 24/10/2009).

Nyamongo, IK. 2002. Health care switching behaviour of malaria patients in a Kenya rural community. *Social Science and Medicine*, **54**:377-386.

Niraula, BB.1994. Use of health services in hill villages in Central Nepal. *Health Transit Rev*, **4(2)**:151-66.

Onwuegbuzie, AJ & Dickson, WB. 2008. Mixed modes methods and analysis and integration visualization: graphic display for effective communication of research results. *The Qualitative Report*, **13(2)**:204-225.

Overdose or drug reaction. [s.a.]. From: http://en.wikipedia.org/wiki/Cytochrome_P450 (accessed 3rd Oct. 2007).

Oxford Dictionary.1989. From: http://en.wikipedia/Oxford_English_Dictionary (accessed 12/8/2009).

Parahoo, K. 2006. *Nursing research. principles, process and issues*. 2nd ed. New York: Palgrave Macmillan.

Parrinder, G. 1963. *Witchcraft: European and African*. New York: Barnes and Noble Inc.

Parsons, C. 1989. *Notes on Maori sickness knowledge and healing practices in South Pacific*. Honolulu Institute for Polynesian Studies. Young University.

Patton, MQ. 2002. *Qualitative research and evaluation methods*. 3rd ed. London: Sage.

Peattie, PI & Walker, S. 1995. *Perception of illness*. Edinburgh: Princeton University Press.

Person, B, Addiss, DG, Bartholomew, LK, Meijer, C, Pou, V & Van den Borne B. [s.a.]. *Health-seeking behaviours and self-care practices of Dominican women with lymphoedema of the leg: implications for lymphoedema management programs*. From: http://www.filariajournal.com/content/5/1/13 (accessed 27/2/2009).

Pillai, RK, Williams, SV, Glick, HA, Polsky, D, Berlin, JA, Lowe, RA. 2003. Factors affecting decisions to seek treatment for sick children in Kerala, India. *Soc Sci Med,* 57**(5)**:783-90.

Pillsbury, BLK. 1979. Reaching the rural poor: indigenous health practitioners are there already. *Aid programme evaluation discussion paper No1.* Washington DC: USAID.

Polit, DF & Hungler, BP. 1999. *Nursing research principles and methods*. 5th ed. Philadelphia: J.B. Lippincott Company.

Polit, DF & Beck, CT. 2008. *Nursing research: principles and methods*. 8th ed. Philadelphia: Lippincott Williams & Wilkins.

Prinsloo, ED. 2001. *A comparison between medicine from an African (Ubuntu) and Western philosophy.* UNISA Research Unit for African Philosophy, Department of Philosophy.

Rea, BD. 2001.*Psychotherapy,* **38 (1)**:97-106.

Rice, PL & Ezzy, D. 2001. *Qualitative research methods. A health focus*. Nairobi: Oxford University Press.

Richmond, VA. 2005. *Interim report on the status, and utilization of community health workers.* Commonwealth of Virginia; Virginia Center for Health Outreach.

Rosenthal, E, Wiggins, N, Brownstein, J, Johnson, S, Borbon, I, Rael, R. 1998. *A summary of the National Community Health Advisor Study. Reprinted 11/00.* Phoenix, AZ: University of Arizona.

Rossman, GB & Rallis, SF. 2006. *Learning in the field: an introduction to qualitative research.* Thousand oaks, CA: Sage.

Rothman, RB. 1976. *Inequality and stratification in race, class and gender.* New York: Prentice Hall.

Rubin, HJ & Rubin, IS. 1995. *Qualitative interviewing, the art of hearing data.* Thousand Oaks: Sage.

Ruebush, TK, Kern, Mk, Campbell, CC & Aloo AJ. 1999. Self-treatment of malaria in a rural area of Western Kenya. Division of Parasitic Diseases (F-22). Centers for Disease Control and Prevention (CDC)*, Chamblee, GA 30341-3724, USA.*

Ruth B. 1983. *The passion for occult in the nineteenth and twentieth centuries.* New York: From: http://en.wikipedia.org/wiki/Alfred_A_Knop (accessed 15th Sept. 2007).

Ryan, G.W.1998. What do sequential behavioural patterns suggest about the medical decision-making process?: modelling home case management of acute illnesses in a rural Cameroonian village. *Social Science & Medicine,* **46(2**):209-225.

Sahn, DE, Younger, SD & Genicot, G. 2003. The demand for health care services in rural Tanzania. *Oxford Bulletin of Economics and Statistics,* **65(2)**: 241-259.

Salaniponi, FML, Harries, AD, Banda, HT, Kagombe, C, Mphasa, N, Mwale, A, Upini, B, Nyrinda, TE, Banerjee, A & Boeree, MJ. 2001. *Care seeking behaviour and diagnostic processes in patients with smear positive pulmonary tuberculosis in Malawi*, National Tuberculosis Programme, Community Health Science Unit, Department of Medicine, College of Medicine Chichiri, Blantyre, Malawi.

Schensul, SL, Schensul, JJ & LeCompte, MD. 1999. *Essential ethnographic methods: observations, interviews, and questionnaires.* Walnut Creek, CA: AltaMira Press.

Schott, J & Henley, A. 1999. *Religion and childbearing in a multiracial society. A handbook for health professionals.* Boston: Butterworth/Heinemann.

Searles, C [s.a] *Towards sustainable development in Kenya: education of the family.* From:http://www.worldfoodprize.org/assets/YouthInstitute/06proceedings/DallasCenter GrimesHS.pdf (accessed 7/2/2009).

Sekwat, A. 2003: Health financing reform in Sub-Sahara Africa: major constraints, goals and strategies. *J Health Care Finance,* **(3)**: 67-78. Institute of Government, Tennessee State University, USA.

Seshagirirao, K. 2007. *Herbalism.* University of Hyderabad India. From: http://en.wikipedia,org/wiki/Herbalism_ref-0 (accessed 15th Sept. 2007).

Skordis-Worall,, J, Mills, A, Pollit, V & Hanson, K. 2007. *The role of gender in health seeking behaviour and expenditure in Cape Town South Africa.* From: http://www.hefp.lshtm.ac.uk/publications/downloads/briefing_notes/jsw-tb_note_3.pdf (accessed 27/2/2009).

