IN QUEST OF HEALTH: RESPONDING WITH BASIC MODERN MEDICINE FACILITIES TO HETEROGENEOUS NEEDS. A QUANTITATIVE SURVEY BASED ON ANTHROPOLOGICAL PERSPECTIVES

Francesca Declich°

°Università di Urbino, francesca.declich@uniurb.it

Abstract

This essay discusses the way in which a quest for health was expressed by resorting to primary health care services set up in the Middle Juba region of Somalia before the civil war started in 1990. The hypothesis concerning this study are grounded in direct and participant observation of the operations of the health service facilities as well as the social dynamics surrounding such operations carried out during one year of project and on interviews with traditional healers as well as observation of traditional healing treatments. The call for care and attention expressed in the services represented a wide concept of well-being but the expectations conveyed by resorting to the health facilities sometimes did not coincide with the services offered. Those specific needs and expectations which were not met by the existing health services have been the main inspiration and focus of this entire survey.

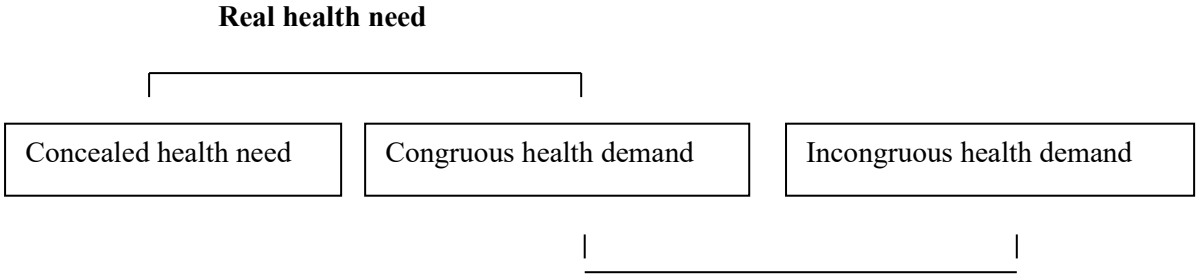
Questo saggio descrive le modalità con le quali veniva espressa la domanda di salute tramite il ricorso alcuni servizi di salute primaria di base messi in piedi nella regione del Medio Giuba in Somalia prima della guerra civile del 1990. Le ipotesi sulle quali si basa questo studio sono fondate su osservazione diretta e partecipante delle operazioni dei servizi di salute e delle dinamiche sociali relative a tali operazioni portate avanti durante un anno di progetto e su interviste con curatori tradizionali e osservazione delle cure tradizionali. La richiesta di cura e attenzione espressa nei servizi rappresentava un ampio concetto di benessere e le aspettative dichiarate nel ricorrere ai servizi a volte non coincidevano con i servizi offerti. Quegli specifici bisogni e le relative aspettative che non erano incontrati dai servizi sanitari esistenti sono stati la maggiore ispirazione e l'interesse centrale di questa survey.

Introduction

This essay discusses the way in which a quest for health was expressed by resorting to primary health care services set up in the Middle Juba region of Somalia before the civil war started in 1990. The hypothesis concerning this study are grounded in direct and participant observation of the operations of the health service facilities as well as the social dynamics surrounding such operations carried out during one year of project and on interviews with traditional healers as well as

observation of traditional healing treatments.[1] Later the issues have been studied by administering a questionnaire to those who resorted to the out-patient of the modern medicine facilities. A number of different needs for care and attention pertaining to a wider concept of well-being were expressed through a resort to the facilities and some expectations in this regard did not coincide with the services offered. The existence of these multiple needs expressed, and the expectations articulated through resorting to the health facilities but not met have been the main inspiration and focus of this entire survey.

Two conceptual premises underlie this study: first, in every human community a demand for health exists and it is managed at the local level; second, national Primary Health Care (PHC) structures induce a new type of health demand through the introduction and use of "modern", if only basic, medical technologies. [2] In other words, the encounter of the different systems of coping with health problems fosters the development of new tastes[3] and inclinations toward the resolution of such troubles. In order to be able to take into account in the analysis two different structures of answering to similar and yet different "social demands" of health it has been applied the framework of the relations between health demand and health need proposed by Akin et al.[4] as outlined in fig. 1.



