NAVIGATING THE THERAPEUTIC LANDSCAPE OF RURAL AFRICA: AN INVESTIGATION OF SOCIAL CAPITAL AND RESPONSES TO DEPRESSION AMONG WOMEN IN WESTERN KENYA

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ERIN M. PEACOCK

APPROVED:

Laura Murphy, PhD (Chair) 4/15/15
Katherine Andrinopoulos, PhD 4/15/15
Gretchen Clum, PhD 4/15/15
Kate Macintyre, PhD 4/15/15
Abstract

Women in rural western Kenya experience depression, yet few formal treatment options exist. What other options for support are available to these African women suffering from depression? How do these women navigate this “therapeutic landscape” of modern and traditional care? What is the role of social capital, including faith-based and community-based networks? I used a mixed methods case study approach to explore how women in Siaya, Kenya experience depression and navigate the therapeutic landscape – the forms of health provision as understood by the women who use them – to deal with poor mental health. I conducted in-depth interviews with women suffering from depression, members of their social networks, and key informants, ranging from clinicians and healers, to community elders, depression survivors, and community group and religious leaders. I used focus group discussions to elicit contextual information and daily mobile phone diaries to collect information on small, day-to-day health actions and social network interactions.

I encountered a “treatment desert” shaped by an inadequate government health system, a deteriorating indigenous healing system degraded by Christianity and modernity, and a religious healing tradition that is considered unacceptable by most women in the study site. This therapeutic landscape is rocky and difficult to navigate and low social cohesion limits the support a woman receives from her in-laws, extended family, friends, group members, and neighbors. While churches and community groups are more reliable in times of need, financial and time barriers limit their utility for promoting mental health. Given this landscape, women’s responses to depression are predominantly inward-focused, consisting of prayer, keeping quiet, and staying busy. I
suggest interventions that offer lay delivery of proven therapies and build collective social capital to address this chronic burden of poor mental health among rural African women. Ultimately, the low social cohesion seen in my study is rooted in material poverty and gender inequality, including oppressive and restrictive marriages. Efforts to build the social capital women need to tackle depression should be accompanied by attention to these structural factors that degrade social cohesion.
Dedication

This dissertation is dedicated to my research participants, the 14 women who invited me into the darkest corners of their lives in the hope that sharing their stories could bring light to others. May you find the peace and happiness that you seek.
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List of Acronyms

AIC  African Independent Church
APECC  Apostolic Evangelical Christian Church
BDI  Beck Depression Inventory
CBT  Cognitive-behavioral therapy
CDC  Centers for Disease Control and Prevention
CHW  Community Health Worker
CU  Community Unit
KEMRI  Kenya Medical Research Institute
MBCT  Mindfulness-based cognitive therapy
MBSR  Mindfulness-based stress reduction
MDG  Millennium Development Goal
MVP  Millennium Villages Project
SDH  Siaya District Hospital
WHO  World Health Organization

List of Luo terms

Ajuoga  Witch doctor
Bedo gi kuyo  Depression (lit. “having sadness”)
Bedo gi paro mang’eny machando chuny  Depression (lit. “having many thoughts that disturb the heart”)
Chang’aa (Swahili)  Local illicit brew
Chira  Disease with HIV-like symptoms; results from breaching social norm, breaking taboo; treated with manyasi by ajuoga or jamanyasi
Githeri (Swahili)  Traditional meal of maize and beans mixed and boiled together
Harambee (Swahili)  Fundraiser
Hoso  Antidote to malevolent spell or curse (kingo)
Jakoro                     Diviner; tells future and reads past; use special candles and water
Jalemo                     Faith healer; a person who prays for health (Christian)
Jalok lek                   Seer, dreamer; explains dreams
Jamanyasi                   One who uses traditional herbs (*manyasi*) to treat Luo diseases; similar to an *ajuoga*
Jaulo                       Interprets when a person is speaking in tongues
Jayalo                     Preacher (infused with special power for preaching; not denomination-specific)
Juogi                       Spirit possession
Kingo                       Malevolent spell or curse (antidote: *hoso*)
Manyasi                     Traditional herbs used to treat ailment that results from breaking taboo
Mgeni (Swahili)             Guest
Mpango wa kando (Swahili)   “Other woman”/mistress
Ndagla                      Witchcraft
Neko/ janeko               ‘Madness’/a person who suffers from ‘madness’
Nya-                        Prefix indicating from where a person originates; many women in the study area are referred to by their place of birth rather than their given or family name
Nyamrerwa                  Previously, a traditional birth attendant; today, refers also to CHW
Omena                       Small, silvery, sardine-like fish
Osiepe                      Friendship
Riwa                        An abnormal mental state wherein a person walks around absentmindedly but is calm and nonviolent
Sihoho                      Evil eye
Shamba (Swahili)            Small farm
Simba                       Bachelor home

**A note about confidentiality**

Throughout this dissertation, I use pseudonyms to protect the confidentiality of all research participants. For professional participants, details about their professional affiliation are omitted so that their identities cannot be easily traced. I have also attempted to obscure the exact study location, referring to it only in general terms.
Shilling conversion

Throughout this dissertation, I’ve employed the abbreviation “Ksh.” for the Kenyan Shilling. At the time of fieldwork, the conversion rate was approximately 1USD = 85 Ksh.
CHAPTER 1: INTRODUCTION

Mental illnesses are always experienced and treated in local health care systems – local systems of cultural knowledge, local family structures, communities, and systems of popular and folk healing, as well as local medical services. Societies have multiple healing traditions that are drawn on not only to treat mental illnesses and psychosocial problems, but to make sense of them, categorize and explain their causes, and organize personal and community responses. Any effort to provide mental health care or clinical services must therefore begin with an understanding of local forms of distress and illness, systems of signs and meaning used to interpret illness and organize responses, and local systems of care (Desjarlais, Eisenberg, Good, & Kleinman, 1996).

1.1 Emily’s story

Emily studied political science and French in college. In 1997, she was working as a personal assistant in a private firm in Mombasa when she discovered that her husband was having an affair. She confronted him, but he refused to discuss it. Over time, he became increasingly violent toward her. She continues:

That went on for a long time. He was traveling too much. He was away too much. And we missed him a lot. You know, I was in a new place, I was in Mombasa and originally I used to stay in Nairobi so I was away from my people and there was nobody to share with.

Seven months pregnant, she experienced a stillbirth and became hysterical: “The thing is, he wanted a baby boy, but I had girls. Now the one that came off was now a baby boy.” People started having concerns about her behavior:

It’s people who were seeing something wrong in me but I really didn’t know what was going on until I went to the hospital and had to put up in a mental hospital. That’s when I knew I was really sick.

She stayed for three months in the mental hospital in Mombasa, receiving treatment of Largactil (an antipsychotic medication), Artane (an anti-tremor medication used to treat the side effects of antipsychotic treatment), and Clopixol (a second antipsychotic medication). Initially, her family and friends were supportive, coming all the way from Siaya to visit her in the hospital. Over time, her mental condition improved.
and her medication dosage was decreased. In 1999, she left Mombasa and returned home to Siaya. There, her mental status declined and along with it, the support she received from her family waned: “The problem persisted because now people regard you as someone who is useless, somebody who is not working, somebody who doesn’t have daily income…Nobody wants to assist you in any way. So it recurred.”

In 2003, she started receiving treatment again from the psychiatry department at Siaya District Hospital. This time, they prescribed for her a combination of Largactil, Amitriptyline (an antidepressant), and Artane. She was receiving virtually no support from her family anymore. She also did not find any support in the Anglican church where she was a member:

They’re terrible people. Those…ah…they only assist the wealthy people. Like I was a member of the mothers’ union – the mothers never did anything to assist me. I was married in that church – nobody came to…even the pastor was told…there is nothing he did about it.

When no support was forthcoming from friends, family, or her church community, Emily “decided to go it on [her] own.” In 2005, she turned toward the Apostolic Evangelical Christian Church for support.

The Apostolic Evangelical Christian Church (APECC) sits on a large parcel of land in Southeast Alego. I visited the church compound, where people afflicted with *juogi* (spirit possession) are healed by prayer. To the eyes of a Westerner, *juogi* looks indistinguishable from schizophrenia or bipolar disorder. The ‘afflicted’ wander around the compound chattering nonsensically to themselves, staring off blankly into space, or digging in the dirt. One man, who had a history of acting out violently, was chained to a tree by his ankle. At night, the patients are locked in 6’ by 4’ cement cells without
windows or bedding. The patients receive no medication and no outside care, but are prayed for several times each day.

Emily describes what life was like at the church:

There it’s like a prison because you’re confined. When you’re sick, you’re not even allowed to go out. In fact, there are rules and regulations…The patients are like inmates. You don’t go anywhere, like there’s a gathering somewhere, you don’t go.

Despite the restrictions, Emily stayed at the church because she “had nowhere to go.” She explains how she coped: “I isolated myself. I didn’t want to associate with them but at least I had shelter. And later on when I got used to their teachings, it made a lot of sense to me.”

Emily was aware of the community’s ill feelings about APECC. Because many of the APECC leaders come from outside of the region, the community considers them “land grabbers.” She continues:

But once you’re in there and you stay with them, then you get to know the truth about it. When I realized they are very harmless, they are good people, they really teach you how to work and to survive and to take care of yourself and to live in the light, you realize they are very good people.

When she first went to live at the church, Emily was still taking her medications. Yet, she was having difficulties with her reactions to them: “I was getting worse and my body was swelling. I was reacting to the drugs.” APECC encourages its people to discontinue allopathic medications in favor of a strict prayer regimen. According to Emily, it is “because they know what drugs can do to somebody.” Soon after taking up residence at the church, she stopped taking her medications:

In the church, they used to just sing for us, they prayed for us, they told me to stop the medicine. I stopped and I got healed. So when I was in church, I’m fine. When I was out, I’m not fine, so I stayed in the church for three years.
Evidently, Emily’s path led her to mental health. She went for review at Siaya District Hospital and they told her she was “fine.” In 2007, ten years after her first mental illness episode, she left the APECC compound and moved in with her aunt. Of her present mental health, Emily remarks: “Yeah, I’m very healthy. I don’t use drugs anymore.” Asked how she stays healthy, Emily reveals:

I just decided not to worry about anything, anybody - not even my children. Just try to be stress-free…When I stayed in the church I looked at the way people live there, the children who have never even seen their parents, there are people who have left their homes for good. Because maybe these problems were from the villages where they came from. And now they’ve just started to keep off from their relatives and they’re doing well. So I decided to try that.

I first interviewed Emily in 2010, just three years after she had moved from the church compound. When I caught up with her in 2012, she revealed that her mental health had continued to improve. Emily has continued to put distance between herself and her family: “I really know who my people are. I value friends more than relatives now.” She continues: “I stopped socializing with the outside world. That is, now I only socialize with the church community. And theirs is just prayerful living...That’s now my family.”

Emily attributes the whole of her recovery to church teachings. She counts among the most important lessons the church has taught her, those related to fellowship:

The way you carry yourself, your dressing, and to love one another. Like in the church, it’s like we are one big family. Everybody is a brother, a sister, your aunt, your cousin…we are just one big family. So a person from your church can’t get stranded. If I was visiting in Nairobi, I wouldn’t get stranded, I would just look for my church people. They are always welcoming. That’s how we are taught.

For Emily, the church community now takes the place of family in her life. She suspects that others could benefit from the same arrangement. When I asked Emily what advice she would give to a woman struggling with depression, she replied:
First you identify the problem. If it is the family that is causing you the problem, just cut them off completely. They’ll look for you later on when you’re doing well. But at that point, you should not indulge in any activities with them…To try and lead her own life as a person. Not to rely on others. Just have self-confidence. You’ll make it.

1.2 Research questions

In some ways, Emily is unique: possessing a college education in rural Siaya is rare. Her experience living and working in Mombasa lends a worldliness that is not common among the other women I encountered in my research. Yet, in many ways, Emily’s story is unexceptional: it is about the crisis of modern marriage in Africa and the mental health toll it exacts on women (after all, even Emily, with all her privilege, could not thrive). It is about the failure of the allopathic health system to adequately accommodate women with mental health problems. It is about a breakdown in forms of social capital (family, church community) that might fill the gap left by an ineffective health system. And her story is about the search for alternative forms of social capital (a new church community) to fill the vacuum left by these failed systems.

Emily’s story is not unique in other important ways. Globally, depression is the leading cause of disease burden among women of child-bearing age (Mathers, Boerma, & Fat, 2008). Poverty; domestic isolation; powerlessness (resulting from, for example, low levels of education and economic dependence); patriarchal oppression; hunger; exploitative work; and sexual, reproductive, and domestic violence all contribute to women’s particular vulnerability to psychological distress (Desjarlais, et al., 1996). Despite the pervasiveness of depression, health systems are unequipped to meet the magnitude of need for mental health services: in developing countries, mental health specialists are scarce, and mental health is typically excluded from national health system
frameworks and funding allocation (Murthy et al., 2001). In this context, what other options for treatment and support are available to women suffering from depression in rural Kenya? How do women navigate the landscape comprised of those options? How do they draw upon their social networks for support? And what role do faith communities and community groups play in supporting their recovery?

Melissa Leach, James Fairhead, Dominique Millimouno, and Alpha Ahmadou Diallo (2008) define the ‘therapeutic landscape’ as “the field of available forms of health provision as experienced, understood and constructed through practice by the populations that live with them” (p. 2158). My research relies on this concept to ask: **What is the therapeutic landscape for poor Luo women facing depression?** For example, Emily’s therapeutic landscape is comprised of allopathic health facilities – the private mental hospital in Mombasa where she first spent time, Siaya District Hospital where she received care during her relapse – and the APECC community. My research seeks to describe the range of options – the landscape – for mental health treatment and support, focusing on one location in rural western Kenya. Recent work around “envisioning future health systems” leads us to expect to find “a blurring of the boundaries between what is public and what is private and a multiplicity of actors and institutions, formal and informal, involved in health care production.” (Bloom & Standing, 2008), p. 2071

My research is based on the premise that people often show incredible ingenuity and adaptability when faced with difficult circumstances, and that women have likely evolved responses to depression that are locally appropriate and meaningful, even if not optimal. Ultimately, my research aims to inform public health efforts to optimize or supplement (by, for example, transforming a dysfunctional government health system),
rather than supplant, those responses. Indeed, Patel and Goodman (2007) remind us that people “may already have ways of responding to these problems which mitigate their negative effects – [and] when they do not, it may be possible to establish these protective and promotive factors through public health interventions” (p. 706). This orientation toward identifying and enhancing existing strategies motivates my second research question: **In this context, how do women respond to depression?** I envision their responses span formal biomedical and informal/local responses, but it is not clear how women navigate these possible responses and my study can shed some light. In Emily’s case, she initially tried a biomedical response, relying primarily on a pharmaceutical approach to mental health management. At some point, she moved back to Siaya, seeking support from her family. Evidently, she tried to reach out to her family and church community for support, but met only rejection. Finally, she sought refuge in the APECC church, at first isolating herself from the people there, but eventually opening up to their teachings. At the church, she abandoned her medications in favor of a strict prayer regimen. Is her response typical of other women in the area? My research seeks to describe and deepen our understanding of the range of ways in which women in rural western Kenya respond to depression given the lay of their therapeutic landscape.

The traditional social capital literature views social relationships as *resources*, and indeed, many of the earliest definitions of social capital state so explicitly (e.g., Putnam, 1995). In situations of poverty, where access to formal services is limited, informal social relationships take on special importance for ensuring access to a variety of social goods (Boissevain, 1974; Granovetter, 1973; Lomnitz, 2014; Stack, 1975; Wellman & Wortley, 1990). Empirical work linking social relationships to the course and prognosis of mental
illness suggests that social networks are indeed mobilized to address mental health (Becker & Lee, 2002; Butzlaff & Hooley, 1998; L. Dixon, Adams, & Lucksted, 2000; Giordano & Lindstrom, 2011; J. H. Jenkins, 2003; Leff & Gamble, 1995; De Silva, Huttly, Harpham, & Kenward, 2007; De Silva, McKenzie, Harpham, & Sharon, 2005). Collectively, these considerations merit an investigation of the ways in which women who are suffering from depression draw on their social networks for support in navigating the therapeutic landscape. Thus, the third research question I ask is: **What is the role of social capital in influencing how women respond to their depression?** My research seeks to acknowledge relevant social factors influencing health decisions about mental health, such as a woman’s church, self-help and other support groups; her birth family (usually residing outside her current village of residence); and the social networks she forms in her matrimonial home.

Ever since the Church Missionary Society (CMS) spearheaded penetration of Christianity into the heart of East Africa in the mid-19th century, operating out of Ng’iya – what is today the commercial hub of the study site – for many years, Christian faith and religious institutions have become a significant (and growing) component of western Kenya’s therapeutic landscape. Most notably, Christian churches directly offer healing, either by funding and operating allopathic health facilities or by offering faith healing and prayer. Faith also has an undeniable effect on people’s choice of healing modality, with concepts like “salvation” exerting substantial influence on the decision to shun indigenous medical practices (R. J. Prince, 2007). Furthermore, according to the social capital literature, participation in faith communities affords people access to ‘bridging’ social networks – relationships with people who are different from oneself – that are
presumed to be in short supply in these rural, impoverished communities. Thus, my research seeks to account for one of the most important institutional influences on people’s social relationships and health behaviors by asking: **What is the role of faith-based social capital, in particular, in influencing responses to depression?**

Much of the early social capital literature viewed social capital as an unequivocal asset. In his oft-cited definition, Putnam (1995) describes social capital as “features of social organization such as networks, norms, and social trust that facilitate coordination and cooperation for mutual benefit” (p. 67, emphasis added). Conventionally, health research has focused on the positive relationships between social capital and good health. But social capital can potentially have neutral or even negative consequences (Kunitz, 2001), such as when social relationships increase mental and emotional stress or promote unhealthy norms of behavior. A breakdown in Emily’s social network, for instance, had negative effects on her mental health, and she was forced to seek out alternative relationships in a new church to access the support she needed to heal. To bridge the theoretical and empirical gap in knowledge about social capital effects, this dissertation will look for nuance in how social capital acts on mental health and related health actions with attention to potentially negative consequences, distinctions between individual and collective levels of social capital, and different effects of the various types of social networks (e.g., relationships with people who are similar to or different from oneself, including those that span differences in power).

**1.3 Overview of dissertation**

This dissertation is divided into 10 chapters. Following this introduction, I summarize the relevant mental health and social capital literatures. In addition, I review
literature on each component of the therapeutic landscape in western Kenya. The study methods are outlined in Chapter 3, the study site and research participants described. In Chapters 4-8, I present the research findings: Chapter 4 describes the mental health situation in the study site, with special attention to emic framings of depression. Chapter 5 explores how the allopathic health system accommodates (or fails to accommodate) depression and the extent to which women access the allopathic health system in responding to their experiences of depression. Chapter 6 delves into the religious and indigenous healing traditions and how they accommodate depression. The relevance of these healing traditions for women in the study site are explored. Chapter 7 explores how women draw on their informal relationships with people (e.g., friends, family, neighbors) for support, while Chapter 8 does the same for formal social networks, particularly those comprised of church communities and community groups. Throughout Chapters 5-8, the varied ways in which different women respond to depression are highlighted. Chapter 9 summarizes the findings from Chapters 4-8 and draws out implications for public health practice. In this chapter, I step outside the social capital paradigm and ask whether there are better explanations for the findings. Finally, I discuss how my research contributes to the mental health and social capital literatures in Chapter 10, identifying future directions for research. This final chapter reflects on the strengths and limitations of my research.

This research is indebted to the participants who made themselves vulnerable by sharing their darkest stories with strangers, in the hope that their words could ultimately help other women suffering from depression. So that their stories are not lost (and are given the prominence they deserve), they are featured in shaded text boxes throughout the dissertation. The stories will be referred to in the text as appropriate.
CHAPTER 2: LITERATURE REVIEW

The most accurate statement that can be made on the frequency of depression is that it occurs often and, directly or indirectly, affects the lives of everyone. (Andrew Solomon, *The Noonday Demon*)

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In this chapter, I begin by summarizing the mental health literature, defining relevant terms, discussing the prevalence and burden of mental health problems, exploring the determinants of poor mental health, outlining information about care and treatment for mental health problems, and taking stock of mental health systems. I then explore health-seeking behavior for mental health, including a review of common theoretical models for health-seeking behavior and what is known about how people seek mental health. I then move on to discussing the therapeutic landscape of rural Africa. I begin this section with an overview of pluralistic health systems, before examining historical and recent trends in allopathic health systems work. I then turn my attention to the social capital literature, defining important terms, discussing faith communities and community groups as components of the therapeutic landscape, and taking stock of work around the links between social capital, mental health, and health-seeking behavior. Finally, I end by describing the therapeutic landscape of the study site.

2.1 Mental health

2.1.1 Definition

“Mental illness” refers collectively to all diagnosable mental disorders\(^1\), which are “health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning” (United States Surgeon General, 1999). “Mental health” encompasses more than just the absence

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\(^1\) Mental or psychiatric disorders are distinct from mental disability (i.e., “mental retardation”) and neurological disorders (e.g., epilepsy)
of mental illness, it is “the state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (World Health Organization, 2011c).

One category of mental illness is that comprised of mood, or affective, disorders – mostly bipolar affective disorders (those in which the sufferer fluctuates between manic and depressive states) or unipolar depressive disorders. Unipolar depression is the most common of all mental illnesses and is the focus of this research. Depression may occur as a single lifetime episode or, more commonly, as one of many episodes throughout a lifetime. It is characterized by both affective and somatic symptoms: sadness, diminished pleasure in daily life, weight change, sleep pattern disturbance, fatigue, feelings of worthlessness and self-blame, diminished ability to concentrate, indecisiveness, changes in motor patterns, chronic pain and persistent headaches.

While mental illness is generally acknowledged to be universal across cultures, defined categories of pathology are not (Patel & Winston, 1994). However, disregarding standardized definitions altogether can cause us to adopt a position of extreme cultural relativism that might result in a failure to recognize true mental suffering. Using both cultural definitions of depression (“emic”) and standardized criteria (“etic”) can help cross-cultural mental illness researchers to walk the line between ethnocentric universalism and extreme cultural relativism (Patel, 1995).

2.1.2 Prevalence and burden

Globally, mental health problems account for a greater portion of disability-adjusted life years (DALYs) than tuberculosis, malaria, cancer, heart disease, HIV/AIDS
and STIs, or malnutrition (Desjarlais, et al., 1996). Unipolar depressive disorders alone are the single leading cause of years of life lived with disability (YLDs) among both sexes and all ages (Mathers, et al., 2008; Murthy, et al., 2001). The burden placed on health systems is enormous: depression and anxiety alone account for 20-30% of all primary care visits worldwide (Desjarlais, et al., 1996).

In low-income countries, depression ranks eighth in causes of disease burden (as measured by DALYs). While this ranking is lower than its worldwide burden ranking (depression ranks third in causes of disease burden worldwide), its importance is increasing: depression is projected to be the leading cause of disease burden by 2030. Already, among women aged 15-44, depression is the leading cause of disease burden, even in low-income countries (Mathers, et al., 2008). The burden of mental illness on health systems is particularly acute in developing countries, where mental health specialists are scarce, and mental health is typically excluded from national health system frameworks and funding allocation. The shortage of mental health services in developing countries contributes to high levels of unmet need, which manifests in a variety of social and economic problems, including loss of employment, reduced productivity, and declines in quality of life (Murthy, et al., 2001).

Research generating prevalence estimates tends to be restricted mainly to developed countries and clinical samples (Maulik, Eaton, & Bradshaw, 2009). Using data obtained from 60 countries, Moussavi et al. (2007) find a prevalence of depression only of 3.2%, but an average of 9.3-23.0% of respondents with at least one chronic physical disease had comorbid depression. In sub-Saharan Africa, prevalence estimates generally come from small studies done in sub-populations: for example, among patients
of traditional healers in two districts in Uganda, Abbo et al. (2008) found a prevalence of psychiatric distress of 65%.

In Kenya, few recent studies have attempted to establish prevalence estimates; even fewer have attempted to do so with a population sample. The prevalence of mental illness among clinic-based samples is 20-45% (Dhadphale, Ellison, & Griffin, 1983; D. M. Kiima, Njenga, Okonji, & Kigamwa, 2004; D. Ndetei et al., 2009; David M. Ndetei & Muhangi, 1979). Outside of these limited prevalence studies, very little mental health research exists, though there is some investigation of post traumatic stress disorder (PTSD) among special populations: Kakuma refugees (Kamau et al., 2004) and individuals exposed to the 1998 US Embassy bombings in Nairobi (North, 2005).

2.1.3 Determinants

Depression is the result of the complex interaction between social, biological, and psychological factors. It is widely accepted that poverty, gender, age, conflicts and disasters, major physical and chronic diseases (e.g., HIV/AIDS), the family environment, and life events contribute to depression (Murthy, et al., 2001).

2.1.3.1 Poverty

While the existence of a link between poverty and mental illness is well-established (Desjarlais, et al., 1996; Patel, 2001, 2007; Patel & Kleinman, 2003; Saraceno, 2007), there is some disagreement on the specific mechanism linking the two concepts. In a review of the literature on the association between indicators of poverty and the risk of common mental disorders (depression and anxiety) in low- and middle-income countries, Patel and Kleinman (2003) found that low levels of education were most consistently associated with mental illness while there was only weak evidence to support
an association between income levels and mental illness. With data from representative samples in five countries, Das et al. (2008) found that it is not poverty per se, but economic and multidimensional shocks (to which the poor are most vulnerable) that predict mental illness. Desjarlais et al. (1996) draw out the importance of circumstances that often accompany poverty, e.g., exploitation, hunger, and malnutrition. In Uganda, Abbo et al. (2008) found that lack of food and being in debt were associated with psychological distress. Underlying these explanations is the idea that the poor are more prone to mental illness because of their vulnerability to other social forces: their experience of insecurity and hopelessness, their risk of being exposed to violence, and their risk of physical ill health (Desjarlais, et al., 1996; Patel & Kleinman, 2003).

While urbanization and rapid social change demonstrate some linkages with mental illness (Desjarlais, et al., 1996; Patel & Kleinman, 2003), the relationships are complex and dynamic. The conventional view that modernization and breakdown of traditional cultures and communities inevitably lead to mental health problems does not stand up to empirical evidence – in fact, development is a multifaceted process and some aspects turn out to impact mental health positively while others are detrimental (Desjarlais, et al., 1996).

Moreover, the relationships between poverty and mental illness are bi-directional (Patel, 2001). For example, the direct and indirect costs of mental illness place financial burden on individuals and households, which may further impact his or her mental health, creating a vicious cycle of poverty and mental illness (Patel & Kleinman, 2003).

2.1.3.2 Gender

Gender differences in prevalence and manifestation of mental illness are
discussed widely. Women are far more likely to experience depression and psychological distress than are men (Akhtar-Danesh & Landeen, 2007; Das, et al., 2008; Giordano & Lindstrom, 2011; Mathers, et al., 2008; Orley & Wing, 1979), while men are more likely to experience substance abuse disorders or drug-related psychosis. Gender disadvantage is often cited as an explanation for the difference in prevalence (Patel, 2007): poverty; domestic isolation; powerlessness (resulting from, for example, low levels of education and economic dependence); patriarchal oppression; hunger; exploitative work; and sexual, reproductive, and domestic violence all contribute to women’s particular vulnerability to psychological distress (Desjarlais, et al., 1996).

Gender issues also surface in a consideration of how mental illness is commonly expressed. In some cultures, mental illness is expressed in local ‘idioms of distress’ – nerves, attacks, spirit possession, etc. Various explanations have been forwarded: these particular forms of expression represent passive suffering in the face of oppression; or they are reflections of the way in which women are supposed to fall ill (Desjarlais, et al., 1996). Desjarlais et al. (1996) assert that mental illness expressions are a form of power and voice for some women: “possessed women are authorized by their experience of possession to voice criticism and demand retribution that is denied to them in everyday life” (p. 183).

The high rates of depression among women are particularly troubling given women’s economic and social contribution to the household and their workload and caregiving responsibilities. Desjarlais et al. (1996) contend that women’s mental health should be one of top five research priorities worldwide and calls for more research examining social factors that influence women’s health in specific cultural contexts.
Furthermore, a comprehensive research agenda should include a focus on special concerns that arise when women do engage with the health system, e.g., how gender-based violence should be addressed by health care practitioners.

2.1.3.3 Life events

Major life events (e.g., experiencing the loss of a loved one through death or abandonment, being the victim of violence) are generally associated with worse mental health. Kenyan patients undergoing treatment for clinical depression in Nairobi were significantly more likely to have had a life event in the 12 months preceding the onset of depression than controls in the same period (Vadher & Ndetei, 1981). Life events involving loss, mostly related to separation or perceived or threatened separation from family members, friends and love relationships, were most common. In some cases, life events involved family members leaving home for prolonged periods of time to look for jobs. Many studies have found a relationship between abuse and depression (Goodman, Rosenberg, Mueser, & Drake, 1997). Goodman et al. (1997) note that poverty, substance abuse, homelessness and stigma are phenomena that co-occur with both victimization and serious mental illness, making the process of teasing out causal mechanisms difficult. Rural African households commonly face separation, divorce, debt, loss of crops, death of household members, etc., but relationships to depression have not been extensively documented.

2.1.3.4 Chronic disease

The links between mental illness and chronic disease are well-established. Generally, depression is more common in people with chronic diseases than in those without (Moussavi, et al., 2007). Mental health problems may also pose a greater burden
when it affects a person who is already coping with chronic disease (Saraceno, 2007). HIV/AIDS may carry with it additional considerations (e.g., social isolation, stigma) that make it a particularly relevant focus for mental health research, especially in my study location.

Research demonstrating increased prevalence of mental illness among HIV-infected individuals is quite compelling. In a study spanning Kinshasa, Nairobi, Bangkok and Sao Paulo, Maj et al. (1994) find that both symptomatic and asymptomatic HIV-positive individuals had higher rates of depression than did HIV-negative individuals (in Nairobi, those rates were 11.1%, 7.5%, and 4.6%, respectively). Another study of patients attending an STD and skin disease clinic in Nairobi found a prevalence of mental illness of 75% for HIV-positive patients and 36% for HIV-negative patients (D. M. Kiima, et al., 2004).

The possibility of reverse causality is suggested by some scholars. Mental illness may lead to HIV-related risk behaviors, substance abuse and homelessness. Moreover, these correlates may impact health-seeking behavior for both mental illness and HIV/AIDS (Goodman, et al., 1997).

2.1.4 Care and treatment

2.1.4.1 Diagnosis

The literature that mentions diagnosis focuses on missed and misdiagnosed mental illness as a barrier to early detection. Missed and misdiagnosed mental illness results from the fact that many patients present with physical symptoms, and from the lack of diagnostic skill among health workers (Desjarlais, et al., 1996; D. M. Kiima, et al., 2004).
Most misdiagnoses in Kenya are mistakenly labeled malaria, typhoid or amoebiasis (Ministry of Health, 1996).

Research in Kenya shows that patients tend to present with somatic symptoms (Dhadphale, et al., 1983; David M. Ndetei & Muhangi, 1979; Vadher & Ndetei, 1981). The most common somatic symptoms are headache and abdominal pain. Research shows that even when patients present with somatic symptoms, affective symptoms can be readily elicited by health professionals when patients are specifically questioned about their mood state (Dhadphale, et al., 1983). Perhaps because of the somatic presentation of symptoms, family members are generally unable to identify depression in the household (though they are able to identify other disorders (e.g., schizophrenia)) (Mbatia, Shah, & Jenkins, 2009; Silove et al., 2008).

2.1.4.2 Range of services

From a conventional biomedical perspective, comprehensive care for mental illness is comprised of pharmacotherapy, psychotherapy, psychosocial rehabilitation, vocational rehabilitation and employment, and housing (Murthy, et al., 2001). The focus on employment and housing is important from two perspectives: to help in the rehabilitation of persons suffering from mental illness (i.e., tertiary prevention) and to prevent relapse (i.e., primary prevention).

Effective psychotherapeutic interventions for depression exist. Cognitive-behavioral therapy (CBT) focuses on examining the relationships between thoughts, feelings, and behaviors. In CBT, persons suffering from depression are led by a therapist to explore thoughts and underlying beliefs that lead to self-destructive actions, and ultimately to improve coping by modifying negative patterns of thinking (National
Alliance on Mental Illness, 2012). The efficacy of CBT for a wide range of psychiatric disorders, including depression and anxiety, has been well-established over the last few decades (Butler, Chapman, Forman, & Beck, 2006).

More recently, mindfulness techniques have been incorporated into psychotherapies. Though the conceptual underpinnings of mindfulness-based psychotherapies differ from those of CBT – while CBT involves systematic attempts to change thoughts judged to be irrational, mindfulness techniques emphasize non-judgmental observation of thoughts (Academic Mindfulness Interest Group, 2006; Baer, 2003) – there is evidence that mindfulness-based therapies are a valid treatment option for a wide range of disorders, including depression, anxiety, stress, chronic pain, and eating/affective disorders (J Kabat-Zinn, Lipworth, Burney, & Sellers, 1987; Jon Kabat-Zinn et al., 1992; Kristeller & Hallett, 1999; Ramel, Goldin, Carmona, & McQuaid, 2004; Speca, Carlson, Goodey, & Angen, 2000; Teasdale et al., 2000). A recent review of four studies of mindfulness-bases cognitive therapy (MBCT) concluded that MBCT appears to have additive benefit to usual care for patients with previous depression issues (Coelho, Canter, & Ernst, 2013). A meta-analysis of 20 studies of mindfulness-based stress reduction (MBSR) suggested that MBSR may help alleviate both clinical and nonclinical problems (Grossman, Niemann, Schmidt, & Walach, 2004).

In theory, mindfulness-based therapies have the added benefit over conventional CBT because they may be more amenable to delivery by “lay” persons (albeit with meditation training). Yet, few comparative effectiveness studies exist. In one study comparing MBSR (delivered by a “lay” person with meditation training) to group CBT (delivered by an “expert”), Koszycki et al. (2007) report that the groups were comparable
in improving mood, functionality and quality of life. While both groups experienced improvements in social anxiety disorder, the CBT group improved more.

There is some evidence supporting the efficacy of psychotherapy in low- and middle-income countries (Patel et al., 2007; Rahman, Malik, Sikander, Roberts, & Creed, 2008; Rojas et al., 2007). Some scholars outline processes for cultural adaptation of therapeutic interventions. Rathod et al. (2010) describe qualitative formative research to adapt CBT for ethnic minority patients in the United Kingdom. Others employ Bernal’s framework for cultural adaptation, which outlines eight overlapping cultural dimensions and features of the treatment population (concepts, language, persons, content, metaphors, goals, method, and context) that should be incorporated into psychotherapy outcome research (Duarté-Vélez, Bernal, & Bonilla, 2010; Papas et al., 2010).

2.1.4.3. Integration into primary health care

There are approximately 0.19 psychiatrists per 100,000 population working in the mental health sector in Kenya (World Health Organization, 2011a). This rate is equivalent to approximately 78 psychiatrists in the whole country, for a population of over 40 million. The social worker shortage is even more dire: there are only 0.01 social workers per 100,000 population working in the mental health sector (World Health Organization, 2011a)\(^2\). Due to the shortage of health professionals specializing in mental health in Kenya, most scholars concur that mental health care must be integrated into primary health care (R. Jenkins et al., 2010a). However, there are barriers to appropriate care that must be addressed: a survey of non-psychiatrist physicians at Kenyatta National Hospital revealed that while drug therapy and counseling were common, referral was not:

\(^2\) In comparison, the rates for the United States are 7.79 psychiatrists/100,000 population and 17.93 social workers/100,000 population.
cited barriers to referral included a lack of coordination, insufficient knowledge and patients’ resistance to referral (Othieno, Okech, Omondi, & Makanyengo, 2001). In a study of the knowledge, attitudes and practices among primary health care workers in Tanzania, Mbatia et al. (2009) found that while the majority of respondents generally held positive views about pharmacological and psychological treatments and their involvement in the treatment of depression, many felt that becoming depressed is a way that people with poor stamina deal with life difficulties. Clearly, proper integration must include training, sensitization, supervision, and coordination. Incidentally, training of primary health care staff, supervisors, and provincial staff across Kenya has begun. The program involves supervision of primary health care staff by psychiatric nurses and inclusion of mental health in district and annual operating plans (R. Jenkins, et al., 2010a).

The idea that mental health should be integrated into primary care is not without detractors. Some argue that overburdened allopathic health systems may not be able to accommodate increased demand for mental health care and that there is no clear evidence that integration of mental health care into primary care delivery systems is a successful strategy to adequately address mental illness in underserved areas (A. Cohen, 2001). Desjarlais et al. (1996) contend that in addition to improving the quality of mental health services in primary care and psychiatric settings, responses to mental illness must include community based treatment and rehabilitation and evaluating local systems of mental health care. Research reveals low-cost traditional practices that can be enhanced in places where health care services are scarce and treatments are limited (Becker & Lee, 2002). Indeed, many scholars argue quite compellingly that local adaptations should be used as the basis for interventions (Desjarlais, et al., 1996; Patel, 2001).
In this light, other solutions to the human resource shortage have been proposed, including training community health workers in the detection and management of depression (D. Kiima et al., 2009) and involving community pharmacists in mental health management (Owusu-Daaku, Marfo, & Boateng, 2010). Research with traditional health practitioners in Maseno Division, Kenya (just east of the study site) reveals several different treatment strategies currently in use, including talking therapy for patients who are passing through stressful life events (Okonji et al., 2008). In addition, the healers were unanimous in their expressed desire for collaboration with the formal health system. Okonji et al. (2008) caution that further research and liaison are important to reduce potentially harmful practices by traditional healers, to improve the early diagnosis and effective treatment for people visiting traditional healers, and to strengthen the continuity of care.

2.1.5 Mental health systems

Patel and Prince (2010) argue that the time is ripe for the emergence of a field of global mental health because of three factors: the recognition that mental disability is not a peculiarity of Western culture but affects all cultures across the globe, the high burden associated with mental illness, and the fact that effective treatment is available. Minas and Cohen (2007) concur, suggesting that the highest global mental health research priority should not be neuroscience or clinical research, but mental health systems research. The evidence base for the development of mental health systems that provide effective, appropriate, and affordable mental health services is currently weak.

In Kenya, efforts toward the development of a national mental health policy and a national mental health strategic plan were underway, and the evaluation and revision of
national mental health legislation was pending in 1994 (D. M. Kiima, et al., 2004), yet by 2011 an officially approved mental health policy still did not exist. However, mental health is mentioned in the general health policy (World Health Organization, 2011b). Though no single document outlines the overall mental health policy for Kenya, it is generally accepted that Kenya’s mental health policy advocates the decentralization of mental health services to the grassroots level, the integration of mental health services into general health care service provision, and the establishment of community mental health services at the primary health care level (with an emphasis on promotional and preventive mental health).

Mental health services began in Kenya with the establishment of Mathari Hospital (then the ‘Nairobi Lunatic Asylum’) in 1910. After independence in the 1960s, attempts to decentralize mental health services to the provincial level were undertaken and provincial psychiatric units were established in the provincial hospitals. Further decentralization to the district level was initiated but is incomplete, due to a lack of human resources (D. M. Kiima, et al., 2004). In 1982, Kenya adopted mental health as the ninth essential element of its primary health care provision, though inadequate human resources hinder its widespread adoption into primary health care systems (World Health Organization, 2005).

With respect to mental health system financing, the global policy context is generally unsupportive of public investment in mental health services: the World Bank’s Investing in Health categorized mental health funding as “discretionary”, outside the package of “essential” services (Desjarlais, et al., 1996). Consistent with this global stance toward public investment in mental health care, Kenya spends only 0.1% of its
total health budget on mental health. Globally, out-of-pocket expenditures by patients or families remain a substantial part of mental health financing (World Health Organization, 2005). Dixon et al. (2006) contend that high levels of formal co-payments and user charges (which are levied alongside taxes used to fund health care) mean that patients may receive free consultation but pay for drugs. The result is that recommended treatment regimens may not be followed, as patients are unable to afford prescribed medications.

More broadly, financing of mental health services generally falls into four categories, each of which has associated advantages and disadvantages. Reliance on user charges usually results in inequitable access to care. Financing by private health insurance poses problems: exclusion of mental health benefits, limited access to those without employment and refusal to insure pre-existing conditions. While social health insurance may offer protection to those with mental health problems, eligibility in many low- and middle-income countries is based on contributions and limited to those in formal employment. Finally, while tax-funded systems theoretically provide universal coverage, in practice the quality and distribution of publicly financed health care services suffer in poor rural communities (A. Dixon, et al., 2006). A consideration of the trade-offs between these options will be important for Kenya as it attempts to design an effective and equitable mental health care system. This study can contribute to an understanding of what those trade-offs might mean for poor, rural women as they navigate the therapeutic landscape for depression.

2.2 Seeking mental health
“Health-seeking behavior” describes all the actions in which a person engages with the goal of moving toward or maintaining a healthy state. The term differs from “healthcare-seeking behavior” in its inclusion of informal actions outside the formal health system; from “treatment-seeking behavior” in its inclusion of actions taken to maintain a state, rather than merely those taken to treat an affliction; and from “help-seeking behavior” in its inclusion of actions taken by an individual for his/her own benefit, rather than merely actions taken to appeal for help from others. “Health-seeking behavior” itself may be a limiting term because it does not include purposeful non-action or actions taken by an individual in response to his/her condition when his/her goal is not necessarily a more healthy state; my research is more accurately concerned with “responses” to depression, though the term “health-seeking behavior” will be employed at times as a close approximation.

Conventional models and approaches to understanding health-seeking behavior are well-summarized by Hausmann-Muela et al. (2003) in a working paper commissioned by the London School of Hygiene and Tropical Medicine. While key points related to each model are summarized in a table in Appendix A, a few general observations will help to position my research:

- Most health-seeking behavior models focus on personal characteristics, overestimating the capacity of an individual to choose and follow a considered health behavior; only the most comprehensive models account for supply-side and structural factors that impact whether an individual ultimately receives care or treatment.

- Health-seeking behavior models assume that individuals are rational and health maximizing, preferring behaviors with the highest expected benefits; considerations of emotions and non-rational behaviors are absent, as are accounts of how health decisions are influenced by power dynamics.
• Most studies of health-seeking behavior explore certain key factors, in isolation from the larger social context. This may serve to mask structural factors that are critical points of explanation and intervention. Pfeiffer (2004) provides an example of the power of contextualization, concluding that, in Mozambique, the rejection of traditional healing does not represent a rejection of the past and rise to modernity so much as disillusionment with intensified commodification of traditional healing in an environment of increasing income disparities. A study that failed to consider the social context of privatization and free markets would have missed this critical finding entirely.

• Models tend to ignore the uncertainties of illness (ambiguous symptoms, unexpected treatment outcomes). In actuality, people may follow a trial and error method of health-seeking (Ryan & Martinez, 1998) given the incertitude they face.

• The extent to which factors related to social capital are included in health-seeking behavior models varies. None give social capital a central role in influencing health behavior.

Though the theoretical foundation is well developed, most empirical work around health-seeking behavior outside of anthropology is rather crude, employing oversimplified categories of health-seeking behavior and testing explanatory variables with seemingly little regard to underlying theory. The most simplistic report a dichotomous outcome indicating simply whether care was sought (i.e., “treatment contact”) (Beljouw et al., 2010; Borges, Wang, Medina-Mora, Lara, & Chiu, 2007; Druss et al., 2007). Others employ alternative categorizations, most often reflecting simplifying dichotomies, e.g., professional care only, informal care only, both, neither (Woodward et al., 2008); or psychiatrist, other mental health professional, general medical professional, human services, complementary and alternative medicine (CAM) (Druss, et al., 2007). Self-management and use of CAM are generally regarded as barriers to effective care (Beljouw, et al., 2010; Borges, et al., 2007).

Much of the empirical work related to health-seeking behavior in low- and middle-income countries focuses on explanatory models of illness and “modern” versus
“traditional” care choices. In East Timor, for example, Silove (2008) finds that cultural explanations for illness are readily grouped into four categories: supernatural, physical, social and resulting from psychological trauma. Psychotic disorders are generally attributed to supernatural causes and treated by traditional healers, while depression and PTSD are attributed to social and traumatic causes and receive little treatment despite being accompanied by substantial disability.

Patel (1995) asserts that within the rich diversity of beliefs relating to mental illness in sub-Saharan Africa are a number of shared concepts: spiritual causes are frequent explanations for mental illness; psychotic illness is often labeled 'madness' and emphasis is on behavioral symptoms rather than delusions; and neurotic illness presentations are often somatic and may not be considered to be mental illness at all. Kiima et al. (2004) identify commonalities within Kenya, noting that common beliefs across Kenya’s 42 ethnic groups include: 1. Mental illness is caused by supernatural powers, 2. Mental illness is atonement for sins committed against the ancestors, and 3. Mental illness is the result of bewitchment. Given the centrality of supernatural powers in illness explanations in Kenya, one would expect that most patients seek help from a traditional healer. Indeed, Muga and Jenkins (2008) report that patients visit different types of providers for different aspects of the same disease: most respondents in Mombasa had a biopsychosocial view of illness, but expected the allopathic health system to take care of the biological/pharmacological aspect and indigenous/religious healers to take care of the psychosocial aspect. These findings are supported by Ndetei et al. (2007), who reveal that 50% of Kenyans who consult traditional health practitioners suffer from psychiatric morbidity; many of these patients use traditional health
practitioners and allopathic providers simultaneously.

Desjarlais et al. (1996) remind us that, while exceedingly important, local cultural meanings are only one factor in understanding health-seeking behavior: the decision to consult a traditional healer, for example, depends also on the extent to which illness is perceived as a threat, ease of access, cost, perceived effectiveness, and the healer’s reputation. Indeed, some research identifies other important factors alongside illness explanations. For example, in Kilifi, Kenya, Kendall-Taylor (2009) examines treatment choices made by families of children with epilepsy, finding that local cultural systems of illness classification and the process of assessing treatment results are fundamental influences on health-seeking behavior. The former tend to be more salient in initial treatment seeking, while the latter dominate subsequent treatment decisions.

Though absent from much of the health-seeking behavior literature, religion likely plays a substantial role in shaping health-seeking behavior in Africa. In Tanzania, in addition to traditional medicine, Christian prayers play an important role in people’s beliefs regarding successful treatment of epilepsy (Winkler et al., 2010). In Kenya, people suffering from post traumatic stress disorder (PTSD) associated with the 1998 US Embassy bombings were found to rely on religious support (North, 2005). It is clear that faith is an important factor that is conspicuously absent from theories of health-seeking behavior.

2.3 The therapeutic landscape of rural Africa

2.3.1 Pluralistic health systems

The World Health Organization (2000) defines health systems as “all the organizations, institutions, and resources that are devoted to producing health actions.”
Modern health systems characterized by the creation of institutional arrangements to make the benefits of scientific knowledge and technologies available to the general population date back to the 17th Century. The technological revolution of the last 150 years has served to accelerate the process of health system development (Bloom & Standing, 2008). Over that time, global health systems have undergone overlapping generations of reforms, which include the founding of national health care systems, the extension of social insurance schemes, the promotion of primary health care as a route to achieving universal coverage, and delivery to all of high-quality essential care (World Health Organization, 2000).

In post-colonial African countries, the evolution of health systems has tended to move from dualism to pluralism. Following Independence, most African governments invested heavily in building health facilities and training health workers. This infusion of resources and access to biomedical health care gave rise to a dualistic health system, characterized by lay-professional, traditional-formal/regulated, folk knowledge-expert knowledge, and related dichotomies. Starting in the early 1980’s, economic factors led to reductions in public sector financing. In the vacuum left by public underinvestment in health, informal, unregulated markets emerged and there was a proliferation in the number and types of players in the health arena, marking the emergence of pluralistic health systems (Bloom & Standing, 2001). Bloom and Standing’s (2001) table detailing the components of pluralistic health systems at the beginning of the 21st Century is reproduced in Appendix B in full because of its importance in defining boundaries for the pluralistic health system as conceived in this research.
Pluralistic health systems are characterized by a multiplicity of actors, and diverse and hybrid healing strategies. Traditional healers engage in a diversity of healing strategies – incorporating allopathic medicine and faith-based healing into their cadre of indigenous healing practices (Marsland, 2007). Nurses and medical staff within allopathic cancer wards silently tolerate the use of traditional and alternative medicines (Mulemi, 2010). While hybridization and appropriation of other healing strategies (from both within the Siaya context and external to it) make it difficult to categorize healers and healing strategies, this dissertation will categorize healers and healing traditions into allopathic, indigenous, and religious traditions. Other aspects of the pluralistic health system (social networks, churches, community groups) will be reviewed in the “Social capital” section below.

2.3.2 Evolution in allopathic health systems thinking

In 1978, a health policy meeting jointly convened by the World Health Organization (WHO) and the United Nations Children’s Fund resulted in the Alma Ata Declaration (World Health Organization, 1978). The declaration’s primary focus was on achieving “health for all.” Representing a shift toward a basic needs approach to health (from which the “health promotion” and “social determinants of health” movements eventually emerged), the declaration advocated a pro-poor approach focusing on strengthening primary health care systems and community-based efforts toward ensuring health. In countries around the world, the declaration was accompanied by government investment and rapid expansion of public sector health services, focusing on overcoming infrastructure, equipment, trained personnel, and medication shortages. Community participation in state-led, centrally-controlled strategies took the form of local health
committees that provided voluntary inputs and served as guardians of accountability (Bloom, 2009).

The next 20 years witnessed a derailing of these efforts by progressive government disinvestment in the public health system as neoliberal ideas swept the globe. Structural adjustment policies ushered in fiscal austerity, privatization and deregulation of health care. In two influential publications released in 1987 and 1993, the World Bank suggested that public health systems should focus on increasing access to a bundle of cost-effective services, while other services could be more efficiently provided through market-based models. Demographic, economic, and epidemiological shifts contributing to older, more urban populations and an increase in the burden of chronic disease (including HIV/AIDS) further stressed public health systems (especially in poor countries that faced the double burden of pre-epidemiological shift infectious disease and a burgeoning chronic disease profile). Emerging pluralism and marketization, associated with economic and political crises and chronic underfunding of the public health system, continued to erode state-led health delivery, especially as institutional arrangements to manage markets failed to keep up with the rapid changes. Moreover, increases in channels for the spread of health-related knowledge, proliferation in the types of organizations participating in health service delivery, and a dramatic increase in health care financing by international aid organizations all contributed to weaken public health systems (Bloom, 2009).

At the dawn of the 21st Century, with most poor countries’ public health systems thoroughly gutted, the global community adopted the exceedingly ambitious Millennium Development Goals (MDGs). The MDGs set global targets for reducing child mortality,
improving maternal health, and combatting HIV/AIDS, malaria, and other diseases, among other priorities. A consensus emerged that stronger health systems would be key to achieving improved health outcomes (Travis et al., 2004). In 2000, the WHO published its World Health Report focused on “Health Systems: improving performance” (World Health Organization, 2000). The report stressed that, while the private sector has the potential to play a positive role in improving health system performance, the ultimate responsibility for the performance of a country’s health system falls on the state. In this view, “stewardship” encompasses defining the vision and direction of health policy, exerting influence through regulation and advocacy, and collecting and using information. At the same time, the report acknowledged the limits that governments face in the context of a shift from centrally-planned to market-oriented economies, reduced state intervention in national economies, fewer government controls and more decentralization. Since the publication of the World Health Report in 2000, the WHO has devoted several subsequent issues to various aspects of health systems strengthening (e.g., its 2003 report, its 2006 report on the global health workforce, and its 2010 report on health system financing). Other actors (e.g., the Rockefeller Foundation, Oxfam) have entered into the debate around the role of the state in providing health for populations (Lagomarsino, Nachuk, & Kundra, 2009a; Marriott, 2009). Meanwhile, in an effort to inform health systems strengthening, the global health community has undertaken the task of better defining the scope of health systems. The health systems literature is replete with frameworks to describe the components, functions, and goals of health systems (Lagomarsino, Nachuk, & Kundra, 2009b; Murray & Frenk, 2000; Shakarishvili et al., 2010; World Health Organization, 2007). Health systems strengthening strategies have
proliferated, ranging from financing mechanisms (e.g., vouchers (Bellows, Bellows, & Warren, 2011; Lenel, Griffith, & Anschütz, 2007) and community-based health insurance (Gnawali et al., 2009)); efforts to improve the performance and regulation of health professions (Dussault, 2008; Rowe, de Savigny, Lanata, & Victora, 2005); community participation in health system accountability (e.g., community health watch (Aziz, 2009) and community-based monitoring/provider report cards (Bjorkman & Svensson, 2009; McNamara, 2006)); and innovations in service delivery by eHealth, mHealth, and ICT-based strategies (Blaya, Fraser, & Holt, 2010; Crean, 2010; Feder, 2010; Gerber, Olazabal, Brown, & Pablos-Mendez, 2010; Lucas, 2008; Shet et al., 2010). To improve its reach, health systems strengthening has been accompanied by efforts at the interface of health system and communities, and in community systems through, for example, deployment of CHWs, microfinance, and cash transfers. Tools and approaches (Alva, Kleinau, Pomeroy, & Rowan, 2009; Islam, 2007) – including the World Health Organization’s Assessment Instrument for Mental Health Systems (Kigozi, Ssebunnya, Kizza, Cooper, & Ndyanabangi, 2010; Saxena et al., 2007) – and case studies (Balabanova, McKee, & Mills, 2011; O. Bhattacharyya, McGahan, Dunne, Singer, & Darr, 2008; Dimovska, 2009) focusing on assessing health systems and measuring the impact of health systems strengthening abound.

In the last five years, increased urgency related to the impending MDG deadline has spurred renewed focus on health systems strengthening and a critical examination of the assumptions underlying current health systems strengthening efforts. Out of this landscape, systems thinking has emerged (Atun & Menabde, 2008; De Savigny & Adam,
2009; Leischow et al., 2008; Paina & Peters, 2011), ushering in new discourses around innovations and scaling up (Bloom & Ainsworth, 2010).

2.3.3 Social capital

Definitions for key social capital terms used in this dissertation are presented in Box 1. This dissertation borrows from Sara Ferlander’s (2007) overview of social capital, with her careful focus on how the different forms of social capital can affect health. In this work, social capital is conceived as being comprised of social networks (the structural component of social capital), and social support (“norms of reciprocity”) and social trust (the cognitive components of social capital). These three aspects of social capital are apparent in Putnam’s (1995) definition of social capital: “features of social organization such as networks, norms, and social trust that facilitate co-ordination and co-operation for mutual benefit” (p. 67). Social support can be conceptually divided into emotional, instrumental and informational support. While “social trust” typically refers to having confidence in other people, institutional trust is another important aspect of social capital, and is particularly relevant for the present work.