SIL International. 2010. Community work From: http://www.sil.org/anthro/communitywork.htm (accessed 14/6/2010).

Sindiga, I, Nyaigoti-Chacha, C & Kanunah, MP (eds). 1995. *Traditional medicine in Africa*. Nairobi: East African Educational Publishers Ltd.

Smeltzer, SC & Bare, BG. 2004. *Brunner & Siddhartha's textbook of medical-surgical nursing*. Philadelphia: Lippincott Williams & Wilkins.

Streubert, HS & Carpenter, DR. 2009. *Qualitative research in nursing. Advancing the humanistic imperative.* 3rd Edition. London. Lippincott.

Spradley, JP. 1980. *The ethnographic interview*. New York: Holt, Rinehart & Winston.

Srinivas, MN.1993. *Decentralized health care. A sociologist view*. In Antia, NH & Mbatia, K (eds). People's health in people's hands. A model for Panchayati Raj. Bombay: The Foundation in Community Health.

Stanhope, M & Lancaster, J. 2004. *Public health nursing. population centered care in the community*. 7th ed.. St Louis: Mosby.

Stephenson, R, Baschieri, A, Clements, S, Hennink, M, and Madise, N. 2006. Contextual influences on the use of health facilities for childbirth in Africa. *AM J Public Health, 96(1):84-93.*

Steen, TW & Mazonde, GN. 1999. Pulmonary tuberculosis in Kweneng District, Botswana: delays in diagnosis in 121 smear-positive patients. *International Journal of Tuberculosis and lung disease,* **2**:627-634.

Strauss, A, & Corbin, J. 1998. *Basics of qualitative research: techniques and procedures for developing grounded theory*. 2nd ed. Thousand Oaks, CA: Sage.

Sumba, PO, Wong, SL, Kanzaria, HK, Johnson, KA & John, CC. 2008. Malaria treatment-seeking behaviour and recovery from malaria in a highland area of Kenya. *Malaria Journal* 2008, **(7)**:245.

Swider, SM. 2002. Outcome effectiveness of community health workers: an integrative literature review. *Public Health Nursing,* **19(1)**:11-20.

Tabuti, JRS. 2008. Herbal medicines used in the treatment of malaria in Budiope County, Uganda. *Journal of Ethnopharmacology,* **(116)**: 33-42.

Taylor, SJ & Bogan, R. 1998. *Introduction to qualitative research methods. A guidebook and resource.* 3rd ed.. New York: John Wiley and Sons.

Tjale, AA. 2004. *Historical perspective* In Tjale, AA & De Villiers (eds): Cultural issues in health and health care. Cape Town: Juta.

Traditional birth attendant. 2009. From: http://en.wikipedia.org/wiki/Traditional_birth_attendant (accessed 10 Sept 2007).

Traditional medicine [s.a].From: http://en.wikipedia.org/wiki/Witch_doctor_%28traditional_medicine%29 (accessed 10 August 2007).

UNDP and the MDGs. 2009. From: http://www.undp.org/mdg/ (accessed 14/10/2009).

UN Millennium Development Goals. 1989. From: http://www.un.prg/millenn.umgoals/. (accessed 12/4/2007).

Uys, HHM. and Bason, AA. 2000. *Research methodology in nursing.* Pretoria: kagiso

Walker, D, Muyinda, H, Foster, S, Kengeya-Kayondo, J & Whitworth, J. 2001. Quality of care by private practitioners for sexually transmitted diseases in Uganda. *Health Policy and Planning,* **16(1)**:35-40. Oxford University Press.

Weiner, BJ & Alexander, JA. 1998. *The challenges of government private partnership. Healthcare Management Review Spring Institute of Medicine* (IOM).   The future of public health. Washington D.C: National Academy Press.

Weitzman, EA & Miles, MB. 1995. *Computer programmes for qualitative data analysis.* Thousand Oaks. CA: Sage.

Weller, SC, Ruebush, TR & Klein, RE. 1997. Predicting treatment-seeking behaviours in Guatemala: a comparison of health services research and decision-theoretical approaches. *Medical Anthropology Quarterly,* **11(2)**:43-67.

Wengraf, T. 2001. *Qualitative research interviewing: biographic narrative and semi-structured methods.* London: Sage.

WHO. 2000-2005. Traditional medicine strategy. Geneva: World Health Organization

WHO. 2002. *Community home-based care in resource-limited setting: a framework for action.* Geneva: World Health Organization.

WHO Report. 2001. *Legal status of traditional medicine Complementary/Alternative Medicine:* A World Review.

WHO. 1974. Community health nursing: report of a WHO Expert Committee, *Tech Rep Series* No. 588, Geneva: WHO.

WHO.1989. Strengthening the performance of community health workers in primary health care. *Report of a WHO Study Group*. Geneva: World Health Organisation WHO Technical Group Report Series No 780.

WHO. 1958. *The World Health Organization: a report on the first ten years*. Geneva, Switzerland.

Wilkinson, RG. 1996. *Unhealthy societies*. New York: Routledge.

Wisner, B. 1976. Health and geography of wholeness. In *Contemporary Africa: Geography and change* C.G. Knight and J.L. Newman (eds). Eaglewood Cliffs: Prentice Hall: 81-100.

Witch-Lovespell. 2006. *Hex/curse removal spellsex/Curse Removal Spells*. From: Pagan/Wiccan Religion (accessed 3 March 2009).

Yoder, PS.1997. *Negotiating relevance: belief, knowledge and practice in international health projects. Medical Anthropology Quarterly,* **11(2):**131-146.

Young, A, Taylor, SB & MacLaughlin-Renpinning, K. 2001*. Connections. Nursing research and practice*. St Louis: Mosby.

YourDictionary:[s.a.]. Sv "*hygiene*" From: http://www.yourdictionary.com/hygiene (accessed 21/2/09).

Yronwode, C. 2004. *Help!Spell, to remove a curse from someone*. From Pagan/Wiccan Religion (accessed 3 March 2009).

Zacharia, R, Nkhoma, W, Harries, A D, Arend, V, Chantulo, A, Spielmann, MP, Mbereko, MP & Buhendwa, L. 2002. *Health seeking and sexual behaviour in patients with sexually transmitted infections: the importance of traditional healers,* In Thyolo, Malawi.