[1] The survey was planned out of reflections made during one year of participant observations while working in the facilities of the PHC project of Mareerey and studying for a university degree. The very fact of carrying out part-time an anthropological study at university level allowed for reflections that went beyond the simple functioning of the project and that projected the application of certain critical thinking to better understand the anthropological encounter which was happening within the health development project. The weekends plus other working days of the four months during which the survey was organized and carried out were used to also visit and interview traditional healers, film some of the communal traditional treatments including jinni possession spirits celebrations and talk with people about healing practices,

[2] Thanks to: Teresa D'Arca medical doctor for continuous collaboration concerning the medical aspects of the data analysis; Chiara Venier for suggestions kindly given while preparing the questionnaire; Francesca Patrizi for patient help during codification and *input* of quantitative data; the workers of the PHC of the Middle Juba region and the Jilib district for their cooperation. The survey has been carried out under the auspices of NGO CISP (Comitato Internazionale per lo Sviluppo dei Popoli) in the Primary Health Care facilities set up by the NGO in coordination with the Somali Ministry of Health in the village of Mareerey along the Juba River. Opinions expressed in the study, however, are only responsibility of the author.

[3] P. Bourdieu, 1983, *Distinzione*, Il Mulino, Bologna.

[4] J.S. Akin, D.K. Guilkey, C.C. Griffin, B.M. Popkin, 1985, *The Demand for Primary Health Services in the Third World*, Rowan and Allanheld, Totowa.

Health demand

Fig. 1. Relation between health demand and health need.

It has been defined a "congruous" health demand a demand of health concerning requirements that modern health systems can meet and treat adequately (for instance, by prescribing efficacious treatments); "incongruous" health demand has been considered one that is expressed with resorting to medical centers yet it is linked to pseudo-health desires or to needs which cannot be regarded specifically as of a medical kind. "Concealed" health needs are those that do not reach the level of awareness in the population and tend to lay unexpressed although they could be satisfied by modern health services. These concepts are relative to the viewpoint taken by those who use them, therefore, depend by the observation point. However, they are instrumental to reveal differences in the way "traditional" and "modern" healing systems deal with the problem of "being ill" and highlight those aspects where the two systems overlap.

In this study it has been assumed also that when importing a modern medical system to deal with health needs in a society, some desires for being treated found expression as health demand in the modern medicine facilities while the preventive aspect of the modern medicine, which is a very important aspect of it, tend to lay behind as a concealed health need. Some health needs, on the other hand, tend to keep being considered as pertaining to the traditional structure of healing, according to local healing categories, and are expressed in health demand within the traditional structure. Moreover, a number of needs that a modern medicine framework would still define as non related with health tend to express themselves through health demand in the facilities offered. [5]

Objectives and methodology

The initial questions concerning the survey were: (a) the extent of liking of the health service facilities offered within the project; (b) the right use of the preventive and curative services; (c) the "congruence" of the health demand expressed with resorting to the services as regards the health needs.

The complexity of the issues at stake might have required a research design entailing an articulated demographic study. However, considering the resources available, it has been opted for choosing a set of indicators constructed according to a simpler procedure.

[5] An Italian larger version of this article was first published in a collection of articles concerning public health in southern Somalia *Salute per tutti? Esperienze e valutazioni da un'area rurale della Somalia*, (Branca F. and D'Arca R. eds.), Franco Angeli, Milano, 1992.

To explore the first question it has been chosen to interview the "new resorts", that is, those who had never had access to the second level health structures of the project, and to verify whether the resort to the out-patient was their first choice to solve a specific health problem. In case they had applied to another system of treatment before resorting it was verified which preference they had given. At least two other systems of treatment were functioning in the district of Jilib: the traditional healers and the commercial private chemists. The assumption was that by choosing those who resorted to the out-patient for the first time as a group to be inquired it would have been possible to highlight the most genuine expectations of the population towards the public health services, because those who had previously resorted to them had already a clearer idea of what they could expect from the health operators.

Concerning the other two questions, it was decided to assess the use of the PHC peripheral network and to estimate the weight of the incongruous "demand" of health (i.e. the health demand that overestimate or assesses in unexpected manner the real health needs) as compared to the congruous one.