**Box 1. Definitions of key social capital terms as used in this dissertation**

**Social capital:** features of social organization such as [social] networks, [social support (“norms of reciprocity”)], and social trust that facilitate co-ordination and co-operation for mutual benefit (Putnam, 1995).

Social capital is related to existing community-level constructs from community psychology – **psychological sense of community, community competence, neighboring**, but the links have not been made explicit (Kawachi & Berkman, 2000).

**Cognitive vs. structural social capital:** some scholars divide social capital into cognitive and structural components; social trust and norms of reciprocity are considered the cognitive components of social capital, while social networks are the structural components.
Social networks: a network of personal relationships (“ties”); may be egocentric – the people (“alters”) connected to person of interest (“ego”) – or whole – all people and their connections within a social system; characterized by horizontal/vertical, formal/informal, strong/weak, bonding/bridging/linking distinctions (see text below and table in Appendix C).

Social support (norms of reciprocity): perception and actuality that one is cared for and has assistance available from other people; may be divided into emotional (including companionship), instrumental and informational (including advice) support.

Social trust: having confidence in other people; specific trust is a property of individuals and generalized trust is a property of collectives; institutional trust refers to confidence in formal systems.

Individual vs. collective: social capital theory is divided into two schools of thought: the “individual” school considers social capital to be the property of individuals and focuses on how individuals gain returns through access to social networks; the “collective” school considers social capital to be a collective asset and focuses on how networks, norms and trust are vital in the creation and maintenance of the collective asset; some social capital scholars (and this dissertation) focus on how social capital acts at both levels – De Silva et al. (2007) study both individual and community pathways leading from low social capital to common mental disorders – depression and anxiety – in four low-income countries.

Social cohesion: extent of connectedness and solidarity among people and groups in society; related to collective concept of social capital in that a cohesive society possesses social capital (in addition to the absence of latent social conflict) (Kawachi & Berkman, 2000).

Social networks are considered by most scholars to be the core element of social capital. Social networks can be conceptually distinguished by the direction of their ties, their levels of formality, the strength of their ties and diversity of their members.

Horizontal ties refer to those between members of equivalent power and status, while vertical ties link agents who are unequal in power and status. Formal ties link contacts within voluntary associations, while informal ties link friends, family, neighbors and colleagues. Ties that are multi-stranded and regularly maintained, for example those between immediate family members or close friends, are classified as strong ties, while ties that are single-stranded and maintained infrequently (e.g., those between
acquaintances) are classified as weak ties. Finally, bonding social capital is a function of networks that are similar with respect to certain demographic characteristics, while bridging social capital is based on connections between people across social groups. A sub-dimension of bridging social capital, linking social capital refers to vertical connections across social groups, that is, ties between people who are different demographically and with respect to status and power. A summary of these social network classifications appears in a table in Appendix C.

Conventionally, health research has focused on horizontal, informal and strong social networks and on the positive relationships between social capital and good health. It is important to acknowledge that social capital can potentially have neutral or even negative consequences (Kunitz, 2001). More recent work acknowledges that strong bonding networks can also have a deleterious impact on health, through increased mental and emotional stress and the promotion of unhealthy norms of behavior. Mitchell and La Gory (2002) hypothesize that participation in community groups may be burdensome to individuals in impoverished communities where resources are already stretched (Ferlander, 2007; De Silva, et al., 2007). Another explanation by Kawachi and Berkman (2001): social support entails role strain associated with reciprocal obligations to provide support to others.

It should be noted that social capital is a property of both individuals and groups. With respect to the former, studies focus on how individuals gain returns through access to social networks. At the collective level, research explores how networks, norms and trust are vital to creating and maintaining a collective asset. This latter view reflects a focus on social cohesion (Ferlander, 2007). The existence of these two levels of social
capital is evident in the empirical literature – some studies distinguish between individual and ecological measures of social capital (De Silva, et al., 2007; De Silva, et al., 2005). Ecological measures of social capital are often constructed by aggregating individual measures; a review of the literature linking social capital to mental illness (De Silva, et al., 2005) did not reveal a single ecological study that did not rely exclusively on an aggregation of individuals’ perceptions about their community. In addition, the observation that levels of aggregation often do not reflect respondents' definitions of their community is problematic.

2.3.3.1 Social capital and mental health

Current research linking social capital and mental health was preceded by research showing that expressed emotions of family members can influence the course and prognosis of mental illness. In particular, hostile responses by family members are associated with rehospitalization for schizophrenia and depression (Butzlaff & Hooley, 1998; J. H. Jenkins, 2003). By changing the emotional atmosphere in the home, the relapse rate can be reduced (L. Dixon, et al., 2000; Leff & Gamble, 1995). Though it does not employ an explicit social capital framework, this body of work emphasizes the importance of the social environment in impacting the course and treatment of mental illness.

Given the paucity of literature around mental illness in developing countries in general (evident in the section of this literature review on mental health) it is not surprising that the literature linking social capital to mental illness is restricted almost exclusively to high-income countries or urban areas of low- and middle-income countries. De Silva et al. (2005) review this body of work, finding strong evidence for an inverse
relationship between cognitive social capital and common mental disorders (depression and anxiety), and moderate evidence for an inverse relationship between combined (cognitive and structural) measures of social capital and common mental disorders. The results are more variable for individual level structural social capital, most likely reflecting the variability in which aspects of structural social capital are being examined.

In general, the existing social capital literature is characterized by serious methodological limitations. Most studies do not account for the multidimensionality of social capital, employing one-dimensional measures to represent social capital (e.g., membership in voluntary associations, generalized social trust) and ignoring important distinctions between bonding, bridging, and linking networks, for instance. Also, there is a lack of consistency in social capital indicators used across studies, and most use tools and measures that have not been validated. Perhaps most significantly, most studies are cross-sectional in design, making it difficult to determine the direction of causality between social capital and mental illness (i.e., does better social capital lead to improvements in mental health?, or does good mental health lead to increased social capital?) (De Silva, et al., 2005). An exception is provided by Giordano and Lindstrom (2011): using longitudinal data from British households, the authors find that generalized trust is protective against poor self-rated psychological health.

A rare example of research on this topic in a developing country context is provided by Becker and Lee (2002), who look at indigenous models for attenuation of postpartum depression using two case studies: Fiji and Hong Kong. Becker and Lee find that social support serves to attenuate postpartum distress and may even reduce the risk of developing postpartum depression. The authors are careful to caution that the findings
may not be generalizable to other cultures, hypothesizing that in some places, as the disappearance of rites of passage due to modernization and urbanization reconfigures the postpartum experience, the simplification or annulment of outdated cultural practices could free modern women from burdensome rituals that may no longer serve a purpose.

In a cross-sectional study across four locations (Peru; Ethiopia; Vietnam; and Andhra Pradesh, India), De Silva et al. (2007) find that individual level cognitive social capital is consistently associated across all four locations with halving of the odds of maternal common mental disorders (depression and anxiety). Valid methodological criticisms can be raised, not the least of which involves questions about what the cognitive social capital variable is actually measuring, i.e., is it possible that trust, social harmony, perceived fairness, and sense of belonging, all concepts used to create the cognitive social capital variable, are correlated with an unobservable personality trait (e.g., a positive outlook on life)?

2.3.3.2 Social capital and health-seeking behavior for mental illness

Scholars have suggested that social capital (variably in the form of social networks, social support, and social trust) should be considered a key factor in explaining how populations engage with health systems (MacKian, Bedri et al. 2004). Despite this call, research connecting the concepts remains sparse and is restricted to psychiatric service use by people with serious mental illness (Maulik, et al., 2009). In addition, there is very little consistency across studies regarding social capital and health-seeking behavior indicators, making it difficult to compare findings.

An early review of the literature concluded that a smaller social network and less support were associated with more frequent hospital admissions (Albert, Becker,
McCrone, & Thornicroft, 1998). Among psychiatric patients, less cohesive social structure was associated with a delay in recognizing psychological problems (Carpenter & White, 2002). Higher social network index scores, based on the number of contacts and frequency of interaction, are associated with accessing more inpatient psychiatric care in local hospitals and less inpatient and outpatient service in state psychiatric hospitals (Kang et al., 2007). Given the inconsistency in measures of social capital and health-seeking behavior in these works, it is difficult to make overarching interpretations of the relationships connecting social capital to aspects of health-seeking behavior.

In more recent work in the United States, Maulik et al. (2009) demonstrated that contact with the social network and higher levels of social support were associated with use of general medical services, while more social support was associated with a decrease in psychiatric service use. Woodward et al. (2008) find that, among African Americans and Caribbean Blacks in the US, those with relatively more people in their “informal helper network” are more likely to use both professional and informal support for mental illness. Measures of frequency of contact and subjective closeness were apparently not related to health-seeking behavior. This small body of literature emerges out of high-income country settings; to my knowledge, no such studies have been conducted in developing country settings.

2.3.3.3 Faith communities

A large body of work indicates strong positive associations between religious involvement and mental health outcomes, including self-rated depression (Koenig et al., 1992) and shorter time to remission of depression (Koenig, George, & Bercedis, 1998). With regard to health-seeking behavior, faith institutions may function as gatekeepers for
health care utilization (Taylor, Ellison, Chatters, Levin, & Lincoln, 2000). The effects of this may be beneficial in some cases, but harmful in others: faith groups may negatively influence patterns of informal and self-care, discourage professional health-seeking behavior, or promote inappropriate (e.g., delayed) use of services (Chatters, 2000).

In general, the theoretical and conceptual frameworks that account for these relationships can be grouped into four categories: lifestyle and health behaviors; social resources; coping resources and behaviors; and attitudes, beliefs and emotions. Of particular relevance to the current research are explanations involving social resources. Participation in faith groups may be accompanied by enhanced social resources, measured in terms of the size of one’s social network, frequency of interactions with network members, actual and anticipated exchange of social support, and positive perceptions of support relationships. Faith organizations serve as a natural forum for the development of supportive relationships and support mechanisms (Chatters, 2000). On the other hand, social relationships, particularly problematic ones, may be a source of distress (Ellison & Levin, 1998; Krause, Ellison, & Wulff, 1998; Krause, Morgan, Chatters, & Meltzer, 2000). Failure to conform to group norms, violations of expectations of social support exchanges, or support that is accompanied by a paternalistic attitude may have negative effects on mental health. In addition, the investment of significant time and money required by some faith groups may have negative impacts on social capital obtained from other sources (Chatters, 2000).

There is some question as to whether faith-based social support is intrinsically different than other forms of social support. Lim and Putnam (2010) attribute the positive connection between religion and life satisfaction to the social networks forged in
congregations and to strong religious identity. Possible explanations for these findings are related to characteristics common to congregational networks: participants engage in meaningful activities together; participants meet in specific a social context; congregational networks provide more effective channels of social support; congregational networks reinforce identity and sense of belonging. With respect to the last explanation, they assert “congregational social networks are distinct from other social networks only when they are accompanied by a strong sense of religious belonging. Conversely, a strong sense of identification enhances life satisfaction only when social networks in a congregation reinforce that identity.” Overall, the research highlights the fact that social contexts and identities in which networks are embedded shape social networks’ effects.

2.3.3.4 Community groups

Self-help groups, like the type commonly found in the study site, fall under the larger category of community-based risk management arrangements, defined as coordinated strategies used by groups of people for the purpose of protection against the adverse effects of risk (Bhattamishra and Barrett 2010). These arrangements are characterized by self-enforcing (unwritten) contracts made possible by repeated interactions between individuals living in close geographical proximity, effective peer monitoring, and fear of social sanctions. Bhattamishra and Barrett identify five types of arrangements that are commonly observed across the developing world, including: (1) informal mutual insurance (i.e., transfers made between households in the event of a shock or change in income), (2) insurance for major life events (e.g., funeral/burial societies, health insurance associations), (3) savings and credit arrangements, including
rotating or accumulating savings and credit associations and microfinance (microcredit, microsavings, and microinsurance) arrangements, (4) social assistance facilities (i.e., community-based charity), and (5) community-based provision of goods and services.

“Membership in voluntary associations” is one of the most commonly used indicators of social capital. Membership is theorized to give people access to horizontal, formal, and weak social networks. Claims on behalf of voluntary associations include their ability to bring people of equivalent status and power together for the purpose of facilitating cooperation and the creation and maintenance of a civil society and social capital (Putnam, 1993). They are seen to build civil society more effectively than informal social networks (Newton, 1997). However, critical scholars argue that membership in voluntary associations is an insufficient measure of social capital because it fails to acknowledge alternative (and emerging) forms of social capital that take the place of participation in voluntary associations and may work just as effectively to build social cohesion; moreover, it fails to acknowledge the burden that membership in voluntary associations places on people with relatively less time and fewer resources (Gidengil & O'Neill, 2006). In practice, studies investigating its relationship with various outcomes, including mortality in the United States (Kawachi, Kennedy, Lochner, & Prothrow-Stith, 1997) and self-reported health, psychological health, and subjective well-being in China (Yip et al., 2007), have produced inconsistent results.

2.3.4 The therapeutic landscape of Siaya

People in Siaya seek health and well-being at the confluence of several interacting systems, making up a complex therapeutic landscape. The “modern” (allopathic) health system, which had its origins in British colonial rule (Boro Dispensary is one of the
oldest health centers in the country, built by the British colonial government in the 1930’s) (D. W. Cohen & Odhiambo, 1989), is pervasive yet inadequate. Current underfunding of the government health sector has contributed to a rise in private participation in allopathic care and reflects a broader global trend in private sector involvement in health care (Lagomarsino, et al., 2009a). The indigenous health system, made up of both healers and local knowledge of herbal and folk remedies passed down from generation to generation, is waning yet persistent. Government criminalization of “witchcraft”, denigration of “tradition” by the mission churches (Mwaura, 2004), and the salience of modernizing forces have combined to degrade indigenous medicinal knowledge. Yet, use of indigenous healing persists, as documented in the literature on traditional medicine (Geissler et al., 2000; Johns, Kokwaro, & Kimanani, 1990; R. J. Prince et al., 2001; Sindiga, Nyaigotti-Chacha, & Kanunah, 1995) and in recent fieldwork by the author: 66% of our surveyed Siaya households used a healer or herbal remedy in the past four weeks (Murphy & Peacock, 2010).

Meanwhile, the modern health and development apparatus is growing in Siaya. Well-known development agencies such as World Vision and Kenya Red Cross are present throughout the district. Siaya District neighbors Africa’s first Millennium Village – Sauri Village – started in 2004 and continuing with infusions of external aid (Millennium Villages). Other national and foreign organizations play an explicit role in Siaya’s government health system: the Kenya Medical Research Institute (KEMRI) and the US-based Centers for Disease Control (CDC) are engaged in malaria vaccine trials and research on drug alternatives to prevent malaria in HIV-positive, pregnant women. KEMRI/CDC Land Rovers and well-equipped fieldworkers are common sights on the
rural roads; a $50 million research facility was recently built at Siaya District Hospital (SDH) (Dickson, 2010). The influx of donor funding for HIV and malaria has spawned a profusion and expansion of non-governmental and community-based organizations that target “orphans and vulnerable children”, livelihoods and food security. These organizations – once authentic manifestations of local self-help spirit – have become an integral part of modern allopathic service delivery. They provide jobs and fill the space created by public underinvestment in health care, representing new forms of “philanthrocapitalism” (Bishop & Green, 2008).

Christian faith and religious institutions constitute another component of Siaya’s therapeutic landscape. Christianity has a long and complex history in western Kenya. The Church Missionary Society spearheaded penetration of Christianity into the heart of East Africa in 1844 and operated out of the Ng’iya, the commercial hub of Southeast Alego Location, for many years. Christianity was later aided by the European era of exploration and colonization, which facilitated the entry of Protestant and Catholic missionaries from Europe and North America, and the East African revival, which swept through Uganda and Kenya in the 1940s. In response to rising anti-colonial sentiment in the early- to mid-twentieth century, African Independent Churches (AICs) began to spring up throughout western Kenya. AICs are Christian churches that originate in Africa and have no foreign financial or ecclesiastical control; they start as a result of African initiative in African countries, but may be affiliated to wider bodies with non-African members. For the most part, they are marked by their retention of an African ethos (Mwaura, 2004). More recently, the AICs have incorporated neo-Pentecostal values and practices, transmitted through close relationships with evangelical churches in
the United States (Hearn, 2002; Hofer, 2003; Mwaura, 2004). Taxonomic details of the churches aside, it is clear that AICs have become a substantial and still growing actor in the religious landscape, with 25% of Kenyan Christians belonging to an AIC (Mwaura, 2004). While the so-called mainline churches – e.g., Pentecostal, Eastern Orthodox, Roman Catholic, Protestant Reformation – advocate a biomedical approach to health, many of these indigenous churches incorporate an African concept of holistic healing into their doctrines; scholars suggest that this fact accounts for widespread conversions and burgeoning membership (Hoehler-Fatton, 1996; Mwaura, 2004; Ndung’u, 2009).

This therapeutic landscape exists against a backdrop of culture and tradition (Prince, 2008); of modernizing, globalizing, and urbanizing forces (Cohen & Odhiambo, 1989); and of dramatic changes in the national political stage, typified by the adoption of a new Kenyan constitution in 2010. These forces create hybrid identities and social institutions that blend indigenous – local, Luo – knowledge, culture and practices with international and Kenyan national cultures, knowledges, policies and practices.
CHAPTER 3: METHODS

Modern science’s most enduring contributions have been concepts rather than causal inferences, and the most fecund concepts have originated in case-based rather than variable oriented research. (Schrank, 2006, p.23)

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3.1 Overview of methods

I used a mixed-methods case study approach to explore how women navigate the therapeutic landscape for depression. I relied on in-depth interviews with four types of actors in Siaya: (1) women experiencing clinically-significant depressive symptoms (n=14; a series of three interviews with each woman); (2) members of their social networks (n=13, single in-depth interview); (3) therapeutic landscape actors (n=15, single in-depth interview), ranging from formal, allopathic providers to informal, indigenous or religious healers (people outside the formal and informal health system, but representing the range of informal responses to depression, e.g., religious leaders and self-help group leaders, are also included in this category); and (4) key informants (n=5, one interview) including survivors of depression and community elders well-placed to provide information on the social, cultural, and historical context of the study. I collected verbal daily diaries from the participants by mobile phone over three weeks; these helped to provide more detail around health-seeking behavior, interactions with their respective social networks and receipt of social support. I conducted focus group discussions (n=3) at the outset of fieldwork to establish boundaries for the therapeutic landscape and to clarify local terms and concepts related to depression. Fieldwork took place over three months in the summer of 2012. Fieldwork activities were centered on Southeast Alego location in Siaya District.

3.2 Study site
Siaya District, located in Nyanza Province in western Kenya, is one of the poorest districts in Kenya. It is home to the Luo tribe, the third largest ethnic group in Kenya (United States Central Intelligence Agency, 2011). Historical and present-day political marginalization of western Kenya is evident in the deteriorating infrastructure and the vast distances between health facilities. Standard indicators of public health and development are poor in Siaya: HIV prevalence, child mortality, doctor-to-patient ratio, and life expectancy are among the worst in Kenya (Ministry of State for Planning, 2009).

While the political boundaries within Kenya are in a state of seemingly constant flux, at the time of fieldwork Siaya District was made up of seven administrative “Locations” (Central Alego, South Central Alego, South Alego, South East Alego, East Alego, North Alego, and Siaya Township), which were further subdivided into 29 sublocations. Most of the fieldwork activities took place in Southeast Alego location, along
a newly paved road connecting Southeast Alego’s commercial hub, Ng’iya, to Kogelo Nyang’oma, the Obama family village. Siaya town, located at the end of a poorly-maintained tarmac road that connects the district to Kisumu, is the district capital. Banking and internet services, a district hospital, and a transportation hub attract people to the town from surrounding communities, some very remote and seemingly ignored by the health and development apparatus, others heavily targeted by development efforts and undergoing rapid social change.

3.3 Research assistants

I hired two female research assistants to assist with fieldwork – I refer to them as “FO” and “MO” in the quotations that appear throughout this dissertation. Both women were young (under 30), Luo, and well-educated (one had received a Bachelor’s degree in Anthropology, the other was studying toward a Bachelor’s degree in Sociology at the time of fieldwork). One research assistant was from the study location; the fieldwork benefited from her knowledge of local norms and institutions, and from her personal and professional contacts in the area. The other research assistant came from a village in South Nyanza, a different district far from Siaya across Lake Victoria. Her ability to offer comparisons to the situation in her home village was invaluable in interpreting the results. I gave the research assistants extensive training related to the research purpose, data collection instruments and aids, and ethical issues, including procedures for properly obtaining consent, maintaining privacy and confidentiality, and protecting participants’ well-being.

3.4 Focus group discussions
I held three focus group discussions in community locations: a church, a primary school, and an outdoor classroom at a hospital. I selected participants purposively from the personal and professional contacts of one of the research assistants. I used maximum variation sampling to achieve sociodemographic and religious diversity. Focus groups were made up of five, six, and five adult female participants, respectively. Sociodemographic information for each participant appears in a table in Appendix D. The research assistants co-facilitated the discussions in Dholuo. Each discussion lasted approximately two hours. One particularly lively group requested to hold another discussion to cover topics that could not be covered in the initial discussion; I accommodated their request.

I used focus group discussions to clarify concepts around social capital and depression, and to explore the scope of the health system. I focused questions on the forms of social capital most salient in this particular cultural context. Because faith-based social capital was hypothesized to be an important component of the conceptual framework underlying the research, I also used focus group discussions to gain more clarity around faith in this cultural context. Given the importance of integrating local illness concepts and standardized case definitions, I used the focus group discussions to explore what it means to suffer from depression in this particular social context. Finally, I used the focus group discussions as an opportunity to explore the scope of the health system around mental illness. The focus group discussion guidelines are presented in Appendix E. The research assistants translated the guidelines to Dholuo prior to administration so that any difficulties in translation could be resolved collaboratively.
I was present to observe and audio-record the discussion and the research assistants took notes. Immediately following each discussion, the research assistants wrote summaries of the main points of the discussion, and noted their reactions to the information discussed. I used these written summaries and the notes taken during the discussions as the basis for a debriefing session with the research assistants following each discussion. Ultimately, I used group discussion results to inform the revision of in-depth interview guidelines and daily diary templates/guidelines, guide the selection of participants for in-depth and therapeutic landscape interviews, and help interpret findings.

### 3.5 Depression screening

I screened potential research participants using the Beck Depression Inventory (BDI) (Beck, Steer, & Brown, 1996a, 1996b). The BDI addresses both affective and somatic aspects of depression and gives a categorization of depression severity (ranging from minimal to severe). The BDI is comprised of 21 items measured on a 4-point response scale (ranging from 0 to 3). For each item, subjects are asked to choose the statement that best describes how they’ve been feeling during the past two weeks.

Example prompts include:

0: I do not feel sad.
1: I feel sad much of the time.
2: I feel sad all the time.
3: I am so sad or unhappy that I can’t stand it.

Another set of prompts are “0: I am not discouraged about my future. 1: I feel more discouraged about my future than I used to be. 2: I do not expect things to work out for me. 3: I feel my future is hopeless and will only get worse.” Another is “0: I do not feel like a failure. 1: I have failed more than I should have. 2: As I look back, I see a lot of failures. 3: I feel I am a total failure as a person.”
Item scores are summed across all items to yield a score for the whole inventory. Those with aggregate scores ranging from 0 to 13 are considered to have symptoms consistent with “minimal” depression; 14 to 19, “mild” depression; 20 to 28, “moderate” depression; and 29 to 63, “severe” depression. The BDI has good psychometric properties and has been used extensively in mental health research (Beck, Steer, & Brown, 2004; Dozois, Dobson, & Ahnberg, 1998), including in recent research in Kenya (David M. Ndetei, Khasakhala, Mutiso, & Mbwayo, 2010). Based on findings from the initial focus group discussions that suggested that items in the BDI were relevant for this cultural context, I did not modify the content of the BDI in any way for this study (the questionnaire is presented in Appendix F). Prior to administration, the research assistants translated the BDI to Dholuo and inconsistencies in translation were resolved through discussion. The BDI demonstrated good internal consistency in this study (Cronbach’s alpha = 0.77).

I recruited potential research participants from a local dispensary, Osiepe group (a women’s self-help group), and lists of potential participants provided by the Anglican priest and two faith healers from the Legio Maria tradition, all of whom were identified in the initial focus group discussions to be key actors in the therapeutic landscape. At the dispensary, I enlisted the clinical officer in charge to assist with recruitment. I gave him numbered referral slips to distribute to all female patients meeting the age criterion (age 18 or older) and instructed him to direct the patients to a private room where the research assistants waited to explain the study, obtain informed consent, and screen those consenting to participate. In addition, the research assistants screened every member of Osiepe group, either outside their group meeting or at their respective homes. Similarly,
the research assistants contacted and screened all potential participants appearing on the list from one of the faith healers in their respective homes. Finally, both the Anglican priest and the second faith healer invited all potential participants on their lists to their own homes, where the research assistants screened them individually.

The research assistants verbally administered the BDI to a total of 65 women. Two women did not complete the screening; the research assistants terminated their screening interviews when they divulged suicidal thoughts or wishes and made appropriate referrals. Of the 65 women screened, 12 were from the local dispensary, 34 were members of Osiepe group, 4 were referred to the research team by the Anglican priest, and 15 were referred by one of two faith healers enlisted to help with recruitment.

I collected basic demographics on the women who were screened; those appear in Table 1. The mean age of those screened was 43. Most had completed primary school (n=54), but very few had completed secondary school or higher (n=9). The most common religions represented in the sample were Roman Catholic (n=14), Roho (n=14), and Anglican (n=9). The majority of the sample was married or cohabitating (n=53). Only one woman was single and 11 were widowed. Research assistants recorded contact information for those with clinically-significant depressive symptoms (BDI score > 13) and informed them that they might be re-contacted to participate in the next part of the study. In addition to administering the screening tool, research assistants kept notes on any critical life circumstances mentioned by participants during the course of the screening. I used this information to select participants for the next part of the study.

Table 1. Sociodemographic characteristics of screening participants (n=65)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
</tr>
</thead>
</table>

54
Mean age = 43

Education
- Some primary: 10
- Completed primary: 30
- Some secondary: 15
- Completed secondary: 7
- College/university: 2

Religion
- Roman Catholic: 14
- Pentecostal: 1
- Anglican: 9
- Roho: 14
- Legio Maria: 5
- Seventh Day Adventist: 2
- King’s Outreach: 2
- Coptic Orthodox: 4
- Church of Christ in Africa: 4
- APECC: 3
- Other: 7

Marital status
- Married: 45
- Not married, but cohabitating: 8
- Single: 1
- Widowed: 11

Frequencies tallied from all BDI screening responses

3.6 Selection of participants for in-depth interviews

Of the 63 women who completed screening, 42 were experiencing clinically-significant depressive symptoms (BDI score > 13). Of those 42, I selected 14 to participate in the in-depth interviews. In selecting the 14 participants, I made every effort to incorporate variation in depression severity, age, religion, and socioeconomic status (i.e., maximum variation sampling) as those were assumed to affect social capital and health-seeking behavior for depression. In addition, I used supplemental information about critical life circumstances gleaned during the screening interviews to select
participants. For example, because initial group discussions indicated that the relationship between a mother-in-law and daughter-in-law is critical in both influencing a young woman’s mental health and shaping the social relationships she forms in her matrimonial home, I selected a mother-in-law/daughter-in-law dyad for participation in the in-depth interviews. BDI scores, sociodemographic characteristics, and rationales for selection for the 14 participants are presented in a table in Appendix G.

3.7 In-depth interviews

The research assistants interviewed each participant three times in Dholuo. Interviews were spaced by 3 weeks and each lasted 60-90 minutes. The initial interview focused on demographic and household characteristics, and religious experience and practice. The second interview documented important social relationships, perceived social support and social trust, and patterns of health-seeking behavior, in general and for depression specifically. The final interview elicited participants’ life histories, with particular attention to history of depression, history of antecedent factors, and history of responses to depression. In-depth interview guidelines are presented in Appendix H. The research assistants translated guidelines to Dholuo prior to administration so that any difficulties in translation could be resolved collaboratively.

Research assistants audio-recorded all interviews. Immediately following each interview, the research assistants wrote summaries of the main findings of the interview, and noted their reactions to the emerging information. I used these written summaries and the notes taken during the interviews as the basis for a debriefing session with the research assistants following each interview.

3.8 Diaries
After the first interview, I asked participants to participate in the diary portion of the study; all 14 women consented. The research assistants had daily verbal contact with participants by mobile phone over the course of three weeks. Diary oral interviews lasted less than 5 minutes. I gave participants Ksh. 50 per week to offset the cost of mobile phone charging. Even with this assistance, diary completion was hindered by technical issues: research assistants frequently found that participants’ phones were switched off due to lack of battery charge. In addition, poor network connectivity and low rates of phone ownership (several participants had to borrow a phone to complete the daily interview) contributed to lower rates of completion. Despite these challenges, 239 of 294 attempted diary contacts (81%) were successful. On average, over the 21 days of diary completion, each participant could not be reached 3.9 times (range 1-7). When a participant was finally reached, she was asked to recall information from the missed days. Positive feedback from the participants suggests potential utility in incorporating verbal mobile phone contact into a mental health intervention.

Diaries focused on social network interactions, social support received, and all responses to depression (even those that were small-scale and ordinary). The diary instrument is presented in Appendix I. The research assistants translated the instrument to Dholuo assistants prior to administration so that any difficulties in translation could be resolved collaboratively. The research assistants conducted the diary interview in Dholuo and took notes on the diary summary form directly in English. Following each call, I reviewed findings and held informal discussions with the research assistants to elicit further information as needed.

3.9 Social network interviews
I conducted in-depth interviews with members of the primary participants’ social networks. I selected participants for this part of the study using theory-based sampling: I attempted to incorporate variation based on bonding/bridging/linking, strong/weak, informal/formal, and vertical/horizontal relationships. I selected one social network participant for each primary participant (a description of the relationships between primary and social network participants is presented in a table in Appendix J). Because some selected individuals did not live near the study area, three interviews were conducted by mobile phone. Of the 14 participants selected for social network interviews, 13 were reached and completed an interview. The one interview that could not be completed was hindered by poor mobile phone network connectivity. The research assistants conducted all but one of the 13 interviews in Dholuo. The remaining interview was conducted by a research assistant in English. Interviews lasted 30-60 minutes.

Social network interviews focused on the nature, frequency and intensity of emotional, instrumental, informational support given to the primary participant; social companionship provided; attitudes toward depression and health-seeking behavior; and the motivations for and barriers to providing advice and help. Social network interview guidelines are presented in Appendix K. The research assistants translated the guidelines to Dholuo prior to administration so that any difficulties in translation could be resolved collaboratively.

The research assistants audio-recorded all interviews, including those conducted by mobile phone. Immediately following each interview, the research assistants wrote summaries of the main findings of the interview, and noted their reactions to the emerging information. I used these written summaries and the notes taken during the
interviews as the basis for a debriefing session with the research assistants following each interview.

3.10 Therapeutic landscape interviews

I conducted in-depth interviews with key actors representing the various components of the “therapeutic landscape”. I identified potential participants for this category through personal and professional contacts in the community and from the pool of therapeutic landscape actors mentioned in the focus group discussions. I selected participants purposively using maximum variation sample: I made every effort to incorporate variation based on healing modality, type of institution, and professional category (e.g., doctor, nurse, faith healer, etc.). In addition, I included key actors specializing in mental health (e.g., the psychiatric staff at Siaya District Hospital) in the sample. In total, I enrolled 15 participants in this category. A list of the therapeutic landscape interview participants is presented in a table in Appendix L.

Interviews lasted 30-60 minutes and focused on the type and quality of available mental health services and support, attitudes toward depression and toward the range of common responses to depression, and the barriers to effective care. The therapeutic landscape interview guidelines are presented in Appendix M. The research assistants translated the guidelines to Dholuo prior to administration so that any difficulties in translation could be resolved collaboratively.

I conducted all therapeutic landscape interviews. Of the 15 interviews completed, I conducted six in English. The remaining nine interviews were conducted in Dholuo with the assistance of a research assistant acting as a translator. I audio-recorded all interviews. Immediately following each interview that they attended, the research
assistants wrote summaries of the main findings of the interview, and noted their reactions to the emerging information. I used these written summaries and the notes taken during the interviews as the basis for a debriefing session with the research assistants following each interview they attended.

3.1 Key informant interviews

I conducted interviews with key informants, including three women who had previously suffered from depression but who now self-identified as being ‘healed’ (i.e., depression survivors) and two community elders well-placed to provide information on the social, cultural, and historical context of the study. I identified four of these individuals through personal contacts in the study area; I identified one depression survivor when she revealed her past struggles with depression during a social network interview.

Interviews lasted 30-60 minutes. Interviews with depression survivors focused on their depression story, with particular focus on their path to healing. Interviews with community elders focused on social, cultural, and historical contextual issues that would help with interpretation of findings. All interviews were semi-structured. I conducted all interviews, one with a depression survivor in English; the remaining four were conducted in Dholuo with the assistance of a research assistant acting as a translator. I audio-recorded all interviews.

3.12 Participant observation

Throughout the three months of fieldwork, I employed participant observation to supplement the group discussion, interview, and diary data. I lived and took meals with a Luo family. This offered me a window into Luo family life and was invaluable in aiding
interpretation of the data. In addition, I immersed myself in several events relevant to the research, including a mobile mental health clinic where I observed clinician-patient interactions, and a funeral of a young mother who died of AIDS-related complications. The research assistants and I wrote field notes immediately following all observations. These notes aided with interpretation of findings.

At various points in the fieldwork, I drew from secondary data, for example, monthly reports of numbers of patients attending the mobile mental health clinic, a list of non-governmental organizations working in the study area, and a written summary of the founding of a local dispensary. I incorporated these into the body of data for this research.

Throughout all phases of the fieldwork, I wrote a personal field diary and engaged in on-going discussions with Luo colleagues and research assistants. I consulted field diary entries and other notes to aid with interpretation of findings. I shared preliminary findings with the study participants at the conclusion of the fieldwork and sought their reactions to the findings and their input on the directions for future action to address depression.

3.13 Transcription, translation, and coding

All interviews and group discussions were audio-recorded. Upon conclusion of the fieldwork, Dholuo recordings were transcribed and translated to English by the research assistants. I transcribed the English recordings. I imported all transcripts into Atlas.TI (7.1.6) for coding.

I based the initial coding scheme on the research questions and elements in the social capital framework. I supplemented this initial list of codes with codes for themes that emerged from the data (i.e., a “grounded” approach (Glaser and Strauss (1967))). The
full list of codes is presented in Appendix N. I considered coding complete when all incidents could be readily classified, when categories were “saturated”, and when a sufficient number of regularities occurred (Miles & Huberman, 1994). Throughout the coding process, I wrote notes and memos as personal, methodological and substantive concepts emerged.

3.14 Data analysis

I summarized the quantitative data collected in the course of the fieldwork (e.g., from the BDI, from the household roster, from the daily ratings of self-perceived health in the diaries) using frequencies, means, etc. as appropriate. That descriptive data is presented throughout this dissertation as necessary to supplement the qualitative data.

I converted the daily diary summaries to a visual format in Microsoft Excel, with the information from each day appearing in a separate column. An example is presented in Appendix O. This format aided in the detection of patterns across time in the diary.

For much of the analysis, I relied on qualitative interpretation of constructs that are typically quantified. For example, I assessed socioeconomic status not by quantitative indicators, but by a global qualitative assessment of each participant’s livelihood strategies, household assets, housing materials, and access to remittances or other financial assistance in relation to that for all other participants. Similarly, in the absence of well-defined indicators on type of social network relationship, I relied on a qualitative assessment of how ‘similar’ the participant was to her alter (a person she listed in her social network) to characterize social network relationships as bonding, bridging, or linking. I gave a participant’s own judgments of her degree of similarity with an alter substantial weight in this determination. This means that that concepts of ‘difference’
and ‘similarity’ are individually-defined, potentially leading to inconsistencies in classification of types of bonds across participants.

To characterize participants’ social networks, I relied primarily on in-depth interview data, particularly those obtained in the second in-depth interview in the three-interview series. Participants were asked to list the five most important people in their lives. While some participants complied with this instruction, several participants listed fewer or more than five people. I included data for all people listed in this step here. It is impossible to know from the data whether those who listed exactly five people would have listed fewer or more had the instructions been more open-ended (e.g., “list the most important people in your life”), therefore comparisons on the basis of size of social network should be made with caution. I have also considered people mentioned in other parts of the in-depth interviews (e.g., in response to questions probing for those who give social support); thus, the social networks described in this dissertation are comprised of social relationships that were recalled both spontaneously and after probing.

An initial step in the analysis focused on within-case analysis – I considered together both the coded, qualitative and the descriptive, quantitative data pertaining to a particular participant and wrote a summary of the most salient information for that participant. Subsequent cross-case analysis allowed for the identification of concepts across the individual women, to generate overarching findings. Following cross-case analysis, I revisited individual cases with the purpose of identifying examples of overarching concepts and assessing concordance/discordance with the emerging themes.

3.15 Ethical procedures
I conducted this research with approval from the Tulane University Institutional Review Board and Kenyatta National Hospital’s Ethics Research Committee. All participants gave informed consent for their participation. To minimize the possibility of coercion and ensure voluntary participation, the research assistants, who were trained in proper consenting procedures, conducted the recruitment and consent process in Dholuo. Participants received compensation for their participation in group discussions (300 Ksh. = US$3.50), interviews (300 Ksh. per interview), and diaries (300 Ksh. per week); I determined compensation amounts through conversations with Luo colleagues about local research norms.

Privacy and confidentiality were maintained throughout the duration of the research. All discussions and interviews were conducted in private spaces. Audio recordings and project documents were stored in secure locations. There were no known breaches of confidentiality. I use pseudonyms throughout this dissertation and will continue to do so in future publications to protect the confidentiality of participants.

As per prior agreement with psychiatry staff at Siaya District Hospital, I referred women who indicated suicidal thoughts or wishes during the administration of the BDI to Siaya District Hospital for evaluation. Two such women were given referrals. One of those women was escorted to the hospital by a research assistant and received treatment. The other woman ignored multiple contact attempts by the research team.

In the next chapter, I draw on data from the group discussions, screening activity, and in-depth interviews to explore the experience of depression in Siaya.
CHAPTER 4: DEPRESSION in SIAYA

FO (Interviewer): Have you ever felt like you are depressed?
Patricia: I have felt that way many times.
FO: How do you feel now?
Patricia: In a human being, I feel [depression] must be there. If you don’t [experience depression] then you are dead.

In this chapter, I explore mental health from the perspective of my study participants in rural Kenya. I aim to impart an understanding of the pervasiveness of depression, of how it is experienced by women in the study site, and of popular conceptions of its underlying causes. This understanding will inform the subsequent investigation of how women navigate the therapeutic landscape for depression.

4.1 Depression prevalence

According to group discussion participants, depression is common and widespread. Participants expressed the notion that feeling depressed is unavoidable, a state that one must pass through by virtue of being alive (see quotation at chapter opening). Of the 63 women who completed screening, 42 (67%) were found to have clinically-significant depressive symptoms. Of those, 23 (55%) had symptoms consistent with mild depression, 17 (40%) with moderate depression, and 2 (5%) with severe depression (see Figure 2).

Figure 2. Beck Depression Inventory Scores among women in sample
4.2 Symptoms of depression

Group discussion participants listed the following symptoms of depression:\^3

- Sadness
- Deep thoughts
- Frowning, long face
- Disturbed
- Crying
- Withdrawn, isolated, lonely
- Acts strangely, not willing to talk
- Quietness
- Gestures, talks to herself
- Loses friends
- Irritability
- Absentmindedness
- Becomes sick now and then
- Continuous headache
- Weight loss, loss of appetite
- Helpless
- Seek extramarital affairs

These symptoms are related to several of the 21 symptoms assessed in the BDI.

In particular, sadness, crying, irritability, absentmindedness (“concentration difficulty” in the BDI), and somatic symptoms appear on this list. Several of the symptoms mentioned

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\(^3\) Group discussion participants also distinguished between “deep” and “shallow” depression. A woman who has “deep depression” does not eat, loses weight, isolates herself, doesn’t want to share her problems, is unhappy, talks to herself, cries, and has dry lips. In contrast, a woman suffering from “shallow depression” eats as usual, shares her problems, “can afford a smile”, and attends groups, but is depressed when alone.
by group discussion participants were related to social isolation (e.g., “withdrawn, isolated, lonely”, “acts strangely, not willing to talk”, “quietness”, etc.); these may correspond to the “loss of interest” item in the BDI that assesses loss of interest in people and activities. Two items appearing on this list are not represented in the BDI: “helpless” and “seek extramarital affairs.” Unfortunately, explanations for these items were not pursued. The extramarital affairs item may be related to an idea expressed elsewhere in the group discussions: women who engage in extramarital affairs are thought to suffer from depression because they experience guilt-related stress.

What is notable is the absence of certain BDI items in the list generated by group discussion participants. Symptoms related to BDI items of self-dislike, self-criticalness, and feelings of worthlessness were not mentioned by participants; nor were symptoms related to the pessimism, feelings of past failure, guilt feelings, and punishment feelings items. Their absence in the list generated by group discussion participants may reflect the fact that they are more abstract and internally experienced than the items that were mentioned, which tend to be expressed outwardly and are visible to others (e.g., crying, somatic illness, social isolation).

After they listed depression symptoms spontaneously, participants were presented with the list of items included in the BDI and asked if those items were indeed symptoms of depression. In two groups, none of the BDI items were contested. The remaining group insisted that indecisiveness, concentration difficulty, self-criticalness, self-dislike, and loss of pleasure were not “brought by depression.” An investigation of alternative explanations offered for these symptoms revealed no underlying pattern for this sub-set of symptoms – e.g., while indecisiveness was attributed to lacking courage, having a
psychological or physical impairment (i.e., head injury), or suffering from poverty (“lack can make a person not think straight”); concentration difficulty was seen to be the result of disparate causes, including laziness, lack of self-confidence, joint pain, hunger, or being mentally troubled or overwhelmed. Given this lack of an underlying pattern and the fact that only one group thought these symptoms were unrelated to depression, differences between symptoms of depression as listed by the group discussion participants and those that appear in the BDI were probably due more to poor lay knowledge among participants of depression symptoms than to a cultural difference in how depression manifests in the study site.

4.3 Depression in the screening

The screening revealed that sadness, tiredness/fatigue, and loss of interest in sex were the most commonly experienced symptoms (see Figure 3). It is important to note, given the average age of screening participants (age 43), that tiredness/fatigue and loss of interest in sex are also symptoms of aging. The former may also result from physical labor (e.g., hand-farming), in which most of the participants are engaged. However, the temporal framing of the question (“past two weeks”) should eliminate any bias introduced by these items. The least commonly experienced symptoms included suicidal thoughts or wishes, indecisiveness, and concentration difficulty.

The number of people who answered “3” (the highest response on the 4-point scale) to each item is pictured in Figure 4. If we take a score of 3 to indicate intensity of experience, loss of interest in sex and crying appear to be the most intensely experienced symptoms, followed by punishment feelings, loss of interest, and pessimism. The least intensely experienced symptoms include self-dislike, suicidal thoughts or wishes,
indecisiveness, changes in sleeping patterns, changes in appetite, and concentration difficulty.

Figure 3. Frequency of depression symptoms among women in sample

<table>
<thead>
<tr>
<th>Frequency of depression symptoms in BDI (n=63)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item</td>
</tr>
<tr>
<td>Sadness</td>
</tr>
<tr>
<td>Pessimism</td>
</tr>
<tr>
<td>Past failure</td>
</tr>
<tr>
<td>Loss of pleasure</td>
</tr>
<tr>
<td>Guilty feelings</td>
</tr>
<tr>
<td>Self-critical feelings</td>
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<tr>
<td>Suicidal thoughts or wishes</td>
</tr>
<tr>
<td>Crying</td>
</tr>
<tr>
<td>Agitation</td>
</tr>
<tr>
<td>Loss of interest</td>
</tr>
<tr>
<td>Indecisiveness</td>
</tr>
<tr>
<td>Worthlessness</td>
</tr>
<tr>
<td>Loss of energy</td>
</tr>
<tr>
<td>Irritability</td>
</tr>
<tr>
<td>Changes in appetite</td>
</tr>
<tr>
<td>Tiredness</td>
</tr>
<tr>
<td>Concentration difficulty</td>
</tr>
<tr>
<td>Loss of interest in sex</td>
</tr>
</tbody>
</table>

Figure 4. Number of women in sample answering “3” for items in BDI

4 Of the 37 women who indicated changes in sleeping pattern, 33 (89%) had been sleeping less than normal. Of the 28 women who revealed changes in appetite, 26 (93%) were experiencing decreased appetite.
All symptoms appearing in the BDI were ranked by frequency (number of people answering > 0) and intensity (number of people answering “3”). Items that appeared in the top tertiles of frequency and intensity were considered “frequent” and “intense”, respectively. Table 2 lists symptoms by frequency and intensity. The numbers in parentheses next to each symptom indicate the ranks for frequency and intensity, respectively. Of note is the frequency and intensity with which loss of interest in sex is experienced. Pervasive marital strain and advanced age, and not depression directly, may underlie this finding.

Table 2. Frequency and intensity of depression symptoms in BDI

<table>
<thead>
<tr>
<th>Item</th>
<th>Frequent (top tertile)</th>
<th>Not frequent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intense (top tertile)</td>
<td>Pessimism (5,5)</td>
<td>Self-criticalness (9,7)</td>
</tr>
<tr>
<td></td>
<td>Crying (6,2)</td>
<td>Agitation (10,7)</td>
</tr>
<tr>
<td></td>
<td>Tiredness/fatigue (3,6)</td>
<td>Punishment (17,3)</td>
</tr>
<tr>
<td></td>
<td>Loss of interest in sex (2,1)</td>
<td>Loss of interest (18,3)</td>
</tr>
<tr>
<td>Not intense</td>
<td>Loss of pleasure (6,9)</td>
<td>Loss of energy (8,13)</td>
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<tr>
<td>-------------</td>
<td>-----------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Guilty feelings (4,9)</td>
<td>Worthlessness (14,9)</td>
<td></td>
</tr>
<tr>
<td>Sadness (1,13)</td>
<td>Irritability (11,9)</td>
<td></td>
</tr>
<tr>
<td>Past failure (13,13)</td>
<td>Self-dislike (15,16)</td>
<td></td>
</tr>
<tr>
<td>Suicidal thoughts or wishes (21,16)</td>
<td>Indecisiveness (19,16)</td>
<td></td>
</tr>
<tr>
<td>Changes in sleeping patterns (11,16)</td>
<td>Changes in appetite (15,16)</td>
<td></td>
</tr>
<tr>
<td>Concentration difficulty (20,16)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Frequency and intensity rankings generated from all BDI responses

### 4.4 Depression in the daily diaries

During each diary contact, interviewers marked the symptoms that were experienced by participants that day. The number of times each symptom was mentioned is depicted in Figure 5. Sadness was by far the most frequently experienced symptom (mentioned on 27% of diary days), followed by tiredness/fatigue (19%), changes in sleeping pattern (11%), agitation (11%), and loss of energy (10%). While the frequent experiences of tiredness/fatigue and loss of energy may be related to the high morbidity (high number of illness episodes) seen in the diary, the prevalence of sadness indicates that emotional distress is common. Frequent experiences of sadness and tiredness/fatigue are consistent with the results of the screening (see above). Other relative frequencies are inconsistent across the two data sources. In particular, while pessimism, crying, loss of interest in sex, loss of pleasure, and guilty feelings were mentioned frequently in the screening, they did not appear as frequently in the diary. On the other hand, agitation, loss of energy, and changes in sleeping pattern were detected frequently in the diary but appeared only infrequently in the screening. These inconsistencies may be due to differential importance ascribed to particular symptoms. For example, changes in sleeping patterns may be experienced and remembered on a daily basis, but may not be
notable enough that they are recalled in a retrospective screening with a two-week reference period. On the other hand, a bout of crying (which is evidently an intensely experienced symptom – see Table 2) may be notable enough to be recalled in response to a screening, but may not occur often enough for any single woman such that it would appear frequently in the daily diary. Feelings of worthlessness and suicidal thoughts and wishes were not seen at all in the diary, which is consistent with the results of the screening.

Figure 5. Frequency of depression symptoms mentioned in daily diaries

4.5 Depression in the in-depth interviews

In-depth interview data confirm a high level of psychological distress among participants. The quotations appearing in Box 2 illustrate how participants express poor
mental health in terms of sorrow, pain, crying, hopelessness, and suicidal thoughts. Even in the unlikely event that the BDI did not identify women who were suffering from *clinical* depression, it undoubtedly identified women who were suffering from intense psychological distress, as evidenced by the way they described their emotional states.

**Box 2. Quotations indicating psychological distress**

<table>
<thead>
<tr>
<th>Interviewer (FO)</th>
<th>Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you think people were against you because you did not have a child?</td>
<td>Evelyn: Yes, I have always believed so. [My co-wives] were given cows because they had children to take care of, while I did not have any child. My heart was pained. Even when I was in the garden I would spend good part of my time just crying.</td>
</tr>
<tr>
<td>Have you ever felt like you have depression?</td>
<td>Millicent: Yes, just the past pain I have explained earlier.</td>
</tr>
<tr>
<td>How do you feel right now?</td>
<td>Millicent: I’m just there. There’s nothing good.</td>
</tr>
<tr>
<td>Are you depressed now?</td>
<td>Millicent: It’s there.</td>
</tr>
<tr>
<td>Tell me about the stories that portray your light moments.</td>
<td>Millicent: Nyaseme, I have looked for something to make me happy but I’m defeated. My life is full of sorrows and problems.</td>
</tr>
<tr>
<td>So you don’t have any delightful story in your life?</td>
<td>Millicent: No, none. There is nothing like that.</td>
</tr>
<tr>
<td>I would like you to think of your future and tell me a possible story about your positive future.</td>
<td>Beatrice: You know I cannot tell what will happen in the future, but if life continues the way it is, then I don’t see anything good in future.</td>
</tr>
<tr>
<td>How important is your religion to you in general?</td>
<td>Susan: My religion has helped me a lot because there is a time before I got saved, I had some problems and I just felt like wiping myself out of this world, but by the time I got saved, I no longer had such thoughts.</td>
</tr>
<tr>
<td>If the church is not there, you can decide on committing suicide but when you are in the church they can help you not to commit suicide by giving you proper advice.</td>
<td>Agneta: I have said earlier that if the church is not there, you can decide on committing suicide but when you are in the church they can help you not to commit suicide by giving you proper advice.</td>
</tr>
</tbody>
</table>

**4.6 Mental illness in Luo culture**
The Luo are not unfamiliar with mental illness. In fact, traditional Luo culture allows for several varieties of atypical mental states. *Neko*, for example, describes a person who is ‘mad’ - possessed by evil spirits and exhibiting loudness, anger and violence. In nearly every village throughout Siaya, at least one *janeko* wanders the streets in dirty, tattered clothing, frightening small children into hiding.

Perhaps the most commonly discussed mental affliction, *juogi* describes a condition in which people are tormented by bad ancestral spirits. *Juogi* can emerge in childhood or adulthood. The afflicted shakes vigorously, acts rowdy, and runs mad. *Juogi* has several distinct causes. Bad deeds may appear as *juogi* in the grandchildren of the perpetrator. For example, if a man is a witch doctor, the spirits of the people he killed during his lifetime may come to torment his grandchildren. Another form of *juogi* occurs when ancestral spirits want an infant to be named after them. If the parents fail to oblige the spirits, they become angry and cause disease and death of the child. There may be more than one ancestral spirit wishing to serve as eponym. In this scenario, a spiritual war may be carried out between the ancestors. Some community members (usually traditional healers or members of the Roho church) have the talent of determining which ancestor comes with good intentions, and casting away the bad ancestral spirits. A third type of *juogi* can be passed from person to person. When a person visits an *ajuoga* (witch doctor) to be cured of *juogi*, he/she may be washed with water. An unsuspecting person who later passes by that water may inherit the *juogi*.

‘Depression’ is translated as *bedo gi kuyo* (literally, “having sadness”), or alternatively, as *bedo gi paro mang’eny machando chuny* (literally, “having many thoughts that disturb the heart”), in the Luo language. Group discussion participants
distinguish between people afflicted with *juogi* and those suffering from depression. While the former (those with *juogi*) talk with the dead, speak in tongues, are loud, and appear “fat and healthy”, the latter (those with depression) speak intelligibly, are often silent, and lose weight. Participants also claim that while those who suffer from depression are always sad, people afflicted with *juogi* usually act normal and healthy and display their symptoms only about once per year. In addition, the perceived etiology of *juogi* and depression may differ. While *juogi* (like other Luo-recognized mental illnesses) is attributed to spiritual causes, the causes of depression appear to be predominantly social.

4.7 Causes of depression

Group discussion participants listed several causes of depression (see Table 3 below). Most often mentioned are those related to poverty – mention of “hunger”, “lack of essential things”, “unemployment” – and marital problems, such as “abuse/mistreatment by husband”, “lack of peace in the home.” Because of the frequency with which they were mentioned, the ways in which those two issues contribute to mental distress are discussed in more detail in the next sections.

<table>
<thead>
<tr>
<th>Table 3. Causes of depression according to group discussion participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Sickness - self and family member (especially child)</td>
</tr>
<tr>
<td>▪ Loss of loved ones (husband -&gt; widowhood, person from whom you received support)</td>
</tr>
<tr>
<td>▪ Death</td>
</tr>
<tr>
<td>▪ Financial strain - especially around school fees</td>
</tr>
<tr>
<td>▪ Hunger</td>
</tr>
<tr>
<td>▪ Poverty</td>
</tr>
<tr>
<td>▪ Lack of essential things (food)</td>
</tr>
<tr>
<td>▪ Unemployment</td>
</tr>
<tr>
<td>▪ Loneliness</td>
</tr>
<tr>
<td>▪ Guilty conscience - have wronged somebody</td>
</tr>
<tr>
<td>▪ Difficulty finding marriage partners or courtship</td>
</tr>
<tr>
<td>▪ Barrenness - pressure/quarrels from husband’s family</td>
</tr>
</tbody>
</table>
- Abuse/mistreatment by husband
- Husband runs away, his family abandons her, she feels lonely
- Promiscuity (quarrels with husband/has irresponsible husband) - looks for emotional and material support - becomes restless, guilty, uneasy - becomes sad
- Family arguments, land disputes
- Lack of peace in the home, quarrels (especially with husband)
- Conflict with in-laws - husband spends time with mother and she tells him many untrue things
- Sons don’t work, drink alcohol
- Stroke
- Madness

Source: Group discussions

According to participants, among women, depression affects all age groups, but is predominantly seen among married women. Young and middle-aged women, who have not “stayed long in marriage” may be the victims of a host of marriage-related adversities. In one example, after a woman bears her first child, love is said to diminish, leading her husband to engage in extramarital affairs and drinking. When he comes home drunk and she tells him that the baby is sick or hungry, he may physically abuse her. Older women, too, are thought to suffer from depression, though their suffering is more often ascribed to their widowhood and the burden of caring for orphans than it is to marital problems. Women who are young and unmarried are thought to be depressed because they have not been able to find a marital partner or because they lack employment.