ANNEXURE A

Request for permission to conduct the study

Permission granted to conduct research

ANNEXURE B

Samples of informants' consent forms for interviews

ANNEXURE C

Samples of interview guides

ANNEXURE D

Samples of interview proceedings

ANNEXURE E

The nodes representing initial categories and sub-categories that emerged from Piave's key and general informants' data

ANNEXURE F

Samples of field notes

DIFFERENT INTERVIEW GUIDES USED FOR THE INFORMANTS

1. **Key informants and general informants/focus groups**

2. **Health professionals**

3. **Traditional healers**

1. KEY AND GENERAL INFORMANTS/FOCUS GROUP (SAME INTERVIEW GUIDE)

An in-depth interview guide was used for interviewing key and general

informants/focus groups in lived experiences of their self-care health

seeking behaviours and was as follows:

1. Tell me how you view healthy/being health/wellness?

Probing question:

➤ When is a person considered health?

2. Tell me how you view illness?

Probing question:

➤ When is a person considered to be ill?

3. Tell me how you view being sick?

4. What in your opinion are the causes of ill health?

5. How many diseases do you know that affect people here in Piave?

6. What do people do when sick?

7. What do you do to maintain good health?

- You and your family and community at large

Probing question:

> What medical strategies do you carry out to prevent and maintain good health?

8. (i) How does your family influence self-care health seeking behaviours?

   (ii) How does your community influence self-care health seeking behaviours?

9. For which illness would you not seek formal or Western medicine/treatment such as going   to the clinic/hospital and why?

   Probing questions:

> Would you be willing to reconsider seeking formal treatment?

> If yes, for which illness (s)?

10. What type of assistance would you welcome from doctors/nurses?

11. How are the sick cared for in this community?

12. How are the sick cared for in your family?

13. How does your community take care of one another socially?

14. Are there any social groups within your community?

> List them if any and tell me what their objectives are

15. What are your suggestions in striving to make this community health?

END

2.

2. INTERVIEW GUIDE FOR THE HEALTH PROFESSIONALS

1. What are the most common illnesses around here?

2. Approximately how many patients do you see in a day?

Probing question:

➢ At what stage of illness do they come to the clinic?

3. Those who do not come to the clinic immediately, do they give any reasons?

4. What would you say is the community's self-care health seeking behaviours?

5. Are you aware of any traditional healers in this community?

Probing questions:

➢ If there are, do they speak openly about their delivery of health care to the sick?

➢ Do you or your colleagues try to find out what they do?

➢ Are they willing to share information on how they manage patients openly and what type of patients they see?

6. Are there any drug vendors in this community?

Probing questions:

➢ If yes, are you aware of the kinds of drugs they sell?

➢ Do they do it in the open?

➢ Where do you think they get their drugs?

7. How would you term the interpersonal relationship between you and the community in this place?

Probing questions:

➢ If good, what is makes it good?
➢ If bad, please give some suggestions why you think so?

8. How can you ensure community members utelise your services more effectively for holistic care?

9. The current health care reforms emphasis on level 1 health care facility as wellness paradigm rather than curative and that community members participate in devising their vision of care and participating in it. The health care also is supposed to follow right based approach to care.

Probing question:

➢ How much of this is being implemented?

10. Would you incorporate traditional healers into the health care system?

11. Any suggestions on the way forward in relation to improving community care?

Probing question:

➢ Are there any strategies in place to incorporate traditional healers in the health care system?

END

3. INTERVIEW GUIDE FOR THE TRADITIONAL HEALERS

1. For what type of treatment do people come to you for?

2. How did you acquire this knowledge and skills to be able to treat the sick people?

3. Do people come to seek health care from you?

Probing question:

 ➢ If yes, approximately how many patients do you get in a month and what categories? (mothers, children, men, elderly etc)

4. How do people regard you in terms of cure?

Probing questions:

 ➢ Do they prefer to come to you instead of going to the formal health facilities?

 ➢ If yes, why?

 ➢ To what extent do you have to do things for patients in comparison to letting people do things for themselves?

 ➢ How are people involved in their treatment?

5. To what extent do you give people health education in order to prevent or promote health?

6. Do you think you are regarded as a health care professional?

Probing questions:

 ➢ If yes, by whom?

> ➢ If yes, why?

> ➢ If no, why?

7. Do you think it is necessary for your services to be regarded as part of the health care system?

Probing questions:

> ➢ If yes, why so?

> ➢ If no, why so?

> ➢

8. Do the health professionals accept your practice?

9. Do you think you need to be trained in a health care institution to gain more knowledge?

10. Do you refer any diseases to the health care facilities?

Probing question:

> ➢ If yes, which ones and at what stage

11. Can you openly show health professionals how you operate?

12. How best can you work as a team with other health professionals?

13. Give some comments regarding the importance of your work?

Probing question

> ➢ Do you work together with drug vendors/herbalists/divine healers/Western medicine people?

END

Public Health Nurse: Nakuru District Hospital

Interviewed the Public Health Nurse in Charge of Nakuru Province.

Interview date: 12th Sept. 1007

Interviewer: Since you have been working in Njoro, what are some of the common diseases that you have come across?

Interviewee: May be you have been on the ground and you may have seen something different but around those areas we have skin condition, malaria, poor infestation is another. When you look at Piave area, water is an issue and availability of the health facilities otherwise people used to come to Nakuru or go to Njoro. Water borne diseases are mainly in that area. But now I think things will improve since we have dug a borehole which is going to serve a bigger area around Piave. They use water from Ndaragwa River. We were trying to introduce water treatment in sachets.

Interviewer: Do you know whether they are using the treatment?

Interviewee: Some, not all. In Piave they have not really started.

Interviewer: Do you know whether community members go to hospital immediately when sick or they use other forms of treatment first?

Interviewee: Most of them treat themselves or buy drugs over the counter.

Interviewer: So they don't go to hospital immediately?

Interviewee: There are those who will go immediately.

Interviewer: Are you aware of any herbalist, traditional healers or witchdoctors in Piave or Nakuru District as a whole?

Interviewee: We have these people who go round selling herbal drugs to people. Some people are used to them. You go to the slums and you find these herbalists there and people are using them.

Interviewer: What else would you say are their self-care health seeking behaviours before they come to hospital?

