



Factors that influence the utilization of traditional and modern medicine among the Samia of Funyula Division, Busia District

Peter Obonyo Ofware

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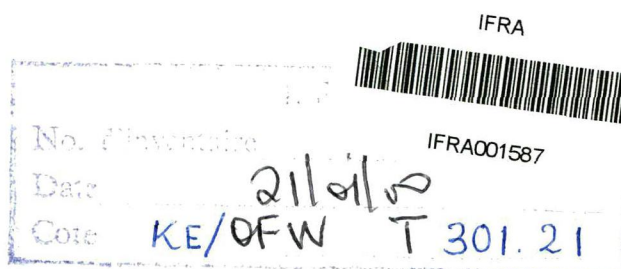
By Peter O. Ofware

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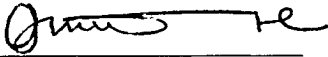
PETER OBONYO OFWARE

**A THESIS SUBMITTED TO THE INSTITUTE OF AFRICAN STUDIES IN PARTIAL
FULFILMENT FOR THE REQUIREMENT OF THE DEGREE OF MASTER OF ARTS IN
ANTHROPOLOGY OF THE UNIVERSITY OF NAIROBI
DECEMBER 1999**



DECLARATION

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

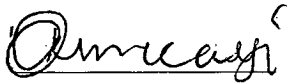


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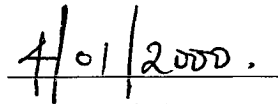


DATE

This thesis has been submitted with my approval as University supervisor



DR WANAKAYI OMOKA



DATE

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DEDICATION

This thesis is dedicated to the memory of my late father Ernest Ofware Aringo, who overcame the misfortune of double orphanhood at a young age to give us life, but whom death robbed before he could share in the joy of this work.

And

To my mother Anastasia Anyango whose patience, tolerance and endurance in a polygynous marriage created an enabling environment for us to go to school.

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Last but not least, I owe all to God the almighty who kept me alive and whose guidance has been with me. Amen.

ABSTRACT

This study was designed to investigate the influence of cultural and economic factors on health seeking behaviour. Fieldwork was conducted in Funyula Division in Busia District, Western Kenya between December 1997 and February 1998. The study sought to find out those factors that are significantly related to orientation towards health seeking for various ailments in a two-way medical delivery system (i.e modern and traditional African medicine). Thus the effects of occupation, formal education level and beliefs on the causation and etiology of particular disease in the area were sought.

The study was based on a sample of 60 households and 12 key informants. The methods used in obtaining data information for this study were survey interviews based on a questionnaire, library reading and indepth studies with key informants. The data were analyzed both quantitatively and information presented in the form of tables and cross-tabulations, and qualitatively in which direct quotations and local taxonomies were used.

The findings reveal that since health has multiple determinants there may be various pathways through which a household could maintain the same level of health; that is to say, households find different mechanisms for adapting to the same circumstances where some are more successful than the others. However, the mechanism to be chosen is contingent upon the perception and the etiology of the disease. The disease etiologies are put into two broad categories, namely natural and supernatural which in turn influence therapy seeking and selection behaviour.

The selection of a therapeutic system does not always follow cause and effect model rather the domain of these two resort systems overlap. When the first model from the etiological concept fails to provide satisfactory results, another one is tried. People do not actually stick to the distinction but move freely from one medical system to the other even on the same type of illness. Health seeking behaviour of the Abasamia in Funyula Division is affected by a number of factors. Occupation and actual beliefs of the people were found to extend a lot of influence on peoples health seeking behaviour while educational level had no significant influence on therapy seeking .

It is, therefore, recommended that since traditional medicine is being used widely for various types of ailments in rural areas and even in some parts of urban settlements, the government of Kenya should recognise traditional healers by way of legislation and to set out to develop their potential and the creation of an enabling environment for them to practice medicine, as it is clear from the findings of this study that they remain a major source of health care for many of the rural dwellers.

CHAPTER 1

1.1 INTRODUCTION

Disease and health care are common to all societies but the types of disease that afflict a given people and in turn how they perceive and treat their afflictions, are indeed varied. Good health is such an integral part of human well being, although, the loss of good health is inherently unpredictable, human behaviour at the individual and social levels profoundly influence the incidence and prevalence of disease. This has been understood since ancient times and indeed the same fundamental factors that determined human vulnerability to disease early in human history paramount today.

The epidemiological environment consists of the conditions and processes, both physical and social that influence the interaction between human beings and disease agents. Societal determinants of the spread of disease pathogens include the frequency and nature of interpersonal contact, travel and migration patterns, access to health care and information, pharmaceutical markets, urbanization, sanitation, poverty, public health policy, funding of medical research and training, and political leadership. Nonetheless, their nexus is little appreciated because the pathogenic actors in it are largely invisible. Recent and projected future changes in the epidemiological environment pose a major threat to health security, which has recently manifested itself in a variety of ways. Old diseases such as malaria, tuberculosis, bubonic plague and cholera are resurgent. Besides, the new epidemic of AIDS is creating fundamental public health problems.

The way people define and respond to illness is learned and varies from one community to the other. Cultures differ in the way they react to the some symptoms such as malnourishment. The symptoms might be attributed to a large number of causes, none of which may be related to food. Ghosts, evil spirits, fright, sin as breach of taboo might be identified as the sources of misfortune. It is axiomatic to the social sciences that health and illness are not simply matters concerning human bodies and their functions, rather, these states and the transition between them represents a complex interplay of physiological conditions, the cultural structures which give them meaning and the social organization and interactions within which they are situated. Therefore, health related behaviour of an individual is the product of a complex interweaving of biological, social and cultural threads.

Illness has always been part of the human condition. Disease affects all people everywhere, but not always to the same degree in the same way.

People view the event of a disease from the perspectives of their particular culture and, thus, they respond to disease in predictable ways and, in every culture, ways have been devised for evading or deflecting its ravages and reducing the anxiety which it inevitably occasions. Any condition which interferes seriously with personal plans and reduces one's capacity to perform the normal activities of daily living affects not merely the individual victim of the misfortune but reverberates through the entire social network of which he is a part, involving changes in the roles of many others who must partly compensate for his enforced inactivity. For the patient a serious illness carries with it the underlying fear of death or permanent disability and constitutes a crisis which requires cooperation efforts both from family members and from the accredited local specialist in physical and psychological (spiritual) care.

There are many ways in which reactions to illness resemble one another in societies which otherwise seem widely dissimilar. For example, regardless of the demonstrable pharmacological efficacy of one form of therapy rather than another, merely to embark upon a treatment regime which is acceptable to all of one's relatives and friends supplies the satisfaction which comes from social conformity. Moreover, the confident naming of an illness or its equivalent, the pronouncement of a diagnosis, will go some way towards reducing the fearful uncertainty which comes from the sense of being assailed by unknown terrors (Maclean 1978).

1.2 THE CONCEPT OF HEALTH

In the preamble to the constitution of World Health Organization (WHO) health is defined as:

"A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". (WHO 1963:1)

Generally among the lay public, disease implies some serious organic or psychic malady such as measles or mental illness. The concept of disease is being broadened by modern medicine to refer to any state, real or imaginary, that disturbs a person's sense of well being. In this sense diseases may threaten life or simply interfere with its enjoyment, it may prevent a sick person from functioning as a normal human being or simply from reaching his self-selected goals.

In Western medicine, at least until recently, the tendency was to concentrate on the physio-chemical aspects of illness. Among the Zulu, Nyakyusa, Gusii and Mandari, there is a more or less unified view of illness.

In these societies health is not an isolated phenomenon but part of the socio-religious fabric, it is more than the absence of disease. Health is bound up with the whole interpretation of life, which means that considerations like peaceful living together, keeping religious and jural laws, are just as essential to health life as essence of or malfunction in the physical body Nyamwaya (1977). Ngubane, says that the Zulu conceives a good health not only as consisting of a healthy body but a healthy situation of everything that concerns him. Good health means the harmonious coordination of the universe. (Ngubane 1977: 27-28).

A healthy community is one in which the people are physically, morally and spiritually "clean" (Wilson 1963). Health as understood by the example of those four societies then approximates to the proposition in the WHO constitution. Since health is believed to involve various realms of reality, a disturbance in one of these, has a bearing on the others. Nyamwaya, argues, that since health seems to imply internal and external conditions from the point of view of the patient, causation should be regarded as embracing those two aspects, the internal referring to the physiochemical process and the external to spiritual and inter-personal factors. Nyamwaya (1977: 83).

For most of the African societies the original concept of nature includes at the same time, the physical world, and the social environment and the metaphysical forces of the universe. This view of life affects the concept of health for a state of illness transcends the merely biological and physical consequences of organic malfunction and affects social and spiritual life in significant ways. This view is possible because according to the African traditional religion, man lives in a religious universe, with him as the centre of this universe. The social, spiritual and physical aspects of the universe dovetail into each other; to the extent that at times and in places one is apparently more "real than, but not exclusive of, the other" (Mbiti 1969: 57).

1.3 BACKGROUND INFORMATION

Prior to the venture of colonialism in Eastern Africa to create a state now called Kenya, every ethnic group had (and still has) diverse systems of indigenous health care.

The harbingers of colonialism, the Imperial British East Africa Company (IBEACO), gained the then East Coast of Africa (included Kenya and Uganda) through a concession with the sultan of Zanzibar, Seyyid Bargash Bin Said, in 1888 (Koinange, 1983; Mburu 1981). The colonial dominance was effected in 1895 when the IBEACO handed over the region to the Foreign Office and later to Colonial Office in 1904 (Mburu 1981).

The first foreign medical services established in Kenya were by IBEACO. As their main goal was economic, their medical systems were limited to the employees of their company, as they needed a healthy population in their endeavour to reap the resources of the land (Mburu 1981, Koinange 1983). Western medicine reached the "natives" in the "reserves" (rural set-ups) through the work of missionaries. The Christian missionaries established health care services along the denominational lines. Missionary health services usually based in inaccessible rural areas provided mainly curative services. However, regardless of the inadequacies in the quality of care and the limited coverage, missionary medical services represented "the single most important attempt to affect Africans in their environment outside the prevailing colonial structures. (Mburu 1979: 524)". They disregarded the indigenous ways of healing and patients were admonished if there were any signs of them having visited these healers previously (or prior to going to hospital). However, their hospitals and dispensaries even as they exist today are better equipped and staffed than those of the public care systems.

The first medical department was established in 1895 after the proclamation of the East African protectorate. The colonial government did not have a public health policy, but rather spontaneous actions and proclamations on health issues. Some of these proclamations were either meant to protect the health of the whites or stamp the powerful influence of the colonial government in the minds of Africans. In 1919 extensions of medical facilities to the "natives" was recommended on the advice of the then Director of medical services, that "a government hospital is a tangible sign of a government activity, which the native understands. (Koinange (1983)". From then up to independence, the colonial government endeavoured to build hospital institutions through the native councils in Districts and Divisions. Most of the health structures in Kenya were developed during this period.

The colonial government had no interest in indigenous medicines "as long as they did not disturb the peace (Beck 1981: 62)".

However, due to concern over witchcraft, the colonial government enacted the witchcraft Act Cap 27, 1925 (Mutungi. 1977), to prohibit its practice which is almost an inseparable element of indigenous etiology. This Law, though, revised in 1962, is absolutely important, as there is no clear-cut division between beneficial practitioners and harmful ones. It is also difficult to prove an act of witchcraft in a court of law, neither is there any distinction between African healing techniques and witchcraft (which in this case perhaps meant sorcery).

It was only after independence that the government constructed a comprehensive health policy. In 1963 the medicine department was changed to the Ministry of Health and Housing. After independence the government formulated the National Health Policy for 1964 - 1970 which recognized the importance of providing adequate facilities for health (Onyango 1970).

A general overview of Kenya's health policy shows that it is basically concerned with curative services (Mburu, 1981; Mwangi and Mwabu 1986) the bulk of Kenya's health budget as in the 1984-88 development plan is utilized in the provision of curative services (GOK 1988). The policy mainly focused on the inadequacies of health services which is only one of the hindrances to the provision of health care for all. The policy did not have any link to water supply, sanitation, food production and nutrition and income distribution, which are the most important facets of Primary Health Care. This development Plans do not seem to address the socio-economic inadequacies that permeate the Kenya society.

In Kenya biomedical services are the only officially sanctioned systems of health care available in the country. As we have seen, this system of healing can only be afforded by a small fraction of the population. Indigenous healing services are the most popular in terms of consultation in Kenya among the poor. In his survey to assess knowledge, attitudes and practice (KAP) on indigenous healing among 212 out-patients at filler clinics and 119 in-patients at Kenyatta National Hospital Good (1987) found out that there is a degree of public support for indigenous practitioners. The government itself distrusts indigenous practitioners as exemplified by the government's Health policy. It is only the Development plan for 1979-1983 that drew some theoretical attention to indigenous healing (GOK 1978). This has never been repeated in subsequent policies.

From 1975 UNICEF and WHO began to emphasize the primary Health care (PHC) approach which would utilize local human material support available in the community to provide adequate medical care to the underserved population (Akerele, 1987; Gollada and Lee, 1980). This approach based on the utilization of the communities' basic resources, meant the inclusion of traditional medical practitioners. The program involved immunization, maternal and child health, family planning, nutrition curative services, health education, environmental health (clean water supply, sanitation etc) and early diagnosis and treatment of diseases.

The PHC approach was adopted at the 1978 Alma Ata international conference on primary health care where 134 countries and 64 United Nations Agencies were represented. The conference declared health a human right and issued a declaration urging the governments to provide affordable and socially relevant health care to each individual (Golladay and Liese 1980). The goal of the approach was "health for all by the year 2000". Which apparently looks a distant dream to the majority of the developing countries emphasis mine.

In the pre-capitalist Africa, as it is today, health and medicine were never separated from the political economy. In fact, it was the nature of the economy that determined specialization in the authentic human activity of healing (Ityavyar 1991).

In the health and medical systems of the pre-capitalist Africa, a healer or medicine man/woman was a person recognized by the community in which he lives as competent enough to provide health care by using plant, animal and mineral substances and certain other methods based on the social, cultural, religious and environmental background, attitudes and beliefs that are prevalent in the community regarding physical, mental, and social well being and the causation of disease and disability (Ityavyar 1991:37)

1.4 PROBLEM STATEMENT

The health care situation in developing countries can be outlined as follows. In terms of both facilities (supply) and access (demands) services are inadequate. The health system is inappropriate both to the needs of the people as regards the disease from which they suffer and to their socio-cultural and socio-economic background.

It gives the root causes of diseases since they fall within the terms of reference of other sectors or are a consequence of the general economic and social situation – i.e. underdevelopment.

The inadequacy of health services could partly be explained by historical emphasis on costly hospital based curative care which puts a premium on expensive technology and the meeting of international standards whilst ignoring the local disease problems. Even where health facilities exist these suffer from shortage of trained health personnel, inadequate supplies and poor management all translating into non-availability of services (Pillsberry 1979; World Bank 1980). Again some of the services are not acceptable as they ignore the participation of the local communities.

The most striking feature of health services in all the Third World Countries is that they are entirely modeled on western medicine and medical care. This is true not only of the physical infrastructure and Training of medical personnel but also of the organization of health services. The technological standards which apply to the Western health systems cannot be transferred to developing countries as they stand because of the major differences in population structure, age structure and socio-economic and socio-cultural conditions and diseases requiring different care and preventive measures.

This study aimed at investigating the socio-cultural and economic factors that influence the way people in Samia seek treatment among the possible alternatives available and their implications in the management of ill health.

The need to focus on these factors arose from the premise that they are very important when looking at the Health Seeking Behaviour (HSB) of an individual or community. Most of the researches carried out have tended to focus on the clinical aspects of the diseases and ignores the contribution of culture in the HSB despite the influence posed by such factors in determining the choice of therapy. When cultural beliefs and practices are left out in the development and management strategies in the eradication of disease and the provision of health services, then there will always be a gap to be filled.

