IV. DISCUSSION

Illness

The perception of illness by a person in a household was used as the starting point for inquiry on actions taken. The findings (Table 3) in general are similar to report from studies in Ethiopia and elsewhere with the attendant possibilities of under reporting and general incomparability of surveys. (3, 9, 27, 32, 78, 90, 99. 114).

Illness Behaviour

The proportion of no action; respondents (table 7) is much higher than that reported or more rural communities in other parts of Ethiopia (9) and those reported from other parts of the world. (19, 53, 81, 114). In general, people in the study communities seem to report less illness, and resort more to internal action.

Eexent of use of self-care

Se1f-care is extensively used all over the world. The distortion caused by the dominating position held by the biomedical approach has led to its neglect in the endemic world which, however, did not mean that it was abandoned by the people. As Doyal (20) has pointed out, access 0£ most people to institutionalized medicine, even in the present day developed countries, is a twentieth century phenomenon. Earlier, "most healing and care was undertaken... on an informal or semi-formal basis, often by women..." But the neglect by academics and health professionals has meant that little has been documented on the nature, extent and varieties of se1f-care. (81,105).

Recent reports from the developed countries clearly show its extensive use. In Dennlark, 90'% of all the cases reported to a general practitioner have practiced some self-care previously (83) .In Britain the percentage goes up to 95% (24), and in England, 75% of symptoms are handled by se1f-care (62). Fry (,1972) has shown that only 20% of symptom experiences result in medical contact and that 75% of all symptoms in United Kingdom .and the US.A. are cared for without seeking professional advice. Kohn and White (51) have shown, in their international collective study, that self care is widely used.

The same phenomena could be discerned from the studies 10 under developed countries. The following percentage of self care (se1f-medication) have been reported from Latin America (52): urban Honduras 64.3%; Cali, Colombia, 59.9% ; Ecuador, 50.1% ; Asia: rural Malaysia 28%; Taiwan.930/0 (48) India 25-.42% and Nepal about 20% (81); Eritrea: Studies in Ghana (55.9%, (4) rural Cameroon- (19.2%), (78); Nigerian University students (88%) se1f.medication) (95) ; Nigerian children (31) and Ken1a. (37% did nothing, 35% self-medication) (90).

Thus self care is extensively used all over the world, however, it is difficult to make any corparative analysis since the definition of self-care, the recall period, the questions asked and the general study conditions have not been standard. It has been estimated in one study the under-reporting of self-care could be high (90), and thus the percentage differences observed among different groups and in different countries might not reflect actual variations in use or non use self-care. However, one well standardized international comparative study (51) has shown that, at least for nonprescription drugs, high variation could be observed in different socio-economic settings.

If "nothing" and self '(lay) care are combined, the findings from the present study (Table 6 and 7) generally correspond to findings elsewhere, specially in developing countries. It might be more instructive to compare these findings with that of Busbkens and Slikkerveer (9) in another part of Ethiopia. They report a low non action (1.6% only) 35.0% internal-action (approximately self (lay) care in this study) and a relatively high .(63.4%) of external action patients (corresponding to our "professional care " category). Over 50% of the latter reported the use of traditional practitioners. Because of differences in definitions and methodology, conclusions from these comparisons are difficult to make hut clearly point Out areas that will need exploring in future studies.

Self (lay) care is used under very different circumstances. It is often used as a first and last resort (as a substitute) (8) when the person believes that the ailment is not serious or when he considers that he knows enough to handle even a possibly serious condition or, in the cases of many underdeveloped countries, when other (modern) care is not available.

self-care could be used as a supplement of professional (modern or traditional) care (18), since patients have been known to use self-care concurrently with doctors care even -when hospitalized (5). In certain cases, self-care is used to supplement and/or continue professional care with the knowledge of end instructions from a professional. This has been the case, for a long time, for chronic communicable disease such as 1.uberCulOlis and leprosy specially in underdeveloped countries (43), It- has been recommended for dailysis (41) or for monitoring the evolution of some chronic diseases eg. diabets (38)and for the care of the elderly* (42). Recently, a lot of studies have been carried out on self (lay) use of oral rehydration therapy (see for example 22,94).

Self-care is also used prior to seeking professional Care, either as an attempt at self-care that fails or as a first measure (suffering reduction or minimization of life-threatening conditions) before seeking external help. That se1f-care could be the first and an important component of the care system even or life threatening condition such as ischemic heart disease is shown by the study of Simon et al (93).