Interviewee: By the time they come to the hospital they have tried to treat themselves.

Interviewer: Even treating the children?

Interviewee: Yes, but we are trying to talk to them.

Interviewer: Are there illnesses they consult doctors and others traditional healers?

Interviewee: I may not know really but we have an experience with the Traditional Birth Attendants (TBAs). They first try to conduct deliveries at home and when they fail they send mothers to a hospital. We have been getting many cases especially around Mauche Division; it is even worse.

Interviewer: What about from Njoro Division?

Interviewee: When we got a Maternity in Njoro Health Center, many mothers started going there because they find an improved facility and the nurses are willing to assist them.

Interviewer: How about Piave? Njoro is a bit far.

Interviewee: It's a bit far so they would rather go to the TBAs or else those who are able they come here (meaning Nakuru District Hospital. However, means of transport from that place is not easy.

Interviewer: Are the TBAs trained or most of them are without any form of training?

Interviewee: They are not trained, they are traditional birth attendants.

Interviewer: Do you try to find what the informal health care providers do such as traditional healers?

Interviewee: I have never engaged in them.

Interviewer: And normally nurses have not really tried because I have found in Njoro Health Center they don't talk to them.

Interviewee: Actually time for talking to them is not there because of the workload also. It is not like our time when we used to go to the community, meet them and discuss with them. This time we are just around the hospital because you are either two or you are the only one who has reported so you have to rush with time to finish what you have to do. We have no time to go to the community.

Interviewer: Do we have drug vendors here?

Interviewee: Kisumu bus stops yes, but Nakuru bus stop none. I have never seen any. But the chemists have been put left right and people buy over-the-counter drugs from them.

Interviewer: But do they sell antibiotics and other drugs without prescription?

Interviewee: Some do.

Interviewer: How would you say the interpersonal relationship between health care providers and the community is?

Interviewee: The attitude, some say they are harsh but it depends with the individuals.

Interviewer: So the community will not hesitate to go the health centre because of the attitude?

Interviewee: These days, people talk and they will say when they are harassed. The health workers know if they mishandle the community they will not be entertained.

Interviewer: What plans do you have for more utilisation of health facilities?

Interviewee: You know with the community strategy, we are moving the health services to Level 1 health care facility, so we want the community health workers to give health care to the community who are in need and those who are sick to be referred to the health facilities. We are going to use the community health workers to make sure that every person within the community utilises the facility.

Interviewer: How about for preventive and promotive services?

Interviewee: All those we want to use community strategy to reach the common citizen on preventive and promotive services and even curative. For curative services, we are going to use the linkage type of system whereby the treatment for minor ailment will link up with the health facility.

Interviewer: What kind of preventive and promotive services are you planning to do?

Interviewee: Promotive will have to use the health education, preventive we have the water treatment and this one we have already started in Piave within Ndaragwa River. We are then planning to come to the facility for immunization, and care of ante-natal mothers.

Interviewer: you are going to start implementing?

Interviewee: We have started with Piave so we want to roll it out to others.

Interviewer: Are there any plans to incorporate the traditional healers within the health care delivery systems?

Interviewee: We have to because we have to talk the same language as they should not sit there and tell people not to use condoms. You know they talk about very bad things.

Interviewer: What do they say?

Interviewee: They talk badly about family planning to the common citizen. They brainwash the people. So if we don't in incorporate them, we will not be able to penetrate our people.

Interviewer: How are you going to incorporate them?

Interviewee: By bringing them closer so that we understand those herbs they are trying to sell to people, what are they made and what they are treating.

So may be we talk to them the way the government is working.

A child is having diarrhoea and is given diarrhoea medicine to flush out malaria and then people end up dying.

Interviewer: Is that common?

Interviewee: Here in Nakuru Town, I don't know what they do, but the best thing is to talk to those people so that we find out what they are doing. When you health educate them, they will know what the Ministry is looking for.

Interviewer:

Will you incorporate them as health workers?

Interviewee: We have planned to have them be brought in.

End

A key informant

Age: 45 years old woman while the husband is about 64 years old

Marital status: married with 4 children with their ages ranging from 24-29 years

Educational status: Standard 7

Period of stay in Piave: has lived in Piave for 27 years

Interview date: 5th Sept. 2007

Interviewer: As I have told you, I want to know how people live and how they take care of themselves when they become sick. Please tell me, when you say you are healthy or somebody says that he/she is healthy, how is that person likely to be?

Interviewee: When one is healthy, one feels he or she is strong and no body aches. You feel you are able to work and eat well and even the parts of the body operate well. When one is unhealthy, you feel you can't work, you get headache and tiredness of the whole body then you know that you are not feeling well but when you are feeling well your work goes on well; things go on well.

Interviewer: Okay, so things go on well?

Interviewee: Yes.

Interviewer: When you are saying your things go on well, what kind of things are you talking about?

Interviewee: Like in the morning you are able to wake up because when you are not feeling well you cannot wake up. When you wake up, you are able to do your work, you can go to the farm, milking, cooking for the children and looking after your family.

Interviewer: So you are looking after your family?

Interviewee: Yes, that's when you are well.

Interviewer: So when you are sick you cannot do a lot of work?

Interviewee: No, you can't because for one, you are unable to wake up in the morning. If it's cooking you cannot cook.

Interviewer: Let me ask you, if someone says he or she is sick, what makes her think so?

Interviewee: You can be feeling weak in the body, may be the body is not in pain but I am not my usual self. You are not even happy; you will feel the body has a problem because you are not usually like that.

Interviewer: Is common cold a disease?

Interviewee: Yes, common cold is a disease. If you have a cold, you can be very sick and unable to leave the house, you can also sneeze until the eyes cannot see nor have nose blockage. You are unable to do anything even cooking is a problem because the smoke makes it worse. It is a disease.

Interviewer: How many diseases do you know that affect people here?

Interviewee: Common cold, malaria, typhoid, mostly people here are suffering from asthma, TB and headache, Joint-aches and diseases like stomach-aches, back-ache and bleeding in women.

Interviewer: Bleeding?

Interviewee: Yes, bleeding and swollen legs in women.

Interviewer: What causes swollen legs?

Interviewee: Kidney problems or blood in the uterus that gets held there. also family planning.