Most of the causes of mortality and morbidity in Busia District are Malaria, intestinal worms, skin diseases, T.B, Respiratory infections, Anaemia, Kwashiorkor, Marasmus, Measles and Vitamin deficiency among others. (Busia District Development Plan 1997-2001).

The last four cases that come as a result of malnutrition are common among children of (0-5) years of age and breast feeding mothers, however most of these diseases largely affect the lower strata of the society which have their genesis in poverty, lack of treated water supply, poor sanitation, food contamination and low standards of personal hygiene. The Districts infant mortality rates is 86 children per 1000 live births.

This is far above the national average rate of 60 per 1000. This high rate of infant mortality in the district is attributed to various reasons such as improper weaning of infants coupled with the increased prices on major food stuffs and certain food taboos on the infants and the mothers. Yet these diseases are preventable either by means of health education or by regular immunization.

The prevention and management of disease shall succeed if those charged with the responsibility understand the place of culture in the perception and interpretation of any given disease among the Samia. It is important to note that when wrong diagnosis of a disease is made it leads to the wrong choice of therapy. There is still strong cultural influence among the people of Samia and this could possibly be due to the low level of income and formal education among the people.

This study was designed to find out whether socio-cultural and economic factors influence the discrimination of health services among the people of Samia at the onset of ill-health. In view of the above it sought to answer the following questions:

Do people's occupation influence their health seeking behaviour?

Does one's level of formal education influence choice of treatment?

Do people's beliefs about illness and causation influence health-seeking behaviour?

1.5 RESEARCH OBJECTIVES

1.5.0 Overall Objective

The main objective of the study was to examine the influence of socio-cultural and economic factors on Health Seeking Behaviour so as to generate and make available information that could form the basis for formulating an effective health policy.

1.5.1 Specific Objectives

To find out how peoples' occupation influence choice of therapy.

To find out and document peoples beliefs about the causes and their influence on therapy seeking.

To find out how peoples' education level influences choice of therapy.

1.6 JUSTIFICATION OF THE STUDY

The justification of this work lies in the fact that good health is related to good senses. We also believe that sound healthy minds with the ability to make good judgements and to think clearly are not likely to develop without good health. It is therefore, important to know how to detect symptoms, how to act in an emergency and how to carry out doctors orders efficiently. However, good health does not happen accidentally. It is not a gift bestowed by the gods upon some and not upon others. To improve the peoples health is to improve the general development in a country. Therefore, there is a need to restructure the existing health strategies to attain better health for all the citizens. Proper understanding of cultural factors which influence HSB and their implication can provide information which can be used by health policy makers to design appropriate policies which will be in line with perceptions and expectations of the people.

This study was also designed to shade light on the continued allegations that traditional African beliefs regarding the causation and treatment of illness are a major hindrance to the "acceptance" of Cosmo politan medicine in Africa. It is argued that basic premises of traditional and western medical practices are conflicting so beliefs in the former should be dropped to give way to acceptance of the latter. This study therefore aims at providing evidence to show that both systems of medi-care could complement one another as none of the two is a panacea.

Although a full account of officially sanctioned research on Kenya's indigenous medical systems is not possible at this time, available evidence suggests that progress remains slow particularly in obtaining the kind of systematic evaluations of indigenous medicine and practitioners that could be essential for formulating workable policies for collaboration.

The results of this study, therefore, will be of use to individual groups or organizations and institutions including government departments, which are involved in interventions for the evaluation of diseases by modifying health intervention programs to suit local conditions. Besides, contributing additional literature on the subject, that future scholars can draw upon for reference.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL MODEL

2.0 Introduction

In this study, literature review is divided into four parts. This includes socio-cultural background, perception, nature of illness and mode of therapy; Education and health, socio-economic status and doctor patient interaction. This chapter also deals with the theoretical model as well as hypothesis, which guided the study.

2.1 Literature Review

Research that have been done show that the understanding of disease, cost at which health care will be obtained, education level, doctor patient relationship, the location of health facilities, and socio-cultural beliefs and practices are factors that have been isolated by some scholars to influence health behaviour. According to Nyamwaya (1992). People's responses to disease are governed by their predominant concepts of health and illness. In Africa he says, such concepts are largely indigenous and usually specific to each cultural group. Reed (1962) states that health workers and social scientists should recognize that the response to health services and programs in rural areas depend upon a deliberate choice by the people. Making decisions about actions to be taken and weighting one choice against another are familiar procedures in daily life.

With the spread of European imperialism in Africa and its economic, socio-political and religious institutions the western oriented medical care system was established. Indigenous medical care systems were confronted with competition but not outlawed. This new medical system has fallen short of meeting the health needs especially among the rural people and the urban poor. Large rural populations therefore, still to a greater number continue to utilize traditional health facilities as their only source of health services (Pearce 1982).

Studies have established that while many of the disease symptoms people experience are recognized as indicating disease process it is not necessarily the case that treatment is sought nor a clear cut selection of medical system. Sindiga (1995:68) on his study among the Luo argues that the Luo believe that western medicine is ineffective for diseases whose causes are human-related but is taken to be efficacious in natural diseases which have their origin in natural circumstances.

He argues that although the Luo may and do distinguish multiple disease antilogies, their HSB does not always follow this distinction. People move freely from one medical system to another even on the same episode of illness.

According to Zola (1973) he postulates that what, when and if action to resolve any problem is undertaken often depends on a number of factors. He has looked at the timing of the decision to seek medical care. He found out that most people tolerate their symptoms for quite a time before they went to a doctor and that the symptoms themselves alone were not sufficient to precipitate a consultation, something else has to happen to bring this about. He identified five types of triggers to the consultations of a doctor.

The occurrence of an interpersonal crisis e.g. death in the family.

Perceived interference with social interpersonal relations.

Sanctioning pressure from other people to consult.

A kind of “temporizing” of symptomatology and the setting of a dead line (setting of the date to consult if the disease persists).

Perceived interference with work or physical functioning.

A clinician who is unable to decode the language of the patient, which may be verbal, somatic or physiological is in danger of making wrong diagnosis and providing the wrong set of treatment. For example, in Zola's study the Italian Americans presented their illness in a more valuable, emotional and dramatic way complaining of many more symptoms and stressing its effect on their social circumstances, while by contrast the Irish tended to underplay their symptoms. He adds that where no organic disease was found, the physicians tended to diagnose the Italians as having neurotic or psychological conditions while the Irish were given a neutral diagnosis such as nothing found on tests without being labelled neurotic (Zola 1973:679)

People recognize a particular disease at different stages depending on familiarity with symptoms and the progression of the illness (Feierman 1985). In some cases a disease may be put in a different category depending on who is doing classification. The result is that people seek help at different times in their sickness and some never seek help at all.

A focus on illness behavior require that we study “not only those who seek care, but also those in the population who do not”(Mechanic 1968:116). Mechanic emphasizes the need to study illness behavior more broadly taking the population in general, and not those who seek care at specialized agencies. In his words:

...Illness behavior affects the utilization of medical care, choice of possible advisors, and responses to illness in general, the selection of patients who seek help from general practitioners, from clinics, even from hospitals is usually biased.

Group of patients with a particular disease, selected from such populations, will usually be biased compared with those in the general population with the same disease, but untreated and this is particularly true for illness of high prevalence... (Mechanic 1968:116)

These calls for health care research that focuses on the larger community through the study of households and individual responses to disease.

In theory, treatment options are available to all seekers. However, in practice, not all are utilized. The search for therapy may follow anyone of a number of therapeutic alternatives available (Young 1981 and Hunter and Sultana 1992) although the treatment outcomes may be unknown to patients. Patients do not always get the anticipated outcome and they have no sure way to determine the type of treatment alternative that will yield the desired state or the best results.

Though unable to pre-determine treatment outcomes, patients still must first prioritize their decisions. They must first order the alternatives available according to some rules of preference and they must decide on a strategy with a perceived good chance of leading to the desired results (Fjellman 1976). If a particular treatment choice fails, patients or the person(s) responsible for their health must make new choices. As time passes, and if the illness persists, the patient becomes desperate and receptive to therapy suggested by others (Feierman 1981: Agyepong 1992).

Whatever the criteria for recognizing disease, lay people's therapeutic choices are determined, in part, through recognition of the disease symptom (Foster and Anderson 1978) and the perception of disease seriousness based on the recognized symptoms.

In many non-western societies illness thought to be the result of supernatural agents, or causes beyond the control of western medicine, are treated using traditional medicine (see Helitzer-Allen 1989 and Fivawo 1993) for example on cerebral malaria.

Several treatment alternatives are available. They include the application of home remedy, self-medication with drugs bought over the counter on the open market, herbal therapies provided by traditional healers and therapies obtained from health centers or hospitals (Colson 1971: Young 1981: Hunter and Sultana 1992). A patient can also choose not to seek any therapeutic intervention. Lay people choose from these treatment alternatives based on the perceived effectiveness of the particular choices.

In theory, treatment options are available to all seekers. However, in practice, not all are utilized. The search for therapy may follow any one of a number of therapeutic alternatives available (Young 1981 and Sultana 1992) although the treatment outcomes may be unknown to patients. Patients do not always get the anticipated outcome and they have no sure way to determine the type of treatment alternative that will yield the desired state or the best results.

2.2 Formal education and Health seeking Behavior (HSB)

Access to education by all Kenyans is a current development theme that has put emphasize on the education of women and girls in order to bridge the gap between them and men and boys respectively (Gok 1997-2001). Education especially high education enhances the status of women through improving their health and that of their families, increasing women's economic opportunities and reducing women's chances of poverty (Khasiani 1995).

Western education has been portrayed by several studies as one mechanism by which modernization of health utilization pattern occurs. For example (Okafor 1983) found that educational attainment was positively related to more frequent use of western type health providers in western Nigeria. However according to the study about beliefs and practices concerning measles and diarrhoea among the Akamba of Kenya, education was found not to influence the type of medical care mothers selected but did influence the use of certain traditional practices (Maina 1978).

Fosu (1995) on his study on women's orientation towards help seeking for mental disorder in Accra Ghana, he found that those who profess christianity or have had higher education might not completely abandon their traditional perspectives on disease causation. This presents a formidable task for health education efforts to change people's perceptions about causal relationships in an attempt to emphasize a biomedical theory of diseases.

Maclean (1971) carried out a study in Ibadan Nigeria and found that increase in age and illiteracy was associated with a high use of traditional medicine. Homes in which a mother had professional training such as nurses and teachers were less likely to resort to indigenous services. However, Erinoshio (1982) observed that all ladies of society use traditional health care services. Ademuwagun (1969:197) asserts that the clients of traditional healers are the masses especially the expectant mothers, the very young and very old.

On the other hand Harrison (1974-75) observed that cross-cultural studies reveal that patients of traditional healers are not only the masses and lower class, but also the elite. Jegede (1981) found out that significant others played an important role in health seeking behavior. It has been noticed that the illiterate relatives of the educated patients called in indigenous practitioners to attend to the sick.

According to Chaiken (1986) health problems such as malnutrition, poor immunization coverage, frequency of preventable diseases and poor sanitation facilities are related to the issue of low public awareness of public issues. If people through formal education are made aware of the need to prevent disease through better sanitation, nutrition and home treatment of common illness, then improved health and child service will follow independently of other interventions in health care delivery. It is therefore, clear to say that education is significant in altering people's attitude and beliefs on health seeking behavior (HSB).

2.3 Culture, Nature of Illness and Health Seeking Behavior

Nationality, religion, caste, class and the other social variables are man-made and may be man-changed, but in so far as they exist, they directly affect the health status of the individuals who share them.

To consider the health status of any individual or group to consider the means of influencing that health status within such groups requires an understanding of these broader socio-cultural variables. Health behavior appropriate to one social setting may be disastrous in another. The changes within himself and others that people identify as symptomatic of illness or other abnormality, the cause, course and the current treatment, control, the potentials of rehabilitation, the implications for self and others of health actions either taken are culturally derived and culturally governed behaviour. (Gretchen; D.C. and Ehrlich; P.R 1996).

Culture is in transition as the forces of western education, Christianity and contact with the outside world exert their influence on the society. These have modified the observance of certain customs traditions and taboos through altering values and themes of reference. Ultimately, these process affect therapy seeking behaviour. (Sindinga et al 1995:77-78)

A cultural background therefore has an important influence on many aspects of peoples lives (inspite of the changes that have been going on) including their beliefs, behaviour, perceptions, emotions, attitudes to pain and other forms of misfortunes, all of which may have important implications for health care (Helman 1994). An important point in understanding the rule of culture is that it must always be seen in its particular context.

This context is made up of historical, economic, social, political and geographical elements. It may therefore be impossible to isolate “pure” cultural beliefs and behaviour from the social and economic context to which they occur, (Helman 1994).

The role of cultural differences in illness behaviour was described by Zborowski(1962) who in a study of ethnic reactions to pain in a New York city hospital observed that while Jewish and Italian patients respondent to pain in an emotional fashion, tending to exaggerate pain experiences, old Americans tended to be more stoical and objective, and Irish more frequently denied pain and were relatively satisfied. When such relief was obtained, the Jews subjects were mainly concerned with the meaning and significant of their pain and the consequences of pain for their future welfare. In trying to explain these differences, Zbwowski reports that Jewish and Italian patients related how their mothers show over protection and over concern attitudes about the child’s health and participation in sports and how they were constantly warned of the adversability of avoiding colds, frights and other threatening situations.

Roberts (1968:581) sees culture as something which man interposes between himself and his environment in order to ensure his security and survival the way people define and respond to illness is learned and varies from society to society. However, cultures differ in the way they react to the same symptoms, such as malnourishment, the symptoms might be attributed to a large number of causes non-of which is related to food. Ghosts, evil words, fright, sin and breach of laws may be identified as the cause of misfortune (Logan 1978).

Another important aspect of culture is its effect on health delivery. Frequently health programs fail because of the differences in culture of those receiving and giving assistance create bearer to effective communication, education and treatment (Foster 1962; Paul 1955).

According to Backett and Davison (1995) they assert that, health and illness are not simply matters concerning human societies and their function. Rather, these states and the functions between them represent a complex interplay of physiological conditions, the cultural structures which give them meaning and the social organization and interactions with which they are situated, hence health related behavior of any individual is the product of a complex interweaving of biological, social and cultural threads. Health promotion therefore, should be seen as a set of behaviour patterns that constitute a socio-cultural role taken by the individual.

These behaviours are socially triggered, social prescribed, labelled and controlled.

(Appiah-kubi, 1976) postulates that the African idea of health is symptomatic of correct relationship between oneself and one's environment and the physical environment around ones fellow men and women. Health, therefore, according to Africans is associated with good, blessing and beauty, all that are positively valued in life. Illness on the other hand shows that one has fallen out of this delicate balance and this is usually attributed to breaking of a taboo, malevolence of an evil or an offended spirit, a neutral spirit, evil eye or witchcraft. Consequently health and disease are inextricably connected with socially approved behavior and moral conduct.

To enjoy maximum health African's belief that individual must have good thoughts about his neighbours, one must learn to avoid aggressive acts and sometimes diseases is believed to be caused by the failure to perform the religious act at the right time and place besides it is also believed that the individual victim may not be the offender but might be suffering from the offence of the kinsman, this may explain illness of the individual and the role of kin group or family). Thus human beliefs concerning his/her cultural environment determine to a large extent his/her interpretation of health and disease and the methods of treatment to be used in resolving this life crisis. for it is the society that determines its own health needs (Ngubane 1977; Appiah-kubi 1976, Busia 1955). (Parenthesis mine).

A study carried out by Denniss(1974-75), on disease and choice of therapy indicated that cultural patterns of illness and sickness alternatives were important factors in the country's health care programs. On the other hand Zeller(1974-75) carried out a study among the Baganda and found out that diseases were divided into four categories.

Trivial illness such as colds

European diseases

Kiganda diseases

Death

European diseases were introduced by Europeans and could only be treated by western medicine. Kiganda diseases were indigenous and could only be treated by traditional healers.

