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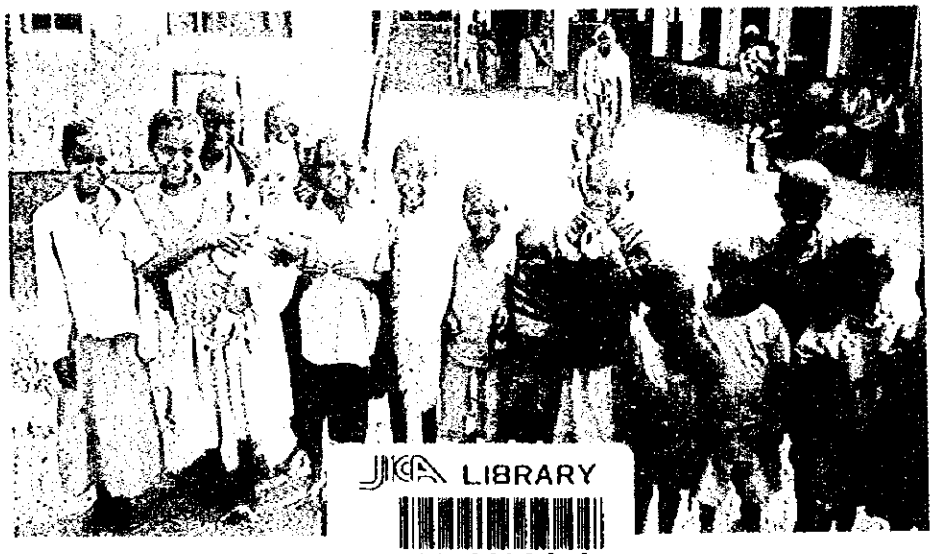
No. 52

JAPAN INTERNATIONAL COOPERATION AGENCY (JICA)
THE MINISTRY OF HEALTH
THE GOVERNMENT OF THE REPUBLIC OF KENYA

The Study on Strengthening the District Health System in the Western Part of Kenya

Final Report

- Supporting Discussion 4 - Community-based Development and Proposed Project



December 1998

Pacific Consultants International
IC Net Limited

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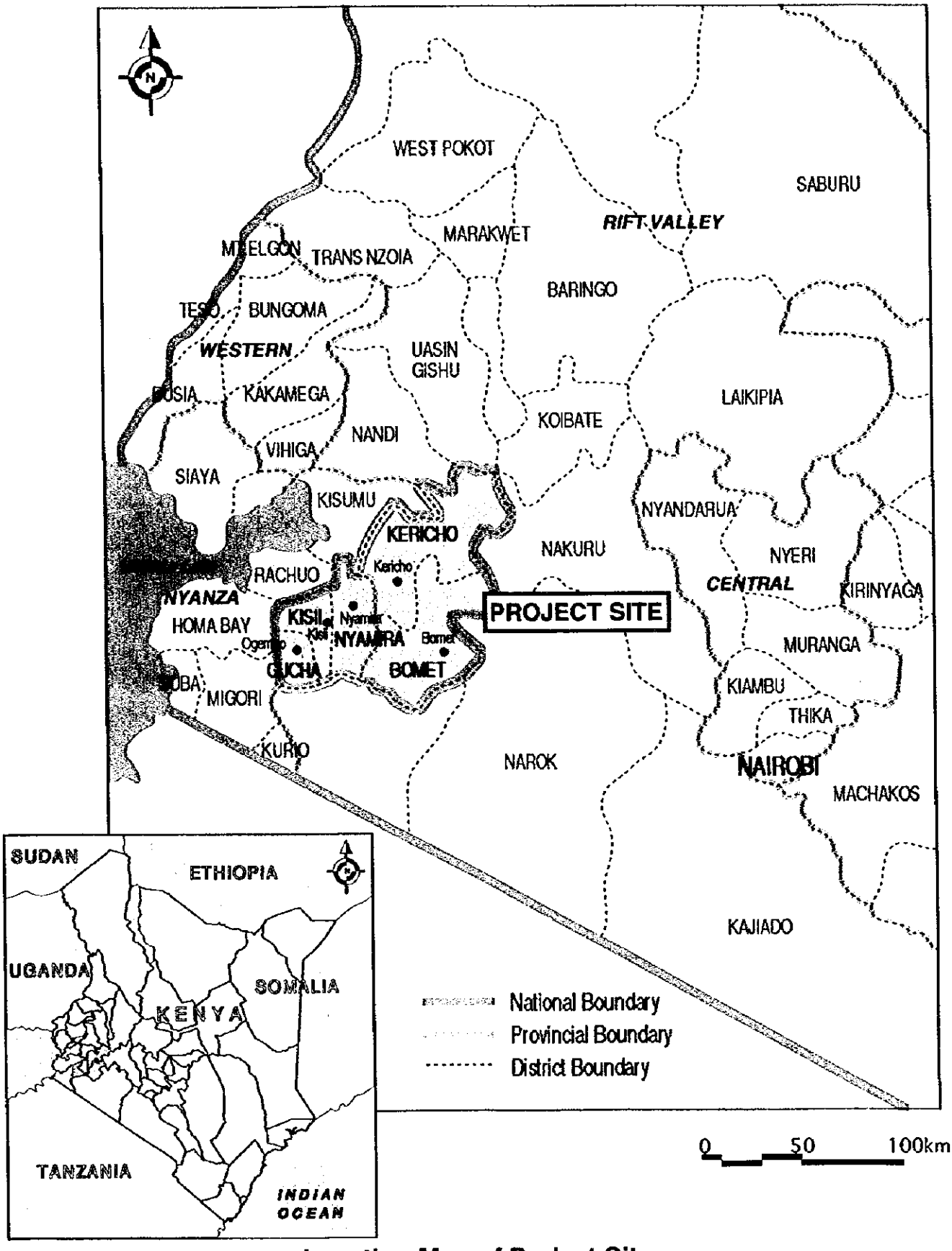
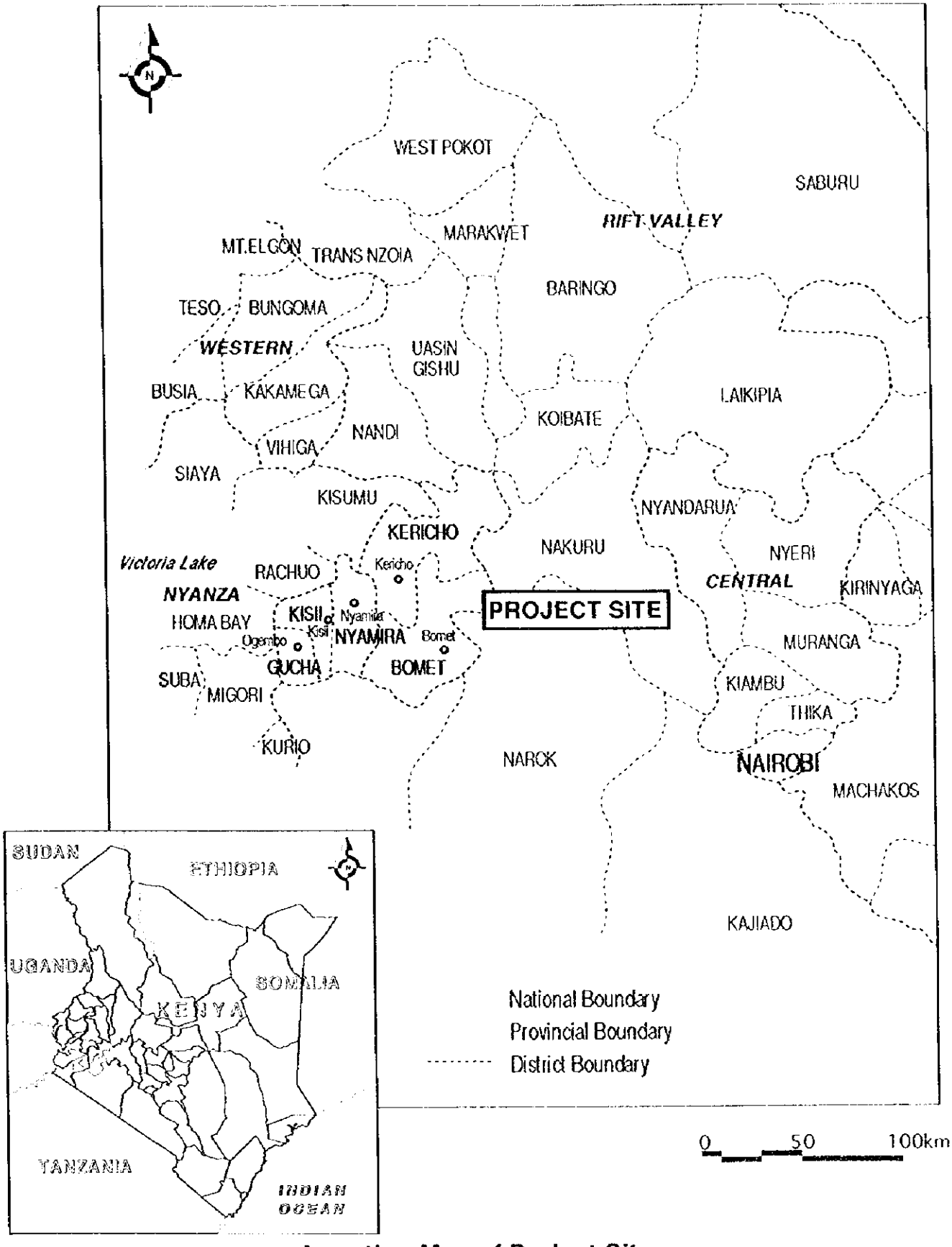
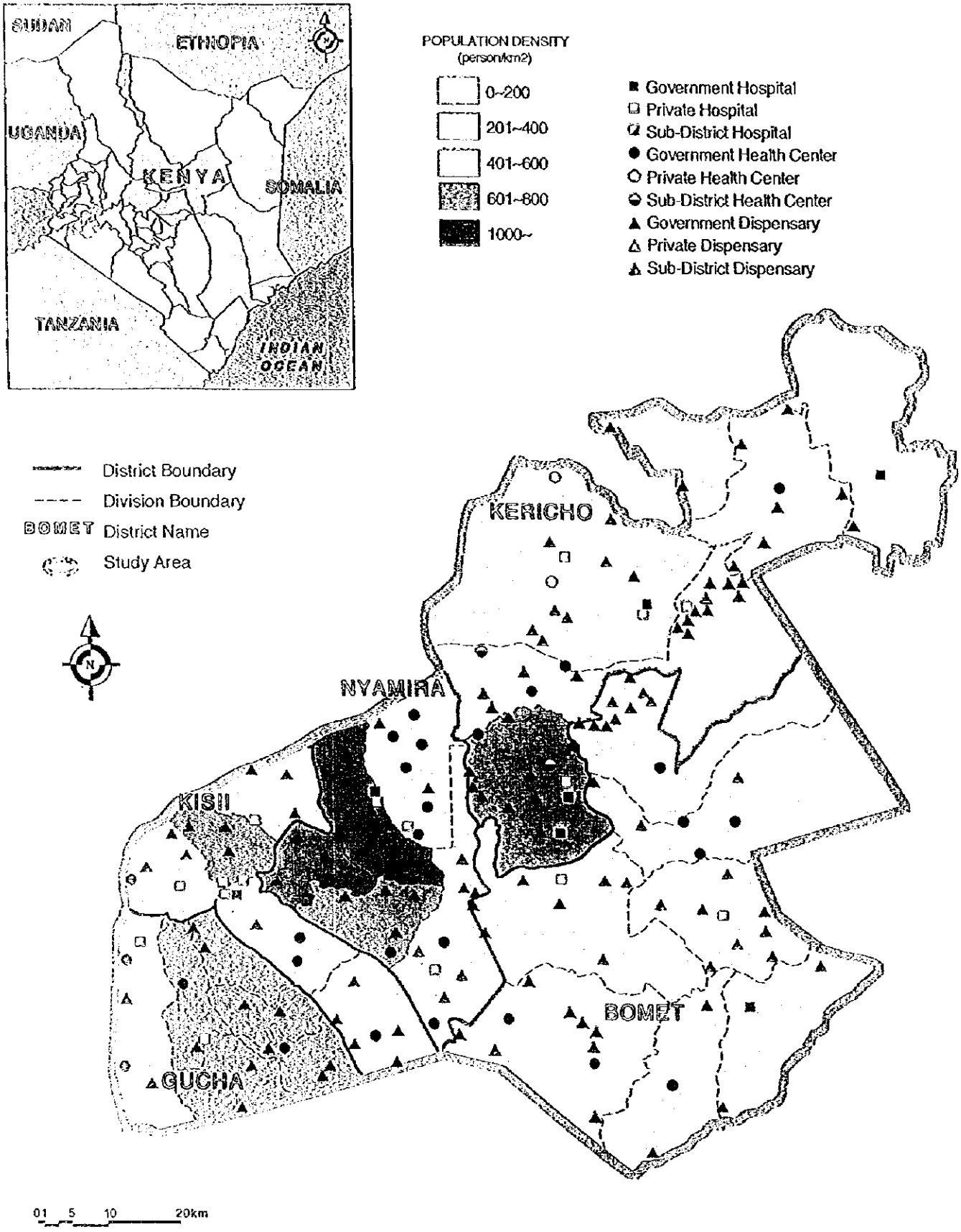
The exchange rates used in the Study are:
US$ 1.00 = 59.57 Kshs
US$ 1.00 = JY 139.60
(as of the end of August 1998)