Interviewer: Do men get swollen legs?

Interviewee: Yes they do. But it's worse in women. You see them with swollen legs. A disease like HIV is a lot here nowadays, many women have diabetics and even ulcers are common.

Interviewer: Do people go to the hospital immediately when they are sick or do they treat themselves at home?

Interviewee: Lets say, a large number do not. It is a little better these days because some community health workers are home visiting, going round in the village but many people are still treating themselves with drugs bought from the shops. They buy medicine from the shops such as panadols and can even take them for up to two weeks even though the hospital is so near.

Interviewer: What kind of diseases do people ignore and don't go to hospital?

Interviewee: All diseases.

Interviewer: All, even bleeding?

Interviewee: That's the worst.

Interviewer: Tell me why it is the worst

Interviewee: One will live with it thinking that bleeding is for a short while but one continues bleeding. The biggest problem is that one does not want to tell anybody.

Interviewer: Doesn't want to tell anybody even the husband?

Interviewee: Even the husband. One wonders when the bleeding will stop, what is wrong with this monthly period (they think bleeding is due to menstrual period) and before she knows she has overstayed.

Interviewer: Why not talk about it?

Interviewee: Some because of not knowing, others because of shame, and some do not even know it is bad and think it is something in passing.

Interviewer: Tell me more about bleeding in women; what is the situation in the community?

Interviewee: I think a person might be laughed at by some people in the community; might not even know what to tell the doctor since the problem is affecting the private parts and the doctor might also treat her with disrespect (says this happens at times particularly if the problem is abortion). Women also feel shy when exposing the private parts. If the husband notices his wife is bleeding, the most likely thing is to send another woman to find out why she is bleeding. By the time the bleeding woman discloses, she might have gone around the bush for many days. Only about 1 in 100 would say immediately that they are bleeding. However, initially many women think the bleeding is heavy menstrual period and only come to realise it is abnormal bleeding when it is too late.

Many women prefer also to go to private doctors far away from their homes. The reason is that the private doctor will not disclose her problem to her people since he lives far away and also they have more trust of these doctors than those in public health facilities. They also think by the doctor not knowing her, he/she will keep the secret and that is why they are called private doctors – keeping private matters secret.

Young girls are even worse; they have abortions very frequently, can abort every time they become pregnant and do not go to the hospital unless they are taken by a good Samaritan (meaning a volunteer) when almost at the point of death. A number of them have died due to induced abortion.

Interviewer: How do they abort?

Interviewee: They use knitting needles, tips of pens or a plant called commelina bengbalensis {wandering Jew} (mukengeria in Kikuyu language). The knitting needles and tips of the pens are used for pricking the pregnancy through the

vagina in order for the bleeding to start and thus cause abortion while commelina bengbalensis is inserted and left in situ, the oozing water from the plant whose the covering has been peeled off is said to cause bleeding.

Interviewer: And that (meaning bleeding) is a passing thing?

Interviewee: It continues like that until that time when they become very weak and are taken to hospital. Some end up dying because of bleeding.

Interviewer: Is the hospital easily accessible?

Interviewee: It is very difficult especially at night because of lack of transport. We can only take the bleeding women or girls to Njoro health Center or Nakuru District Hospital and both of them are far away and to make it worse, the means of transport are very scarce during the day and almost none at night. During the day, a person can be taken by bicycles up to the main road (about six kilometers from here and then put on a public transport (matatu) to be taken to the hospital. At night, we rely on very few people who have cars around here and it is not unusual to go to them and find that the car has no petrol or the person is charging money while the family members are not able to afford. The victim might therefore die as a result.

Interviewer: How about diseases like syphilis which affect the same body parts (meaning private parts)?

Interviewee: Even those ones are a problem because people don't want to be known; it is kept as a secret and one can stay for a long time without telling anybody and when they decide to tell their friends, it's when it becomes serious after taking over-the-counter drugs and herbs (mostly from their surroundings). Before the news go round from one person to another and the sick woman gets somebody to advice her, that time she is very sick.

Interviewer: So the person is seriously sick?

Interviewee: Yes.

Interviewer: Why don't they go to hospital and the hospital staffs do not normally know them?

Interviewee: Some because they are afraid and ask, "*What I am I going to tell the doctor*"? Some lack money but I don't think money is the cause; most likely being afraid is the main reason.

Interviewer: So, let's say many people first treat themselves with shop medicine before visiting a hospital or clinic. Where else do they go for treatment?

Interviewee: There is one who was sick here and we took her to hospital by force. Her private parts were sick and she was given herbs and used to wash herself with them and was saying that since she was cursed, the black soil was coming from her body parts which were bewitched. We took a step and approached her because she was getting no better and asked her to go to hospital; if she failed to go her sickness would get worse. By that time, she was very seriously sick and had a boil on her private parts. She told us she had taken drugs and was to revisit the witchdoctor after a few days. She had been told that the people who had cursed her were her neighbours. She was told by the witchdoctors that there was a pint of blood under her bed and they came to her house and showed her. We (meaning herself and other community health workers; she was a community worker) still pursued in assisting her because we did not want her to die and live us looking after her children. Since she was not getting better we took her to Njoro Health Centre and a doctor was called to a VCT centre to take her a HIV test. This was done and she was confirmed as HIV positive while initially she did not know; she had thought she was cursed. That time she was very sick and the doctor said that people are strong because she could walk and one could not think that she was that serious. She had initially been cheated.

Interviewer: How about her husband?

Interviewee The husband is still there.

Interviewer: Is he HIV positive?

Interviewee: The husband refused to be tested.

Interviewer: He was not tested?

Interviewee: The husband refused and the wife did not take the medicine. She is not very okay.

Interviewer: Those people who are HIV positive, what do they do before they go to the hospital. This one visited the witchdoctors do many people do the same?

Interviewee: Yes but you cannot know. If they don't go to the hospital, they look for herbs thinking that herbs will heal them. We had another one who had taken herbs; he was sick and had a child with the first wife where he was working, the child and the wife died. When he came here (he was initially working away from Piave) he remarried and had one child who died. The wife also died and the man became very sick and kept it as a secret; he did not want to believe what had killed the wife. These people who are HIV positive believe in herbs. He was cheated by the witchdoctors and was given five jerican of herbs as treatment. One jerican cost 1,000/- and after taking the four jerican, he accepted to disclose to his father that he was sick and that it was HIV/AIDS. He visited Njoro Health Center, was counselled and treated and now he drives a tractor because he is a driver and takes care of his child. He looks well.