Fosu (1995) on his part argues that traditional healers use a social theory of disease within this framework, the cause and consequences of disorders are viewed in relation to the functioning of the social and cultural systems. Hence natural, social and supernatural components of disease causation are recognized and responded to accordingly. This he asserts contrasts with a biomedical theory, which addresses the causes and consequences of disorders in mainly biological terms.

According to Morley (1978) the diagnostic categories of disease causality affect the extension of medicine into the broader social arena and identification and classification of symptoms, social factors and the perception of practitioners. This Morley, explain is why diverse information and content may be summed into four main broad categories, supernatural, non-supernatural, ultimate and immediate causes. He says that supernatural causes are those, which place the origin of diseases with super sensible forces malevolent agents or acts, which are not directly observable. Within this category we find explanations such as witchcraft and sorcery, spirit or demon infusion and evil eye. Non-supernatural disease categories are those based wholly on observed cause and effect relationship regardless of the accuracy of the observation made. On the other hand, the category of immediate cause follows from non-supernatural explanations and accounts for diseases and sickness in terms of pathogenic agents, and the ultimate cause explain the fundamentals which “govern and condition, the occurrence of disease”. In short, immediate cause explains “how” disease materializes and ultimate causes “why” they happen.

Many African communities’ categories diseases and illness according to cause. This in turn influence therapy seeking and selection behaviour. Patients will go to biomedical facilities when their families, friends or neighbours or even themselves when an illness is considered to be naturalistic. On the other hand they will turn to traditional healers when they conceive an illness to be caused by supernatural illness, patients in the African context have been observed to be quite flexible sometimes using a number of systems together for the same episode of illness (Sindiga *et al* 1995, Nyamwaya 1992).

All these cross-cultural studies localize disease to their respective cultures. No culture is the same everywhere. Given this uniqueness in cultural practices, it is imperative that investigations on cultural beliefs and illness are also localized. Cultural factors have been isolated by some scholars to keep patients with different ailments from western oriented medical care services. For example, measles among the Samia and Pokot Nyamwaya (1992), tuberculosis among the Akamba Ndeti (1972), leprosy among the Luo, Van Luijk (1977) and functional disorders among Luo Whisson (1964).

It is therefore imperative to note that all cultures do involve methods of dealing with disease and health.

2.4 Socio-economic status and health seeking behaviour

Western medical care in many developing countries is quite expensive and the distribution of medical facilities and personnel is uneven. In Kenya, low level of income by majority of the citizens limits patients' health care alternatives. Poor households are likely to wait for a longer period before action is taken. If disease persists they may attempt to use cheaper options, first, trying non-prescriptive medicines bought over the counter in shops and kiosks and if this fails, going to the health centre or hospital.

Families in developing countries spend between 2-5% of their income on private medical care (Gomes1993). However the difference in health expenditure between the poor and the rich on a typical illness episode is large in some countries. In Kenya the poorest 20% of the population spend 64% of household income on an illness episode compared to the percentage spent by the highest quartile Gomes (1993).

Mothers in coastal Kenya wait for three days before visiting a health facility. Reasons given for waiting include: perception that the illness is mild, partner being absent: other important matters to attend to, lack of someone to attend to, lack someone to mind the ill child's siblings, lack of money for transport and use of the counter drugs Mwenesi *et al* (1995).

There is a consistent evidence throughout the world that people at a socio-economic disadvantage suffer heavily the burden of illness and have higher mortality rates than their better off counterparts (Whitehead 1989, Illsey and Svenson 1990, Mielek and Rosario 1993). These socio-economic inequalities in health are a major challenge for health policy because the burden of health problems to the disadvantaged groups offers great potential for improving the average health status of the population as a whole (Mackenbach and Kunst 1997)

Lois Mointerio (1973) did an extensive comparison of the 1968 national health survey and a sample of Rhode Island residents. She concluded that:

when, an illness is present, there is equal tendency among all income groups to see a physician.

When illness is not present lower income residents tend to report higher physical utilization but if free care is available, otherwise, lower income persons show about the same level of use as upper income persons who have no free care available

Therefore, higher rates of demand for physicians and the availability of publicly financed care resulted in an increased use of health services to the poor.

In rural Nigeria (Gester, 1979) and in Mexico (Heller Chalfat, Quesada Riveraworley 1981) studies showed that high socio-economic status was related to high effort to seek modern health care. Whereas in Sudan a survey in seven residential districts found significant variations in diseases prevalence and the provision of basic health and health care services. These variations predictably reflect levels of wealth with the poorest areas having the most ill health and the fewest health care related services. This is said to be the product of under development and unequal distribution of resources and health (Hersert and Hijazi 1984).

According to Lahelma and Rahkonen (1997), the current and future socio-economic determinants of health and illness are important for those concerned with social research in general since social forces continue to shape health and their distribution across the population.

Other studies (Barley and Philips 1986, Montieri 1973) have also produced results which suggest that, low household income is a barrier to the utilization of modern health services even when they are publicly provided. The relatively well-to-do use the services of the trained practitioners and physicians more and spend more on those services than do the poor.

That is, income is seen as having a qualitative effect shown as a shift to more expensive and sophisticated practitioners on the same type of services.

According to Eckholm (1977), poorer people or regions within countries like poorer countries internationally, tend to have the highest infant mortality rates and the lowest life expectancy averages. However there is further proof that generalizations about income and health do not hold. For instance, the average income in the Indian state of Kerala is among the lowest in the nation, yet Kerala's rural infant mortality rate is well below half the Indian national average (Eckholm 1977) and at 61 years, the life expectancy is pretty well above the national average.

2.1.5 THEORETICAL FRAMEWORK

The situational approach theory

This theory focuses on the idea of a crisis, the definition of the situation and the concept of social disorganization, which bring about a redefinition of the situation. Its major proponents were Thomas and Znaniecki (1974).

Its proponents argue that human behaviour occurs under certain specific conditions. When people act as expected in a group organization, there is nothing to define. But when new influences appear to disorganize existing habits, thus, interfering with the existing situation or when a group is unprepared for an experience such as disease, then, the phenomenon results into crisis. This is viewed as a threat, a challenge, a strain on the attention, and it is, thus, a call to new action (Volkart 1951). What may, however, appear as a crisis to the observer may go unnoticed by the participant.

In this theory a crisis is seen as the most significant of human experience affecting the definition of individuals and groups, their behaviour and also influencing the context of culture and personality as well as the directions of socio-cultural change. The social disorganization that arises as result of any crisis calls for social reorganization to ensure proper direction to the future course of events. Behaviour, therefore, is situationally determined.

According to the proponents of theory, a redefinition depends on cultural factors which either independently or collectively influence subsequent behaviour, socio-economic, biological and psychological factors plus the physical environment, the social norms, values, attitudes as well as the people one interacts with. How an individual perceives a situation may influence his next approach to it; what it means to them and what their definition of the situation is.

The theory holds that the definition of the situation is begun by the parents through the process of socialization and it is continued by the community; through the process of socialization the group endeavours to have the individual internalize its own definitions and make them part of his/her habitual self. However, as Thomas and Znaniecki (1974) note the personality development through the process of socialization is not a “bundle of traits” but rather unique and dynamic, revealing itself in adjective efforts in various situations which are determined by a complex of internal and external factors.

In this theory the efficiency of the definition of the situation of the situation depends also on factors such as education, age, sex and travelling exposure, in defining a situation especially a disease situation.

A certain culture may demand the consultation of a traditional healer with regard to particular healer to particular symptoms. However, with time people may come to the realization that the traditional healer cannot cure the disease, but modern medicine can. This knowledge is most likely to lead to a redefinition of the situation such that if the same disease is suspected the sick person is taken to hospital for treatment.

The situation approach theory perceives human behaviour as malleable and that people are always trying to come to terms with or adjust to the situation in which they find themselves; the theory, however, holds that adjustment is not a smooth, uniform process in which cause and effect can be isolated simply by knowing the objective behaviour. When a member of a group falls ill, the action to be taken does not necessarily emanate from the known scientific aspect of the condition. Though the action taken may be illogical to the observer, it does make sense to the actors. This is because the course of action to be taken is not reached at random; rather various factors are weighed which lead to the most suitable action.

2.1.6 HYPOTHESIS

Health seeking behaviour is contingent upon individual's occupation.

Formal education level attained influences the discrimination in the choice of health care utilization.

The choice of a health care system is contingent upon community's cultural beliefs on disease etiology.

Independent variables

Occupation

Formal education

Cultural beliefs

Diseases etiology

Dependent variables

Health care services

Utilization

2.1.7 Operationalization of variables in the hypotheses

Occupation

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

Formal education

Refers to the formal schooling undertaken by the information the number of years spent in formal schooling.

Cultural beliefs

Refers to the people's perception, attitude and the interpretation of a particular illness and how they respond to it based on their learned behaviour.

Disease etiology

This refers to the perceived causes of particular diseases.

Health care services

This term has been used generally to refer to any practice related to the restoration of health or prevention of ill health.

Utilization

Has been used to refer to the steps taken to apply the appropriate techniques of curing.

CHAPTER THREE

METHODOLOGY

3.1 BRIEF HISTORY OF THE DISTRICT.

Busia District is situated at the extreme Western edge of Kenya in Western province. It was created in 1963 by bringing together Marachi, Bukhayo, North Teso and South Teso Locations which were formally under Elgon Nyanza (Now Bungoma District) and Samia and Bunyala then under central Nyanza (Now Siaya) District Development plan 1979 – 83).

The District previously occupied an area of 1819(sq kilometres) before Teso District was hived off, Busia District now has an area of 1478 (sq Kilometres). It is divided into Nambale 390 (sq Kilometres) Budalangi 390 (sq km.) Butula 238 (sq Kms) Busia Township 43 (sq km) and finally Funyula Division which occupies an area of 268 (sq kms). Busia District Borders with Teso District to the North, Kakamega to the east; and Siaya District of Nyanza Province to the south east; westwards it borders with the Republic of Uganda.

The District falls within the high rainfall Savanna ecological Zone with generally well distributed rainfall throughout the year. Out of 168,000 ha. Comprising the land surface area of the District, 151,900 ha. Are available for agriculture of these 145,600 ha constitute high potential land, 3,100 ha medium potential and 3,200 ha low potential land characterized by rockiness and poor soils, the remaining 16,100 ha covers land not immediately available for agriculture, such as the low-lying land around the lower reaches of the River Nzoia and Yala and extending to the shores of Lake Victoria, which is annually covered by floods.

3.1.1 Topography and Drainage.

The District falls within the lake Victoria Basin. The altitude rises from about 1,130m above sea level at the lake shore to a maximum of about 1500m in the Samia hills. Most of the central parts of the District especially Bukhayo and Marachi is occupied by a peneplain erosional surface marked by low flat divides of an approximately uniform, height, often capped by laterite and shallowly incised swampy drainage system.

Granitic outcrops occupy parts of North and central regions. The southern part of the area is occupied by a range of hills comprising the Samia and Funyala hills which run from Northeast to Southwest culminating at Mt Victoria, forming a very conspicuous topographic feature.

The Yala swamp occupies the southernmost part of the District. This is a downwarped area associated with the formation of lake Victoria. Most of the streams of the District are of intermittent flow depending on heavy rains. The permanent rivers are Nzoia and Sio. The smaller seasonal rivers are often silt-laden, indicating severe erosion along their courses and in the upper catchments.

3.1.2 History

The early history of the District as derived from oral traditions, is complex, since each of the numerous clans has its own origins and history of migration and settlement. The most convenient summary of traditions is that of Were (1967) though this deals mainly with Abaluyia as a whole.

The Luyia sub-groups of Abamarachi, Abakhayo, Abasamia and Abanyala each consists of congeries of heterogeneous clans of numerous different origins, most of which arrived in the area though not necessarily in their present locations, between eight and twelve generations ago roughly between 1600 and 1730 A.D. A majority of these clans, however, came by various round about routes from one broad linguistic area to the west-Busoga, Bunyole, parts of Buganda and Bugisu – and it is these who have provided the general Luhya sub-stratum of language and culture, homogenised to a large extent by high local mobility after arrival. Some of these “core” clans (eg, Abasamia and Abakhekhe of Samia) have a tradition of ultimate origin in “Misiri” conventionally interpreted as Egypt (though this location seems extremely improbable). Other clans originated from a variety of sources mainly Kalenjin and Luo and these have been assimilated both culturally and linguistically by the Bantu speaking majority, though they have left their own influences in different areas.

3.1.3 The Luyia Religious Belief systems.

The conceptualization of God was based on Were the only one God. He was thought to be living up in the skies, as opposed to the spirits of the dead ancestors, which were believed to be living in the under-world. Were was also perceived as Khakaba (the provider for each individual). However, Christians do not refer to God as Were but as Nyasaye a synonymous concept (District socio-cultural profile Busia District Date;).

The traditional beliefs as mentioned are still predominant among the Samia of Busia District. However, new beliefs are slowly reversing the situation. First came Islam through Arab traders who used to pass through Samia to Uganda from Mumias, later, of course Christian denominations such as Catholic and Anglican Churches were introduced. In more recent times syncretic regions such as Legion Maria have come in.

3.1.4 Agriculture

Traditionally the Samia people were farmers, except the Abakhekhe in Sio port who are primarily fishermen. The traditional staples were sorghum and millet; but new crops have been accepted in cases where they presented clear practical advantages for cash or subsistence, notably cassava introduced only 60 or 70 years ago (Were 1967) which has assumed a fundamental role in agriculture and diet, being drought resistant, invulnerable to locusts and capable of remaining in the ground until required, hence, obviating the need for storage.

Today, however, acreage under cassava has decreased due to competition for land from population pressure and newer crops. Although some people would still prefer Ugali made from cassava and Sorghum flour, Maize is now widely cultivated as well though not suitable for climatic regime of the lower drier areas. Besides, cotton was also widely cultivated as a cash crop before the cotton industry collapsed in mid 1980's.

3.2 The Study Area

This study was done in Funyula Division, Busia District. The Division covers Nangosya, Odiado, Mudoma, Ganjala, Bukhulungu, Busembe and Busijo locations. The 1979 census reported a population of 47,000 people giving an assumed reduced growth rate of 3.5% and population density 318 persons per (sq km). The main occupation of the residents is peasant farming of subsistence food crops such as maize, cassava, millet, sorghum and sweet potatoes. Others include beans, cow peas, groundnuts, simsim and several kinds of bananas. These crops are therefore, sometimes sold for petty cash, thus serve several purpose of food and cash but mostly at subsistence level. The non-food crops grown in the area include cotton, sugarcane, sunflowers and a few trees of robbusta coffee. There is also livestock farming on small-scale levels. There is also fishing in the lower parts of the division and in the Munana Valley. The people in the division are greatly influenced by existence, accessibility and distribution of social and economic infrastructure available.

3.3 Health facilities and disease incidence.

Busia has 39 health facilities of which 8 are hospitals (3 government and 5 private mission hospitals) in addition there are 14 health centres (11 government and 3 private) and 17 Dispensaries of which Funyula Division has the best in the District. It is relatively well supplied with health services.

No figure exists regarding the extent to which traditional medicine is used but random evidence suggests that this form of health care is still utilized by majority of the people in the Division (District).

The commonest health problem in the Division is malnutrition. The low level of health education and particular diseases such as malaria, T.B., venereal diseases, measles, pneumonia and gastro-enteritis, bilharzia, amoebiasis and cholera are also reported especially in perennially flooded parts of Samia. In spite of the fact that Samia is well supplied with modern health facilities, compared with the other parts of the district the pattern of major diseases has changed very little. Traditional beliefs and practices are still quite important in the people's response to disease.

3.4 Study Population

The study population includes all the people of Funyula Division. However, for the purpose of this particular study, not all the people in Funyula were studied because of the limitation in time and resources. Therefore, what was considered to be a representative number was randomly sampled, thereby giving every person in Samia an equal and a non-zero chance of applying in the sample. Those who were interviewed in this study were household heads, preferred because they are the most important decision-makers in the household. Besides, others were those who were considered to be knowledgeable in the topic of study (i.e. key informants). These included the local health personnel in both the government sponsored and private hospitals/clinics, traditional healers/herbalists, traditional birth attendants and a selected village elders. Others were those who were hospitalized and those who had gone for consultation at traditional African medicine men's/women's homes.