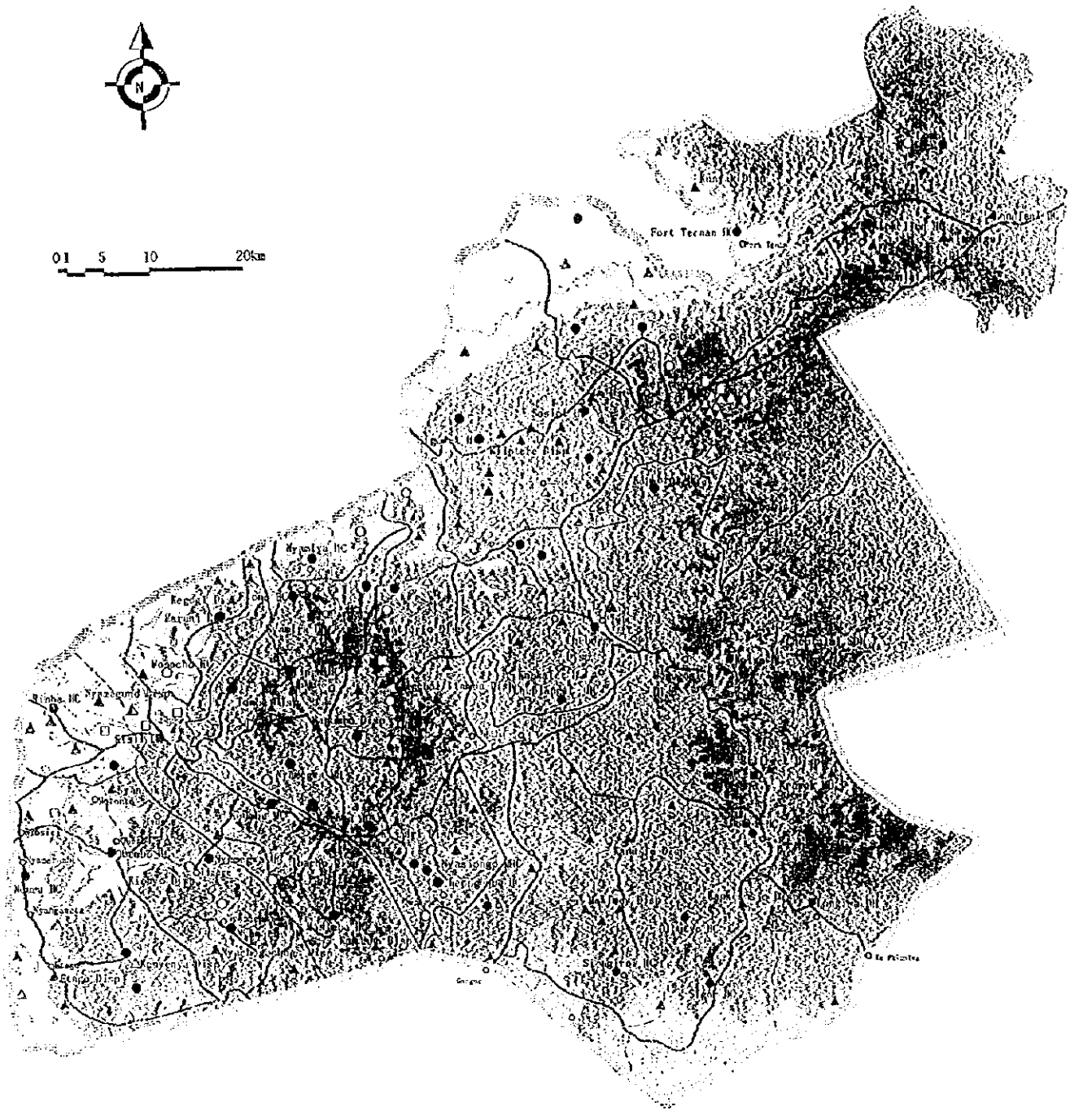


Location Map of Project Site



Location Map of Project Site


SUDAN
ETHIOPIA
UGANDA
KENYA
SOMALIA
TANZANIA
INDIAN OCEAN
POPULATION DENSITY
(person/km2)
0~200
201~400
401~600
601~800
1000~
Government Hospital
Private Hospital
Sub-District Hospital
Government Health Center
Private Health Center
Sub-District Health Center
Government Dispensary
Private Dispensary
Sub-District Dispensary
District Boundary
Division Boundary
BOMET District Name
Study Area
KERICHO
NYAMIRA
KISII
BOMET
GUCHA
01 5 10 20km



District Boundary

Division Boundary

contour

~5,000Ft (=1,520m)

5,000~5,500Ft (=1,680m)

5,500~6,000Ft (=1,820m)

6,000~6,500Ft (=1,980m)

6,500~7,000Ft (=2,140m)

7,000~8,000Ft (=2,440m)

8,000~

Government District Hospital

Private Hospital

Sub-District Hospital

Government Health Center

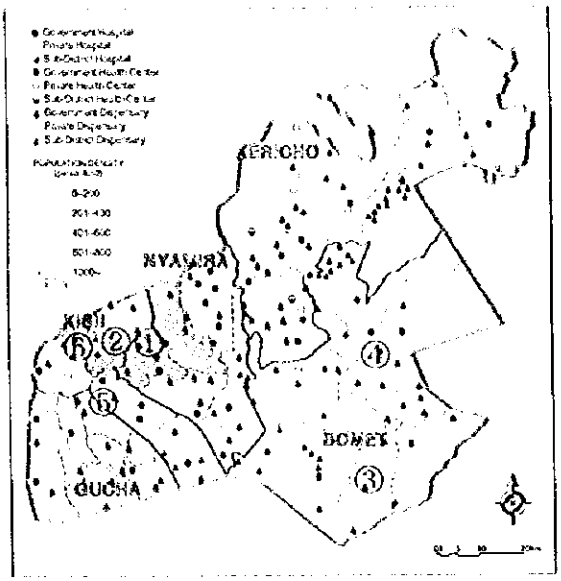
Private Health Center

Government Dispensary

Private Dispensary

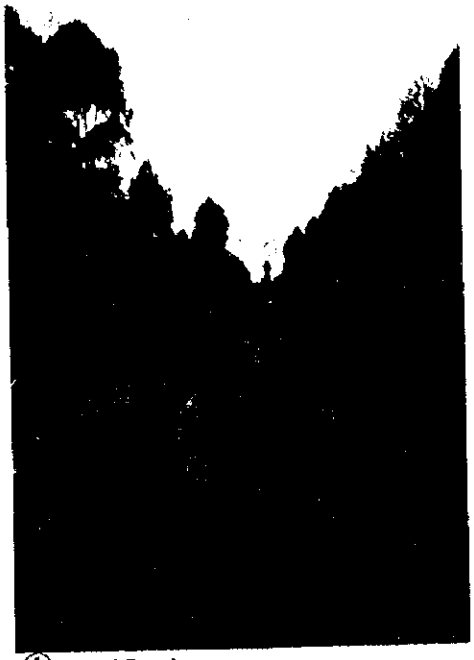
Sub Dispensary

Distribution of Health Facilities in the Study Area



Socio-economic and Natural Environment

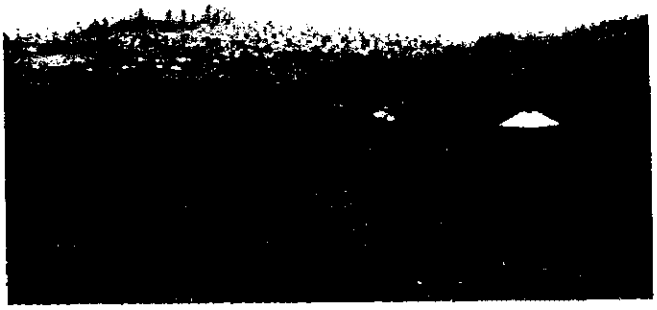
③ Landscape in Bomet
(Sigor, Dry Area)



① Rural Road
(Nyamira)

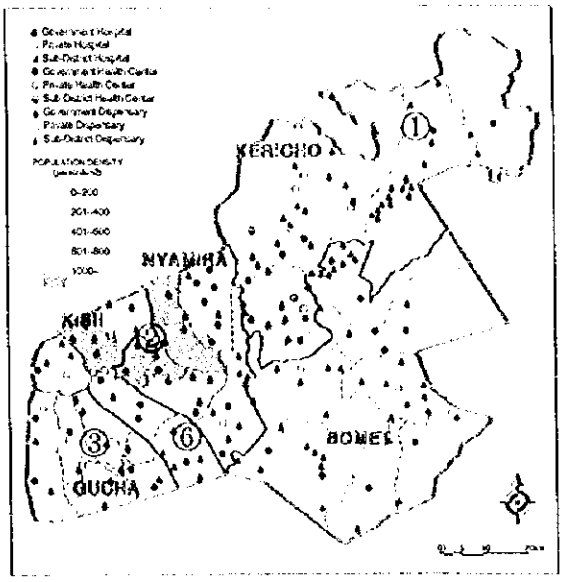
④ Landscape in Kericho/Bomet
(Tea Growing Area)

⑤ Major Market in Kisii Town



② Typical Landscape in Kisii

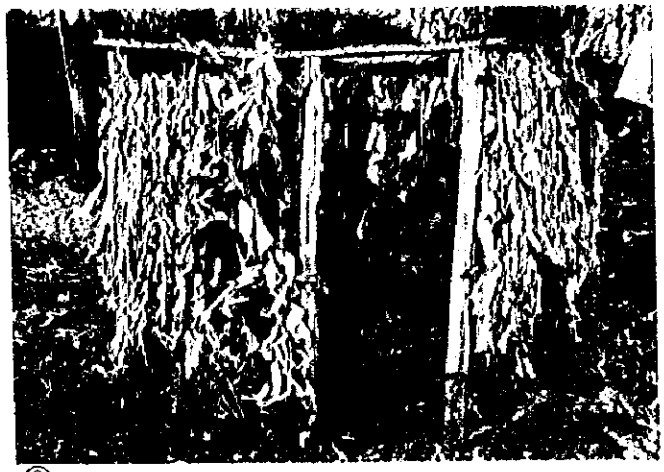
⑥ Major Crops
(maize, finger millet)



Socio-economic and Natural Environment

① Carrying Water
(Kipkelion, Kericho)

② Latrine Constructed by Water Sanitation Project
(Nyakome, Nyamira)

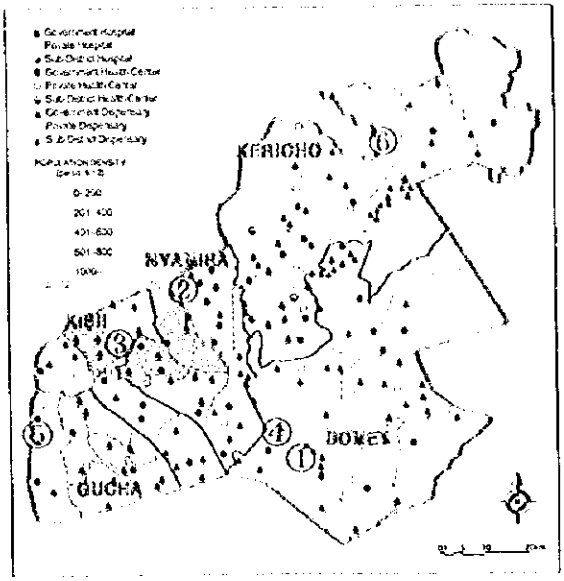


③ Pit Latrine
(Kenyaya, Gucha)

④ Dish Lack

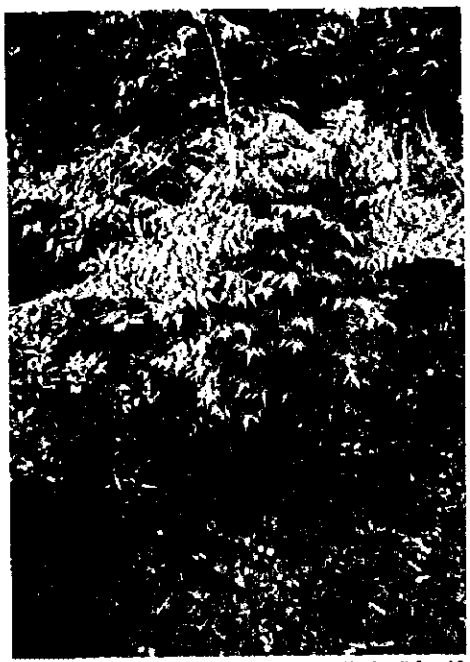
⑤ Kitchen
(3 stone stove commonly used in the Study Area)

⑥ Washing Clothes at Stream
(Masimba, Kisii)



Surveys at Communities

① Local Shop Selling Drugs
(Nyambugo, Bomet)



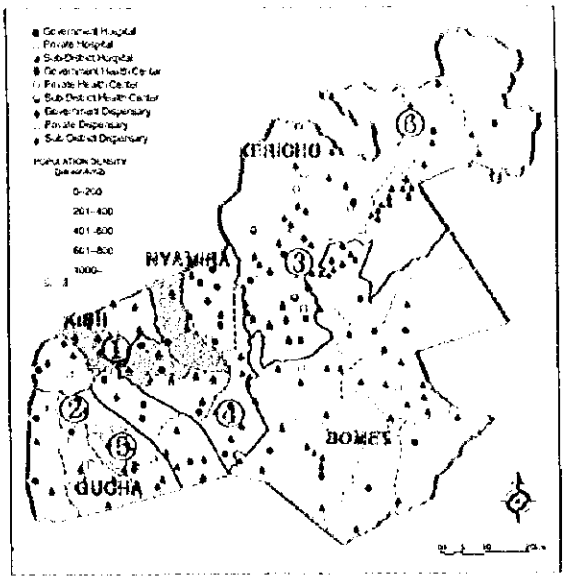
② Traditional Local Herb "Omoalbaine" for Malaria
(Masosa, Nyamira)

③ Interview to Water Group
(Suneka, Kisii)

④ PHC Activity Meeting by Mission
(Makimeny, Bomet)

⑤ Moticho Dispensary and Primary School Pupils
(Etago, Gucha)

⑥ Rural Rapid Appraisal
(Fort Ternan H/C, Kericho)



Community Group Activities

① Tree Nursery and Cow Grazing by Women Group
(Suneka, Kisii)

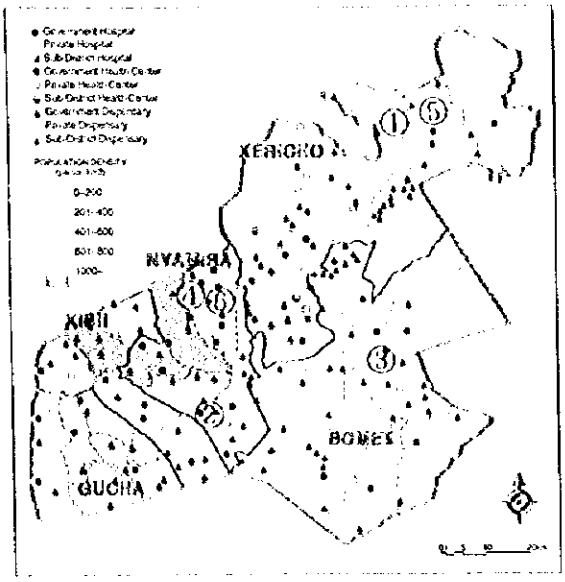
② Distribution of Impregnated Cloth for Malaria Prevention by Tabaka Soapstone Carvers Cooperative (Tabaka, Gucha)

③ Posho Mill Run by Women Group
(Koptige, Kericho)

④ Protected Water by Pilot Water and Sanitation Project
(Nyakome, Nyamira)

⑤ Interview to Keore Women Group Running Health Centre
(Kenyanya, Gucha)

⑥ Traditional Handicraft Making by Women Group
(Koisagat, Kericho)



Malaria KAP Survey

① House of Kipsigis - Low Income Class -
(Fort Ternan, Kericho)

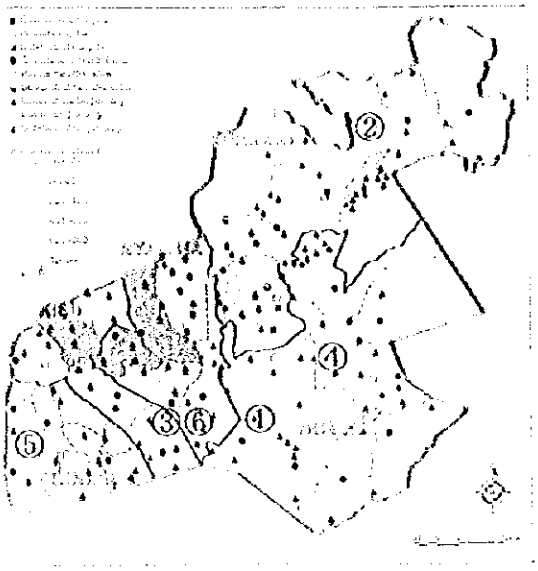
② House for Kisiis - Low Income Class -
(Keroka, Nyamira)