It was not possible to select a statistically representative sample because for organizational reasons it would have been very difficult to obtain the data from this remote basic health service structure. Notwithstanding, three fourth of those who accessed to the facilities of the health center in September 1987 as new resorts of all ages were interviewed. For the majority of the children under eight years of age the accompanying adult was interviewed.

A questionnaire written in English and translated in Somali language was administered to this sample of 287 people. The form was finally formulated after a pre-testing on 22 users. The team for the survey was composed by myself and two interviewers who both spoke Italian, southern Somali languages, kiswahili and kizigula. The interviewers had been instructed during the pre-test phase on the aims of the study and the modalities of administering the questionnaires.

The form was divided in 5 different parts: (a) demographic and socioeconomic data; (b) data on the symptoms of the illness as described by the sick person; (c) data on the reasons for resorting to the out-patient; (d) data on the resorts to other kind of healing structures and results of such resort; (e) results of medical examination. Finally, a judgment on the congruence of the resort to the health facilities was expressed subjectively by a medical doctor of the team after the examination of the patient.

Description of the sample studied

In the sample of the new users[6] interviewed there was a majority of women who were the 53% as opposed to a 47% of males. As reported in table 1 it can be noted a prevalent affluence of males among the children. Amid the users under five years of age a 60,7% are boys and only 39,3% are girls; more or less the same percentages is maintained in the age range between 6 and 15 years where the males are the 53,7% and the women are the 46,3%.

	Females	*%*	*Males*	*%*	*Total*	*%*
≤ 5 years	24	15,8	37	27,4	61	21,3
6-15 years	19	12,5	22	16,3	41	14,3
16-25 years	44	29,0	27	20,0	71	24,7
26-45 years	47	30,9	27	20,0	74	25,8
> 45 years	18	11,8	22	16,3	40	13,9
Total	152	53	135	47	287	100,0

Table 1. Age of the users by sex

The flow of users can also be described by cultural background. Groups of people from a nomadic pastoral background resorted to the out-patient four times more than the others. Although there were no demographic data available to assess statistically the ethnic composition of the area, nevertheless it can be said that this disproportion reflected the demographic composition of the district where agriculturalists planted their farms along the river, some pastoral families settled temporarily close to the agriculturalists' villages and several thousands of people of a pastoral background had been resettled in the villages nearby Mareerey after the drought of 1972 from northern areas of the country.

Analyzing data concerning the villages of provenance of the users (table 2), it can be seen as the bigger number of users, 224 (78%), came from villages located within a radius of 20 km of distance from the out-patient.

Villages	*Distance*			*Total*	*%*
	≤ 5 km	*6-20 km*	*> 20 km*		
Not included in the project's facilities	--	14	63	77	26,8

[6] To simplify the reading of the text from now onwards the "new users" included in the sample will be pointed out generically as "users".

Included in the project's facilities (from 1985)	28	--	--	28	9,8
Included n the project's facilities (from 1987)	85	97	--	182	63,4
Total	113	111	63	287	100,0
%	39,3	38,7	22,0	---	---

Table 2. Villages of provenance of the users

It is still high the percentage of those (22%) who attended the health structures of the project coming from longer than 20 km of distance. This entailed for the patients walking longer than four hours on foot and, therefore, dedicating at least the entire day to the issue. This high percentage may be explained partly by the fact that the data are referred to the new users, highlighting in the meanwhile the lack other health structures in the area. The 9,8% of the total users came from villages involved in the activities of the health service facilities since 1985, while the 63,4% of the uses lived in villages interested by the project only from 1987. Approximately one third of the users, the 26,8%, finally, comes from villages uninterested by the activities of the project, and out of these, more than 80% from villages located more than 20 km away from the health centre.

The most common occupation among the users was agriculture with 46%; the 16,5% had a salaried job, while the 12,5% used to work as occasional laborers. The 30% of the interviewed had more than one occupation and almost all the women worked, behind carrying out the usual domestic activities. A 70% of all users interviewed were illiterate.

Analysis of the results

One of the most relevant data for analysis is that 67,2% of the users resorted to the out-patient after having tried to recover by using another treatment: out of these, the 14,6% had applied to traditional healing, the 38% to the private commercial chemists and the 14,6% had resorted to both, traditional and modern private systems. Thus, the 29,2% of the users asserted to have turned to traditional healing before resorting to the out-patient, as shown in table 3.