3.5 The Study Design

The design of the study aimed at collecting both quantitative and qualitative data. The study lasted sixty days during which the first phase adopted the survey research design within which the basic tool for data collection was the structured interviews based on questionnaires with both open and closed ended questions. The study was designed to elicit information on the socio-cultural and economic factors, which influence the utilization of traditional and Western medicine. In this phase, quantitative data was collected on age, marital status, educational level, household size, and other household economic indicators.

The second phase involved the use of in-depth studies (key informants) that gained complete and detailed information aimed at understanding the topic under study. Data were collected at two levels, the household and the community.

The reason for choosing the household as the unit of analysis is because it is an important decision making organ in rural areas, and can therefore, greatly influence the decision making process and sick behavioural patterns within the household. Households also vary in their characteristic composition based on socio-economic conditions. We sought to make observations to determine whether or not traditional and western medicine utilization in the area under study is differentially registered in relation to household variations in socio-economic conditions. The reason for choosing the community is because issues of sanitation and hygiene are not limited to the household; for where the environment is contaminated the community as a whole may be affected. It is imperative therefore, to understand how the community views issues related to HSB.

3.6 Sample Selection

Funyula Division consists of seven locations namely Nangosya, Odiado, Mundoma, Bukhulungu, Ganjala, Busembe and Busijo. According to the 1979 census results the area had a population of 47,514 people and was projected to be 85742 by the year 2001 (Busia District Development Plan 1997-2001).

This Universe is very large and could not entirely or adequately be studied given the constraints of time and financial resources. There was therefore a need for selecting a sample from the population to be studied.

Experience has shown that a large-scale survey study covering a big area such as a division rarely makes use of simple, systematic and stratified sampling because of time and the expenses involved. This study recognised that limitation and therefore used cluster sampling.

First the division was divided into locations and then a cluster sample of four locations selected out of the existing seven locations; from each location two sub-locations were selected which gave a total of eight sub-locations that were included into the sample. Subsequently, from each of the sub-locations the researcher selected a sample of households directly under each headman as is described administratively in Kenya.

Finally, under the jurisdiction of each headman, the researcher selected two households, which were studied.

Since listing households under the headman is relatively easier due to the small number of households represented by the headman, the lottery method was used in selecting households to be interviewed under the method of simple random sampling. In each household the head of the household was interviewed that included both male and female head households. In total 160 households were interviewed. However, also taken in to consideration was the fact that a cluster sample design precludes the use of affixed sample size in which case the researcher was forced to adjust accordingly for the sample size to be representative enough.

3.7 Data Collection Procedures.

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

3.7.1 Questionnaire

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

3.7.2 Direct Observation

During the course of the research, simple observation techniques were used. Of particular interest to the research were activities going on in traditional healers homes. The behaviour of clients to each other and to the attendant traditional healer. Through visits during healing sessions, a lot was learnt, especially about the traditional healing rituals.

Health institutions were also visited and the general behaviour of patients and the medical personnel were observed and recorded in the researchers' notebook.

3.7.3 Key Informants

Unfocused in depth interviews were carried out with twelve key informants and they were interviewed at different places. They were not sampled but they were interviewed on identification. The aim was to solicit additional information on the local people's perception of ill health and their response. These are people highly regarded in the society and are conversant with the communities' practices and perception of illness.

They included two elders, one clinical officer, one nurse, two TBA, two patients at the local hospital, two patients at the different traditional healers, two herbalists. An informal discussion was held by each one of these people separately and at different places and their responses noted in the researchers note book. The interview guide questions were very much related to the ones on the questionnaire allow for comparison of the responses.

This method can be disastrous if the informant selected is an "outcast" or a marginal member of the community such informant would prevent the researcher from reaching other informants because of his association with someone who is not respected. To overcome this an attempt was made at careful scrutiny of the informants such that the people who were selected in the long run could qualify to be termed socially recognised personalities. Informants have also been known to lie, for this reason the information obtained was thoroughly cross checked by relating it to the known facts about the people and any inconsistencies ironed out.

3.7.4 Secondary data.

Documentary material through library research were a major source of data for this study, particularly at the formulatory stages, relevant literature concerning traditional and western medicine was reviewed to provide background information to the study. Pertinent issues were examined and it was from the written works that the research problem and hypotheses were identified.

Written materials that were reviewed included books, journals and articles. More relevant materials were consulted to back up information from other sources where necessary, during the study period. These included materials from the local archives in the field, e.g. those in the district documentation office and records from the local health facilities.

Methods of data analysis

Both quantitative and qualitative methods were used in data analysis. In the quantitative approach the study made use of descriptive statistics whereby percentages and frequencies of various responses were calculated and correlated. The study also used cross tabulations in which chi-square tests of significance were employed.

The qualitative method was used in describing and discussing the data pertaining to attitudes, beliefs and practices regarding health-seeking behaviour. These data were mostly collected through key informants, where direct quotations and selected comments from informants were used.

Problems Encountered.

Several problems were encountered in the process of fieldwork. The areas, which were studied in most cases, are far from the major roads. This consequently led to the problem of transport. At times reaching the respondents entailed walking over long distances. It, therefore, became difficult to make first progress because of the minimal number of interviews carried out in a day. Considering the time and financial constraints at hand it became necessary to cut interviews to a manageable size.

The question of how the respondents were going to benefit from the research was very persistent. The respondents often related their experience with past researches and complained that despite pouring out their problems nothing had been done to change their conditions on such an event.

The respondent would digress and start expounding on what he/she thought was important and therefore, needed changing. However, on the whole most of the respondents and the administration were very co-operative.

Another problem had to do with the instrument of data collection. The questionnaire, which was the basic instrument for data collection, had a number of problems. The respondents complained that the questionnaire was too long and therefore took a lot of their time.

The respondents also felt that some questionnaires touched so much on their privacy, e.g. what is your monthly income? Thus questions on sexuality and on income were either answered vaguely or met with silence.

On the problem of income we tried to intervene by assuring the respondents that the information sought was not for any ulterior way but just to help the researcher in establishing whether income of the individual has any bearing on alternative health care sought and hence the information is secret, on the other hand, on the questions asking on sexuality, alternative words in the local language were used which were less embarrassing and acceptable to the people.

The study touched on health and more often than not the author was mistaken to be a medical doctor. In such circumstances the informants would ask questions concerning diseases which normally affect them and their mode of treatment. We tried to overcome this by answering questions, which deal with basic health information.

At one point the research created a situation of fear without the intention of doing so. The research process came at a time when the areas Divisional Officer (DO) had given an order to the effect that those without pit latrines would be arrested as a reaction to Cholera outbreak in the area at the time of the study. Some respondents, therefore, feared reprisal from the authority and gave false information concerning alternative health care. This problem was resolved in part by assuring the respondents that we were only interested in finding the factors that influence the utilization of traditional and western medicine and were in no way government agents.

Finally, a problem that came quite often was that of immediate financial handouts to the informants. A good number of the respondents thought that the researcher had money to give in exchange for information, and therefore, at the end of an interview they could ask if there was nothing for them. It was not only financial but even some gifts including drugs for various ailments. However, on the whole majority of the respondents were co-operative, patient and willing to give information sought.

CHAPTER FOUR.

DATA PRESENTATION AND ANALYSIS 1.

4.0 INTRODUCTION.

This chapter presents the findings of the study together with data analysis. The chapter is divided into two sections, namely the general socio-economic characteristics of the household that has impact on the health seeking behaviour and the level of formal education obtained and its contribution to health seeking behaviour.

4.1 BACKGROUND INFORMATION ON RESPONDENTS.

4.1.1 Demographic Characteristics.

As shown in table 4.1 there were 160 respondents in the sample. This table depicts clearly that a majority of the households in Funyula are headed by males (88.1%), whereas (11.9%) are female-headed households. This finding supports the integrated rural survey of (1974-75, which stated that slightly less than one-fifth of the households in Kenya were headed by women. In such households it is observed that the husband was either diseased or absent for long periods and the woman had to assume the economic responsibilities and decision making without reference to the absentee husband. Besides this study based on the divisional administrative unit show that female headed households in Funyula are still few and far between.

Table 4.1 Sex of household heads.

SEX	NUMBER OF RESPONDENTS	PERCENTAGES
Male	141	88.1
Female	19	11.9
Total	160	100.0

Source: Study data

As shown in table 4.2 most of the household heads (43.8%) are aged upto 40 years 22.5% are aged between 41 and 50 years. The average is 53.3 years and the range is 34 years, evidence from this table, therefore suggests that on the average households in Funyula are headed by people in their middle and late adulthood.

Table 4.2 Age of households heads.

AGE	NUMBER OF RESPONDENTS	PERCENTAGE
Upto 40	70	43.8
41-50	36	22.5
51	54	33.7
Total	160	100.0

Source: Study data

Table 4.3 indicates that a majority of the respondents 85.0%, were married, 5% were single, 2.5 were divorced and 7.5% were widowed. This table reveals some very important demographic information, it shows that married people (85.0%) head most of the households in Funyula. It also that only 5.0% of the households in Funyula are headed by single people, most of whom were found in the trading centres of Funyula and Mulukhoni, these are those who have never entered a marriage union, 2.5% of the households are headed by divorcees and only 7.5% are headed by widows and widowers.

This, therefore shows that there are very few single and divorce case headed households in Funyula division on the other hand with the prevalence of the practice of widow inheritance one may want to know why the widow have not been inherited. However, this could be explained by the fact that probably these widows could have actually been inherited but feared to divulge this information due to many other reasons. One of them could be that the relationship with the man may not have been communally sanctioned and another reason could be the fact that widow inheritance has in recent times been associated with spread of HIV/AIDS.

Table 4.3 Marital status of household heads.

MARITAL STATUS	NUMBER OF RESPONDENTS	PERCENTAGE
Single	8	5.0
Married	136	85.0
Divorced	4	2.5
Widowed	12	7.5
Total	160	100.0

Source: study data

SOCIO-ECONOMIC FACTORS

4.2.1 Introduction

The socio-economic context within which people must operate has an important influence on the way they go about taking care of their health or generating information about their problems. The present economic recession in Kenya has had a differential impact on the various medical systems. The dependence of the western medical services imported drugs and technology has resulted in a sharp rise in the cost of treatment. There is, thus a growing argument that biomedicine is very expensive and also not a panacea. This has led to renewed interest in faith healing and traditional medicine. In this section the socio economic status of the respondent is represented, the factors discussed include income, occupation and education.

4.2.2 Occupation

The level of formal employment among the respondents was 6.3% those formally employed in these area included teachers, nurses, and the clerks in the divisional offices, while 3.8% were casual labourers, in this sector are, those bicycle repairers and tailors. On the other hand, a greater majority (82.5%) of the respondents were in petty businesses. This could be partly due to the fact that, the research was done in a rural area where formal sector employment is scarce. There is no larger scale commercial farming in this area. Previously people in Funyula were relying on cotton farming as a cash crop, however, with the collapse of the cotton industry people have since abandoned it, but, there is a great potential for horticultural production, especially tomato farming. Most of the households in this area engage in small-scale farming. They mainly grow maize, sorghum, beans, cassava, sweet potatoes, millet and sugarcane. There is also livestock and, poultry, rearing the include cattle, goats, sheep, chicken and ducks. Livestock is reared for domestic products such as milk, meat and dung for manure and smearing (plastering) floors and walls of houses and poultry for eggs and meat.

The farm products are done on small scale mainly for home consumption, though in some cases they are sold to earn them some money to buy other basic household requirements such as paraffin, soap, sugar, salt, matches, beef, fish and many others. Apart from farming other respondents engage in petty businesses along the road within the villages or at the neighbouring trading centres of Funyula, Nangina, Mulukhoni, and Bukiri among others. They sale products such as fish used cloths, both raw and cooked potatoes, bananas, maize, sorghum, beans, and many other household products.

The income distribution among the respondents reveals that only 2.5% of the respondents earned more than six thousand Kenya Shillings in a month, only 4.4% of the respondents earned between 3001 and 6000 thousand Kenya Shillings in a month whereas 25.6% of the household falls in the category of 1000 and below Kenya shillings a month. However, it is worth to note that majority of the respondents, 93% belong to the lower and middle income earners (0-3000) Kenya shillings in a month according to the Kenya standards. This could be explained by the fact that a majority of the people are peasant farmers as shown on table 4.4. However, those with the bigger income are those in the formal employment such as teachers, nurses and clerks at the divisional offices, the rest depend on petty trade casual labour or money sent by relatives working in urban centers in other parts of the country.

Table 4.4 Occupation of household heads

OCCUPATION	NO. OF RESPONDENTS	PERCENTAGE
Farmers	132	82.5
Formal Employment	10	6.3
Informal Employment	18	11.2
Total	160	100

Source: study data

4.2.3 Cross-tabulation and hypothesis testing.

Significance tests were employed to evaluate the relationship between variables in selected cross-tabulation. In all cases the 01 significance level was used in testing the hypothesis. A calculated chi-square (X^2) value that is less than or equal to the tabulated, (critical chi-square) fails to attain the significance in which case the null hypothesis is upheld while the alternative hypothesis is rejected. A calculated chi-square value exceeding the critical value attains the significance with the resultant acceptance of the alternative hypothesis (H_1) and the rejection of the null-hypothesis (H_0). The two hypothesis formulated in chapter two were tested by this criterion. The tests were further supported by an attempt to discuss the hypotheses using inferences from the descriptive results.

4.2.4 Patterns of occupation relative to health seeking behaviour (HSB).

The first hypothesis stated that health-seeking behaviour is contingent upon ones occupation, in testing this hypothesis number of variables both independent and dependent were involved. Variable occupation the influencing variable was measured by the following:

- The utilization of modern health services.
- The utilization of indigenous health services.
- Action taken following illness episode.

Contingency tables were derived by cross-tabulating the dependent variable with independent variables. Most of the chi-square values yielded by the cross-tabulation attained significance at 0.01, significance level.

Table 4.5 Shows that variable occupation by if ever utilized modern health care services attained significance association at 0.01 significant levels when the calculated chi-square (X^2) is greater than the tabulated (X^2) in which case the alternative hypothesis (H_1) is accepted and pull hypothesis (H_0) rejected.

It shows that ones occupation determines whether one would seek help in a modern health facility or not. The table further reveals that out of 160 respondents in the sample 134 (84%) of them had availed themselves of the use of cosmopolitan health services, at least ones in their life time whereas as 26 (16%) of the respondents who said that they have never utilized cosmopolitan health services whenever they are sick.

Table 4.5 Occupation by if ever utilized modern Health Care Facilities.

OCCUPATION	EVER UTILIZED		
	YES	NO	ROW TOTAL
Farmers	70.1%(113)	11.9%(19)	82.5%(132)
Formal Employment	6.3%(10)	-	6.3%(10)
Informal Employment	6.8%(11)	4.4%(7)	11.2%(18)
Column Total	83.8%(134)	16.3%(26)	100%(160)
X2=9.257 DF=2 Sig=0.02606 Contingency coefficient=0.23386			

Source: study data

Occupation and the use of indigenous health care facilities did not attain significance association at 0.01 level of significance when the calculated x2 in which case the will hypothesis (H_0) is upheld and the alternative hypothesis (H_1) is rejected.

Table 4.6 data however, reveals that more than a half, of the respondents (59.4%) have once in a while used indigenous medical- case, whenever they where faced with health a disease whereas only 65(40.6%) of the respondents said they have never used indigenous medical services in their life time. The findings from the same table indicates that 78 (48.8%) of a total of 132 of the respondents who were farmers have used indigenous health services once in their life time; 2(1.3%) of a total of 10 respondents who are finally employed have utilized indigenous medical services whereas a out of a total of 18 respondents in informal sector employment have once in their life time availed themselves of the use of traditional medical care services.