③ House of Kipsigis - Middle Class -
(Central Bomet, Bomet)

④ House of Kisiis - Middle Class -
(Nyamira, Nyamira)

⑤ House for Kipsigis - High Income Class -
(Kapsoger, Kericho)

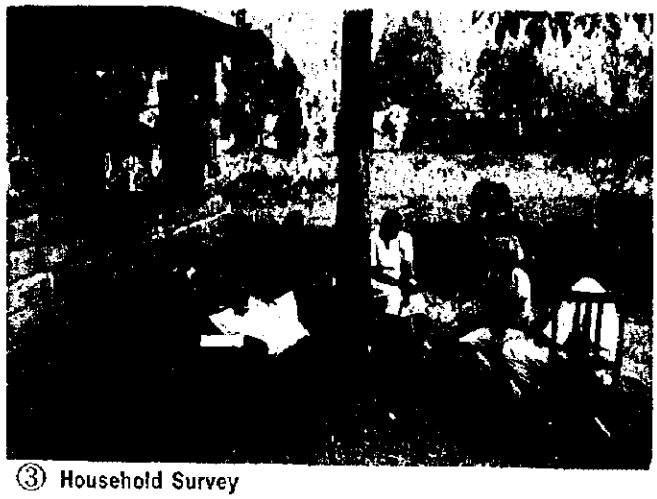
⑥ House for Kisiis - High Income Class -
(Kesurura, Nyamira)



Malaria KAP Survey

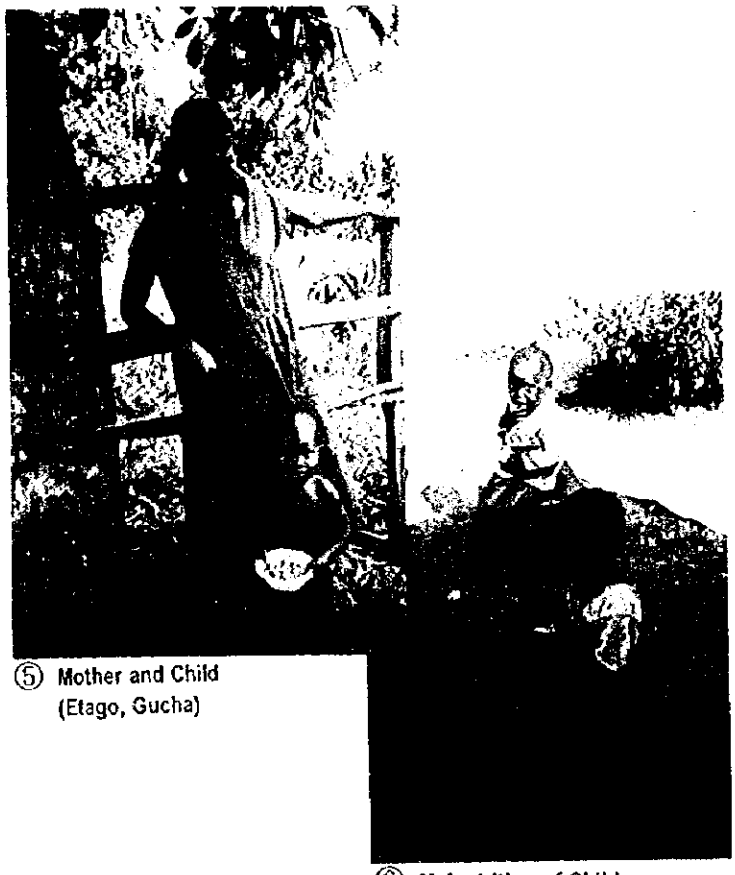
① Traditional House for Kipsigis

② Household Survey
(Fort Ternan, Kericho)



③ Household Survey
(Masimba, Kisii)

④ Focus Group Discussion with Women
(Kapkoros H/C, Kericho)



⑤ Mother and Child
(Etago, Gucha)

⑥ Malnutrition of Children
(Rigoma, Nyamira)

ABBREVIATION

AFD	African Development Bank
AIDS	Acquired Immunodeficiency Syndrome
AIE	Authority to Incur Expenditure
ALS	Average Length of Stay
ARI	Acute Respiratory Infection
BCG	Bacilli de Calmette-Guerin
BFA	Budget and Financial Analysis
CBD	Contraceptives
CBHC	Community-based Health Care
CBS	Consumers Baseline Survey
CDD	Control of Diarrhoea Disease
CIDA	Canadian International Development Agency
CO	Clinical Officer
CPM	Capital Project Management
CSM	Cerebrospinal Meningitis
DALY	Disability Adjusted Life Year
DANIDA	Denmark International Development Agency
DCEC	District Continuing Education Coordinator
DCO	District Clinical Officer
DDC	District Development Committee
DFID	Department for International Development
DH	District Hospital
DHEO	District Health Education Officer
DHIS	District Health Information Officer
DHMB	District Health Management Board
DHMT	District Health Management Team
DMOH	District Medical Office of Health
DMS	Director of Medical Service
DPHN	District Public Health Nurse
DPHO	District Public Health Officer
DPT	Diphteria-Pertussis-Tetanus Vaccine
DSP	Dispensary
DTB	Department Tender Board
ECN	Enrolled Community Nurse
EDF	European Development Fund
EDL	Essential Drug List
EDP	Essential Drug Program
EEC	European Economic Community
FIF	Facility Improvement Fund
FINNIDA	Association
FP	Family Planning
FY	Financial Year
GOK	Government of Kenya
GTZ	Deutsche Gesellschaft fur Technische Zusammenarbeit
HC	Health Center
HCF	Health Care Financing
HECAFIP	Health Care Financing Program
HEROS	Health Sector Reform Secretariat
HESSP	Health Sector Support Program
HFC	Rural Health Facility Committee
HIMS	Health Information Management System
HMUs	Hospital Maintenance Unit
HPTC	Hospital Pharmacy Therapeutics Committee
IEC	Information, Education and Communication
JICA	Japan International Cooperation Agency
IPD	In-Patient Department
KAP	Knowledge, Attitude and Practice
KDHS	Kenya Demographic Health Survey
KEDL	Kenya Essential Drugs List
KEMRI	Kenya Medical Research Institute
KHCFP	Kenya Health Care Financing Program
KEPI	Kenya Expanded Program on Immunisation
KHPF	Kenyatta Health Policy Framework
KHRP	Kenya Health Rehabilitation Project
KMA	Kenya Medical Association
KMTC	Kenya Medical Training College
KNDP	Kenya National Drug Policy
KNH	Kenyatta National Hospital
MCH / FP	Maternal Child Health and Family Planning
MESD	Medical Engineering Service Division
MIS	Management Information System
MLG	Ministry of Local Government
MoPW	Ministry of Public Works
MSCU	Medical Supplies Co-ordinating Unit
MTB	Medical Tender Board
NASCAP	National AIDS/STDs Control Program
NGO	Non-governmental Organization
NHIF	National Hospital Insurance Fund
NPA	Non Project Assistance
NPHL	National Public Health Laboratory
OPD	Out-Patient Department
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
OTC	Over-the-counter Drug
PCM	Project Cycle Management
PHC	Primary Health Care
PHMT	Provincial Health Management Team
PHO(M)	Public Health Officer (Maintenance)
PHT(M)	Public Health Technician (Maintenance)
PIH	Pregnancy Induced Hypertension
PMIU	Unit
PMOHs	Provincial Medical Office of Health
POM	Prescription-Only Medicine
PTA	Pharmacy and Therapeutics Committee
PTPP	Part Time Private Practice
PVC	Voluntary Organizations
RHTC	Rural Health Training Centre
RHF	Rural Health Facilities
RTI	Reproductive Tract Infections
SAD	Stores and Distribution
SDH	Sub District Hospital
SDP	Service Delivery Points
SIDA	Swedish International Development Agency
STD	Sexually-Transmitted Disease
TBA	Traditional Birth Attendant
TEC	Technical Evaluation Committee
TFR	Total Fertility Rate
TOT	Training of Trainers
TT	Tetanus Toxoid
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USAID	U.S.Agency for International Development
VHC	Village Health Committee
WHO	World Health Organization
WB	World Bank

Table of Contents

ANNEXES TO CHAPTER 5

Chapter 1

Introduction

1. INTRODUCTION

1.1 OBJECTIVES OF THE STUDY

The Objectives of the Study consist of the followings:

(1) To establish a master plan which strengthens the district health system in the Study Area and to formulate an action program for priority Projects/programs as a result of the master plan, and

(2) To conduct technical transfer to the Kenyan counter personnel in the course of the Study, in terms of methodologies on: 1) surveys and analyses for strengthening of the health sector; 2) people's participation in the planning process; and 3) a PCM approach to identify planning issues.

1.2 THE STUDY AREA AND TARGET

The Study Area is encompassed with five (5) Districts, namely, Kericho, Bomet, Nyamira, Kisii and Gucha. The catchment areas served by Kericho District Hospital, including part of Nandi, Uasin Gishu and Kisumu Districts, are also included in the Study Area.

As of January 1998, Nyamira, Kisii and Gucha were officially named North Kisii, Central Kisii and South Kisii respectively. However, in order to keep the consistency among the series of the study reports, old names were adopted in this report.

The area has a population of 3 million in 8,031 square kilometres of land. The master plan covers the time framework up to the year 2005.

1.3 THE STUDY SCHEDULE

The Study takes 14 months from August 26, 1997 up to the end of December 1998, being divided into two phases:

- The 1st Year Study : for the Base-line Study and Formulation of a Master Plan: up to March 1998
- The 2nd Year Study: for Formation of Action Plans and Projects/ program from June to December 1998.

1.4 STUDY WORKFLOW

The Study was conducted in accordance with the workflow as shown in Figure 1.1.

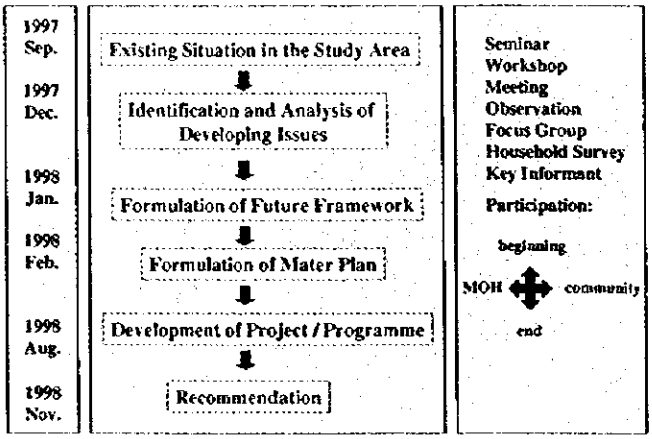


Figure 1.1 Study Workflow

Through the process of the Study, participatory approach is encouraged as much as possible from the beginning to the end of the Study as well as from the Central Ministry of Health to down the communities in the Study Area.

The Study also applied a wide variety of approaches including direct observation, key informant interviews, focus group discussion and household survey.

The products from those surveys and dialogues are brought to formulate 10 strategies in the Mater Plan aiming the following 2 objectives in the Study Area.

> To provide all the residents with universal access to minimum promotive and preventive health care as well as curative health service and upgrade the quality of the services.
>
> To strengthen linkages with other sectors to facilitate community development relating to health improvement.

Following the strategies in the Master Plan, then 5 Project/program packages were developed from 37 components of possible intervention with the criteria such as the consistency with National Health Sector Reform, cost effectiveness, and important base for the future development.

1.5 PROPOSED PROJECT/ PROGRAM

The figure 1.2 shows the composition of 5 Proposed Program Packages formulated through phase I Study. Five are:

(1) Priority Diseases Program ;
(2) District Hospital Rehabilitation Program;
(3) Rural Health System Improvement Program;
(4) Community-based Preventive/promotive Health Care Program; and
(5) District Health Service Education Program.

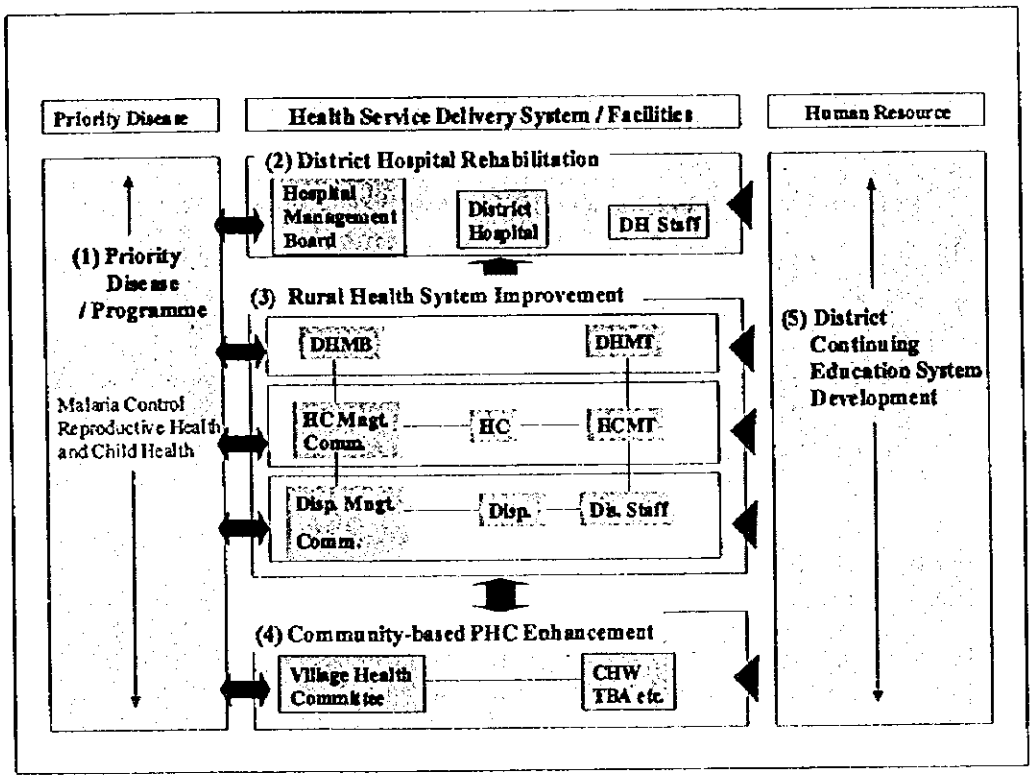


Figure 1.2 Composition of Proposed Priority Program Package

1.6 SCOPE OF THE REPORT

The Study report consists of the following volumes.

(1) Summary Report

(2) Main Report

(3) District Health Service Delivery System (Supporting Discussion 1: Baseline)

(4) Priority Diseases and Proposed Project (Supporting Discussion 2)

- Malaria Control Project
- Reproductive and Child Heath Project

(5) Facility-based Health Service and Proposed Project (Supporting Discussion 3)

- Hospital Rehabilitation Program
- Rural Health System Improvement Program

(6) Community-based Development and Proposed Project (Supporting Discussion 4)

- Community-based Preventive/promotive Health Care Program

(7) Human Resource and Proposed Project (Supporting Discussion 5)

- District Health Service Education Program

This volume is to explain (6) **Community-based Development and Proposed Project** (Supporting Discussion 4).