The most common community perception of people who experience depression is that they are infected with “the big disease” - HIV/AIDS. This may be due to the association of weight loss with both depression and AIDS. Notably, another perception mentioned by group discussion participants is that women who are depressed must be suffering from jealousy, caused by a husband taking a second wife or engaging in
extramarital affairs. Such women are seen to be following their husbands around, worrying themselves into a depressed state.

Participants were also asked to list what circumstances might lead to each symptom appearing in the BDI. The results are presented in Table 4. Of note is the number of symptoms that are thought to be at least partially caused by poverty or lack of material resources (see italicized items in the table). In fact, poverty is second only to sickness in explaining the most symptoms.

Table 4. Circumstances leading to various depression symptoms

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Circumstances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past failure</td>
<td>Person is discouraged - sees former classmates having a good life and worries if she will ever be in that position</td>
</tr>
<tr>
<td>Sadness</td>
<td>Sick, stressed, or disturbed about a particular issue</td>
</tr>
<tr>
<td></td>
<td>Poverty – she is thinking of what she will eat next</td>
</tr>
<tr>
<td>Guilt feelings</td>
<td>Person is backbiter or thug, not perfect in what she does; has done things wrong</td>
</tr>
<tr>
<td>Punishment</td>
<td>Experiencing quarrels at home - if she does anything, even if not in wrong, she will be punished</td>
</tr>
<tr>
<td>Guilt feelings</td>
<td>Person is backbiter or thug, not perfect in what she does; has done things wrong</td>
</tr>
<tr>
<td>Punishment</td>
<td>Experiencing quarrels at home - if she does anything, even if not in wrong, she will be punished</td>
</tr>
<tr>
<td>Suicidal thoughts</td>
<td>She is overburdened; the result of pressure from family, drug abuse, a fight with someone, having a stubborn child “Devil’s thoughts”</td>
</tr>
<tr>
<td>Crying</td>
<td>Loss of loved one, loneliness</td>
</tr>
<tr>
<td></td>
<td>Person thinks a lot when she is alone</td>
</tr>
<tr>
<td></td>
<td>Person is a last born who was always being pampered</td>
</tr>
<tr>
<td></td>
<td>She is just born with that habit</td>
</tr>
<tr>
<td></td>
<td>Juogi</td>
</tr>
<tr>
<td>Indecisiveness</td>
<td>She is not courageous</td>
</tr>
<tr>
<td></td>
<td>Mentally disturbed or hit by something on head</td>
</tr>
<tr>
<td></td>
<td>Poverty - lack can make you not think straight</td>
</tr>
<tr>
<td>Loss of energy</td>
<td>Sickness – especially jiggers</td>
</tr>
<tr>
<td>Changes in</td>
<td>Laziness</td>
</tr>
<tr>
<td>sleeping patterns</td>
<td>Stress, deep thoughts, irritability</td>
</tr>
<tr>
<td></td>
<td>Sleeping disorder</td>
</tr>
<tr>
<td></td>
<td>Mentally disturbed - several things to think about without solutions</td>
</tr>
</tbody>
</table>

5 Loss of interest and worthlessness were excluded in error
<table>
<thead>
<tr>
<th>Difficulty</th>
<th>Description</th>
</tr>
</thead>
</table>
| Irritability | Jealous or high tempered person, antisocial  
Sick, tired of talking  
Experiences frequent quarrels  
Person doesn’t trust herself - feels bad whenever anyone tells her anything  
Expecting, growing older |
| Changing in eating patterns | Sickness – especially malaria or typhoid (due to poor handling and cooking of food)  
Too much food to choose from |
| Concentration difficulty | Laziness  
Lack of self confidence  
Mentally disturbed, angered/troubled, has many issues to handle  
Joint pain, hunger |
| Tiredness or fatigue | Person thinks too much |
| Loss of interest in sex | Sickness – especially stroke, diabetes  
Partner is unfaithful; husband is drunkard so she is not interested  
Menstruation  
Past rape  
Certain contraceptives, alcohol |
| Self-criticalness | Person is selfish - does everything for self; when she fails she criticizes herself  
Jealousy, stress |
| Self-dislike | Jealousy – person compares self with others  
Not comfortable with what she gets (born that way)  
*Poor - thinks others have more wealth*  
No self dignity |
| Pessimism | *Poverty - realizes she doesn’t have anything, doesn’t see anything good happening*  
She grows crops every season but they don’t do well - feels frustrated and thinks same will happen in future  
She has lost hope in life  
Infected with deadly disease – the only thing ahead is death  
Selfish person |
| Loss of pleasure | *She has not been able to get money as she used to*  
Overestimates self - wants to be like learned people but is not |
| Agitation | Forgetfulness - forgets what she is supposed to do |

Source: Group discussions
Participants mentioned being ‘mentally disturbed’ as a circumstance leading to some of the symptoms in the BDI. This ascription to a psychological cause is questionable. Being “mentally disturbed’ was mentioned as a circumstance leading to indecisiveness, changes in sleeping patterns, and concentration difficulty. In context, being “mentally disturbed” may be more accurately understood as having “many things to think about” or “many issues to handle,” as opposed to representing an understanding of those symptoms as being caused by psychological circumstances. In fact, with the exception of two causes listed by group discussion participants (stroke and ‘madness’), depression is perceived to be predominantly social (and to a smaller extent spiritual) in origin. Biological or psychological explanations for depression are notably absent from the collective understanding of depression. This fact has implications for the extent to which women with depression engage with the allopathic health system, a topic that will be discussed in more detail in the next chapter.

4.8 Marriage in rural Siaya

Of all the challenges faced by participants, those related to marital issues were discussed with the most frequency and intensity. Key informants confirm that modern marriages are fraught with conflict and difficulty. Though she doesn’t know the reasons for it, one key informant insists that men and women “live but with constant disputes and separations; there is no peace.” Constant quarreling is unique to recent times. Long ago, she insists, relationships were good. Women had more wealth and were not stressed. “Women today have a lot of problems related to marriage and the married life.” Another key informant concurs: “There is a lot of separation and conflict in marriages.”
Among participants, marital tension is considered to be inevitable. When asked if she had previously experienced depression, Helen replied, “Yes, you know where people live together there must be issues.” For some, the correlation between marriage and depression was considered to be total. For example, Patricia insists that her depression is totally attributable to her marital problems. When asked what she can do to deal with her depression, she replies that the only thing she can do is pray to have a peaceful marriage. Group discussion participants confirm: “so many” women in the study area suffer from depression, “as long as you are married.” The following exchange is particularly noteworthy:

FO (Interviewer): What do you think? I’m not married but the research I do has made me have a negative attitude toward marriage. Could you advise me?
Susan: That’s marriage. It’s a lot of challenges. Men are just domesticated animals.

Problems associated with marriage include intimate partner violence, substance abuse, strains associated with polygamy and infidelity, and detrimental expectations related to widowhood, childbearing and patrilocality. Examples of two of those issues are presented in Box 3 and those that warrant more attention are discussed below.

**Box 3. Examples of physical and substance abuse in the context of marriage**

**Intimate partner violence**

One day, when Evelyn was 15, she went to fetch water and was abducted and taken to a man’s home. This was how people got married in those days, she explains. While living there, he beat her - one time even kicking her stomach so that it was swollen for a long time. She ran home and her mother told her that the man did not have a right to beat her just because he had paid two cows as brideprice. Evelyn and the man later separated. See also Box 4 for a discussion of Eunice’s experience as a domestic violence survivor.

**Substance abuse**

Though Pauline’s husband is now sober, there was a time when she describes her life as a living hell. Her husband began to drink and “he would spend two consecutive nights
without coming back home and when he came back the third day he would again leave without knowing our status.” When he was paid, he went drinking and when he returned home “he never had even a coin.”

**Box 4. “Whenever I see him carrying any weapon, I should not wait, I should run”**

Eunice’s experience with battering emerges only when she is asked to describe a time when she was given advice or encouragement in the last month:

MO (Interviewer): Can you remember any advice or encouragement that you received in the last month?
Eunice: It was only Jane.
MO: What was it all about?
Eunice: It was about a fight with my husband, who carried a jembe that scratched my face. She told me that whenever I see him carrying any weapon, I should not wait, I should run.
MO: Did he mean it or did he want to scare you away?
Eunice: He was drunk, so when I was opening the door I think he accidentally raised it and hit me.

Now 54 years old, Eunice told us the story of how she married her husband many years ago. While attending a burial, she saw her sister speaking to an older man. The man later approached Eunice and asked her to marry him. She declined his proposal because he was married and much older than her. He tried to take her with him by force but Eunice escaped. One day, the man’s wife came to visit Eunice. She asked Eunice to accompany her to their home. At the home, Eunice was locked inside the house. Thereafter she was guarded, always under watch and never given the chance to be out. Over one month, the man sexually assaulted Eunice repeatedly. One day, Eunice got the chance to escape. She ran back to her sister’s home.

Eunice: Unfortunately I missed my periods on that month. I went and bought some tablets to abort but they never worked. Instead they almost killed me. Then one day when we went to fetch firewood, a vehicle came with some boys and I was captured and brought here. I was helpless and I just decided to get married to him rather than killing the innocent infant.

MO (Interviewer): So when you decided to get married, how old were you?
Eunice: I was fifteen years old.

4.8.1 Polygamy and Infidelity

According to key informants, polygamy – the practice of a man taking multiple wives – was once nearly ubiquitous. As it is told, polygamy worked well in days past - wives never left and the children related well to their stepmothers and stepsiblings. One
participant told of her father marrying seven wives. She explains, “My father was harsh and cruel and if he could ever realize that members of his family fought or quarreled he could beat the persons involved.” Evidently, this arrangement kept some sort of peace in the family.

Key informants insist that these days, polygamy is not as widespread. Still, where it does exist it creates incredible tension and conflict and exacts a substantial toll on mental health. (See, for example, Josephine’s story in Box 5.) Group discussion participants reveal that many people assume that a woman who is suffering from depression is just jealous over her husband’s second wife. A discussion about her recourse is particularly illuminating (emphases added):

MO (Interviewer): What can you do if your husband with whom you have five children decides to marry another wife while you are still there married to him?
R: I can just keep quiet and listen to what he says. If he has good reasons then the lady can stay.
MO: No, in this case he has changed a lot – he no longer does things he used to do. He doesn’t buy you food or pay school fees for the children.
M5: I can inform the authority so that his salary is deducted for such expenses.
FO (Interviewer): Maybe he doesn’t have a job.
MO: What can you do – what do most women do?
M4: I can think of committing suicide.
M5: If the newly married wife is there then I can boil very hot water and pour it on her.
MO: Maybe he is married to another wife whom you don’t know where she lives. What can you do?
R: Some do commit suicide.
M6: Some leave the house for some time.
R: Some can take the husband’s photograph and take it to ajuoga for ill intentions.

The hostile relations that characterize modern polygamy are not restricted to co-wife relationships. Several participants told stories of abuse they suffered as children at the hands of a stepmother. Josephine’s story is told here, but the stories of several other participants echoed this one.
My father left us when he went to work in Nairobi. There was a time my mother went to see him and we were left with her co-wife. We were denied food. We were suffering. [My father] had sons who were older. After we slept, they could come with fire in their hands and in their mouths. They used to scare us and the mother did not even tell them to leave us alone. When it was about to rain, that’s when we would be told to go fetch water from the river, which was far from home. There was a time I became very sick because I was rained on in a hailstorm.

Apart from illustrating the burden of polygamy on children, this story also calls into question the romanticism of polygamy’s past as portrayed by several participants. Even when the participants were young, polygamous arrangements were accompanied by some measure of strain. Karen, who is 67 years old, reveals that when she was married at age 16, her co-wife would attack her and tell her to “get [her] own husband”. “There were squabbles”, she reveals. Even today, the two women have found only a tenuous peace.

### Box 5. “He had turned all his attention and resources to that woman”

Josephine is 48 years old and lives with her husband, Samuel. She first experienced depression three years ago: “My husband married a second wife and he took most of his time there. I thought of leaving this house as well because it was like my husband ran away.” Her distress peaked when earlier this year, her husband broke into her grain store and stole some grain. He had planned to sell the grain so he could take the money to his second wife. What is remarkable is that until now, Josephine’s husband has never told her outright that he is married to another woman; Josephine has discovered the relationship by piecing together information she has learned from others.

This is not the first time Samuel has taken a second wife. She tells a story of an explosive argument with her husband and previous co-wife:

Josephine: It was in 1994. He had married another wife and he had turned all his attention and resources to that woman. I was just making ropes for a living[^6]. [...] I had problems with her and there was a day I seriously fought with her.

FO (Interviewer): Did she have her own house?

Josephine: Yes, she was married and her house was already built. He wanted us to cook and eat together, which was not very easy given that she was my co-wife. When my husband went to work, he could bring food but take to my co-

[^6]: Making ropes by hand from sisal grown on the farm is a labor intensive, low-paying cottage industry, and a sign of serious poverty.
wife’s house. There was a day I don’t know what went wrong but we fought seriously. He was not there but when he came back he was told that I was the one who started it all. [...] She bit my finger and I also bit her ear. I think I cut it.

Josephine’s husband sided with the co-wife, even chasing Josephine with a knife at one point during the altercation. After that incident, Josephine’s family demanded that he pay the brideprice he owed them (in cattle). When her co-wife discovered that Samuel had paid Josephine’s brideprice, she too demanded that her brideprice be paid immediately. Unsatisfied with the response, Josephine’s co-wife left and never returned.

Eventually, Josephine revealed to us that even she was not the first wife. When she married her husband, she found that he was already married to a woman. Josephine is convinced that the woman blocked her from conceiving by visiting an ajuoga. After 14 years of remaining childless, she moved into a new house in her husband’s homestead and three months later she was pregnant. The first wife left with her son, but the authorities eventually seized the boy and returned him to his father’s care.

Key informants claim that back when almost all men practiced polygamy, there were very few extramarital affairs. Today, most men have at least one mpango wa kando (“other woman”). Group discussion participants reveal that having a husband who “starts spotting fresh girls outside” can drive one to depression. To prevent infidelity, a woman may even resort to visiting an ajuoga for “medicine” that she can put in her husband’s food. Despite the supposed pervasiveness of infidelity, with the exception of Agneta (see Box 6), participants did not speak of their own experiences with cheating husbands. If infidelity is indeed as pervasive as it is widely considered to be, its near absence in the in-depth interviews is likely the result of the fact that infidelity is so ubiquitous as to be rendered unremarkable.

Box 6. “I would not love my life to end very soon”

Though other women who participated in our study spoke of their fears around HIV (e.g., “Sometimes when I wake up in the morning, I find my legs swollen and I’m tempted to think that it might be the ‘big disease’ so I’m left wondering how my future will be with this disease.” Evelyn), Agneta revealed that she is, in fact, HIV-positive.

Agneta is 26 years old and the mother of three children. She suspects that she was infected three years ago when she conceived her last-born, four years after she married
her husband. About seven months before we recruited her to participate in the research, Agneta and her husband went to test for HIV and were told that they were positive. She felt “very unhappy and very sad” but because she had attended the clinic with some acquaintances, she “had to put on another face so that they would not suspect anything about [her] result.”

Today, Agneta cares for her health by taking medication and eating well, but she feels that she needs “assistance in the form of foodstuffs, as sometimes I can stay the whole day without taking lunch, just with the breakfast.” She is hopeful because “I know there are hospitals or support groups or even organizations that support such [people] like me, though I have never met one.” Evidently, Agneta’s HIV status affects her mental health and the way she thinks about her future: “I have got a fear of being bedridden because of sickness where I would be helpless and I would not love my life to end very soon.”

Meanwhile, Agneta’s husband stays in Nairobi, where, she suspects, he is supporting another wife. Agneta has “never known happiness in [her] married life.” Early in their marriage, for instance, Agneta’s husband had a girlfriend, for whom he would take out loans to pay school fees. He would buy alcohol and drugs with the balance, while Agneta struggled to feed their children. His substance abuse got so bad that he was fired from his job. To add to their financial woes, he refuses to help Agneta restart the tailoring business she closed down when she married, despite having promised as much upon their marriage seven years ago: “Up to today he has refused to support me to restart the business. Instead at every month end he gets drunk. That’s what has always dragged me behind.”

4.8.2 Patrilocality

Patrilocality, the social system in which a married couple lives with or near the husband’s family, has significant implications for women’s mental health. Social ties with a woman’s birth family are replaced by the relationships she eventually forms in her matrimonial home. The latter may be characterized by tension, animosity, and conflict, especially when household resources are scarce. This issue is discussed in detail in Chapter 7 below and Grace’s story in Box 7 illustrates some of the challenges associated with this cultural tradition.

Box 7. “She never loved me”

Grace was working as a maid in Naivasha when she met Moses, the man who would later become her husband. “[At the time,] I thought that by getting married I could bring end to my problems. Unfortunately, I found that marriage was full of problems, more than I
could imagine.” Grace and Moses moved to Nairobi where Moses’s mother, Salome, ran a moderately successful business selling fish. “I was very slim, so when we got to their house, his mother complained about my slimness. She said that I would destroy her food to make me gain weight.” Considering that first impression, Grace surmises, “She never loved me.” Moses himself was jobless, so he and his new bride had to be supported by Salome. He asked her to assist his mother while he looked for a job.

MO (Interviewer): Was the problem lack of enough money or was it that your mother-in-law never liked you?
Grace: My mother-in-law never liked me. Furthermore, she made her sons to feel the same about me, and so every time there was a misunderstanding about a small issue in the house, it led to quarreling.

For one year, Grace did not become pregnant, a fact that only exacerbated the tension with Salome. “My mother-in-law started complaining that she could not feed a woman who could not give birth.” Finally, Grace did become pregnant and continued to help Salome with her business until the eighth month of her pregnancy.

I woke up very early in the morning and brought her fresh fish. The worst is that she was never appreciative. At times, I might mistakenly give back extra change to a customer and at the end of the day, I would run short of Ksh. 20 [USD 0.25]. She would make me go without food that night.

One day late in her pregnancy after hiding all of her possessions at her neighbor’s home, Grace ran away to her mother’s home in Siaya. She stayed at home until she gave birth. Around that time, Nairobi exploded into violence following the disputed presidential election, and Salome, Moses and the rest of their family relocated back to their family home in Siaya.

After some campaigning by Grace’s brother, Moses agreed to take Grace back with him in his home in Siaya. They stayed at his home for a short time until he was called back to Nairobi for casual work. “Though he wanted to leave me back home, I objected since I could not stand living with his mother in the same home in his absence.” He went to Nairobi and after a short time, he sent Grace money and she joined him in Nairobi. With Salome back in Siaya, Grace picked up the fish business.

My life changed when I entered into business, since when I needed money it was not a must for me to ask, and then he also never dictated how I used my money. Then there was no one who could fill his mind with wrong information. He once told me that a friend of his taught him that after getting married you should not put your mother closer than your wife. During those days, I felt relieved.

Unfortunately, the relief that Grace felt being free from her mother-in-law’s torment did not last long. In Nairobi, she was involved in a bad car accident that shattered her right arm. Doctors at Kenyatta National Hospital repaired the bone as best they could and installed a metal plate that would keep her bone in place as it healed. The plate was to be
removed in a year’s time but Grace did not ever have enough money for the follow-up surgery. Unable to work and in extreme chronic pain, Grace returned with her husband and children to Siaya to live in Salome’s homestead. That is where we found her.

Today, Grace is 26 years old and has three young children. Her right arm dangles from her side. She is unable to bend it and it is a constant source of pain, especially when the weather turns cold or she carries a child on her back. The pain prevents her from helping around the house as much as she is expected to, inspiring more resentment from Salome. Moses helps her with chores sometimes and seems to offer emotional support: “we went together to fetch water, when I told him of the pain in my arm and back. He told me that I should just hold on, that as soon we get money he will take me to the hospital to remove the metal.”

Initially, Grace took pain medication given to her by doctors at Kenyatta National Hospital, but because they advised her that long-term use could cause high blood pressure, she stopped using it. Now she simply suffers through the pain, waiting for a day when she will have enough money to get the metal plate removed. Her diary reveals that she prays for comfort and good health nearly every day. But it’s more than relief from pain Grace is seeking; she also yearns for the ability to work so that she doesn’t need to depend on her mother-in-law.

MO (Interviewer): Do you think that you are in need of help?
Grace: Yes, I really need it to remove this metal from my arm. I can’t do anything. I can’t work on my farms and I can’t keep on depending on my mother-in-law.

When asked what troubles her in life, Grace responds that it is the fact that she has never “attained as [she has] always wished for.” She continues, “Though a person cannot get all he wants, he must have things that he wants to do.” Without any source of income, Grace is unable to do the things she wants to do. But she is hopeful: “I think once I get assistance to remove this metal from my arm, I think I can find my own way to solve that issue.”

At the conclusion of fieldwork, Mildred and I took Grace to Nairobi to have the metal plate removed from her arm by doctors at Coptic Hospital. After her operation, her surgeon reported to me that he had tried to forcibly bend Grace’s elbow while she was under general anesthesia, but to no avail. His opinion was that she had probably waited too long to remove the metal plate and her elbow will be frozen in place for the rest of her life.

4.8.3 Childbearing
One of the most significant burdens (and joys) associated with marriage is the expectation of childbearing. Luo wives are expected to bear children early in their marriage and often. Struggles with fertility take their toll on mental health. This is nowhere more evident than in Evelyn’s story presented in Box 8.

### Box 8. “Even when I was in the garden I would spend the good part of my time just crying”

Several participants struggled with difficulty conceiving, most notable among them Evelyn. Evelyn is a 58-year-old woman and *nyachira* - the last of three wives. When we asked Evelyn to talk about an event in her life that stands out in her memory, she chose to discuss “the story about children, how I was to become a mother and remain childless for the rest of my life.” Evelyn relocated from neighboring Gem District to her matrimonial home when she was married at age 22. She was already six months pregnant when she married. Evidently, she was not warmly welcomed into the homestead by her husband’s first wife, who told her “You are happy that you married, [but] you will die with the pregnancy.” Evelyn continues,

> So when I was to give birth I went through Cesarean in Kenyatta Hospital. I came back home with my baby. After one year with the baby, I fought with my first co-wife. We went physical, which is a taboo to a breastfeeding mother, so my son had to die out of that taboo. After eight months, I became pregnant again, it took me eleven months before I gave birth to the baby. I was not operated though. I gave birth with her dead – it was dead. So I have been very bitter about these [losses] following the remarks that my co-wife made.

Evelyn was never able to conceive again. Evidently, her problems with fertility are a defining feature of her life - she frequently mentions her infertility and links it to a number of other issues in her life, including her perceived social exclusion, her economic hardship, and distress about her future prospects. Evelyn’s friend notes that, “Her main problem is lack of children, that is what depresses her most...She always has a feeling that people don’t like her because she doesn’t have children. Any small mistake must be attributed to the lack of children.” Evelyn herself claims that she has been abused and called names because she was not able to give birth.

> FO (Interviewer): Do you think people were against you because you did not have a child?
> Evelyn: Yes, I have always believed so.

These feelings of social exclusion are illustrated in an incident to which Evelyn repeatedly refers. She describes her “lowest life experience”: "When my first co-wife was still alive my husband had ordered that cows be bought for the two wives excluding me. So from there I had always been high-tempered and tough-headed. I thought that he
was doing so because I did not give birth to children. That is when I got high pressure, the disease that I presently have.” Apart from this physical manifestation of her stress related to the incident, the effect on Evelyn’s emotional well-being was profound: “My heart was pained. Even when I was in the garden I would spend the good part of my time just crying.” At some point, her husband built houses for his first and second wives, leaving Evelyn out. Even today, her floors are made out of earthen material while the houses of her two co-wives have cement floors.

The impact of Evelyn’s infertility on her economic situation extends beyond neglect by her husband. Today, her husband’s homestead is comprised of six households: Evelyn's, that of her husband’s second wife and grandchildren, that of her husband's late first wife, and three households belonging to the sons of her husband’s first and second wives. While Evelyn must depend on farming as her main source of income, the sons of the other wives have formal employment in Nairobi - one as a painter and another in the insurance business. It is through these relationships that the second wife and the first wife (when she was living) access non-farm income. As a stepmother, Evelyn is excluded from that material support, a fact that brings her much distress and harkens back to her infertility: “What always brings me stress is when I’m sick and I ask for money from my stepsons and they refuse to give me. They make me think of my lost children and childlessness. I feel that if I had a child, he or she would be helping me.”

Beyond her present inability to access financial support, Evelyn worries that she will not receive the material support she needs in the future: “One thing that has been disturbing me for awhile is that when I will be old and in bed, who will give me water, who will bathe me, or change my beddings? How will it be without children?”

Josephine’s experience adds nuance to the story around the importance of childbearing. After seven months of pregnancy, Josephine gave birth to a stillborn baby boy. Josephine conceived again and gave birth to another boy who died around the time he was starting to walk. A third pregnancy resulted in the birth of a baby girl, who survives up to today. Josephine continued to try to grow her family amidst harsh criticism:

After [the birth of my daughter], I took ten years before giving birth. People said that I would not give birth again...My father-in-law was on my case that I’m a prostitute. He even told his son, ‘My son, marry another wife because this a prostitute who will never give birth.’

She became pregnant for the final time in 1996, but her baby boy died when he was only three months old. She continues:
I asked myself what was wrong with me. From then I have never been interested in giving birth again. I’ve left everything to God. I’m always depressed. I feel pained when I think of them. People do tell me that I didn’t have children because they are in the ground.

What is most remarkable about this story is not the cruelty to which Josephine was subjected due to her reproductive difficulties, but the degree to which she and others discount her surviving female child. That son preference exists in Luo culture and among the study participants is indisputable. The reason for that preference may relate back to poverty and access to resources: the pattern of patrilocality has adult daughters leaving the family home and residing with their husband’s family. All assets, including children, are considered property of the husband’s family once he has completed the brideprice payment. Given this arrangement, the only way for parents (especially mothers) to ensure that they will be supported in their old age is to give birth to sons who will continue to reside within or near the family home. When Josephine expresses son preference, she does so for the same reason that Evelyn laments her own infertility. In a situation of economic insecurity, not having a child, particularly a male child, is tantamount to vulnerability – living one illness, or drought and poor harvest away from financial ruin. This fact is also what makes losing an adult child particularly disturbing (see Box 9).

**Box 9. “From then I have always felt I don’t have any reason to live”**

Millicent is 50 years old and has given birth to seven children. Of those, only two are living, most having died from illness when they were young. Most recently, her last-born son was killed when a vehicle struck his motorcycle. Millicent refers to this incident as her lowest life experience because he had reached adulthood and was providing for Millicent out of the wages he received as a casual worker in the Mombasa port. “The previous ones were dying when they were still young, but this died when he was old enough and also he was my breadwinner.” Her only surviving son left and married a woman “who is old enough to be his mother”; the negative impact on Millicent’s mental health cannot be overstated: “From then I have always felt I don’t have any reason to live.” The actions of her surviving son seem to exacerbate the grief she feels for her late son: “God decided to leave me the one who is very irresponsible and makes me feel sad.
all the time.

Grappling with her late son’s death, she even admits feeling that God is unfair to her: “As a human being I can think of that. I may think that He is the one taking them. Because it’s very hard to explain how one can be knocked by a vehicle from nowhere.”

4.8.4 Widowhood

There are a number of Luo cultural norms and practices surrounding widowhood. One of the most discussed is widow inheritance. When a woman loses her husband, she is “inherited” by one of his brothers who is meant to ensure that all of her material and sexual needs are met. Though the practice was officially banned by the Provincial Commissioner of Nyanza Province in 2000, it persists today. According to a key informant, the practice has changed: where before the elders would convene a meeting to decide on the best person to inherit a widow (usually an older man with means to support her), now even young men without the means to support another wife are engaging in the practice without the endorsement of community elders.

Women who choose not to be “inherited” are faced with a barrage of social sanctions. Shunned by their neighbors, widows who have not been inherited are restricted from building homes. If a widow is able to build a home by her own means, or if one already exists, neighbors refuse to help with its upkeep for fear of punishment by spirit ancestors. See Box 10 for a description of the struggles that Salome experiences in widowhood.

Box 10. “I was shedding tears over the burden that I was left to carry”

During her narration of her life story, Salome tells of the events of one Tuesday in 1992:

[My husband] had gone to market but when he came back he complained of fatigue. I prepared for him some traditional medicine that he had requested. On Friday the sickness persisted and he sent me to go and call for a local doctor, but before going far I heard wails of his death. Instead of shedding tears over his
death I was shedding tears over the burden that I was left to carry.

Salome tried to carry on with farming and selling produce but her earnings were not sufficient to meet the household needs. She began brewing illicit alcohol, until one day she was arrested by police. She was later released but the police and her family told her to leave the alcohol brewing business.

One day, her sister came to her and told her that, being a widow, she’d have to work harder. “She told me, ‘Daughter of Gem, now that your husband is dead you become both the husband and the mother as well.’” Her sister found a job for Salome in Nairobi. Salome requested permission from her grandfather to leave her children with the family and travel to Nairobi to work as a caregiver of an elderly woman for Ksh. 500 (USD 6.25) per month. Her grandfather gave his permission, telling her that she was now the husband here and “should take the lead role to do whatever can help”.

The meager salary wasn’t enough to cover her necessities, leave alone to send money home to her children. She worked for a year before she was informed that her children were suffering at home, about to become street children. They weren’t attending school and no one was taking care of them. A friend told Salome that she was willing to teach her the business of fish mongering. Salome entered the fish business and quick success enabled her to bring her children to live with her in Nairobi where they started school.

I proceeded with the fish business and you know, God cares for his people. If you are a widow and keep to God’s promise, then he doesn’t forget about you. By this business now I had money to pay rent and school fees. School fees of Loreto was by then Ksh. 18,000 and I paid that with ease. From this business, I bought all the household equipment. I even started growing fat. Fish has a lot of protein.

Salome’s success came to an abrupt end. In the final days of 2007, violence erupted in Kenya following a disputed presidential election. Tension between ethnic Luos and Kikuyus that goes back many years came to a head when Kikuyu incumbent Mwai Kibaki appeared to steal the election from Luo challenger Raila Odinga (son of the late Oginga Odinga, the hailed Luo leader who served as Kenya’s first Vice President under Jomo Kenyatta). The violence was particularly severe in parts of the Rift Valley and in Nairobi, peaking with the killing of more than 30 unarmed civilians in a church near Eldoret on New Years Day. In total, 800 to 1500 Kenyans were killed and another 180,000 to 250,000 were displaced. Salome and her sons are among that latter number.

The beginning of problems was the post-election violence. I had made a living from my business in Nairobi. I was some steps ahead but after the violence I went back to scratch. I came back home. Everything that we had remained in Nairobi. Here our house had been demolished in 1994 and you have children and there is nowhere you can go to.

Salome returned to brewing illicit alcohol to get money for her children to complete school. She had already paid Ksh. 10,000 for one of her sons to attend Form 4 at his
school in Nairobi, but when he transferred to a school in Siaya, they put him in Form 3. Scraping together meager profits from the alcohol business, Salome managed to pay school fees for all of her sons, except for her eldest, who studied only through Primary 3, and her youngest son, who is still in school. After he finishes, Salome plans to go back to farming.

You see, being Saved you cannot combine with other things which are unclean. On one side you are praising the Lord Jesus, and on the other side you are brewing alcohol. Therefore you can see you are not raising the name of Jesus but lowering it.

Today, Salome is 54 years old and her widowhood remains the defining feature of her life. As a woman who refused to be inherited, Salome is aware of the social meaning her decision carries. “You see, this home, many people fear it because the husband had died and it was built minus the husband and you know the tradition doesn’t allow for this” and “I am blessed to be in my own home. Some give me wrong advice, that I should go back to town, while some tell me that I will die because I have decided to be in my own home yet am a widow.” She advises a close friend who is not at peace with her late husband’s brother, “Being a widow, you have to pass through so many trials and some people will love to cause problems for you.”

Further, when a Luo man dies and leaves a widow and young children, those children are considered property of the deceased’s family, as long as he has paid full brideprice. If he hasn’t completed the brideprice obligation, his family may organize to pay his balance posthumously so that the children will remain in their family. In this situation, a Luo widow may be forced to decide between staying with her children on or near the compound of her late husband’s family, or moving away in search of a new life and leaving her children to her late husband’s mother or sister. This norm serves to restrict options for a young widow, as she must choose between a life of restricted opportunity under the watchful gaze of her late husband’s family on the one hand, and a life without her children on the other.

4.9 Considering poverty

There are many mechanisms by which material poverty contributes to depression. Poverty may be antecedent to many of the problems noted in the section
above: within marriage, financial strain may lead to quarrels with husbands (see Susan’s story in Box 11), conflict with in-laws and co-wives, and substance abuse. Poverty is a driving factor in the pressure on women who struggle with infertility and in the son preference that prevails in the study site. In addition to underlying many of the factors that lead to depression, an inability to meet the basic needs of one’s family itself causes psychological distress.

**Box 11. “It’s me and me alone”**

Many of the participants bemoaned their husbands’ unemployment. Susan, in particular, lists her husband as the person who has most negatively influenced her life story “because [he] is just there. He doesn’t do anything that generates income.” Susan is 45 years old. She is caring for a son who has epilepsy and she is overwhelmed by hospital fees, transportation costs, and medication costs. She frequently quarrels with her husband because he doesn’t help her pay for her son’s needs and the quarrels lead her to feel depressed. She first experienced depression when her husband lost his job - he resigned because he was frustrated at work, and to make matters worse, he did not immediately tell Susan. After his resignation, Susan felt that they still had hope: “He had some cash and shares in the batik (cloth) business so at least he could sell his shares for our upkeep.” At that time, however, an estranged daughter, unknown to Susan, reentered his life. She had been looking for her father her whole life and had hoped that he could clear her high school fees so that she could join university. Susan’s husband used the family’s savings to pay his daughter’s school fees.

Since his resignation, Susan’s husband has never worked again. She insists that what would make her most happy is to see her husband “try to do something that contributes to the family.” But for now, she is left to mull over a limited number of poor options. She has considered leaving her husband, but she thought deeply and realized it would do her no good. She would be forced by custom to leave her children as well and they would be no better off without her there. Further, she is admonished by her mother, “You want to quit now that your husband doesn’t have a job. It would be like you married him because he was working. Those are temptations that people undergo in marriage. It isn’t that easy.” Increasingly, Susan feels that her only choice is to find a way to support her family on her own. She feels that this alone would ameliorate her mental health:

> FO (Interviewer): Would you want any help regarding depression?
> Susan: I can say that if I can find a way of supporting my family, because most of my family members depend on me. It’s me and me alone because my husband is not looking.

4.9.1 The cost of education
One of the main demands on household capital is the school fees required for primary and secondary school education. Research participants overwhelmingly agree that education is now more important than ever. In recent years, rates of primary school completion have jumped in Kenya and as Kenya becomes increasingly involved in the global economy, opportunities requiring secondary (high school) and university degrees become more common. One key informant shares:

Now education is even more important than ever. Without secondary education and certificate, even if this child is called for an interview, without the Form 4 certificate (high school degree) it is hard to secure a job. My son, for example, did an interview for a position in Breweries firm. It was a job that required observation to practice the work. Even though the manager advised against my son doing the interview with only primary education, my son insisted to do it. He did well and was second on merit list but he did not get the job because he did not have a secondary certificate.

Other participants put the bar even higher than Form 4. A participant in the group discussion: “Let’s say you have children, but you cannot take them to school to a level that can help them - maybe up to Form 4, and if you leave them at Form 4, there is nothing much they can do.”

To be clear, education in no way ensures that a young Kenyan will gain employment. Rather, jobs are scarce and even those with degrees languish waiting to be hired into positions for the lucky few. One key informant stated, “There is no employment. Many of our children get educated but are not able to get employment.” Still, despite the fact that the link between education and employment is tenuous, all participants believe that their only hope for accessing a better life is to sacrifice greatly now in order to educate their children to the highest possible extent. In discussing the future, many participants hang their hopes on their children’s education: Grace states, “I wish to educate my children up to the level they can and wish
that God will bless them so that one day they will support me and have a nice
life.” Patricia hopes that she can see her daughter go to school “and achieve all that other
people enjoy.” Millicent places her hope in her young son: “I pray that God helps him,
he gets educated, and one day he gets me out of these problems.”

In the present cultural context, activities associated with raising children reside
within the women’s sphere. Thus, the burden of paying for formal schooling falls
primarily on the woman. It is not uncommon that she is not supported in this endeavor by
her husband. Grace explains:

You can ask your husband something like concerning children’s uniforms, books
or health, and you know, when these things happen to the child it is the parent
who bears the burden. But his response may not be pleasing to you at all and that
is where the quarrel begins. These [conflicts] may lower your faith and you start
asking yourself whether you got that child alone.

Group discussion participants confirm:

M: Sometimes I have a child who has done her exams, and is waiting to join a
college. You realize that I may not have any money to pay school fees, even for
the first term.
FO (Interviewer): But such a problem can face both parents in a family, not only
women.
M: Very few men take the responsibility for their children or know that their
children should go to school. In most cases it’s a woman’s responsibility.

Lacking the support of their husbands, women must call upon their social
networks to help with school fees. After assistance with the financial needs associated
with healthcare (e.g., hospital fees, transportation to the hospital, medication costs),
payment of school fees was the most common form of material support received by
research participants. In some cases, participants appealed to a wider social network,
organizing small, local fundraisers (harambee) to raise money for school fees.
Apart from the burden of paying school fees, households struggle to afford other common expenses. Health-related expenditures (including hospital fees, transportation to the hospital and medicine costs) make up a large portion of household expenditures. Other significant expenses include brideprice and home construction. Frequent expenditures associated with funerals (“contributions” to the bereaved for the cost of the burial and funeral, transportation to the funeral) show up throughout the diaries. Finally, fees for membership in various groups and church contributions burden already overstretched household budgets. Yet, while the demands on household financial capital are numerous and increasing, the means of acquiring capital are incredibly limited.

4.9.2 Making money

While the lucky few are able to use their schooling and social connections to find work, formal employment opportunities in Kenya are extremely limited. In the absence of formal employment opportunities, some people engage in casual labor, enduring difficult work for low pay and little job security. Others with an entrepreneurial spirit may start small businesses, selling produce, prepared foods, or household goods. Among the research participants, small income generating activities are evident in abundance: one participant sold milk to raise money to go to the hospital, another sold a cow to pay for a coffin. Throughout the diaries and interviews, participants reveal that they engage in small transactions, mainly as stopgap measures to address an immediate need. More sustained investment in business is more rare among the participants.

While direct investment in business is uncommon, people invest indirectly through their paid membership in community groups. One of the main functions of community groups is to pool capital that members may use to start businesses, either
collectively, or individually through small loans. Most group-initiated businesses involve farming and are launched to address a particular need among the members (most often school fees). Groups may also provide forums for training on income-generating activities (e.g., soap making, dairy farming). Development or investment partners may initiate programs not by giving to individuals, but by giving to groups.

There is some indication that the future of small business in Siaya is bright. One key informant cited the changes around business (more business opportunities, more access to capital through small loans) as the only positive changes she has seen in the community over the last several years. Another key informant noted that electrification and construction of roads will bring many positive developments to the community, not the least of which is infrastructure to support new small business activities, like garages and welding. In addition:

The road will also increase business for those with business enterprise. For example, the junction at Ndori is vital for fish mongers and therefore those in the business of fish here in Ng’iya will greatly gain. That for sure is development.

Evidently, social networks are readily mobilized to provide support for business opportunities, either in the form of encouragement and advice, or via capital investment. One of the most common topics of discussion between participants and their social networks is business:

FO (Interviewer): What do you discuss when together?
Susan: Just about how I can do something that can generate income. In fact, she promised that there is only something that has been preventing her from giving me capital, but she will give me soon if she is in a position to.

She gives me teachings. She always tells me that I have small children. I should try as much as possible to do some business so that I can feed my children. - Helen
She suggested that I should start a small business such as bringing shoes from Busia and selling them for my upkeep. - Eunice

She can also encourage me to do business to help myself. There is a day she took mangoes to the market, which she sold, and she told me to also try my luck on the same. - Josephine

Though there is much hope for the future of business opportunities, it is tempered by the current reality. The key informant who envisioned a bright future with the impending infrastructure investments qualifies her vision by stating that it’s “those with capital” who will be able capitalize on these developments. Indeed, nearly every research participant expressed a desire to engage in small business activities, but then listed the capital to start a business among her most pressing needs. For example, when asked what she wants for her future, Jacqueline responded, “I just pray that God adds me more days on earth so that He can bless me to at least develop.” She continues:

MO (Interviewer): What type of development?
Jacqueline: Development such as beginning any small business that is able to sustain me with my household.

Patricia talked of her failed business:

I used to do small business of selling things at home, but it went down after realizing I was not getting much…Sometimes I would start a business of sugar and doughnuts but no one buys them and I end up using them here [at home].

Others abandoned their small businesses for health reasons. Helen describes her life with her previous husband as “very good”: her husband was working and she had a small restaurant and boats that they used to fish. When she got pregnant, she became very sick and couldn’t work. She never went back to work after she gave birth.

Even in the case of a “successful” business like Josephine’s, there is little security. Josephine told us that her life changed for the better when she borrowed money to start a business selling tea leaves, beans, peas, millet and cassava: “I used to be
dependent. I used to rely on the things that were given to me. But nowadays I do my business and I earn a living from that.” Yet, she reveals that her depression is linked to those times when her business is not doing well.

Finally, business can put a real strain on interpersonal relationships, particularly between a woman and her a husband. Focus group participants describe the situation in which a husband sits idle all day and then, upon her return from working all day, forces his wife buy him alcohol out of her business profits. At times, the business doesn’t go well and a wife will return home with only enough profit to provide food for the children, and not to buy alcohol and cigarettes for her husband; quarreling results.

4.10 Chapter summary

Depression is common, widespread, and considered to be unavoidable. The perceived high prevalence of depression was supported by the results of the screening activity, in which 67% of women screened were found to have at least mild depression. Group discussion participants were able to identify several symptoms of depression, including sadness, crying, irritability, absentmindedness, social isolation, and somatic symptoms. Other symptoms, including self-dislike, pessimism, guilty feelings, etc., were not identified spontaneously, probably due to their private and cognitive nature. Generally, findings indicate that there may be some deficiencies in lay knowledge of depression symptoms, which may have bearing on recognition of depression and the subsequent social support offered to a woman who is suffering from depression.

Depression manifests most commonly through a number of symptoms, including sadness, crying, tiredness/fatigue, and loss of interest in sex (see Table 5 for common symptoms indicated by the various data sources). Sadness was the most frequently
experienced symptom in both the screening and the diary. Crying, on the other hand, was mentioned frequently in the screening but not in the diary, indicating that while it is experienced intensely (based on the number of women screened who assigned the highest possible score to crying), it may occur rarely for any single woman so as not to appear with much frequency in the three-week diary. Tiredness/fatigue and loss of interest in sex are frequently mentioned and experienced intensely. These symptoms may be due to the advanced age of the sample and to prevalent comorbid illness, while the latter may also reflect widespread marital strain in the study area.

Table 5. Comparison of depression symptoms across data sources

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<th>Symptoms listed by group discussion participants</th>
<th>Most frequent symptoms in the screening</th>
<th>Most frequent symptoms in the diary</th>
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<tr>
<td>Somatic symptoms</td>
<td>Tiredness/fatigue</td>
<td>Tiredness/fatigue, loss of energy</td>
</tr>
<tr>
<td>Loss of interest</td>
<td>Pessimism</td>
<td>Changes in sleeping pattern</td>
</tr>
<tr>
<td></td>
<td>Guilty feelings</td>
<td>Agitation</td>
</tr>
<tr>
<td></td>
<td>Loss of pleasure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Loss of interest in sex</td>
<td></td>
</tr>
</tbody>
</table>

In-depth interview participants express their own poor mental health in terms of sorrow, pain, crying, hopelessness, and suicidal thoughts. The reference to suicidal thoughts is notable given their absence in the screening and diary. This may be an effect of intense stigma associated with suicide: suicidal thoughts were mentioned only after we established rapport with participants.
Finally, Luo culture recognizes a variety of mental illnesses, many of which are spiritual or social in origin. Similarly, perceived causes of depression are predominantly social (and to a smaller extent spiritual). In particular, issues related to poverty and marital strain are thought to lead to depression. Modern marriages are characterized by frequent conflicts and difficulty, manifested in intimate partner violence, substance abuse, strains associated with polygamy (which, despite being romantically re-imagined, was probably never ideal for women’s mental health) and infidelity, and detrimental expectations related to widowhood, childbearing (including son preference) and patrilocality. In addition to underlying most sources of marital strain, poverty itself causes distress. The most significant draw on household resources is for school fees (which is especially problematic when one considers that educational achievement in no way guarantees employment in modern Kenya), followed by health-related expenditures, brideprice and home construction, costs associated with funerals, and group and church contributions. Access to formal employment is limited. Some engage in casual labor or start small businesses. While new developments in the area have improved business prospects, inconsistent and unequal access to capital hampers small business success.

Biological and psychological understandings of the origin of depression are absent in the collective cognizance. The perceived etiology of depression as a social disease has implications for how women navigate the therapeutic landscape, particularly in relation to the allopathic health system. That is the topic of the next chapter.
CHAPTER 5: ALLOPATHIC HEALTH SYSTEM RESPONSE

You can’t receive happiness from the hospital. It can’t be treated. They only give you medicine to make you sleep. (Selline, herbalist)

*****

In this chapter, I explore the modern, or allopathic, health system component of the therapeutic landscape. I begin by describing the facilities and providers in the study area. Then I explore the ways in which people engage with the allopathic health system for illnesses and conditions other than depression. This enables an appreciation of how engagement with the modern health system is different for women facing depression. Finally, I explore the state of allopathic mental health care in the study site, highlighting challenges and opportunities for providing mental health care through the allopathic health system.

5.1 Health facilities and providers

In 2011, Japan International Cooperation Agency and Kenya’s Ministry of Public Health and Sanitation partnered to develop a Health Facility/Community Unit Directory for “larger” Siaya District. At the time of that writing, Karemo Division (one of three divisions in “smaller” Siaya District), was home to 17 health facilities servicing its population of 84,981. This yields a ratio of one facility per 4999 residents. While this value falls intermediate to the other divisions within smaller Siaya District (1:4588 for Uranga Division and 1:7483 for Boro Division), most facilities in Karemo are concentrated in Siaya township (see map of facilities in Karemo Division in Figure 7).

---

7 While the ratification of a new Kenyan constitution in 2010 ushered in changes in government administrative units, those changes had not been fully implemented at the time of fieldwork in 2012. Thus, this dissertation refers to old units and boundaries.

8 Until 2007, Siaya District was comprised of what is now known as Gem District, Ugenya District, and (“smaller”) Siaya District. The previous boundaries are often referred to as “larger Siaya District”.

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Thus, health facility coverage of the more remote study site remains relatively sparse, despite recent efforts of the Kenyan government to decentralize the health system by building health facilities in more remote communities.

Figure 6. Health facilities in Karemo Division

The 17 health facilities in Karemo Division are listed in Table 6. Those that are relatively near the study site are highlighted.

Table 6. Health facilities in Karemo Division

<table>
<thead>
<tr>
<th>Facility name</th>
<th>Type of facility</th>
<th>Catchment population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bama Hospital</td>
<td>Private</td>
<td>3075</td>
</tr>
<tr>
<td>Bar Agulu Dispensary</td>
<td>Government</td>
<td>5580</td>
</tr>
<tr>
<td>Bar Olengo Community Dispensary</td>
<td>Government</td>
<td>5751</td>
</tr>
<tr>
<td>Future Life Community Dispensary</td>
<td>FBO</td>
<td>1281</td>
</tr>
<tr>
<td>Kogelo Dispensary</td>
<td>Government</td>
<td>8654</td>
</tr>
<tr>
<td>Mulaha Dispensary</td>
<td>Government</td>
<td>3075</td>
</tr>
<tr>
<td>Mur Malanga Dispensary</td>
<td>Government</td>
<td>171</td>
</tr>
<tr>
<td>Nduru Masumbi Dispensary</td>
<td>Government</td>
<td>769</td>
</tr>
<tr>
<td>Ng’iya Health Centre</td>
<td>FBO</td>
<td>11,701</td>
</tr>
<tr>
<td>Nyathengo Dispensary</td>
<td>Government</td>
<td>5921</td>
</tr>
<tr>
<td>Paula Maternity and Nursing Home</td>
<td>Private</td>
<td>683</td>
</tr>
<tr>
<td>Name</td>
<td>Type</td>
<td>Population</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------</td>
<td>------------</td>
</tr>
<tr>
<td>Randago Dispensary</td>
<td>Government</td>
<td>769</td>
</tr>
<tr>
<td>Siaya District Hospital</td>
<td>Government</td>
<td>44,923</td>
</tr>
<tr>
<td>Siaya Medical Centre</td>
<td>Private</td>
<td>569</td>
</tr>
<tr>
<td>St. Luke’s Clinic</td>
<td>FBO</td>
<td>3160</td>
</tr>
<tr>
<td>Ting’wang’i Health Centre</td>
<td>Government</td>
<td>11,871</td>
</tr>
<tr>
<td>Umala Dispensary</td>
<td>Government</td>
<td>4954</td>
</tr>
</tbody>
</table>

Source: Japan International Cooperation Agency and Kenya Ministry of Public Health and Sanitation’s Health Facility/Community Unit Directory for “larger” Siaya District (2011)

In addition to government health facilities, the allopathic domain consists of faith-based facilities like Ng’iya Health Centre (operated by the Anglican Church). Generally considered to deliver high quality care, they are also expensive. Local government facilities like Nduru Dispensary and Kogelo Dispensary, in contrast, are more affordable, but are plagued by staffing problems and stockouts of critical supplies and medications. Indeed, during two separate visits to Kogelo Dispensary, one in 2010 and one in 2012, Coartem, the first line treatment for malaria in this malaria-endemic area, was out of stock (in 2010, the dispensary was also stocked out of gloves and needles).
In 2007, the Ministry of Public Health and Sanitation adopted a Community Health Strategy to strengthen community participation in health. The strategy established Community Units (CUs), groups of trained Community Health Workers (CHWs). These CHWs work on a voluntary basis and are supervised by trained Community Health
Extension Workers who are employed by local health facilities. Though the strategy represents a promising approach to engaging the community in allopathic health care, in practice CUs are under-resourced and plagued by problems typical of other ventures relying on significant work by volunteers. There are only two CUs in Karemo Division (see Table 7). Only one (Kogelo CU) is relatively near the study site.

Table 7. Community units in Karemo Division

<table>
<thead>
<tr>
<th>Community unit</th>
<th>Home facility</th>
<th>Number of CHWs trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kogelo CU</td>
<td>Kogelo Dispensary</td>
<td>50</td>
</tr>
<tr>
<td>Nyajuok CU</td>
<td>Ting’wang’i</td>
<td>50</td>
</tr>
</tbody>
</table>

Source: Japan International Cooperation Agency and Kenya Ministry of Public Health and Sanitation’s Health Facility/Community Unit Directory for “larger” Siaya District (2011)

When asked to list the health facilities in the area, group discussion participants list only Nduru Dispensary and Kogelo Dispensary. In-depth interview participants note several others in the course of explaining their actions during previous illness episodes. Most of the facilities listed are relatively distant to the study site because they were mentioned in the context of a recent significant illness episode (minor illness episodes, for which care is obtained locally, were probably not recalled as readily as more significant illness episodes). Table 8 lists all allopathic health facilities mentioned by participants.

Table 8. Health facilities mentioned in in-depth interviews

<table>
<thead>
<tr>
<th>Facility</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aga Khan Hospital</td>
<td>In Kisumu, 73 km by road</td>
</tr>
<tr>
<td>Busia District Hospital</td>
<td>Out of the district, 58km by road; participant went for a blood draw/lab</td>
</tr>
<tr>
<td>Siaya District Hospital</td>
<td>In Siaya township, 10km by road</td>
</tr>
<tr>
<td>Nduru Dispensary</td>
<td>Very near study site</td>
</tr>
<tr>
<td>Alupe Hospital</td>
<td>Out of the district, 61km by road</td>
</tr>
</tbody>
</table>
Bondo District Hospital  Out of the district, 22km by road; participant went to “add blood and water”
Tanaka  Out of the district, 57km by road
Kenyatta National Hospital  In Nairobi, 404km by road

Source: In-depth interviews

Participants mentioned other entities providing allopathic medicine, including pharmacists, small store (kiosk) owners, CHWs, and Lion’s organization. Additionally, a key informant mentioned the CHWs employed by the CDC and Columbia University’s ICAP (originally known as the International Center for AIDS Care and Treatment Programs). A directory of nongovernmental organizations and donor agencies operating in Siaya as of 2008 lists 36 organizations. These include large international organizations like Care Kenya, AED (formerly the Academy for Educational Development), Kenya Red Cross, AMREF, CDC, and Heifer International, as well as faith-based organizations like World Vision, Young Women’s Christian Association, and Christian Children’s Fund. While many of those focus primarily on agriculture or poverty alleviation, nearly every program has a health component. Most focus on HIV/AIDS prevention, care, and support; others address malaria control, nutrition, or reproductive health. None offer mental health services. Collectively, these organizations are viewed as partners that bolster the work of the underfunded government health system. Thus, they are included here as an auxiliary component of the allopathic health system.
5.2 Women’s engagement with the health system

This section addresses how participants engage with the health system for illnesses and conditions other than depression, providing the context for understanding how the case of depression is unique. I begin with a brief discussion of health care pluralism, placing the allopathic health system within the larger therapeutic landscape. Then I discuss two of the most salient factors influencing movement through the allopathic health system: access and effectiveness. Finally, I consider real health actions in response to recent acute and chronic non-depression ailments.