Table 4.6 therefore, reveals that indigenous health services still persist and are equally in high demand in the presence of it's powerful rival (cosmopolitan medical services). This study supports studies done by other scholars: for example Bonnerman (1983) noted that traditional medicine still remains the only source of care for many people..... "It is their primary health care". On the other hand (WHO 1978, Pillsbury: 1979, Philips 1985) have argued that the cost of traditional medicine is variable depending upon the treatment and relative health of the client as perceived by the healer. The pay is also not necessary in monetary terms but one could settle the bill by use of a cow, bull, chicken, goat or sheep depending also on the ailment and the ability of the client to pay. This study also compares with estimates given by (Ampofo and Johnson-Ronald 1978) that over 75% of the rural population in Africa seek medical care among the traditional healers. Therefore, throughout Africa they argue traditional medicine is thriving.

Table 4.6 Occupation by if ever utilized indigenous health care services

OCCUPATION	EVER UTILIZED		
	YES	NO	ROW TOTAL
Farmers	48.8(78)	33.8(54)	82.5(132)
Formal Employment	5.0(8)	1.3(2)	6.3(10)
Informal Employment	5.6(9)	5.6(9)	11.2(18)
Column total	59.4(95)	40.6(65)	100.0(160)
X ² =3.4603 df=2 sig=32595 correlation coefficient = 0.145496			

Figures in parentheses are column totals

Source: study data

The researcher was also interested in finding out immediate therapeutic option people would resort to at the on-set of ill-health and that, the health care facility opted to is a consequence of occupation. In Table 4.7 below, contingency table derived by cross-tabulation reveals that there is an association between occupation and the first health care resort system at the onset of ill health. Therefore there is a discernible significant relationship between occupation and the first resort system at the onset of disease at 0.01 level of significance.

Table 4.7 Occupation by Choice of Therapy at the onset of Illness Episode

OCCUPATION	CHOICE OF THERAPY		
	Modern	Traditional	Row Total
Farmers	56.3(90)	26.2(42)	82.5(132)
Formal Employment	4.4(7)	1.9(3)	6.3(10)
Informal Employment	8.1(13)	3.1(5)	11.2(18)
Column Total	68.8(110)	31.2(50)	100(160)
X2=11.86031 DF=2 Sig= 0.68957 correlation coefficient=0.2627			

Figures in parentheses are column totals

Source:study data

The key informants revealed that at the on-set of ill-health a majority of the people would first seek cosmopolitan assistance and then when it fails people would therefore sought health care from indigenous African healers. It was also revealed that through informal discussions that diseases that attack with disastrous results are usually taken to the cosmopolitan health experts. As one of the key informants Mr. Otieno Mbem commented:

Most people who are brought here for assistance are always helpless, with very little remaining of them. They come to me when they have exhausted other possible avenues. It is as if they bring people here to die and blame it on me. Over the last two years, I have had about seven of these emaciated helpless people coming to me. I have been able to treat four and three have died. You see some people sometimes see us as if we the traditional healers are useless and have nothing to offer.

In table 4.7 it is indicated that people in the area of study still widely believe in the efficiency of traditional medicine irrespective of one's occupation.

The study reveals that in some cases of disease there are differences in the indigenous perception of the same illness. Basically in all cultures there are ways in which people classify diseases, this applies to abasamia too. The way the diseases are classified affects the type of medical services sought for its treatment. The use of health care services may depend on whether a disease is considered to have a natural origin (In domain of scientific medicine or of supernatural origin, in the domain of traditional and/or faith healers).

Fosu, (1981) carried out a study in which he investigated how people of Berekuso, a rural community in Ghana classified diseases and examined the extent to which this classification affected the utilization of existing health care facilities. He found that the people of Berekuso distinguished between three main causes of diseases, Natural, supernatural, and both natural and supernatural. Most supernaturally caused diseases were treated in the context of traditional medicine.

It was also found that with the supernaturally caused disease there was a belief that the hospital or clinic remedies were ineffectual and could even aggravate them. However, when such diseases are taken to the clinic the people do so mainly for symptom relief and they trust the traditional, healers to effect the actual spiritual cure. Fuso observed that, to most people of berekuso, especially the illiterate, a disease was inseparably linked to its cause. He therefore, came to the conclusion that even though the symptoms and signs of supernaturally caused diseased may abate with help of scientific medication the subjective sense of being sick may persist so long as the spiritual cure has not been effected. On the basis of the observation made the preceding literature the number of cases in support of the hypothesis is far in excess of the cases discordant with the same hypothesis. The hypothesis is therefore accepted overall.

4.3 Formal education level obtained influence the discrimination in the choice of health care services. This hypothesis was formulated with the assumption that the level of education one has obtained influences Health Seeking Behaviour (HSB). In testing this hypothesis a number of variables were involved. The contingency tables were derived by cross-tabulating dependent variable by independent variables. Most of the chi-square values yielded by the cross-tabulation did not attain significance at the 0.01 significance level.

Table 4.8 indicates that χ^2 value for the variables formal education obtained by ever utilizing cosmopolitan health facilities did not attain a significant association. It was expected that formal education level attained by somebody would influence seeking modern health care facilities.

However, the tables shows that a majority (71.9% of the respondents had acquired formal education, whereas, (28.1%) had not been to any school. A majority of those who had obtained formal education, (51.9%) had obtained primary education, (14.4%) had secondary education and only (5.6%) had obtained post-secondary education. The table further reveal that out of a sample of 160 respondents 134 (83.5%) of them have used modern health facilities once in their life time and only 26 (16.3%) of them said they have never utilized cosmopolitan health services.

It could also be said that whereas, it is not known how much of formal education attainment is relevant to the utilization of modern health services in Kenya, it is possible that what most people learn in school about diseases and their remedies comes to them informally through non-classroom situations. It is also important to note that western education has been potrayed by several studies as one mechanization by which modernization of health utilization patterns occurs. For example Okafor (1983) found educational attainment was positively related to more frequent use of western type health providers in rural Nigeria. The same is true of Uyanga (1979) working in Nigeria and Mwabu (1986) in Kenya also assert the importance in the determination of the type of healer sought.

However, Colson (1971) concluded that it is often the nature of the disease more than any characteristics of the population or household that determines whether western or traditional health services are sought.

Table 4.8 Formal Education Obtained by Ever Attended Modern Health Care facilities

EDUCATION	USE OF THERAPY		
	YES	NO	ROW TOTAL
None	11.8(19)	1.3(2)	13.1(21)
Primary	51.9(83)	12.5(20)	64.4(103)
Secondary	14.4(23)	1.9(3)	16.3(26)
Post secondary	5.6(9)	0.6(1)	6.2(10)
Row total	83.7(134)	16.3(80)	100.0(160)
X2= 2.1684 DF=3 Sig= 0.53817 Contingency coefficient= 0.1156377			

Figures in parentheses are column totals

Source: study data

Formal education attained by the utilization of indigenous health care services did not attain significant association at 0.01 level of significance (Table 4.8). However, when highlighting this variable the researcher, was of the opinion that there is an association between formal education attainment and the use of indigenous health services. By looking at the table cells it is indicated that more than half of the respondents represented in the sample (59.4%) who had formal education had availed themselves of the use of indigenous health services, while 35.6% of those respondents with formal education have never attended the indigenous health care services in an event of disease. The table further reveals that 38.8% of those who had once in their lifetime consulted indigenous health experts had primary education while 7.5% had secondary education and 5.0% of the respondents had post-secondary education.

The inference that can be drawn from the table is that educational attainment does not influence the utilization of indigenous health care services. This also confirms what one herbalist aid.

" My clients are people of varied background, they come from all walk of life. I attended to all classes of people both poor and rich, illiterate and literate, because as you know disease does not discriminate against human beings". This finding also supports other studies done on Health Seeking Behaviour (HSB). It seems that tradition persists among the educated. There is also the situation normally encountered where the parents are illiterate and the offspring are well educated.

The old people hold strong beliefs that certain diseases cannot be cured by biochemical and hence they would seek treatment in traditional medicine for their educated kin (Sindiga at al 1995;78). According to the study about beliefs and practices concerning measles among the Akamba of Kenya, education was found not to influence the type of medical care mothers selected, but did influence the use of a certain traditional practices (Maina 1978). However, other studies for example by Maclean, 1971 in Ibadan found that increase in age and illiteracy was associated with high use of traditional medicine. He argues that homes in which a mother had a professional training such as nurses and teachers were less likely to resort to indigenous services. However, Erinosho (9182) observed that all cadres of society use traditional medicine. Studies carried out among the Kamba, Kikuyu, Gusii, Turkana, Duruma, Digo, Luhya, Luo, Tugen and Pokot in both rural and urban Kenya shows that regardless of place of residence, education and religion most people hold concepts of health and illness which have two common features. The first feature relates to the recognition that most illness has a sociological basis, which is whole embracing. Health and illness among the communities studied include both the "how" component and the "why" component.

The how component relates to the causation of an illness and the interventions thought appropriate to eradicate the illness. The "why" component refers to the peoples explanation for the particularity of an illness. This component relates to the timing of an illness Nyamwaya (1992).

From his study Osero (1990:76) says that "Medical Science has not provided answers to some of the problems that face the people in way they can accurately interpret and understand, where such a situation arises people fall back to seek answers and remedies from their traditional systems. Clinicians don't explain causes of therapy, may be thinking people wont understand. This may not encourage faith in modern medicine.

Table 4.9 Formal education obtained and if ever used traditional health services

FORMAL EDUCATION LEVEL	RESPONDENTS		
	YES	NO	ROW TOTAL
None	8.1(13)	5.0(8)	13.1(21)
Primary	38.8(62)	25.6(41)	64.4(103)
Secondary	7.5(12)	8.8(14)	16.3(26)
Post secondary	5.0(8)	1.2(2)	6.3(10)
Column total	59.14(95)	40.6(65)	100.0(160)
X ² = 3.73208 DF=3 Sig= 0.2918 Contingency coefficient=0.1509762			

After the chi-square statistic and contingency coefficient were calculated in table 4.9 the results was that there is a significant relationship between variable formal education obtained by the reason why the decision to consult a particular health facility is taken. As can be seen from the table, there is a strong relationship between the variables at the contingency coefficient 0.3624557 at 0.01 level of significance.

Again from the table one learns that a majority of the respondents in the sample 59.4%, who had formal education consulted a medical facility at the on-set of ill-health because it was appealing, 19.4% of the respondents with formal education sought medical care from a given facility because it is the nearest, whereas 18.2% of the respondents who had a formal education did so because it was the cheapest.

The table therefore, reveals that over half of those respondents with formal education did not mind about other factors other than a medical facility which in their view is appealing probably by offering the best services and thus do not care about the distance or the cost of treatment. This also shows that a majority of the people when faced with a situation of ill-health would prefer that facility that gives those services that restore the clients confidence. It also reveals that some patients and/or his relatives or friends (19.4%) would be compelled to seek care at a particular facility not because it is the best or cheapest but because it could serve their immediate need of relieving a patients pain, this is common with cases of acute attacks. Besides, some people are not ready to travel to a far place because they want probably to save time. Funyula division being a rural area some people (18.2%) would not be in a financial position to seek help from a private medical practitioner who charges much more money than the heavily sub-sidized government facilities.

My observations revealed that there were very few patients at Nangina mission Hospital compared to those who are attending Nangina dispensary. My investigations from Nangina mission, Hospital personnel and patients attending the dispensary said that people find private facilities unaffordable as attested by one of the patients attending the dispensary:

" That mission hospital is for the rich, I'm a poor widow who is not able to get more than Shillings 300 they may require from me. Another thing is that they are quick at admitting patients, with ailments that do not warrant such action, besides, they also like blood transfusion and that costs a lot of money. However, the dispensary at times has drugs at no cost and that is why widows like myself prefer it"

As stated above the poor in Funyula would not go to a facility because it is the best but because it is affordable. Mrs. Ann Ajwala, a herbalist told me thus:

" People come to me because I charge less money and the payment is not strictly on monetary terms, people pay me in terms of chickens, goats and sheep depending on one's ability and the kind of disease being treated. However, at times I just demand money for "blessing the medicine" like five shillings. Because medicine cannot work effectively without a token gift to the ancestors who guide me in my work".

It is therefore, possible to say that in rural division like Funyula where poverty abound, some people would be inclined to seek help from a cheaper financial facility due to their financial inability to pay for

the services rendered by private facilities even if their services are superior.

Table 4.10 Formal Education obtained by the reason for the action taken at the onset of illness episode

EDUCATION	RESPONSE			ROW TOTAL
	NEAREST	CHEAPEST	MOST APPEALING	
None	4.2(7)	3.1(5)	5.6(9)	12.9(21)
Primary	11.3(18)	8.8(14)	44.5(71)	64.6(103)
Secondary	0.6(1)	6.3(10)	9.4(15)	16.3(26)
Post sec	3.1(5)	0.6(1)	2.5(4)	6.2(10)
Column Total	19.2(31)	18.8(30)	62(99)	100(160)
X2= 24.199 DF=6 Sig=0.01911 Contingency coefficient=0.3624557				

Figures in Parentheses are Column totals

Source: study data

In the table 4.11 the respondents were asked to say in their own opinion that is more Patient with them between traditional health workers and cosmopolitan health personnel. The aim was to find out if there is any relationship between the utilization of a health personnel by formal education attained. The variables did not attain significance. However, the table shows that 51.3% of the respondents who had formal education said that traditional health workers were better in their approach whereas, 35.6% of the respondents with formal education on the other hand, felt that modern personnel were the best in approach. The table also reveals that 36.6% of those respondents in the sample who had primary education level thought traditional health experts were approachable and patient with the clients, whereas, 27.5% of them thought it was the cosmopolitan health personnel who are good in approach to clients.

But only 15.4% of those with secondary education and post secondary saw traditional health workers, as patient with clients while 8.1% of them considered modern health workers as the best when it comes to approach to clients.

Some scholars (Okafor 1983, Kruger 1974,) have observed that traditional healers were approachable during illness because they were open to the patients, but Ngubane 1977, attributes the fact that traditional healers were approachable during illness because of their ability, (rather assumed ability) to name the disease without waiting for the patient to disclose his ailment. Fako 1980, adds that traditional medicine attempts to restore a balance between the individual, and his institution and the society. It provides for the spiritual as well as social needs to which contemporary cultures has no answer. However, Lambo 1974, on the other hand, argues that practice of medicine is more than the administration of drugs and potions. It encompasses all activities personal and communal that are directed towards the promotions of human well being.

Table 4.11: Formal Education attained and approach given to patients by both indigenous and modern health workers

EDUCATION	HEALTH WORKERS		
	Traditional	Modern	Row Total
None	7.5(12)	5.6(9)	13.1(21)
Primary	36.9(59)	27.5(44)	64.4(103)
Secondary	11.3(18)	5.0(8)	16.3(26)
Post secondary	3.15)	3.1(5)	6.2(10)
Column Total	58.8(94)	41.2(66)	100.0(160)
X ² =1.601 DF=3 Sig=0.65748 Contingency coefficient= 0.09975			

Figures in parentheses are column total

Source: study data

In table 4.12 the respondents were asked weather they had witnessed the process of healing by use of indigenous methods. The findings of this table when the chi-square statistics are calculated shows that there is no associated between formal education and witnessing indigenous healing. At the same time the contingency coefficient of 0.10 level. From the findings a majority of the respondents in the sample 110 out of 160 answered that they had witnessed traditional healing either on themselves, relatives, friends or a neighbour, whereas only 29 out of 160 of the literate respondents had never witnessed indigenous healing in their lifetime.

However, when the respondents were asked the type of illness they had witnessed, they give varied

answers, however, these were some of the common ailments mentioned barrenness, madness, spirit possession, Ekhiria, (a condition resulting from breaking a taboo), measles, bone setting, general body weakness, elephantiasis, impotence and evil eye. When carefully checked the diseases mentioned above, majority of them are considered to be inflicted by the super natural factors.