	Frequency	*%*
None	94	32,8
Traditional	42	14,6

Private modern	109	38,0
Mixed	42	14,6
Total	287	100,0

Table 3. Healing strategies before resorting to the out-patient

Even taking into consideration the fact that a certain number of resorts to traditional healing might have not been declared to the interviewers for cultural reasons concerning the perceived conflict with Muslim beliefs[7], the high percentage of resorts to the private modern medicine (38,0%) is an element to be analyzed attentively. Since in the radius of 50 kilometers from the out-patient did not exist polyvalent structure for public health assistance one must infer that the interviewed had resorted to private commercial chemists functioning in the area or to any other person considered knowledgeable in the use of "western" medicaments. In the private commercial chemists, nurses or other practitioners without certified skills used to sell medicines on the basis of a depiction the patients made of their illnesses. It goes without saying that a number of their diagnosis might not have been accurate and their treatments not really appropriate to the patient. Doubts might also rise on the expiration date of certain medicines sold in such shops as most people living in the surroundings were illiterate and would not be able to verify. Moreover, some people in the district had had occasion to collaborate with foreign medical doctors in the past decades in connection with missions or aid projects and, thereafter, learned how to practice injections; these individuals were considered particularly knowledgeable and able to suggest treatments to be injected, including penicillin. There was much trust in the power of modern treatments such as *kaniin*, namely pills, and overall injections, even though nothing was known about the reasons why these treatments may work or not. In this respect the answers given to the question concerning the kind of modern treatment they received before the resort to the out-patient are particularly relevant. "*Kaniin addei*", i. e. white pills, "*kaniin guddud*", i. e. red pills, "*kapsul*", i.e. capsule, pill, and "I do not know" were the most frequent answers given to the question.

It can be said that it was widespread a system of medicine we could call "para-modern" and "commercial" basically constituted by private shops either specialized in selling medicines or that sold medicines together with other items. Considering the poor diagnosis made in such contexts this system did not have the positive impact on the health status of the population as it could have a modern system under certain conditions. Yet, it was similarly attractive for patients and had

[7] In Muslim countries often traditional healing practices are discriminated against as contrary to the religion (I.M. Lewis, *Islam in Tropical Africa*, Oxford U.P., 1966) and are, therefore, aspects sometimes concealed in public contexts.

analogous characteristics as an institution and in terms of social control. It created power roles for people who were believed to hold a specialist knowledge and maintained their power role through the access to distribution of medicines. Yet, large layers of the population placed theirs hopes for health in such system reinforced by its powerful capacity to heal, if temporarily, sharp pain. The users which had resorted to traditional medicine before visiting the out-patient were 66,7% women and 33,3% men. In addition, the percentage of children under 5 years of age who resorted to traditional medicine was more than double (33,3%) in comparison with the percentage of children treated through modern systems (15,6%). On the basis of these data it would seem that women, who are those taking care of the children under five years of age, tended to use frequently traditional healing also in a context in which other forms of medicine of a modern kind was accessible in their villages.

Table 4 shows the asserted results of different healing strategies undertaken before the resort to the health center of the PHC program. The number of total occurrences in this case is 193, having been excluded those who had declared not to have undertaken other treatments before resorting to the centre.

From the data emerged, the percentage of declared recovery – it is of no relevance whether they were real or presumed recovery – seems quite low (14%).

Treatment	Recovered	Non recovered	Partly recovered	Total	%
Traditional	6	19	17	42	21,8
Modern	13	45	51	109	56,4
Mixed	8	19	15	42	21,4
Total	27	83	83	193	100,0
%	14,0	43,0	43,0	100,0	

Table 4. Results obtained from healing strategy preceding the resort to the out-patient

The 86% of the 193 users that had resorted to other treatments before visiting the out-patient, were not satisfied with them. Among those who asserted to have recovered, the majority was among those who used a "mixed" healing strategy (8 out of 42, therefore a 19%). Concerning those "partly recovered" the higher percentage goes to those who had used modern medicine.

As one can notice from table 5 the individuals who mostly used a different kind of treatment before resorting to the district health centre were those ranging from 16 to 45 years of age, those in productive age. The second were the children under 5 years of age and the elders. The percentage of those older than 5 years and adolescents who did undertake other treatments before resorting to the health centre is decisively smaller and does overcome the 51% of the entire group.