Pluralism

Modern health systems are characterized by a high degree of pluralism, with different types of healers practicing a number of healing strategies, often blended from various healing traditions. Typically, for individuals engaging with pluralistic health systems, several different strategies may be called upon for addressing a single ailment, either concurrently or in series. This is particularly true for complex ailments like
epilepsy. Both Patricia and Susan have used a variety of healing strategies in seeking epilepsy cures for their respective sons. Susan explains:

FO (Interviewer): Can this disease be treated?
Susan: I have tried very much. He was given some drugs. So far he has taken them for six years without any change.
FO: Have you ever asked where it can be treated?
Susan: I have tried. Sometimes I took him to Makini. They also told me to give him the same medicine. Recently I took him to my sister…She told me she should be coming with some herbs she was given by a colleague she works with, that he used on his brother and he got cured. The herb is taken for six months.
FO: What about faith healers?
Susan: No, I have not yet gone there.
FO: Even Legio Maria, there’s nothing they can do?
Susan: I have never gone to Legio but I was told to try at Dr. Owuor because he performs miracles.

Patricia even admits seeking the help of an ajuoga:

FO (Interviewer): Have you gone to [famous ajuoga] Owuor Odongi’s place?
Patricia: We have tried all those. There is nowhere we have not gone…We have tried our best but it seems he will not get treatment. We have gone to many ajuoga who are just deceiving us. There’s one who told us to go with a chicken and striped ram, but he still could not cure him.

Illness narratives of other participants reveal that they may use home remedies (e.g., salt on a wound to stop bleeding, according to Jaqueline) before going to a health facility for treatment. They may receive prayer healing before being taken to the hospital (e.g., Grace), or vice versa (e.g., Patricia). They may follow a course of malaria medicine with herbs, as advised by a nurse friend (e.g., Susan).

Some participants, particularly those who attend mainline churches, insist that they use allopathic medicine only. If they are prayed for, it is by a church pastor who is not endowed with any special spirit powers beyond calling upon “God’s grace”.
Josephine states, “When I get sick, I decide on my own to go to pray or I go to see a doctor. I don’t go to anyone else.” This type of healing prayer is distinct from that
delivered by a faith healer. The historical circumstances leading to this distinction between praying for health and seeking out spirit-infused prayer healing will be discussed in the next chapter.

Access

In the study area, access and affordability are most salient factors influencing health-seeking behavior. Nearly every participant recounts stories of deferring or not receiving needed medical care because of lack of money for hospital fees, transport, or medication. Evelyn explains:

I was sick, and I was referred to Aga Khan hospital [Kisumu, 1 hour by bus]. I didn’t have any money but I knelt down and prayed to God. It’s now two weeks since I was referred to the hospital but now feel okay even though I have never gone to hospital.

Alternatively, participants may make self-prescribed substitutions for costly procedures and medicines. For a previous visit to Aga Khan, the Ksh. 2500 Evelyn borrowed from a friend was not enough to cover blood tests that totalled Ksh. 10,000. Evelyn decided to forgo the recommended blood test, opting instead to test for pressure for Ksh. 600.

Participants make the same decisions for major, life-threatening illnesses too. At the hospital in Siaya, Salome was told that she needed to go for an x-ray before she could undergo an operation to remove her goiter. When she was told the x-ray would cost Ksh. 500, she returned home unexamined. She appealed to her social network for support, but “not even one person responded.” Meanwhile, Salome has quit massaging the goiter and it continues to grow. Additional examples of poor health system access are presented in Box 12.

Box 12. Examples of poor health system access
Salome was prescribed medication for her arthritis that she is unable to take because of its cost (Ksh. 700).

Grace prays for money to go to the hospital to get the metal in her arm removed. She receives encouragement from her husband that she should “hold on,” “that as soon we will get money, he will take me to hospital to remove the metal.” She also makes self-prescribed substitutions, explaining that she bought Panadol “because the amount I had I could not afford to go to hospital.”

Eunice uses a rub to treat her severe back pain. She feels that she needs help to seek treatment: “For the treatment it needs enough money that I don’t have. For now I just surrender it to God.”

Millicent deferred a recommended operation because of its prohibitive cost (Ksh. 36,000). Instead she uses herbs to treat her stomach problem.

Susan could not afford the spectacles she was advised to buy at Siaya District Hospital, “so it’s like I didn’t complete the dosage.”

Agneta describes waiting for assistance from her mother-in-law so that she can go to the hospital. In the meantime, she buys Panadol because it is “affordable since I had only Ksh. 5 by then.”

Another access issue relates to accessibility. Because most people in the study area must walk to a health facility for treatment, accessibility issues arise, especially in the case of a severe illness that hampers mobility. Helen explains that she is unable to go to the hospital when she experiences severe abdominal pain “because at that particular time I cannot walk.” Other access issues, including availability and acceptability, were not mentioned by participants, suggesting that they are not salient concerns in this context.

Effectiveness

A second factor that shapes health-seeking behavior is related to perceptions of effectiveness. Participants recount numerous instances in which medications and care provided at allopathic health centers were not effective in curing a particular ailment. Recently, for example, Eunice visited Siaya District Hospital and was diagnosed with
typhoid, yet she reports, “The medicines that I was given don’t even work.” See Patricia’s story in Box 13.

Perceived ineffectiveness of allopathic providers and medications is powerful in redirecting health-seeking behavior away from the allopathic domain. Group discussion participants note that while most people turn to God and the hospital when they fall ill, the hospitals are thought to be ineffective at treating those things that are “caused by bad omen.” When a person consults a number of doctors and fails to get cured, he typically turns to a witch doctor for help. Stories of people being successfully cured by witch doctors or faith healers abound and shape the collective perception of the continued relevance of these healing traditions. A group discussion participant notes that, “There are some [faith healers] where someone can go while they are very sick, but they come out of there treated.” Similarly, Patricia tells of taking her son to a faith healer for an ailment of which he was cured. When asked if she thought the healer’s prayer was useful, Patricia responded, “Yes it was, because I did not go to the hospital.”

**Box 13. “All the ways are blocked”**

Patricia is 35 years old and the mother of five children. Her eldest son suffers from severe epilepsy. He suffered his first epileptic episode 13 years ago, when he was just three years old. Patricia believes that he caught it when he “passed it on the road.” She explains, “It seemed like someone else who had the same disease was treated, then he ‘left the disease on the way’ and my son passed it.” She has taken her son to the hospital for treatment but the outcome has been less than satisfactory:

> I have tried my best. He has been given many drugs that worsen it instead. I was told not to give him the drug anymore so that he can just be like that. We tried another medicine that did not react with him very well. We used to spend Ksh. 50 every week. We left that too. The doctor advised us to.

Over the years, she has also sought out assistance from faith healers. In fact, her quest to find a cure for her son’s epilepsy led her to the church where she currently prays, despite the fact that their prayers have not cured him. The church tells Patricia that the affliction from which her son is suffering is not epilepsy. A faith healer at another church once told
Patricia, “I pray for people and they get cured, but this one will never get healed.” Patricia is losing hope: “We have tried prayers, hospitals and everywhere else and at the moment we feel there is not a cure at all because it’s getting worse instead.” When asked to name her lowest life experience, Patricia cites her son’s sickness, “because you know other events are there for awhile but this will always remain. It takes away my thoughts.”

The burden of paying her son’s hospital bills exacerbates the economic hardship she faces and she feels that there are no options:

| FO (Interviewer): We have been talking about your depression. How do you feel right now? |
| Patricia: It is there. You know what disturbs me is peace in my house and the welfare of my children, nothing more. |
| FO: Like now what’s disturbing you? |
| Patricia: Peaceful living is brought by security of money but if there’s nowhere to get the money do you think things will be okay? All the ways are blocked. |

Ultimately, perceptions of effectiveness shape institutional trust. Essentially, people seek health care from facilities and providers whom they trust. Trust may depend in part on abstract notions of faith. According to a group discussion participant:

| It depends on what people believe in. It’s like everywhere is trusted by different people. If you go to hospitals you will get many people there. The same applies when you go to churches. When you go to ajuoga and jamanyasi (traditional herbalist who treats Luo diseases; similar to an ajuoga), you will equally get people there. |

5.3 Responses to acute recent and chronic non-depression ailments

Evidently, poor access and perceived ineffectiveness serve to drive people away from the allopathic health system. Yet, an examination of the health actions taken by participants in response to recent acute and chronic illnesses reveals that the allopathic health system still figures largely in their health-seeking strategies. Tables 9 and 10 present the health actions taken by participants in response to acute and chronic illnesses. While some individuals delay treatment-seeking for an acute illness (in favor of seeking lay advice or trying home remedies like salt on a wound, massage, and sleep), all
eventually receive allopathic care. Several proceed through multiple steps in their allopathic health-seeking process, including trying multiple medications and visiting multiple facilities. Only one participant used herbal medicine for a recent illness; and this, only after she received care from a dispensary. Moreover, one individual was treated by a *nyamrerwa*. While this term traditionally referred to a traditional birth attendant, today it is used to refer to a CHW. It is unclear in this context which meaning is implied. In any case, it appears that, for recent acute illnesses, participants overwhelmingly rely on allopathic healing strategies, despite issues related to poor access and perceived ineffectiveness.

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Diagnosis (self-diagnosis and/or diagnosis by health provider)</th>
<th>Health actions</th>
</tr>
</thead>
</table>
| Elevated heart rate, tiredness   | Initially malaria, eventually high blood pressure             | - Went to Nduru Dispensary where she was given Panadol and Coartem  
- Went back to the same facility where she was given “some capsules” and told to buy diclofenac cream  
- Was taken to Busia District Hospital where blood tests were performed  
- Was taken to Alupe District Hospital by niece, diagnosed with pressure and given medication |
| Swollen face                     | Boil                                                          | - Asked neighbor what could be wrong, was told that is might be a boil  
- Took Septrin  
- Went to hospital after swelling had reduced |
| Cold, shivering                  | Malaria                                                       | - Bought Panadol  
- Next day, bought Mara Moja  
- Next day, sister went to pharmacy and bought malaria tablets according to pharmacist’s instructions |
<table>
<thead>
<tr>
<th>Injury</th>
<th>Source: In-depth interviews</th>
</tr>
</thead>
</table>
| Leg injury, headache, stomachache | -Used salt on wound to stop bleeding  
- Went to hospital as per advice from a “certain woman” |
| Headache, chest ache, nosebleed | -Did nothing, slept  
- Went to hospital where she was given medication for the headache and chest pain |
| Headache, joint pain, fatigue | Malaria, low blood pressure  
-Bought medication – for malaria and pain  
-Went to Nduru Dispensary where she was given medicine  
-Used herbal medicine |
| Fever, headache, difficulty breathing | Malaria  
-Bought painkillers  
-Next day, went to hospital where she was given medication |
| Headache, body aches | Typhoid  
-Went to Nduru Dispensary where she was given malaria tablets and painkillers  
-Went to Siaya District Hospital where she was given Panadol and told to buy other medicines |
| Dizziness | None  
-Went to hospital where she was given Septrin |
| Headache, body aches | None  
-Took Panadol and Franol |
| Boil, back pain | Boil  
-Went to hospital where she was sent for an HIV test |
| Joint pain, diarrhea, weakness, lack of appetite, headache | Malaria  
-Went to nyamrerwa in the area; was given medications that she took for three days |
| Shivering, chest pain | None  
-Kept herself warm by putting on a sweater and took Panadol  
-Went to hospital |
| Neck pain, headache | Meningitis  
-Did nothing, continued with chores  
-Was massaged by co-wife  
-Went to hospital |

With respect to health-seeking behavior for chronic ailments, major delays in care attributable to poor access are evident. Two participants note that they are in need of
major operations that they have put off because they can’t afford them. Others discontinue recommended medications because of their cost. However, despite the barriers to accessing allopathic care for chronic ailments, it does not appear that participants substitute actions from other healing modalities. With the exception of making dietary changes (e.g., eating a balanced diet, using milk to calm the pain of ulcers), participants who have elected to refrain from allopathic care take no other health actions, instead resigning themselves to “doing nothing.” Thus, though the allopathic health system leaves much to be desired in the way of access and effectiveness, it is still the predominant healing strategy invoked in response to acute and chronic ailments.

Table 10. Health actions taken for chronic illnesses/conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Health actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>High blood pressure and bloody diarrhea</td>
<td>-Goes to hospital only</td>
</tr>
<tr>
<td>Goiter and arthritis</td>
<td>-Lived for a long time without seeking treatment for arthritis</td>
</tr>
<tr>
<td></td>
<td>-Eventually went to the hospital where blood test was performed</td>
</tr>
<tr>
<td></td>
<td>-Was prescribed medication but she doesn’t always use it because it is very expensive</td>
</tr>
<tr>
<td></td>
<td>-Uses diclofenac to reduce the pain</td>
</tr>
<tr>
<td></td>
<td>-Used to massage goiter but it continued to grow</td>
</tr>
<tr>
<td></td>
<td>-Went to the hospital but cannot afford to get the operation they recommended</td>
</tr>
<tr>
<td>Injury (pain)</td>
<td>-Initially treated at Kenyatta National Hospital where she was given pain medication; discontinued it after doctor warned her about developing dependence</td>
</tr>
<tr>
<td></td>
<td>-Now she does nothing for the pain</td>
</tr>
<tr>
<td>Boils and back pain</td>
<td>-Usually receives malaria injection at hospital (works for some time, then boils reappear)</td>
</tr>
<tr>
<td></td>
<td>-Was once told to test for HIV</td>
</tr>
<tr>
<td>Abdominal pain and constipation</td>
<td>-Was given medication at hospital</td>
</tr>
<tr>
<td></td>
<td>-Hospital recommended operation but she cannot afford to get it</td>
</tr>
<tr>
<td></td>
<td>-Takes herbs, eats fruits, avoids ugali</td>
</tr>
<tr>
<td>Condition</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Ulcers</td>
<td>Initially used herbal medicine, but now it exacerbates the pain&lt;br&gt;Uses Actol and drinks milk</td>
</tr>
<tr>
<td>Chest pain</td>
<td>Goes to the hospital where she receives tablets</td>
</tr>
<tr>
<td>Eye pain, hip pain</td>
<td>Takes tablets for eye pain (was given by doctors)&lt;br&gt;Was advised by Lions Organization to buy spectacles and use gentamicin&lt;br&gt;Went to Siaya District Hospital where she was told to buy medicine and spectacles&lt;br&gt;Has not sought treatment for hip pain</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>Initially went to hospital&lt;br&gt;Now doesn’t take any action</td>
</tr>
<tr>
<td>HIV</td>
<td>Regularly takes medicine&lt;br&gt;Eats a balanced diet</td>
</tr>
<tr>
<td>Back pain</td>
<td>Goes to hospital where she is told it is typhoid&lt;br&gt;Uses rub for pain relief&lt;br&gt;Once massaged it but it exacerbated pain</td>
</tr>
<tr>
<td>Dizziness</td>
<td>Goes to hospital only</td>
</tr>
<tr>
<td>Asthma and headaches</td>
<td>Takes Panadol and Franol&lt;br&gt;Avoids going to hospital because they will give alternative medications while she prefers Franol</td>
</tr>
</tbody>
</table>

Source: In-depth interviews

### 5.4 Women’s engagement with health system for depression

Participants were asked about their experience of depression, including their perceptions of what has caused them to feel depressed and all the actions they have taken to respond to their depressed state. Responses are presented in Table 11. What is absent from the responses listed by participants is notable. Overwhelmingly, participants fail to mention medical treatment options. When Millicent loses her children and becomes sick and depressed, she is advised to “refrain from depression and go to the hospital.” It is unclear whether she is advised to go to the hospital for treatment for depression or
because of the accompanying physical ailments, but based on the body of responses, I suspect the latter. In addition, while group discussion participants insist that “counseling” is available for women who suffer from depression, none of the participants mention seeking it out or even knowing of its availability. In addition, discussions with staff at local dispensaries confirm that no formal mental health counseling is available. Group discussion participants may be referring to the psychosocial support given to people living with HIV/AIDS as a component of the care continuum, to the informal counseling (more appropriately, “advice”) delivered by CHWs during home visits, or to the formal mental health counseling delivered at larger, district and regional hospitals.

Table 11. Causes of and responses to depression

<table>
<thead>
<tr>
<th>Causes</th>
<th>Responses</th>
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</thead>
<tbody>
<tr>
<td>“I’m always depressed when I don’t have money or when I don’t have</td>
<td>“I always kneel down and pray to God for help.”</td>
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<tr>
<td>food – grains, cereals.”</td>
<td>“I just stopped asking money from [my stepsons] because if I ask and</td>
</tr>
<tr>
<td>“What always bring me stress is when I’m sick and I ask money from</td>
<td>they don’t give me, it makes me think of my own children.”</td>
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<tr>
<td>my stepsons and they refuse to give me. They make me think of my</td>
<td></td>
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<tr>
<td>lost children and childlessness. I feel that if I had a child, he</td>
<td></td>
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<tr>
<td>would be helping me.”</td>
<td></td>
</tr>
<tr>
<td>“There are those things that can befall you after losing a</td>
<td>“At night I do pray to God.”</td>
</tr>
<tr>
<td>breadwinner. Being a woman, there are things that you can’t</td>
<td>“I always indulge myself with activities to make me busy, that also</td>
</tr>
<tr>
<td>accomplish and you start wishing that, if he could be here, such</td>
<td>distract my mind.”</td>
</tr>
<tr>
<td>thing could have taken place.”</td>
<td>“Maybe to go for our groups meetings, like now after departing ways</td>
</tr>
<tr>
<td>“Am always troubled since I have never attained as I have always</td>
<td>with you, I will go for the meeting where we will make stories, that</td>
</tr>
<tr>
<td>wished for. Though a person cannot get all he wants, he has to</td>
<td>help me to forget all my issues.”</td>
</tr>
<tr>
<td>have those things that he want to do.”</td>
<td></td>
</tr>
<tr>
<td>“I have always told my husband about it, but he always tells me</td>
<td></td>
</tr>
<tr>
<td>that one day God will open a way for us and it will be fine. We</td>
<td></td>
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<tr>
<td>should not be in a hurry.”</td>
<td></td>
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<tr>
<td>“It was because I had no source of income generating activity.”</td>
<td>“It was just marital problems…You know when you are together, there are many things that go wrong between. But you cannot get the same at your maternal home. If one is a drunkard, you can easily understand him, but imagine one who doesn’t drink and behaves as if he is one.”</td>
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<tr>
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<tr>
<td>“My main problem now is my son who is just there and cannot help anything…He doesn’t send any [money]. Even when the wife is now here, he doesn’t.”</td>
<td>“They are just every day thoughts that an adult must have…[They are triggered by] pain.”</td>
</tr>
<tr>
<td>“I’m lonely since my mother died. When I’m alone I think of her most of the time.”</td>
<td>“I didn’t like the way I dropped out of school.”</td>
</tr>
<tr>
<td>“Right now it’s about my epileptic son and another one who has been sent for school fees.”</td>
<td>“One had happened when my husband lost his job.”</td>
</tr>
<tr>
<td>“It is just small quarrels with the people I stay with…It’s my co-wife. She has many issues like rainfall.”</td>
<td>“Mostly when I lack what to eat, or when I am wronged by my husband.”</td>
</tr>
<tr>
<td>“Mostly I pray…Am always stressed when am idle, so I do try to be busy.”</td>
<td></td>
</tr>
<tr>
<td>“The deep thought that I have always have is about my sickness…The stress of buying food during hunger time.”</td>
<td>“Nothing other than praying.”</td>
</tr>
<tr>
<td>“I’m just depressed on how I can get money to solve my problems…It’s just about poverty. It’s the one that brings all these.”</td>
<td>“I don’t do anything. I leave everything to God.”</td>
</tr>
<tr>
<td>“My husband married a second wife and he took most of his time there.”</td>
<td>“I thought of leaving this house as well because it was like my husband ran away.”</td>
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<tr>
<td>“Right now it’s just about my son who is still in jail…Just maybe how I can eat with my family who some of them are ever in need of food oblivious of where it is coming from.”</td>
<td>“After being encouraged by my friends, I dedicated it to God…At hard times I do borrow some maize for flour.”</td>
</tr>
<tr>
<td>“At times I always wonder why it had to happen that way, losing all men in a home, leaving behind incapable women. It has stressed me a lot, like their children who were in good life, always had access to money, but since the death of their fathers they force themselves to be in that life. That’s why they have opted to steal.”</td>
<td>“I just always pray…I just always comfort myself that all those happenings are far less than losing my children.”</td>
</tr>
</tbody>
</table>

Source: In-depth interviews

This absence of allopathic health actions represents a departure from the health-seeking behavior for other ailments. Information presented in Chapter 4 revealed the perceived social and spiritual (versus biological or psychological) etiology of depression, and the causes of depression listed in Table 11 refer to social issues, so it is no surprise that women do not seek allopathic care for depression. Emily (see Chapter 1) is the exception, but in her case, she was living in urban Mombasa at the time, was highly educated, and was suffering from depression so severe that she was committed to a psychiatric hospital for some time. For the average woman living in rural Siaya, allopathic medicine is not part of the therapeutic landscape for depression because depression is not seen to have a biological or psychological origin. Selline, an herbalist
who herself has experienced depression, sums up this idea: “You can’t receive happiness from the hospital. It can’t be treated. They only give you medicine to make you sleep.”

Of course, there are also supply side factors that prevent any meaningful engagement with mental health on the part of allopathic health providers. The rest of this chapter explores the state of allopathic mental health care in the study site. While participants did not seek out this form of health care for depression, it is important to account for its capacity to accommodate mental health issues, were an intervention to transform the health system to be implemented.

5.5 Mental health care

The following discussion relies on field observations and interviews with the following allopathic health care providers.

- Kareem is a clinical officer in the Comprehensive Care Center (for HIV/AIDS care and treatment) at a dispensary near the study site. Born in Kericho in the Rift Valley, Kareem has been working in Siaya for the past two years.
- Christine, originally from Kitale in the Rift Valley, is a nurse at one of the local dispensaries for the past two years.
- Deborah is a CHW working in the areas surrounding one of the local dispensaries. Deborah moved to her matrimonial home in Siaya in the early 1980’s and became a CHW in 1994. She was instrumental in advocating for the construction of the local dispensary in 2007.
- Michael is on the psychiatric staff at Siaya District Hospital. Michael is also responsible for running the Millennium Villages Project mobile mental health clinic (discussed below).
5.5.1 Siaya District Hospital

I first encountered the allopathic mental health system at Siaya District Hospital. In a building located offsite from the main hospital compound, patients with mental illness were locked in communal rooms, one for men and one for women. The nurse escorted me to a glassless window covered by a wire grate to visit the six female patients. The women were heavily sedated; the few who were awake had the glossy eyes of the overmedicated. A stench emanated from the dark and filthy room: there was no toilet in the women’s wing. According to the nurse, most of the men were suffering from drug-induced psychosis, while the majority of the women were afflicted by family-related “stress”, brought on most often when a woman rejects gender norms about marriage or childbearing and is persecuted by neighbors and relatives. No distinction between mental illness, mental disability and neurotic disorder was made by hospital-based care-givers here: patients with epilepsy were locked in the room with patients with severe psychosis. A separate cement room with a locking door awaited patients prone to violent outbursts (see photo, Figure 14 below). The petite, middle-aged nurse revealed that she was fearful because she didn’t believe she could protect herself from the patients were they to turn on her.
Inside the main hospital compound, a more inviting space was provided for outpatient mental health services. A handwritten sign adorned the door, identifying the space as the “Mental health clinic.” Available services, fees and wait times were painted directly on the wall under a banner that read “Mental Health Clinic and Community Mental Health.” All services were free. Wait times varied: the posted wait time for a “Psychiatric emergency” was 5 minutes, while a patient seeking a “Mental status assessment” could expect to wait 20 minutes. “Psychotherapy” and “Mental health education to patients and their families” were also offered; patients could expect to wait 15 minutes for those services. While other wards of the hospital were overflowing with patients, there were no patients at the mental health clinic during either of my two visits. The clinic was staffed by one psychiatric nurse who divides his time between the clinic, the offsite psychiatric ward, and a mobile mental health clinic in a neighboring district. Not surprisingly, it was rare to find him in the clinic.

5.5.2 Mobile mental health clinic
Working in nearby Gem District, the Millennium Villages Project (MVP) supports a mobile mental health clinic. Every week, the clinician from Siaya District Hospital travels to one of four sites in Gem District to provide mental health care. The four sites are two health centers, a private hospital, and a market center. These serve rural and other remote residents. In addition to covering transportation costs for the clinician, the MVP reportedly provides four medications at no cost: Amitriptyline (an antidepressant), Artane (an anti-tremor medication used to treat the side effects of antipsychotic treatment), Largactil (an antipsychotic medication), and Tegretol (an anticonvulsant and mood stabilizing medication). The MVP also supports mobile clinics at three so-called “special schools” in the area – those accommodating children with mental disabilities.

Reports were available for the patients seen at these mobile clinics in the two months prior to fieldwork. I inspected these for details. Seventy-one patients were seen in March, while 66 patients (62 of whom were revisits) were seen in April. Of the 71 patients seen across all four clinics in March, 10 (14%) were diagnosed with schizophrenia, 6 (8%) were diagnosed with depression, 34 (48%) suffered from epilepsy, 15 (21%) were deemed “intellectually challenged”, 3 (4%) suffered from “psychosomatic illness” and 3 (4%) had drug-induced psychosis resulting from alcohol and marijuana use. The breakdown was similar in April. For five of the patients diagnosed with depression, the clinician had listed the cause as “stress”, while the cause of the sixth case was listed as “HIV”. Age of patients varied: one patient with depression fell in the 11-20 year old category, one was 21-30 years of age, three were 31-40 years old, and one was 41 or older.
I accompanied Michael to one of these mobile health clinics. The clinic was held on the grounds of a private hospital just off the tarmac road connecting Siaya to the provincial capital of Kisumu. Twelve patients sat around a table under a tree awaiting Michael’s arrival (later, he recorded 16 patients on the MVP reporting form, prompting my suspicions about the accuracy of those data). Five of the patients were schoolchildren from a nearby school, wearing their school uniforms and accompanied by a teacher who explained to me his passion for working with children with mental disabilities. The children did not make eye contact or interact with anyone, instead staring off into space. When Michael arrived, he greeted the patients exuberantly and sat at the table. The clinic session started with a group prayer. One of the patients, a middle-aged man with a goofy smile, who evidently suffers from drug-induced schizophrenia, volunteered to take notes for Michael. As Michael turned his attention to each patient sitting around the table in turn, the scribe noted the patient’s name and any medications provided. The now-familiar trio of Largactil, Amitriptyline, and Artane were handed to each patient at the table, whether he suffered from schizophrenia, depression, epilepsy or mental retardation. Michael explained to several of the patients that the MVP was currently stocked out of Tegretol and so the patients would have to buy it for themselves at a local pharmacy. He told me later that Tegretol costs Ksh. 10 per tablet. For epileptic patients taking the medication two to three times per day, that amounts to a Ksh. 600 to 900 outlay per month. Beyond its prohibitive cost, Tegretol is not usually available at village pharmacies. Thus, he confided, he did not really expect that the patients would buy it.

Only one of the patients – an older woman – was suffering from depression. Michael revealed to me later that most people who suffer from depression don’t seek out
mental health care because they view depression as “normal.” To be sure, there were also supply side factors at play here. The lack of privacy and confidentiality afforded by the group format, the inconsistent supply of medications, and the absence of tailored treatment prompted me to write in my field notes, “Not a place for women with depression.”

5.5.3 Community-level care (CHWs and local dispensaries)

5.5.3.1 Diagnosis and Treatment

Kareem, who works primarily in HIV/AIDS care and treatment, sees many cases of depression among patients who are newly diagnosed. He notes that one is often able to detect it when taking the patient’s history. At other times, in the process of talking, the patient may exhibit confusion, as if her “mind is in other side”, breaks into crying without knowing the problem or while explaining the situation she is in. Kareem gives them time and eventually tries to find out the exact cause of the problem. He notes that some are not willing to share, they “just shed tears and eventually walk away.” To others, he provides reassurance, telling them, “It is not only you, but the majority of people are taking [antiretroviral] drugs.” In addition, he facilitates psychosocial support groups for people living with HIV/AIDS.

Sometimes, his patients experience depression severe enough to require medical attention. In this case, he tries to elucidate the exact cause and then treats them with an antidepressant called Amitriptyline, which is considered a “Y drug” for treating opportunistic infections associated with HIV/AIDS. He refers very severe cases to Siaya District Hospital, “because in Siaya, even if there is not psychiatrist, I think there are people who have been trained on psychiatric unit.” If the patient cannot afford
transportation to Siaya, Kareem may pay for their transportation with his own or the facility’s money. After the patient receives care at the district hospital, all follow-up happens with him at the dispensary. Curiously, Kareem was unfamiliar with Michael, the main clinician in the psychiatric department at Siaya District Hospital.

At her dispensary, Christine states that the only mental health support available is that delivered through the psychosocial support groups for people living with HIV/AIDS. For most people who come to her with depression, she gives health information and may tell the patient to avoid stress and engage herself in something that will make her not get depressed. She explains: “You just try to advise her according to her problems. But medication-wise - you know, there are drugs, but you can’t keep someone on drugs for…(trails off)”

Like Kareem, Christine refers very severe cases to the district hospital, facilitating their transport if they cannot afford fare. What is more difficult is diagnosis. According to Christine, most patients with depression come in complaining of something else:

Unless you talk to them, they will just come crying of headache. But unless you talk to them closely, they won’t tell you that they’re depressed. But you share with them, maybe you ask them why headache? Why this? They’ll tell you.

Christine feels that CHWs are the key to finding and managing cases of depression out in the community. According to Deborah, while CHWs receive training in public health care, monitoring, essential drugs, and family planning, they receive no training for counseling. When Deborah detects that one of her clients is suffering from depression, she may make a referral to the HIV/AIDS department at Siaya District Hospital for psychosocial support, or to a support group at nearby Nduru Dispensary. She continues to visit until the patient “comes up.” At other times, a
clinician may instruct Deborah to visit a particular person of concern. With further training and formalization of these linkages, all of these mechanisms may be exploited to more effectively reach people in need of mental health care.

5.5.3.2 Causes

According to Kareem, depression is a seasonal condition. He sees more cases when the weather is cold and before harvest. During these times, mothers have many problems, including hunger and lack of food to take with their ART. At these times, the “problems pile up” and women “don’t know what to do.” Deborah adds that poverty may contribute to quarreling, and with no constructive way of solving conflicts, quarrels take a toll on mental health. In addition, Deborah blames alcohol for many problems that contribute to poor mental health.

In his work in HIV/AIDS care and treatment, Kareem sees many scenarios that lead to mental distress among women, such as when a husband refuses to get tested, when a partner throws a woman’s HIV medications away, or when pregnant mothers consider that their baby might become infected. In Christine’s experience, depression mainly affects battered women. She laments the fact that most women do not follow her advice to leave an abusive marriage, but concedes that many are in desperate situations. Other issues, she says, contributing to depression include low socioeconomic status, the fact that women do most of the work but rarely receive recognition, cultural beliefs that restrict a woman from building a house without a man and otherwise prevent women from advancing themselves, and the preponderance of men who forbid their wives to use family planning. With respect to the latter, she explains:

There was a woman who came - she’s given birth nine times. Two kids are dead, she has seven kids, so when she came to us, we told her about family planning
and she accepted, so we had to put in her implant - Implanon. So that was in December we had to fix it. But it was last week that she came - she said the husband told her to go to her place - to her parents’ place - because he doesn’t want anything like family planning… The reason she came, she was to come and give birth to kids - so why does she not give birth to kids? Why is she doing family planning? So she came to us but we just empowered her. We told her, it’s your health. Go take care of the kids, we are not removing that Implanon. Just go and explain to the man what we told you. If he doesn’t understand, come with him. But she hasn’t come back.

In the community, the clinicians encounter many misconceptions about depression. According to Kareem, people often confuse depression with bewitchment and set out to try to discover who cast the spell, usually suspecting the culprit’s ill intentions the result of jealousy. Deborah adds that most people believe that witch doctors are better able to treat (in general) than government hospitals. In addition, in Deborah’s experience, people conflate depression with HIV because of the weight loss that may occur. In that event, people suffering from depression experience AIDS-related stigma, contributing to further isolation.

5.5.3.3 General challenges at community level

In Kenya, a nurse, clinical officer, or doctor who enlists to work in the public sector may be sent to any health post in the country. Thus, the health care provider working at any local health facility is not likely from that community. The health care providers in Siaya are no different: both Christine and Kareem are outsiders, originally from the Rift Valley. In fact, Kareem speaks very little of the Luo language, which is notable in a place where the majority of the people speak only Luo. Even more troubling, Christine expresses disdain for the local population: “People are so negative sometimes. Maybe they see you - they come from the Obama family and what have you, so they look down on people.”
In our short interview, Christine expresses the sentiment that “they are not good people” three times. She cites the near constant disputes:

I don’t know why there are so many internal wrangles. Even in the facility as we work. The community - the representatives of the community - they are not even wanted by the community. Sometimes maybe the chairman is bad. Maybe somebody who is working here should come from this place. You see? They are not friendly as such. They are not.

At times, the generalized antipathy she describes may be directed toward Christine. When there are drug stockouts at the dispensary, the community may turn against her: “Sometimes…they haven’t supplied the drugs [so] you tell them to buy the drugs. They tell you you’ve stolen the drugs - maybe the drugs have come and you’ve stolen and what have you.”

Christine cites other challenges in her work. The government doesn’t supply medications with adequate consistency, resulting in frequent stockouts of essential drugs. In the case of stockouts, patients are instructed to buy the medications at a local pharmacy, but many cannot afford to do so. Other times, Christine feels that the low levels of education contribute to non-compliance with her advice. She believes that many people seek out indigenous healing before coming to the dispensary, which may delay their treatment.

Because CHWs are elected by the community, Deborah does not experience challenges that other allopathic health care providers may experience due to their origination in communities outside the facility catchment area. Deborah’s main challenge arises due to the voluntary nature of her work. Despite working full-time and being responsible for 200 households who depend on her for family planning, polio vaccinations, vital record registration, and detection and monitoring of community health
issues, she works on a purely voluntary basis. Only when they are in seminar do the CHWs receive compensation, and then it is only lunch and a transportation allowance. Not surprisingly, turnover is high: of the 30 CHWs who were trained in Deborah’s cohort, only 15 remain working. Deborah explains her struggles:

If they can pay us, we can work so hard. But there’s nothing like money. Because you know, if you have children like these ones, when you go somewhere you leave them in the house. They need somebody to look after them, and this person you must pay. But they don’t give us anything, so we are really struggling and asking the government to look for us something small.

5.5.3.4 Barriers to optimizing mental health care

According to my interviews with clinicians and my own observations, there are several barriers to improving mental health care. Kareem notes the inconsistent supply of Amitriptyline (it is “more often out of stock” than in stock). He may advise patients to purchase the drug on their own, but while some can afford it, others cannot. Kareem notes, “Even 10 shillings can be expensive for somebody.” Also, Amitriptyline is not available locally; only chemists in Siaya town stock the drug. Thus, a patient wanting to purchase Amitriptyline would incur transportation costs in addition to the cost of the medication.

Kareem also notes the lack of mental health training in the Kenyan health care workforce. He received training in HIV care and counseling. While mental health was touched upon in the training, the issues were not well elaborated. He was never taught about how to manage patients in need of mental health care. In the absence of a knowledge base, Kareem has few options and typically resorts to prescribing Amitriptyline or referring the patient to the district hospital.
Christine and Deborah also bemoan the lack of treatment options. Both women feel that their only option is to give advice. For example, Deborah may advise a household to keep a hen for eggs or plant soya beans so that they can make a nutritious porridge out of soya, groundnuts and millet. While these practices may indirectly improve mental health by addressing food insecurity and nutritional deficiency, Deborah feels that she needs training on providing counseling to people with depression. Christine feels that she can provide information, but it is difficult for many women with low levels of education to understand and follow her advice. She also feels that there is nowhere to refer mild or moderate cases of depression. She feels strongly that what is needed are groups focusing on income generating activities so that women are able to buy drugs and address other problems that lead to depression.

Finally, there are practical challenges to delivering optimal mental health care. Kareem notes that outside of HIV/AIDS care and treatment, clinicians have extremely limited time with each client (approximately three minutes per client). In this case, clinicians have time only to document the patient’s main complaint and then discharge. With limited time, a clinician may see an abnormality and attribute it to the presenting illness, without probing further to detect underlying mental health issues. Kareem feels that this situation is sensitive because when depression is missed (or furthermore, when any disease is mismanaged), people may seek out alternative care from an indigenous healer, thinking that they have been treated at the health facility, but treatment was not effective. Barriers to proper diagnosis and management include inadequate time with the client, lack of laboratory facilities (forcing clinicians to rely on clinical diagnosis), the preponderance of many diseases with non-specific symptoms (e.g.,
malaria, pneumonia, typhoid), and the practice of allowing undertrained students to see patients.

5.6 Chapter summary

Despite government efforts toward decentralization of health care, health facility coverage of the study site remains relatively sparse, presenting barriers to access. The government health facilities in the study area are plagued by staffing problems and stockouts of essential medications and supplies, while the faith-based facilities are recognized to deliver high quality yet unaffordable health care. The allopathic system is pluralistic to a degree, combining CHW (in Community Units), commercial kiosks, pharmacists, non-governmental organization staff, and formal clinics.

Participants seek care from various actors within and outside the allopathic health system, especially for complex ailments like epilepsy. They may blend allopathic care with religious or indigenous healing, home remedies and herbal treatments. Many participants (mainly those attending mainline churches) eschew indigenous and religious healers, preferring to blend allopathic healing with prayer. With respect to allopathic care, poor access related to lack of money to pay clinic fees, transportation, and medication costs, causes participants to defer needed medical care or make self-prescribed substitutions. Poor geographic accessibility, especially when illness hampers mobility, also contributes to inadequate access. In addition, perceived ineffectiveness of allopathic care may direct health-seeking behavior away from the health system. Yet, despite these barriers, my data on recent illness episodes shows that allopathic health care is still the most commonly chosen strategy (by patients) for treating acute and chronic illnesses.
Health-seeking strategies for depression, however, depart from strategies for other acute and chronic illnesses: no participant indicated that she sought allopathic treatment for depression. This is most likely due to the perceived social etiology of depression (suggested by group discussion participants, confirmed by women participants and clinicians) – the widely held belief is that depression cannot be treated in the hospital. In addition, most people perceive (correctly) that the district hospital and mobile mental health clinic serve only those suffering from severe mental illness.

Several supply-side factors exclude allopathic care from the therapeutic landscape for depression. Those are summarized in Table 12.

<table>
<thead>
<tr>
<th><strong>Factor</strong></th>
<th><strong>Description</strong></th>
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<tbody>
<tr>
<td>Medication stockouts</td>
<td>▪ Inconsistent supply of medications</td>
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</table>
| Shortages of competent mental health workforce | ▪ Staff shortages  
▪ Lack of mental health training  
▪ High turnover of CHWs  
▪ With exception of CHWs, clinicians often originate outside community – leads to language and cultural barriers, misunderstandings, and animosity |
| Limited treatment options           | ▪ At community level, only options are to give advice, treat with Amitriptyline  
▪ Only psychosocial support for people living with HIV/AIDS                                                                                                                                                 |
| Inadequate treatment options        | ▪ Patients tend to be sedated rather than treated  
▪ Conflation of neurotic disorder, mental disability, mental illness  
▪ Absence of tailored treatment (all patients prescribed same medications)                                                                                                                                   |
| Improper treatment options          | ▪ At SDH, patients are caged in communal rooms with no toilets; violent patients are locked in cells  
▪ At mobile clinic, lack of privacy/confidentiality                                                                                                                                                            |
| Difficulties in diagnosis           | ▪ Diagnosis requires time and skill due to psychosomatic presentation (clinicians are undertrained and have limited time)                                                                                       |
Given these findings, it is clear that Emily’s experience with allopathic treatment (see Chapter 1) is unique. This anomaly is probably explained by her urban residence, wealth, high level of education, and the severity of her illness. Yet, even Emily left her medications at some point, turning to religious healing. That is the subject of the next chapter.
CHAPTER 6: INDIGENOUS and RELIGIOUS HEALING RESPONSE

MO (Interviewer): We need those names that we do hear our grandmothers talk about during their time, maybe during our time, ‘When somebody’s cow eats your maize, just go to so-and-so.’
R: Those passed away long time ago.

MO (Interviewer): Do we sometimes tell them to go see ajuoga?
All (except D1): Nobody can tell anyone to go to ajuoga
D1: I also have a different opinion on that point. I think we have some pretenders in this group. Let us not assume that we cannot advise one to go and consult ajuoga in any case. Remember not all ajuoga do evil things. There are some who treat diseases that cannot be treated in the hospital and some are very bad. It’s us who advise other friends that they should go see an ajuoga.

*****

If people do not seek out allopathic healing for depression due to its ascription to social causes, then what of religious and indigenous healing? In this chapter, I explore these two components of the therapeutic landscape. I begin by exploring the domain of religious medicine, focusing on its approach to mental health care. Then, I explore the same for indigenous medicine. Finally, I consider the extent to which participants draw on religious or indigenous medicine in responding to depression.

6.1 Religious medicine

The interview transcripts with Siaya women facing depression are replete with examples of how women draw on their religious communities for various forms of social support. Among other things, people seek support from their church communities for health issues. Participants are prayed for when they are ill, either by individual church members (including church leaders) or in groups. When she is sick, Beatrice tells the members of her church and her brothers and they pray for her. Millicent is visited by a fellow congregant and “encouraged with the word of God.” Participants perceive having benefited from prayers: for example, Millicent reports conceiving after a long struggle with infertility. In addition, people pray for their own protection from disease and harm. This is, in a sense, healing infused with religion, practiced by members of
mainline and other churches inclusively, promising the relief of suffering resulting from cognitive and spiritual benefits of faith and prayer. That powerful form of faith-based social support will be discussed later in Chapter 8. The focus of this chapter is instead on an entirely different type of religious healing that is specific to local, indigenous African Independent Churches, particularly those in the Spirit lineage, such as Legio Maria and Roho. Participants draw distinction between these and mainline churches based on their healing powers. Helen, who prays in the Legio church, explains:

Helen: In Legio, you can be prayed for, even if someone is sick, you can be prayed for till you get well. But Catholic is different because they have a “dumb” God. [laughing]
FO (Interviewer): Do you mean Catholic’s God is “dumb”?
Helen: Yes, he is dumb. Here when you have bad dreams you can tell them, then they advise you to bring candles which they use to pray for you. That is why I like Legio.
FO: So you don’t think one can be prayed for in Catholic until he gets cured?
Helen: They can be prayed for but I doubt if they cure.

Even Susan, who is a member of the Anglican Church, admits that her priest doesn’t have special powers for healing prayer:

FO (Interviewer): Can your priest pray for someone when sick?
Susan: Yes, just praying generally for everybody in the church but he doesn’t specialize in that. Only if he is informed that someone is bedridden then there is a time to pray for such people.

Historical circumstances have led to this distinction between praying for health, which tends to be more associated with mainline churches, and seeking out spirit-infused prayer healing, which is associated with Spirit churches. Spirit churches arose in part as a response to colonization. As such, many Spirit churches adopted an anti-colonial stance, rejecting Western healing practices in favor of a traditional African concept of healing and health that emphasizes a spiritual dimension to illness. Today, that dichotomy persists. While mainline churches may engage in prayer for health, they
accept biomedical explanations of illness and allopathic healing strategies, and prayer supports that. Spirit churches, on the other hand, have retained their belief in the spiritual etiology of illness, calling for spiritual methods of healing. This dichotomy is reinforced by political and economic power: mainline churches count the wealthy and more modernized segments of society among their congregants, while Spirit churches are typically attended by the poor. Not surprisingly, the former tend to be viewed by many participants as “legitimate” while the latter are seen as “fringe.”

The Spirit churches that engage in healing prayer have different specialities and use varied strategies. Some, like APECC, the church where Emily took refuge (see Introduction), use holy water for healing and specialize in praying for “the mentally disturbed, neko, riwa (an abnormal mental state wherein a person walks around absentmindedly but is calm and nonviolent, unlike those afflicted with neko) and other diseases.” The Roho church specializes in interpreting dreams and seeing the future.

Strategies range from simple to complex. Mercy, a faith healer from the Legio Maria tradition, explains her process for addressing low libido:

In the case of loss of interest in sex, somebody can be diagnosed to know what exactly has taken place especially when they are still young. It may be because of some injection, just loss of interest or when the man is the victim – he cannot get erection. In such cases, Legio are the best churches that one can get healed. For men who cannot get erection do come to me I will pray for him using rosaries and different colors of candles. I can also massage him especially on the abdomen and at the back. Secondly I can also tell him to come with the wife so they can do that together. I use holy water to pray for them. Then they can use the remaining water to bathe – after that both of them will be okay. As they leave my compound, I will also use some herbal medicine, always powdered, to give them blessing by blowing it at their backs.

There are different categories of religious healers. Table 13 lists five types of religious healers.
Table 13. Types of religious healers

<table>
<thead>
<tr>
<th>Healer</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jalemo</td>
<td>Faith healer; a person who prays for health (Christian)</td>
</tr>
<tr>
<td>Jakoro</td>
<td>Diviner; tells future and reads past; use special candles and water</td>
</tr>
<tr>
<td>Jalok lek</td>
<td>Seer, dreamer; explains dreams</td>
</tr>
<tr>
<td>Jayalo</td>
<td>Preacher (infused with special power for preaching; not denomination-specific)</td>
</tr>
<tr>
<td>Jaulo</td>
<td>Interprets when a person is speaking in tongues</td>
</tr>
</tbody>
</table>

Source: Field notes

Participants were able to list 11 faith healers in the area, all belonging to Roho or Legio Maria churches. Participants were unable to remember the names of several healers but could recall where they came from or some characteristic about them (“Roho man who rides a motorcycle”). A lengthy discussion about one faith healer reveals that, despite their religious status, they are not automatically trusted and respected by the community:

M6: Roho man who doesn’t walk...his leg has a problem...where does come from?
M5: Agoro Oyombe. The one whose one eye doesn’t see (some laughing).
M6: We can only describe him in that way.
R: His name is not known but his eyes are not okay.
M5: He likes women very much.
M4: Everyone calls him father.
C3: His clothes are torn most of the time.
M5: His one eye is bad.
FO (Interviewer): I think I saw him sometime back.
M5: He walks around here.
MO (Interviewer): Is his name Ochero?
All: Yes
M6: He takes care of some home and he stays there.
MO: Is he the one who likes women?
M6: He doesn’t say the truth. There is a time he went to ‘tako’ some child of Nyakan of Kokello Kosuga. They realized that he was lying after he took a lot of money – Okello wants to kill him (some laughing).

Roho and Legio Maria faith healers may be consulted for illnesses for which people seek allopathic healing, either before or after the person visits a health facility.

Treating one illness by both spiritual and physical means ensures that a person addresses all aspects of its etiology. This is particularly true for complex diseases for which
allopathic medicine is not completely effective. For example, despite the fact that she prays in a mainline church, Susan has sought the services of a faith healer for her son who suffers from epilepsy. Patricia, too, has visited a faith healer for her epileptic son. In fact, she explains how the promise of healing prayer drew her to the Roho church:

You see that my son, we have taken him to jalemo. I never used to pray in that church before, it’s the sickness that made us to gain this church. We also went to a certain church where we were told that we should just pray but our son will not get cured. “It’s better I tell you the faith, I pray to people and get cured but this one will never get healed,” he said.

6.2 Mental health care delivered by the Roho and Legio Maria Churches

The following discussion relies on interviews with faith healers and leaders of Spirit churches. I interviewed two faith healers from the Legio Maria church (Mercy and Diane) and two leaders of Spirit churches (Okoth from Roho and Okello from Legio Maria).

- Mercy inherited her ability to heal from her father. After his death, she saw her deceased father in a dream and thus was called to adopt his work. Mercy specializes in praying for women to find husbands, for married women to solve their marital problems, and for those who have had their possessions stolen.

- Diane received the holy spirit and power of praying for people in a rather dramatic event. She was attending a training course with thousands of people when a dove flew in and landed on her chest. The matron told her it was a blessing and that she had to go with it to her home. When she arrived home, other doves came because they were called by the first. From that point on, Diane found that she could speak in and translate tongues. Diane is able to interpret dreams and know someone’s problems. She prays to heal juogi and address
unemployment, among other things. She specializes in treating infertility, depression, and unemployment.

- Okoth joined the Roho church for its ability to treat health problems. He became a member in 1992, after his son was healed by the church. He worked his way up through church leadership, first becoming a junior teacher, then a senior teacher, a lay reader, a pastor, a senior pastor, a Bishop, and finally an Archbishop. Today, after a division in the church prompted him to start his own Roho denomination, he is the Archbishop of 18 congregations in the area.

- Okello was called to the Legio Maria church through visions. After converting from Catholicism, Okello has been the leader of his Legio congregation for over 48 years.

In addition, during pre-dissertation fieldwork conducted in 2010, field observations were made at the Apostolic Evangelical Christian Church. See Chapter 1 for information related to that institution.
6.2.1 Diagnosis and Treatment

Both Mercy and Diane insist that they rely only on their own visualization of a woman’s problems for diagnosis of depression. Mercy explains:

With such a woman, you neither receive her with prayers nor ask her anything. First you give her a chair, you make a little story and you prepare something to eat. After that I will pray for her is when I should visualize what’s her problem alone. I don’t ask her.

Diane is “informed by the Holy Spirit” about her client’s problems:

I say some words that even personally I don’t understand. And I ask them what they are saying and Joseph (in a photograph hanging on Diane’s wall) explains what the Holy Spirit means. This happens when someone with a problem comes in…I can know all that is in someone’s mind. After they sit then I open my bible. There is where I get revelations of what is happening to the client so I ask her about the problems and as she answers, the problems go away.
In addition to using conversation to address her client’s problems, Diane prays for them, and “then they become free of depression and they go back happy people.” Depression cannot be treated in a hospital because the “hospital treats the physical body, but not mind or what you have in your heart.” She concedes, the hospital is able to treat high blood pressure that accompanies depression. If one is holy, then she can overcome depression. Evidently, Diane believes in the effectiveness of her healing powers: she uses an outcome-based payment scheme, charging clients for her services only after they have been healed.

Mercy’s healing strategy for depression also relies primarily on conversation and prayer. She explains:

She can be suffering from heartbreak as a result of what is happening in her home, so like that, I will put her down and talk to her, teach her and comfort her. Then I will offer a prayer that will calm her husband if he is violent.

“Giving comfort” and “making stories” figure largely in Mercy’s arsenal of healing strategies. Her approach is exceedingly pragmatic: if a client comes in depressed because she has lost something or is lacking a material need, if it is in Mercy’s means, she simply gives the item to the client. She refers clients to other healers if she finds she is unable to treat their problems (e.g., for bewitchment, madness, absentmindedness, and impotence). Depression is a special case: Mercy insists that there are no herbs to treat depression and depression cannot be treated in the hospital. What’s more, untreated depression has physical health effects, leading to heart attacks. Given her beliefs about depression, her response to her own experience of depression is understandable: “I do just sit down and decide that this depression won’t help me and decide to continue with my life as normal.”
The Spirit church leaders offer similar non-medical prescriptions to women suffering from depression. Okoth explains that he can “pray for healing” only for those problems that are caused by other people (usually through witchcraft, e.g., mental illness or epilepsy). Other problems that “affect the body or blood of a person, for such we take to the hospital.” Evidently, depression is more closely related to the former category – it is “Satan at work that interferes with the person’s mental wellbeing” – and therefore it cannot be treated in the hospital. Instead, Okoth offers the following prescription: “One who is suffering from depression, first we must teach the person the word of God...teach about the peace that comes from God.” If people don’t experience improvement based on his advice, he concludes that it is because they lack understanding.

According to Okoth, other people view those who are suffering from depression as “useless” because they are “incapable of achieving anything.” Similarly, Okello recognizes that depression among women is a big problem because “it deters them from doing their everyday chores and activities.” For example, some lose their appetite and they are unable to till their farms. When Okello identifies a woman who is suffering from depression (usually by asking her what is causing her to miss church), he “teach[es] her to know that there is always a season for everything, a season to be happy and a season to be sad.” He may also pray for her, use the scripture to teach her, “and if she is in lack of something that I can afford, then I can help her out with it.” Most practically, he usually advises women who are suffering from depression to join a women’s group, where she will be taught about “development” and “how to live peacefully in [her] home.” The effectiveness of this strategy depends on a woman’s “heart” and her ability to understand his advice:
A woman with a good heart will change as long as you start talking to her since she will see that you have removed her from the bad situation to a better one…There are some women who have low understanding, no matter how you talk to her she won’t change her perception. She will just feel that there is a better way forward. But others have high understanding. They will quickly take your advice.

6.2.2 Causes

Overwhelmingly, these religious healers place blame for depression with the person who experiences it. Mercy believes depression is caused by a woman being unfaithful. When her husband discovers her infidelity, he becomes violent and withdraws his financial support from the household, causing her to become depressed. Both Spirit church leaders explain that a woman’s depression is caused by a variety of problems, including having a sick child or a husband who is disturbing her, having issues that are seemingly without solution, lacking something or living in poor conditions. Okoth blames a woman for comparing herself to others who are doing well, or comparing the conditions in her matrimonial home to her birth home. Okello offers that “maybe her husband has been telling her more than once or twice to do something, of which she fails, then when she is being quarrelled she would feel that she is not important.” He adds that most people assume that a woman who suffers from depression is not being taken care of by her husband, or is disturbing her husband.

Diane’s ascription of blame to the sufferer speaks more generally to concepts of good and evil. She insists that depression is caused by the devil, but that “good people” are protected from being possessed by the evil spirits that cause depression. She explains:

It depends on what the women trusts or believes in. Some may believe that they are poor - every time she thinks that she is not worth being where people are. In this case, she allows evil spirits to work in her. But if you are in God, nothing bad
happens to you. There are some people who pretend to be good but inside they are evil people. For God’s people nothing bad happens to them.

6.3 Indigenous medicine

Much of the discussion about indigenous medicine revolves around its purported decline (“These kinds of things, people had left them a long time ago.” – Salome). Key informants speak of a time when women delivered at home with the assistance of a traditional birth attendant; now most deliver in hospitals. Herbal medicines were used to treat many ailments, especially those affecting children. According to one key informant:

Long ago our people used to rely on traditional herbs. For example, when a child had fever, there was specific medicinal herb that was boiled and given to the child to drink and that was all. Today people have shunned using the traditional herbs and also most people do not know these herbs so that they can administer to the sick.