From the findings of this study we can deduce that indigenous healing practices are still common as exemplified by those with formal education and have ever witnessed traditional healing techniques. It is also possible that the number could be much higher because there are those who do conceal their knowledge of witnessing and participating in a traditional healing ritual probably because of religious affiliation and also perhaps due to the fact that some people associate indigenous healing techniques with witchcraft and therefore, some people would not want to associate with it openly. This is largely a colonial legacy that condemned African healing techniques as harmful and heathen.

It is to be noted however, that traditional healers, far from narrowing their focus to the merely technical (as in modern health care) are open to a wide range of mostly “mystical” explanations. Hammoul-Tooke, points out that much illness is explained in quite explicitly religious terms not only as being caused by spiritual entities, but also in terms of moral responsibility (Hammoul-Tooke 1989). For most western practitioners’ explanations of illness, which falls outside the laws of natural science is pseudo-scientific, primitive and simply wrong. This perception which begun with first historical contacts with African cultures continues to have strong support.

Table 4.11 Education level attained by ever witnessed a traditional ritual.

EDUCATION	YES	NO	ROW TOTALS
None	8.7(14)	4.3(7)	13.0(21)
Primary	50.6(81)	13.7(22)	64.3(103)
Secondary	13.1(21)	3.1(5)	16.2(26)
Post secondary	5.0(8)	1.2(2)	6.2(10)
Total	77.5(124)	22.5(36)	100(160)
X ² =1.685 DF=3 Sig=0.64017 Contingency coefficient=			

Figures in parentheses are column totals

Source: study data

Afonja (1986) has reported that the prevalence of a belief in metaphysical (preternatural and supernatural) causes in addition to natural causes did not hinder visits to medical centres in rural communities. Western medical practitioners are generally sought out, after home remedies have been tried. Ofonja concluded that “the data on the hierarchy of resort in infants and adults illness do not corroborate beliefs and perceptions of illness and health” (1986-10). In addition, he discovered that western medicine is assessed as good as for providing an initial diagnosis. This perhaps explains why some find it expensive to visit the hospital first. However, even those who visit hospital first expect the prognosis to be immediate and any delay will see them looking for an alternative medical care. What a person finally decides is affected by the individual's own Socio-political events influencing individual's views and reactions. These are in part, affected by the individual's own Socio-economic standing. Deep-seated feelings exist about, each of the competing medical systems. For instance there are indications that while the educated believe in the supernatural dimensions of health and illness, the present generations of traditional healers are viewed with suspicion.

CHAPTER FIVE.

DATA PRESENTATION AND ANALYSIS II.

5.1 Introduction

This chapter presents the findings of the study together with data analysis. The chapter examines how beliefs about illness and causation influence the discrimination between utilization of public sponsored health services and indigenous health care services.

5.2 Perception of illness and choice of therapy.

The Samia have evolved overtime some techniques to help them manage various forms of ill- health. These beliefs are backed by various concepts regarding causation treatment and prevention of illness. The Samia recognize several factors as causing disease. The Samia are also able to differentiate between the naturalistic and supernatural forces as causing illness "*Obulwaye*". However, at other times, they attempt to explain the particularity of an illness, hence they resort to identify things like witchcraft, violation of food and moral taboos and the evil eye: *Obusura*" as "causes". Spirits "*Ebikhino*" especially "*Emisebe*" ancestor spirits are also given as causes of certain conditions. The Samia categorize diseases into those that are best handled by modern health facilities and those that are best handled by traditional medicine. In the wake of societal changes, there have been also a number of transitional diseases and illnesses some hitherto were known to the community whereas symptoms may be difficult to distinguish one from the other (Sindiga 1995, p.78).

Studies of illness episodes in different societies reveal that each society's definition of illness becomes institutionalized within its cultural patterns. Some individuals recognize specific physical symptoms such as headache, common cold, and a fever and seek out a physician for treatment; others with similar symptoms may attempt self-medication or dismiss the symptoms as not needing medical attention. In a study done By Sigerist (1960) found that among the Kuba of Sumatra, skin disease and injuries to the skin were quite common because of the difficult jungle environment. A person suffering form a skin disease would not be considered to be sick among the Kuba, because the condition, while unhealthy, is not considered abnormal. Examples such as this have led to the realization that an essentially unhealthy state may not always be equated with illness when the persons involved are able to function effectively and the presence of the disorder does not affect the normal rhythm of the daily life.

There are many different kinds of medicine- men and women among the Abasamia. The general name for these practitioners is *Omulakusi*” (p. Abalakusi) though they differ in their field of specialization. Many exist and operate in various parts of Funyula division. The people trust many of these, however quacks have been increasing steadily.

Some of the quacks have acquired the paraphernalia of modern medicine, like syringes and needles and inject people with drugs like penicillin and chloroquine. They also administer capsules, tables all of that are regarded highly by the residents.

This section examines how the beliefs about illness and its causation influence the discrimination between publicly sponsored health services and indigenous health services.

Table 5.1 Categories of reported illness in funyula and the associated diseases of the illness.

KINDS OF ILLNESS	TYPES OF DISEASES ASSOCIATED WITH IT
NATURAL ILLNESSES	Asthma, Venereal diseases, Dysentery, Measles, Coughing, Common cold, Headache, Diarrhea, Leprosy, Typhoid, Malnutrition, Cholera, Diabetes, Respiratory infections, intestinal worms, Backache
SUPERNATURAL ILLNESSES	Madness, Hysteria, Epilepsy, infertility, evil eye, accidents, excessive worries, bad dreams, sleeplessness, snake bite, body wasting, ekhira, abdominal pains.

Table 5.1 shows some of the diseases that were reported by the respondents in Funyula and their cultural explanations. It is important to note that those diseases that are said to be caused by infectious agents (disease causing pathogens) such as bacteria and virus were categorized. On the other hand there were diseases which were considered to be caused by supernatural power, this means that these diseases were thought to come about as a result of witchcraft, breaking a taboo, evil spirits and ancestral spirits.

It is important to note that whereas there is increasing knowledge of disease as arising from natural causes, the view that diseases arise from supernatural causes is still prevalent. This shows that cultural factors on causes of illness are important in understanding people’s response to health services. Onokerhoraye (1984) observed that in African communities, the traditional conception of disease causation incorporated belief in natural or God –given illness and in supernatural forces. These include witchcraft, ghost and spirit disturbances.

The medical view of the illness is that of deviance from a biological norm of health and feelings of well being. This view involves the mechanism of pathogenic within a body that can be objectively documented. The diagnosis of a disease results from a correlation of observed symptoms with the knowledge about the psychological functioning of the human being. It is against this view that the hypothesis on knowledge about beliefs on diseases mode of transmission and the decision to take action at a particular point in time or not to do so at all, besides, the type of therapy sought is tested in this chapter.

A variety of symptoms were used in testing this hypothesis with a view of examining how they fitted into the respondent’s perception of illness and mode of therapy seeking.

Table 5.2 Illness and choice of therapy in the household after determining the symptoms.

ILLNESS	CHOICE OF THERAPY		TOTAL
	MODERN	TRADITIONAL	
NATURAL	85	24	109
SUPERNATURAL	6	45	51
TOTAL	91	69	160

Evidence from the above table indicates a discrimination of health facilities by patients depending on the understanding of illness. A majority of the patients suffering from natural illnesses opted for modern health services. Table 5.2 shows that out of 109 cases that had natural illnesses only 24 were for indigenous therapy. However, 45 of those suffering from supernaturally induced illnesses went to traditional healers while 6 of them sought modern medical services. This table also indicates that most common ailments in this area are natural.

However, it is important to note that even where diseases were classified as natural, patients still utilize traditional health facilities. Likewise in the case of supernatural some sought help from modern health facilities. It has been observed that traditional healers even in urban areas are increasingly participating in the treatment of asthma, bronchitis, hypertension, infertility, madness, diabetes, ulcers and measles. The findings in this table also suggest that the kind of illness influence choice of therapy.

Ademuwagun (1979) observed that the Euro- American model of care is better suited at solving some types of problems such as accidents, burns and communicable diseases while indigenous facilities should be used for such problems as sleeplessness and excessive worries. One herbalist told me that there are many diseases such as bad dreams, “Ekhirā” (caused as a result of violation of a taboo) and those diseases caused by witchcraft are only curable by use of traditional herbs. The findings of this study also reveals that diseases arising from malnourishment are better managed by modern healthcare services. However, it is worth to note confusion do arise in Samia between violation of sex taboo and malnourishment when a child gets emaciated. Some people do associate it with either the father or the mother of the child having violated sex taboo before the end of the postpartum period when the performance of ritual sex is done. However, this is only with children. Although accidents and burns are better managed in modern health facilities people still belief they caused by supernatural forces. If an accident occurs the victim would be bound to ask why at that time? or why him or her?. Those are some of the questions that the traditional healer seeks to answer. It is almost always agreeable that modern health personnel attend to the injury occasioned by the accident. However, after healing one has to find out why his person was the target from indigenous health personnel. During the period of his/her recovery in hospital the relatives may consult the indigenous practitioner seeking to uncover the latent cause of the accident. It is also important to note that some diseases, which are otherwise natural, can be produced through sorcery or witchcraft.

These findings agree with the fact that the way the disease is perceived influences the choice of therapy. Studies by Nyamwaya (1992), Odhiambo (1996-1997), Dennis (1974-1975), Lambo (1971), Spears (1980) Ndeti (1972), Whisson (1964). Have shown cross-cultural evidence to the effect that the type of illness influences the choice of therapy but it is not absolutely exclusive that those diseases that are categorized as naturally caused sought cosmopolitan health care and likewise supernaturally induced seeks indigenous medical therapy. Evidence from the above table therefore, shows that both systems compete and sometimes compliment each other. Ailments that are naturally induced do also have clients going to modern as well as traditional health care experts. It is interesting that neuro-behavioral illness is believe to be caused by supernatural forces yet a small percentage went to modern health care services. This was also attested to by one key informant who said that madness and hysteria come about as a result of the victims or his relatives failure to obey the clan’s jural rules or due to the ancestors anger with the treatment. The living close relatives are giving them (ancestors). He also told me it could also come about through one’s ancestry; this is to say through inheritance.

According to the informant, treatment is only possible through use indigenous rituals and herbs to appease the departed angry soul and not through hospital.

The Abaluhya believed that ill-health in people was brought about by a multiplicity of factors. Most of the illness could however, be ascribed to what one may term as magic-religious forces. Nevertheless, the attribution of illness to multiple causes meant that therapy was equally sought in multiple systems and that the curative and preventive measures taken were both magical and empirical. (Wandibba in Sindiga et al, 1995).

Several informants noted that infertility among the Abasamia was never taken lightly as it touched on the very existence and the continuity of the family and the entire lineage.

When a family member was befallen with this misfortune all was done to see that the condition is reversed, but when all those efforts failed to achieve any fruits, then an alternative was to be found. The man was then prevailed upon by relatives and friends to look for another woman to bear for him children, however, sometimes it was the woman who lured her sister or a relative to her husband to bear children on her behalf. Such an arrangement in Olusamia was called “esibekho” who on her part would have her total allegiance to the sister. However, on the other hand if the woman was fecund and her trouble was with the man, on receiving information the elders would sit down decide on the man’s brother to sire children for him (not real brother but lineage-wise) and this had to be kept as topmost secret. The chosen man was also expected to behave decently not to embarrass the impotent man. Children born out of such union belonged to the woman’s husband and they were also up to that reality.

Among the Samia, infertility was not the failure to bear children but also bearing only girls or all the children dying in their childhood. In both the two cases the man was prevailed upon to marry another woman who would give birth to a male child for the sake of the continuity of the family and the clan. Infertility made woman to be always under constant pressure from both her relatives and the husband’s, because they were expected to raise to the occasion but not only giving birth to children but to boys too.

As a 60 year-old informant who is also a traditional birth attendant told me that in the past it is children who made a woman worth her status and position in a marriage. She said that a woman with male children had stronger roots in the marriage and was sure of protection from her enemies. However, she noted that everything within human power was done to reverse the condition with rituals being carried out to appease the spirits of the dead to open up the woman’s womb.

She added that if witchcraft was suspected then a medicine man or woman was consulted to give direction by way of therapy. However, she said that a case of inheritance that comes about as a result of a curse to a family is irreversible .On the issue of modern family planning methods she said that these artificial methods are the ones which are responsible for the escalating level of infertility among the young women.

Table 5.3 Perceived causes of infertility.

ETIOLOGY	NUMBER OF RESPONDENTS	PERCENTAGE
Witchcraft	17	10.6
Hereditary	24	15.0
Taking FD tabs	20	12.5
STDs	11	6.9
Stomach pain on menses	35	21.9
Don't know	53	33.1
TOTAL	160	100.0

Table 5.3 is an illustration of the respondent’s views on the causes of infertility. 10.6% of the respondents attributed barrenness to witchcraft, 15% attributed it to inheritance. 12.5% thought it was caused by taking family planning tablets. 6.9% said it was due to Sexually Transmitted Infections (STI) whereas 21.9% attributed it to the stomach pain that occurs during menses to a woman and 33.1% of the respondents said they did not know what causes infertility. This table therefore suggests that the response on the causes of infertility is varied and no single attribute gains significance when all of them are compared.

When asked about the best mode of treatment for infertility a majority of respondents (50.6%) said traditional African remedy was the best for infertility; while only 10.0% thought hospital remedy could reverse the condition, however, 11.9% of the respondents said that one need to use both traditional and modern health services. Whereas 27.5% of the respondents said that they were not aware of any way out of the condition. Infertility as a disease can be classified as a non-incapacitating dysfunction because it manifests drawn out long periods of mental suffering. As shown in table 5.3, infertility problem may result from human causes it is apparent that besides inheritance and “*omuyaka*”-related infertility, the other causes are human induced either through a curse or envious person or from the victims actions (or in action) and /or that of the husband or their relatives.

Spring (1987), Good (1990; 1987) and Sindiga (1992) have reported that diseases believed to originate from human hand are said to be best managed by traditional medicine. This herbal medicine is the first line of therapy taken to remove impurities from the womb and cure the “*omuyaka*” condition. If the condition persists other causes are suspected, in which case the diviner (*omulakusi*) is consulted to decipher the cause. These may fall within the traditional agency, ancestral spirits or from breaching of taboos and customs. Once the cause is revealed the diviner prescribes the most suitable therapy.

The struggle by a childless woman can be exasperating. All possible remedies are explored and exploited until there is no hope. Mbiti (1969: 110-11) notes that unhappy is the woman who fails to get children for whatever qualities she might possess, this failure to get children renders her a dead end of human life on both the genealogical and her own line since no one from her blood will remember her and keep her in constant state of personal immortality when she dies. Mbiti adds that childlessness is an irreparable humiliation for which there is no source of comfort in traditional life and even if it is the husband at fault, the wife is accused in the eyes of the society.

According to (Kawango cited from Sindiga et al (1995) in her study among the Luo she says that during pregnancy women must observe certain taboos and regulations to the best of herself and the unborn child. One of the leading regulations relates to sexual relationships, for example, the assertion that sex outside wedlock may lead to miscarriage or ante-partum hemorrhage. This is also the case among the Abasamia. However, abdominal problems may also lead to miscarriages and these are believed to be best treated by traditional medicine.

As already shown above it is now clear that the perception of illness, by the patients and their relatives influences the choice of therapy. The people of Samia have a wide variety of therapies to choose from and the choice is made on the basis of the disease and the circumstances surrounding its occurrence. Therefore, when a disease like infertility was thought to be caused by witchcraft breach of taboo or a curse, remedy would never be sought in a cosmopolitan facility but indigenous health system.

TABLE 5.4 PERCEIVED TREATMENT FOR INFERTILITY.