Interviewer: Thanks God.

Interviewee: He is driving and providing for his child. If he had followed the treatment of herbs, he would have died but he made a wise decision.

Interviewer: So many people do not accept they are sick and even those who are HIV positive go for herbs?

Interviewee: Yes, they believe it's witchcraft. They also go to private doctors who want their money but will not tell them what they are ailing from. It is not easy to

test. Even if you are suffering from diabetes, they will not tell you what you are suffering from. They just want your money.

Interviewer: These privates persons who have clinics in town, are they doctors or nurses?
Interviewee: They are doctors.

Interviewer: Doctors or nurses?
Interviewee: We do not know, we call them doctors. Those people who are sick and want privacy run to them. They are treated without being done laboratory tests and they get worse. Abortion patients go there because of their privacy.

Interviewer: You mean government doctors do not keep secrets?
Interviewee: If sick women go to government hospitals, the doctors will pursue the issue if its abortion unless it is threatened abortion. It was bad here and it was decided that anybody aborting would be dealt with by the law.

Interviewer: If you are aborting, what will the doctor do?
Interviewee: You will be taken to police immediately. Your case will end there before you are taken anywhere else. That person will fear.

Interviewer: One can die in the house?
Interviewee: Yes, one can die.

Interviewer: You would take her to police?
Interviewee: The person aborting? We will take her to the doctor but end up in police.

Interviewer: What will the police do?
Interviewee: They will take her to court so those who want to follow suit can't because they know the consequences of abortion.

Interviewer: So that is what you do?

Interviewee: If you are known by the women you will be in trouble. They must hide (meaning those who are aborting illegally). Why I am saying private doctors do that private work is because they do not care as long as they are paid.

Interviewer: So you are telling me in all diseases people are given over-the-counter drugs?

Interviewee: Yes, exactly.

Interviewer: Or go for herbs?

Interviewee: Yes, and before they reach the hospital they are very serious.

Interviewer: Why don't they go to hospital at once?

Interviewee: Not knowing and taking things for granted.

Interviewer: Taking things granted?

Interviewee: Yes, if you have a little pain you wait and buy rob (ointment for pain killer) and rub and you do not know why you have the pain.

Interviewer: Do they charge at the hospital?

Interviewee: They charge 50/= so it's not the money which makes them not to go to hospital.

Interviewer: So, it is not the money?

Interviewee: No, it is taking things for granted. It is making things easy, think about that rob, it costs only 25/= shillings and the hospital plus drugs is Kenya shillings 50; you see it's taking things easy and ignorance.

Interviewer: Let's talk about here in Piave, how do people keep themselves healthy?

Interviewee: Eating well. People have to be educated in the village about nutrition because they do not know. They sell nutritious food like eggs to buy sugar and other foodstuff like rice and potatoes. You see people are using things that don't help them. They sell foodstuffs that would help them to keep their bodies health.

Interviewer: Is it?

Interviewee: People like tea and it's of no help. People are milking but sell milk because they want sugar and tea leaves. That milk is not helping and the cows belong to them. That's lack of knowledge. If you take porridge you will help yourself but you would rather take tea because it's fast in preparation, your health deteriorates and will be attacked by diseases especially in villages (meaning rural areas).

Interviewer: Are there other things that people do to prevent diseases apart from the one you have told me, that is eating well?

Interviewee: There is but it is not done a lot because a disease like malaria you can prevent it by removing water pods and clearing the bushes so that the mosquitoes have no place to breed into. A disease like diarrhoea you make a pit latrine because people here do not know about pit latrines; people can help themselves there instead of doing it anywhere. You can then prevent diarrhoea. Again boiling water and cooking food well prevent diarrhoea but mostly people do not know and take life for granted. To them all that matters is eating.

Interviewer: What do you do within your family to prevent and stay healthy?

Interviewee: We don't take tea in our family. Tea spoils the body and doesn't add anything in it, so we take porridge.   I mix flours of sorghum, wimbi, maize, soya, groundnuts, cassava, fish, beans and green gram to make it.

Interviewer: Where do you get them from?

Interviewee: I buy and some I plant, I plant wheat, wimbi, maize and cassava. The rest I buy, wash them and take for milling. It is good because I have raised my children including my grandchildren with it and it prevents them from diseases.

Interviewer: Do people carry out a lot of self-treatments here in Piave?

Interviewee: They do, if they go to the hospital and they do not get well, they think herbs are the best. I hear there is another person who comes here to treat people with herbal treatment.

Interviewer: Do they influence other people to go there? Let's say a family like yours, if you go for herbs or buy drugs from the shops, would your children and other people follow your example? Do people follow ideas like those?

Interviewee: People do this, if I go to a herbalist and I am given herbs, I will tell other people that a certain person is giving herbs, that person will also go and will inform another person who will do that also.

Interviewer: So they do?

Interviewee: Yes.

Interviewer: Are there diseases people say they won't go to the hospital even if they can afford to pay, while for others they would prefer to go elsewhere or just stay at home? Also tell me about yourself.

Interviewee: As for me, if the problem is brought by a curse, I would seek traditional help because I know the hospital will not be of any assistance. I may have been cursed by a relative for wrong doing and therefore I would rather try to amend the curse by doing what might be dictated by a traditional person. This could be an elder or any other person who knows what should be done.

Interviewer: Would you be willing to reconsider your decision?

Interviewee: I would not be willing to consider any other form of treatment in such a case.

Interviewer: Why so?

Interviewee: If a person is sick and believes it is an inherited disease or a curse, they say if they go to the hospital they will die and that drugs interact with curses making the problem worse. Therefore one refuses to go.

Interviewer: Like what sickness?

Interviewee: If one is sick but doesn't know where he/she is suffering from, that person might refuse to go to hospital.

Interviewer: Are there other diseases people do not go to the hospital when suffering from them?

Interviewee: Yes there are other diseases. I don't know whether it is custom but they seek herbalists first. You find in a home many people are sick but they can't go to the hospital.

Interviewer: Do they change when counselled?