Chapter 2

Medical Anthropologigal Issues and People's Knowledge, Attitude and Practice (KAP)

2. MEDICAL ANTHROPOLOGICAL ISSUES AND PEOPLE'S KNOWLEDGE, ATTITUDE AND PRACTICE (KAP)

2.1 RESEARCH METHODOLOGY

The data on medical anthropological issues and people's knowledge, attitude and practice (KAP) on health were collected by using the following research methodology. (1) Literature Review and (2) Key Informant Interviews were conducted by a member of the JICA Study Team from September to October 1997, and (3) Household Questionnaire Survey, (4) Focus Group Discussion, and (5) Exit Interviews were conducted by a subcontracted local consultant, Keipet Consultants from November 1997 to January 1998.

(1) Literature Review

The following literature on traditional medicine and the related topics is reviewed:

1. "Chapter 11: Health and Medicine" (by Dr. David Nyamwaya of AMREF) in *Kisii District Socio-Cultural Profile* (Ministry of Planning and National Development and University of Nairobi: Nairobi, 1986).
2. "Chapter 9: Gusii Traditional Medicine" (by Prof. Isaac Sindiga of Kisii College Campus, Egerton University) in *Traditional Medicine in Africa* (edited by I. Sindiga, C. Nyaigotti-Chacha, and M.P. Kanunah, East African Educational Publishers: Nairobi, 1995)
3. *African Indigenous Medicine: An Anthropological Perspective for Policy Makers and primary Health Care Managers* (by Dr. David Nyamwaya, African Medical and Research Foundation: Nairobi, 1992)
4. Japanese book entitled *Gusii* and other articles written by Japanese anthropologist Prof. Makio Matsuzono of Tokyo Metropolitan University who has been conducting ethnographic fieldwork among the Gusii people
5. Japanese articles written by Japanese anthropologist Prof. Toru Komma of Kanagawa University who has been conducting ethnographic fieldwork among the Kipsigis people

(2) Key Informant Interviews

The key informant interviews were conducted with the following experts on traditional medicine and the traditional healers in the study area.

1. Prof. Isaac Sindiga, Principal, Kisii College Campus, Egerton University, Kisii (traditional medicine among the Gusii people)
2. Dr. Violet N. Kimani, Senior Lecturer (Medical Sociology/Anthropology), Department of Community Health, University of Nairobi, Nairobi (traditional medicine in general)
3. Dr. Kaendi Munguti, Research Fellow (Medical Anthropology), Institute of Developing Studies, University of Nairobi, Nairobi (traditional medicine in general)
4. Dr. Mabel N. Nangami, Lecturer (Sociology/Demography), Department of Health Management and Health Economics, Faculty of Health Sciences, Moi University, Eldoret (traditional healers in Kisii)
5. Mr. Omar B. Egesah, Lecturer (Anthropology), Department of Behavioral Sciences, Faculty of Health Sciences, Moi University, Eldoret (behavioral study on AIDS)
6. Dr. W. M. Kofi-Tsekpo, Chief Research Officer and Director, Traditional Medicines and Drug Research Center (TMDRC) in Kenya Medical Research Institute (KEMRI), Nairobi (traditional medicine and healers in general)
7. Dr. Halima Mwenesi, Senior Research Scientist (Medical Sociology), Scientific Coordinator, TDR/IDRC ITNs Initiative, Medical Research Center (MRC) in Kenya Medical Research Institute (KEMRI), Nairobi (people's KAP on malaria)
8. Mr. Bernard Lavusa, Head, Kenya Resource Center for Indigenous Knowledge (KENRIK) in National Museums of Kenya, Nairobi (traditional herbs in Kenya)
9. Mr. T. M. Oduoi, District Cultural Officer, Kericho (herbalists in Kericho district)
10. Mr. Laban N. Siocha, District Cultural Officer, Nyamira (herbalists in Nyamira district)
11. Dr. Paul M. Okibo, herbalist in Keroka, Nyamira District
12. Dr. Peter Otuke Meroka, herbalist in Kisii, Kisii District

(3) Household Questionnaire Survey

A total of 250 household interviews were conducted in the study area, using a household questionnaire, in order to collect information on people's knowledge, attitude and practice (KAP) on health.

For each of five districts in the study area, 50 questionnaires were administered in five different communities (10 questionnaires for each community). The five communities surveyed in each district were selected as sample communities on the basis of accessibility to health services: ranging from the community with the best accessibility (whose nearest health facility is a district hospital) to one with the worst accessibility (whose nearest health facility is a dispensary). Accessibility to health services was gauged in terms of the level of the health facility (building, equipment and staffing) and the physical accessibility to the health facility (distance, road condition and modes of transport), and the District Medical Officer of Health in each district was consulted to rate the communities and the health facilities using this criteria. Table 2.1 shows the sampled communities in each district and the nearest health facility for each community. Each sampled community is in the immediate catchment area of the health facilities, that is, within a radius of five kilometers.

Table 2.1 Sampled Communities in Five Districts

Accessibility to Health Services	District	Kisii	Gucha	Nyamira	Kericho	Bomet
Best	Community (Nearest Health Facility)	Bogiakumu (Kisii District Hospital)	Nyabisingororo (Ogembo Health Center)	Egesieri (Nyamira District Hospital)	Kericho (Kericho District Hospital)	Longisa (Longisa District Hospital)
Better	Community (Nearest Health Facility)	Riana (Riana Health Center)	Boitangare (Nyamache Health Center)	Keroka (Keroka Health Center)	Sigowet (Sigowet Health Center)	Kapkoros (Kapkoros Health Center)
Medium	Community (Nearest Health Facility)	Sosera (Masimba Health Center)	Etono (Kenyenya Health Center)	Chepng'ombe (Chepng'ombe Health Center)	Lemotit (Lemotit Health Center)	Sigor (Sigor Health Center)
Worse	Community (Nearest Health Facility)	Marani (Marani Health Center)	Bogetenge (Nduru Health Center)	Etono (Etono Health Center)	Fort Teman (Fort Teman Health Center)	Siongiroi (Siongiroi Health Center))
Worst	Community (Nearest Health Facility)	Ramasha (Ramasha Dispensary)	Bogesake (Kionyo Dispensary)	Borabu (Kijauri Dispensary)	Kunyak (Kunyak Dispensary)	Makimeny (Makimeny Dispensary)

Within the sampled communities, 10 households were sampled using the following wealth ranking criteria perceived by the community, which led the identification of households belonging to three wealth categories: the poor, the medium rich and the rich:

The poor
- temporary house (mud house with a grass thatched roof)
- small piece of land
- no cash crop

The medium rich
- semi-permanent house (mud walled house with an iron sheet roof)
- 3 to 5 acres of land
- about a half acre of cash crops

The rich
- permanent house (concrete walled house with an iron sheet or a tiled roof)
- large pieces of land (more than 5 acres)
- cash crops (tea, coffee, etc.)

A total of 10 households covering all of these three wealth categories were selected from each of the five communities in each district. Three households for each wealth ranking

category were sampled and the tenth household in each community was picked from any of the three categories, within a distance of 200 m from the last household interviewed. In total, 50 households were covered in each district and 250 households in the entire study area.

The questionnaires were pre-tested in Kericho district before the actual study was conducted, and the results from the pre-test were used to improve the instruments used in the final study. The household questionnaire was conducted with the head of the household or the spouse.

(3) Focus Group Discussion

Focus group discussions were conducted in each of the five sampled communities in each district, in order to collect information on medical anthropological issues such as traditional beliefs and customs related to health and traditional healers. With the help of the village elders or the area chief, participants were selected from among the community members. The average number of participants was about 10. The focus group discussion lasted for an average of 2 hours. There were some problems on the composition of the participants in the focus group discussions: i) almost all the participants were male, ii) young and old men were combined into one group, and iii) some of the groups had far too many participants.

(4) Exit Interviews

Stationed at the waiting bay of the out-patient service department in the district hospitals, a researcher interviewed patients on their way out, in order to collect information on people's knowledge, attitude and practice (KAP) on health. The respondents were randomly selected. Questionnaire interviews were administered to a selection of patients as they left the facility following the treatment.

2.2 TRADITIONAL MEDICAL SYSTEM IN THE STUDY AREA

The study area covers five districts, namely Kisii, Gucha, Nyamira, Kericho, Bomet, which used to be two districts: the old Kisii district which now consists of Kisii, Gucha and Nyamira, and the old Kericho district which now consists of Kericho and Bomet. Since these old districts better correspond to the socio-cultural characteristics of the people living there, this simple classification of the old Kisii and the old Kericho is used in this section. According to the 1989 Population Census, the old Kisii area is inhabited predominantly (about 95%) by the Gusii people (a part of the Bantu ethnic group), and the old Kericho area is inhabited mainly (about 85%) by the Kipsigis people which is a clan among the larger Kalenjin ethnic group (a part of the Nilotic ethnic group).

Kericho is an area of large tea estates, and many immigrant workers come and stay in Kericho from other parts of the country, which makes Kericho a multi-ethnic area. So especially in the urban and commercial centers in Kericho, there are many traditional

healers from other parts of the country (and even from Tanzania), which makes it a little difficult to single out a traditional medical system used by Kipsigis people.

On the contrary, Kisii is a more-or-less self-contained area inhabited overwhelmingly by the Gusii people, so there are many Gusii-specific traditional practices and practitioners observed in Kisii.

Since the British colonization period, Christianity has been propagated in the study area. Among the Gusii people, the Catholic Church, Seventh Day Adventist (SDA), Pentecostal Assembly of God (PAG), and Lutheran Church are the main denominations, and among the Kipsigis people, Catholic, African Gospel Church, and African Inland Church (AIC) are the main denominations. Religion has a direct impact on people's attitude and practice related to health. The Catholic Church opposes the use of artificial family planning methods, and SDA opposes polygamy and alcohol/drug use.

In the following sections, the traditional medical system, beliefs and practices observed by the Gusii and Kipsigis people are described and discussed in detail.

2.2.1 Traditional Medical System among the Gusii People

The Gusii are a culturally homogenous group of Bantu-speaking people. They occupy the three districts of Kisii, Nyamira and Gucha in the South Western part of the Kenya highlands. The Gusii trace their descent to one man, Mogusii whose several sons, among them Mogirango, Mokitutu, Monjale, Nyabasi, Momachoge and Nyaribari settled on the east, west, north and south of the hilly terrain. Over the years, each of these sons expanded into lineages and clans. The clan system is respected among the Gusii and intermarriages within one clan is highly discouraged probably to avoid inbreeding. There were no details available on this.

The people interviewed reported cultural similarities in the belief system and taboos among the Gusii people in general, irrespective of their locality. They refer to themselves popularly as "mwanyagetinge". This carries a connotation of oneness by socio-cultural factors, therefore, not by demarcated districts.

The participants confirmed awareness of battles their ancestors fought with the neighboring Kipsigis, Masai and Luo communities. Most of these wars were based on territorial disputes and cattle rustling. These battles must have had a deep impression on the lives of the people. Both the Gusii and Kipsigis know about disputes.

Perception of Health and Diseases among the Gusii People

Asked to define health and illness, the Gusii defined health as a state in which a person feels strong and is unaffected by diseases, a condition when the bodily organs function normally. A health person works normally. Physical, mental and social aspects are included. Personal cleanliness, clean clothes, clean toilets and appropriate waste

disposal i.e. digging waste disposal pits, also denote good health. A healthy child grows normally (is not retarded physically). A health adult is able to do his work normally.

Illness on the other hand is a state when a person is suffering from a specified disease or when a person is not feeling physically and mentally well, a feeling of pain or suffering. Illness is defined as a state that makes a person a weakling, always sick and taking a long time to heal in case of disease. The condition incapacitates normal functioning of the body and working. An ailing person cannot do hard work. He cannot fend for his family adequately.

The Gusii people (*Abagusii*; sing. *Omogusii*) have an elaborate traditional medical system with a variety of practitioners, specializations, drugs and medical equipment. This traditional medical system exists side by side with the modern medical system in Gusii. In practice, both Gusii and western forms of medical treatment may be used for one and the same illness albeit at different levels. One can then say that there is only one integrated medical system with both indigenous and western elements. But, from a theoretical point of view as well as from the perspective of the Gusii themselves, Gusii indigenous medicine and western medicine are two different systems, although the two are closely interrelated.

The Gusii people know that certain conditions are thought to be better treated using indigenous medicine. One often hears people saying, for example, "*Oborwaire obo nobwegenka.*" which means that this is an illness which should be treated using Gusii therapeutic techniques. The typical example is when measles (*omokururo* or *ekanyamoguku*) appears in children. The Gusii people do not take measles victims to the hospital before the rash appears. Other conditions for which the Gusii people do not seek modern medicine are evil eye (*ebibiriria*) and infantile diarrhea (*orosao rwa abana*); the latter they believe is caused by abnormal development of milk teeth (*ebisara*).

This illustrates the fact that the Gusii people make a distinction between diseases or conditions which have to be drawn to biomedical attention and those that are reserved for traditional medicine. How is the distinction made? Who makes the distinction? Why is the distinction made? Does therapy-selection follow the distinction? To understand this phenomenon, one must delve into the disease etiologies of the culture concerned.

Disease Causation and Therapy Choice

The Gusii people do not distinguish between disease, illness or misfortune. Although diseases (*amarwaire*; sing. *oborwaire*) are believed to be caused in a number of ways, when a person falls sick or even dies, the Gusii people tend to attach a human-induced cause, often witchcraft, to the case.

Equally important are the supernatural causes of disease. In the realm of the supernatural, diseases may be caused by ancestral spirits (*chisokoro*; sing. *esokoro*). It is

the duty of the living Gusii person to lubricate relationships between them and the departed ancestors. This takes the form of livestock sacrifices, usually cattle, sheep, goats and chicken. In normal circumstances, once a father has offered a sacrifice to the ancestral spirits, the son or sons need not do it. But the grandsons are obliged to do so. Failure to remember the ancestors may lead to the punishment of family members. They may remain poor or they could be afflicted with ill health and sometimes death.

The anger of ancestral spirits may be expressed through evil spirits (*ebirecha*; sing. *ekerecha*). If, for example, a father is not buried properly on his death, his spirits could become angry and affect a family member. This would result in madness (*ebarimo*) or make a woman barren/infertile (*omogomba*; pl. *abagomba*) or cause a child to contract epilepsy (*endurume*). A father's proper burial consists of first slaughtering a cockerel (*etwoni*), followed by a he-goat (*egoree*) after three days. After two to three months, another he-goat (*egoree*) or ram (*emingichi*) is slaughtered to cleanse the home. At this stage, a surviving fertile widow may be inherited by another man for the purpose of continuing procreation in the dead man's name.

There are a number of other causes of evil spirits (*ebirecha*). These include spotting a python or killing a person. The affected family is expected to go to a diviner (*omoragori*) to find out the underlying cause and then take required action, usually taking herbal medicine and sacrifice. In the case of killing a person, a black sheep is usually slaughtered. This is believed to chase away the evil spirits.

The Gusii people also believe that witchcraft is responsible for certain medical problems. These include mental disturbance (*ebarimo*), infertility (*obogomba*), and developing a chronic wound (*rikwege*; pl. *amakwege*). Another problem resulting from bewitching (*ogokonwa*) is epilepsy (*endurume*) and evil eye (*ebibiriria*). Both witches (*abarogi*, sing. *omorogi*) and sorcerers (*abanyamosira*) are well known within the Gusii society. Witches are particularly feared among the Gusii people and their actions appear to be motivated by jealousy. Sometimes sorcerers also act as healers to deal with the effects of witchcraft in society.