	None	%	Trad.	%	Mod.	%	Mixed	%	Total	%
≤ 5 years	23	24,5	14	66,7	17	6,4	7	16,7	61	21,3
6-15 years	21	22,3	3	14,3	14	12,8	3	7,1	41	14,3
16-25 years	18	19,2	10	47,6	28	25,7	15	35,7	71	24,7
26-45 years	24	25,5	11	52,4	29	26,6	10	23,8	74	25,8
> 45 years	8	8,5	4	19,0	21	19,3	7	16,7	40	13,9
Total	94	32,8	42	14,6	109	38,0	42	14,6	287	100,0

Table 5. Healing strategies preceding the visit to the out-patient by age class

Concerning the choice of different healing strategies, the modern one appear the most applied one by users between 16 and 45 years of age while for the children until 5 the treatment pre out-patient visit was most often oriented towards a traditional kind (66,7%).

The occupation of the users is another variable that discriminate between treatments applied before visiting the out-patient. The 52,6% of the users who practiced agriculture had resorted to traditional healings before arriving to the out-patient unlike those who had a pastoral background of which only 24,8% had had contacts with healing strategies of a traditional kind. A similar percentage of both groups (54,8% for the pastoralists and 52,6% for the agriculturalists) had resorted to modern medicine before visiting the out-patient. Only 19,3% of the agriculturalists had visited the out-patient without having previously used other treatments in comparison with the 36,1% of the livestock breeder. The tendency towards using traditional healing seems related to the cultural characteristics of the population. On the other hand, as the majority of the livestock breeders followed-up in the out-patient were part of a group of resettled populations, a number of other factors linked to this status might have intervened to foster their attitude towards traditional healing. For instance the familiarity with modern treatments provided to the resettled population before and during the resettlement process. Moreover, with the process of resettlement ideas about traditional healing as well as availability of traditional healers and of herbal treatments might have undertaken modifications.

Finally, by examining the relation among interviewed and village Community Health Workers (CHW), it became evident that only 72 users had passed through the filter of the CHW of their village before visiting the district health centre. Although this should have been the rule as envisaged by the national health system, only in 25,1% of the occurrences the CHW had been able to be the first level filter of the health demand expressed. By excluding all those who came from

villages where no CHW were operating, still a group of 87 users residents in areas where CHW were working had not visited them before resorting to the district centre. It is quite a high proportion, representing the 54,7% of all those among the interviewed who potentially had access to CHW.

This result must be integrated with the question concerning acquaintance with the CHW operating in the villages. To all users was requested if they knew the CHW of their village. The 34,5% pointed out at the exact name of the CHW, the 20,9% did not know the name, while the remaining 44,6% asserted to know nothing about the CHW and the services they offered (table 6). However, the 35,4% of those who knew the name of the CHW had not consulted them before visiting the out-patient. In general, it became evident that the filter of CHW network was not sufficiently known and attended by the users of the out-patient despite the efforts of continuous communication with the local authorities.

Concerning the health demand expressed through visiting the health centre according to data presented in table 7 the 85,4% of the new users showed that this was pertinent; nevertheless, the 14,6% of the users perceived symptoms which did not correspond with those recognized by the staff of the out-patient. Within this last category, however, only 2,1% of the users expressed a demand in relation with a need not recognized as health need by the staff.

Congruence		Seriousness		Total	%
	Non serious	Serious	Very serious		
Congruous	13	118	108	239	85,4
Incongruous	6	19	16	41	14,6
Total	19	137	124	280[a)]	100,o

[a)] Of the 7 missing cases has not been possible to estimate the congruence of the resort in relation with the seriousness of their illness

Table 7. Congruence of the resort to the out-patient in relation with seriousness of illness.

Those who arrived to the district out-patient in the worst health condition were the children under 6 years of age: they constituted the 50% of the very serious cases and the 37,9% of the serious. The majority of the non serious cases was instead accumulated in the age class between 16 and 25 years of age with a 42,1% on the total.