Many claim that indigenous healers have died off:

MO (Interviewer): We need those names that we do hear our grandmothers talk about during their time, maybe during our time, ‘When somebody’s cow eats your maize, just go to so-and-so.’
R: Those passed away long time ago.

Yet, despite this insistence that indigenous medicine has all but disappeared, its furtive persistence is evident throughout the data. While group discussion participants list only two nearby allopathic health facilities, they are able to recall dozens of indigenous healers. Stories involving witchcraft and indigenous healers abound. For example, in 1993, Millicent’s mother became sick and died suddenly. Millicent attributes the death to witchcraft. She explains:

Millicent: She passed something on her way to the garden. When she reached, she felt something was wrong with her. She was feeling sick and she decided to go home. She explained that to those who were at home, that ‘when I was going to the garden I passed some container with ash and eggs in it’ and my father asked her why she did not call anyone to witness that. It was too early and she never thought she was the target of that ndagla (witchcraft). She died the same day.
FO (Interviewer): What kind of ndagla is that?
Millicent: Ndagla is very dangerous, especially if it gets the target as set. That was meant for her, that’s why she died. Otherwise many people must have passed it but were not affected because she was the target.

Similarly, Jaqueline believes that she, herself, fell sick when one of her business colleagues “used her evil powers” after a business disagreement. She went to a local doctor for treatment. Grace tells of being treated by an ajuoga for fainting spells:

I was taken to a” Man of God” who told me that they were spirits sent from home, so I should go back home and have my treatment from there. I went home. While I was at home it happened to me once. When I gained my consciousness my mother told me that I was calling the name of one of my sisters, Pamela, who had died with her husband in the lake but was never buried in her matrimonial home. My mother looked for a witch doctor who treated me.

In addition to visiting indigenous healers, people use herbs that they know, or that are given to them by other people. For example, Millicent uses herbs “from around here” to treat constipation; Salome is given “traditional medicine” to treat her son’s asthma and she tells of how she gave her husband “traditional medicine” at his request just before his death; and Susan tells of being “really helped” by herbs sent by her mother for her sickness.

The explanation for this paradox may revolve around the conflation of indigenous healing with witchcraft, and the resulting stigma associated with using indigenous medicine. One excerpt from a group discussion is particularly illuminating:

MO (Interviewer): Do we sometimes tell them to go see ajuoga?
All (except D1): Nobody can tell anyone to go to ajuoga
D1: I also have a different opinion on that point. I think we have some pretenders in this group. Let us not assume that we cannot advise one to go and consult ajuoga in any case. Remember not all ajuoga do evil things. There are some who treat diseases that cannot be treated in the hospital and some are very bad. It’s us who advise other friends that they should go see an ajuoga.
Evidently, there is much variability in practice. Some indigenous healers use herbs, others use prayer. Some may specialize in treating children or in treating particular diseases, like chira, sihoho, herpes, infertility, and cramps (see Table 14 below). Others protect homes or provide snake venom antidote. Those who engage in witchcraft trade in kingo and hosho, the malevolent spell or curse and its antidote (if one exists), respectively. While many have learned their craft from an elder family member, some spontaneously recognize a gift for healing in themselves.

Ailments for which people seek out indigenous medicine are similarly varied. In general, people prefer to seek indigenous healing for epilepsy, syphilis, jiggers, infertility, and some ear problems, in addition to the Luo diseases in Table 14. Many illnesses that are treated by indigenous healers are considered to be spiritual or social in origin. Group discussion participants also claim that many people with HIV seek treatment from an indigenous healer. A group discussion participant explains, “You know one who is sick cannot agree that he is sick. When one starts growing thin, he has been bewitched; you go to the witch doctor.”

<table>
<thead>
<tr>
<th>Disease</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chira</td>
<td>Disease with HIV-like symptoms; results from breaching social norm, breaking taboo; treated with manyasi by ajuoga or jamanyasi</td>
</tr>
<tr>
<td>Juogi</td>
<td>Person is haunted by ancestral spirits, who want baby to be named after them; treated by ajuoga, or by naming baby after deceased family member</td>
</tr>
<tr>
<td>Sihoho</td>
<td>Evil eye</td>
</tr>
<tr>
<td>Segeta/sejere</td>
<td>Condition related to menstruation, cramps</td>
</tr>
</tbody>
</table>

Source: Field notes

Apart from illness, people may acquire the services of an ajuoga for the purposes of getting a financial break or job promotion. More nefarious uses of ajuoga services
include settling a grudge over land, punishing a neighbor whose child has excelled in school, or taking revenge on a husband and his new wife (the latter may be alternatively addressed by acquiring a love potion to increase his love).

Just as for religious medicine, there are different types of indigenous healers. A table in Appendix P lists types of indigenous healers and their functions. Actual names of healers are listed where relevant, with more clarification where merited. The traditional birth attendant (nyamrerwa) is absent from this table; over recent years, the meaning of the term has evolved so that nyamrerwa now refers to the CHWs who work in the allopathic realm. With the exception of ajuoga (by far the most commonly discussed type) and sometimes jamanyasi, people may visit the healers in this table openly without fear of judgment.

6.4 Mental health care delivered by indigenous healers

We interviewed two indigenous healers - Otieno, an ajuoga, and Selline, an herbalist. It should be noted that, while every other category of research participant readily agreed to participate in the study, as a group, indigenous healers were very wary of the research. We approached several healers before we found two that would agree to be interviewed. Others demanded large sums of money to participate or avoided the research team altogether, agreeing to meeting times and then not showing up multiple times over the course of days or weeks. This reticence on the part of indigenous healers to participate in the research is likely due to the stigma associated with their craft.

- Otieno inherited his craft from his parents. His healing power comes through juogi (spirits) that tell him how to heal through dreams. Evidently, the spirits are not always agreeable: they make him sick if he eats certain foods. Otieno’s craft
relies on the use of herbs for bathing or drinking. He specializes in treating chira, bewitchment (though he is adamant that he does not kingo, or place curses), and poor business performance. For most illnesses, he refers the client to the hospital first, treating them only when they don’t recover. He does not treat eye problems, ear problems or toothaches; for those, he refers directly to the hospital. Otieno refers to the church for some problems, including juogi (spirits). Curiously, while Otieno claims that he doesn’t treat juogi, Selline insists that she refers her patients who are afflicted with juogi to him. This secrecy and apparent inconsistency are common in accounts of indigenous medicine.

- Selline learned her craft by accompanying her mother to the forest to pick herbs. When her mother passed, Selline took over the practice. Selline specializes in treating stomachaches, wounds, and herpes. She describes another condition that she may treat: “Sometimes you feel that your heart has fallen. I bring it back to its position again.” She does not kingo (place curses) and cannot treat juogi, bewitchment, or problems in the workplace; for those ailments, she refers to Otieno. Selline may also give manyasi (herbs) to cure problems associated with breaking taboos. Apart from practicing herbalism, Selline gives information and advice to clients, for example, if somebody wants to build his home, or in the event of conflict between co-wives.
6.4.1 Diagnosis and Treatment

Otieno treats depression only after a woman has visited the hospital. He gives herbs picked from the bush that the client should use for bathing. He concedes that depression may also be reduced by going to church and hearing the word of God, or by visiting a hospital. While Selline tells us that Otieno uses a magic calabash for the purposes of diagnosing the problem, Otieno himself admits only to relying on the client to tell him what has been disturbing her.
Similarly, Selline relies on the client to tell her about any experience of depression; she has no powers to otherwise diagnose it. For treatment, she encourages and advises the client. She explains: “I just encourage them and ask them to forgive those who wronged them since even Jesus forgave them or maybe they go somewhere far to rest their mind and then come back.”

When Selline herself fell victim to depression, she “prayed for God to see me through and give me energy to overcome it.” Selline is adamant that depression cannot be treated in a hospital: “You can’t receive happiness from the hospital. It can’t be treated. They only give you medicine to make you sleep.”

6.4.2 Causes

Otieno believes that depression is the result of “stress” from doing unacceptable things. Thus, someone who is depressed must change her habits. Depression may also result from losing a child or husband. In addition, when one receives kingo (a curse), he or she will begin to show the signs of AIDS. This manifestation of AIDS signs causes one to become depressed.

Selline, who admits to having experienced depression when she lost three of her sons, attributes depression to lack: “Somebody can be depressed because she is in lack of something, and when she finds who can give her that then she can be happy but some are very difficult to stop.” In addition, depression may be the result of being wronged by somebody (in which case she offers comfort) or of an unwanted pregnancy (in which case she counsels against abortion). According to Selline, the conflict that underlies many cases of depression is caused by the devil.

6.5 Women’s engagement with religious and indigenous medicine for depression
Of the 14 in-depth interview participants, four pray in Spirit churches. Salome, Grace, and Patricia belong to the Roho church, while Helen prays with the Legio Maria church. These participants tell of availing themselves of the religious healing offered by these churches. When Helen is sick with “malaria or some depressional sickness”, she goes to her Legio Maria church and is “prayed for there, then I can get well.” Patricia, too, gets help from the members of her Roho church: “It’s possible, you can kneel down and pray for your health. If that doesn’t work, then you can join other members of your church and they help you in praying, you can get a solution.”

Some participants have experience with calling for a person to come to their homes to perform a healing prayer. Helen calls a man from her church to come pray for her when she is seriously depressed. She explains, “He heals if possible, or else he tells you to look for somewhere else.” Salome recounts a time when her child was behaving as if he were “mad”. She called for a faith healer to pray for him “and until now there are no signs of it.” Though this healing strategy is employed by those attending Spirit churches, its fringe status makes it unappealing for other women. Thus, while seeking out prayer healing for depression represents a common strategy for a segment of the study population, it is neither a widespread nor optimal response for a large part of the population.

Engagement with indigenous medicine for depression is even more rare than engagement with religious medicine. In recounting the ways in which she has responded to depression, no participant mentioned seeking the services of an indigenous healer or using herbal medicines. The absence of reported indigenous healing responses is surprising given conventional wisdom about the use of traditional medicine for mental
health problems. It is possible that this finding is the result of social desirability bias. The fact that use of indigenous medicine is highly stigmatized, that participants were able to identify dozens of indigenous healers despite their insistence that healers are dying off, and that, in unguarded moments, participants told of using traditional medicine in the past all support this possibility. On the other hand, there are reasons to believe that this finding is valid. Over the last 170 years, mainline churches have relentlessly degraded indigenous medicine, pushing it underground where it struggles to survive. Moreover, the rise of spirit healing in African spirit churches has probably shunted users away from indigenous healing and toward religious healing. In this light, the absence of reported indigenous healing responses to depression is not surprising. In any case, while participants may have secretly availed themselves of indigenous medicine to address depression, the practice is certainly not widespread and may be used only as a last resort. There is some evidence that, far from helping to alleviate depression, engaging in indigenous healing can actually exacerbate emotional distress, bringing accusations of witchcraft from other people that undermine social relationships and create generalized mistrust. The case of Karen, detailed in Box 14, exemplifies this high price. In addition, the common perception of indigenous healers (based on my field observations) as money-hungry quacks further undermines the perception that they are a legitimate option in the therapeutic landscape for depression.

Box 14. “You can see how those words can be painful to your heart”

Karen is a 67-year-old widow. All of Karen’s seven children are deceased. People in the community, including her bereaved daughters-in-law, blame her for the deaths of her children, thinking it the result of witchcraft. “Something may annoy you like somebody telling you that you have killed your children and you don’t know how you have killed your children. Now you can see how those words can be painful to your heart.” When she is confronted with these accusations, Karen often just keeps quiet. She may elect to
stay indoors to avoid criticism, contributing to her social isolation. But because, according to Luo custom, her bereaved daughters-in-law remain living in her homestead, she cannot completely avoid her tormentors. Her grandchildren, who are living in the homestead, have taken to deviant behavior, disrespecting and even stealing from Karen. This causes Karen to recall the pain associated with the loss of her children: “Those many thoughts do come back when my grandchildren do silly things or cause troubles and when I talk, their mothers protect them and even make me feel guilty. I do wonder why they don’t pay respect to me when their husbands are dead, unlike when they were alive.”

6.6 Chapter summary

Members of mainline and other churches alike commonly pray for health and perceive real health benefits from faith and prayer. This is entirely different from “religious healing”, which involves appeals made to special persons in the Spirit churches who are thought to hold healing powers. The former is viewed as legitimate while the latter is held to be “fringe”. Religious healers of the second type are not necessarily trusted or respected by many people in the community. Still, some people seek religious healing, especially for complex illnesses that have no easy cure.

There is much variation across religious healers in terms of treatment specialties and healing mechanisms. In general, religious healers believe that depression is caused by social factors that are similar to those listed by other categories of research participants; other explanations include possession by Satan or evil spirits, or some shortcoming or misdeed committed by the woman suffering from depression (e.g., infidelity, defiance of her husband). Religious healers agree that depression cannot be treated in the hospital. Instead, they use strategies reminiscent of talking therapies to assist women who are suffering from depression. Treatment success depends on the qualities of the woman being treated – whether she is “holy”, “has the right heart”, or has enough “understanding”. While the research participants who pray in Spirit churches
seek help from religious healers for depression, this is not a viable treatment option for the other research participants and many women in the study site.

Much of the discussion around in indigenous medicine centers on its decline; healers have died off, women have lost knowledge of the herbs. Yet a paradox emerges; despite the insistence that indigenous healing is waning, it still persists. Group discussion participants are able to recall the names of dozens of indigenous healers and stories of witchcraft and healing abound. The likely explanation for this paradox is that indigenous healing fills a void, yet has been pushed underground due to the stigma that arises because of its conflation with witchcraft.

Like religious healing, there is much variation across indigenous healers in terms of treatment specialties and healing mechanisms. Healers attribute depression to social factors that are similar to those listed by other categories of research participants (e.g., conflict, lack). However, they may also believe that depression is caused by the devil and results from doing unacceptable things. Healers typically use strategies that evoke talk therapies. In addition, one of the healers I interviewed insisted that there are herbs that the patient must bathe themselves with to be cured of depression. The two healers I interviewed differed on their opinions about whether depression could be treated in a hospital. No research participant mentioned seeking indigenous healing for their depression. This absence is likely due to several interacting factors: indigenous healing is stigmatized as witchcraft, true and able healers (and knowledge of their healing herbs) are declining with time, and seeking indigenous healing can actually exacerbate mental distress by fear of being charged with engaging in witchcraft. This in turn undermines social cohesion, which will be discussed further in the next chapter.
Every person has got different love. Some may love passionately, some may just love and some may love to deceive you. (Jaqueline)

After paying my hospital bill, [my family members] are nowhere to be seen. They don’t call to know how I am faring. So at times I think that they are waiting for me to fall sick or even die so as to buy me a decent coffin. (Karen)

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In the absence of engagement with the allopathic health system and given the fringe status of indigenous and religious healing, women who suffer from depression might turn to members of their social network for support. This chapter describes a fourth aspect of the therapeutic landscape – social networks. The social capital literature is replete with typologies characterizing social network relationships (e.g., strong vs. weak, horizontal vs. vertical, informal vs. formal, bonding vs. bridging/linking). This dissertation employs the formal/informal categorization in discussing relationship types because it is the most similar to how study participants conceive of their relationships. This chapter focuses on “informal” social networks; “formal” social networks will be discussed in Chapter 8. The social capital literature defines informal social network relationships as those linking friends, family members, neighbors, and colleagues, for example (Ferlander, 2007). They are thought to be the main source of social capital where more formal forms tend to be lacking. Formal social network relationships, on the other hand, are those linking people within voluntary associations, for example. They are thought to be critical for accessing informational support and building civic skills. In some respects, this distinction is counter-intuitive. One of the most “formalized” institutions in the study site is that of marriage, yet relationships arising from marriage (those with a husband’s family, for example) are considered to be “informal” in the social
capital literature. On the other hand, relationships forged in self-help groups tend to be more fluid, reflecting the dynamic and self-organizing nature of these groups. Yet, these relationships are almost always categorized as “formal” in the social capital literature. While I acknowledge this paradox, I will continue to use the formal/informal distinction as it is conventionally employed in the social capital literature.

I begin this chapter by describing the informal social networks of the study participants, exploring the types of relationships that were most frequently listed by participants. Then I outline the social support that these informal relationships provide, highlighting instrumental, emotional, and informational support. I explore the extent to which women draw on informal relationships in responding to depression. Finally, I discuss the caveats associated with informal social network relationships with an eye to possible negative consequences of this form of social capital.

7.1 Women’s informal social networks

The number of relationships listed by participants ranges from three to ten (mean = 7.1). Depression severity (BDI score tertiles), wealth (qualitative wealth tertiles - “poorest”, “middle”, “wealthiest”), age (below 40 vs. 40+), and religion (mainline vs. other) were qualitatively explored as possible explanations for the noted variability in number of relationships. Of those, only age appears to have some relationship to the number of relationships. In general, younger women (who may have more recently relocated to their matrimonial home) have smaller social networks. Over time, women seem able to build their social networks, especially as their children grow into adulthood and become critical members of their social networks.
Participants’ remarks about how “close” they are to people reveal how they conceive of “closeness”. Salome rates P as one of the closest people in her social network. She explains: “I do turn to P when am really passing through a difficulty. She is always like my mother, not that she supports me, but she always gives me motherly advice and I can always share with her my secrets.” In fact, “discussing problems” and “sharing secrets” were mentioned by many participants in describing their closest relationships; evidently, those are the hallmarks of a “close” relationship. Other “close” relationships may develop around shared activities (e.g., bible study), knowing someone for a long time, and being family members.

7.1.1 Types of relationships

In this study, I make qualitative judgments about the type of relationship (bonding, bridging or linking) based on the degree of similarity between a participant and alter (a person she listed in her social network) and the apparent direction of the relationship (horizontal vs. vertical). Participants most frequently framed similarities or differences with alters in economic terms. A participant might be similar to an alter in “how [they] get food” or in their employment situation (e.g., “We are not so different because he also does casual jobs”). Other commonalities include having children, having grown up together (in the case of siblings), and having similar life circumstances (e.g., both widows). Such relationships were characterized as bonding based on emic expressions of likeness.

Bridging relationships included those with alters who are “more stable” or “better off”, either because they receive assistance from children or others, or they are employed (or have a spouse who is), either in the formal sector or in casual jobs. The only linking
relationships listed in the interviews were those with church leaders (n=3) and the chairman of Ng’iya Youth Group (n=1). The apparently low linking social capital is noteworthy as it is these relationships that are thought to enable people to access resources and information outside their own social network. Other relationships were divided relatively evenly between bonding (n=44) and bridging (n=51) types.

There is variability in the types of people listed in social networks. Sixty-five percent of people listed in the social networks are female. Informal relationships are split among birth family (n=30), next generation (children, grandchildren, nieces and nephews – n=20), friends (n=20) husband and his family (excluding sisters-in-law – n=13), and sisters-in-law (married into husband’s family – n=12). It is notable that birth family relationships far outnumber those with a husband’s family, with or near whom a married woman resides. In addition, relationships with other women who have married into the husband’s family (i.e., sisters-in-law) are just as common as those with all members of a husband’s family combined. The apparent underrepresentation of relationships with a husband’s family is notable for what it suggests about a woman’s ability to draw on her relationships with her in-laws, and particularly with her mother-in-law, for support.

7.1.1.1 Matrimonial family

According to group discussion participants, the relationship between a woman and her mother-in-law is fraught with tension and conflict. Strict mores surrounding patrilocality in Luo culture dictate that a woman leaves her birth family when she is married and resides with her husband’s family. Traditionally, a grown son would start his homestead outside his parents’ home, but in modern times, land pressure and economic difficulties lead many adult sons to start their family homes in their simbas
(bachelor homes), in the very compound where their parents still reside. Thus, modern Luo brides have unprecedented contact with their mothers-in-law.

Traditionally, the mother-in-law assumed the role of mentor, instructing her new daughter-in-law on how to cook and take care of the home. The relationship was probably always accompanied by some measure of strain, as the new daughter-in-law was watched closely and judged for her fitness as a wife and mother. However, the tremendous resource strain that characterizes modern times exacerbates this tension, pitting a woman against her mother-in-law in competition for her husband’s meager wealth. This strain is exacerbated by a woman’s loss of contact with her birth family, who may reside far away from her matrimonial home. Mobile phones have, to some extent, ameliorated this isolation – most phone calls documented in the daily diaries were to or from members of a woman’s birth family, to whom she would often turn for advice about problems she was having in her matrimonial home. Still, the friction she experiences with her mother-in-law and the isolation from her birth family cause a young Luo bride to feel alienation and social exclusion during the first several years of her marriage. One group discussion participant explains: “[Mothers-in-law] want to ensure that they intimidate you. It’s always, ‘My son, my son,’ so, you, the daughter-in-law, you look as if you don’t belong there.”

The tension between a woman and her mother-in-law occasionally extends to other members of the husband’s family. A couple participants mentioned quarrels with their brothers-in-law. Jaqueline tells of being beaten by her brother-in-law when she was first married at age 15. “Even up to now it’s always fights with my in-laws.” When
asked what they fight over, she replied, “It is always over land and other small family issues.”

To add to a young bride’s woes, in the midst of this conflict, a man’s loyalties tend to lie with his mother. A group discussion participant explains:

I may have a husband who works in a certain town but when he comes back, he stays with his mother more than he does to me. At his mother’s home, not only does he take much time but also he is told so many untrue stories by his mother so when he comes to me, instead of doing the usual, he starts quarreling me.

Not surprisingly, poor mental health is not uncommon during this period of adjustment. The situation is especially dire when one considers that the women closest to her – her mother-in-law and the women in her husband’s family – to whom she might turn for emotional support, are in large part responsible for undermining her mental health in the first place. For Grace’s story about the profound effect her strained relationship with her mother-in-law has had on her mental health, see Box 7.

7.1.1.2 Sisters-in-law

The frequency with which sisters-in-law are listed in participants’ social networks reveals one way women cope with being marginalized in their own homes. As it is told, the once ubiquitous practice of polygamy supported a network of co-wives who assisted and supported one another. Modern marital relationships have replaced these networks with networks of sisters-in-law (notably, also referred to as “co-wives”). Many participants listed co-wives (the wives of their husbands’ brothers) as some of the most important people in their respective social networks. Modern “co-wives” (sisters-in-law) share resources and advice, discuss family problems and encourage one another, much in the way that co-wives of old (the multiple wives of one man) are reputed to have done.

7.1.1.3 Next generation
Ties to the younger generations (children, grandchildren, nieces, nephews) account for a large portion of all bonding relationships. Most often, these relationships are maintained across long distances, as young people migrate to pursue academic and employment opportunities in larger towns and cities. These relationships are critical for many women, as they represent the only avenue through which they can access instrumental support.

7.2 Emotional support

Emotional support, defined as the provision of empathy and caring, takes many forms. Participants tell of being encouraged and being given hope by members of their social networks. This form of emotional support is proffered most often in times of difficulty and customarily has a religious undertone. For example, when Jaqueline is sick or stressed, her sister encourages her “that I should not lose hope since God will bless me one day.” She also values the encouragement she receives from her spiritual teacher “to keep on praying and I will recover very soon.”

Companionship is a second valued form of emotional support. Participants describe how merely sitting with a close friend and telling stories can make emotional distress fade away. Pauline notes the support she received from the chairlady of her church: when Pauline’s son died, her chairlady accompanied Pauline to Nairobi. Later, her chairlady accompanied Pauline to Imbo to bury her daughter. Evidently, providing company in times of need is a recognized form of support.

In this cultural context, visitation, too, is very meaningful. Close friends visit each other frequently, and these visits allow for the exchange of emotional support and advice. A visit from someone during sickness, or in the event of bereavement or another
problem, puts that person among the most important in a woman’s life. For example, Eunice can tell that her daughter loves her, because “whenever I am sick, she does come.” Visitation may change over the life cycle, leading to greater social isolation among the most vulnerable. For example, Millicent notes that once her husband died, the neighbors stopped visiting. Given the tremendous emotional and material burden placed on widows in this context (see Salome’s story of widowhood in Box 10), the halting of this form of emotional support is problematic.

At times, emotional support may be given in lieu of material support. When Grace complains to her husband about the pain in her arm, he tells her to “hold on, that as soon as we will get money, he will take me to the hospital to remove the metal.” At other times, the provision of material support makes a woman feel as if she is being emotionally supported. When Eunice’s daughter-in-law helps her with chores such as fetching water and firewood and weeding the garden when she is ill, Eunice feels as if she is being supported, beyond the instrumental value of the assistance. Other examples of emotional support are presented in Box 15.

**Box 15. Examples of emotional support given to participants**

Helen recounts the story of her fertility struggles, insisting that the person who helped her most told her to “hold on and be calm, that one day God would bless me with children.”

Agneta speaks about the emotional support she receives in the face of her financial struggles. Her husband tells her to “persevere as it will be okay in the future, I shouldn’t lose hope”, while her main topic of conversation with her mother-in-law is how she can support herself: “She keeps on giving me hope that one day I will get.”

Pauline tells of her sister who “strengthens [her] in many ways”: “When I tell her that I am in need of something or I lack something, she will always encourage me that a human being cannot get everything she needs, but God in his right time will provide.”

7.3 Instrumental support
In this context, instrumental support, defined as practical help (e.g., money or labor), takes many forms. Participants tell of being assisted with household chores, like fetching water, weeding the garden, and cooking. Eunice describes her relationship with her son:

The reason why I love him is that any time he is at home, he does any chore such as cooking, going to the farm and taking care of the chickens. And whenever I don’t have money he always tells me to sell any chicken. He doesn’t discriminate against these casual jobs, he does any that can give him money and always remembers me. In fact, at times he does give me money to pay somebody to work in the farm.

Special assistance is needed and proffered during the planting and harvesting seasons. Support may take the form of labor (e.g., Millicent helps her brother with the harvesting at home, Salome helps her friend harvest cassava), money for plowing, or land. Pauline is lent a piece of land where she plants beans because her own land is very small.

Participants also describe being given money or items of necessity. For example, some are given money or building supplies to construct or maintain their homes. Participants mentioned receiving or giving the following items: salt, sugar, matches, groundnuts, beans, shoes, githeri (traditional meal of maize and beans mixed and boiled together), soap, omena (small, silvery, sardine-like fish), maize, flour, sweet potatoes, chapati, and clothing. Farm produce may be given in lieu of financial support, often provided when the giver has no money to give.

It is remarkable that even in the context of generalized poverty, in which nearly every person is either struggling to make ends meet or struggling with the demands of supporting a large extended family who are financially vulnerable, financial support is still exchanged with great frequency. At times, participants’ requests for financial
assistance are denied because the potential giver has no money to give, but even when a person does not presently have money, she may attempt to get money in order to lend it to someone in need. Patricia explains of her step-daughter-in-law, “If she doesn’t have money at the time I ask her, she tells me to wait so that she can find me money later on.”

Other participants reveal that a person who has access to material wealth through a working adult child may split their bounty with someone in need. For example, Josephine’s sister-in-law divides the goods brought by her niece with Josephine. In other cases, a person may appeal directly to a son or daughter for assistance on behalf of her needy friend.

**Employment opportunities** comprise another category of instrumental support. Many participants describe being brought to live with a relative to work as a maid in their youth. Some describe the employment opportunities that have been offered to their children. For example, Salome credits her brother for bringing her children to train in tailoring. Salome’s personal story highlights the promise associated with this type of instrumental support:

One day my sister came home and told me that, being a widow, I had to work harder. She told me that she had found a job for me…I left one of my children with my co-wife and the other two took back to my brother. I went. I was to take care of an old grandmother and the pay was Ksh. 500. All went very nice and I would send money back home…One of my friends told me that she was willing to teach me her business of fish mongering…That’s how I entered into that business. The business was good and I later brought my children to live with me in Nairobi where they started their school.

In addition to employment opportunities, people may provide support for starting a small business. Grace was once given capital to start her small business and Susan reveals that her sister “promised that there is only something that has been preventing her from giving me capital, but she will give me soon if she is in a position to.” Participants
note that people may also pay group contributions on their behalf, effectively providing access to a host of income generating and microfinance opportunities.

Instrumental support is most often used to obtain health care, in the event of bereavement, or to support children. The next sections provide more information about these uses for instrumental support.

7.3.1 Health care

It is exceedingly common that a person assists someone who is ill by escorting them to seek health care, whether at a nyamrerwa (CHW) for diarrhea (Millicent), or to a hospital for malaria (Evelyn). When Helen’s eyes were swollen so that she couldn’t see, her friend found her at home and took her to the hospital. At times, a financial outlay is required on the part of the giver, as in the case that a bicycle or vehicle must be hired.

Apart from escorting a sick person to the hospital, people offer cash to pay for transportation, clinic fees, and medicine. Nearly every participant explained that they must appeal to their social network for financial support in the event that they fall ill. The amount of support ranges from Ksh. 30 for transportation to the local dispensary to Ksh. 600 for clinic fees at the district hospital. When Grace was involved in an accident in Nairobi, her sister came to take care of her children and gave Grace’s husband Ksh. 2000 to buy food for her children.

In place of money, some participants are assisted with medication and lay advice. When Beatrice discovered she was pregnant with an unplanned pregnancy, a woman gave her herbs to cause an abortion (the procedure was unsuccessful). Whenever Josephine is sick, her friend buys her medicine. Medicine may be provided even in the case of a minor illness as when Pauline is given Panadol for her headache. Occasionally,
the medication that people are given comes directly from the giver’s stocks. Grace explains: “At times [my sister-in-law] can take her doses and give them to me when I am in pain.”

7.3.2 Bereavement

The costs associated with funerals are substantial and participants often receive instrumental support to offset expenses. Most commonly, participants receive money to pay for transportation to the funeral. Some participants receive money or food to hold a funeral at their homes. Josephine explains:

If I have any problem I can just tell her and she helps me out. For instance if I don’t have maize, I can tell her so and she gives me. There was a time I had some funeral at my home so I called her and she put maize on a motorcycle up to my place.

Other significant funeral costs include the coffin and the vehicle hire to carry the body to its place of rest. Pauline describes the assistance she received from her sister’s husband when her daughter passed away at the district hospital:

He is very close to me because he always helps me whenever I have a problem. Like when my daughter passed away in Siaya Hospital, I called him and informed him of the death. He hired for me a vehicle that helped me to carry the body and a few people to her husband’s place, Imbo, where she was placed to rest. He helped me because my husband could not make it, since even to acquire the coffin, we had to sell one of our cows. Without that vehicle we could have buried the body at Siaya (which would have been a disgrace).

7.3.3 Children

Much of the instrumental support exchanged in this context goes to supporting children. Many participants describe the financial support they’ve received to help pay school fees. Both Pauline and Karen struggle to pay school fees for their grandchildren. Pauline pieces together their school fees with contributions from several people. She explains:
I always try and when I am defeated I approach my brother who is my follower. My sister is married at Masiro. It is her that I sometimes turn to and after giving me something then I take to school for fees. Sometimes when [the children] are sent home for school fees I usually send them to her, she is of much help to me.

Even with support, Pauline is left with a balance of Ksh. 1000 for the district examination fee, which her son has told her he will try to pay. Karen’s balance is much more substantial. She owes the school Ksh. 9000. Her nephew, who works as a casual worker, has told her that he will try to send money in small installments.

Apart from school fees, much of the child-centered instrumental support is dedicated to health care costs. During the study period, Susan received money to discharge her son who has been in the hospital for health issues related to his epilepsy. Helen remembers receiving assistance when her son broke his leg, while Pauline was given medicine to treat her granddaughter, who experiences chronic swelling and pain associated with a childhood burn.

7.4 Informational support

Informational support, provided in the form of information or advice, accounts for a large portion of the social support received by participants. In particular, participants describe being assisted in decision-making (Millicent) and advised when they are experiencing a problem, including depression (Evelyn).

Much of the advice that is shared between people has a religious orientation. For example, Helen is advised “to leave everything to God, He is the answer to everything,” and on a more practical level, “to be strong in the church so that if anything happens to me then I can get people to help me.” Evelyn recounts being told by an old man “to be contented with what I have, as long as I’m alive I should not think of things that are not meant for me. He told me that my wealth is in heaven.”
Advice is often given by people who are perceived to have experienced similar problems. Salome may discuss her problems related to her “stubborn children who can’t even recognize and respect their mothers” with S, “since she has children too, she has passed through those.” This example was offered during the group discussion: when a female child reaches adolescence, “you can look for a mother who has passed that stage” to seek advice.

Much of the advice received by participants falls under a limited range of topics, including health, marital issues, family issues, and farming and business. The next sections describe the typical advice received for each of these topics.

7.4.1 Health

Most of the advice received by participants relates to health. People tend to “advise each other on what steps to take whenever we fall sick” says Helen. Advice on what type of medicine to use to treat a particular infection abounds. Group discussion participants note: “You may be infected by any disease and you may decide to go to one of your friends for advice because you either know she has similar disease or she can direct you where you can receive help.” For example, Salome recounts a day when she woke with her face swollen. She continues, “So I wondered what it was, and went to ask Evelyn what it could be. She told me that it might be a boil. I just took some Septrin.”

Rather than being advised on particular health-seeking steps, many people are advised simply to go to a hospital. For example, Grace’s husband advises her to visit the nearest hospital for family planning. Jaqueline suffered a very severe leg wound when working in the field one day. She tells of how a woman advised her to go to the hospital “since such wounds always cause tetanus.”
This type of advice may be accompanied by emotional support (e.g., encouragement with the word of God) or instrumental support (e.g., Ksh. 300 for transportation and hospital fees (Millicent)). Evidently, people dispense this advice even when they are not able to provide the requisite financial support. Grace is told by various people to “look for money so that I can go to Siaya to remove the metal in my hand”, that she should “keep on praying so that one day I will get money and go to hospital.” Jaqueline, too, recounts a recent illness episode during which she was told to “rush to the hospital for treatment”, “as soon as I get the amount.”

There is some evidence that people are occasionally advised to seek indigenous healing and medicine. Susan tells of her last illness episode during which she sought advice from a nurse friend regarding whether it would be safe to take herbal medicine along with the medicine she was given at the hospital to treat malaria. She explains, “She told me it was okay to take it even though I was not supposed to mix them, to take each at a time.”

7.4.2 Marital issues

After health, advice about marital issues may account for the largest portion of advice exchanged in this context. In particular, social networks are called upon for advice in the event of a quarrel. According to group discussion participants, advice may range from encouraging a woman to “maintain peace” to telling a married daughter that she should leave her husband and return home.

Pauline and others spoke of being taught “how one should live in her house.” Both Grace and Eunice quarrel with their respective husbands over their church participation. Grace is told to “calm down”, that she “should not respond harshly”, and
that “raising my temper won’t help me.” The advice Eunice receives is similar: she is told to “try to determine his moods; whenever the moods are good, I could go, and when the moods are bad, I stay.” She is told by the same person that whenever she sees her drunken husband carrying a weapon, “I should not wait, I should run.”

Evidently, it is very rare for a woman to be advised to dissolve a strained marriage. Patricia is told that “nowadays people do persevere in order to stay in marriage” and Evelyn is told to “leave everything to God” when her husband buys cows for her two co-wives but does not buy a cow for her. Many participants describe reaching a breaking point, at which they considered leaving their husbands, but were advised by others to stay in the marriage. When Josephine’s husband breaks into her grain stores and steals grains to give to his second wife, she is advised by her sister-in-law to stay in the marriage. Pauline receives similar advice:

She always encourages me in terms of family matters teaching how to live with my husband. In fact there is a time when I thought that enough was enough and wished to end the marriage, but after encouraging me today I still find myself with my husband.

The advice to stay in a bad marriage may be rooted in material concerns: Eunice advises her daughter, that “if a man provides you with the upkeep, then just hold on.”

7.4.3 Family issues

Much advice is aimed at helping a family to “live in peace” in the face of serious strain. Much like for marital advice, the burden of keeping peace often falls on women. For example, when Grace argues with her mother-in-law, rather than finding sympathy, she is admonished “that that’s not the best way to live with your mother-in-law.” Agneta recounts her mother-in-law’s fury when she discovered that Agneta assisted another woman on her farm. Rather than having her viewpoint validated, Agneta
was told by a friend that her mother-in-law “has a better reason to be furious, so I should calm down.” Karen, too, was told by her neighbor to “calm down and leave her [daughter-in-law] alone” after they had a quarrel.

Much of the family advice is of a practical nature. When Pauline’s son was arrested in Nairobi, she is advised to wait before traveling to see him since she “may go and lack fare to travel back with.” Agneta advises her drunken husband to use his “off” days to drink, rather than drinking on work days. The advice that Susan receives from her sister with respect to her epileptic son is pragmatic:

The first time she just told me to take my son to hospital in order to know whether [his condition] is mental. Secondly, she told me to take him to any counseling in order to accept his condition as he is. Sometimes when he sees other children go to school, he asks why he is not. My sister therefore advised me to take him to any technical college to make him busy as well as not to feel neglected.

7.4.4 Farming and business

Finally, participants note receiving practical advice and information related to farming and business. A group discussion participant explains, “You can see the neighbor’s garden doing well year in, year out and yours is not all that right so you can go and ask how he does his.” Similarly, Jaqueline’s sister once encouraged her to plant sweet potatoes because she anticipated that there would be enough rain.

With respect to business, much of the advice relates to launching a small business to meet financial needs. Helen explains:

She always tells me that I have small children. I should try as much as possible to do some business so that I can feed my children. That I should try my best to educate them up to Form Four.

Suggested business models vary: Salome encourages her son to start a small fish business, Eunice is advised to start a shoe-selling business, and Josephine is encouraged
to sell mangoes at the market by a woman who recently had success doing the same. Others are advised to join a group for help with financial problems.

7.5 Who gives?

Of all the forms of social support received from alters, emotional support is the least common. Of the 100 alters listed by the 14 participants, emotional support is received from only 43 of them (compared to 65 of the 100 alters providing instrumental support and 70 of the 100 alters providing informational support).

Though the nature of the sample precludes an inferential statistical approach, various characteristics of social relationships appear to be related to social support (see Table 15). While the receipt of instrumental support is less common from bonding relationships than bridging relationships (instrumental support is received from 61% of bonding relationships versus 73% of bridging relationships), receipt of emotional and informational support is much more common in bonding relationships. The gender of the alter also appears to be related to social support: while male alters are more likely than female alters to give instrumental support, female alters are more likely than males to give emotional and informational support. Faith-based relationships tend to give less instrumental support than non-faith-based relationships, but slightly more emotional and informational support. Finally, members of a woman’s birth family are more likely than any other category of relationship to provide emotional support. Friends give less instrumental support than others while co-wives give more. Informational support is received with roughly equal frequency from all relationship categories except next generation alters (children, nieces, nephews, etc.) who are much less likely to give informational support.
Table 15. Breakdown of social support by characteristics of social relationships

<table>
<thead>
<tr>
<th></th>
<th>Instrumental support (%)</th>
<th>Emotional support (%)</th>
<th>Informational support (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of relationship</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bonding (n=44)</td>
<td>61</td>
<td>52</td>
<td>82</td>
</tr>
<tr>
<td>Bridging (n=51)</td>
<td>73</td>
<td>37</td>
<td>65</td>
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<tr>
<td><strong>Gender of alter</strong></td>
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<td></td>
</tr>
<tr>
<td>Female (n=65)</td>
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<td>80</td>
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<tr>
<td>Male (n=35)</td>
<td>68</td>
<td>31</td>
<td>51</td>
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<tr>
<td><strong>Relationship category</strong></td>
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</tr>
<tr>
<td>Next generation (n=20)</td>
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<td>85</td>
</tr>
<tr>
<td>(excluding co-wife)</td>
<td>83</td>
<td>42</td>
<td>83</td>
</tr>
<tr>
<td>Co-wife (n=12)</td>
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<td>83</td>
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<tr>
<td><strong>Faith-based</strong></td>
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<td></td>
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<tr>
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<tr>
<td>No (n=87)</td>
<td>70</td>
<td>43</td>
<td>69</td>
</tr>
</tbody>
</table>

Source: In-depth interviews (n=14)

Faith-based relationships are those formed and maintained primarily around shared religious activities – fellow congregants, church teachers, or chairpersons of church groups. Some participants mention people who, in addition to being family members or friends, share in religious activities (e.g., pray together, discuss the bible, etc.). For the purposes of this analysis, they are classified as family members or friends and not as faith relationships.

7.6 Women’s engagement with informal social networks for depression

Given these low levels of emotional support relative to other types of social support (advice, material goods), this section explores the extent to which, in the face of depression, participants draw on their informal social networks for various forms of emotional support. Participants may respond to depression by seeking the companionship of others. “Stories” are a particularly valued form of social communication during these interactions. When Millicent is depressed, she seeks out her friend, “so that we can tell stories.” She continues, “Then I find it fade away.” Beatrice
reveals that to combat depression, “I go visit my friends and story with them. By that I find depression fades away.”

Some participants share their problems with and seek advice from others, typically a small group of trusted confidantes. People are careful to guard their secrets, revealing their problems only to one or two of their most trusted acquaintances: when Susan shares her problems with “somebody I know can keep them secret”, she finds that her depression “reduces.” Millicent reveals that she shares her problems only with her friend “because you cannot tell your problems to everyone.”

Participants describe others helping them to “calm down” (Helen) or to “calm their heart” (Josephine). When she feels discouraged by life, Grace tells her husband and he assures her that “one day God will open a way for [them].” They may be “consoled” when they are depressed (Helen), or told to “have peace of mind” (Jaqueline) or “be at peace” (Pauline) when they lack something. Jaqueline describes her relationship with her uncle:

We do talk about current life, how life is difficult. He gives me heart to be in peace and never think of my sufferings because I am a widow, since it is the same all over. He does tell me that even if one gets one shilling per day and another person one million per day, both will be alive if only you have hope.

Some participants receive comfort from messages about the universality of struggle. Agneta is encouraged when her mother-in-law tells her “that people struggle” and when her friend reminds her “that life is not easy, it needs perseverance. Life is the same everywhere.” Pauline, too, feels uplifted when she is reminded that the problems she is experiencing are “part and parcel of life.”
Similarly, participants are **comforted by knowing other people have problems** too, even when those problems are not the same as those they are experiencing. Patricia describes how her oldest sister has recently been “cooling her heart”:

She has been giving me bible verses to read that can reveal to me that I’m not alone in the battle, because even her, she had been troubled. The husband got an accident until he was almost dying but God saved him.

Millicent finds common ground with her friend, though their problems are not exactly the same:

We talk about many things. You see, her house is also in trouble. She has problems too, like she has a son who is [old enough] to marry but is just inheriting old widows or having sex with other people’s wives. So when we are together we do talk about ourselves, like last time she poisoned herself and she almost died because of the stress, so we do talk to each other and support each other emotionally.

Participants also derive comfort from **expressions of empathy**. They may choose to share their problems with someone who has previously experienced or is currently experiencing similar problems. Eunice shares her problems with her husband’s alcoholism with her friend, “since our problems are more like the same.” Josephine, too, derives comfort from her relationship with her sister-in-law, who is similar to her in an essential way: “We encourage each other because even herself, her husband married a second wife after her, and the husband loves his second wife more than her.”

### 7.7 Caveats

Clearly, it is common for participants to receive emotional, instrumental, and informational support from their informal networks. While this support is mostly beneficial for their well-being, some scholars note the potential negative consequences of social capital. Most notably, the receipt of social support may obligate a person to reciprocate, placing a strain on that person’s time and resources. The first part of this
section explores the extent to which reciprocity is expected, and the forms it can take. Then I explore other negative consequences of social capital that manifest in informal relationships.

7.7.1 Reciprocity

Among the relationships described by participants, there are many in which there is no expectation of reciprocity. Beatrice says of her brother, “I don’t help him much. He helps me every time.” Helen notes that her brother’s wife “doesn’t take anything in return” for her assistance. Patricia indicates that she would be open to reciprocating the support she receives from her sister-in-law, but she is never asked for it:

FO (Interviewer): How do you support her?
Patricia: I don’t support her because she has never asked for it. How would I know she is in need of it if she doesn’t ask for it?

There is some indication that these types of arrangements are rare. Agneta considers her friend “important because it is very hard to get somebody who just helps you with money without minding when you will refund her.” Salome counts Jacky among her closest friends because “she is always there for me in all my problems without prejudice of my place or suspicion that I may not refund her.”

Even when reciprocity is expected, it may take an indirect form. In exchange for money, for example, a person may reciprocate with labor or farm produce. For example, Evelyn notes that while her niece assists her with money, Evelyn reciprocates with farm produce like groundnuts and beans. Salome, too, provides potatoes to those who assist her. Susan reciprocates the assistance she receives from her brother-in-law to plan a fundraiser by preparing food for his children when his wife is not home. Other indirect reciprocal arrangements involve assistance with harvesting in exchange for money, as per
Millicent, and assistance with brewing chang 'aa (local illicit brew) in exchange for help getting to the hospital, as Helen experienced.

Other arrangements are characterized by direct reciprocity. Many participants describe relationships in which they give the same support that they receive. Sharing health advice with each other (Helen), encouraging each other with the word of God (Eunice), or providing money and household goods to each other (Patricia, Grace) all constitute examples of direct reciprocity offered by participants. Josephine, in particular, maintains a number of relationships that display direct reciprocity. To her sister-in-law, she gives beans and maize “when she doesn’t have and vice versa.” She and her sister-in-law share their problems with each other, she and another sister-in-law “teach and encourage each other”, and she and her mother-in-law “help each other, especially on pieces of advice.” She may also pay the group contributions for a third sister-in-law, who in turn supports her with business advice.

Far from being a draw on scarce resources, this type of reciprocity appears to cement social bonds. Even in cases where reciprocity is not expected, the lack of reciprocity tends to enhance the social status of the giver. There are, however, some examples of potential pitfalls of reciprocal arrangements. Some expectations of reciprocity cause undue social strain. Agneta describes that when she approaches some people for help, they question, “‘If you don’t have it now where will you get it to return to me?’” Pauline is troubled that she must rely on support from others, because it isn’t always possible to repay the support. She explains: “At hard times I do borrow some maize for flour and then you will be left stranded when it is over since you can’t go back to borrow again before paying the other one.”
Sometimes, as these cases show, expectations of reciprocity diminish the benefits of social capital by limiting future support. On the whole, however, participants spoke of reciprocity in mostly positive (or neutral) terms.

7.7.2 Burden

Another potential negative consequence of social capital involves the burden of maintaining large, relatively diffuse social networks. People who are in a position to give material support may find themselves overwhelmed by the magnitude of need among their family members, neighbors, and friends. This is especially acute when there is a death in the family that prompts a person to assume responsibility for caring for orphans. One group discussion participant explains:

Maybe you can get someone in a position to manage his family in a proper way, then all of a sudden, so many deaths we are facing now, maybe sister or brother died. So he has the burden of staying with the orphans. Now you have an extra burden to manage all these.

Pauline is in such a position, raising five of her orphaned grandchildren (her story is presented in Box 16). Even when children are not orphaned, they may live with a grandmother or aunt for the purposes of schooling or to avoid causing problems with a parent’s new marriage. In some cases, a parent will send money for the child’s care, but when a parent does not, it places a large burden on the caregiver. Salome cares for her grandchildren while her daughter is away working at a flower plantation. Salome explains:

There is a day when one of her children caused a problem here at home, so I called and informed her. I told her if they feel that they are incapable of even sending something little since I am the one living with their child and at times I may lack even soap to give him to wash himself after coming to help in the farm. It was very bad, and if they feel that is very difficult for them then I can resume my earlier life of washing napkins for people to sustain myself.
Pauline is 56 years old. When we asked her to recall a positive life experience, Pauline replied, “There is nothing good I have experienced, because I gave birth to seven children and three passed away.” Pauline’s despair related to these deaths appears to have both spiritual and material roots. She confesses that the stress that resulted from the deaths caused her to start going to church: “When my children passed away I knew my time was also near or I was next. My son was the first to pass, then followed by my daughter and there and then I started having stress. Therefore I decided to be one of the faithful because I did not know my time.” Perhaps more importantly, the deaths of her adult children exacted an economic burden. After her daughter’s death, Pauline had to sell a cow to pay for the coffin and family members helped her to pay for transport of her daughter’s body to the homestead of her daughter’s late husband for burial (to be buried elsewhere would have been a cultural taboo and would have brought much disgrace). Moreover, the loss of material support was significant. Pauline reveals that the reason for her stress was that she relied on her children. “Death has deprived me of the good life I thought I could get.”

Compounding these economic burdens is the difficulty of providing for her orphaned grandchildren. Today, Pauline is the primary caregiver for five of her orphaned grandchildren. Her explanation of how she manages to pay their school fees illustrates the financial difficulties she faces:

I have organized for a fundraiser, since when they sat for Standard 8 exams, all of them passed. I chose the girl to proceed to Form 1 and the boy to repeat because I couldn’t manage both of them at a go. The girl went to Form 1 as you can see the lifespan of a girl is shorter than the one of a boy. The following year the boy also passed and I sold the calf to take him to Form 1. I am planning to have another fundraiser during August since the balance I have for them is now big. Even when I was looking for exam fee, I did a fundraiser and got Ksh. 11,000 of which I paid 10,000 for the exam. The head teacher wanted to take the whole amount for school fees but I pleaded with him and he decided to help me and I paid the exam fee and the remaining 1000 was taken to fee arrears. Members contributed and even those who did not come sent something.

Pauline worries about what will happen to the children when she passes: “What causes all this stress are these grandchildren of mine, because the burden is so much and I don’t know how they will survive in case I pass away. They depend on me in almost everything.”

Sometimes the extra burden is brought not by caring for children, but by taking in a daughter-in-law whose husband has gone to Nairobi for work. A woman’s son is obligated to send money to his mother for the care of his wife, but in cases when this
arrangement breaks down, the woman may be burdened with supporting her daughter-in-law. Millicent has taken in her son’s wife while he lives and works in Nairobi. She complains that “he has never sent even clothes” for his wife’s upkeep. Salome, too, must care for her son, daughter-in-law and their three children. Though her son lives on the compound, he is unemployed and therefore depends on Salome’s support.

Even when a person is not caring for additional household members, competing interests cause a strain on household resources. Participants speak of not always receiving the support they need from their social networks because the resources are being committed to other purposes. For example, Jaqueline does not receive financial support from her uncle, because he used his money to build a house in Siaya, or from her son who uses all his resources to subsidize his struggling tailoring business. Participants note a particular person who is not in a position to assist because “he has many children to take care of” (Evelyn), because of “the fees she is paying for her child who is in secondary school, and the flower plantation where she works pays very little” (Salome), or because “her co-wife divorced [her husband] and she has the responsibility of taking care of [the co-wife’s] children.” (Josephine)

7.7.3 Dependence

Occasionally, reliance on social support can create a dependence that becomes problematic when the support is not forthcoming. Participants describe situations in which they are promised support but the assistance never comes. Both Evelyn and Karen, who have no living children, are particularly vulnerable to this scenario. Both women describe being promised money by younger relatives. Karen’s nephew promised her cash to buy medicine. Evelyn’s stepsons promised to buy construction materials for her home.
These were never received. Evelyn expresses her disappointment: “I just stopped asking for money from them because if I ask and they don’t give me, it makes me think of my own [deceased] children.”

The negative consequences of dependence intensify in the event that the source of the support passes away. Pauline speaks very openly of the stress that results when an adult child passes away:

I had stress because I banked on my children who passed away. They were the people who were helping me. My daughter was in Nairobi with her family, her husband passed away, then after a short while she passed away so this gave me a lot of stress that made me go to church to pray. This stress had taken root in me.

These problematic exchanges influence how people feel about one another. Salome describes how people don’t always assist as much as expected, especially in the case of death or funeral. This allows her to judge how close a friend really is. She also describes a situation in which a friend may be able to offer material support on one day, but not on another day. She concludes, “even though you are friends, the friendship is not helpful in times of need.”

Even when support is given, it may cause the recipient to feel like a burden to the people around her. Karen offers the following example:

Sometime back I was hospitalized at Siaya. [My nephew] never called me or visited me, but it just happened that Nyamwalo, my co-wife, had a number and called thinking that she was calling my first grandson, but it was [my nephew’s] number. So out of shame [my nephew] called his brother who came the following morning and paid my bill. I don’t always like the idea of calling a person and failing to get him, then he fails to call back. That always makes me feel that I am a bother and therefore I forget about it. After paying my hospital bill, [my family members] are nowhere to be seen. They don’t call to know how I am faring. So at times I think that they are waiting for me to fall sick or even die so as to buy me a decent coffin.

7.8 Mistrust and jealousy
Participants almost universally agree: social trust is flagging in the study area. Relative newcomers like Agneta and Grace, distinguish levels of social trust in the study area versus elsewhere:

MO (Interviewer): Is there trust among people living in this village?
Agneta: No, I have never seen [any].
MO: Why so?
Agneta: There is no love among them like in our home village. Everybody is segregated, and always hold grudges even over small issues.

I have never seen [trust] in this village. I don’t, because I am not used to them, but I see that they are not always close to that extent…people are not living in harmony. - Grace

Key informants who have lived and worked elsewhere (e.g., the nurse at a local dispensary) agree that mistrust is rampant.

EP: How do people relate to each other here? Do you think the relationships are good or are they a little bit strained?
Christine: They are not good. They are not good. The disputes are always so many…I don’t know why there are so many internal wrangles.

Overwhelmingly, participants claim that jealousy is the driving factor. People “don’t like other people’s development,” says Beatrice, or “don’t love when others are progressing,” says Salome. They “feel very bad when others are moving forward”, observes Eunice. Jealousy leads to antagonism. For example, Salome explains that you may have worked hard in your farm and a person who is jealous of your bounty may sabotage your work by letting his cows feed on your crops. According to Salome, “You can’t trust such a person.” Evidently this issue of sabotage is common, surfacing multiple times in the group discussions as well. Even the Anglican priest offers an example of jealousy-fueled sabotage:

It is common knowledge that there is a lot of jealousy and mistrust… And they may trust only those of them who support them and the others is like, ‘Why have you bought a car, not giving me any good time to ride in it. Next time we will
actually plant some trees on the road to block you or just put some stones so you fall away. We'll bury you.’…There is no good Samaritan today. They would rather trust a priest from a foreign land like me to come and be their judge and not from their own clan because they will be quite unfair on their judgments, quite unfair. They will just be lopsided to suit either one from whom they have received a gift - even a gift of a cow, as huge as a cow. ‘Now I will give you this, now just say you did not see when I was unplanting this.’