Certain diseases are believed to be inherited (*ororeria*). Such diseases may be passed along the lineage line to the offspring. A good example is liver cirrhosis (*enyaini* or *endonge*). The liver enlarges and hardens ultimately developing a wound. Chronic liver cirrhosis (*enyani*) causes edema of the feet. At this stage, a person will die. Chronic liver cirrhosis is treated by Gusii traditional medicine. Another condition which is believed to be inherited is mental disturbance (*ebarimo*). However, passing diseases along the lineage line need not be direct (i.e. from the parent to the children). The diseases could be passed from the living or dead members of the family, especially grandparents, to the offspring.

Another cause of disease and ill health among the Gusii people is breaching taboos, taking perjured oaths, and sexual offenses, especially adultery. These sets of offenses draw the anger of ancestral spirits which administer punishment. Adultery is punished

by the disease called *amasangia*. It is the supernatural punishment against the infidelity of a wife. The actions of an adulterous woman affect her husband and children and may cause death. Men's extramarital relations with married women is also held in check by *amasangia*.

Finally, the Gusii people believe that disease may be caused in a naturalistic way. *Enyamo* or *omwaga* is a problem of bad air which attacks children and adults. The primary symptom is an allergy demonstrated by swelling all over the body. It is believed that changes in seasons may bring bad air from distant lands. The Luo have a similar condition called *yamo*. In general, naturalistic diseases are picked in the environment. They are amenable to herbal remedies. Such include asthma (*ekeera* or *egekuba egeku*), splenomegally (*endwari ya inda*), malaria (*esosera*) and diarrhea (*orosao*).

Table 2.2 summarizes the Gusii people's classification of diseases, explanation of causes to these diseases, and choice of therapy.

Table 2.2 The Gusii People's Classification of Diseases, Explanations and Choice of Therapy

Illness Classification	Causal Explanation	Source and Type of Therapy
Natural (diseases) (e.g. malaria, pneumonia, respiratory conditions)	Natural causes (e.g. seasonal changes, climatic changes, vectors, parasites, germs, wind, dust, etc.)	Modern medicine; Herbalist for herbal medicine
Socio-cultural diseases (e.g. infertility, excessive bleeding at birth, obstructed labor, miscarriage)	Breach of taboo (e.g. Amasangia)	Ritual therapy; Ritual black cat passes over the over the patient; Fetch father's girlfriend's underclothes, put them on the bleeding girl
Infant death, excessive bleeding (circumcision), fever, crying; hard and bloated stomach	Ebibiria (Evil eye)	Ritual cleansing
Retained placenta	Amasangia	Chew herbal medicine "Chisanga"
Miscarriages	Severe anemia Amasangia	Raw blood from cow/goat to drink
STDs/HIV/AIDS	Infidelity in marriage	Herbal treatment (HIV/AIDS no cure)
Barrenness	Coming across a live python (girls)	Ritual therapy
Sudden death	Amasangia Burying husband without antidote	Feed on intestines of a cow from the land of the dead husband

Although we attempted in the above section to delineate clear disease etiologies held by the Gusii people, in reality, the Gusii people maintain contradictory explanations of disease. Some Gusii person may view one disease as a punishment for sexual, aggressive, property and ritual offenses, while the other Gusii person may blame it on the unwarranted malevolence of others. This is what makes the Gusii people pragmatic about treatment and willing to try anything that promises help and that has the

confidence of someone they respect. When one remedy fails, they try another, running through injections, tablets, sacrifice and sorcery with no feeling of inconsistency.

According to Dr. David Nyamwaya of AMREF, the Gusii people first seek meaning in the physical causation or what he calls the "how" explanation of illness. Only in cases of mental illness or chronic disease, a "why" explanation is sought. There are two categories of causes which are attributed to the "why" explanation, namely interpersonal (witchcraft, curse or breaching of a taboo or custom) and spiritual (ancestors). The interpersonal factors are the stresses, guilt and emotional disturbances which are the consequences of sins or crimes committed by the patient or his fellow men. In short, the "why" type of causation deals with social responsibility for an illness. An individual who deviates from the social norms held by the community will bring punishment on himself or his family.

Thus, the Gusii people look for various possible causes when a disease occurs. They may utilize modern medicine together with herbal remedies. The latter are to protect them against evil people. Simultaneously, they may sacrifice an animal just in case the problem comes from the supernatural. In other words, the Gusii people make an open-ended search for treatments within the medical systems which are accessible and available until the disease/illness is cured. Rather than providing a key to the simple and swift selection of a medical system, the diverse disease etiologies tend to provide the basis for uncertainty as to the actual cause of a given illness. The result is a rather diffuse pattern of therapy- seeking behavior among the Gusii people.

The preferred treatment for diseases depends on the type of diseases and their causes. Some diseases need simple treatment and others need special attention or else death may result. This may be done using modern techniques (going to hospital) or traditional use of herbs by traditional healers or at home. There are diseases that respond to modern medicine, religious remedies, and others strictly to traditional healing. For example, evil eye (*ebibiria*) responds only to traditional healing and cleansing. "Amasangia" is the consequence of adultery in a woman and responds only to ritual cleansing.

Typhoid needs special attention and this is mainly treated in hospital. For those diseases believed to be caused by witchcraft and evil eye, ritual cleansing and traditional healing is always required.

Traditional Health Practitioners among the Gusii People

The Gusii traditional medical system comprises several specialists. These are listed in Table 2.3.

Table 2.3 Major Categories of Gusii Traditional Health Practitioners

Category		Function
Singular Form	Plural Form	
omonyamete	*abanyamete*	herbalist
omoragori	*abaragori*	diviner
omoriori	*abarioti*	one who unearths magic witchcraft materials and medicine ("witch smeller")
omorabi	*abarabi*	traditional birth attendant
omobari	*ababari*	surgeon
omosari	*abasari*	circumcisor
omoromeki	*abaromeki*	one who performs localized blood letting to relieve pain.
omoebia	*abaebia*	dealer in love medicines
omwati	*abati*	undertakes autopsies
omonyibi embura	*abanyibi embura*	rain maker
omokireki	*abakireki*	one who uses medicines to prevent disease and misfortune.
omobani	*ababani*	one who foretells the future.
omonyamosira	*abanyamosira*	sorcerer

The basic traditional healer is *omonyamete*, literally herbal dispenser. He or she is found everywhere and usually dispenses herbal remedies. The healer who deals in love charms is called *omoebia.*

Another category of healers is the diviner (*omoragori*). The diviner usually unravels the cause of a given condition, especially one emanating from either supernatural or human-induced causes. After diagnosing the cause, the diviner also advises on a course of action to resolve the problem.

There is a category of people who foretell the future through prophecy called *ababani*, who are rather like fortune-tellers.

There is also another category of healers comprising traditional birth attendants (*abarabi*). They provide a variety of services including antenatal, prenatal and postnatal care and counsel expectant mothers on the appropriate foods to eat. Traditional birth attendants are significant in the Gusii society because of the high demand for children.

The most remarkable feature of Gusii traditional medicine is surgery. The surgeons (*ababari*) are particularly known for the surgical procedure called craniotomy or head trephining which really is the opening of the brain case to relieve pressure which causes headaches in brain tumors. The brain surgeon has deep knowledge of the human body, suturing and antisepsis, essential for his surgical work. Such specialization is also well known among the Meru, Kuria and Marakwet.

Other traditional medical specialists are circumcisors (*abasari*), *abati* who drain abscesses and undertake autopsies and *abaromeki* who puncture a part of the body to release pressure thereby relieving pain. Male circumcisors operate on boys, whereas the

women conduct clitoridectomy. Female circumcision is still very much a revered tradition among the Gusii people.

As explained above, witchcraft is quite feared among the Gusii people. Witches use certain magical materials to inflict suffering on their targets. However, such harm can also be done by sorcerers (*abanyamosira* or *abanyanabi*). Sometimes the sorcerers can be used as healers. In this capacity, they utilize their medicines to retaliate against witchcraft or to protect a family from it by performing a protective ritual called *okoosia*. Also, witches usually consult sorcerers to obtain protective medicine to counter the effort. Also, a special healer called *omoriori* uses medicine to sniff out and unearth the magic or witchcraft materials and medicines causing illness. Medicines neutralize their potency and render them useless. *Omoriori* is sometimes dubbed a "witch-smeller", although he works only to remove the paraphernalia of witchcraft rather than smelling the witches themselves.

There are both male and female traditional healers in Gusii, many of whom are older people, usually over 50 years of age. Most of the traditional healers in Gusii are herbalists. Most practitioners inherit the vocation from their family members and/or work as apprentices to the practicing healers. Most of the Gusii traditional healers practice medicine as a part-time activity, cultivating their land holdings for food and/or cash crops. A survey of traditional healers in Bonchari in 1993 showed that they attended to a median of four patients per week. A large range of medical conditions were treated with herbal remedies collected by the healers themselves. Most of the herbs were collected from the bush although many healers also planted some herbs in their neighborhood.

This section has outlined the Gusii people's concept of what causes disease, illness and misfortune. Although distinctive disease etiologies are articulated, the Gusii people's therapy-seeking behavior tends to be pragmatic. The Gusii people move from one medical system to another without a sense of contradiction. Gusii traditional healers have many specializations; however, herbalists form the largest group among them.

2.2.2 Traditional Medical System among the Kipsigis People

The origin of the Kipsigis is traced from the origin of the Kalenjin. The Kalenjin refers to an affiliation of all the sub-tribes in the district e.g. Kericho, Bomet, Nandi, Uasin Gishu, etc. in the Rift Valley. The Kalenjin tribe is believed to originate form a place called Misri (Swahili name of Egypt) in Northern Africa. They migrated southwards to Southern Sudan and they entered Kenya through the Mt. Elgon area. Since they were pastoralists, they migrated to the plains of the Rift Valley looking for good pastures for their animals. The group divided into four groups. One group went towards the Kericho area and this is the group which formed the Kipsigis sub-tribe, the other group went toward the Nandi hills and later formed the Nandi sub-tribe, another went towards the Baringo area and later formed the Tugen sub-tribe, and the final group went towards the Iten area and formed the Keiyo/Marakwet sub-tribe.

The Kipsigis sub-tribe occupied areas of Kericho, Pelkut/Belgut, Puret (present Buret) and present Bomet district. Before they occupied these places they had to chase the Gusii away who had occupied the place earlier. They fought with the Gusii people at a number of places including Kabianga, Chemoiben and Mabasi. They also fought the Masai at Kaptaket and Kaplong areas and managed to drive them to their present areas.

The Kipsigis originally were pastoralists, but with their constant interaction with the Gusii people they copied some of their lifestyles, one of which is farming millet and sorghum. They later adopted maize cultivation. Tea cultivation started later in the 20th century when Africans were allowed to plant cash crops.

After settling down they grew in number by intermarrying with the Gusii people and adopting their war captives. Raiding of cattle from Kisii and Masai was a common practice among the Kipsigis. The most prominent was the war of Mogore fought in Kisii, in which many Kipsigis were killed. The few men who survived procreated to form the present Kipsigis. An enemy who uproots some grass and holds it up at the moment of their impending killing is spared. This act is a sign of surrender among the Kipsigis and one is not supposed to be killed. In such a situation, the survivors were adopted into some of the Kipsigis clans and allowed to marry. At present, cattle raiding is minimal since people are engaged in other income generating activities (although none is as profitable as cattle raiding).

Perception of Health and Disease among the Kipsigis People

Health is defined by the Kipsigis people as a state whereby a person feels well and is able to perform and attend to his usual or normal chores. The body functions normally and the person feels robust. Observing personal hygiene in terms of using clean clothes, use of latrines and proper waste disposal all enhance health of the individual, family and community in general, according to the narratives.

Disease, on the other hand, is described as pain and other bodily discomforts which incapacitates the individual's normal, physical, biological, emotional and social functioning. A state in which a person becomes incapable or unable to perform normally as a result of bodily disorder, pain and/or weakness. Being kind and social is regarded as a healthy disposition.

Diseases such as sexually transmitted infections entail psycho-social effects such as embarrassment and thus reduced social status. Once sick the patient's top priority is to obtain immediate relief of the symptoms and discomfort. Quite often this is from the herbalist or injections from unqualified personnel.

Diseases are classified according to its causative factors. Food and water related diseases include malaria, diarrhea, amoebae, typhoid, among others. Most respiratory diseases such as tuberculosis, coughs and colds, and pneumonia are attributed to exposure to cold wind, rain, dust and other elements of nature. Another category is the diseases believed to be

caused by the individual's immoral behavior. This includes sexually transmitted infections, including HIV/AIDS. Promiscuity is seen as responsible for sexually transmitted diseases which can cause infertility.

In such cases, the patient is not exonerated from blame for his behavior. Another classification of diseases is believed to occur as a result of breach of societal norms and taboos. For instance, society prohibits stealing and murder. Even though this may be done in secret the guilty individual may never escape the wrath of the supernatural. Punishment is manifested in form of illness and/or death. Some diseases and sudden death are believed as manifestations of witchcraft often masterminded by one's enemies. Other classification includes: symptoms on a particular part of the body, e.g. headache may signify malaria; or the type of treatment required, for instance, is it medicine only or a combination of therapies and rituals?

In a focus group discussion at Fort Teman in Kericho, we were informed that some diseases like scabies are associated with mothers and children, STDs are associated with the youth (15-30 years old), malnutrition with children, and problems of retention of urine to older men.

Traditional Health Practitioners among the Kipsigis people

Various types of traditional health practitioners among the Kipsigis people are summarized in Table 2.4.

Table 2.4 Traditional Health Practitioners among the Kipsigis People

Traditional Health Practitioner	Kipsigis name	Prevalent sex
Herbalists	Chepkerichot	Both sexes (50% each sex)
Witchdoctors	Chepsogeiyot	Both sexes (females slightly higher than males)
Fortune tellers	Orgoiyot	Males only
Traditional birth attendants (TBAs)	(no special name)	Older females only
Female circumcisor	Chebabor	Females only

a) Most respected traditional health practitioners (THP):

Herbalists (*Chepkerichot*), because of the essential service they offer. Traditional birth attendants (TBAs) and fortune-tellers are respected, too, but this respect does not supersede that of the herbalists.

b) The most frightening traditional health practitioners (THP):

Witchdoctors (*Chepsogeiyot*), due to their perceived ability to cause harm to people using supernatural powers.

c) The most used traditional health practitioners (THP):

Traditional birth attendants (TBAs) were the traditional health practitioners whose services were sought for most by the people, followed by the herbalists. But as people realize the better services provided by health centers and other institutions, this changes: herbal medicine is now more commonly sought than TBA services. Some retired nurses work as TBAs or female circumcisors at home.

2.3 TRADITIONAL BELIEFS AND PRACTICES RELATED TO HEALTH

2.3.1 The Gusii People's Traditional Beliefs and Practices Related to Health

There are a number of problems which have persisted among the Gusii people because of their indigenous medical beliefs. Only the major ones are mentioned below:

1. The Gusii people believe that a case of measles (*omokururo*) should not be referred to the hospital if the rash has not erupted. It is believed that if an injection is given before the rash comes out, the child will die. In most cases, therefore, children with measles are taken to the hospital only when complications have developed.