MODE OF TREATMENT	NUMBER OF RESPONDENTS	PERCENTAGE
TRADITIONAL AFRICAN MEDICINE	81	50.6
MODERN MEDICINE	16	10.0
BOTH TRADITIONAL AND MODERN	19	11.9
DON'T KNOW	44	27.5
TOTAL	160	100.0

Table 5.5 illustrates that majority of the respondents 97 (57.6%) attribute madness to witchcraft, 18 (11.3%), said it came about through hereditary, 7 (4.4%) attributed it to spirit possession, 25 (15.6%) of the respondents said it was due to breaking a taboo. While 18 (11.3%) of the respondents sampled said they did not know what causes madness. It is important to note that causes of illness are not simply attributed to the unknown, but they are always linked to the patient's world of social events. This supports a study done by Lambo (1974) in which he argued that Africans concept of health and illness like those of life and death, are intertwined. Health is not regarded as an isolated phenomenon but reflects the integration of the community. It is not merely absence of disease but a sign that a person is living in peace and harmony with his neighbors, that he is keeping the law of the gods and tribe.

TABLE 5.5 PERCEIVED CAUSES OF MADNESS

CAUSES	NUMBER OF	PERCENTAGE
WITCHCRAFT	92	57.6
HEREDITARY	18	11.3
SPIRIT POSSESSION	7	4.4
BREAKING A TABOO	25	15.6
DON'T KNOW	18	11.3
TOTAL	160	100.0

To determine the tenacity of such beliefs in a rural area and such beliefs in how they influence help seeking behavior.

Therefore respondents in this study were presented with a case of psychosis “person is absent minded”, finds it too difficult to communicate with people and at times may go naked and were asked about their perception of the causes. It is shown clearly by the response that many people in Samia believe that madness is caused by witchcraft and other related factors, very little thought it came about as a function of blood relationship (hereditary).

It must be noted that madness describes a degree of severity, a grossly impaired sense of reality, possibly coupled with emotional and longitudinal disability which may severely comprise ones ability to function. The person may talk and act in a bizarre fashion and may be confused and disoriented.

The dependent variable, the orientation toward help seeking, was measured by asking the respondents where they would go for treatment in case one or their own became ill. Table 5.6 illustrates that 56.9 % of the respondents said that they would seek help from traditional African healers or herbalists, 13.1% stated that they would consult mental psychiatric hospitals, another 13.1% of the respondents said they would seek other interventions (for example avoid excessive thinking, solve personal problems).

However a person’s religious affiliation, Education and occupation are not related to the orientation towards help seeking, unlike in the western societies, among the Samia the perceived cause of a disease is the most critical factor in help seeking.

Diseases that are perceived to be caused by natural agents must be remedied by natural procedures while those perceived to be caused by supernatural forces must equally be resolved through supernatural means. Therefore western professional help for mental illness must be seen to be compatible with the local beliefs about the origin of mental disorder.

This therefore, shows that the fact that a majority of the respondents attribute the causes of madness to supernatural causes. Thus, this therefore, impact upon the mode of therapy to be sought by the patient and his/ her relatives, for instance a thirty eight year old male informant related to me how his older brother was taken to the hospital after the latter experienced dizziness and a splitting headache. However, on reaching hospital stress was diagnosed as the cause of his condition. After staying in the hospital ward for three days without his condition improving, as he started making uncoordinated statements and also having difficulties in talking, the family members decided that that he be removed from hospital as: *obulosi*” (the evil mechanization of others) was suspected.

He was finally removed and put at the care of the diviner, as hospital appeared to have no answer to his condition.

Once the diviner had compelled the immediate and the remote cause diagnosis was complete and the diviner decided on the cause of the therapy. After the prescribed ritual was performed involving family and other villagers the sick man started changing his behavior gradually until he is very fine and sane.

When asked why they took him to hospital first if they suspected that witchcraft was involved. He said that they did so because they wanted to monitor his condition safely in hospital rather than risking outside. "When we had not perceived what it could be all about". He also said that hospital doctors are not known to say that they have been defeated and will never refer one to the indigenous healers even if they know its witchcraft.

Evidence like the one above indicates that people are likely to take a patient first to a cosmopolitan facility when they are not sure about the symptoms of a particular disease. It also shows that the way the symptoms of a disease are perceived has a bearing on the choice of therapy. In Kenya, in addition to the Government mental hospital (Mathare) in Nairobi and modern non-public care provided by the religious missions and independent physicians, two other important sources of mental health care providers are traditional healers and faith healers.

Bell (1990) has aptly stated about traditional healers thus – "sensitive to the social dimension of illness as well as popular beliefs, traditional healers answer of clients. Accessible and credible, they help people cope with the psychological effect of failure, employment, witchcraft, and magic, along with the misunderstanding caused from social and family conflicts, realms of life largely outside the western medicine. Significant of the therapy of native practitioners always succeeds in at least one sense. The healers re-assure the clients' popular confidence in them, which remains high even if they cannot heal an affliction or remove the symptoms.

Fosu (1981), on his part argues that traditional healers use a social theory of disease within this framework the causes and the consequences of disorders are viewed in relation to the functioning of social and cultural systems. Hence, natural social and supernatural components of disease causation are recognized and responded to accordingly. This contrasts with the biomedical theory, which addresses the causes and consequences of disorders on mental biological terms.

The results of this study provide evidence on the benefits of social support systems on help seeking behavior. This is pertinent especially in rural Kenya where search for a serious illness is usually a collective family affair. However, the influence of the family and the extended kin networks on help seeking, on specific illnesses, should be examined in greater details.

TABLE 5.6 PERCEIVED TREATMENT FOR MADNESS.

MODE OF THERAPY	NUMBER OF RESPONDENTS	PERCENTAGE
TRADITIONAL		
HEALERS	91	56.9
HOSPITAL	21	13.1
FAITH HEALERS	21	13.1
OTHERS	27	16.9
TOTAL	160	100.0

Patients usually want rapid treatment (cure) and if they don't get from modern health care providers, they try traditional healers. Illnesses that have psychological components may be more likely to be cured by traditional healers because of confidence in them. Katz and Kimani observed that, because the patients of traditional healers are psychologically set to expect decisions about choice of healthcare; preparation of medications, and assistance in paying for the therapy, and in visiting the patients like the case of madness in terms of lay development of medical knowledge, this arrangement gives maximum opportunity for the joint construction of ideas about the cause and choice of therapy. This corroborates the widespread belief among the Samia that each group of providers has its own strengths and weaknesses. Certain types of illness are seen to be best treated by certain types of providers. Broadly speaking, western medicine is believed to be good for surgical problems, accident cases and a variety of aches and pains. Problems of the mind such as sleeplessness, bad dreams and mental disorders should be left to the indigenous practitioners and faith healers.

Table 5.7 is an illustration of the respondent’s view on the etiology of backache. 45.6 per cent of the respondents attribute it to heavy work especially work that involves much bending of the back and carrying of heavy loads. 7.5 per cent said that it was due to witchcraft, 6.9 per cent attributed backache especially by men to staying for long without sexual intercourse to release the back of the sperm stored there. To these group of respondents, therapy for the backache rests with regular sexual activity; 12.5 % of them attributed it to various forms of accidents; whereas 27.5% of the respondents in the sample attributed it to the other forms of factors (such as diseases, hereditary, lack of physical exercises, old age, e.t.c.). As shown, respondents in this study were peasant farmers. Most of these people are always working on their subsistence plots of land for virtually almost all the year round. Breaking the ground, planting and weeding are done using crude, farming methods such as the use of the hoe.

There are very few exceptions where ox- ploughing comes in as a substitute. This is a pointer to the fact that most of the work is done by use of the hoe. The views of the respondents in this regard and the evident conditions tally with the assertion by Susser and Watson (1962), that man’s economic and social involvement is part of his natural environment and helps to determine the incidences and prognosis of diseases. Medicine has come to recognize that many diseases are not natural calamities that strike in hap-hazard way, but are injuries inflicted on people by the nature of their daily occupation and their customary modes of life.

TABLE 5.7: PERCEIVED CAUSES OF BACKACHE.

ETIOLOGY	NUMBER OF	PERCENTAGE
HEAVY WORK	73	45.6
WITCHCRAFT	12	7.5
TOTAL	160	100.0

When respondents were asked about the best mode of treatment for backache most of them said they were not aware of any way out of the condition. A majority of the respondents (57.6%) however said there is no cure for backache they know about, 13.1 5 said it heals on its own without bothering about medication whereas 14.6% said they would use traditional African medicine for the cure of backache respectively. However, it is worth to note that most of the respondents seem to take the condition as one that does not respond to any form of treatment.

Backache as a disease condition can be classified as a chronic non-incapacitating dysfunctioning because it manifest drawn out long periods of suffering which are sometimes cyclical in nature and in a way enables the sufferer to maintain assemblance of his daily routine. Some respondents noted that the elderly people who suffer from backache are because of their natural state and that there is no way of relieving them of this problem. Thus they believe it is hard to get a cure for diseases that come about as a result of old age.

TABLE 5.8: PREFERED MODE OF TREATMENT FOR BACKACHE.

MODE OF TREATMENT	NUMBER OF RESPONDENTS	PERCENTAGE
TRADITIONAL HEALING	23	14.6
MODERN MEDICINE	24	14.8
SELF HEALING	21	13.1
DON'T KNOW	92	57.5
TOTAL	160	100.0

Nangina mission hospital's records of 1998 in-patient and out-patient mortality and morbidity data show that the main causes of illness in the area are malaria, measles, diarrhoeal diseases, typhoid, acute respiratory infections, intestinal worms, malnutrition (kwashiorkor and marasmus) and skin diseases among others. This data compares closely with that of the whole district (see Busia District Development Plan 1997-2001). Health problems in the study area could be said to stem mainly from the environmental conditions namely the high prevalence of mosquitoes, reliance on untreated river water, poor food preservation methods especially those sold in the market and unhygienic home conditions and poor diet.

In view of the above, this study sought to find out the respondents' views on two of these fatal diseases that mostly affect children of ages 0-5 years in funyula division, namely malnutrition and measles. The reason for choosing the two is that they are shrouded with a lot of mystery in the cause and means of treatment.

Malnutrition is a complex nutritional problem for which no single factor has been cited as a sole cause. For this reason it has been viewed as one of the salient health problems in the developing world. Malnutrition has been defined as a pathological state resulting from a relative or absolute deficiency of one or more essential nutrients. In the case of malnutrition, wasting results from deficiency in energy and proteins of recent onset while stunting is due to long standing deficiencies. The most vulnerable groups in terms of nutritional status include pre-school children of low income groups in the society, pregnant and lactating mothers, masses of peasant farmers not only in Funyula but in other poverty ridden areas in the world. In all categories the most vulnerable group is that of children under five years of age. The nutritional status of a child is dependent on many factors including food availability, dietary habits and the various socio-economic situations of different families.

Table 5.9 is an illustration of what the respondents viewed as the causes of malnutrition is strongly influenced by traditional beliefs. African cleansing ritual to purify the offending parent and the child was the most appropriate remedy for malnourishment (for example the case of kwashiorkor). While only 5 % said they would seek hospital help. It is worth noting that Funyula being a rural area, the diet content makes children susceptible to malnutrition, thus resulting in greater losses of life.

Modern health personnel at Nangina mission hospital and a nurse at Nangina dispensary hospital told me that malnutrition is a preventable condition but because of the prevalence in the belief that kwashiorkor for example is caused by the violation of sex taboo by the concerned parents of the child or "Obusura" evil eye. Therefore, cases of malnutrition are mostly dealt with at home partly because of the influence of culture on the etiology of malnourishment and partly due to the fear by mothers of being ridiculed by the hospital workers for denying the child's nutritious foods and also the fact that such children get detained when they are taken there for treatment of other ailments since they usually become less resistant to diseases.

I was also told by nurses at Nangina mission hospital that the hospital has a section that deals with malnourished children, avoiding that if such children get to hospital, they are given drugs to improve their appetite and provided with a balanced diet in adequate quantities and the mother provided with useful information on dietary. However, they also noted that there are some parents who are too poor to be able to afford a meal in a day leave alone a balanced diet- the fact that they attributed to low rainfall in the area.

They further noted that lack of education on useful foods is also contributing highly to the escalating cases of malnutrition in Funyula.

From the findings, it could be stated that lack of knowledge and information on nutrition is widespread in Funyula. This is due to the general and false concept of “full belly” which explain many of the nutritional diseases. It is incomprehensible to many people that a person who is never hungry can suffer from a disease associated with lack of dietary ingredients. Most people have abundant food had their disposal but lack knowledge on the choice of appropriate diet. One of the things that usually emphasized among the rural Abasamia is food richer in carbohydrates, but lacking in other essential nutrients. There are cases where protein foods like eggs and milk available at home are used to buy starch foods.

Another issue that came out of this study is that of poverty, low incomes at the household levels are common explanations for malnutrition. As shown in Table 4.4, majority of the people in Funyula are peasant farmers with an estimated income of (0- 3000) Kenya shillings per month and they constitute 93 % of the residents of Funyula. This therefore cannot allow them to buy animal foods, which are richer in proteins. Todaro (1984) in his research in Kenya for example, found that the widespread poverty and inequalities in the distribution of resources give rise to innumerable social and health problems, the latter of which includes malnutrition. Similarly, Mason (1985:109) who views malnutrition as a consequence of poverty identifies such conditions of poverty as inadequate food purchasing power, bad health environment, lack of access to resources and services and poor environmental health, as contributing to the persistence of malnutrition. However, Trant (1974) on the other hand looked at the causal role of taboos in the analysis of malnutrition, arguing that such taboos may make people live hungry in the midst of plenty. But such taboos and beliefs, he observed, are found all over the world.

According to situational approach theory, which holds that, the process of socialization begins the definition of the situation and the community continues it. Through this process the individual endeavors to internalize its own definition of s and makes them part of his habitual self but it is a dynamic process, is adjustable in various situations which are determined by a complex of internal and external factors. Because of this, in certain cultures like the Samia where a case of malnourishment is thought to emanate from violation of sexual taboo rather than poor diet where therapy is sought from traditional healers is illogical to the scientific observer, but it does make sense to the Samia people.

A majority of the respondents (61.9%) interviewed said that malnutrition results from lack of food. It appears from the results that a reasonable percentage (33.85) still believe that malnourishment is caused by either child’s parents breaking sex taboos. The Samia belief that if any of the parents get involved in an extra- marital affair (sex) and then on coming back to the house holds the child before bathing to remove the impurities, the child will develop symptoms that are like those of a malnourished child. No connection is made between feeling and malnutrition for those who believe in the breach of sexual taboo and evil eye as the causes of malnourishment.

TABLE 5.9: PERCEIVED CAUSES OF MALNUTRITION.

ETIOLOGY	NUMBER OF RESPONDENTS	PERCENTAGES
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LACK OF ENOUGH FOOD	99	61.9
BREAKING OF SEX	54	33.8
TOTAL	160	100.0

It was noted that known symptoms of a disease like Kwashiorkor which is a function of malnutrition is associated with *Ekhira* (violation of sex taboo). Since kwashiorkor is common among young children the associated breach of taboo has to do with sexual purity; that is dependent on both parents of the child, especially before the child starts waking.

Different societies have different cultures and ideas about what is edible and what is not. This limits their access to certain foods. It is a known factor in cultural anthropology that apart from culture shaping the people’s behavior towards other aspects of the society it also dictates which foods are to be eaten and by who. Some people may not utilize many of the available nutritionally suitable food substances due to cultural values. Among the Samia women are culturally prohibited from eating chicken and eggs. Children are also not allowed to eat eggs and meat, which are believed to introduce greed or theft like characteristics to the children as they grow up.