Very commonly, success in school inspires the jealousy of neighbors, and causes tension. According to Eunice:

I don’t know why people do feel very bad when others have progress. There is no love and unity of helping one another to progress. Let’s say your child has passed and you are unable to raise the fee, nobody will feel like helping you.

Group discussion participants confirm: “At times your child may have passed and needs to join secondary school. A good number of the society won’t be pleased to assist as they know that one day the child may uplift the home.”

According to key informants, levels of social trust were higher in the recent past. One key informant, who moved from the area to Mombasa for a number of years and then returned in 1998, states that she saw that people were “living individually” when she came back from Mombasa. She insists: “Today there is no sense of communal responsibility as before. This new generation does not exhibit the sense of togetherness as before.”

Speaking of the past, another key informant claims:

People trusted each other and there was good relationship between people. If for example, something bad happens to you, then people would readily help. That does not happen now. Even during funerals, the bereaved is more burdened than ever because all the expenses have to be incurred by the bereaved family members.
The shift from the communal to individualistic lifestyle is well-documented in the sociological literature on the area. Participants, too, remark on the individualistic lifestyle that characterizes modern life.

FO (Interviewer): Do people around this area trust each other?
Millicent: No, we don’t such have people here.
FO: You don’t trust each other?
Millicent: No, we don’t
FO: Why?
Millicent: People are different.
FO: I thought here you live as a clan and therefore trust is here more than those in different areas?
Millicent: People are just on their own. Everyone is alone.

Others affirm that “people have different hearts” (Susan, Helen) and are “different in characters” (Pauline). There is a sense among key informants that this individualism impedes development. One key informant states:

I foresee a lot of development here. What people can do now is just to remain united. As you know, unity is strength and when there is no unity, things will be slow, benefits that have to come will take a slow pace.

The Anglican priest attributes the low levels of collective social capital to the inequality:

I don't know why that is but I guess it's because...well, maybe they say it's poverty, because when you have and the have-not is watching you, is becoming more jealous – ‘I didn't even have a meal and you have always had three meals a day.’ Then even when your sheep is getting hanged by a rope, he will not save it. ‘Better it gets dead so that we can share the muscle.’ Even on areas of education, ‘Why would we go to support so-and-so for his children’s fees while we have not gone to that level. We don't care - why doesn't he become like us. We still live anyway.’ So that is still there with most of these communities.

7.8.1 Influence of mistrust on responses to depression

Mistrust impedes sharing: participants speak of a small, trusted circle – sometimes only one other person – with whom they can share their secrets. These are people who can offer proper advice, or who can keep secrets. Salome describes her relationship with
her sister-in-law: “I share with her serious personal issues or secrets since she is able to keep them. She always acts like my mother who can guide in many customary issues.” Patricia trusts only her neighbor and her mother-in-law, and “nobody beyond that.” Millicent has “one or two people [to] whom I can tell my problems.”

The risks associated with sharing secrets are varied. Salome doesn’t tell anyone in the family her problems because “they will just laugh at you”. Others worry about being the subject of gossip, rampant in the study site and a factor that undermines mental health (see Box 17). According to Helen, “some pretend that they are your friends but if she hears your problems then she tells everyone.” Eunice warns, “If you share with [people in my family], then tomorrow be ready to get the same message.” Karen broke off a relationship with a particular person after she would share a secret with her and then hear a different version of the story from others. And Salome has stopped going to others for help because “you receive no assistance, but he starts broadcasting your problem.” In some cases, gossip brings conflict between people: Pauline claims that people can change the words of what you say “to mean other things that can bring fighting.”

**Box 17. “It has not made me happy in life”**

Beatrice is 24 years old and unmarried. When she was to begin Form 1 (first year of high school), she got pregnant and had to drop out of school completely: “It has not made me happy in life.” At the time, she tried to terminate the pregnancy:

> When I realized [I was pregnant], I wanted to do abortion because my parents were very fierce. I tried my best but it wasn’t successful. I wanted to use some crude methods to abort it. There was a lady who gave me some herbs to use, saying that she had also used it and the abortion was successful. I just used local tablets from the hospital. I overdosed. What helped me was that my sister came at the time I was taking the medicine. I suffered over the night but the intention was not achieved. In the morning, my sister took me to the hospital where a doctor explained to me that I was risking my life a lot. He then gave me some medicine that made me diarrhea a lot, but after all, my baby did not come out.
Today, Beatrice’s son is 5 years old. She receives assistance from her eldest brother, BA, for her son’s care. BA reveals the extent to which her unmarried status impacts her mental health:

There are some relatives there at home who have many scandals. Definitely as a human being, when people talk ill about you, you must feel bad. Like they say that she has not been married and she has a kid at home. She feels bad about them. … What makes her unhappy is when she meets somebody who mistreats her.

Finally, group discussion participants listed many reasons to keep secrets private. Among them is the fact that others are experiencing problems of their own. You may share a problem with someone, but that “this person is going through this and this problem, you don’t know.” The danger is that the person may respond, “‘She came to tell me her problems, does she think I don’t have problems of my own?’”

Aside from the negative impact on mental health, the lack of outlet for sharing private information can bring a significant burden upon a household. This is particularly relevant when a household member suffers from a stigmatized disease. According to group discussion participants, a person may “struggle to nurse the sick only by herself” for fear of revealing the person’s health status to others.

This culture of reticence has implications for how women respond to depression. Overwhelmingly, participants describe “doing nothing” as their preferred response to depression. While Josephine insists that she doesn’t tell people her deep thoughts for lack of trust, she has found that stress “can be reduced by themselves.” She continues: “I just think over them and forget them slowly. I’ve always seen other people with the same problem and I feel I can do better.”

Others “keep quiet” because, as Beatrice noted, they “don’t feel like telling anyone”. Salome explains that she has “deep thoughts” that she doesn’t share with
anyone. She explains that, “You just have to comfort yourself.” Often, people “keep quiet” for fear of their secrets being exposed. Patricia explains:

You know sometimes you can decide to tell a friend of something that happens. Then she/he tells someone else. So I feel it’s better I keep quiet about them. [...] I feel that is the best because nobody will know what’s happening so that they can talk about it.

Some participants insist that “staying busy” is the best way to respond to depression. A group discussion participant explains: “Another way of removing stress is to keep yourself so busy so that if you go to bed you feel tired, too exhausted to think, you just sleep. So you keep yourself very busy.” Both Salome and Agneta admit that they use distraction to combat stress and depression. Salome “distracts [her] mind” with activities and Agneta reveals that she is “always stressed when idle”, so she tries to “be busy.”

Perhaps the most common response to depression is to “turn toward God”, either implicitly through cognitive surrender or actively through the act of praying. Evelyn explains that when she is “depressed over something”, she can “pray over it and [her] heart softens.” Karen reveals, “At times I get stressed and after praying I feel relieved and sleep.” She clarifies that after she prays, “everything seems okay.”

Apart from directly improving mental health through stress reduction, “leaving everything to God” is also thought to bring about improvements in other factors that influence mental health:

There are some difficulties that you cannot tell anyone. I can just keep quiet, think over it, and leave everything to God. And even when you have a problem maybe you don’t any money to even buy soup, you can be surprised to see someone giving you money. I may say in such case I believe it’s God’s hands. (Helen)
Often, prayer is perceived to be more effective than other responses, including appealing to the social network and “keeping quiet.” Millicent insists that “prayer has helped [her] more” than going to her friend for consolation or “just keeping quiet”. However, she goes on to state that she needs financial assistance to “be okay”, suggesting that prayer is not actually considered to be sufficient to completely overcome depression.

Another faith-related response to depression involves reading the bible. When Josephine is depressed, she reads the bible “for comfort.” She explains, “Then I forget a lot of things.” Evidently, this strategy is effective. Both Pauline and Millicent describe feeling relieved from stress upon reading the bible.

7.9 Chapter summary

This chapter related “informal” social networks and their uses for handling depression. The number of people in the informal social networks of participants may be related to study participant age: younger women listed fewer persons as “important” to them. This may be due to having more recently relocated to their husbands’ homes. They have had less time to build up their social networks in their matrimonial homestead. Sharing secrets and discussing problems were the hallmarks of a “close” relationship. “Likeness” was expressed in terms of wealth.

The number of bonding and bridging relationships listed by participants were roughly equal, while very few participants listed linking relationships. The few linking relationships listed were with church or community group leaders. In general, participants receive more informational and emotional support from women, bonding relationships, and faith-based relationships and more instrumental support from men,
bridging relationships, and secular relationships. Relationships in which emotional support was provided were less common than those that provided informational or instrumental support. Despite being maintained over great distances, relationships with members of participants’ birth families were most common and are important for providing emotional support. Birth family relationships were followed in frequency by those with friends and those with younger generations (e.g., children, nieces, nephews, grandchildren). Friends give less instrumental support relative to other relationships categories, while younger generation relations provide less informational support. Combined, all relationships with husbands and husbands’ families (excluding other women married into husbands’ families) were only slightly more common than relationships with other women married into husbands’ families, indicating the importance of sisters-in-law in participants’ social networks. Indeed, sisters-in-law give more instrumental support relative to other relationship categories. Patrilocality may explain many of these patterns: a smaller social network at younger age due to more recent marriage and relocation to husband’s home, relationships maintained with members of her birth family across great distances, relatively fewer relationships listed with her husband’s family (due to conflict with her in-laws). Sisters-in-law are also strangers in the husband’s community, so they bond over their alienation and other things.

Emotional support given in informal relationships takes the form of encouragement, companionship, and visitation. Instrumental support consists of help with household chores, planting, and harvesting (including labor, lent land, money for renting a plow); money and items of necessity; employment opportunities; and
investment in small businesses or through payment of group contributions. Most instrumental support is used for health care, upon bereavement, or to care for children. Informational support primarily takes the form of advice about health, marital issues, family issues, farming and business. Notably, most marital advice favors staying in a difficult marriage rather than leaving, likely the result of concerns about economic well-being.

When a woman suffers from depression, she may appeal to her informal social network for emotional support. Participants derive comfort from companionship, sharing their problems with a limited number of trusted confidantes, and seeking advice. They are told that struggle is universal and encouraged to calm themselves.

While they have much potential for their palliative effects, informal social networks may be limited in several ways. It is rare that support is given without the expectation of repayment. This might be direct repayment of exact support that was received, or indirect repayment (e.g., labor hours for money). Evidently, there are two types of reciprocity: one in which the person must reciprocate before any future support can be received. I term this the “debt” form of reciprocity. Another is when the person reciprocates a non-specified good or service at a non-specified time in the future. I call this the “mutual assistance” form of reciprocity. While the latter serves to cement social bonds, the former may contribute to psychological distress, as it constrains options for future support.

The effectiveness of informal social networks may also be limited when a person is burdened by caring for orphans or other dependent family members or when competing interests dominate meager household resources. Some participants describe being
dependent on members of their informal networks for support; when support is not forthcoming they feel distressed.

Finally, rampant jealousy and mistrust indicate low social cohesion. This low social cohesion limits the range of options for responding to depression, including open conversation. Women are reticent for fear of being the subject of gossip, preferring, when depressed, to “do nothing”, “stay busy”, or “turn toward God.”
CHAPTER 8: FORMAL SOCIAL NETWORKS and SOCIAL SUPPORT

MO (Interviewer): Whenever you have a problem, or in need of any advice about your health problems, whom do you always first turn to?
Eunice: Nobody apart from God.
MO: Apart from God, who else?
Eunice: My church members.

FO (Interviewer): What kind of work do you do for her?
Helen: Planting, weeding and even brewing chang ‘aa.
FO: Aren’t you going to church? [laughing]
Helen: But where would you get even the church offering? All the money that are needed in the church, where would you get them?

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While people can appeal to their informal social networks for support, in some cases this strategy is not ideal. People then turn to their formal social networks to augment the support from family and friends. In this chapter, I explore the final component of the therapeutic landscape – formal social networks. Formal social networks are established through participation in established, formal religious communities and formal, legally recognized community groups. First, I describe the faith landscape, distinguishing between various Christian church denominations. Second, I discuss the motivations for women to participate in religious communities, which include access to various forms of real and intangible social support. Third, I turn to community groups, describing the range of community groups, their functions, motivations for participation, and caveats to the evident benefits of participation in these formal social networks—there are burdensome requirements for members of these groups. Finally, I draw on my data to show how women rely on their formal social networks of churches and community groups in responding to depression.

8.1 Church communities

Community elder key informants note the remarkable proliferation in the number of Christian denominations in recent years. Earlier in her life, one key informant knew of
only the Anglican and Catholic churches, which established schools in the area. Now, she lists several types of churches in the community. Another key informant attributes this shift to power struggles within churches and subsequent splintering: “There are many churches and splinter groups. This happens when people fight for leadership posts in the church. There is a lot of politics in churches. They even elect leaders.”

According to one key informant, people are more religious today than they were in the past. At the same time, Christianity has become more accessible: where before only priests and church leaders were allowed even to hold the bible, today the bible is read by lay people. This key informant views the rise of Christianity as a predominantly positive development, having set people free from having to follow restrictive cultural traditions.

Group discussion participants list a number of churches in the area. They can be divided roughly into “mainline” churches, including Catholic, Anglican, Church of Christ, Coptic Orthodox, Jehovah’s Witness, and Seventh Day Adventist; “African Independent” or Spirit churches, including Roho and Legio; and “Pentecostal” churches, including Apostolic, Deliverance, Chrisco, Future Life, APECC, King’s Outreach, and many others.

Participants were asked to list differences between denominations. What is notable in their responses is not the particular differences, but the types of differences they deem important. For example, the most important characteristic noted about each church is related to time management. Some churches are thought to “keep time” while others have “poor time management” and “move in slow motion”. This reveals the premium women place on time.
Critical language (some veiled and some frank) around denominations reveals that a tension between people of different denominations exists just below the surface civility. For example, when one participant notes that Catholics pray for soldiers, another jumps in to clarify, “They pray for people to kill one another.” Characterizations of various churches presented in Box 18 summarizes information from group discussion participants.

**Box 18. Characteristics of churches**

The Catholic church is known for its celibate priests. Participants note, “They say that, but we see they are not good”. The church is noted for its support of orphans and the needy, and its good time management. Participants note also that while they don’t tithe, they do collect offering and one must give an offer to see the body of a loved one who has passed. Participants are critical of the priests interdiction between his congregants and God, stating that rather than confessing to a priest, people should just speak directly to God. Their praying over pictures depicting the birth and death of Jesus leads one participant to state, “I am tired of those things seriously.” Group discussion participants conclude that Catholics are “pretenders”.

Anglicans are known to dress smartly and “show off” their wealth, a charge similar to that leveled at Luos by other ethnic groups in Kenya. In fact, some group discussion participants note that the church welcomes only those are rich and well-dressed. While they are considered to have poor time management, other aspects of their conduct is very orderly. People have assigned seats so that everyone may know when someone doesn’t attend church. All congregants know the amount of each person’s offering. Restrictive rules for joining study groups bar most young people from participating. Special benefits (e.g., trips) are given to particular people in the congregation. Overall, participants view Anglicans as “dedicated” and “loving”, though some participants voiced disagreement with the latter.

In the minds of participants, the Roho church may be the antithesis of the Anglican church. They have poor time management, no order, and they “make a lot of noise”. Participants note that they use spirits to direct them. They “pretend to be speaking in tongues”. While some have real power for prayer, others just want to earn money by charging for prayers. Participants also claim that the Roho church brings enmity between people - they may tell a person that his sick child was bewitched and that person may blame family members for putting the sickness on his child.

Those in the Legio church are known predominantly by their customs and rituals. They carry a cross, refrain from wearing shoes in church, drink only blessed water, dress in red and hold knives to chase evil spirits. Like, the Roho church, the Legio church relies on
guidance from spirits. The Legio church has many members who are sick or “mad” - they are prayed for and get cured, remaining in the church for life. Participants are careful to note that while they can heal many diseases, they cannot cure HIV or chira. While praying – for a sick or lost child, or a drunkard husband – can sometimes fix the problem. Participants note that the outcome depends on one’s faith.

The discussion around the Apostolic Evangelical Christian Church (APECC) was particularly tense. Perhaps more than any other church, APECC inspires devotion among its congregants and resentment among those in the community. While a congregant who participated in the group discussion describes the church as “one big family” with “much love”, others noted that APECC members “think they are holier” and think that those who pray in other churches aren’t saved. The congregant herself notes that APECC members hear rumors about their own church and know that they are not “loved” by the community. She is dismissive of this antipathy, stating that people talk about them being slaves but then visit at lunch time when they are hungry.

APECC is known for taking care of the sick, the elderly and orphans. Those being treated or cared for are resident at the APECC compound, where they are trained and put to work to grow crops. The church is known especially for using prayer to treat severe psychosis, including neko and riwa. Once people are cured, they are given a house on the compound. Often, they don’t want to return home for fear the disease will return. Many live there until they pass, renouncing their families completely. See Chapter 1 for more information about APECC.

Other churches discussed include Dr. Owuor’s church, which believes its leaders can cure all diseases including HIV/AIDS, causing its congregants to defect from their antiretroviral therapy regimens. Jehovah’s Witnesses visit homes and “force you to change”. The Apostolic church had their church built for them by western missionaries and therefore, “don’t work hard.”

In-depth interviews add a more nuanced perspective to the consideration of differences between churches. While the churches may differ, there is only one God and “God is everywhere”. Salome believes that “each and every person knows himself [where she belongs] and you know that is like a peg where one is tied. The word of God is one.” Further, Salome insists that for practical purposes, denominations are very similar:

Church is your strength so you can decide to be in one of them. Even if you have a problem, the way you can be in this one is the same way you can be in another one...Sometimes you may be a member of one church and you are not attending any Sabbath and merry-go-round. Now you see when you are in problem there is
no way you can be helped. Even when you go to Duond Warruok you will get that. Even if you go to another Roho you will get the same thing. This is in line also with Orthodox. So it is you to decide which one to go.

Others note small differences between churches. Patricia’s Roho church is different from other churches because “it foresees things and they can tell you before it actually happens”. Susan’s Anglican church “listens to people’s problems and they are helpful too” while Agneta has heard people remark that her Anglican church has slow songs and choruses (“we don’t know how to sing”) and its people don’t “make noise”.

Finally, some comparisons are more antagonistic. Compared to her Legio church, Helen insists that Catholics have a “dumb” God because they may be prayed for but not get cured. Eunice, who prays in the Catholic church, returns the antipathy:

This church of ours, I love it, because you go pray and come back to the house. But these other churches love themselves. Sometimes you know these people are said to be spirit filled but they can mislead you by telling you that one of your neighbors is responsible for this. But me, I don’t like this. If you have given yourself to God then he will always be on your side.

Perceptions related to financial requirements are a source of tension. According to most people, the Church of Christ in Africa requires that its congregants donate a lot of money through contributions. Pauline feels the opposite:

I like this church because it has no issues compared to other churches. Some churches scorn others. They cannot come and sit in my wooden house as you have done. We members of this church don’t have such kind of behavior. Before I built this house I had a small house, and when they visited me all the members came here and some were staying outside without having pride in them and that is the major issue making me to love this church.

Another source of tension is related to salvation. Karen states that some people say that members of her Seventh Day Adventist church are not saved, “but we know we are saved.”
8.2 Motivations for participation

People participate in church communities because they receive a variety of benefits, including social support. Though the exchange of social support is not unique to church communities, a few participants noted how faith-based support differs from
support received from secular sources. Grace insists that the church is her only source of help in the event that she is bereaved. Others talk of how they are able to depend on support from their church community more than from their family members. One group discussion participant, for example, reveals that she is estranged from her family and therefore “[her] problems go to the church.” Pauline states:

The church normally helps me…They have been on the forefront more than my family. The family at times may leave you with the problem but the church cannot do that. They will be with you to the end and that is why I love them.

It should be emphasized that in most cases church or group membership is required in order to be eligible to receive support. Several participants made note of this requirement:

It is compulsory for one to identify himself with a church because when you are in problem or bereaved then the first thing is, ‘Where does he go to church?’ – Group discussion participant

When there is a problem they will want to know and ask where the individual goes to church. - Agneta

In some cases, membership alone may not be enough to qualify one for support. Faith-based support may be accessed only through small groups (fellowship groups, merry-go-rounds) within the larger church structure:

Sometimes you may be a member of one church and you are not attending any Sabbath and merry-go-round now you see when you are in problem there is no way you can be helped. - Salome

If people detect that I’m the one with the problem, then I can get help from the fellowship or small groups in the church as long as you are a member. - Susan

The following sections discuss the support that motivates people to participate in church communities.

8.2.1 Personal betterment
One of the most prominent motivations for religious participation is that it inspires one to “be a better person”. Participants talk of the church “saving” them from a host of bad deeds. Pauline confesses that without church, her life would be very bad “because the church has saved me from so many other things which are bad and even it has removed stress from me.” Religious participation works in two main ways to inspire personal betterment: it helps people to avoid “sin”, and it helps people to forgive others’ wrongdoing:

It makes me realize things daily and makes me change to the better from sin, because as human beings, we cannot say that we cannot do anything bad. Or [when] somebody else does to you, you can have the heart to forgive. - Susan

With respect to avoiding sin, participants speak generally of the church pulling them back when they have gone astray. Patricia reads the bible for “strength”. She continues, “When I have problems and want to go astray then it brings me back to the line.” Eunice draws a distinction between those who attend church and those who do not:

Someone who is going to church and listening to the gospel has some kind of difference in [him]. If ever you are going in a different direction you will remember the gospel and it will guide you not to do something bad, and someone who is not going to church has no guidance. He will just do things anyhow.

For her part, Agneta agrees that church is where one learns to follow a moral code. Without church, “you can do bad things and don’t realize it is bad.”

Many participants speak specifically of the way in which church helps them to avoid attending night discos and drinking alcohol. When someone is buried in the village, raucous discos are held; the parties can go on for weeks. Beatrice insists that if it were not for religion, she would be dead by now because she would have continued attending the discos. Helen also thinks she would have died if not for religion. As proof, she tells that the friends she had as a teenager “who loved having fun like I did are all no longer
here.” Pauline, too, saw that many girls were involved in “issues that interfere with their daily lives”, and so did not attend night discos, instead devoting her life to religion.

Apart from avoiding night discos, Salome speaks more broadly of avoiding alcohol:

If you don’t fear God, then you can do whatever you can at your own disposal. You can drink as much as you can. When you are taking alcohol you know you lose sense of reasoning and may do something that only a minor can do and see it suited to you. Being without knowing God is hard and you know the start of knowledge starts when you begin to accept God in your life.

The relationship between religion and avoiding alcohol extends beyond the personal. Grace turns to prayer in the hope that her husband will one day “know the ways of the Lord and stop drunkenness.” Jaqueline tells her sons to “refrain from the bad habits like drinking alcohol and smoking or even just roaming around aimlessly. They should pray to the able God to help them.”

With respect to forgiveness, many participants note how religion influences their relationships with others so that they are able to move past disagreements in constructive ways. Salome notes that listening to the pastor’s preaching and reading the bible can help her to reflect on a disagreement and see her responsibility for the conflict. Evelyn and Patricia reveal that they were “high-tempered” before they found religion and religion has enabled them to find peace. According to Josephine: “It brings me goodness because I used to have high temper, but nowadays it has reduced. Even if someone bothers me, I don’t care much.”

Though there is some sense that anger is intrinsically harmful, it is also instrumental in bringing other kinds of negativity. Agneta describes a situation in which a person is angered and takes her anger out on a child, beating him to the point of
death. Josephine insists that were it not for the calming influence of religion, she “would have done something wrong to someone and [she] would have been killed.” Karen notes how anger can even make someone leave their homestead; “in God, that cannot happen.” She credits church for training and encouraging people “in the right path.”

Finally, Pauline reveals how this mediating effect works in the context of marriage:

The words from the bible can change someone to be a good person. There are some teachings in it that can transform your life. The bible has some teaching like having respect for the partner you are staying with. There are some irresponsible behaviors that I should not show him, even at times when he says there is no money, I should just take that. Maybe if I push further he may be tempted to steal, but I don’t want him to do so and even the bible refutes that.

8.2.2 Protection

Many participants spoke of the protective value of religion. Participants pray daily, asking God to protect them throughout the day, and at night, thanking him for his protection. Eunice asks God to be her “shield” and Evelyn attends church to thank God for taking care of her during the preceding week. Evidently, protection is a powerful motivation for participating in religion: it is why Eunice wants to “love and serve” God. Pauline plans to make an offering of Ksh. 200 because “for the whole year, God has been keeping me safe, and this is a way of thanking him.”

In particular, people appeal to God for protection from illness. Several participants describe scenarios in which they could not afford medical care, but by God’s grace, were healed from their respective afflictions. According to Eunice: “Sometimes I’m sick and I don’t have any money on me so I fall upon my knees and as I do so I get well. This is God just helping me without me knowing.” Pauline and Evelyn provide
similar accounts. Pauline states plainly, “It is prayer that is helping me and so God normally heals me.” Evelyn attributes her present health to God’s protection:

There is a way it can help me. For instance I was sick, and I was referred to Aga Khan hospital. I didn’t have any money but I knelt down and prayed to God. It’s now two weeks since I was referred to the hospital but now feel okay even though I have never gone to hospital.

Healing prayer may be offered by an individual or by a group. Grace describes how she can rely on her church members to pray for her or her children in the event of a sickness. Patricia, too, joins other church members to pray for her own and her son’s health. The promise of healing is so attractive that she joined the Roho church to get help for her epileptic son. Even though he didn’t get healed, she remains a member. In fact, the promise of healing is responsible for many conversions from mainline to African Independent Churches like Roho and Legio.

There is a sense that God also protects one from death or catastrophe. For example, Karen knows that God loves her because he has “increased her days.” Both Josephine and Pauline talk of God’s protection when they travel. According to Pauline:

I pray so that God should be on my side since you normally hear of so many calamities nowadays on the road, and if he is going to provide a vehicle for me then it should be a good one.

Apart from travel protection, God offers protection from other imminent catastrophes. For example, according to Agneta:

When we eat, sleep and do other things then we know that God is the one allowing us to do all these things. Take for instance me, I’m in a thatched house. I sometimes feel that if it is not for God, then somebody can come and burn my house with just a matchstick. Therefore I feel that I’m protected by God.

Finally, participants believe that God also protects them in other, less dramatic, ways: he may help with a good harvest (Josephine), by providing food when there is
nothing to eat (Pauline), or by intervening when a child has been sent home for school fees (Salome).

8.2.3 Guidance

The promise of receiving guidance and help in the face of problems motivate religious participation. Many participants reveal that they pray in the morning for God to guide them, and in the evening, they thank God for his guidance. Many also pray for guidance when problems arise or before making any major decision. Agneta prays so that God “will help [her] in times of troubles.”

People receive guidance in different ways. Some participants speak of an almost divine intervention in their affairs. According to Karen: “Sometimes after praying over a problem, then there is a solution to that. Not directly, but somehow it is a solution to the problem. Then I can easily say God has answered my prayer.”

Grace tells of attending her fellowship group where she is taught the word of God and may feel touched to share her problems with him. God speaks to her through bible teachings, “telling [her] what kind of direction [she] may take in case of any problem that may arise.” Like Karen, she describes how the solution to her problem may be indirect:

I feel God is close because whenever I pray on something, it doesn’t necessarily matter that you get the reply straight, but it can come slowly and by that you can see God helping you. By that, you may know that God is close to you, if whatever you asked for is happening to you.

God intervenes for a variety of issues. In the past, if Evelyn got a good harvest she would sell the whole of it and remain with nothing. She explains: “One day I knelt down and prayed to God to help me keep my harvest. From then I was able to keep my harvest until the following harvesting season.”
Others tell of receiving **guidance in the face of temptation**. Evelyn insists that if she has strong faith, God will lead her through temptations. Similarly, Josephine goes to church to pray for God to guide her against evil things. Sometimes guidance takes the form of teaching. Both Grace and Josephine claim that they receive teachings on “how to live” from sermons and bible readings. Agneta is taught by the Holy Spirit who comes to her as a voice telling her “that this is bad or good.”

Finally, people seek **guidance in the face of seemingly intractable problems**. Evelyn describes a time when her stepchild quit school just before he was to take his examinations. After he refused to return to school, she went to church where the church members helped her to pray. The boy returned to school by his own will. Agneta seeks God’s guidance and help for her marital problems. When her alcoholic husband failed repeatedly to get sober, she finally “surrendered to God to take control.” Salome’s prayers relate predominantly to her seemingly impossible financial situation. She prays because “I need so many things I can’t count them all.” In the face of so many difficulties, she “found out that it is only God who can help me with them.” She explains:

There are times that are hard for me. Like now I can go to sleep, then I wake up because I am thinking over an issue and there is nothing I can do over it. I asked my brothers for help, I asked them if possible to look into ways I can get iron sheets to build a house and they told me they will do that during December, but when the date came they postponed it and keep on postponing it. When you are in bed and all the children are also asleep, then you can start thinking over that and question yourself, what you can do? At that time I cannot think of anything beyond that, it is only praying and asking God, that ‘I have nobody to ask, but only you, God, can see what to do’. So when I woke up, I found an answer. In the morning, something told me to try and find where grass is and upon finding it go and talk to the mason to build for you the house and pay him bit by bit. Now you can see there is none to ask but God, he is the one guiding me in whatever I do.
In addition to receiving divine guidance from God, participation in church communities affords people access to advice and teachings from fellow congregants. Participants describe receiving help from fellow congregants in making decisions. Susan shares her problems with “the [Anglican] priest or the old women in the fellowship.” They “help [her] decide because sometimes lone decision-making can be negative.” Grace, too, goes to the mothers in the church when she needs advice. Group discussion participants confirm that elderly mothers in the church serve as advisors to younger women. Apart from older women, some appeal to “the church father or his wife” for advice.

Much of the advice dispensed by people in the church community relates to living a “good” life. The advice may concern being “strong in the Lord and church” (Josephine), how to “foresee a bad thing [one is] yet to do and try to avoid it” (Evelyn), or learning to “forgive and forget” (Evelyn). Agneta reveals that the church’s advice can even “help you not to commit suicide.”

In addition to advice, many participants receive teachings from the church and fellow congregants. Grace has a friend who visits her at her home often. Together they read the bible and “teach each other”, discussing how “God speaks to you telling you what kind of direction you may take in case of any problem that may arise.” Grace also receives “training” from the pastor’s preaching, and from the pastor’s wife “on how we can stay with our husbands and households in order that these small problems may not bring any difference in the house.”

8.2.4 Material benefit
Another motivation for religious participation relates to the promise of material benefit. Several participants relate how prayer has helped to bring customers to the market to buy their produce. Salome explains:

I took this money and went to Akala market, I don’t know whether you know where Akala market is. I went and bought some fish for trade. So you know from this 300 Ksh. I bought fish worth 250. And you know out of it I got 500 when I sold the fish at Ng’iya market. [...] This I saw was not normal but through the power of God.

Salome also believes the power of prayer caused her otherwise unsupported husband to send money from Nairobi:

Their father was staying in town and he never bothered about us. Even sending money, he was not doing that though he was a carpenter. I was the one looking after these children, struggling to see how they can survive. When we went to [fellowship] and they requested to come and fellowship with me here at home, that was in 1982 on a Thursday and when it came to pass, on Saturday God did break the wall and money was sent to me from Nairobi, which wasn’t earlier happening. It was a miracle to me.

It is unclear to what extent churches as institutions, rather than as a community of congregants, provide instrumental support. Some participants insist that their churches do not provide instrumental support. Agneta and Eunice, for example, insist that the only support their churches offer is prayers. Karen, too, receives only prayers and consolation. She explains, “That is why my daughter-in-law has left our church because there is no help.” Others reveal that, while they themselves have never received material assistance, the church does provide it to those in need (Jaqueline). Evelyn, for example, insists that her church may build a house for someone whose home is burned. Whether or not the church as an institution provides instrumental support, it is evident that people receive material support from fellow congregants, mainly through small donations (“contributions”) made in the case of a special event (e.g., a funeral or
wedding). According to Agneta, “When there is a problem, that is when people come together, funeral or wedding, and that is where people are giving.” For example, Beatrice was given food to provide for the visitors who came when her mother died. Additionally, individual congregants or members of small groups within the church may take household goods (soap, sugar) to a church member who is ill (Evelyn), or donate clothes and household necessities when they visit various homesteads around the village. Finally, Susan and Pauline received contributions to help with school fees. Susan notes:

They have helped me in terms of school fees that I told you is a burden to me. They brought the idea that people should contribute to each other’s problems so these fundraisers have been helpful to me so much.

Church members may buy a coffin or burial clothes, supply grass thatch for replacing a roof, or take up a collection to help support a sick person.

This support is not given indiscriminately. Church membership is often prerequisite for receiving support. Salome explains: “If you have a problem now what they will ask first is which church you go to. There is a part your church will play in this and relatives will also bear some.” In fact, if one does not attend a church or fellowship group, “there is no way you can be helped” if you have a problem.

8.2.5 Emotional support

Participants describe accessing emotional support through their church communities. Most significantly, for Helen, church provides a place “where I can rest my problems when troubled.” In the case of a problem, Helen receives “moral support” from her church community. For Agneta, the church “listen[s] to you”. For Karen, it “help[s] you in prayer”. It “give[s] you encouragement” that may “help you overcome,”
says Grace. Susan shares her problems with her fellowship group and they “pray over them together.”

Many participants tell of being prayed for her in their homes. Others describe the importance of receiving visits from fellow congregants when they are sick. Agneta explains: “If you are sick and your brethren pay you a courtesy call or pray for you then you can feel you are nearer to God.”

Participants talk of being “encouraged by the word of God”, and insist that “the church unites us.” Karen, who has buried all of her children, knows that “there are very many people with such problems”. She gets “encouraged by the church”. Some of the encouragement relates to financial security. When Eunice is unable to pay her group contributions, she is encouraged by her church teacher that “God is the one who provides”. When Jaqueline meets someone who is struggling financially, she “will encourage her that God is able and all that will come to an end.” She continues: “Before you were born you had your share and blessings, so even though you have not received it you will receive it one day no matter the years it takes unless you die.”

8.3 Groups
Though they are not new to the social landscape of rural Kenya, in recent years, self-organizing groups have proliferated. They replace some of the more conventional and informal social networks that are overstretched:

FO (Interviewer): I would want to ask you about important people in your life - those who can help you when you are troubled.
Patricia: I don’t think I have such a person.
FO: What do you mean?
Patricia: I don’t have.
FO: Do you mean there’s no help you get from anyone when you have a problem?
Patricia: I don’t have such a person. Maybe just the group that I have can help but around here there is [no person who helps].

Group discussion participants list “groups” right after “church” as a source of help. They note several types of groups, including welfare groups, clan-based groups, church-based service groups, church-based fellowship groups, women’s groups, youth groups, and support groups for special populations such as widows, orphans, and people living with HIV/AIDS. Groups vary in their functions and membership.
requirements. Minimum “contributions” (membership fees) range from Ksh. 50 to Ksh. 1000 per month. Membership in most groups is voluntary, though in some clan-based groups membership is mandatory (as are accompanying contributions) by virtue of being a family member. In some groups, members must meet certain criteria: group discussion participants described one church-based service group that admits only women who are Anglican and married. Members who are widowed during their membership tenure are expected to remarry in the church: “If you play hide and seek with a man then we have to stop your membership. Our main objective is to promote Christianity.” Meeting times and frequency vary: some groups meet weekly (e.g., church-based fellowship groups typically meet once per week outside of normal church hours), while others meet less frequently so as not to interfere with farming and other daily activities. Meeting purpose varies across group type as well. While a women’s group may use their meeting time to discuss group issues and business, make contributions, and strategize on group income generation activities, church-based fellowship groups may occupy themselves with reading and discussing the bible.

Most groups adopt a formalized governance structure. Accordingly, there are several opportunities for participants to take on leadership roles in groups. Of my 14 primary study participants, nine had previously occupied or currently occupy leadership roles in their respective groups, ranging from secretary, to assistant secretary, to treasurer to chair. Some are appointed “department head” at church, or are assigned special duties. Pauline is responsible for opening and cleaning the church. She and another woman entrusted with this duty are identified by floral dresses and they keep a duty
roster. She takes her assignment as department head very seriously: “I don’t give any chance to that department to bend or miss the church in any way.”

Membership in one or more groups is nearly ubiquitous: of my 14 participants, 13 belonged to at least one group, with a mode of two groups (maximum = 4). In total, the 14 participants belong to 17 groups. An additional 9 nearby groups were mentioned by group discussion participants. Only Grace, one of the youngest participants who moved to the area relatively recently, did not belong to any group, suggesting that group membership requires a minimum level of social integration.

The importance of groups is evident in how often they are the topic of conversation: group recruitment, group development, and group issues are frequently discussed with acquaintances. Group membership may also be an indicator of social status. Jacqueline reveals that during better times, she was doing business and her husband was well off: “The business was good and I was a member of a number of merry-go-round groups.”

8.4 Motivations for participation

Motivations for joining groups vary. Group discussion participants variously note that groups give material support (e.g., assistance with school fees or purchasing a coffin, a small loan), provide a forum to exchange news or discuss family matters and how to care for the family, “remove boredom”, and relieve women of loneliness so that they “stop worrying and thinking too much”. More abstractly, group discussion participants claim that “togetherness is strength”, suggesting that group membership has intrinsic as well as instrumental value.
Among my 14 participants, motivations for group participation range from material to emotional. Group membership is seen to provide an avenue for accessing assistance in a time of need. Participants revealed that they joined particular groups to “get help”. Much like membership in a church community, group membership assures a minimum level of support: “If you belong to any group you can be assured of some help if something happens to you” says Helen. Eunice reveals that she decided to join Osiepe (lit. “friendship”) when she saw that “they could come together whenever one of them had a problem and help”. Apart from this instrumental support, she was attracted by the fact that “they love one another”. Karen echoes this sentiment about Osiepe: “I joined it because the members are always together during problems.”

8.4.1 Material support

Some participants joined to access material support. Patricia joined Osiepe “because [she] wanted to have somewhere [she] could lean whenever [she] was financially low”. In addition, she and her husband founded a group whose purpose is to alleviate the burden of paying school fees. Others joined Osiepe to address their “difficulty in income generation” (Evelyn) and to borrow money (Millicent). Participants seek material support from groups for needs ranging from broad (“household support” - Jaqueline) to specific (flour and sugar for preparing a Christmas meal - Evelyn). Other examples of direct support include money for purchase of livestock, school fees and uniforms, or a coffin or other goods (a sheep and sack of maize) in the event of bereavement. Other material support is delivered indirectly through the following strategies:

8.4.1.1 Training on income generation
Groups may teach their members how to make bar soap that they can sell for profit, or salon and tailoring skills. Susan belongs to a group that coordinated workshops to train members to engage in dairy farming. At the time of data collection, the group was waiting for the Ministry to Livestock to bring cows to jumpstart their dairy farming business.

8.4.1.2 Other income generation strategies

Some groups pool money to purchase tents and chairs that they can rent out for profit during events such as funerals. Other groups rent land that they farm together. Pauline’s group implements a groundnut project: they farm groundnuts together on rented land and then sell the product for group profit.

8.4.1.3 Savings programs

A special category of instrumental support is the provision of savings plans. Some participants joined groups not so they could be given money and goods, but so that they could be assisted to save their own money. In Salome’s group, each member is provided an account: “You can save any amount that you have and at the end of the year everybody gets his savings for the year.” In her estimation, this strategy “fosters development”. Jaqueline joined her group to save money that she could use at the end of the year to pay “church thanksgiving”.

Groups allow participants to save small amounts of money for later withdrawal. Minimum amounts are very low. Agneta’s group allows members to save as little as Ksh. 50. Evidently members do not benefit from accruing interest in these savings plans; the savings opportunities are attractive simply from the standpoint that
members can ferret away money that would otherwise be absorbed by insatiable household budgets.

8.4.1.4 Loans

Participants borrow money from groups to pay for health services, to start small businesses and to finance funerals. As with savings, the amounts are relatively small but seem impactful. Josephine’s group allows members to borrow up to Ksh. 1000. Josephine used a group loan to buy tea leaves, beans, peas, millet and cassava to start a small business. Loan programs are typically delivered through one of two strategies. In a **merry-go-round**, each participant is given the chance to take a loan in turn. After a loan is repaid, the opportunity moves on to the next person on the list. Merry-go-rounds are used to lend small amounts - Patricia’s group lends as little as Ksh. 10. There are non-financial merry-go-rounds as well. Church groups often engage in merry-go-rounds whereby they hold their weekly fellowship meetings at the household of each member in turn. These non-financial merry-go-rounds *may* have a monetary component, with each member contributing a small amount (e.g., Ksh. 30 for Pauline’s group) to the host. The contributions may be used to purchase the tea and snacks that are consumed at the meeting, or may just be accepted as a gift. **Table banking** is a second lending strategy. In a table banking scheme, members do not need to wait their turn to borrow money; they may borrow money at any time. In Salome’s group, the loan must be repaid within two weeks, ensuring that the group retains enough liquidity to continue to lend. While table banking requires a large sum of initial capital (and, according to one group I met with, this poses a barrier to engaging in table banking for some groups), the strategy is widely praised. Group discussion participants describe it as a strategy that
allows mothers without access to formal employment to “elevate themselves”. Susan insists that table banking has helped her group.

8.4.2 Emotional support

In addition to material motivations, people join groups for social or emotional reasons. Beatrice, the youngest participant, joined her church group because her friends were members. She finds that when she is stressed, she talks to group members and “the stress reduces.” Millicent joined Osiepe “for togetherness with my fellows” and Jaqueline joined her group “to be together with [her] friends” and because of “the kind of love that they show to one in times of need.” Pauline echoes this sentiment: “I joined [Osiepe] because of the love they had for one another, for whoever had problems such as deaths, they would come to comfort you.”

Support groups for widows or people living with HIV/AIDS provide a place where people can “counsel one another”. Agneta notes that she is looking to join one such support group. In addition, the companionship that is afforded by group participation is a valued form of emotional support. One group discussion participant explains: “If I have a problem and I think about it, I can go to a group – even Osiepe – and we story together, then I forget about my problems.” Josephine notes that she is particularly close to one woman in Osiepe; they can “sit down and tell stories.” Osiepe members also came and visited when she lost her brother, visitation in the event of bereavement being a particularly valued form of emotional support.

Praying together and for each other is another form of emotional support common in groups. Susan’s fellowship group shares their problems and members “pray over them together”. She explains, “Those who are in fellowship mostly are people of the same
feather. The problems we have we share together.” Agneta’s group uses the first thirty minutes of each meeting to pray for each member. Finally, one key informant who was in a severely abusive marriage started a support group with her siblings. Once per month the siblings would come together to talk and encourage one another. They formed the group because they thought “as siblings it was important to constantly visit each other and know the well being of one another or the problems faced by some of [them].” In the meetings, they read and discussed the bible, prayed together, and offered advice.

8.4.3 Informational support

Finally, groups serve as forums to exchange information and advice. Participants offered the following examples:

- A group discussion participant praises the age diversity in her group; the younger members “tend to get advice from the elderly mothers. [...] They teach different things like taking care of a house, a husband and children.”
- Evelyn’s group discusses farming issues, deciding together on the best time for harvesting groundnuts or maize.
- In Patricia’s group, they “teach each other how to handle [themselves]”
- Susan talks to her secular group about salvation: “I also talk to them about how our church conducts its people. You can be comfortable if you become a member.”
- The purpose of Susan’s group is to help young women to “do things that would ensure they grow less dependent.” To that end, the older members advise the young members “to avoid idleness” and to stay busy.
• Group discussion participants reveal that special function of clan-based groups is to ensure that people know their relatives so that they do not inadvertently marry within the clan.

8.5 The price of participation

While participating in groups and church communities represents a potentially powerful strategy to build a social safety net, it is not without problems. The most significant caveat to accessing the benefits of formal social networks involves the excessive requirements that people must meet to participate. For example, some participants describe conflicts that occur when they do not attend church gatherings. Evelyn explains:

There is a time my church teacher quarreled me for not attending church meetings. I felt so bad and my friend called me down and she told me to calm down. After all, it was true that I didn’t attend most of the church meetings.

Grace, too, has experienced problems with the same issue. She explains that if she misses church too many times, “then someone may question your competence, but if you are close to church then they may also be close to you.” Evidently, support from the church is contingent upon regular attendance.

One of the most visible requirements of group membership is related to membership fees, or “contributions”. Some groups have mandatory participation with commensurate contributions (e.g., Seje Development members, who are members by virtue of being part of the Seje clan, are required to contribute Ksh. 40 per month to the group). It is clear that the requirement to pay group contributions place a large burden on overstrained household budgets. Indeed, lack of money for contributions is the most cited barrier to participation. Participants describe the stress associated with trying to get
money to pay contributions, and appeals to social networks for the means to pay group contributions are common. Jaqueline explains:

On Wednesday when we went to our merry-go-round group at Nyapuoyo, I didn’t have money to pay and even today I was thinking how to get money that I will pay in our next meeting on Saturday and Sunday. Now what always stresses me is the thought of getting money.

While some groups apply sanctions for members who cannot meet their minimum contribution (e.g., in Pauline’s clan group members who miss three consecutive meetings must give an explanation and are fined when they return), many groups take a more compassionate approach. The chairman of Jacqueline’s group encourages people to attend meetings even if they don’t have contributions; instead, members can pledge future contributions. Eunice is told by a church group leader that even when she doesn’t have money to pay contributions, she should attend the meetings “since God is the one who provides”; Eunice is given permission to pay later when she gets the money.

Another financial challenge associated with groups involves loan payback. Pauline shares: “My son was arrested so I needed to borrow some money from the group to use as fare to Nairobi, but unfortunately I found out that so many people had borrowed and had not paid back.” For that reason, Pauline did not travel to Nairobi. In this way, group members may become dependent on group financial resources that are not consistently available. Moreover, loan payback may cause strain within families. A group discussion participant described such a situation:

Sometime I can take a loan, then something happens. You are not able to pay back in time, so those people also demand that they want their money. But at home they only see some property which belongs to your husband, so once they come and take that, and if you never told your husband, then you are in a big problem.
In church communities, tithing is a more formalized version of contributions. Grace explains that her church requires congregants to pay one-tenth of their income to the church. Jaqueline participates in every church fundraising, and “always pay[s] [her] tithe.” Though not formally required, Pauline plans to contribute money to the church at the end of the year to thank God for keeping her safe. Evidently, the monetary requirements of church participation are not insignificant. Helen reveals:

FO (Interviewer): What kind of work do you do for her?
Helen: Planting, weeding and even brewing chang’aa.
FO: Aren’t you going to church? [laughing]
Helen: But where would you get even the church offering? All the money that are needed in the church, where would you get them?

Churches and groups also place a large demand on people’s time, a resource that is exceedingly valuable in the study context. Susan explains that the more reasonable time requirements are what attract her to her church and group. She likes the way her church “carries out their services”, clarifying that they are “time conscious” and “finish quite early and I go ahead and do other things at home.” She belongs to a group that changed their meeting frequency from weekly to monthly when they realized that meetings were interfering with farming issues. For her part, Pauline describes how the requirement that is placed on her by her church to visit the sick interferes with the time she can be working. She finds the requirement “difficult”.

Key informants suggest that groups themselves are a source of conflict. In recent years, the number of groups has increased dramatically, due mostly to splintering of existing groups. Pauline belongs to Opogre Defectors Group, so named because they defected from a group that embezzled funds. Jealousy may plague groups: Eunice describes how some of the group members were unhappy when she was chosen to lead
the department. Finally, membership in one group may cause strain with other groups. Karen describes how her church forbids her participation in groups outside the church. She explains, “They say that it occupies women, hence they can not attend some of the church anniversaries.”

Despite all the challenges, group membership offers one remedy to the social capital crisis. Through groups, women are able to access financial and emotional resources. One (otherwise critical) key informant frames group participation in this way:

Some women have a voice in governance. This is especially so in women’s groups. There are registered groups which are able to get loans from the government and this helps them to start income generating activities of their choice and improve their lives.

8.6 Women’s engagement with formal social networks for depression

Participants engage with their formal social networks for relief from depression. In order to relieve stress, participants may attend church to pray (Millicent), to talk with fellowship group members (Beatrice), or to talk to the church father or his wife (group discussion participant). Participants reveal that they go to church to “release yourself from depression” (Susan) and that they “feel relieved” after hearing the preaching and see their problems disappearing (Grace). Eunice explains: “I wasn’t going to church before but sometimes I feel pain deep in my soul. Sometimes, I feel like going to church and when I go there I feel the pain disappearing.”

Similarly, participation in group activities offers a formalized version of companionship that helps women to cope with depression. When asked what she does when she is depressed, Salome responds: “Maybe go for our group meetings. Like now after departing ways with you, I will go for the meeting where we will make stories, that will help me to forget all my issues.” Support groups that spring up around shared
identities or circumstances (e.g., widows’ groups, support groups for people living with HIV/AIDS) may also afford women relief from depression. A group discussion participant explains:

Through these groups, when they meet, they tend to counsel one another. So even if you are in a group where all of you are living with AIDS, you are uniform, so you are comfortable that you can solve whatever you are going through. You can get help from one another.

Apart from the direct positive effects on mental health, church and group participation have an indirect effect on mental health by addressing some of its underlying factors that contribute to poor mental health. Access to microloans and table banking, and training in income generating activities, for example, may relieve the stress of financial insecurity, thereby contributing to improvements in mental health. Others describe the instrumental value of attending church: Patricia attends church to receive prayers for a peaceful marriage and for a resolution to her son’s epilepsy. Finally, attending church causes some to “forget” their problems, providing at least temporary relief.

8.7 Chapter summary

Though they have a long history in the study site, both churches and community groups have proliferated in recent years. With respect to churches, there is some tension between denominations, with time management and ability to perform religious healing often evoked in descriptions of the differences between denominations. Several types of community groups exist – welfare groups, clan-based groups, church-based service groups, church-based fellowship groups, women’s groups, youth groups, and support groups for special populations – all with different functions. Both churches and groups require that members devote time and resources – most notably through “contributions”
or tithing – and meet certain criteria. These formal social networks are seen as more reliable than informal relationships for providing access to assistance in times of need, but membership is required. Membership is nearly ubiquitous – all but one participant belonged to at least one community group and it would be difficult to find a woman in the study site who is not a member of some church.

Churches and community groups provide access to slightly different benefits. Church membership assists women to better themselves by avoiding “sin” (especially alcohol) and forgiving others. Women may access protection from illness, death and catastrophe, or guidance in the face of temptation or intractable problems through religion. They may also receive advice, teachings, or emotional support from fellow congregants. Finally, church membership allows women to access material benefits through divine intervention, on the one hand, and from fellow congregants, on the other.

It is unclear to what extent churches as institutions provide material support; most of the material support that women access from churches appears to come from individual congregants.

Membership in community groups provides access to material support, through direct contributions or through a host of strategies including training for income-generating activities, pooled income-generating strategies, and microsavings and microcredit arrangements. Women also access emotional and informational support in groups through companionship, sharing of problems and exchanging advice, and praying for each other.

Despite the potential of formal social networks in providing a social safety net in a context of high uncertainty, excessive time and resource requirements prevent women
from accessing all the benefits. The difficulty of paying church and group contributions causes stress. Women are forced to appeal to their informal social networks for support in paying the fees and in some situations, the financial requirements of group membership can act as a barrier to participation. With respect to microcredit arrangements, loan repayment can cause strain for individuals and at the group level, problems with liquidity arise when members fail to repay their loans in a timely manner.

Despite these barriers, participants do appeal to their formal social networks when they experience depression. Attending church, talking to group members, and talking to a church father or his wife all provide some measure of stress relief. Participating in these formal social networks allow women to access companionship, forget their personal problems, or solve common problems. The material support that women may access through church or group participation allows them to address many of the underlying causes of depression.
CHAPTER 9: PUTTING IT ALL TOGETHER: Understanding how women navigate the therapeutic landscape for depression

FO (Interviewer): What kind of help do you need?
Beatrice: I want how the depression can get out of my heart.
FO: Where do you think you can get such help?
Beatrice: I’m not sure of anywhere.

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In this chapter, I summarize the findings presented in Chapters 4-8 to answer the central questions motivating this research: What is the therapeutic landscape for depression? In this context, how do women respond to depression? What is the role of formal and informal social capital – including faith-based forms – in shaping how women respond to depression?

I draw from all findings to address the original research questions, putting the findings in context and discussing how they relate to each other and the literature. I then reflect on the social capital paradigm and explore alternative framings of the findings. This discussion then sets the stage for suggesting public health interventions to address the burden of depression in rural African settings: we need a more balanced approach that combines individual and interpersonal level interventions, such as innovations in delivery of psychotherapy and efforts to optimize and build social capital, with larger, structural interventions to address poverty and women’s oppression – some of the many underlying factors influencing mental health. This balanced approach can then amplify women’s own responses to depression.

9.1 The therapeutic landscape for rural African women facing depression

The therapeutic landscape is defined as “the field of available forms of health provision as experienced, understood and constructed through practice by the populations that live with them” (Leach, et al., 2008). The use of the landscape metaphor allows us to
see the importance of different framings of the field of health provision. From different vantage points, the landscape looks very different: contrast a young Luo bride who recently relocated to her matrimonial home versus that of an older woman who has spent years attending to her social network, weathering storm after storm of conflict with her husband and his family. For the former, the landscape may be rather sparse and her attention may be drawn to the horizon from where she came; from the vantage point of the latter, the landscape is complex and unpredictable and it is difficult to navigate the rocky terrain built up by years of conflict and shifting allegiances. Both of these framings are valid and accounting for both is important in giving us a complete view of the therapeutic landscape for depression.

I have attempted to give due attention to the diverse vantage points of individual women. Their stories are told in the main narrative and in text boxes throughout this dissertation. I reveal a landscape that is, in some places, sparse – a desert for mental health treatment and support – and in other places, rocky, unpredictable, and difficult to navigate. I offer a map through the landscape, pointing toward possible pathways to women’s mental health.

9.1.1 Treatment desert

The pluralism – the multiplicity of health actors and hybrid forms of treatment – that exists in the general therapeutic landscape in rural western Kenya is absent for mental health, leaving a vacuum for mental health care and treatment. For one, the overburdened allopathic health system is unable to meet the significant physical, much less mental health needs of the population. Despite efforts on the part of the Kenyan government toward decentralization, geographic coverage of health facilities remains
sparse in some remote areas. Clinicians note (and my own observation confirms) that supply side factors – frequent stockouts of medications, a paucity of mental health professionals, few treatment options, a lack of mental health training for primary care clinicians, and barriers to proper diagnosis of mental health problems – combine to limit the capacity of the health system to adequately accommodate mental health problems. These reflect broader challenges facing health systems around the world as governments have progressively disinvested in primary health care in the years since the Alma Ata Declaration (Bloom, 2009).