2. The Gusii people believe that infantile diarrhea can be caused by the development of abnormal milk teeth called *ebisara*. *Ebisara* are canine teeth in the process of erupting. Because such teeth are believed to cause diarrhea, they are extracted by an expert. The extraction is done without anesthesia and causes the baby a lot of pain. In some cases, the removal of *ebisara* is followed by serious infections of the gums. There are cases where removal of *ebisara* destroys the roots of the permanent teeth which therefore do not appear at all.

3. The Gusii people believe in a phenomenon called "evil eye" (*ebibiriria*). It is claimed that the condition is brought about when a person who has *ebibiriria* looks at a child. It is said that by looking at the child, the person with *ebibiriria* causes small objects like soil, flour, hair and even finger-millet to enter the child's body. The child's temperature rises and breathing becomes difficult. When the child's body is rubbed with oil, the small objects come off. Some medical experts believe that *ebibiriria* is pneumonia, but others seem unsure about it. *Ebibiriria* is never referred to the hospital, and many children have died of this condition. It is urgent to explain to the people what the symptoms and signs now called *ebibiriria* are and how the condition should be managed.

4. The Gusii people believe that epilepsy (*endurume*) is contagious. When an epileptic is in a fit, people usually run away and the victim can easily get hurt. An epileptic usually eats alone because Gusii people think that the disease can be spread by sharing a meal with an epileptic. The life of an epileptic is therefore miserable and lonely .

5. Overdrinking of home-brewed liquor called *chang'aa* is causing a serious health and social problem in many parts of Gusii area.

6. The demand for children is very high among the Gusii men and women, because childlessness is believed to be a sin-consequence for perjured oaths, punishment for breaching a taboo or custom, and displeasure of the ancestors for failing to appease them. The resulting high population growth rate in Gusii area has put high pressure on the provision of health services.

7. Female genital mutilation (FGM), widely known as female circumcision, is often considered as one of the most harmful traditional practices in the Gusii area, which negatively affects the physical and psychological well-being of girls and women. The next section (2.4) is dedicated to describe this issue.

2.3.2 The Kipsigis People's Traditional Beliefs and Practices Related to Health

Many cultural taboos and beliefs related to illness are still observed by the Kipsigis community, especially by the elderly members.

A person who has taken herbal medicines to treat vomiting and diarrhea should not be visited, because if a visitor crosses the shadow of the patient, the herbal medicine will not be effective.

Calabash plants should not be planted near a public path to avoid people with the evil eye over admiring it, because there are beliefs that such people possess the power to cause the plant to dry up.

In the narratives, the communities' perceptions of health and disease contrast with their knowledge and behavior. For instance, although the people know typhoid and amoebae are caused by drinking untreated water, there is also a belief that drinking boiled water too frequently causes stomach illness.

Some taboos pertain to women regarding fertility, reproductive health and babies. For instance, a pregnant woman should not kill a snake. If she does, she would give birth to a snake. An attempt to find a meaning behind some of these beliefs is made by focus group discussion participants. For instance, it is not easy to kill a snake and a woman could expose herself to unnecessary risks.

Pregnant women should not eat eggs, sweet potatoes, chicken, sugarcane nor honey, because it was believed that such foods would make the baby too big and thus cause complications during delivery.

One should not prepare a milk gourd for carrying baby's milk, before the baby is born. That means avoid prior preparations for the unborn baby. This is understandable in a

situation where neonatal mortality, for various reasons, used to be high. To avoid disappointments and attracting evil powers, many African communities did not make any obvious preparations for the unborn baby.

Many Kenya communities commonly perceive that water from a river is always safe to drink. The Kipsigis have a saying "*Toiyon beek*" whose direct translation means "water is clean". The Kikuyu equivalent is "*ma ruui matiri mugiro*" which directly means "river water has no taboo, it is safe". This does not apply in modern community whereby effluents are drained into rivers. This saying should be replaced with "water is polluted."

People thought to have an evil eye are not allowed to see a newborn or sick person. A newborn baby should drink and/or be bathed in a herbal solution to protect it from the powers of the evil eye.

Naming children after the wrong dead person causes illness to the child.

Beliefs and taboos touching on the community in general include the following:

1. The community holds strong beliefs in the powers of the evil eye to cause diseases or even death.

2. It is a taboo to steal or kill somebody because the culprit will suffer from diseases.

3. Green grasshoppers cause colds.

4. It is a taboo to sit on a sharpening/grinding stone or the manger where the cattle take water.

5. It is a taboo to point at somebody directly because it might cause disease.

6. Committing murder or injury (spilling another person's blood) causes disease to the offender.

7. Uprooting fences during border disputes brings illness to the person who is wrong.

8. If a person on a journey happens to see a crow, a scavenger bird, facing away from him, this is perceived to be a bad omen. The traveler must abandon his mission/trip to avoid serious disease. If he was going to woo a girl into marriage, the children brought out of such a union might die.

9. Stealing other people property, especially livestock or grabbing land, brings disease.

10. Milk should not be boiled, since this is equivalent to burning a cow. Milk should, therefore, be taken raw.

11. Promiscuity reduces the ability to reproduce.

12. Children are warned against defecating in the river. If a child did this, his mother will die.

13. A child should not walk on the grinding stone. If this happens, such a child would grow as short as a mortar (stunted).

14. Children should not be told stories during daytime, lest they become blind.

15. A child should not assault his parent. If he does, he will die.

Such taboos appear to put social control over unhealthy behavior such as laziness and disrespect of one's parents.

These beliefs and taboos are relevant to health and illness from several perspective. For instance, some are meant to protect people from potential dangers. Others enhance harmony in the community, which serves as a social control to reduce social evils in the community such as theft, homicide, quarrels, fights and threats over valued property such as land and livestock. Some of the food-related taboos are meant to avoid allergies and protect the expectant mother, while others make sense from the point of view of public health. For instance, prohibitions from sitting on the grinding stones, or on the cattle manger could be meant to avoid contaminating these places with human fecal matter.

Stripping naked is not only indecent but also inappropriate in many circumstances. The scavenger bird frequents places of death and rot. This could imply death either of an animal or a human. This could be probably be through tribal wars, or attack by wild animals. It makes sense that people should be alert to their general ecology and utilize natural phenomena for survival.

The green grasshopper appears at a certain season, indicative of weather changes, and a number of diseases are perceived to be seasonal. In communities where reading was unknown, the people relied on observing nature and responding to its warnings and indicators of danger. Adaptation to climatic changes, natural elements and seasonal variations brought harmony to the lives of the people. This was common among many other ethnic groups. Time is estimated by looking at the sun. When the shadow is at a certain angle, this is the time to do various activities such as bring cattle home for milking.

2.4 FEMALE CIRCUMCISION

It is important to point out that all Kenyan communities with the exception of the Luo and the Turkana, undergo male circumcision. The actual operation is only part of a detailed and systematic process of transition from childhood to adulthood. It is unusual that an adult male has not been circumcised and if one is found, he is compelled to undergo the operation. There are detailed and meaning-centered explanations for the

process. Female circumcision on the other hand varies from one community to the other. Not all communities who circumcise the males did the same to females. For instance, among the Luhya groups only males are circumcised. Among most of the pastoral communities such as the Masai, the Kalenjin, the Samburu and others, both males and females undergo the initiation rites.

Most of the Bantu-speaking groups such as the Muslim coastal Mji Kenda groups, the Taita, Kamba, Kikuyu, Meru, Embu, Gusii, Kuria and others circumcised and continue to circumcise both males and females to a certain degree. Christianity, school education, general modernization and advocacy have brought about increasing awareness among many of the communities about the dangers of female circumcision. Indeed most of the communities have reduced the degree of cutting or have stopped the practice altogether.

In the study area, both the Gusii and the Kipsigis continue to conduct female circumcision. Female circumcision, or female genital mutilation (FGM) in a medical term, involves the surgical removal of parts or the whole of the external female genitalia. Among three types of female circumcision operations (Type I - clitoridectomy, Type II - excision and Type III - infibulation), Type I (clitoridectomy) is widely practiced by the Gusii and Kipsigis people.

Female circumcision causes irreversible, life-long health risks for girls and women, at the time of operation, during consummation of marriage, and during childbirth and delivery. Its immediate and long term complications depend on the type of operation, the location (in a rural community or a hospital in an urban setting), the age, eye sight and dexterity of the circumcisor, the instrument used (knife, razor blade, or sterilized instruments). and the struggle put up by the young girl. Immediate and long term physical, mental and psychological complications may occur. These range from hemorrhage and infection to the socially ostracizing vesico-vaginal and recto-vaginal fistulae. While the psychological effects of female circumcision or are not very well documented, some researchers have associated female circumcision with nightmares, anxiety, depression and even psychosis.

During the past decade, different governments, international development agencies, United Nations, international and national women's organizations, and professional associations have developed policies condemning the practice of female circumcision. The outcome of the International Conference on Population and Development at Cairo in 1994 and the Fourth World Conference on Women at Beijing in 1995 have documented female circumcision as a harmful traditional practice affecting women, for which concerted efforts must be made to eliminate the practice. The Ministry of Health and the Kenyan Government also condemn all traditional practices affecting the health of women and children including female circumcision, early marriage, and nutritional taboos.

2.4.1 Female Circumcision among the Gusii People

Female circumcision is a traditional rite of passage performed on all Gusii girls at the age of 8-12 years old. The purpose of the operation like for boys is to mark transition period, from childhood to adulthood. During the circumcision rite the tip of the clitoris is cut off. There is no anesthesia but millet flour is sprinkled on the wound to control bleeding. The ceremony that accompanies the operation is supposed to prepare the girl to take up adulthood responsibilities. Circumcision ceremonies were traditionally used to mark and identify with age mates and girls circumcised within the same year (circumcision is done every end of year, during December) consider themselves age mates. Any other girl then who is not circumcised cannot easily associate with circumcised girls, unless they are family members, and such a girl cannot refer to her friends by 'abusive' pet names that age mates are fond of, since she will always be reminded that she is not circumcised, "Ege sagane," the uncircumcised girl. Peer pressure and demand by parents makes young girls look forward to circumcision. Cases of young girls sneaking away to be circumcised without the knowledge of at least one of their parents are common.

Another reason for female circumcision is that the Gusii believe it reduces sexual libido for girls. Girls who are not circumcised are believed to be sexually overactive. Focus group discussion participants at Nyabisingororo noted that an uncircumcised girl was more likely to engage in sex and get pregnant than a circumcised one.

In the Gusii area, an American NGO called the Program for Appropriate Technology in Health (PATH) sponsors female circumcision eradication programs in Kisii, Gucha and Nyamira Districts. PATH works with Maendeleo Ya Wanawake Organization (MYWO) in Kisii and Gucha Districts, and the Seventh Day Adventist-Rural Health Services (SDA-RHS) in Nyamira District. These programs employ an approach that empowers the local communities, especially the affected women, through the information, education and communication (IEC) activities, which was inspired from the successful female circumcision eradication program in Nigeria. In Nigeria, the National Association of Nigerian Nurses and Midwives (NANNM) successfully mobilized their members at the community level to educate the Nigerian public about the harmful effects of female circumcision.

According to the studies carried out by PATH and MYWO in Kisii and Gucha Districts in 1991/1992, 98 percent of interviewed women over the age of 14 have been circumcised, often in very unhygienic conditions. Even though most of the circumcised women experienced complications attributable to female circumcision, more than 65 percent expected to circumcise their daughters. The quantitative research findings indicate that while the prevalence of the practice is still high in Kisii and Gucha Districts, female circumcision is on a downward trend. For example, 78 percent of teenage girls have been circumcised, as opposed to 100 percent of women 50 years and older.

PATH and MYWO also conducted focus group discussions and interviews with members of the community including parents, community leaders and youth in Kisii and Gucha Districts. This qualitative research sheds additional light on the social significance of the practice and the reasons for its continuation. Female circumcision is considered to be the most significant rite of passage to adulthood, enhancing tribal cohesion, providing girls with respect and important recognition from their peers, and increasing girls' chances of marriage. The practice is also perceived as a means of preventing promiscuity and is believed to promote easy childbirth. Women have emerged as the group most attached to the practice. However, the role of men who support to continue female circumcision because it is necessary for girls to become marriageabile to men has not yet been fully investigated.

It is clear that there are many general community enforcement mechanisms that have allowed the practice to continue, including the multitude of myths regarding female circumcision (e.g. the husband of an uncircumcised girl will die, the midwife who helps uncircumcised women's delivery can go blind, the baby will be abnormal, the genitals will grow uncontrollably, uncircumcised girls will be immature and tiny). Women who do not circumcise their daughters are seen by some as irresponsible, "loose," and imitators of western culture; others see them as strong and liberated. This demonstrates community ambivalence about accepting change.

The research also indicated that the celebrations, gifts, and family life education associated with female circumcision compensate for the hardships that women endure in undergoing the ritual. These celebrations and gifts could become positive tools for eradicating female circumcision, if the ritual were modified so as not to include the ritualistic cutting. Based on this research, MYWO and PATH started to promote an alternative ritual to female circumcision which mobilizes the community to celebrate the adolescent girls entering into adulthood with the presents. This alternative ritual approach was first introduced successfully in Tharaka-Nithi District and is currently planned to be introduced in Kisii and Gucha Districts.

In Nyamira District, PATH started a female circumcision eradication program in partnership with SDA-RHS in 1996/1997. PATH and SDA-RHS has conducted research to document health workers' knowledge, attitude and practice regarding female circumcision. Fifty-five health professionals were surveyed through the use of a standardized questionnaire and through focus group discussions and in-depth interviews. Representatives from different community members, including religious and political leaders, parents, youth, circumcisors and traditional birth attendants, were also interviewed. Highlights of the research results are as follows:

1. The community still values the coming of age ceremonies and the education that is bestowed on their daughters during the time of female circumcision. However, many community members believe that the circumcision aspect (cutting the external genitalia of females) has lost its significance since it is now done mostly before ten years of age - a time when girls are too young to pass to adulthood.

2. Concerned about the many health complications associated with female circumcision, such as bleeding, infections, including the potential risk for HIV/AIDS, many parents are taking their daughters to health providers (clinics) for circumcision. This is being done at much earlier ages (7 - 10 years). They believe that girls will bleed less and heal faster if circumcised at a younger age and if circumcision is performed by health care providers.

3. Some parents and religious leaders have joined forces to stop female circumcision in the community, starting with their own daughters. They have formed support groups and taught their daughters how to respect themselves, their parents, elders and the community at large, and their daughters were encouraged to do well at school.

4. Several female community members mentioned that they have marital problems directly related to their female circumcision. They also mentioned that they "suffer in silence" since it is a difficult subject to discuss with their husbands.

5. Health providers from 16 district health facilities (out of a total of 34), confirmed that they receive frequent requests from the community for services related to female circumcision, including treating recently circumcised girls with various complications (50.9%), and providing tetanus injections to the girls before circumcision.

6. Almost three quarters (74.5%) of health providers are not personally in favor of female circumcision due to its lack of benefits and its health complications. Only 20% of health providers are in favor of female circumcision. Some of those (12.7%) perform female circumcision for the community, mainly for financial gain.