For incongruence of the resort it has been defined a concept stemmed from observations made during the initial activities of the health centre. It has been considered “incongruous” the case of users who resorted to the health centre for the treatment of conditions that could not be treated through a medical intervention. It has been considered “incongruous” also the case of individuals

who visited the centre complaining of not very serious symptoms but that turned up to be seriously ill people after the doctor's medical examination; these patients did not perceive the illness that serious before visiting the out-patient. This concept, obviously, is only instrumental to highlight crucial aspects of the encounter between a traditional and a modern system of answering to health needs. At the beginning of the survey it was hypothesized that a large part of the incongruous cases were likely to be of women, linking the diffusion of the idea of "presumed" illness to a general concept of marginality of the women in the society. Contrarily to what expected, however, the majority of the cases that were proved "incongruous", the 58,1%, were males, while 41,9% were female. This result is even more relevant when considering that the women were the 53% of the users studied.

Conclusions

On the basis of the data presented above some interpretations can be put forward. A large sector of the population resorted to the network of the PHC only as a second choice. Motivations for this are not completely clear: may be the services were insufficient, may be there was not a sufficient involvement of the population in the organization of the PHC in the area, may be it was difficult to find transportation to reach the health centre facilities and, for this reason, people only visited the centre after having attempted to recover otherwise. For those who resorted first to traditional healing and thereafter to the commercial chemists, the PHC facilities were the last hope to find a treatment. The high rate of dissatisfaction after the other treatments seems to have brought them to visit the out-patient. It is not clear whether the PHC project could offer solutions in consideration of the evident scarcity of structures in relation with the size of the population. It would be interesting in the future to assess the satisfaction that new users obtained from resorting to the PHC centre. It is worrying that CHW were not consulted nor were particularly functional as filters before visiting the out-patient; there may be a number of reasons for this and new considerations may be put forward as to their role in PHC networks, to what extent they may really work as brokers of the PHC medical system in peripheral areas and in which context.

As regards the congruence of the health needs it can be concluded that there was not as much an over-estimation of the need as an underestimation of them, especially considering the existence of concealed needs.

Those who had resorted only to traditional healing before visiting the health centre are those who showed a lower rate of "incongruence" in the resort. These constitute the 7,5%, compared to the 16,1% of those who did not treat themselves, the 17,8% of those who had resorted to modern

medicine and the 14,3% of those who had tried both. It is not easy to interpret this data. Yet, if it is true that the incongruent cases can also be symptom of social discomfort, those who resorted to traditional medicine before reaching the out-patient are those who maintained a more clear and less conflictive structure of answering to health needs. In fact, they did not resort to the medical system we identified as "para-modern" or "commercial". Such system constitutes a surrogate of the modern system, it is often perceived by the local people of the same kind as the national PHC system but does not held the same guarantee of standard nor does it offer the same assurance of treating illnesses. Rather, it also entails a misuse of modern treatments such as anti-biotic and anti-malaria pills which, in a long term, fosters reproduction of population of enduring bacteria or parasites.

Epilogue

Finally, an important reflection that goes beyond the practical and applied results in terms of the project's activities evaluation of the survey mentioned above concerns the positionality of the researcher in this survey. The research questions pursued by the survey were produced by one year long anthropological participant observation carried out by me as an anthropologist while working in the facilities of the PHC project. The hypothesis of this study stemmed from practicing an anthropological perspective in the attempt to compare the local point of view (e*m*ic) on cultural practices concerning health and wellbeing with the foreign point (*etic*) of view about health care, treatment and prevention of diseases. Thus, the tools used, the design of the questionnaire with open and closed questions was prepared according to this pre-comprehension. It was this perspective, and no other technical/medical approaches or humanitarian desires to supply health services in an area without basic facilities, which allowed disclosing and interpreting the dissonance between the multiplicity of needs expressed by the users of the health facilities and the services that the facilities could actually provide. Usually, health care services are set up according to a somehow universal standard model which, for this specific project, followed guidelines envisaged in the Alma Ata conference with the hashtag health for all towards the year 2000. The ways the model is embodied in different socio-economic conditions varies greatly, but overall, does not necessarily overlap with different philosophies and cosmologies of wellbeing held by the people the model encounter. The recognition of the importance of these philosophies and cosmologies for achieving a real relation of healing is crucial but not always obvious. This was also reflected by internal discussions within the project technical team in which not all shared the idea that carrying out social research to highlight more effective lines of activity and strategy was important.