Interviewee: Some change but some don't. Some even threaten their families who change and tell them," *If you go we are not together*" (meaning they would disown them and would therefore become family outcasts).

Interviewer: What type of assistance would you welcome from nurses/doctors?

Interviewee: Nurses and doctors have a lot of knowledge on health matters. I would therefore like to see them getting into our community and giving us health education on health problems that are inflicting us. We need to know how to prevent disease, how to eat well and keep our environment clean. We have little knowledge on these issues but we want to know more as I find a lot of people sick here. I am one of the community health workers and we teach also about HIV/AIDS but seems like some people ignore us because they know we are not

well educated. We need nurses and doctors to come so that they can reinforce what we teach.

Interviewer: How do people look after the sick in the community?

Interviewee: Neighbours take care of their sick and the church members also visit the sick person if one is a follower of their respective churches.

Interviewer: Do you have other social groups here?

Interviewee: Yes, many self-help groups.

Interviewer: How about self-help groups, what do they do?

Interviewee: When one is very sick we organise ourselves and visit the sick and carry things like food including money. Depending on the condition of that person, we decide whether to give money or to take the person to the hospital. We also help in house chores and also help the children even in farming.

Interviewer: Do you contribute money?

Interviewee: Some contribute and some don't. Some groups meet twice monthly. They contribute to assist and help others grow as they feel right.

Interviewer: What is the money used for?

Interviewee: They contribute and use the money for table banking or assist one another in times of need such as a sickness in the family and funeral services.

Interviewer: How about those who do not contribute and still meet?

Interviewee: They meet to discuss about community issues such as orphaned children and other community problems. They seek for assistance to help the orphaned children in from of clothes, food and money. Many of our men both old and young drink alcohol a lot and also take illicit drugs and we do not know what to do. Women meet to discuss these issues and sometimes go to see the chief who seems to be of little help. It seems like he favours those people, may be they

give him some bribes because even if they are arrested, they get out almost immediately without any charges. They have formed a formidable group and it helps one another in case the law catches up with them. We are also afraid of the group because sometimes we think they can kill us when we report them to the authorities.

Interviewer: How is the sick cared for within a family?

Interviewee: We take the sick to the hospital most of the times now that it is near us (meaning Piave discipensary). Previously, we used to use a lot of shop medicine and herbs from our environment. Sometimes we used to wait to see the course the sickness would take and if one became serious, we would look for money and take the person to Nakuru District Hospital or Njoro health Center. However, transport is a problem here and if one gets sick at night and there is no vehicle nearby, we just wait until morning (the dispensary is closed at 4 PM and weekends).

Interviewer: When you think about Piave, what things would you do to improve the health of the community?

Interviewee: The things we can do are visiting in groups. Lets say our counseling group is invited by groups and we advice them on good nutrition and way of living as we have been taught and they understand and change. Some have no knowledge but as we teach they understand and change.

Interviewer: What other progressive things would you like to see that also contribute towards community health?

Interviewee: Progress like?

Interviewer: I can see the construction of roads in your area, what else would make the people live happily and eradicate problems?

Interviewee: Roads, but mainly water. We have water problems. The water project is not enough to serve the community and we have one river which you

saw. Everybody uses this river water. We do not have water boreholes but the donors dug a borehole in the hospital. If we had more boreholes this would help. When there is water shortages some people drink water from dirty dams.

Interviewer: They drink dirty water?

Interviewee: Yes, some are weak and can't walk; some have no means of fetching water.

Interviewer: And you do not have water disinfectants to put in the water?

Interviewee: Yes.

Interviewer: Any other problems?

Interviewee: Water, electricity that's what we lack. I use battery (shows me the battery); this is a donation from a group called Search of Light.

Interviewer: And they gave you?

Interviewee: Yes, these are donors and they are not in Piave they are only starting now.

Interviewer: Where did you get this one from?

Interviewee: I got it from Pwani when I heard about it, I went there, that is where I joined the group. We are not many in Piave.

Interviewer: What else?

Interviewee: Water, Roads and electricity are the main problems.

Interviewer: Is there anything else you would like to tell me?

Interviewee: You are the one who wants to know, just ask.

Interviewer: Thanks, I think we can end there for now. Thank you very much for giving me your time and very useful information.

Tree Nodes

Name	Sources	References
Health professionals	0	0
01 Common illnesses	0	0
02 Number of patients per day	0	0
03 Reasons for immediate attendance to health care fa	0	0
04 Type of communtys health care seeking behaviour	0	0
05 Awareness of traditional healers in the community	0	0
06 Presence of drug venders in the community	0	0
07 Nature of inter personal relationship between health	0	0
08 Strategies for effective service utilization by the com	0	0
09 Level 1 health care implementation	0	0
10 Possibilities of inclusion of traditional healers into the	0	0
12 Suggestions on implementation of community care	0	0
Interviews key informants and focus group	0	0
01. Perception on being healthy or well	0	0
02. Perception on illness	1	1
03. Perception on self sickness	0	0
04. Causes of ill health	0	0
05. Diseases in Piavi	0	0
06. Actions on sickness	0	0
07. Maintenance of good health	0	0
08A.Family influence on self-care seeking behaviours	0	0
08B. Community influence	0	0
09. Diseases community members do not seek formal	0	0
10. Assitance required from nurses and doctors	1	1
11. Care of the sick in the community	0	0
12. Care for the sick in individual families	0	0
13. Ways that the community take care of one another	0	0
14. Social groups and what they do	0	0
15. Suggestions to make the community health	0	0
Traditional healers	0	0
01. Diseases and type treatment given	0	0
02. Means of knowledge acquisition	0	0
03. Types and composition of Clients	0	0
04. Reasons for the choice of the traditional healers	0	0
05. Type of preventiive and promotive health care educ	0	0
06. Perception of health care given	0	0
07. Perception of traditional healers services with regar	0	0
08. Acceptance of traditional healers practice by health	0	0
09. Perception on need for formal training	0	0
10. Diseases refered to health care facilities	0	0
11. Williness of diclosure of practice to health care profe	0	0

A sample of field notes

4th Sept. 2007-09-24

The field work preparation started three weeks ago when I requested the National Coordinator of Society for Women and AIDS to make various appointments for me for my filed work in Njoro Division. She immediately contacted the Coordinator, of the Society for Women and AIDS for Nakuru Province who made appointment on 4th Sept. 2007 for me to meet the following people:

- Medical Officer in-charge of Rift Valley District Hospital
- Public Health Nurse for Nakuru Province
- Chief of Njoro Division
- A Community worker in Piave Location (within Njoro Division) where the field work mainly took place.