For physical ailments, people evidently overcome geographic remoteness, economic barriers to health care, and perceptions of its ineffectiveness to seek allopathic health care. Participants revealed health-seeking strategies in response to recent acute and chronic illnesses that are predominantly biomedical, albeit with treatment delays and self-prescribed substitutions. Yet, for mental health issues, it is exceedingly rare for a person to seek allopathic care: no participant (other than Emily in Chapter 1) noted having done so. Demand side factors resulting from the perceived social etiology of mental health problems contribute to the omission of the allopathic health system from the therapeutic landscape for depression: women simply do not view biomedical treatment options as part of their landscape because they don’t view depression as having biological or psychological causes, only social causes such as poverty and marital strife. This finding is consistent with much of the literature on beliefs about the etiology of mental health and subsequent health-seeking behavior (D. M. Kiima, et al., 2004; Silove, et al., 2008).

The role of religious and indigenous healers in supporting women with depression is ambiguous. Historical circumstances related to the rise of indigenous churches
contribute to their continued perception as “fringe” elements of the religious landscape. In particular, their roots in anti-colonial sentiment and their subsequent rejection of Western healing practices in favor of a traditional African healing ethos (giving rise to spirit healing) differentiates them from mainline churches that espouse a biomedical concept of healing. While mainline churches count the wealthy and more modernized segments of society among their congregants, Spirit churches are typically attended by the poor. Not surprisingly, most of my participants (with the exception of those who attend Spirit churches) tend to view the former as “legitimate” while the latter are seen as “fringe.” Thus, while a small group of women – specifically, those who are members of Spirit churches – access religious healing for depression, the fringe status of religious medicine eliminates it as viable alternative for many women – specifically, those who are members of mainline churches – to seek mental health care and treatment.

Similarly, the denigration of African indigenous healing by Christian churches and by the forces of modernity has contributed to its decline. Participants claim that healers have died off and knowledge of herbal remedies has been lost, yet when pressed, they are able to name dozens of indigenous healers (in fact, more than allopathic health facilities and religious healers combined). Some women (again, those who are members of Spirit churches) recount stories that involve seeking the services of an indigenous healer. And use of herbs appears in illness narratives of several participants. Yet, while there is some indication of its furtive persistence, indigenous healing is considered by all my participants to be on the decline and does not constitute a significant mainstream component of the therapeutic landscape for most women facing depression. Just as for the allopathic health system, there are also supply-side factors that limit the capacity of
indigenous and religious healing to accommodate depression. Recall, for instance, that the traditional and religious healers I interviewed were quick to place blame on women suffering from depression and consider treatment outcomes an indication of her “goodness”. This situation is far from ideal for women seeking mental health.

I call this resulting vacuum in the therapeutic landscape for depression a “treatment desert”. Modern clinicians bemoan the lack of treatment options for depression, while religious and indigenous healers lack a robust conception of and strategy for healing depression. Appeals to external caregivers of any sort – to allopathic providers, religious and indigenous healers - are largely absent among women’s responses to depression, because these do not work for them. The “treatment desert” women face is the result of long-standing disinvestment in primary care and deterioration of indigenous forms of care. Renewed investment is needed more than ever where women are poor, marginalized, and depressed.

9.1.1.1 Offering a map: pointing out new pathways through the treatment desert

Given the numerous supply-side factors limiting how the allopathic system is able to accommodate depression, it is clear that many health system reforms are needed. Those might focus on improving the medication supply chain, better training in diagnosis and treatment for health professionals (generalists and mental health specialists), and efforts to increase the health workforce. A review of all the needed reforms is beyond the scope of this dissertation. I choose to focus here on one possible intervention that would address many of the challenges impacting the health system’s mental health care capacity: lay delivery of proven therapeutic interventions.

This focus is motivated by thinking that imagines health systems as “knowledge
economies” or “ways of organizing access to expert knowledge or expertise, embodied in both people and products, and in which multiple types of power relations are embedded” (Bloom & Standing, 2008). The changing nature of health systems (described in Chapter 2) gives rise to new ways of obtaining knowledge and services, and new inequalities of access to competent knowledge agents (Standing & Chowdhry, 2008). Thus, Bloom (2009) warns that the current health systems strengthening preoccupation with research- and development-based innovation and scaling up leads to underinvestment in actors who play an important role in providing health-related goods and services to poor. The intervention I am proposing addresses inequalities of access to competent knowledge agents by reinvesting in the actors on the front lines of health care delivery to women in the study site – the lay, community health workers. My advice is also in line with that in recent health systems strengthening work by the Rockefeller Foundation (O. Bhattacharyya, et al., 2008): “training of laypersons” to acquire skills that have until recently been exclusive to qualified medical personnel will lead to reduced cost of operation, increased staff availability, empowerment of the local community, and increased program sustainability.

Demonstrating the efficacy of lay delivery of psychotherapy is an emerging area of research. Already, a handful of studies support the efficacy of delivery of therapies by a lay therapist (Ekers, Richards, McMillan, Bland, & Gilbody, 2011; Papas, et al., 2010; Rahman, et al., 2008; Stanley et al., 2014; Van Ginneken et al., 2013). Of the number of health actors that could be enlisted to deliver lay therapy in the study site, perhaps the most promising are CHWs. While clinicians from outside the community cite language and cultural barriers to their own work, they note the comparative advantage of CHWs
and their potential to deliver locally-appropriate mental health care in the village setting. Some literature confirms this: CHWs are seen to have particular advantages over other health actors as they are typically locally-chosen and may be more likely to engender trust on the part of the community (Standing & Chowdhury, 2008).

I interviewed a CHW who claimed that the voluntary, unpaid nature of her position contributes to high attrition and is the most significant barrier to optimizing her effectiveness. This position is generally supported by the literature, which documents high attrition rates among CHWs, leading to a lack of continuity in the relationship between CHWs and communities, increased training costs, and lost opportunities to build experience (K. Bhattacharyya, Winch, LeBan, & Tien, 2001). It is clear that efforts toward delivery of psychotherapy by CHWs must be accompanied by monetary remuneration as well as attention to other non-monetary incentives that may serve as motivators and compensation. Efforts to provide remuneration to CHWs are well in line with priorities outlined in Kenya’s National Health Sector Strategic Plan II (Ministry of Health, 2005), the update to that – the Kenya Health Sector Strategic and Investment Plan (Ministry of Medical Services and Ministry of Public Health and Sanitation, 2013) – and Kenya’s Community Strategy (Ministry of Health, 2006). As of this writing, however, national coverage of community units is low and the service package for community health services is not adequately funded (Ministry of Medical Services and Ministry of Public Health and Sanitation, 2013).

9.1.2 Rocky, unpredictable and difficult terrain

Given the almost total lack of any organized care, women in rural Siaya are adaptive, developing locally appropriate and culturally meaningful responses to
depression. These involve appeals to informal social networks of friends, family, and neighbors) and formal social networks of churches and community groups. I investigated egocentric social networks by soliciting names and descriptions about the people who are most important to participants; probing for additional alters using resource generators (“Who would you go to if you needed help with money?”); and asking about participation in formal networks, particularly churches and community groups. I characterized relationships as bonding, bridging, or linking, and alternatively by relationship category (birth family, husband and his family, friends, etc.). In this part of the therapeutic landscape, I found rocky terrain – complicated relationships characterized by support and promise on the one hand, and tension and conflict on the other.

9.1.2.1 Unreliability and cost of maintaining informal social networks

Not surprisingly, informal social networks, comprised of family members, friends, and neighbors, constitute a major component of the therapeutic landscape for depression. Bonding and bridging relationships are almost equally represented in the social networks of the study participants. Linking relationships, on the other hand, are scarce – of the 100 relationships listed across participants, only four could be classified as linking. The few linking relationships that were mentioned are with church and community group leaders. This low linking social capital is evident throughout the literature on poor populations. A lack of linking social relationships is associated with persistent poverty (Ferlander, 2007) and low linking social capital has been linked to poor mental health (Lofors & Sundquist, 2007).

Across different types of relationships, women can call on others for access to emotional support, instrumental aid, and advice. Emotional support consists of
encouragement or hope, companionship and visitation. Common forms of instrumental support are help with household chores, farming, money, basic goods, employment opportunities, small business capital, and help paying group membership fees.

Instrumental support is most often given to help with healthcare, in support of children, or in the event of bereavement. Finally, women seek advice on health, marital problems, family problems, farming, and business.

Types of social support vary by the type of relationship: the bonding relationships, relationships with other women, and faith-based relationships listed by participants tend to provide more emotional support and advice. Bridging relationships, relationships with men, and secular relationships provide more instrumental support. This is not entirely consistent with the social capital literature, which suggests that bonding networks offer emotional and instrumental support and bridging relationships provide informational support. There are two explanations for this inconsistency. Because of ambiguities in definition, the social capital literature is inconsistent with respect to how advice is classified: some studies classify “advice” as a form of informational support while others consider it a separate category of social support. I employed the former strategy and indeed much of the informational support I detected consisted of “advice”. Because the exchange of advice presupposes some level of intimacy between people, it is possible that my decision to classify advice as informational support contributed to the finding that informational support was more common in the context of bonding relationships. In addition, given that a large portion of the instrumental support received is in the form of money (rather than labor, for example), and given that my participants were cash-poor, it makes sense that they would have to appeal to people who are different from them for
instrumental support. Participants’ own framings of difference in socioeconomic terms supports this claim.

Of all the social forces shaping networks and social support, the strains of patrilocality are most salient. When a young Luo woman is married, she relocates to her husband’s home, often residing in the homestead of her husband’s parents. Tension with her in-laws is not uncommon during the period of post-matrimonial adjustment. Old relationships with members of her birth family are maintained over time and sometimes great distance and provide emotional support. New relationships that are formed with her sisters-in-law (the wives of her husband’s brothers) based on their common experience as family outsiders are important in providing instrumental support. Advice is provided most often by friends, sisters-in-law and a woman’s matrimonial family. Group discussion participants suggest that the enmity that characterizes a woman’s relationships with her in-laws fades over time as the woman bears children and sheds her status as an mgeni (“guest”) in the homestead – indeed, older participants had larger and more varied social networks than younger participants. Consider that 26-year-old Grace’s network is made up of her husband, sister-in-law, and three family members back home, while 48-year-old Josephine’s network is made up of six sisters-in-law, two brothers-in-law, and her mother-in-law. Still, modern marriage is traumatic alike for both poor, rural women as for better-off women like Emily from Chapter 1, who was wealthy, educated and living in Mombasa. Marriage is characterized by intimate partner violence, substance abuse, strains associated with polygamy and infidelity, and detrimental expectations related to widowhood and childbearing. Thus it is difficult to imagine that social
networks built with in-laws and other poor people, in the absence of formal care, would do much to alleviate the psychological distress burdening poor, rural married women.

With respect to the ways informal social networks function as a component of the therapeutic landscape for depression, women draw upon them for stress relief and comfort. In times of need, informal social networks provide companionship, a medium for sharing problems and exchanging advice, expressions of empathy, and messages about the universality of struggle.

Unfortunately, the tremendous potential of informal social networks in accommodating depression is limited in certain important ways for these rural women. According to literature exploring the potential negative consequences of social capital, informal relationships are characterized by obligations of reciprocity that may become burdensome for the poor (Mitchell & LaGory, 2002). My study reveals the presence of two types of reciprocity. One form of direct reciprocity obligates a person to repay a debt: “you help me when I need it and I repay you when I have it”, and tends to cause mental distress. Another, far more common form of reciprocity involves a looser exchange of support: “you help me when you are able, I help you when I am able”, and tends to cement social bonds. Consider, for instance, Pauline being “left stranded” after she borrows maize since she can’t borrow again before repaying the loan. In contrast, more comfortable Josephine can successfully maintain several relationships that display reciprocity, through the giving and receiving of beans, maize, advice, encouragement with her sisters-in-law. This distinction is largely absent from the social capital literature; on the contrary, “reciprocity” and “mutual aid” are often combined into one composite “trust” construct (Yip et al., 2007).
In addition, there is the burden of maintaining large social networks, since caring for additional household members, such as orphans or the wife of an absent son, draws on meager household resources. There is the challenge of balancing competing demands for scarce household resources. There is the distress associated with dependence on unreliable social support from others. All together, these limit the amount of support that a woman can reasonably access from her networks and expect to “pay back”. Navigating all this can aggravate, rather than relieve, mental distress.

9.1.2.2 Tensions of formal social networks

Formal social networks are established through participation in organized, structured church communities (e.g., Catholic, Anglican, various evangelical and local churches) and official community groups (e.g., self-help groups, savings clubs, AIDS support groups, clan-based groups, church fellowship groups). These formal social networks are rife with ambiguities and tensions. They are highly structured on the one hand, with budgets, governance structures, and membership requirements. Yet, the “formal” distinction may obscure the self-organizing nature of these community groups (and church groups that emerge out of the formal church environment), which splinter and re-organize with relative frequency. Ultimately, these groups are both spontaneous and flexible responses to persistent material deprivation, emerging out of a spirit of ingenuity and self-help, yet they are also problematic.

Furthermore, there is much ambiguity in how well formal social networks function for depressed women seeking help. On the one hand, they are widely considered to be more reliable than informal social networks in times of need. Participation in a church offers women benefits of personal betterment, protection, guidance, emotional
support, and the promise of material support. Community groups, in contrast, offer access to material benefits – via savings groups, work groups – and to a smaller extent, emotional support and advice. Participants do appeal to their formal social networks when they experience depression. Attending church, talking to group members, and talking to a church father or his wife all provide stress relief. Participating in these formal social networks allow women to access companionship, forget their personal problems, or solve common problems. The material support that women may access through church or group participation allows them to address many of the underlying causes of depression.

Yet, these formal institutions are not reliable safe-houses nor neutral, community-based solutions. They fail to meet women’s needs in certain important ways. While these types of arrangements have particular advantages over public or private risk management schemes, they may also be vulnerable to fraud, corruption, and manipulation by influential or powerful individuals, they can provide incomplete coverage for the most vulnerable and powerless, and they are generally ineffective if all members experience the same shock or income change at the same time (Bhattamishra & Barrett, 2010). My research findings demonstrate that the financial requirements of groups do indeed serve as barriers to participation for the poorest women: membership requirements such as fees bar some women from joining. Groups struggle with liquidity when a member defaults on a loan repayment or fails to pay monthly contributions. My participants raised questions about whether the material promise of church participation is ever actually realized. It seems that most of the material support exchanged within church communities comes not from churches as institutions, but through small contribution from fellow
congregants, who themselves are likely struggling to make ends meet. These realties are relevant for considering how women respond to depression insofar as they limit women’s ability to provide for their basic needs and those of their families, which contributes to depression.

Furthermore, some critics have raised concerns about how the time and resource burdens of participation are not distributed equitably. Maxine Molyneux’s (2002) work in development studies shows how by relying on women’s unpaid labor, voluntary self-help schemes addressing poverty impose large burdens on women, thereby restricting the benefits they derive from social capital. In fact, one of the most serious criticisms leveled against social capital relates to the substantial time and resources required to maintain it. Given that the accumulation and preservation of social capital is dependent on the resources and time that one is able to devote to social capital formation and investment activities, it becomes clear that social capital depends on material wealth (Gidengil & O’Neill, 2006). Evidently, there is much room for efforts to optimize how these formal networks function.

9.1.2.3 Offering a map: pointing out new pathways through the rocky terrain

My findings suggest interventions to address the shortcomings of informal social networks. First, counseling could help attenuate the substantial mental health burden brought by modern marital arrangements (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998). Undergirding groups to better support each other, through group therapy or investment in savings, income-generating, or lending schemes (discussed more below), could yield significant mental health benefits among women in the study site.
The diary data I collected revealed that women use mobile phones to manage relationships with their birth families, located at some distance. At the same time, my experience of collecting data via mobile phone showed that, poor network connectivity and low rates of phone ownership contributed to lower rates of successful contact with participants. When we did succeed in communicating, participants were generally positive about the daily phone interaction. Increasing access to mobile phone communications (for example, by phone-charging stations, lower costs, and more efficient use of airtime could help women communicate with their birth families from whom they receive emotional support. From a capabilities approach, this may also serve to “enhance their freedoms to do more and be more in ways they have reason to value” (Murphy & Priebe, 2011), including being at peace, feeling free, connected with loved ones, and other mental health benefits.

We might also look to formal social networks as potential targets of public health interventions. Self-help and other formal community-based groups can help reduce financial strain that causes psychological distress, but barriers to participation and proper functioning must be addressed. Subsidizing the cost of participation for poorer households and providing external resources to alleviate challenges that groups face are possibilities (Bhattamishra & Barrett, 2010). In the study site, this may take the form of cash transfers to individuals for help with group fees and grants given to community groups to improve their liquidity and buffer seasonal shocks.

It is important to note that external intervention can change the nature of the network with unintended and unpredictable consequences. For example, in a randomized evaluation of external assistance to women’s groups in western Kenya, Gugerty and
Kremer (2008) found that, in the presence of external aid to groups, group membership and leadership shifted toward younger, more educated, better-off women and the dropout rate due to conflict doubled. The findings of this study should act as a caution against dramatic and widespread intervention. Any efforts to support self-help groups in the study site should be small-scale (focused on a few test cases) and tailored to the needs of individual households and groups.

9.2 A panoramic view of the landscape

Up to this point, this discussion has portrayed the therapeutic landscape from the vantage points of individual women. In places, that landscape is sparse – the vacuum created by an underperforming allopathic health system and a deteriorated indigenous healing system. In other places, the landscape is rocky and difficult – built over time on complicated social relationships. I have discussed how women navigate the landscape to respond to depression; they are primarily drawing on their informal and formal social networks for various kinds of support. And finally, I have attempted to offer maps, pointing out policy and practical pathways through those two landscapes. At this point, I take a panoramic view of the therapeutic landscape. While it is clearly important to study and work at these individual and interpersonal levels of social capital, the findings of this study suggest that poor collective social capital, evidenced by rampant jealousy and mistrust, is more problematic. It limits the range of potential responses to depression. It is on this level that the remaining discussion will focus. I hope to point out, not pathways through, but ways to transform the landscape.

9.2.1 Jealousy and mistrust
The rampant jealousy-fueled mistrust I found in the study area is perhaps the most significant barrier to realizing the benefits of informal social networks. Recall that every participant, including key informants and group discussion participants, remarked on the lack of trust in the study area, attributing it to jealousy over others’ “success”, for example, when a child is selected to join a prestigious school or when a family enjoys a bountiful harvest. In turn, widespread mistrust caused my participants to “do nothing”, “keep quiet”, “stay busy, or “turn toward God” when they experience depression, for fear that their private issues will be exposed if they seek help from members of their social network. Consider how Salome doesn’t tell others about her marital problems for fear that they will laugh at her; how Eunice warns that if one shares her problems with others, she should be prepared to be the subject of gossip; and how Pauline fears that other people will change her words to bring conflict between people.

This experience is consistent with Berkman et al.’s (2000) conceptual framework linking social networks to health. This framework outlines the role of social-structural conditions at the macro level in conditioning the extent, shape, and nature of social networks at the mezzo level. These in turn provide opportunities for psychosocial mechanisms at the micro level, which impact health through various pathways (see the top row of boxes in Figure 28). Applying Berkman et al.’s framework to my research, low social cohesion at the macro level leads to low intimacy in social networks at the mezzo level, which in turn leads to low social support and norms against seeking help for depression at the micro level, ultimately leading to persistent poor mental health and a reticence to seek help for depression (the “pathways”). The conceptual model suggested
by my research findings appears in the row of white boxes below Berkman et al.’s grey boxes in Figure 28.

Figure 28. Conceptual framework linking low social cohesion to persistent poor mental health and reticence to seek help for depression. Top row of boxes from Berkman et al., 2000. Bottom row are mine.

9.2.2 A social capital crisis with deep roots

In considering what may be done to transform this landscape – and how it constrains options for women – we must consider the roots of low social cohesion in the study area. I argue that jealousy and mistrust ultimately arise from structural issues. My research findings suggest that the most salient structural issues are material deprivation, and gender inequality. Participants repeatedly cited material deprivation – chronic hunger, the inability to pay school fees for their children, the inability to seek treatment for life-threatening illness, lack of household essentials such as soap – as the most important factor contributing to their poor mental health. My research indicates that it is also the most important factor contributing to low social cohesion, often leading to conflict – with in-laws over scarce family resources (e.g., land), with husbands over financial strain.
within the household, and with neighbors over shared community resources (e.g., grazing land).

Moreover, gender inequality, especially as it manifests within marriage, contributes to poor mental health and constraints to health-seeking behavior. Women are oppressed and not free, leading to a lack of control over their fertility, vulnerabilities associated with polygamy and normalized infidelity, and destitution in the face of widowhood. Due to constraints on their own income generating potential, women are often pitted against each other – co-wives in competition for their husband’s meager resources, a mother’s security threatened by her son’s new wife absorbing all of his resources, a woman jealous when her husband diverts his resources to his new mistress.

To what extent does current social capital theory acknowledge these factors? Much work in the field of social capital focuses on its effects, paying no attention to the structural conditions from which it arises. Work focusing on the determinants of social capital focuses almost predominantly at the individual level, examining associations between social capital (as individual belonging, group membership, relationships) and an individual’s age, sex, socioeconomic status, and health. Studies of structural determinants of social capital are more rare; those that exist focus on historical influences and national demographic factors, such as economic growth or welfare systems (Hanibuchi & Nakaya, 2013; Patulny, Siminski, & Mendolia, 2015).

Berkman et al. (2000) attempt to incorporate structural determinants of social capital into a unified social capital framework, cited above. Their work is perhaps the most promising. They acknowledge the contributions of Lin et al. (1986), House (1981), and Sarason et al. (1990) toward advancing understanding the richness and complexity of
social support. Yet, they question the assumption underlying all of this important work, namely that what is most important about networks is the social support they provide. In their view this detracts from a need to focus on the structural underpinnings that influence the types and amount of social support provided. The authors conclude that “serious consideration of the larger macro-social context in which networks form and are sustained has been lacking in all but a small number of studies and is almost completely absent in studies of social network influences on health” (p.846). Their work represents a serious attempt to reposition social capital within a broader context, yet even Berkman et al. conflate structural (e.g., laws and policies) and super-structural (e.g., social justice, class, race, gender, equity – Sweat and Denison 1995) forces. Moreover, the authors fail to address power, thereby minimizing the role of poverty and gender inequality that give rise to mistrust and jealousy in rural Siaya. Thus, my work highlights an apparent shortcoming of much of the theoretical work in social capital: it minimizes or ignores structural factors that shape social capital formation and distribution. The tendency for theoretical and empirical work in social capital to ignore these structural factors undermines greater social justice and better public health (Lynch, Due, Muntaner, & Smith, 2000).

9.3 Transforming the landscape: building social capital and beyond

Transforming the therapeutic landscape of rural Siaya calls for addressing underlying factors in low social cohesion. More work is needed. We have a relatively well-developed theoretical foundation delineating social capital in general, and a burgeoning empirical literature demonstrating its health effects, but the theoretical and empirical foundation around building social capital is light. The few examples employ
group-based microfinance interventions as a method to facilitate social interaction (Al Mamun, 2014; Feigenberg, Field, & Pande, 2010; Pronyk et al., 2008; Thabethe, Magezi, & Nyuswa, 2011). Outside the realm of microfinance, sociotherapy (community-based psychosocial groups) has been shown to increase civic participation and improve mental health (Verduin, Smid, Wind, & Scholte, 2014). And Ogden et al. (2014) relied on field experience related to addressing HIV-related stigma and discrimination to develop a three-step model for building social capital. The process includes: (1) bringing together individual people or organizations for focused training and workshops to bond them into groups, (2) bringing these bonded groups together to create a bridged regional network, and (3) linking bridged networks with policy-makers.

Evidently, the defining feature of all current attempts to build social capital is the facilitation of social interaction. Given the association between social participation and well-being in the social capital literature, it is logical to try to create social capital by facilitating participation. But one must ask, if merely bringing people together was effective at building social capital in the study site, wouldn’t it have worked by now? Community and church groups built around a common purpose are nothing new in Siaya. My research findings suggest no shortage in the quantity of social interactions. Yet low social cohesion characterizes social life.

My analysis of the factors contributing to low social cohesion in rural Siaya reveals the supremacy of material deprivation – people are poor – and gender inequality – women are oppressed. These constrain health behaviors and shape mental health through the production of jealousy and mistrust. No amount of effort toward “building social capital” will be adequate in improving mental health if it does not also address the roots
of deprivation and inequality – poverty, powerlessness, vulnerability, and patriarchal oppression.

Thus, my findings suggest a new framing with which to view responses to depression in western Kenya. Rather than focusing solely on individual or interpersonal factors that limit the range of responses in which women engage, we need a focus on **structural factors that shape health behaviors and outcomes**. This shift in framing has real implications for women’s lives. It calls for serious recommitment toward addressing the structural issues of poverty and oppression that lead to poor mental health and constrain health-seeking behavior, *alongside* efforts to improve mental health at the individual and community levels. These efforts entail delivery of proven treatments, addressing the shortcomings of informal social networks, and supplementing the important support that formal social networks are already providing. In this view, poor mental health is rooted not only in a breakdown of social cohesion, but in larger forces maintaining poverty and gender inequality. These are government health systems that fail to deliver health care, and a tense political landscape characterized by tribalism and nepotism that serves to marginalize much of western Kenya. These are policies and cultural norms that disadvantage and disempower women, and changing environmental conditions (e.g., impacts of climate change and increasing population density) that exacerbate resource scarcity. In this framing, commitments to addressing poverty and gender inequality reemerge as vital tools in the effort to promote mental health in rural western Kenya. In laying out a new vision for building social capital that embraces these structural factors as well as interpersonal social relations, Lynch et al. (2000) caution:

> [Unless the vision of social capital that is developed embraces structural factors], the rhetoric of social capital and social cohesion may run the risk of becoming a
lament about “why can’t we all just get along, like we are one big happy family?”.
[...] We are not one big happy family – there are the haves and the have nots; the exploiters and the exploited; the enfranchised and the disenfranchised. Our societies are divided by economic, racial, ethnic and gender inequalities that receive institutionalized political, legal and corporate sanctions. If we understand social capital as a societal-wide capacity for inclusiveness, human rights, social justice, and full political and economic participation, then indeed public health should invest.
CHAPTER 10: CONCLUSION: Taking stock and looking forward

MO (Interviewer): We have done so well and I think I am through. I have heard very well all that you have told me, unless you have got a question to ask?
Salome: I actually don’t have a question, but just want to thank you for the time. It is a blessing because you have strengthened me. The little we have talked about is very nice and I am very happy. I don’t have much.

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I used a mixed-methods case study approach to explore how women in rural Siaya, Kenya navigate the therapeutic landscape for depression. I relied on in-depth interviews with women suffering from depression, members of their social networks, therapeutic landscape actors, and key informants. I collected daily diaries from the participants by mobile phone over three weeks to elicit more detail around health-seeking behavior, interactions with their respective social networks and receipt of social support. I conducted focus group discussions to establish boundaries for the therapeutic landscape and to clarify local terms and concepts related to depression.

I have demonstrated that depression is perceived by women in rural Siaya to have an entirely social etiology, caused by poverty and marital strife, for example. It was not surprising, then, when I described these Luo women’s lack of engagement with the modern allopathic health system for depression, despite the widespread reliance on the health system for most physical ailments. While the religious healing and indigenous healing traditions are used by some women for some ailments, neither are considered ideal nor even acceptable by a large portion of the population in the study area. Informal social networks – family, friends, neighbors – provide various forms of support that address the social roots of depression, but there are drawbacks to these networks. Obligations of reciprocity, competition for limited resources within a network, and the creation of relationships of dependency limit the amount and type of support available. Formal social networks – churches and official groups – may be more reliable in times of
need, but are accompanied by challenges that limit participation and proper functioning. Throughout, I have documented how women navigate this therapeutic landscape. With a few exceptions, responses to depression are predominantly inward-focused, consisting of prayer, keeping quiet, and staying busy. In some cases, women may turn to a trusted confidante for advice or distraction. In Chapter 9, I discussed the findings, and considered public health implications of my research, suggesting interventions focused on lay delivery of proven therapies, on improvements in how social relationships function, and on building collective social capital. I demonstrated that the low social cohesion seen in my study is rooted in poverty and gender inequality and called for efforts toward addressing these structural factors alongside those focusing on social capital. In this final chapter, I discuss how my research contributes to the mental health and social capital literatures and identify future directions for research. I close by reflecting on the strengths and limitations of my research.

10.1 Contributions to the literature

Low- and middle-income countries are dramatically underrepresented in mental health research, despite having a high prevalence of depression, a preponderance of factors known to lead to depression, and often underequipped health systems with which to coordinate a health care response. My study adds to the sparse literature around depression in low- and middle-income country settings in several important ways. First, two-thirds of the women I screened were found to have experienced clinically-significant depressive symptoms in the past two weeks. This is an astounding statistic and calls attention to this prevalent and largely untreated problem. While I used a non-probability sample for the depression screening and therefore cannot infer a population prevalence, a
few remarks will serve to contextualize the prevalence I detected in this study. Of the 65 women I screened, 12 were recruited from the clinic setting and 12 were recruited from lists supplied by faith healers. Depression often manifests in somatic symptoms for which people seek treatment (allopathic or spiritual). Therefore, the prevalence among clinic-based samples (and by extension, healer-based samples) is usually higher than among the general population. On the other hand, some research suggests that social connectedness reduces depression risk. The 41 women sampled from community groups (secular and religious) and perhaps even the 24 sampled from healing settings may be more socially connected than other women. Thus, the prevalence of clinically-significant depressive symptoms among this purposive sample may be lower than we would find in the general population.

My research also contributes to the literature by describing how depression is expressed in the study site. While this was not the intended purpose of the study, my findings do suggest that expressions of depression in rural Siaya are not unlike those in Western contexts, characterized by sadness, crying, and some amount of psychosomatic expression. My findings about perceived causes of depression also confirm what is put forward in much of the literature on the topic: depression is seen to be the result of social factors, not hormonal or biochemical imbalances.

Most importantly, with respect to the mental health literature, my study reveals a “treatment desert”. I contribute to the literature on mental health treatment by documenting barriers to good mental health care in the allopathic health system, which might be used to inform health systems strengthening efforts. I also add to the literature on pluralistic health systems, by reframing indigenous and religious medicine not as
cultural “barriers” to timely allopathic care as they are often portrayed, but as functionally irrelevant for most women in the study site. Mainstream health research, especially related to malaria and HIV, documents delays in allopathic care resulting from the use of traditional healers and herbs. On the contrary, my research reveals that the first health action for most women when they fall ill (from non-depression illnesses) is allopathic, not traditional. Very few participants noted having availed themselves of traditional healing, and none sought traditional healing as a first or only line of care. Instead, delays in care are due mostly to poor access resulting from high transportation and treatment costs. The use of traditional healing as an alternative to allopathic care was mentioned by only one participant – a clinical officer – who worried that perceived ineffectiveness of allopathic medicine (based on people’s experience of seeking allopathic care and being misdiagnosed or mistreated) pushes people toward traditional healing.

Facing a treatment desert, my study documents women’s personal responses to depression – repeated appeals to informal and formal social networks for small amounts of emotional, informational, and instrumental support. Most of the research around health-seeking behavior for mental illness focuses on large health actions – seeking help from a mental health professional, for instance. Information about small, day-to-day coping strategies is absent in the mental health literature. My research contributes nuance to our understandings of health-seeking behavior for depression, especially in contexts where formal mental health care is largely absent.

My description of the types of relationships represented in the social networks of study participants draws out important contributions around the effect of patrilocality on
mental health. When a Luo woman is married and relocates to her husband’s home, she leaves the relatively supportive environment of her birth family and is placed in a social context that is, at best, unfamiliar, and at worst, hostile. My research documents relationships with birth family as sources of emotional support, maintained over sometimes great distances. I also contribute evidence of the importance of sisters-in-law in supporting each other (with advice and instrumental support) in their matrimonial homes. While my finding that linking social capital is scarce is consistent with the literature on the shortage of linking social capital in poor settings, some of my findings on social support by type of relationship are unexpected: in particular, informational support was more common in the context of bonding relationships, while instrumental support was more common in the context of bridging relationships. This points toward an area for more research.

Further, my study confirms the presence of some of the negative effects of social capital theorized in the literature, but offers nuance in the understanding of reciprocity requirements. Obligations of reciprocity that involve direct repayment of a monetary or in-kind loan (i.e., the “obligation” form of reciprocity) contribute to psychological distress by stressing overstretched household budgets and limiting options for future support. On the other hand, reciprocity that involves “repayment” of a non-specified good or service at a non-specified time in the future (the “mutual assistance” form of reciprocity) serves to cement social bonds – participants note this form of mutual assistance in their most important relationships. While much of the social capital literature conflates these two forms of reciprocity, my research suggests that this
distinction is important for understanding the mental health effects of reciprocity requirements.

Finally, perhaps the most significant contribution my study makes is to push for more attention in public health research and practice to the structural determinants of low social capital, such as poverty and gender inequality. I have argued that attempts to build and protect social capital – by fostering social interaction for example – are likely to fail in the absence of serious attention to the structural factors that shape social capital. This attention is absent in the social capital literature. While previous gender-based critiques of social capital research call vital attention to the male-bias in social capital studies, scholarship around this issue focuses predominantly on more affluent, educated, urban, white women in Western contexts. My study adds an important dimension to this literature by revealing the complex ambiguities and reliance on social capital among poor, rural, African women.

10.2 Future directions for research

My study points toward several new lines of inquiry. First, many of the findings of this study would benefit from a comparative analysis of other contexts. For example, I would like to know to what extent the low social cohesion found in the study site is unique to this location (and if it is indeed unique, what are the historical, cultural, economic, social influences that have created this situation?). This has bearing on efforts to address low social cohesion through intervention: attempts designed and tested in other locations may or may not be relevant for this one. An understanding of the structural forces contributing to low social cohesion would be helpful not only when designing an intervention to improve social cohesion, but also when intervening to improve any health
issue (so that efforts do not have the unintended consequence of further undermining social cohesion). For example, if further study were to reveal that development programs that have historically offered benefits to only a few individuals actually serve to undermine social cohesion, then better development policies and programs could be designed.

This study suggested that sisters-in-law and birth families are important sources of support for a married woman. Further research is needed to understand the potential of these two sources of support: how are these networks established and maintained? What facilitates or hampers the exchange of support in these relationships? What are possible ways of intervening to optimize these relationships? This information is critical to inform any strategy that calls upon sisters-in-law and birth families to support a woman suffering from depression. A positive deviance approach (Wishik & Vynckt, 1976) has potential for helping us to understand what makes these relationships work for some women.

Formative fieldwork and pilot studies are warranted for innovative interventions to address depression among women in this location. Specifically, with respect to lay delivery of psychotherapy, the evidence base supports the design and testing of a lay delivery strategy involving CHWs in Kenya. Much of the work that CHWs already do is reminiscent of talking therapy. Indeed, attempts to formally incorporate CHWs into mental health service delivery are already afoot in Kenya (Jenkins et al., 2010b). More work toward understanding the mental health training requirements for CHWs is needed. In addition to testing the effectiveness of this approach, the research should explore ways
of providing remuneration (or other incentives) to CHWs. We need to be mindful of the unintended consequences of strategies to strengthen this aspect of the health system.

10.3 Strengths and limitations

My study is notable for its grounded and in-depth nature and use of multiple methods and framings to achieve triangulation. These contribute to high internal validity. My study also has limitations. The most significant limitations relate to the study site and case selection, language barriers, and study design.

**Study site/case selection:** As is the case with much qualitative inquiry, my specific study findings have limited generalizability to other contexts. I chose the study site based on previous work in the site, which aided my entry into the field. The choice of this site was not made with attention to its ability to represent other contexts. On the contrary, there are reasons to believe that this site is unique in certain important ways (e.g., as the familial homeland of the President of the United States, which is bringing attention and contributing to rising levels of inequality). However, some of the principles emerging from the study may have application in other contexts that are similar to the study site (e.g., sites with similarly low social cohesion). While the choice to ground my study in one location has implications for what I can say about other contexts, my choice to prefer an in-depth, grounded, contextualized approach to an approach that would generate externally valid findings was no accident.

Moreover, due to the purposive nature of case selection, caution should be exercised when generalizing my findings outside the study participants. I chose participants because they represented critical issues associated with mental health as identified in the group discussions, not necessarily because they represented the range of
cases or even the average case. I would argue that much of the data I collect and present relates to collective cultural knowledge; so there is little reason to believe that my purposive sampling strategy led to bias in findings and interpretations.

**Language barriers:** In addition, I do not speak Dholuo and thus had to rely on translation by my research assistants. While I worked closely with my research assistants to encourage proper translation of data collection instruments to Dholuo and proper translation of Dholuo transcripts to English, it is still possible that nuance was missed in translation. Transcription and translation of interviews was not concurrent with data collection (the English transcripts were completed months after fieldwork ended) so I was not able to follow up on all points requiring clarification or further probing. I attempted to overcome the limitations introduced by language barriers by hiring and training local women to lead most of the interviews directly in Dholuo (rather than conducting the interviews in English with a translator, for instance). Given my attempts to account for these limitations, I believe that threats to internal validity posed by language barriers are minimal.

**Study design:** My study emphasizes in-depth understanding in a single site, and lacks a comparison group. While not typically a feature of qualitative inquiry, this raises concerns. A comparison group – a group of women who were not depressed, or another study site, for example – would have made it easier to interpret some of the findings. For example, while key informants suggested that the low social cohesion I detected was unique to the study site, incorporating data from other locations would help me to say whether the low social cohesion here is exceptional relative to other locations. Moreover, I have suggested that the high levels of participation in community groups and persistent
low social cohesion represents a paradox. This claim is built on an assumption that levels of participation are in fact high in my study site (a reasonable assumption, I would argue, given nearly ubiquitous participation). But without knowing how the levels of participation in this community compare to others, I can be only moderately confident in this assertion.

**Ethical issues:** Finally, while they do not represent epistemological limitations per se, ethical issues that arose during the fieldwork deserve mention. In particular, my decision to provide modest remuneration for study participation (300 Ksh. = US$3.50) may have presented undue influence. While remuneration in the amounts I offered is well in line with local research norms, it is certainly true that that small income was very significant to research participants and may have influenced their decisions to participate. On the other hand, there are very valid arguments to suggest that *not* compensating study participants for their time is unethical, especially given that I demonstrated the premium placed on time by the research participants (who valued churches and community groups that “keep time”). Apart from the monetary incentives, my very presence in the study site as a white, American woman may have presented a coercive influence to the extent that I was seen as a source of wealth (e.g., I was approached by more than one participant who asked me to invest in her small business idea). I attempted to counteract any undue influence my presence posed by being clear about the purpose of my presence in the study site and by giving my research assistants autonomy so that they became the face of the research effort.

In some cases, undue influence may have research-related consequences, for example if that influence leads to recruitment of only poorer women, thereby biasing
results toward the poorest. Due to the uniformly high rates of participation across all types of participants except indigenous healers, I am confident that the potential undue influence introduced by remuneration did not have significant research-related consequences.

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Despite these limitations and ethical issues, my research has internal validity related to its in-depth, grounded nature. As with any qualitative, in-depth research, prolonged engagement and persistent observation increases the credibility of my findings. I have spent a substantial amount of time in rural East Africa and in the study site and I was able to draw upon my experiences to interpret some of the research findings. I believe my attempt to overcome many of my shortcomings as a cultural outsider by working closely with research assistants with local knowledge was successful; frequent conversations with my research assistants and Luo colleagues helped me to interpret the cultural phenomenon I was detecting.

I relied on many different data sources and people to tell this story. In addition to allowing me to triangulate the data, the approach allowed me to incorporate diverse framings (e.g., those of women, their friends and families, clinicians, healers, religious and group leaders) into this dissertation. My attempt to represent various stakeholder perspectives in this text speaks to the first of Lincoln and Guba’s “authenticity criteria” – the hallmarks of authentic, trustworthy, rigorous, and “valid” inquiry (see Box 19). While I hope that my adherence to the “fairness” criterion is evident in this document, I plan to attend more fully to the other criteria as I continue to work with women in the study site.

**Box 19. Authenticity criteria**
Fairness – all stakeholder views, perspectives, claims, concerns, and voices should be apparent in the text to prevent marginalization and to ensure that all stories are treated fairly and with balance

Ontological and educative authenticity – raised level of awareness by individual research participants and individuals with whom they come into contact

Catalytic and tactical authenticity – ability of inquiry to prompt action on the part of the research participants and involvement of the researcher in training participants in specific forms of social and political action if such training is desired

Most significantly, my study sheds light on a pervasive yet hidden problem of chronic depression that impacts women around the world. Many of those women face therapeutic landscapes that are similar to the one I have described: sparse – deserts for mental health treatment and support – and rocky, unpredictable, and difficult to navigate. I hope that I have honored the resilience of the women who must traverse these landscapes. After all, they continue striving, adapting, and innovating, against all odds, to reach a place where they might feel happier, more empowered, more capable of caring for themselves and their families. Hopefully, this dissertation inspires work to transform these landscapes so that they become easier to navigate.
APPENDICES
# Appendix A. Health-seeking behavior models and approaches

Table 16. Summary of health-seeking behavior models and approaches (Hausmann-Muela, et al., 2003)

<table>
<thead>
<tr>
<th>Model or approach</th>
<th>Description</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Knowledge, attitudes and practice (KAP) surveys</td>
<td>Knowledge: to what extent community knowledge corresponds to biomedical knowledge; other forms of knowledge are characterized as “beliefs” Attitudes: complex interaction of feelings, beliefs, values Practice: intended to capture behavior; in practice, usually represents normative behavior or knowledge about practices</td>
<td>Descriptive information: no explanation for why person engages in particular health behavior Assume that knowledge translates into practices Neglect factors other than knowledge, attitudes (e.g., stigma, supply-side factors)</td>
</tr>
<tr>
<td>Focused ethnographic studies and rapid assessments</td>
<td>Borrows from anthropology, but more streamlined process than conventional ethnography Aim to arrive at local illness concepts and categories through use of vignettes (to arrive at normative behavior), collection of illness narratives, for example Example is Kleinman’s (1986) Explanatory Models that aim to characterize etiology, onset of symptoms, pathophysiology, the course of the sickness (severity, type of sick role), treatment</td>
<td>Potential to reveal health system failures, intra-household power dynamics, etc. due to open-ended nature Focus on cognitive aspects at the exclusion of grounding in real life</td>
</tr>
<tr>
<td>Health Belief Model</td>
<td>From Sheeran &amp; Abraham (1995): Perceived susceptibility and severity Perceived benefits and barriers Health motivation Demographic and psychological characteristics</td>
<td>Neglects factors that are present in other models: previous experiences, advantages of mal-adaptive behavior, behavioral intention, perceived control, etc.</td>
</tr>
<tr>
<td>Theory of Reasoned Action/Theory of Planned Behavior</td>
<td>Centers on behavioral intention Behavioral intention determined by attitudes toward behavior, subjective norm, perceived control, demographic and personality traits</td>
<td>Though the subjective norm variable marks an advancement in consideration of interpersonal factors, the importance of social forces remain understated Structural aspects are undervalued</td>
</tr>
</tbody>
</table>
| **Health Care Utilization Model** | Predisposing factors: characteristics, attitudes, knowledge  
Enabling factors: e.g., services available and affordable, social network support  
Need factors: e.g., perception of severity, help from outside for caring  
(Andersen & Neuman, 1975; Kroeger, 1983; Weller, Ruebush II, & Klein, 1997) | Social capital is considered an enabling factor  
Model includes material and structural aspects  
While factors considered are comprehensive, does not yield explanation for *why* person engages in health behavior |
| **Four A’s** | Availability, accessibility, affordability and acceptability of health services | Inadequate attention to demand side and structural factors |
| **Pathway models** | Describe path that people follow until they use various health services (e.g., home treatment, biomedical facility, traditional healer) | Some pathway models consider the influence of a ‘therapy managing group’ – family and friends  
Portrays health-seeking behavior as a dynamic process  
Narrow definition of health-seeking behavior process: starts from a recognition of symptoms and progresses through key steps (decision-making, medical encounter, evaluation of outcomes, reinterpretation of illness) |
| **Ethnographic decision making models** | Identify key factors according to the community; use vignettes to explore factors further; series of rules is elaborated | Allows inference of basic logics and mechanisms guiding health-seeking behavior |
| **Contextualization** | Approach that aims to contextualize health behaviors by incorporating consideration of gender, poverty, inequality, or vulnerability; in this view, a health behavior depends on a person’s knowledge, will, capacity and on his/her position in society | Retention of personal factors in this approach prevents shift to structural determinism |
Appendix B. Components of pluralistic health systems

Table 17. Components of pluralistic health systems at the beginning of the 21st Century (Bloom & Standing, 2001)

<table>
<thead>
<tr>
<th>Health-related function</th>
<th>Unorganized health care economy</th>
<th>Organized health care economy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Non-marketized</td>
<td>Marketized</td>
</tr>
<tr>
<td>Public health</td>
<td>Household/community hygiene</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled consultation and treatment</td>
<td>Use of health-related knowledge by household members Some specialized services such as traditional midwifery provided outside market</td>
<td>Traditional healers Unlicensed and/or unregulated health workers Covert private practice by public health staff</td>
</tr>
<tr>
<td>Medical-related goods</td>
<td>Household/community production of traditional medicine</td>
<td>Seller of traditional and western drugs</td>
</tr>
<tr>
<td>Physical support of acutely ill, chronically ill and disabled</td>
<td>Household care of sick and disabled Community support for AIDS patients, people with disabilities</td>
<td>Domestic servants Unlicensed nursing homes</td>
</tr>
<tr>
<td>Management of inter-temporal expenditure</td>
<td>Inter-household/inter-community reciprocal arrangements to cope with health shocks</td>
<td>Money lending Funeral societies/informal credit systems Local health insurance schemes</td>
</tr>
</tbody>
</table>
### Appendix C. Social network classifications

<table>
<thead>
<tr>
<th>Distinction</th>
<th>Classification</th>
<th>Definition</th>
<th>Example</th>
<th>Importance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direction of relationship</td>
<td>Horizontal</td>
<td>Ties between members of equivalent power and status</td>
<td>Voluntary associations</td>
<td>Crucial for building up, maintaining social capital</td>
</tr>
<tr>
<td></td>
<td>Vertical</td>
<td>Ties between unequal agents, asymmetrical relations</td>
<td>Church, organized crime</td>
<td>Enable people to access resources and information outside their bonding network; can be used for nepotism, corruption and suppression</td>
</tr>
<tr>
<td>Level of formality</td>
<td>Formal</td>
<td>Ties linking contacts within voluntary associations, for example</td>
<td>Voluntary organizations, citizens-civil servants</td>
<td>Build civic skills, provide access to formal (informational) support from agencies</td>
</tr>
<tr>
<td></td>
<td>Informal</td>
<td>Ties linking friends, family members, neighbors and colleagues, for example</td>
<td>Friends, family, neighbors, colleagues</td>
<td>Vital in sustaining social networks, providing sources of emotional support, main source of social capital where more formal forms tend to be lacking</td>
</tr>
<tr>
<td>Strength of relationship</td>
<td>Strong</td>
<td>Intimate relationships, multi-stranded and regularly maintained</td>
<td>Immediate family, close friends</td>
<td>Tend to provide emotional and instrumental support</td>
</tr>
<tr>
<td></td>
<td>Weak</td>
<td>Non-intimate relationships, single-stranded and maintained infrequently</td>
<td>Acquaintances</td>
<td>Play role in job searching; may provide informational support</td>
</tr>
<tr>
<td>Diversity of members</td>
<td>Bonding</td>
<td>Ties within networks that are similar with respect to certain demographic characteristics; homogenous and inward-looking</td>
<td>Close friends or immediate family with similar social characteristics, members with similar social characteristics within voluntary associations</td>
<td>Strengthen exclusive identities (can be positive or negative); tend to provide emotional and instrumental support</td>
</tr>
<tr>
<td></td>
<td>Bridging</td>
<td>Horizontal relationships between people</td>
<td>Close friends or immediate family with different social</td>
<td>Generate broader identities and reciprocity; may</td>
</tr>
<tr>
<td>Linking</td>
<td>Sub-dimension of bridging; vertical relationships between people across social groups</td>
<td>Close work colleagues with different hierarchical positions, distant colleagues with different hierarchical positions, citizens-civil servants</td>
<td>Enable people to access resources and information outside their own social network; can be used for nepotism, corruption and suppression</td>
<td>provide informational support</td>
</tr>
</tbody>
</table>
### Appendix D. Sociodemographic information for group discussion participants

#### Table 19. Characteristics of focus group discussion participants

<table>
<thead>
<tr>
<th>FGD</th>
<th>Name of participant</th>
<th>Description</th>
</tr>
</thead>
</table>
| I M1 | Village A           | Once married but now separated  
Not employed, does small business (sells groundnuts)  
Highly educated, but lost job due to sickness |
| B   | Village B           | Married, children  
Unemployed (husband unemployed also)  
Works as CHW |
| E   | Village A           | Married, no children  
Small business  
Problems with mother-in-law |
| C1  | Village C           | Not married (was cohabitating but came back to birth home after disagreement with husband), 3yo child  
Assistant teacher at nursery school  
Form 4 leaver, no professional training |
| M2  | Village C           | Not married, 3yo child  
Finished Form 4  
Unemployed |
| II D1 | Village B         | Married, cares for orphaned grandchildren and sick husband  
Unemployed  
Works as CHW |
| M3  | Village D           | Married (cohabitating)  
Deals in pottery  
Jalemo |
| C2  | Village E           | Widowed, two children  
Unemployed  
Subsistence farming, sells produce |
| D2  | Village E           | Married, takes care of orphaned children  
Subsistence farming |
| A   | Village F           | Widowed  
Unemployed  
Subsistence farming |
<p>| S   | Village B           | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>II</td>
<td>Single&lt;br&gt;College graduate&lt;br&gt;Unemployed</td>
<td>III</td>
<td>M4&lt;br&gt;Village D&lt;br&gt;Married, large family&lt;br&gt;Unemployed – makes and sells sisal rope – breadwinner</td>
</tr>
<tr>
<td></td>
<td>C3&lt;br&gt;Village G&lt;br&gt;Separated&lt;br&gt;Small business</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R</td>
<td>Village H&lt;br&gt;Married&lt;br&gt;Unemployed – sells bananas</td>
<td>M5&lt;br&gt;Village H&lt;br&gt;Widowed&lt;br&gt;Unemployed – breadwinner&lt;br&gt;Subsistence farming</td>
<td></td>
</tr>
<tr>
<td>M6</td>
<td>Village C&lt;br&gt;Widowed, cares for aging parents&lt;br&gt;Small business – sole breadwinner</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Appendix E. Focus group discussion guidelines

<table>
<thead>
<tr>
<th>Main question</th>
<th>Follow up questions</th>
<th>Probes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PART I: SOCIAL CAPITAL, RELIGION, THERAPEUTIC LANDSCAPE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tell me about life in this area.</td>
<td>What are some of the biggest challenges people face? How do they cope?</td>
<td></td>
</tr>
<tr>
<td>If you need help, who/what groups would you turn to?</td>
<td>What kind of help can they give you?</td>
<td>Probe for emotional, instrumental and informational help</td>
</tr>
<tr>
<td>Who are the most important people in your life?</td>
<td></td>
<td>Probe for people who provide emotional, instrumental and informational support</td>
</tr>
<tr>
<td>Tell me about the kinds of things you do with people.</td>
<td></td>
<td>Probe for differences between family members, close friends, neighbors, people you pray with, relatives living far away, acquaintances, co-workers</td>
</tr>
<tr>
<td>Tell me about the kinds of things you discuss with people.</td>
<td></td>
<td>Probe for differences between close friends, neighbors, people you pray with, relatives living far away, acquaintances, co-workers</td>
</tr>
<tr>
<td>What types of churches are in this area?</td>
<td>Describe them.</td>
<td>How are they different from or similar to each other? How are the people who attend those churches different from or similar to each other? Probe for specific names of churches (and where they are located)</td>
</tr>
<tr>
<td>How can you tell if a person is very religious/not religious?</td>
<td></td>
<td>How do they act?</td>
</tr>
<tr>
<td>What types of health facilities/healers are in this area?</td>
<td>Describe them.</td>
<td>Probe for specific names of individuals and facilities (and where they are located)</td>
</tr>
<tr>
<td>Do people in this area generally trust &lt;health system component&gt;?</td>
<td>Why/why not? How can you tell?</td>
<td>Probe around specific individuals and facilities</td>
</tr>
<tr>
<td>Do people in this area trust each other?</td>
<td>Why/why not? Do they trust outsiders?–Why/why not? What types of people are most trusted? Which people in a person’s life are most trusted?</td>
<td></td>
</tr>
</tbody>
</table>
## PART II: DEPRESSION

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What are the symptoms of bedo gi kuyo/bedo gi paro mang’eny machando chuny?</strong></td>
<td><strong>Probe for different “types”</strong></td>
</tr>
<tr>
<td><strong>What causes this?</strong></td>
<td><strong>Probe around different “types”</strong></td>
</tr>
<tr>
<td><strong>How do cases differ in severity?</strong></td>
<td><strong>What is the difference between a woman who has a mild case and a woman who has a severe case? How are the symptoms different? How are the causes different?</strong></td>
</tr>
<tr>
<td>Are there women in your community who suffer from this?</td>
<td><strong>How do you know?/ How can you tell?</strong></td>
</tr>
<tr>
<td><strong>What do people think about these women?</strong></td>
<td><strong>Probe around different “types”</strong></td>
</tr>
<tr>
<td><strong>What are all the things that can be done for a woman who suffers from this?</strong></td>
<td><strong>What do you think about these strategies? Which are the best/worst? Why?</strong></td>
</tr>
<tr>
<td><strong>What are all the ways a woman can respond herself?</strong></td>
<td><strong>Probe around different “types”</strong></td>
</tr>
<tr>
<td>If someone you know were suffering from this, what would you do to help her?</td>
<td><strong>Probe for differences between family members, close friends, neighbors, people you pray with, relatives living far away, acquaintances, co-workers</strong></td>
</tr>
<tr>
<td><strong>&lt;Show list of symptoms&gt; If a woman has some of these symptoms, what is wrong with her?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>&lt;IF WOMEN IDENTIFY THIS AS DEPRESSION, FOR EACH SYMPTOM THAT APPEARS ON THE LIST BUT WAS NOT PREVIOUSLY MENTIONED:&gt;&gt;</strong></td>
<td><strong>Do you disagree that this is a symptom of depression? If so, what is this a symptom of?</strong></td>
</tr>
</tbody>
</table>

One of the symptoms here is **<symptom>**. You did not mention it when we were talking about bedo gi kuyo/bedo gi paro mang’eny machando chuny before. Why did you not mention it?
<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>&lt;FOR EACH SYMPTOM THAT WAS MENTIONED BY THEM, BUT DOES NOT APPEAR ON THE LIST:&gt;</strong></td>
<td>Tell me more about when women experience <code>&lt;symptom&gt;</code>.</td>
</tr>
<tr>
<td><strong>Can this be a symptom of anything else besides depression? If so, what?</strong></td>
<td>How can you tell the difference?</td>
</tr>
<tr>
<td><strong>&lt;IF WOMEN DO NOT IDENTIFY THIS AS DEPRESSION:&gt;</strong></td>
<td>Probe for different “types” (if applicable)</td>
</tr>
<tr>
<td>How is this different from <em>bedo gi kuyo/bedo gi paro mang’eny machando chuny</em>?</td>
<td>How is it the same?</td>
</tr>
<tr>
<td>What causes this?</td>
<td>Probe around different “types” (if applicable)</td>
</tr>
<tr>
<td><strong>How do cases differ in severity?</strong></td>
<td>What is the difference between a woman who has a mild case and a woman who has a severe case? How are the symptoms different? How are the causes different?</td>
</tr>
<tr>
<td>Are there women in your community who suffer from this?</td>
<td>How do you know?/ How can you tell?</td>
</tr>
<tr>
<td><strong>What do you think about these women?</strong></td>
<td>Probe around different “types” (if applicable)</td>
</tr>
<tr>
<td>What are all the things that can be done for a woman who suffers from this?</td>
<td>What do you think about these strategies? Which are the best/worst? Why?</td>
</tr>
<tr>
<td><strong>What are all the ways a woman can respond herself?</strong></td>
<td>What do you think about these responses? Which are the best/worst? Why?</td>
</tr>
<tr>
<td><strong>If someone you know were suffering from this, what would you do to help her?</strong></td>
<td>Probe for differences between family members, close friends, neighbors, people you pray with, relatives living far away, acquaintances, co-workers</td>
</tr>
<tr>
<td>ENGLISH</td>
<td>LUO</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------------------------</td>
</tr>
<tr>
<td>Sadness</td>
<td>Sin/ bedo gi kuyo</td>
</tr>
<tr>
<td>Pessimism</td>
<td>Neno ni onge ber moro amora</td>
</tr>
<tr>
<td>Past Failure</td>
<td>Rem kuom timo maber kinde mikalo</td>
</tr>
<tr>
<td>Loss of Pleasure</td>
<td>Weyo winjo mor</td>
</tr>
<tr>
<td>Guilty Feelings</td>
<td>Neno ni akoso</td>
</tr>
<tr>
<td>Punishment Feelings</td>
<td>Paro kuom kum</td>
</tr>
<tr>
<td>Self-Dislike</td>
<td>Chaaruok</td>
</tr>
<tr>
<td>Self-Criticalness</td>
<td>Ng’iruok matut</td>
</tr>
<tr>
<td>Suicidal Thoughts or Wishes</td>
<td>Gombo derruok kata paro kuom derruok</td>
</tr>
<tr>
<td>Crying</td>
<td>Yuak</td>
</tr>
<tr>
<td>Agitation</td>
<td>Chandruok kuom paro</td>
</tr>
<tr>
<td>Loss of Interest</td>
<td>Ongo gi gombo</td>
</tr>
<tr>
<td>Indecisiveness</td>
<td>Pek mar ng’ado paro</td>
</tr>
<tr>
<td>Worthlessness</td>
<td>Nenruok ka nono</td>
</tr>
<tr>
<td>Loss of Energy</td>
<td>Teko marumo</td>
</tr>
<tr>
<td>Changes in Sleeping Pattern</td>
<td>Lokruok e chenro na mar nindo</td>
</tr>
<tr>
<td>Irritability</td>
<td>Winjo marach kuom weche matindo tindo motimna kata mowachna</td>
</tr>
<tr>
<td>Changes in Appetite</td>
<td>Lokruok kuom gombo chiemo</td>
</tr>
<tr>
<td>Concentration Difficulty</td>
<td>Pek kuom keto pacha e gima atimo</td>
</tr>
<tr>
<td>Tiredness or Fatigue</td>
<td>Oolo</td>
</tr>
<tr>
<td>Loss of Interest in Sex</td>
<td>Gombo mar yunga</td>
</tr>
</tbody>
</table>
Appendix F. Depression screening questionnaire

INITIAL SCREENING QUESTIONNAIRE

<table>
<thead>
<tr>
<th>Date ______________</th>
<th>Time ______________</th>
<th>Facility/institution ____________________________</th>
</tr>
</thead>
</table>

Interviewer name __________________________

Was consent administered?  ____YES  ____NO  → obtain consent for screening before proceeding

I would like to start by asking you some questions about yourself.