7. The overwhelming majority (80%) of health providers interviewed will not circumcise their daughters in the future. Of those health providers whose daughters reached circumcision age, only 27.3% circumcised their daughters, and of the 21 health workers with young daughters, only five plan to circumcise them in the future.

8. Health workers agreed with the community that parents and the community should be educated about the harmful effects of female circumcision. They recommended the involvement of government, churches, NGOs, parents, teachers and health workers themselves if female circumcision is to be eradicated from Nyamira District.

9. While parents are seen as a key to stopping female circumcision, the community trusts and believes in the role and leadership of the chiefs, sub-chiefs, elders and the religious leaders for eradicating female circumcision from their community.

Following this research, PATH and SDA-RHS have started an intervention phase in 1997, which primarily targets health workers for education and materials about female circumcision and the role they themselves can play in discouraging and stopping the performance of the practice. Interventions at community level have begun through training health workers and thereafter, key community leaders and change agents. Subsequently, materials development training has been done with the different community members themselves, in order to develop appropriate information, education and communication (IEC) materials and messages for use within the project community. Implementation through community outreach activities have begun through the SDA-RHS community networks.

Despite advocacy by MYWO and SDA-RHS, it is reported that so far only a few people in the district have stopped circumcising their daughters. What is apparently slowing down the trend towards ending the practice is the lack of openness among the anti-female circumcision crusaders. Focus group discussion participants reported that some community leaders such as MYWO representatives, who preach against the practice, are known to take their girls for the operation secretly. This double standard attitude among the community leaders discourages community members who might like to adopt an anti-circumcision stand.

2.4.2 Female Circumcision among the Kipsigis People

As indicated in the section on historical background, the origin of the Kipsigis is traced from that of the larger Kalenjin group, which includes the Nandi, Keiyo, Marakwet and Tugen. Their cultural practices are fairly similar. The Nandi and the Kipsigis initiation rites appear similar from the available literature.

Female circumcision is one of the most critical points in the life of the Kipsigis. It marked the transition from irresponsible childhood to an adult tribal member. Circumcision gives an individual an identity as a fully accepted member of the society. An uncircumcised woman would never be married. She cannot be allowed to deliver a baby because she herself is a child. A child is not a Kipsigis, but is regarded as the offspring of Kipsigis until one obtains legitimacy as a full Kipsigis through circumcision. A child is a non-entity referred to as "Chepto". The child of a non-entity is nothing in itself. Therefore, a child born of an uncircumcised woman was never allowed to breathe (I. Orchardson, 1961). The initiation process marks a rebirth, with circumcision being the outward sign. A series of rites were performed over a period ranging between four months to about a year.

The practice of female circumcision is still quite prevalent, on average but this varies in different parts of Kericho and Bomet districts. In areas where the literacy level is still low like Chepalungu in Bomet, 80-90% of all females still get circumcised. In Kericho district, where people are on the whole more literate the prevalence is approximately 30-40% of all females. These are rough estimates to give an idea of the prevalence of female circumcision. What appears clear is that the prevalence of female circumcision is inversely proportional to the literacy level. It tends to be more prevalent also in areas of

Bomet district bordering Gusii, and in the Masai communities who themselves continue the practice.

Reasons of female circumcision: The practice is considered as an important rite, that marks the entry of a female into adulthood. It is taken as a preparation for marriage. A less important reason is the reduction of female libido and, therefore, reduced promiscuity in society.

During initiation, the girls are socialized to become fully accepted members of the Kipsigis, learn to discard all childish things, to control their feelings, and behave in ways superior to those of the uninitiated. They learn how to relate to their husbands and how to become good mothers and wives.

Age of female circumcision: In the 1970s and 1980s, the average age was 14-18 years. Now it has gone down to 12-13 years when girls are in class 5-7, certainly before entry to a high school.

The circumcisors are old women (specialized in the job, and called Chemosiat). Female nurses especially the retired ones now perform a significant number of circumcision, using some of the modern supplies such as spirit, iodine, etc.

Similarities and Differences with the Gusii people

1. Prevalence of female circumcision: In both communities, the operation is quite prevalent .

2. Type of female circumcision: Both Gusii and Kipsigis communities cut the clitoris only.

3. Age of female circumcision: Gusii people circumcise much younger girls (sometimes below 10 years, but on average between 8-12 years old) than Kipsigis people.

4. Purpose of female circumcision: For the Kipsigis, preparation for marriage and transition from childhood to adulthood. The circumcised girl should discard all childish behavior and behave and even think like an adult. For the Gusii, the main idea for female circumcision was transition from childhood to adulthood and also to reduce libido among girls.

The Process of Female Circumcision

Among the Kipsigis, female circumcision involves excision to the glans of the clitoris (the whole of it). A herb (Sigowet) is then applied to act as an antiseptic. The other components of the vulva (i.e. the labia, mons pubis, etc.) are not touched, but the hymen is intentionally torn during the process and virginity therefore lost. This is symbolic of opening the way for procreation.

After the circumcision process is over, in a matter of a few weeks the Kipsigis girls are married off. With school etc., this is changing and the girls are not necessarily married off immediately. Girls' education is low with a ratio of about 1:2 girls to boys in school. This is largely because girls are married off immediately after circumcision in their early teens. This in effect means that girls miss the opportunity to learn basic personal hygiene and environmental sanitation at school. In such cases the husband who might be a little more educated assists her to make health decisions, such as taking the baby for immunization, domestic cleanliness and provision of balanced diet such as meat to supplement food from the farm. The importance of mothers' education cannot be over-emphasized. Community awareness of this appears low.

At night prior to the cutting, the initiation candidates (girls) are taken into the operation room where they are made to sit with legs open and the clitoris is tied tightly with a ligament to cut off blood supply. The girls then dance and jump themselves to exhaustion. The clitoris is then stung with nettles to cause numbness and swelling. This acts both as anaesthesia and reduces bleeding. The breasts of the girls are also stung with the nettles. Since this is very painful, women dance and sing very loudly to drown the cries from the girls.

The next morning, a group of participating women stand in a circle and the initiator/circumcisor sits in the middle of the circle. The girls are examined for virginity; the virgins sit on stools and the non-virgins sit on the ground. When the time comes for the operation, the girls are seated with legs apart. The circumcisor, or Chebabor, holds the clitoris with her left hand and a curved knife with her right hand, and quickly chops the clitoris off. There is little pain felt because the stinging nettles have numbed the girls' sex organs.

When the operation is over, the girls and their helpers go into a period of seclusion from six months to three years. During this period, the girls are educated in tribal knowledge and customs. For example, how to sleep with their husbands, how to be wives and how to bring up children. They are also educated on proper eating habits e.g. taboo foods. They are also taught how to behave as women, for example, working hard and being courteous, etc. During the period of seclusion, the girls eat meat and milk for the first four days. During the entire period, they eat with "Seketik" (a wooden spoon). They cannot touch anything because they are seen as religiously impure. The girls are also not allowed to touch their wounds. Men must not see them when they go out. They remain indoors for the most part of the day except in the evening and early morning.

During initiation, it is highly important for the initiates to prove their courage. Before the operation, their boyfriends gather together to try and vex them by calling them cowards and other derogatory names. This is intended to build courage in the girls until the actual operation is carried out. During the operation, there are spectators who watch for the girls who showed signs of cowardice. If a girl showed fear, she is a shame to the family. These families hang a burnt climbing plant ("Sinendet") at the door of their house to indicate that their daughter showed cowardice during initiation. An unburned climbing plant

("Sinendet") hung at the door of a house indicates to outsiders that the daughters of the house has been initiated.

The Kipsigis believe that if a woman's clitoris has not been cut, it will grow long and develop branches, and her children will be born abnormal. She is considered to be a "child" until she is circumcised. An uncircumcised woman, if discovered will be the laughing stock of the group and it is believed that misfortune will befall her, unless she is circumcised.

To the Kipsigis, female initiation is a rite of maturation, which symbolizes the transition from childhood into adulthood. The ceremony is deeply sacred because in it lies the survival of the nation. The sexual organs are a symbol of life and by cutting the clitoris, the issues of life are unlocked and will flow. Through initiation, the life of the people/group is revived and anyone, therefore, who refuses to be circumcised is viewed as trying to kill the nation and the entire society.

2.5 PEOPLE'S KNOWLEDGE, ATTITUDE AND PRACTICE (KAP) ON HEALTH

2.5.1 People's Knowledge on Health

Local people's knowledge on the causes, treatment and prevention of diseases is found very limited especially in the rural area and among mothers with low educational background. They are strongly influenced by traditional beliefs and customs and many people seek the remedy both in modern medicine and traditional medicine, depending on the availability of and the access to health facilities.

In the focus group discussions, the participants were asked about the symptoms, causes, prevention and remedy of the most common diseases in their area. Female groups reported that there was a tie between malaria and respiratory conditions. Very few groups could distinguish between gonorrhea and syphilis and even HIV/AIDS. All STDs were given similar symptoms. Both males and females talked of females urinating blood in advanced stages of syphilis! Only two women in one focus group mentioned smelly discharge as an early symptom of gonorrhea in females.

In the women-only focus group discussion, attempts were made to probe for diseases specific to gender. Participants gave the following diseases as ones that affect women only, mainly due to reproductive related activities: morning sickness during pregnancy, especially in early stages of pregnancy miscarriages, and obstructed labor. In general, the males gave vague symptoms for almost all illnesses specific to women.

For the local population, disease causes were not always clear. For instance, the community postulates that certain foods cause malaria, besides unclean water. Their concept of the causes of malaria did not always reveal clear understanding of the link between water and mosquito. Some people thought drinking unclean water or eating

certain foods caused malaria. Amoebiasis is believed to be caused by drinking untreated water. Amoebiasis is included in the category gastro-enteritis.

As for the disease prevention, many people suggested that boiling drinking water was thought to prevent most diseases such as amoebiasis, malaria, gastro-enteritis and acute respiratory infections. Administration of traditional herbs, to induce vomiting and diarrhea, is used for both prevention and treatment of malaria. In treatment, the herbal mixture is supposed to clean the stomach of the disease. The herbal treatment is also complemented with medicines from the local dispensary and if no improvement is observed the patient seeks the services of private hospitals. A traditional healer is sometimes preferred due to the belief that some chronic diseases, like cancer, cannot be treated at the modern medical facilities. Another reason is due to the high hospital bills. Tenwek Mission Hospital was cited as an example of high cost hospitals.

The participants in focus group discussions among the Gusii people were asked to list all the common diseases in their community, the observable symptoms for each disease, the perceived causes, the suggested ways of preventing the disease and the regular course of therapy followed in the event of contracting the disease. This information is summarized in Table 2.5.

Table 2.5. The Gusii People's Knowledge on the Common Diseases (1/3)

Disease (Local name)	Symptoms	Causes Perceived by Local People	Prevention Suggested by Local People	Remedies Suggested by Local People
Malaria (Esosera)	high fever; vomiting; headache; aching of joints; general body weakness; loss of appetite	climatic change - dry / rainy season; mosquito bites; bad water	drain stagnant water; use mosquito nets; boil drinking water; destroy mosquito breeding sites	drain stagnant waters and clear bushes; seek medical attention; Herbal solution of 'Mwarubaini' is taken; Leaves of bark of Mwarubani tree is boiled in water and the solution taken, one glass per day
Pneumonia (Ikeuno)	coughing; very sharp piercing; pain felt from the back of the chest; difficulty in breathing and also in body movement; in severe cases, one may cough blood and die	cold weather	avoid hard work; warm clothing	Herbs are rubbed over the affected area; Herbs used are "Egwagwa"; seek medical attention; keep oneself warm

Disease (Local name)	Symptoms	Causes Perceived by Local People	Prevention Suggested by Local People	Remedies Suggested by Local People
Headache (Okoatigwa Omotwe)	feeling nauseated; throbbing pain of the muscles; poor eyesight; high fever; sweating	climatic changes; sometimes malaria; bad blood; being in hot sun for too long	avoid extreme weather changes; avoid malaria	In cases of severe headache, there is a special kind of operation done "Ofosaragwa" whereby small cuts are made on the forehead and bad blood drawn then some herbs are rubbed into the wound. Mild headaches need drugs which are bought from the chemists (Panadols)
Scabies (Obosisa)	rashes that have pus all over the body (septic scabies); fever (high temperatures) and the sores are itchy	poor feeding habits; dirty bedding; poor hygiene; lack of fruits in diet (vitamins)	observe hygiene (bath regularly); wash bedding; application of ointments; bathing oneself using herbs	"Egwagwa" mixed in water for bathing; visit hospital
STD - Gonorrhea (Egesonono)	pain in lower abdominal region; problems in urinating - passing our pus when one urinates	having sex with infected partner	avoid sex with strangers; avoid promiscuity	traditional herbs given to both husband and wife
Syphilis/ AIDS	hair loss; mouth sores and swelling of genitals (testicles), women urinate blood when they are about to die	having sex with infected partner; using the same drinking straws during beer parties	avoid sharing drinking straws; avoid sex with infected partner	traditionally healed by taking herbs orally; also hospital medicine is good
Typhoid (Risabeso)	diarrhea, vomiting, headache, sweating, general body weakness	drinking untreated water	seek medical attention	boil drinking water

Disease (Local name)	Symptoms	Causes Perceived by Local People	Prevention Suggested by Local People	Remedies Suggested by Local People
Evil eye * (Ebibiriria Ogosoya)	child cries all the time with no good reason ; fever; abdomen becomes hard and child recoils when touched; in case of Ogosoya there are stretch marks on the affected parts like the breasts, legs and neck the stretch marks are itchy and some may have blood oozing out	one who has an evil eye may look at a child and it gets its pollen from maturing maize (Chintin)	avoid maize pollen; keep child away from people with evil eye; fat from pig for evil eye; cover child with red cloth	Animal fat got from the lion, sheep or oil used in cleaning guns is used to prevent it; An elderly woman to remove the particles that may be in the abdomen rubs vaseline ointment on the stomach; "Egete" - stick got from a traditional healer that has power to prevent it.
Diarrhea (Ogosaa)	sunken eyes; whiting eye lids; baby refuses to eat/breastfeed and cries a lot	eating with dirty hands; contaminated food; dirty feeding bottles; dirty drinking water	wash hands before eating; avoid feeding bottles; use cup and spoon; cover food; boil drinking water	oral rehydration salts; seek medical help at hospital; traditional medicine (Mwarubaini)
Worms (Ebiadaa)	running stomach (diarrhea; distended abdomen; loss of appetite; stomach pains; cracked cheeks	eating food not properly cooked; dirty food and water	cook food properly; stop children from eating soil	buy deworming medicine; go to hospital for medicines; boil and drink herbs (Omouta Kiebo)
Amoebiasis / Typhoid (Oborwaire / Bwamache)	diarrhoea; abdominal pain; sweating; blood in stools	dirty water; uncooked vegetables and dirty food carried by hooves of cows	boil drinking water; east well cooked food; cleanliness	take Flagyl (medicine); seek medical help
Coughs and colds (Rikuba)	headache; running nose; fever; blocked nose	climatic changes; dusty weather	keep oneself warm; avoid wind and dust	buy cough syrups from shop
Allergic anus (Enya-morero)	reddish brown hair; redness at the opening of anus (affects children only)	cause unknown	prevention unknown	traditional herbs (Omosobosobo)
Measles (Ebiaye) **	rashes all over body; red eyes; inability to eat	climatic changes	immunization at early age	hospital medicine; herbal steam - patient covered with blanket to inhale the hot steam of boiled herbs

Note: * The child with infection may die while the mother is seeking traditional cure for evil eye.
** The direct interpretation of "ebiaye" is "his/her own" that means when a child gets it, he or she has acquired what is perceived as a ticket to live. Therefore it is "theirs".