TABLE 5.10 PREFERRED MODE OF TREATMENT FOR MALNUTRITION

MODE OF TREATMENT	NUMBER OF RESPONDENTS	PERCENTAGE
Eating enough food	81	50.6
Traditional African ritual	71	44.4
Hospital	8	5.0
TOTAL	160	100.0

In table 5.10 the respondents were asked to say in their own opinion what they know as the remedy for malnutrition. 50.6% of the respondents said that the victim should be given enough food, whereas 44.4% of the respondents said that the traditional African cleansing ritual to purify the offended parent and the child was the most appropriate remedy for malnourishment (for example the case of kwashiorkor). While only 5% said they would seek hospital help. It is worth noting that Funyula being

As illustrated in table 5.11, the respondents were asked what they consider to be cause of measles. 61.3% of the respondents attributed it to contagious air (air borne disease), 3.1 % said it was brought about by witchcraft, 6.3% of the respondents said it was caused by failure to complete immunization course of measles and 29 % said they did not know what causes measles. This is a disease that is shrouded with a lot of mystery as a nursing mother is not supposed to mention it by name, as it is believed that doing so will cause it to attack the child.

TABLE 5.11 PERCEIVED CAUSES OF MEASLES.

CAUSES	NUMBER OF RESPONDENTS	PERCENTAGE
Contagious air	98	61.3
Witchcraft	5	3.1
Incomplete Immunization	10	6.2
Don't know	47	29.4
TOTAL	160	100.0

Table 5.12 is an illustration of the respondent's view on what they perceive to be the treatment for measles. 23.1% of the respondents said they would use traditional African medicine, 36.9% said they would seek both traditional African medicine and cosmopolitan medicine to cure measles whereas 29.45 of them said they did not know the cure of measles. The most common regulation about the management of measles is that no episode should be referred to hospital before rashes have erupted. Some key informants told me that if a child with measles were given an injection before the rash comes out he/she would die. This belief is common in rural Kenya and urban slums. Samia people believe that an injection is more effective than any other form of administering modern medicine. Some patients go home disappointed if not treated with an injection. But in the case of measles the Samia fears that if a child with measles gets hospital injection before the rash erupts, he/she would die. Due to limited knowledge about the early stages of the disease, this could develop into a critical condition as people still grope around for a cure and this has led to several deaths. Nyamwaya (1992) states that while cosmopolitan medicine is used widely in Kenya, the majority of lay people hold concepts of health care providers have little understanding of these concepts. This hinders effective communication between health care providers and their clients.

CHAPTER SIX

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS.

6.1: DISCUSSION.

This study has examined factors that influence patient's response to both modern and traditional health care services. Traditional healers were established throughout Africa in one form or another prior to the arrival of Europeans and continued to practice even after western scientific medicine became well established. The traditional healers were of different kinds; some were herbalists, some bone setters and manipulators and some dealt with spirits placating or exorcising them. One important part of their work was diagnosis, which was practiced by divination rather than by multiple tests being used in modern medicine. Into these several indigenous systems of medicine therefore, western modern medicine came as a yet a further alternative medicine. One possible reason for the advance of alternative western medicine in Africa was that, like most systems of alternative medicine that gained some acceptance, it fulfilled a particular need not being met by the more entrenched traditional system. However, the colonial and the successive African governments deliberately promoted the development of the latter system over its competitor. Through this model, it has been assumed that in order to provide proper health care services and improve on the living conditions of the people in developing countries, western medical systems must be imposed upon the people.

Public health workers are increasingly acknowledging that the behavior of an individual in any instance of illness is greatly influenced by the cultural definition and interpretation as by the biological nature of the illness. For what may appear as natural in one cultural setting may be unnatural in another setting. Notions exist that certain illnesses are European and thus susceptible to western mode of treatment whereas, other illnesses are considered to be traditional and therefore only susceptible to indigenous African medicine. Such diseases are considered to be people or supernaturally induced. In Kisamia, this is known as *Abulwaye bwa esialo*.

In a particular situation, illness might be seen not to have responded to western scientific medicine. If this fails, it becomes evident that local agents caused the illness after all. This can be true of any illness. It is sometimes said that the sole concern of traditional medicine is with sorcery and witchcraft, but this is not true. There is clear recognition of different illnesses and often of specific causes and remedies. At the same time, an illness may be said to be due to witchcraft, which is used to explain why a particular illness afflicted a particular person and at a particular time.

Scientific medicine, after all, is often unable to explain why it should have come now rather than at some other time.

Therefore, it is significant to note that cultural beliefs and practices of a given population forms an integral part in appreciating the practice of both modern and traditional African health care systems. Medical beliefs or knowledge and behaviour of the people occur within a framework of that particular culture upon which events are interpreted and given meaning. From the data in this study, it was found that traditional healers still influence the cause of medical practices in the area under study. This perhaps could be due to the fact that they belong to the same culture as the recipients, share common beliefs, values and the medium of communication. In their therapy, they integrate social, cultural, economic and psychological and the general environment to explain human malfunctions. Their services were found to be particularly useful in those illnesses that were perceived to be human or supernaturally induced (through sorcery, witchcraft, evil spirits, ancestral spirits) that are lightly regarded to be within the domain of traditional medicine. In this study, it has been ascertained that that the two medical systems compliment and sometimes compete with each other for clientele. Patients have reasons for a given mode of therapy as exemplified by their knowledge of the causes of illness, their cultural understanding of illness and the efficacy of a given medical system. However, this does not preclude them from seeking

The findings of this study confirms the situational approach theory which focuses on the idea of a crisis, the definition of the situation and the concept of social disorganization which brings about the redefinition of the situation which in the case- an experience such as a disease. It is argued that the perception and role of therapy of a given illness is situationally determined. How an individual perceives a situation may influence his/ her approach to it in this theory the efficiency of the definition of the situation depends also on factors such as education, sex, age, and travelling exposure. For example, a certain culture may demand the consultation of a traditional healer say in the case of malnutrition like in the case of Abasamia. However, as already shown above, some people have come to the realization that traditional healers cannot cure malnutrition, but modern health care system can. It is possible that this knowledge is most likely to lead to a redefinition of the situation such that if malnutrition is suspected the sick person is taken to hospital for treatment and not to a traditional healer.

However, the individual's culture which is imparted in him/her through the process of socialization is important in the definition and understanding of illness that influence the choice of a therapeutic system. It is this last fact that explains the case of measles among the Samia, where it is strongly believed that a person suffering from it should not be injected in hospital before the rashes erupt and this makes people with the disease not to present their case to the hospital.

Scholars like Sigerist (1960); Onekerhoraye, (1984); Ademwagun (1979); Nyamwaya 1992, Odhiambo (1986-87); Dennis (1974-75); Lambo (1971); Spears (1980); Ndeti (1972); Whisson (1964) have observed that culture of a person has a bearing on the perception and choice of therapy in an episode of illness.

Evidence from this study indicates that some socio-economic variables are important in the utilization of a particular medical system whereas others are insignificant. For example, in this study, people with formal employment were found to be more willing to attend modern health care services and those in informal employment were more likely to attend traditional health care facilities. However, all the people in different occupation in Funyula division use both health care systems. The only variation came in the proportion of those opting for each of the health care systems. For instance, 56.3% of farmers opted for modern health care systems as the first resort while 26.2% of them opted for traditional health care services. 44.5 and 1.9% of those in formal employment opted for modern and traditional health system respectively as a first resort at the onset of illness. The degree of association between occupation and choice of the first resort system at the onset of illness was found to be significant at $\chi^2 = 2627$. On the other hand, individual's occupation was found not to influence the use of indigenous health care services as the hypothesis failed to yield any association between the variables in occupation and the consumption of indigenous health care services.

Findings of this study indicate that educational attainment did not have influence on the choice of either modern or traditional health care services in Funyula division. However, as shown in table 4.7 a majority of the respondents (71.9%) had utilized modern health services whereas only 15.0% of those who had formal education said had never used modern health services. It is therefore clear from the findings that literacy is not a determinant of the use of modern health services. On the other hand, it is indicated in table 4.8 that 51.3% of those who were literate had used indigenous health services.

The findings of this study also reveal that literacy reflected an association between education and reasons (nearest, cheapest and most appealing) for choice of therapy following illness episode. It is of significance to note that 59.4% of the respondents opted for a particular medical service because it was the most appealing. 19.4% and 18.2% Opted for a particular medical service because it was the nearest and cheapest respectively.

According to Maclean (1971), age and literacy are highly associated with a high use of traditional health care services. Although Erinosh (1982), observed that all cadres of society utilize both health care systems. In this study, only looked at occupation and education as the socio-economic factors that bear on the choice of therapy.

This study found that the Samia categorize illness by stating those that can be treated effectively by modern medical facilities and those by traditional health services. However, as shown in the findings, though disease etiologies are articulated, this does not lead to clear-cut selection of a medical system when faced with actual sickness. Even though the Samia categorize a disease like malaria as naturally induced by the disease causing organisms (pathogens), it is also not unusual to hear people saying that they will catch malaria because of cold weather or being rained on. This is a clear indication that such people are ignorant the fact that mosquitoes are responsible for the carriage of the plasmodium that causes malaria disease. This therefore shows that certain aspects of the germ theory are still far from being understood by some people. Because of this, the drainage of mosquito breeding grounds cannot be appropriately carried out. Another, issues relates to dirty water, majority of the Abasamia still believe that boiling drinking water makes it lose its test.

The Samia believe that Western medicine is ineffective for diseases for which causes are supernatural or human related but is taken to be efficacious in natural diseases but is taken to be, effective in natural diseases which have their origin in natural circumstances. People do not actually stick to the distinctions but move freely from one medical system to another even if it is the same episode of illness. Out of 160 respondents sampled, 85 said that if illness is naturally induced, they would seek therapy from a modern health care service whereas only 24 of those who thought that the illness was naturally caused said they would seek help from the traditional healers.

On the other hand, 45 Of the 160 respondents after determining the patients illness to be caused by supernatural factors would look for therapy from the indigenous healers while only 6 of them would seek help from modern health care services when illness is perceived to be caused by supernatural forces. For example certain diseases are known to be difficult if not impossible to treat by western methods. Thus even though epilepsy can often be managed the whole problem of giving continuous maintenance medication is difficult both to explain to patients and relatives to administer. This is rather with the frightening nature of the illness; no doubt explains why epilepsy in many parts of Africa is considered to be a traditional illness. This labeling of it as being in the domain of traditional medicine curtails efforts to get western treatment. There is a stigma associated with this disease, which is almost certainly nothing new, the patients were and are still isolated socially. Beliefs like the above prevail because of lack of basic health education. This factor leads to the perpetuation of practices, which are in themselves harmful to good health like unhygienic food handling and storage especially during large gatherings like funerals, drinking unboiled water from streams and improper disposal of faecal matter.

It is also of significance to note that when a disease is explained purely on supernatural terms it blocks the patient from seeking help from some other sources that may offer assistance and probably cure.

The communication between the patient and the practitioner also play a significant part in health seeking behavior. Scholars like Helman (1994) have observed those doctors and their patients even if they come from the same social and cultural background view ill health in very different ways. He adds that, the meaning given to symptoms and the emotional response to them, are influenced by their own background and personality as well as the cultural, social and economic context and this Helman says will also affect the patient's behavior and sort of treatment he/she will seek out. Many factors have contributed to the attitudes and patterns of behavior in rural populations, which are essentially antagonistic to modern health practices. Findings of this study reveal that majority of the respondents 58.8% said that traditional healers were patient with them while only 41.25 of the respondents thought modern medical experts were patient with them. The respondents further said that traditional healers do not harass patients to get diagnosis and that they also look caring and welcoming. On the other hand, modern health experts are known to harass patients especially those who are in labour pain unlike the TBA's. A part from that, the waiting time in modern health facilities especially the publicly sponsored hospitals are too long. Whatever one is suffering from, the hospital personnel seems not to take notice thus even resulting to death due to negligence before the patient is attended to.

6.3: CONCLUSION.

HYPOTHESIS 1.

There is a relationship between occupation and health seeking behavior (HSB) among the Samia. After the data analysis, the above hypothesis was accepted overall. The variables which were cross tabulated with occupation included the following: utilization of modern health care services, if over-utilized traditional health care services, and the first resort of ill-health. The variable, modern health care services gained significance at 0.01. This clearly shows that occupation, which also has a bearing on income, has an influence on the use of modern health care facilities. It showed that 83.8% of those interviewed had availed themselves of the use of modern health care services whereas only 16.3% said they never utilized modern health care services wherever they or their relatives were sick. It also reveals that none of those who are formerly employed have ever availed themselves of the use of modern health care services.

When the variable of occupation was tabulated against ever use of indigenous health care services, it did not gain significance at 0.01 significance level.

However, it is revealed from the findings that 59.4% of the respondents had availed themselves of use of indigenous health care services while only 40.6% have never used indigenous health care services. These findings therefore show that indigenous health care services are used across the socio-economic spectrum.

Finally when the variable occupation was cross tabulated by the first resort system at the onset of ill health. It gained significance association at 0.01 level of significance. The table reveals that modern healthcare facilities are most preferred when it comes to the first choice of therapy. This is true irrespective of the type of illness. The findings further reveal that people would prefer to take their sick to hospital and then when it fails to work, they look for alternative modes of therapy. The table findings were corroborated by the key informants revelation that modern health care facilities are the most preferred as the first form of therapy and especially with the diseases that incapacitate faster.

HYPOTHESIS II.

The findings did not render support to the hypothesis that formal educational level attainment had influence on health seeking behaviour in the utilization of modern and indigenous health care services. As shown in this study, literacy does not influence the utilization of modern health care services. This is probably because modern health care facilities have entrenched themselves and therefore, whether when is literate or illiterate, they both seek help from such facilities. There was no relationship between education and if ever used indigenous health care services. When the chi-square statistic and contingency coefficient were calculated, the χ^2 did not attain a significant association at 0.01 level of significance whereas the contingency coefficient showed that there was a moderate relationship. This reveals that the utilization of traditional health care services persists even among the educated. However on education and the reasons for seeking a particular healthcare, it gained significance at 0.01 level of significance. The findings reveals that majority of the respondents 59.4% would consult a medical facility because it is appealing perhaps in terms of the services rendered there. Whereas 19.4% sought for services from medical facility because of its proximity to the patients resilient whereas 18.2% preferred a medical facility because of the cost and would not seek help from it because it is appealing or near to his/her resident. When the respondents were asked on the basis of their educational level whether they had witnessed a traditional healing ritual by education, it failed to gain significance at 0.01 level of significance. However, it revealed that 77.5% of the respondents had actually witnessed a traditional healing ritual whereas only 22.8% had not.

From this finding, we can deduce that indigenous healing practices are still a common place in Samia and it is also possible that the number could be much higher as some people do conceal their knowledge of indigenous healing practices.

This could also be because of their religious affiliation or perhaps of the reasoning that see indigenous practices as witchcraft, harmful and have nothing to offer and hence no need to give them recognition.

HYPOTHESIS III.

The conclusion drawn from this hypothesis is that traditional and publicly sponsored health services not only co-exist but also compliment each other. The choice of a given therapeutic system does not necessarily depend on the scientific understanding of a given illness but on the cultural perceptions on the nature and etiology of the disease.

Most diseases are perceived within the framework of their cultural background, they are explained in terms of human agency, through ancestral spirits and from breaching of taboos and not always by the Louis Pasteur germ theory. It is also revealed by the data on the findings that the respondents categorize diseases into naturalistic and those that are supernatural. In the latter therapy, is exclusively indigenous while the former therapy would be found in both. However, all these depend on proper determination of symptoms.

6.3: RECOMMENDATIONS.

The solution to the problem of childhood mortality and morbidity in Kenya's rural villages and urban slums will not be technological or reliance on medical achievement, construction of health facilities or on increasing the number of medical practitioners, but rather on the optimal and equitable use of existing resources geared towards the reduction of poverty and ignorance.

Mothers do play a significant role in the health care of the family and the problems in health nutrition and in population cannot be solved adequately without their active involvement. Women have traditionally been the central providers of health care within the households particularly in their roles as mothers. Hence a better understanding of the mothers orientation towards help seeking would help planners in designing more realistic and effective health programs not only for themselves, but also for their families.

Since traditional medicine has been shown to have wide use, it should be promoted and its potential development is necessary for the wider benefit of mankind, it needs to be given due recognition and developed so as to improve its efficiency, safety, availability and wider application at low cost. Hence official recognition of indigenous healers will go along way in destroying the suspicion in which they find themselves.

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