The last two persons, the Chief of Njoro and Community Worker were also requested to contact some opinion leaders and other well-informed people as the key and general informants/focus groups for the study.

The meeting for Medical Officer of Health was supposed to be at 11 AM but I had to request for postponement until 2 PM because of some delay in Nairobi, the traffic was hectic and also the road to Nakuru Town is very bad as t is under some major construction.

I arrived in Nakuru Town at 12.30 PM, and fortunately was able to see all the people listed above. The Chief and Community Health Worker were in Nakuru Town attending a court case and they agreed to meet me there before going back to their respective places. I was extremely happy because all my plans went on as arranged.

I handed my letter requesting for the field work for my study to the Medical Officer of Health, Dr Kariuki and was given permission to conduct the study in writing. He commented that such a study was long overdue and was happy that I had decided to do it. He also requested me to make sure I share the results with him and other health professionals in Nakuru and Ministry of Health as a whole. I gladly promised to do so and also told him it was my initial plan to do so.

I also got permission from the chief and told me I would be free to go to anywhere in Njoro Division and since he was going to Nairobi that afternoon, he asked me to see the sub-chief of Piave Location just in case I needed further assistance.

The Community Worker whom I had met before told me she had already organised some focus groups and key informants for the interview. I explained to her that, I would meet them as scheduled; however, it was also likely for me to add some more in exchange for the ones she had requested just in case I thought it was necessary. I told her this after explaining in detail the nature of my study particularly on the issue of saturation. I also told her I would start with the key informants because she had already requested some women to come for the interview. I made a tentative programme with her as follows:

5th Sept. 2007	Meet with key informants and arrange with them to visit their homes for the interviews. That day I was able to interview 3 women as key informants as follows: - Two were community health workers. These are women who have no formal education but are referred to as counsellors because they have been taught how to assist women and girls in post-abortal care. They counsel women on issues concerning abortion. - The other woman is an opinion leader in the community. She is a chairlady of six women groups within Njoro Division, more of them being in Piave
6th Sept. 2007	• Interviewed a Pastor from Piave belonging to Christian

	Restoration Church of Kenya
	• Interviewed also were two men, one an opinion leader and a farmer and the other one a young man who has been very active in community affairs
7th Sept. 2007	• Interviewed the sub-chief of Piave Location as a key informant • Interviewed men's and women's groups
8 Sept. 2007	• Interviewed a traditional healer cum-witchdoctor-cum circumciser • Interviewed youth groups, one for young men and the other one for young women
10th Sept 2007	Interviewed: • A Divine healer cum-witchdoctor • One herbalists in Njawathe Village in Njoro Town and • One herbalist from the shopping Center in Njoro Town
11th Sept. 2007	Interviewed: • Health professionals at Njoro Health Center and • Piave Dispensary • Two shop keepers at Piave who sell over-the-counter drugs in their shops
12th Sept. 2007	• Interviewed the Public Health Nurse of Nakuru Province • Had a chance of talking to a herbalist in Nakuru Town who sell herbal medicine at the bus terminal. Wanted to have a general idea of what kind of herbal medicine they sell and also the diseases they treat
13th Sept. 2007	• Interviewed a herbalist in Nakuru Town, the reason being that the patients from Piave Location also go Nakuru Town to seek help from herbalists Same day in the evening, I came back to Nairobi

Below is a schedule for the 2nd visit for the participant observation, member checking and additional interviews

22/11/07	Visited Nakuru District for the second time mainly to do: • Participant observation

	• Member checking (confirm whether the documented information for the first interview was done in line with what the informants (key and general informants) and traditional healers had said; and • Interview two herbalists who sell drugs at the bus stop
22/11/07	I arrived in Nakuru Town at 3 pm and immediately went to my study site to participate in a social meeting organised by SWAK to discuss about postal-abortal care. The group was composed of 25 women who interacted together very well although their age varied. There were young, middle aged and elderly ladies. A number of the women had their babies with them and seemed to take good care of them in the way of feeding and general care – seemed to give a lot of attention and love. Summary of the discussion will be reported in the participant observations.
23/11/2007 **24/11/07**	Interviewed one herbalist in Njawathe village in Njoro Town – already reported in verbatim. Also attended another group meeting organised by SWAK on post-abortal care. The discussions were very lively and will be reported in the general observation together with participant observations. Interviewed a herbalist in Nakuru Town bus stop. Attended a workshop organised by SWAK, again on post-abortal care. Noted the discussion outcome were similar to what I had listened to before; in the other two groups. The only difference was that there were a number of men who were participating in the workshop and were excited about it. They promised to be active participants in post-abortal care and any other issues related to health. In all the three workshops I attended, at least the chiefs of the areas participated and promised to be an active partner through assisting the participants to implement what they were taught within their respective communities.

25/11/07	Did participant observations as well as follows: Spent the whole day in Piave location, socializing with different groups. Had a chance of attending church services (Catholic Church and Miracle Restoration Church) with one of the community members. Also visited two of the drinking dens and did general observations of the area – participant observation has been ongoing at all times of my field visits within (observations will be added to the documents on the previous observations). Member checking and additional information as suggested by my promoters and also my own initiative after critically scrutinising the interviews previously reported in verbatim.
27 and 28 Nov. 2007 **29th Nov. 2007**	Met individual key informants, 1, 2, 3, 4, 5, 6 and 7 (fortunately, I was able to meet all of them) and after reading what I had documented to them, they confirmed the information written down was what they had reported. Added information during the second interview: Interviewed a herbalist in Nakuru Town at the bus stop Also met various groups of general informants as follows: **Women group**: five members of the focus group **Men group**: three members of the group **Young women group**: five members of the focus group **Young men** (youth) six members of the focus group Was not able to meet all the group members but those I met represented the other members. Again I read the verbatim reports for each one of the groups and they confirmed that what had been documented was the correct information. I was also able to get additional information.