The participants in focus group discussions among the Kipsigis people were asked to list all the common diseases in their community, the observable symptoms for each disease, the perceived causes, the suggested ways of preventing the disease and the regular course of therapy followed in the event of contracting the disease. This information is summarized in Table 2.6.

Table 2.6 The Kipsigis People's Knowledge on the Common Diseases

Disease (Local name)	Symptoms	Causes Perceived by Local People	Prevention Suggested by Local People	Remedies Suggested by Local People
Malaria (Eset) - Kipsigis (Cheptigonit) - Kalenjin	vomiting weak body loss of appetite	cold weather mosquito bites fatty foods untreated water	drain stagnant water, boil stagnant water, clean bushes, use mosquito nets avoid cold weather	anti-malaria tablets, traditional herbs
Typhoid (Eset) - Kipsigis (Kwarimo) - Nandi	fever weakness nausea	contaminated water (virus and amoebae) contaminated foods	drink boiled water, cook food well, wash hands after toilet, clean environment	medication from health facility
Cholera (Kipkeita) and Diarrhea (Komandae moct) *	loose frequent stools (sometimes bloody)	contaminated water unbalanced diet contaminated food	clean and well prepared food boil drinking water cut finger nails	medication from health facility drink solution of clay soil
Tuberculosis (Teget)	bloody coughs, thinness and weakness	cold weather, smoking, chewing tobacco carrying heavy loads	keep the body warm avoid heavy loads vaccination	medication from health facility traditional herbs balanced diet
Colds (Tingoek)	cough and sneezing	cold weather rains	avoid playing in cold weather wearing heavy clothes	anti-cold tablets (shop medicine)
Kwashiorkor (Sinet)	protruding stomach swollen feet	poorly provided food feeding soil	give good food. avoid soil	traditional herbs medication from health facility
Worms (Tiongik)	protruding stomach	poorly cooked food		
Measles (Kamberuk)	rushes all over body - red eyes	high temperatures unbalanced diet lack of milk	immunization balanced diet	traditional herbs
Diabetes (Miondab Sugaruk)		too much starchy food	avoid sugar, eat less starchy foods	
Amoebiasis (Lubaniat)	stomach pain	contaminated food and water	boil water, clean environment and food	medication from health facility
Pneumonia (Kipruteit)	piercing pain in back of chest	cold weather	avoid cold weather	medication from health facility
Dental diseases (Keleek)	teeth falling off	sugary food	avoid sugary foods	herbal plant go to hospital

Disease (Local name)	Symptoms	Causes Perceived by Local People	Prevention Suggested by Local People	Remedies Suggested by Local People
Spleen (Nwakta) and liver disease (Koet)	vomiting bile (yellow stuff)	chronic malaria, bad water	avoid dirty water	traditional herbs
Skin disease (Simbireek) and scabies (Kochek)	scratching, oozing wounds	contaminated water contagion from travelers	clean clothing avoid sharing clothes	medication from health facility
Ulcers ** (Kworimet)	pain in stomach, vomiting blood	emotional tumult too much worry	share problems, seek medical advice, take boiled water	traditional herbs hospital drugs (but no cure)
Anemia (Kobetio Korotik)	lacks blood	cold weather, unbalanced diet, frequent and unspaced births	eat protein foods birth control	traditionally, women got cow's blood to drink. get multi-vitamins
AIDS/HIV (Miondab Kasari)	irresponsible sex	stick to one partner	herbs, avoid sex with infected persons	traditional herbs
Asthma (Teget)	difficult in breathing	cold weather, dust , wind	cover warmly	medication from health facility
Meningitis	headache	crowded place and cold	avoid crowded places	medication from health facility

* Both conditions present with fever and often vomiting and diarrhea, especially in the case of cholera.
** The name is derived form a "spiky animal" which is believed to cause severe pain in stomach.

Media for Health Education

Although many mass campaigns related to health has been conducted through posters and radio in the study area, there is disagreement on their effectiveness.

Some people indicated that there had been an effective campaign to improve people's knowledge and promote new behaviors on health. The common ones are the campaigns for HIV/AIDS, oral polio, immunization such as hepatitis, personal hygiene, nutrition and disease prevention. The popular methods used for health education are posters, radio programs, films, and lectures by health personnel at village chief's barazas, health facilities, church assemblies, plays or concerts.

But some people stated that not all people believe what they hear on the radio terming it propaganda, and they gave an example that when people first heard about AIDS, they did not believe it was real. It is only when many people have died of it that they believe. Similarly, we can find many posters on AIDS in the study area, but many young people do not relate the message of these posters with their sexual behaviors. They usually learn new information from their peer group, so it is important to increase personal communication activities such as peer-to-peer education, in order to effectively convey health-related messages.

2.5.2 People's Health-Seeking Behaviors

In general, people's health-seeking behavior appeared to be determined by distance, access and the seriousness of the disease. People go to the nearest health facility when they are sick, regardless of the cost if the disease is serious, but they might go to the nearest district hospital if the disease was not serious.

When people fall sick, a behavior pattern is developed to cope with the situation. In most cases, they start with self medication at domestic level, e.g. taking warm water, salt solutions and avoiding certain foods such as fats and milk in the case of abdominal upsets and so on. If relief is not obtained, they buy shop medicines, and only after this, they would seek outside assistance.

During a focus group discussion with youth, this behavior pattern is summed up thus:

> "The first thing a person does when they are sick is to take tablets bought from the local shops. This applies to diseases like malaria, coughs and colds and suspected STDs. STDs are treated with local herbs bought from the traditional healers. If the disease persists, the patient seeks treatment from private or public health institutions."

Asked to estimate the proportions of patients who seek the services of the various health resources, the youth group reported that 5% of the community seeks the services of traditional healers, 25% go to the private sector, while 70% go to the public health institutions. This tallies with the ranking of use from household data where institutional health services came as a top of the list.

It is necessary, however, to take such data with caution, since the majority of Kenyans do not openly admit that they seek the services of healers. This is due to colonization and Christianity which condemned all traditional practices and behavior as primitive and devilish. Nyamwaya (1996) and Sindiga et al (1995), who maintain that traditional medicine is widespread in the Gusii community, confirm this. In addition to this, the focus group discussion participants explained that traditional herbs are usually taken as First Aid, before people seek specific treatment from health institutions.

The name Kericho is said to originate from a famous healer "Kericho" whom the Kipsigis people admired highly. This is a clear indication that traditional health care has always been sought and utilized. Sayings and other traditions also support the idea that in the quest for therapy there is no stopping. "When sick, a person should try everywhere." Judging from the household data, the communities did not often openly admit seeking the services of a traditional healer. However, in the focus group discussions, the female participants unanimously agreed that there are diseases whose etiology and presentation can only be managed traditionally, such as spleen and liver conditions, polio, whooping cough, stomach disorders and ulcers. Table 2.7 summarizes the people's choice of health providers according to disease conditions.

Table 2.7 Choice of Health Providers by Disease Condition

Health Provider	Disease Condition
Modern (dispensaries, health centers and hospitals)	Malaria Diarrhea Headaches Meningitis STD Pneumonia Typhoid Chest pain
Mobile Units*	Pregnancy related conditions
Private Clinics	Malaria; Wounds
Herbalists / healers	Whooping cough Swelling of legs and feet Cancer, polio Swelling of the spleen Diseases associated with witchcraft and curse Liver General abdominal illnesses

* Only Tenwek Mission Hospital had a well established mobile unit service.

Concerning the decision as to which health facility is to be visited, the husband or in the absence of a husband, the one who is paying for health services makes the decision. As the women put it "this depends on the pocket" that is, he who holds the purse calls the tune. At a private hospital in Kisii town, the women clearly voiced their interests. They pointed out that although men have the control of family resources, disease will not wait until he can sell land to pay the hospital bill. This showed an increasing awareness that the health of the family should come first.

In general, people reportedly prefer modern health services both at dispensary and district levels, because they cost less, sometimes as little as Shs. 20 at the local dispensary and about Shs. 200 at the district hospital; while the average cost at the main private hospital (e.g. Tenwek Mission Hospital) is about Shs. 5,000 - 20,000 for in-patient services. However, in spite of the high charges people show preference for Tenwek Mission Hospital, because they trust the level of treatment provided. Patients who visited Tenwek Mission Hospital come from most of the five districts in the study area.

The health provider's behavior influences the people's choice of health services. The government health providers were often described as rude, and give out pain-killers even for complicated problems, and therefore the patient has to go where his needs can be met adequately irrespective of the cost, distance and other inconveniences. Focus group discussion participants reported that at the public facilities, "Patients are scolded and given only prescriptions instead of drugs!"

Some private clinics are run unscrupulously by people whose aim is to make money. Drugs given in some of these facilities are allegedly often expired, but, in the public

health centers, there are often no drugs and therefore the people are left with little option but to go where they can obtain drugs. Private chemists are making a booming business out of the plight of patients. Visits to the private pharmacy shops revealed that some of the so-called private pharmacists were not qualified for the job.

While people reportedly prefer modern health facilities, it is also common knowledge that the majority also visit traditional healers secretly for ritual cleansing and to receive protective charms for conditions such as evil eye and other socially perceived illnesses such as 'Amasangia'. The majority of the people were acquiescent to using modern health service alongside the indigenous ones. In all the districts, few people openly admitted to using indigenous services, probably to avoid reproach.

The indigenous health providers also are viewed as the only alternative, especially for protective purposes and healing of diseases that are believed to be cause by witchcraft. Even common diseases may be viewed as caused by a jealous neighbor who practices witchcraft or evil eye, thus causing dependency on the traditional healers, because people believe that these diseases cannot be treated using modern medicine, or else death may occur.

2.6 PLANNING DIRECTION AND POSSIBLE INTERVENTIONS

2.6.1 Planning Direction

In this section, the key recommendations regarding the indigenous health care system, beliefs and practices related to health development are described.

(1) Traditional Healers

Of the many types of traditional healers, the herbalists, bone-setters, trephining experts and traditional birth attendants deserve further attention. These experts are usually well-trained and perform very useful functions in the local communities. In line with the Primary Health Care (PHC) approach which emphasizes the use of local resources, these local health experts should receive some re-training so that they can overcome some of the problems they face in their practice. Most of these traditional healers are quite willing to undergo any training aimed at improving their service. In contrast, those specialists who deal with interpersonal and spiritual forces in illness are in no hurry to be recognized by the government.

Official recognition of these healers is also necessary. A license from the government would allow one to practice freely without any fear of government officials. Currently the Ministry of Culture and Social Services registers herbalists but the Ministry of Health should train traditional healers and issue official licenses to those trained.

Some traditional healers said that they need the cooperation of hospital staff when they carry out operations. The hospital can supply anesthesia and antiseptics in such a case.

Psychiatric services are non-existent in the western health services in the study area. Indigenous healers have something to contribute to the establishment of these services. Most psychiatric problems arise from socio-cultural stresses which the indigenous healer understands quite well.

(2) Indigenous Health Care System

The indigenous approach to health care emphasizes community and individual participation in health care. Modern health services tend to provide services which make the community and the individual only passive receivers. This has led to the failure of several projects aimed at improving the health of the people. The government has much to learn from the indigenous health care system especially with regard to the management of the services.

Western trained health workers should be assisted to acknowledge and, where possible, exploit the indigenous concepts of delivering the health services. The same concepts can be applied to the delivery of western health services. It is suggested that health workers should be given the proper orientation regarding indigenous health concepts and practices in the locality where they are working.

There is the need to educate the modern health workers on the relevance of socio-cultural and economic factors in the delivery of health services. Proper information and understanding about the culture of the local people will enable the health workers to provide more acceptable services to the local population by reducing the social distance between health providers and patients which has been one of the major reasons for the people's preference to traditional healers than governmnet health providers.

(3) Female Circumcision

To eradicate harmful traditional beliefs and practices such as female circumcision, large scale information, education and communication (IEC) activities are needed. The community should be sensitized and mobilized to initiate such IEC activities through the use of existing networks of health facilities, churches, women's groups, youth groups, schools and so on.

2.6.2 Possible Interventions

(1) Mobilizing Traditional Healers as Primary Health Care Providers

In order to enhance community-based sustainable primary health care activities in the Study Area, it is proposed to mobilize traditional healers as primary health care providers. This involvement of traditional healers in primary health care activities can:

1. improve the quality of care provided by traditional healers;

2. establish linkage/communication channels and strengthen of mutual collaboration between traditional healers and MOH health personnel; and
3. enhance the community's sense of ownership in primary health care activities by mobilizing local resource persons such as traditional healers.

To implement this approach, the following activities should be conducted:

1. to survey the existing traditional healers, evaluate their curative services, and identify the traditional healers who are willing to learn modern medicine and work with MOH
2. to train traditional healers with the modern medical knowledge through a series of training workshops (introductory, intermediate, updating, and so on)
3. to facilitate traditional healers to organize themselves into professional associations
4. to help traditional healers' associations and MOH to set up the professional standards of the service by traditional healers
5. to make traditional healers' associations and MOH jointly to register/certify/license the qualified traditional healers who satisfy the above-set standards
6. to set up regular consultative meetings between MOH and the representatives of traditional healers' associations
7. to help traditional healers' associations to exchange information and knowledge among traditional healers as well as between traditional healers and MOH personnel
8. to assess and redefine the roles of MOH and traditional healers, explore mutually fruitful ways of collaboration between MOH and traditional healers, and develop them into a new MOH policy or guidelines on collaborating with traditional healers

(2) Community-based Health Education for Endogenous Community Development: "Rethink Our Traditions in a Changing Society"

In order to improve health status in the community, it is proposed to promote the useful traditions for people's health as well as changing the harmful traditions against people's health. This community-based health education can:

1. promote sustainable and self-reliant health education activities by the community
2. revive and promote the useful traditions for people's health
3. change people's knowledge, attitude and practice on the harmful traditions against people's health

To implement this approach, the following activities should be conducted:

1. to identify community groups (such as women's groups, youth groups, school groups, church groups, community health workers' groups, community based distributors' groups, traditional birth attendants' groups, traditional healers' groups, and so on) which are interested in health education and community development and motivated to implement these programs

2. to train the above-identified community groups on:
   (a) how to survey the problems of the community, the traditional beliefs and customs in the community which affect people's health and nutrition positively or negatively, and analyze the relationship between the present problems and the loss of the good traditions and the effects of the bad traditions
   (b) how to design effective health education strategies and activities based on the findings from the above survey
   (c) how to develop effective key messages which appeal to people's hearts
   (d) how to select an effective and affordable medium (public talks, poems, songs, dances, dramas, posters, and so on) for the group to convey the above messages
   (e) how to design effective communication channels to convey the above messages
   (f) how to mobilize external as well as local financial resources to sustain health education activities
   (g) how to self-evaluate their own activities and feed back the findings from the self-evaluation for future planning
3. to monitor and help the community groups to mobilize external and local financial resources, survey the traditions, design and implement health education activities after training, and evaluate their own activities