It is difficult to conclude from the persons study how self-care is used as compared with modern institutional care, The possibility for substitution of self-care for modern health services is high given the distance (physical, socio-economic and cultural) of the modern health services (112). The fact that a large proportion (47%) of the sick in Adamitulu did "nothing" about their problems could be surmised as indicating a large amount of unmet needs even though none mentioned non-avaliablity of health care as a reason for using sell. care.

On the other hand, the high rate of active self Care (49.5%) in the Addis Ababa Kebele seems to indicate a substitution effect at least £or the more urbanized communities i.e., Addis Ababa and Zewai 02. In the few combinations noted, self-care is used to supplement (intact, perhaps, t,) replace a failing) modern care. This is supported by the fact that the most frequent reason given for sell-care is that the respondent considered the case minor. (Table 11).

*Recently (1984) WHO has published "Self (heakh) Care and the Oldler People" -A Manual £or Public Policy and Programme Development IRD/ADR, 1980/2001.

DRUG HOARDINC & USE

Drug, hoarding (Table 13) is apparently quite low in our study communities. The highest, 0.8 item per household in, Addis Ababa, one of the most urban communities in 'Ethiopia, is very low when compared to those reported from Britain, 10.3 per houses hold (21; over 10 in Isreal (28); 9.2, in Demnark (10) and 22.5 for the US.A (49) .In these studies, all or almost all households had least one, drug while in our study quite a large proportion had no drugs.

Unfortunately there are not many studies on drug hoarding in the third world (8). In communities, in South Africa, Buchanan (8) found that urban whites had 8.8 drugs per household i.e., close to what has bee}} observed in the developed capitalist countries while urban ,blacks and Indians were not far behind with 5.6 and 3.4, respectively. Rural blacks had 0.8 drug per household with 51.5% of the families with no education. The limited scope (64 rural families) and the probability that Buchanan (8) did not include traditional drugs in what he termed 'medication' makes any Conclusion hazardous, but the striking closeness of the finding between rural black and our communities draws attention.

The issues of drug hoarding will not be considered here but the importance of drugs in the health care system in general (11) and the possibilities of "drugging the third world" (92) in spite of the self-serving protests (84) of representatives of the multi-national drug companies must be appreciated.

More interesting from the self (lay) care aspect is the knowledge on the use of the drugs hoarded (Table 15) and the related issue of safety of self (lay) care (89) disturbing to note that for a high number of modern drugs, 40% in Adamitulu, 'there were no lables (or the labels were illegible) on the container. In 8 to 180; of the drugs, the respondent did not know the use of the drug they had at home. Even more disturbing is that in 15%-121% the cases the use reported by the respondents was incorrrect (inappropriate). Thus, in all the communities, only for less than 50% of the drugs could correct use be ascertained importance of this is clear since we know that, some of the drugs in question are very potent (antibiotics. cardiovascular, etc. drugs/eventhough a lot of the drugs have been kept for a long time in the households and their potency is suspect.

TRADITIONAL MEDICINE

Only few people reported the of traditional practitioners and it is known (40) that patients do not often volunteer easily information concerning the use of such practitioners. We know, on the other hand, that some traditional practitioners have very busy' practices {9, 33, 40, 97) .The fact that few mental illnesses, an area almost exclusively reserved to certain types of traditional healers, are reported and the high use of traditional therapies such as Table* in the household, indicate the possibility of under reporting.

The method of data collection did not include individual, long lasting preventive/curative measures such as amulets etc. that are worn on the individual. Thus this aspect of the use of traditional practitioner, which could be quite extensive (9, 88, 97, 115) is not reported in the present study.

In contrast, most people used traditional drugs for self (lay) care (Table (13) and a large number of traditional drugs are available in the markets in the study area. They are used for prevention (some being held or exibited in the household for years) "or for curative purposes. Those used for curative purposes could be for various kinds of symptom-compexes.ln fact most drugs are for ubiquitous use, the often heard answer lor use being "for all conditions."

It is important to note {Table 13) that the use of traditional remedies decreases with urbanity. Thus 83% of the se1f (lay) care in Adamitulu, the most rural 0£ the study communities, is with traditional drugs while only 29% for Kebele 21/11 in Addis Ababa, the most urban.. It is clear that the use and knowledge erosion phenomenon that has been documented elsewhere is also starting in Ethiopia. This has important implications for future action.

*See Glossary