<table>
<thead>
<tr>
<th>a. What is your age in years?</th>
<th></th>
<th>[ \text{________} \rightarrow \text{if under 18, tell the respondent that she is not eligible to participate in the study and thank her for her time.} ]</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>b. What is the highest level of education you achieved?</th>
<th></th>
<th>[ \text{__NO EDUCATION} ]  [ \text{__SOME PRIMARY} ]  [ \text{__COMPLETED PRIMARY} ]  [ \text{__SOME SECONDARY} ]  [ \text{__COMPLETED SECONDARY} ]  [ \text{__COLLEGE/UNIVERSITY} ]</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>c. What is your religion?</th>
<th></th>
<th>[ \text{__ROMAN CATHOLIC} ]  [ \text{__PENTECOSTAL} ]  [ \text{(SPECIFY: ________________)} ]  [ \text{__ACK} ]  [ \text{__ROHO} ]  [ \text{__LEGIO MARIA} ]  [ \text{__SALVATION ARMY} ]  [ \text{__OTHER (SPECIFY: ________________)} ]</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>d. What is your marital status?</th>
<th></th>
<th>[ \text{__MARRIED} ]  [ \text{__NOT MARRIED, BUT COHABITATING} ]  [ \text{__SINGLE} ]  [ \text{__DIVORCED} ]  [ \text{__WIDOWED} ]</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>e. Where do you live?</th>
<th></th>
<th>[ \text{LOCATION ________________} ]  [ \text{SUBLOCATION ________________} ]  [ \text{VILLAGE ________________} ]</th>
</tr>
</thead>
</table>

| 274 |
Now I would like to ask you about how you've been feeling lately. This part of the questionnaire consists of 21 groups of statements. Please listen to each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. If several statements in the group seem to apply equally well, tell me. [INTERVIEWER: If the respondent tells you that several statements in the group apply equally well, circle all of them, but use the one with the highest number when you total the score.]

<table>
<thead>
<tr>
<th>1. Sadness</th>
<th>6. Punishment Feelings</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I do not feel sad.</td>
<td>0 I don’t feel I am being punished.</td>
</tr>
<tr>
<td>1 I feel sad much of the time.</td>
<td>1 I feel I may be punished.</td>
</tr>
<tr>
<td>2 I feel sad all the time.</td>
<td>2 I expect to be punished.</td>
</tr>
<tr>
<td>3 I am so sad or unhappy that I can’t stand it.</td>
<td>3 I feel I am being punished.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Pessimism</th>
<th>7. Self-Dislike</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I am not discouraged about my future.</td>
<td>0 I feel the same about myself as ever.</td>
</tr>
<tr>
<td>1 I feel more discouraged about my future than I used to be.</td>
<td>1 I have lost confidence in myself.</td>
</tr>
<tr>
<td>2 I do not expect things to work out for me.</td>
<td>2 I am disappointed in myself.</td>
</tr>
<tr>
<td>3 I feel my future is hopeless and will only get worse.</td>
<td>3 I dislike myself.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Past Failure</th>
<th>8. Self-Criticalness</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I do not feel like a failure.</td>
<td>0 I don’t criticize or blame myself more than usual.</td>
</tr>
<tr>
<td>1 I have failed more than I should have.</td>
<td>1 I am more critical of myself than I used to be.</td>
</tr>
<tr>
<td>2 As I look back, I see a lot of failures.</td>
<td>2 I criticize myself for all of my faults.</td>
</tr>
<tr>
<td>3 I feel I am a total failure as a person.</td>
<td>3 I blame myself for everything bad that happens.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Loss of Pleasure</th>
<th>9. Suicidal Thoughts or Wishes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I get as much pleasure as I ever did from the things I enjoy.</td>
<td>0 I don’t have any thoughts of killing myself.</td>
</tr>
<tr>
<td>1 I don’t enjoy things as much as I used to.</td>
<td>1 I have thoughts of killing myself, but I would not carry them out.</td>
</tr>
<tr>
<td>2 I get very little pleasure from the things I used to enjoy.</td>
<td>2 I would like to kill myself.</td>
</tr>
<tr>
<td>3 I can’t get any pleasure from the things I used to enjoy.</td>
<td>3 I would kill myself if I had the chance.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Guilty Feelings</th>
<th>10. Crying</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I don’t feel particularly guilty.</td>
<td>0 I don’t cry any more than I used to.</td>
</tr>
<tr>
<td>1 I feel guilty over many things I have done or should have done</td>
<td>1 I cry more than I used to.</td>
</tr>
<tr>
<td>2 I feel quite guilty most of the time.</td>
<td>2 I cry over every little thing.</td>
</tr>
<tr>
<td>3 I feel guilty all of the time.</td>
<td>3 I feel like crying, but I can’t.</td>
</tr>
<tr>
<td>11. Agitation</td>
<td>17. Irritability</td>
</tr>
<tr>
<td>---------------</td>
<td>----------------</td>
</tr>
<tr>
<td>0 I am no more restless or wound up than usual.</td>
<td>0 I am no more irritable than usual.</td>
</tr>
<tr>
<td>1 I feel more restless or wound up than usual.</td>
<td>1 I am more irritable than usual.</td>
</tr>
<tr>
<td>2 I am so restless or agitated that it’s hard to stay still.</td>
<td>2 I am much more irritable than usual.</td>
</tr>
<tr>
<td>3 I am so restless or agitated that I have to keep moving or doing something.</td>
<td>3 I am irritable all the time.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12. Loss of Interest</th>
<th>18. Changes in Appetite</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I have not lost interest in other people or activities.</td>
<td>0 I have not experienced any change in my appetite.</td>
</tr>
<tr>
<td>1 I am less interested in other people or things.</td>
<td>1a My appetite is somewhat less than usual.</td>
</tr>
<tr>
<td>2 I have lost most of my interest in other people or things.</td>
<td>1b My appetite is somewhat greater than usual.</td>
</tr>
<tr>
<td>3 It’s hard to get interested in anything.</td>
<td>2a My appetite is much less than before.</td>
</tr>
<tr>
<td></td>
<td>2b My appetite is much greater than usual.</td>
</tr>
<tr>
<td></td>
<td>3a I have no appetite at all.</td>
</tr>
<tr>
<td></td>
<td>3b I crave food all the time.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13. Indecisiveness</th>
<th>19. Concentration Difficulty</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I make decisions about as well as ever.</td>
<td>0 I can concentrate as well as ever.</td>
</tr>
<tr>
<td>1 I find it more difficult to make decisions than usual.</td>
<td>1 I can’t concentrate as well as usual.</td>
</tr>
<tr>
<td>2 I have much greater difficulty in making decisions than I used to.</td>
<td>2 It’s hard to keep my mind on anything for very long.</td>
</tr>
<tr>
<td>3 I have trouble making any decisions.</td>
<td>3 I find I can’t concentrate on anything.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>14. Worthlessness</th>
<th>20. Tiredness or Fatigue</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I do not feel I am worthless.</td>
<td>0 I am no more tired or fatigued than usual.</td>
</tr>
<tr>
<td>1 I don’t consider myself as worthwhile and useful as I used to.</td>
<td>1 I get more tired or fatigued more easily than usual.</td>
</tr>
<tr>
<td>2 I feel more worthless as compared to other people.</td>
<td>2 I am too tired or fatigued to do a lot of the things I used to do.</td>
</tr>
<tr>
<td>3 I feel utterly worthless.</td>
<td>3 I am too tired or fatigued to do most of the things I used to do.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>0 I have as much energy as ever.</td>
<td>0 I have not noticed any recent change in my interest in sex.</td>
</tr>
<tr>
<td>1 I have less energy than I used to have.</td>
<td>1 I am less interested in sex than I used to be.</td>
</tr>
<tr>
<td>2 I don’t have enough energy to do very much.</td>
<td>2 I am much less interested in sex now.</td>
</tr>
<tr>
<td>3 I don’t have enough energy to do anything.</td>
<td>3 I have lost interest in sex completely.</td>
</tr>
</tbody>
</table>
16. Changes in Sleeping Pattern

<p>| | | |</p>
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<tr>
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</thead>
<tbody>
<tr>
<td>0</td>
<td>I have not experienced any change in my sleeping pattern.</td>
<td>Subtotal – page 1: ________</td>
</tr>
<tr>
<td>1a</td>
<td>I sleep somewhat more than usual.</td>
<td>Subtotal – page 2: ________</td>
</tr>
<tr>
<td>1b</td>
<td>I sleep somewhat less than usual.</td>
<td>TOTAL: ________</td>
</tr>
<tr>
<td>2a</td>
<td>I sleep a lot more than usual.</td>
<td>0-13 minimal depression</td>
</tr>
<tr>
<td>2b</td>
<td>I sleep a lot less than usual.</td>
<td>14-19 mild depression</td>
</tr>
<tr>
<td>3a</td>
<td>I sleep most of the day.</td>
<td>20-28 moderate depression</td>
</tr>
<tr>
<td>3b</td>
<td>I wake up 1-2 hours early and can’t get back to sleep.</td>
<td>29-63 severe depression</td>
</tr>
</tbody>
</table>

For those with **minimal** depression
Thank you very much for your time today. We will not need to contact you in the future.

For those with **mild**, **moderate** or **severe** depression
Thank you very much for answering these questions. Based on your responses, you are eligible to participate in our study. I would like to tell you about our study. After I explain, I will give you time to ask questions and think about whether you would like to participate. May I tell you about our study now?

___YES → Proceed to IDI consent process; if the respondent consents to participate, arrange a day, time and location for the first interview, which will take approximately 2 hours (record below); record the respondent’s name and mobile phone number (if available)

___NO

Is there another time that may be better for me to tell you about our study?

___NO → Thank you for your time today. We will not contact you in the future.

___YES → Arrange day, time and location to meet with the respondent (record below); record the respondent’s name and mobile phone number (if available)

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<table>
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<tbody>
<tr>
<td>DAY____________________</td>
<td>TIME____________________</td>
<td></td>
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<tr>
<td>LOCATION (provide enough details so that you may find the location)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>NAME____________________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MOBILE PHONE NUMBER________________________</td>
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</tr>
</tbody>
</table>
## Appendix G. List of in-depth interview participants

<table>
<thead>
<tr>
<th>Name</th>
<th>BDI score</th>
<th>Characteristics</th>
<th>Rationale for inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beatrice</td>
<td>19 (mild)</td>
<td>Age 24&lt;br&gt;Primary education&lt;br&gt;Unmarried, 1 child&lt;br&gt;Catholic church, active in church youth group&lt;br&gt;No work, but receives money from brothers</td>
<td>Unmarried with child</td>
</tr>
<tr>
<td>Agneta</td>
<td>20 (moderate)</td>
<td>Age 26&lt;br&gt;Some secondary education&lt;br&gt;Married (husband lives in Nairobi), 4 children&lt;br&gt;Anglican church&lt;br&gt;Livelihood: tailoring (defunct business), farming; husband doesn’t send money&lt;br&gt;Belongs to groups (church and community)&lt;br&gt;HIV-positive</td>
<td>Husband living in Nairobi with suspected other wife</td>
</tr>
<tr>
<td>Grace</td>
<td>26 (moderate)</td>
<td>Age 26&lt;br&gt;Primary education&lt;br&gt;Married, 3 children&lt;br&gt;Roho church, belongs to fellowship group&lt;br&gt;No work (disabled), husband does casual jobs</td>
<td>Daughter-in-law to Salome</td>
</tr>
<tr>
<td>Patricia</td>
<td>20 (moderate)</td>
<td>Age 35&lt;br&gt;Some primary education&lt;br&gt;Married, 5 children&lt;br&gt;Roho church&lt;br&gt;Livelihood: farming (own ox ploughs, cattle, land)</td>
<td>Son has epilepsy (contrast with Susan)</td>
</tr>
<tr>
<td>Susan</td>
<td>24 (moderate)</td>
<td>Age 45&lt;br&gt;Secondary education&lt;br&gt;Married, 6 children&lt;br&gt;Anglican church&lt;br&gt;Livelihood: ECD teacher; husband farms&lt;br&gt;Belongs to group</td>
<td>Son has epilepsy (contrast with Patricia)</td>
</tr>
<tr>
<td>Josephine</td>
<td>21 (moderate)</td>
<td>Age 48&lt;br&gt;Some primary education&lt;br&gt;Married, 1 adult daughter&lt;br&gt;Coptic Orthodox church&lt;br&gt;Livelihood: farming (own ox ploughs, cattle, land)&lt;br&gt;Belongs to groups</td>
<td>Husband has secret other wife</td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>Education</td>
<td>Marital Status</td>
</tr>
<tr>
<td>-----------</td>
<td>-----</td>
<td>-----------</td>
<td>----------------</td>
</tr>
<tr>
<td>Millicent</td>
<td>28</td>
<td>(moderate)</td>
<td>Married, 3 children (1 living away)</td>
</tr>
<tr>
<td>Jaqueline</td>
<td>28</td>
<td>(moderate)</td>
<td>Widowed, adult children; lives with orphaned grandchildren</td>
</tr>
<tr>
<td>Salome</td>
<td>19</td>
<td>(mild)</td>
<td>Widowed, adult children (still depend on her)</td>
</tr>
<tr>
<td>Eunice</td>
<td>22</td>
<td>(moderate)</td>
<td>Married, adult children</td>
</tr>
<tr>
<td>Helen</td>
<td>23</td>
<td>(moderate)</td>
<td>Married, 3 children</td>
</tr>
<tr>
<td>Pauline</td>
<td>25</td>
<td>(moderate)</td>
<td>Married, adult children, youngest 16yo; lives with orphaned grandchildren</td>
</tr>
<tr>
<td>Evelyn</td>
<td>22</td>
<td>(moderate)</td>
<td>Married, no children</td>
</tr>
</tbody>
</table>
Anglican church  
Livelihood: farming  
Belongs to group  

Karen  30 (severe)  
Age 67  
Some primary education  
Widowed, all children deceased; lives with daughters-in-law and grandchildren  
Seventh Day Adventist church  
Livelihood: farming, small business  
Belongs to groups (church and community)  

All children are deceased
Appendix H. In-depth interview guidelines

IN-DEPTH INTERVIEW QUESTIONNAIRE and GUIDELINES – FIRST IN SERIES

<table>
<thead>
<tr>
<th>Date______________</th>
<th>Start time______________</th>
<th>End time______________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondent name____________________</td>
<td>Translator name____________________</td>
<td></td>
</tr>
</tbody>
</table>

Was IDI consent administered during the screening session?
   ____YES ➔ remind respondent of **key points** listed below
   ____NO ➔ obtain IDI consent before proceeding

**Key points**
- You do not have to participate in this study if you do not want to.
- If you agree to be in this study, but later change your mind, you may drop out at any time.
- You do not have to answer any question that you do not want to answer.
- There are no penalties or consequences of any kind if you decide that you do not want to participate.
- All the information you share with me today will be kept private. It will not be shared with anyone else but the research team.
- If, during this interview, you have any thoughts or feelings that you want to hurt yourself, it is very important that you tell the research team. They can give you information about someone who can help you.

Did the respondent consent to audio recording?
   ____YES ➔ During the consent process, you agreed that we could audio record this interview so that I don’t miss anything you say. Is that still okay with you? / May I start the recorder now?
   ____NO ➔ proceed with interview without audio recording
HOMESTEAD ROSTER and INFORMATION

I would like to start by asking you some questions about who normally lives in this homestead. Let’s start with your household. Who normally sleeps under your roof? Start with yourself. [INTERVIEWER: Before interview, fill in shaded boxes from information provided in screening.]

<table>
<thead>
<tr>
<th>Name (first only)</th>
<th>Sex</th>
<th>Age (specify unit of time)</th>
<th>Religious Status</th>
<th>Place of birth (be specific)</th>
<th>How long has he/she lived in this village? (specify unit of time)</th>
<th>Relationship to head of household</th>
<th>Highest education level achieved</th>
<th>Religion</th>
<th>Main daily activity</th>
<th>In the past year, was he/she ill for a period of one month or longer? If so, how long? (specify unit of time)</th>
<th>Community groups (e.g., self-help, church, youth groups) to which person belongs</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
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<td></td>
<td>N Y → ________</td>
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<tr>
<td>F M</td>
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<td>N Y → ________</td>
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<td>F M</td>
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<td>N Y → ________</td>
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<tr>
<td>F M</td>
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<td>N Y → ________</td>
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<td>N Y → ________</td>
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<td>N Y → ________</td>
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<td>N Y → ________</td>
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<td></td>
<td>N Y → ________</td>
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</tr>
</tbody>
</table>

9 1=married, 2=not married, but cohabitating, 3=single, 4=divorced, 5=widowed
10 1=head, 2=spouse, 3=child, 4=step-child, 5=foster child, 6=adopted child, 7=grandchild, 8=niece/nephew, 9=in-law (specify), 10=parent, 11=brother/sister, 12=other relative (cousin, aunt, uncle, etc. – specify), 13=unrelated, 14=domestic worker, 15=other (specify)
11 1=no education, 2=primary incomplete, 3=primary complete, 4=secondary incomplete, 5=secondary complete, 6=college/university
12 1=Roman Catholic, 2=Pentecostal (specify), 3=ACK, 4=Roho, 5=Legio Maria, 6=Salvation Army, 7=other (specify)
13 1=no activity, 2=regularly works here (farm/household), 3=usually works away (casual labor - specify), 4=usually works away (regular employment - specify), 5=usually works away (self-employed – specify), 6=goes to school, 7=other (specify)
IF THERE IS A MALE HEAD OF HOUSEHOLD: Does the head of household have another home?
NO ____ YES ___ → Where? (be specific): __________________________

How many other households are in this homestead? List them by first name of household head. How is each head of household related to the head of your household? If the head of household is male, does he have another home? Where?

<table>
<thead>
<tr>
<th>Household</th>
<th>Head of household</th>
<th>Relationship to head of your household</th>
<th>IF MALE: Does head of household have another home?</th>
<th>Where?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td></td>
<td></td>
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<tr>
<td>3</td>
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</table>

Let’s talk about the household that is headed by [NAME]. Please tell me the following information for each person in that household. If you don’t know or are unsure about this information for some people in the household, just say so. [INTERVIEWER: Start with the head of household. After finishing one household, proceed to the next household until all persons living in the homestead are listed. Use a separate sheet for each household.]

<table>
<thead>
<tr>
<th>Name (first only)</th>
<th>Sex</th>
<th>Age (specify unit of time)</th>
<th>Marital status</th>
<th>Place of birth (be specific)</th>
<th>How long has he/she lived in this village? (specify unit of time)</th>
<th>Relationship to head of household</th>
<th>Highest education level achieved</th>
<th>Religion</th>
<th>Main daily activity</th>
<th>In the past year, was he/she ill for a period of one month or longer? If so, how long? (specify unit of time)</th>
<th>Community groups (e.g., self-help, church, youth groups) to which person belongs</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>M</td>
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</table>
Did anyone you listed in this homestead join the homestead within the past year (since [MONTH YEAR])?  
No_______ Yes_______ →

<table>
<thead>
<tr>
<th>Name (first only)</th>
<th>How long has he/she lived in the homestead?</th>
<th>Reason for joining</th>
</tr>
</thead>
<tbody>
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</table>

In the past year (since [MONTH YEAR]), has anyone in this homestead moved or passed away?  
No_______ Yes_______ →

<table>
<thead>
<tr>
<th>Name (first only)</th>
<th>Sex</th>
<th>Reason for leaving (e.g., death, marriage, school, work)</th>
<th>Age at time of departure/death (specify unit of time)</th>
<th>To which household did this person belong? (write name of head of household; if person was head, write name of current head)</th>
<th>Relationship to current head of household</th>
<th>Was this person the head of household at the time of his/her departure/death?</th>
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</tbody>
</table>

What are the top three livelihood activities for each household? (e.g., own farm production, sale of farm produce, casual work, etc.) [If livelihood activities are shared across households, note this.]

<table>
<thead>
<tr>
<th>Household (write name of head)</th>
<th>Most important</th>
<th>Second most important</th>
<th>Third most important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your own:</td>
<td></td>
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</tr>
<tr>
<td>1:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2:</td>
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<td>3:</td>
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<tr>
<td>4:</td>
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</tr>
<tr>
<td>5:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do any of the households in this homestead normally receive pension, or income/gifts from people who do not normally live here? (e.g., remittances, NGO assistance, etc.) [If communal, note this.]

<table>
<thead>
<tr>
<th>Household (write name of head)</th>
<th>Receive?</th>
<th>What is received?</th>
<th>From whom/what organization?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your own:</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>1:</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>2:</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>
Do the households in this homestead own any of the following items? If yes, how many? [If items are owned communally, write the total number of items next to the name of the item and divide the number of items across all the households that own those items.]

<table>
<thead>
<tr>
<th>Household (write name of head)</th>
<th>Your own:</th>
<th>Own?</th>
<th>Own?</th>
<th>Own?</th>
<th>Own?</th>
<th>Own?</th>
<th>Own?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1:</td>
<td>2:</td>
<td>3:</td>
<td>4:</td>
<td>5:</td>
<td>6:</td>
<td></td>
</tr>
<tr>
<td>Ox plough</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Mobile phone</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Cattle</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Goats/sheep</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Bicycle</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Mosquito bednet</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Land*</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

*For land, record number of hectares in the “#” column.

Please tell me the following for each household:

<table>
<thead>
<tr>
<th>Household (write name of head)</th>
<th>Your own:</th>
<th>Own?</th>
<th>Own?</th>
<th>Own?</th>
<th>Own?</th>
<th>Own?</th>
<th>Own?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1:</td>
<td>2:</td>
<td>3:</td>
<td>4:</td>
<td>5:</td>
<td>6:</td>
<td></td>
</tr>
<tr>
<td>Primary cooking fuel</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(paraffin stove, improved</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>charcoal/wood stove, firewood,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>other – specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary lighting source</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(electric bulb, candles,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>paraffin lamp, solar panel,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>other – specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary water source</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(tap, well/borehole, stream,</td>
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<td></td>
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<tr>
<td>other – specify)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Floor material</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wall material</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roof material</td>
<td></td>
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</table>

Compared to other people living in this area, are you:

- __ Poorer than most
- __ About the same as most
- __ Richer than most

Do you know of any organizations working in health and development around here? Which ones?
RELIGION

Now I would like to ask you about your religious beliefs and practices.

Please tell me about your church.
- Which church do you attend?
- How often do you attend?
- Why do you attend church?
- When and why did you start attending that church?
- How is your church different from other churches in the area?

Are you “saved”? Please tell me about that experience.

Please tell me about how you express your religion in other parts of your life.
- How often do you pray?
- Why do you pray?
- How often do you read scripture?
- Why do you read scripture?
- When and why did you start doing these things?

Do you talk about your religion with other people?
- Who?
- How often?
- What do you discuss?

Are the other people in your congregation like you? How are they the same/different?

How do other people in your congregation help/care for you? How do you help/care for them?

Do you have close friends in your congregation? Family members?

Do you have family members or close friends who have a different religion from you? How do you see their religion? How do they see yours?

How important is your religion to you in general?
- How does it impact your life?
- Can you imagine what your life would be like without religion? Please describe it.

How important is your religion to your daily life? To your decision making? To your health? To your happiness?

When you have a question or problem, how does your religion help you?

How close do you feel to God? How do you feel God’s love? How do you feel God’s judgment? How do you experience God’s presence?

Have you ever had a disagreement about religion with a friend or family member? Please tell me about it.

Have you ever feel like your faith wavers? Explain. Do you ever feel like God is being unfair to you? Explain.

Have you ever felt like your faith was causing you stress? Please tell me about it.
IN-DEPTH INTERVIEW QUESTIONNAIRE and GUIDELINES – SECOND IN SERIES

Date________________ Start time________________ End time________________

Respondent name________________________ Translator name______________________

Key points

• You do not have to participate in this study if you do not want to.
• If you agree to be in this study, but later change your mind, you may drop out at any time.
• You do not have to answer any question that you do not want to answer.
• There are no penalties or consequences of any kind if you decide that you do not want to participate.
• All the information you share with me today will be kept private. It will not be shared with anyone else but the research team.
• If, during this interview, you have any thoughts or feelings that you want to hurt yourself, it is very important that you tell the research team. They can give you information about someone who can help you.

Did the respondent consent to audio recording?

_____YES ➔ During the consent process, you agreed that we could audio record this interview so that I don’t miss anything you say. Is that still okay with you? / May I start the recorder now?

_____NO ➔ proceed with interview without audio recording
SOCIAL CAPITAL

I would like to start today by asking you about the people in your life. They may or not be people you live with or pray with.

Please list the five most important people in your life. These can be people you live with/work with/pray with or someone else. They may even be people you don’t see or communicate with very often.

FOR EACH:
Please tell me about this person.
- How do you know this person? Describe your relationship.
- How close is your relationship? (rank)
- How is he/she like you?
- How is he/she different?
- What is his/her religion?
- Why is this person important to you?
- What kind of help or support do you get from this person? How good is this support?
- What kind of help or support do you give to this person?
- What types of things do you discuss with this person?
- Do you discuss health issues? Tell me about the last time you discussed health with this person. How good was this information/advice?
- Do you discuss with this person when you are feeling depressed? Tell me about the last time you discussed depression with this person. How good was this information/advice?

Do you ever communicate with people who do not live here? Do you ever communicate with people who live here but come from outside this area? List all these people who you have communicated with in the past month. [PROBE FOR PERSONS AFFILIATED WITH NGOS, CHURCHES.]

FOR EACH:
Please tell me about this person.
- How do you know this person? Describe your relationship.
- How close is your relationship? How often do you communicate?
- How is he/she like you?
- How is he/she different?
- What is his/her religion?
- What kind of help or support do you get from this person? How good is this support?
- What kind of help or support do you give to this person?
- What types of things do you discuss with this person?
- Do you discuss health issues? Tell me about the last time you discussed health with this person. How good was this information/advice?
- Do you discuss with this person when you are feeling depressed? Tell me about the last time you discussed depression with this person. How good was this information/advice?
Have you received any money or material support (such as food, medicine, etc.) from anyone in the past month? List everyone who has given you material support in the past month.

FOR EACH:
Please tell me about this person.
- How do you know this person? Describe your relationship.
- How close is your relationship?
- How is he/she like you?
- How is he/she different?
- What is his/her religion?
- Elaborate on the type of support you receive from this person.
- Do you have to pay this person back?
- Why do you think he/she gives you this support?
- How good is this support?

Can you think of a time in the past month when someone gave you emotional support? List everyone who has given you emotional support in the past month and explain the situation.

FOR EACH:
Please tell me about this person.
- How do you know this person? Describe your relationship.
- How close is your relationship?
- How is he/she like you?
- How is he/she different?
- What is his/her religion?
- Elaborate on the type of support you receive from this person.
- Why do you think he/she gives you this support?
- How good is this support?

Can you think of a time in the past month when someone gave you information or advice? List everyone who has given you information or advice in the past month and explain the situation.

FOR EACH:
Please tell me about this person.
- How do you know this person? Describe your relationship.
- How close is your relationship?
- How is he/she like you?
- How is he/she different?
- What is his/her religion?
- Elaborate on the information/advice you receive from this person. Did you follow this advice/use this information? Explain. Why/why not?
- Why do you think he/she gives you this support?
- How good is this support?

Who would you go to if you needed help or advice related to your health? List these people.

FOR EACH:
Please tell me about this person.
- How do you know this person? Describe your relationship.
• How close is your relationship?
• How is he/she like you?
• How is he/she different?
• What is his/her religion?
• Tell me about the last time you received help or advice related to health from this person.
• How good was this advice?

Who would you go to if you needed help or advice related to depression? List these people.

FOR EACH:
Please tell me about this person.
• How do you know this person? Describe your relationship.
• How close is your relationship?
• How is he/she like you?
• How is he/she different?
• What is his/her religion?
• Tell me about the last time you received help or advice related to depression from this person.
• How good was this advice?

Do you belong to any community groups? Which ones? Why are you part of this group? How often do you meet? What do you do/discuss? Do you serve/have you ever served in a leadership role? Explain.

Do people around here generally trust each other? Why/why not? Do you generally trust other people? Why/why not?
HEALTH

Now I would like to discuss your health.

Please tell me about the last time you were ill.
- When did your last illness occur?
- What symptoms did you have?
- What illness did you have? How do you know?
- What do you think it was caused by?
- What did you do first? Why did you choose this action? How effective was it?
- What did you do next? Why did you choose this action? How effective was it?, etc.
  (Probe for informal responses.)
- Who helped you make decisions about what you would do? How did he/she help?
- Did anyone help you with money? With information? With emotional support?
  Explain.
- Tell me about your experience at each place you went. Were you satisfied? Would you go again? Why/why not?

What is your most significant health issue? What are all the ways you have responded? Which ways of responding have worked best for you? Which have been the worst? Explain. Do you think you need more help with this issue? If so, what kind of help? Will you get it? Why/why not?

****DEPRESSION****

Have you ever felt like you had depression? Do you feel like that now? When did it start? What is causing it? What have you done about it? Why did you choose to do that? Has it worked?

Have you felt like this at any other time in your life? When was the first time you felt like this? What was the cause? What did you do? Why did you do that? Did it work?

How often do you feel like this? What are all the ways you have responded besides the ones you’ve already mentioned? Which ways of responding have worked best for you? Which have been the worst? Explain. Do you think you need more help? If so, what kind of help? Will you get it? Why/why not?

When do you feel the happiest? What makes you feel happy?
IN-DEPTH INTERVIEW GUIDELINES – THIRD IN SERIES

Date______________ Start time______________ End time______________

Respondent name______________________ Translator name________________________

Key points
• You do not have to participate in this study if you do not want to.
• If you agree to be in this study, but later change your mind, you may drop out at any time.
• You do not have to answer any question that you do not want to answer.
• There are no penalties or consequences of any kind if you decide that you do not want to participate.
• All the information you share with me today will be kept private. It will not be shared with anyone else but the research team.
• If, during this interview, you have any thoughts or feelings that you want to hurt yourself, it is very important that you tell the research team. They can give you information about someone who can help you.

Did the respondent consent to audio recording?
_____YES → During the consent process, you agreed that we could audio record this interview so that I don’t miss anything you say. Is that still okay with you? / May I start the recorder now?

_____NO → proceed with interview without audio recording

Introduction
This is an interview about the story of your life. We are asking you to play the role of storyteller about your own life – to construct for us the story of your own past, present, and what you see as your own future. In telling us a story about your own life, you do not need to tell us everything that has ever happened to you. A story is selective. It may focus on a few key events, a few key relationships, a few key themes that recur in the narrative. In telling your own life story, you should concentrate on material in your own life that you believe to be important in some fundamental way – information about yourself and your life which says something significant about you and how you have come to be who you are.

The interview is divided into a number of sections. In order to complete the interview within, say, an hour and a half or so, it is important that we not spend too much time in the early sections, especially the first one in which I will ask you to provide an overall outline of your story. The interview starts with general things and moves to the particular. Therefore, do not feel like you must provide a lot of detail in the first section in which I ask for this outline. The detail will come later. I will guide you through the interview so that we can finish it in good time. I think that you will enjoy the interview. Most people do.

Before we begin, do you have any questions?

Life Chapters
We would like you to begin by thinking about your life as a story. All stories have characters, scenes, plots, and so forth. There are high points and low points in the story, good times and bad times, heroes and villains, and so on. A long story may even have chapters. Think about your life
story as having at least a few different chapters. What might those chapters be? I would like you to describe for me each of the main chapters of your life story. You may have as many or as few chapters as you like, but I would suggest dividing your story into at least 2 or 3 chapters and at most about 7. If you can, give each chapter a name and describe briefly the overall contents in each chapter. As a storyteller here, think of yourself as giving a plot summary for each chapter. This first part of the interview can expand forever, so I would like you to keep it relatively brief, say, within 15 minutes. Therefore, you don't want to tell me "the whole story" now. Just give me a sense of the story's outline – the major chapters in your life.

Critical Events
Now that you have given us an outline of the chapters in your story, we would like you to concentrate on a few key events that may stand out in bold print in the story. A key event should be a specific happening, a critical incident, a significant episode in your past set in a particular time and place. It is helpful to think of such an event as constituting a specific moment in your life story which stands out for some reason. Thus, a particular conversation you may have had with your mother when you were 12-years-old or a particular decision you made one afternoon last summer might qualify as a key event in your life story. These are particular moments set in a particular time and place, complete with particular characters, actions, thoughts, and feelings. An entire season – be it very happy or very sad or very important in some way – or a very difficult year in school, on the other hand, would not qualify as key events because these take place over an extended period of time. (They are more like life chapters.)

I am going to ask you about 8 specific life events. For each event, describe in detail what happened, where you were, who was involved, what you did, and what you were thinking and feeling in the event. Also, try to convey what impact this key event has had in your life story and what this event says about who you are or were as a person. Please be very specific here.

Before we continue, do you have any questions?

Event #1: Peak Experience
A peak experience would be a high point in your life story – perhaps the high point. It would be a moment or episode in the story in which you experienced extremely positive emotions, like joy, excitement, great happiness, uplifting, or even deep inner peace. Today, the episode would stand out in your memory as one of the best, highest, most wonderful scenes or moments in your life story. Please describe in some detail a peak experience, or something like it, that you have experienced some time in your past. Tell me exactly what happened, where it happened, who was involved, what you did, what you were thinking and feeling, what impact this experience may have had upon you, and what this experience says about who you were or who you are.

Event #2: Low Experience
A low experience would be a low point in your life story – perhaps the low point. Thinking back over your life, try to remember a specific experience in which you felt extremely negative emotions, such as despair, disillusionment, terror, guilt, etc. Even though this memory is unpleasant, I would still appreciate an attempt on your part to be as honest and detailed as you can be. Please remember to be specific. What happened? When? Who was involved? What did you do? What were you thinking and feeling? What impact has the event had on you? What does the event say about who you are or who you were?

Event #3: Turning Point
In looking back on one's life, it is often possible to identify certain key "turning points" –
episodes through which a person undergoes big change. Turning points can occur in many different spheres of a person's life – in relationships with other people, in work and school, in outside interests, etc. I am especially interested in a turning point in your understanding of yourself. Please identify a particular episode in your life story that you now see as a turning point. If you feel that your life story contains no turning points, then describe a particular episode in your life that comes closer than any other to qualifying as a turning point.

Event #4: Earliest Memory
Think back now to your childhood, as far back as you can go. Please choose a relatively clear memory from your earliest years and describe it in some detail. The memory need not seem especially significant in your life today. Rather what makes it significant is that it is the first or one of the first memories you have, one of the first scenes in your life story. The memory should be detailed enough to qualify as an "event." This is to say that you should choose the earliest (childhood) memory for which you are able to identify what happened, who was involved, and what you were thinking and feeling. Give us the best guess of your age at the time of the event.

Event #5: Important Childhood Scene
Now describe another memory from childhood, from later childhood, that stands out in your mind as especially important or significant. It may be a positive or negative memory. What happened? Who was involved? What did you do? What were you thinking and feeling? What impact has the event had on you? What does it say about who you are or who you were? Why is it important?

Event #6: Important Adolescent Scene
Describe a specific event from your teen-aged years that stands out as being especially important or significant.

Event #7: Important Adult Scene
Describe a specific event from your adult years (age 21 and beyond) that stands out as being especially important or significant.

Event #8: Antecedent Scenes
a. We have talked before about how you have recently been feeling depressed. Describe a specific event that occurred just before you started feeling this way.
b. I want you to think back to the first time you felt this way. Describe a specific event that occurred just before you started feeling this way for the first time.
c. Thinking back over all the times you feel this way, is there any common event that occurs just before you start feeling this way? Please describe it for me.

Life Challenge
Looking back over the various chapters and scenes in your life story, please describe the single greatest challenge that you have faced in your life. How have you faced, handled, or dealt with this challenge? Have other people assisted you in dealing with this challenge? How has this challenge had an impact on your life story?

Influences on the Life Story: Positive and Negative
Positive
Looking back over your life story, please identify the single person, group of persons, or organization/ institution that has or have had the greatest positive influence on your story. Please describe this person, group, or organization and the way in which he, she, it, or they have had a positive impact on your story.
Negative
Looking back over your life story, please identify the single person, group of persons, or organization/ institution that has or have had the greatest negative influence on your story. Please describe this person, group, or organization and the way in which he, she, it, or they have had a negative impact on your story.

Alternative Futures for the Life Story
Now that you have told me a little bit about your past, I would like you to consider the future. I would like you to imagine two different futures for your life story.

Positive Future
First, please describe a positive future. That is, please describe what you would like to happen in the future for your life story, including what goals and dreams you might accomplish or realize in the future. Please try to be realistic in doing this. In other words, I would like you to give me a picture of what you would realistically like to see happen in the future chapters and scenes of your life story.

Negative Future
Now, please describe a negative future. That is, please describe a highly undesirable future for yourself, one that you fear could happen to you but that you hope does not happen. Again, try to be pretty realistic. In other words, I would like you to give me a picture of a negative future for your life story that could possibly happen but that you hope will not happen.
Appendix I. Diary template

DAILY DIARY

Name:_____________________________  Date:________________

Social capital

List the most important people/groups of people you saw or communicated with today (you should include groups in which you participated if they are important).

<table>
<thead>
<tr>
<th>Person/group</th>
<th>By what means? (in-person, over the phone, etc.)/ Where? (at your home, at church, at the market, etc.)/ For how long?</th>
<th>What was discussed/done/communicated?</th>
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</table>

Did you communicate with anyone who lives far away? Who? How/by what means? For what purpose?
Did you receive any help or support (can be emotional, instrumental, informational) from any person/group today? From whom/what group? What did you receive?

Health actions

What did you do today for your health?/happiness? e.g., visited health facility, pharmacy, kiosk, traditional healer, faith healer; used herbs, ate certain foods, prayed; went to church, participated in a group, etc. Why did you do this? (What issue were you responding to? What state were you trying to achieve/maintain?) How effective was it?

<table>
<thead>
<tr>
<th>Action (be specific)</th>
<th>Why done? What issue were you responding to? What state were you trying to achieve/maintain?</th>
<th>How effective was it?</th>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Self-rated health

How would you rate your health today?

Very poor    Poor    Neutral    Good    Very good

Explain why you gave that rating.
How would you rate your happiness today?

Very poor    Poor    Neutral    Good    Very good

Explain why you gave that rating.

Circle the things you experienced today:

<table>
<thead>
<tr>
<th>ENGLISH</th>
<th>LUO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sadness</td>
<td>Sin/ bedo gi kuyo</td>
</tr>
<tr>
<td>Pessimism</td>
<td>Neno ni onge ber moro amora</td>
</tr>
<tr>
<td>Past Failure</td>
<td>Rem kuom timo maraber kinde mikalo</td>
</tr>
<tr>
<td>Loss of Pleasure</td>
<td>Weyo winjo mor</td>
</tr>
<tr>
<td>Guilty Feelings</td>
<td>Neno ni akoso</td>
</tr>
<tr>
<td>Punishment Feelings</td>
<td>Paro kuom kum</td>
</tr>
<tr>
<td>Self-Dislike</td>
<td>Chaaruok</td>
</tr>
<tr>
<td>Self-Criticalness</td>
<td>Ng’iruok matut</td>
</tr>
<tr>
<td>Suicidal Thoughts or Wishes</td>
<td>Gombo derruok kata paro kuom derruok</td>
</tr>
<tr>
<td>Crying</td>
<td>Yuak</td>
</tr>
<tr>
<td>Agitation</td>
<td>Chandruok kuom paro</td>
</tr>
<tr>
<td>Loss of Interest</td>
<td>Ongo gi gombo</td>
</tr>
<tr>
<td>Indecisiveness</td>
<td>Pek mar ng’ado paro</td>
</tr>
<tr>
<td>Worthlessness</td>
<td>Nenruok ka nono</td>
</tr>
<tr>
<td>Loss of Energy</td>
<td>Teko marumo</td>
</tr>
<tr>
<td>Changes in Sleeping Pattern</td>
<td>Lokruok e chenro na mar nindo</td>
</tr>
<tr>
<td>Irritability</td>
<td>Winjo marach kuom weche matindo tindo motimna kata mowachna</td>
</tr>
<tr>
<td>Changes in Appetite</td>
<td>Lokruok kuom gombo chiemo</td>
</tr>
<tr>
<td>Concentration Difficulty</td>
<td>Pek kuom keto pacha e gima atimo</td>
</tr>
<tr>
<td>Tiredness or Fatigue</td>
<td>Oolo</td>
</tr>
<tr>
<td>Loss of Interest in Sex</td>
<td>Gombo mar yunga</td>
</tr>
</tbody>
</table>
### Appendix J. List of social network interview participants

Table 21. Description of relationships between primary and social network participants

<table>
<thead>
<tr>
<th>Name of primary participant</th>
<th>Name of interviewee</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helen</td>
<td>HP</td>
<td>Husband; helps when children are sick, gives advice but no emotional support → bonding</td>
</tr>
<tr>
<td>Evelyn</td>
<td>EE1</td>
<td>Friend, church member; gives emotional support → bonding</td>
</tr>
<tr>
<td>Salome</td>
<td>SJ</td>
<td>Friend; business woman – gives money; don’t always share secrets (young) → bridging</td>
</tr>
<tr>
<td>Grace</td>
<td>GR</td>
<td>Co-wife (sister-in-law); helps when sick, helps with chores, lends money, gives advice about marriage, health, etc., gives emotional support → bonding</td>
</tr>
<tr>
<td>Susan</td>
<td>SC</td>
<td>Sister; employed - gives money; gives advice when depressed, emotional support → bridging</td>
</tr>
<tr>
<td>Beatrice</td>
<td>BA</td>
<td>Brother; provides for all material needs; share some problems → bridging</td>
</tr>
<tr>
<td>Jaqueline</td>
<td>JJ</td>
<td>Brother-in-law, owner of home, church member; offers protection, instrumental help, health advice → bridging</td>
</tr>
<tr>
<td>Millicent</td>
<td>MR</td>
<td>Friend; business woman – gives instrumental support; discuss problems → bridging</td>
</tr>
<tr>
<td>Josephine</td>
<td>JR</td>
<td>Co-wife (sister-in-law); gives health advice, talk about church, gives food → bonding</td>
</tr>
<tr>
<td>Karen</td>
<td>n/a – no SNI conducted</td>
<td>n/a – no SNI conducted</td>
</tr>
<tr>
<td>Agneta</td>
<td>AS</td>
<td>Mother-in-law; gives food and money, encouragement, advice about issues in home → bridging</td>
</tr>
<tr>
<td>Eunice</td>
<td>EE2</td>
<td>Daughter-in-law; helps with chores, gives instrumental and emotional support → bridging</td>
</tr>
<tr>
<td>Pauline</td>
<td>PP</td>
<td>Sister; provides for material needs, gives encouragement and advice → bonding</td>
</tr>
<tr>
<td>Patricia</td>
<td>PR</td>
<td>Mother-in-law; gives advice, food → bridging</td>
</tr>
</tbody>
</table>
Appendix K. Social network interview guidelines

Social network interview guidelines

I would like to start by learning about you. Tell me a little about yourself.

• Where/when were you born?
• When did you come to live here? (if applicable)
• Describe your family (marital status, number of children).
• Where do you pray?
• What level of education have you attained?
• What is your occupation/main daily activity?

As you are aware, <NAME> is a participant in our study. Now I would like to speak with you about your relationship with <NAME>.

• What is your relationship with <NAME>? How long have you known her? How close is your relationship? How often do you see/communicate with her?
• How are you alike/different?
• What kind of support do you give <NAME>? (Probe for emotional, instrumental, informational.) How often do you give this support?
• Why do you give this support?
• Are there other kinds of support that you would like to give but are unable? What kinds? Why are you unable?
• How much time do you spend with <NAME>? What activities do you do together? What kinds of things do you discuss?
• Why do you spend time with <NAME>?
• Would you like to spend more time with <NAME> but are unable? Why are you unable?
• How much do you trust <NAME>? What are the things you would/would not tell her about? (Probe on health, family problems, marital issues, etc.)
• How much does <NAME> trust you? What are the things she does/does not tell you about? (Probe on health, family problems, marital issues, etc.)

Finally, I would like to talk to you about issues related to <NAME>’s health and happiness.

• How would you describe <NAME>’s health? What are her biggest health problems? What do you think <NAME> needs to do to improve her health? (Probe for formal, informal responses.) Do you tell her to do this? If not, why not? Does she take your advice? Why/why not, do you think?

• Tell me about how you see <NAME>’s happiness. What makes her happy? What makes her sad? What do you think <NAME> needs to do to improve her happiness? Do you tell her to do this? If not, why not? Does she take your advice? Why/why not, do you think? Do you help her to do this? How?

• Have you yourself ever experienced depression? Please tell me about it. When was this? (Probe for recurrent/cyclical depression or multiple depression episodes.) What brought (typically brings) it on? What did (have) you do about it? (Probe for multiple actions.) Which of these actions were most effective?

• Tell me about depression in this area. Do many women experience depression? What types of women usually experience it? Why these women? What usually causes it? What do people think of them/how do people treat them? What can be done to help these women?
## Appendix L. List of therapeutic landscape interview participants

Table 22. Therapeutic landscape interviews

<table>
<thead>
<tr>
<th>Name of interviewee</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michael</td>
<td>Psychiatric staff – SDH</td>
</tr>
<tr>
<td>Diane</td>
<td>Faith healer (Legio)</td>
</tr>
<tr>
<td>Chief</td>
<td>Chief (SE Alego)</td>
</tr>
<tr>
<td>Reverend</td>
<td>Anglican pastor</td>
</tr>
<tr>
<td>Selline</td>
<td>Herbalist</td>
</tr>
<tr>
<td>Otieno</td>
<td>Ajuoga</td>
</tr>
<tr>
<td>Christine</td>
<td>Nurse at local dispensary</td>
</tr>
<tr>
<td>Angela</td>
<td>Chair lady – Seje</td>
</tr>
<tr>
<td>Consolata</td>
<td>Chair lady – Osiepe</td>
</tr>
<tr>
<td>Celestine</td>
<td>Chair lady – Jakech</td>
</tr>
<tr>
<td>Deborah</td>
<td>CHW</td>
</tr>
<tr>
<td>Okello</td>
<td>Legio pastor</td>
</tr>
<tr>
<td>Kareem</td>
<td>Clinical officer at local dispensary</td>
</tr>
<tr>
<td>Okoth</td>
<td>Roho pastor</td>
</tr>
<tr>
<td>Mercy</td>
<td>Faith healer (Legio)</td>
</tr>
</tbody>
</table>
Appendix M. Therapeutic landscape interview guidelines

Guidelines for interviews with key actors in therapeutic landscape

- <List symptoms of depression; include those identified in focus group discussions.> When a person comes in with these symptoms, what do you think is wrong with him/her? What is the cause?
- What are your impressions of people who have this problem?
- What can you do for them? Please explain to me in detail what type of help they can receive.
- How effective is the help? What are the barriers to effective help, if any?
- If they don’t come here, where else can they go for this type of help?
- Are there any alternative types of help available in this community? How do you feel about those alternatives? Do you encourage/discourage people to go for these alternatives?
- Are there ways that people can address this problem at home or in the community? What are those options? How do you feel about these options? Do you encourage/discourage people to use these options?
- If you had a loved one with this problem, how would you advise them? Where would you tell them to go? What would you tell them to do?
- Why do you think people sometimes don’t seek help here or with another health professional for this problem?

<Use vignettes about different people with depression (variation by antecedent factors, manifestation, responses) – derived from focus group discussions.>

- What do you think is wrong with this woman?
- What is the cause of this problem?
- How do you feel about her/her problem?
- What do you think she should do?
- If this were a patient/congregant/etc., a close family member, a close friend, a neighbor, an acquaintance, a co-worker, someone you pray with, a family member living in Nairobi, etc., what would you do to help her?
Appendix N. List of codes

<table>
<thead>
<tr>
<th>Code family</th>
<th>Code family</th>
<th>Source</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Culture</td>
<td>Culture</td>
<td>Inductive</td>
<td>Catch-all category for mention of Luo cultural norms other than those listed below</td>
</tr>
<tr>
<td></td>
<td>Juogi</td>
<td>Inductive</td>
<td>Mention of juogi</td>
</tr>
<tr>
<td></td>
<td>Spirits</td>
<td>Inductive</td>
<td>Any spirit possession other than juogi</td>
</tr>
<tr>
<td></td>
<td>Widow inheritance</td>
<td>Inductive</td>
<td>Mention of widow inheritance</td>
</tr>
<tr>
<td>Depression</td>
<td>Antecedent to depression</td>
<td>Deductive</td>
<td>Any incident that preceded onset of depression</td>
</tr>
<tr>
<td></td>
<td>Counseling</td>
<td>Inductive</td>
<td>Mention of counseling</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
<td>Deductive</td>
<td>Description of depression, including severity</td>
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<tr>
<td></td>
<td>Depression – poverty</td>
<td>Inductive</td>
<td>Mention of link between depression and poverty</td>
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<tr>
<td></td>
<td>Depression frequency</td>
<td>Inductive</td>
<td>Mention of how often depression is felt</td>
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<tr>
<td></td>
<td>Happiness</td>
<td>Inductive</td>
<td>Mention of happiness, including what makes participant happy</td>
</tr>
<tr>
<td></td>
<td>Recognition of depression</td>
<td>Deductive</td>
<td>Indications that participant recognizes depression</td>
</tr>
<tr>
<td></td>
<td>Response to depression</td>
<td>Deductive</td>
<td>Mention of response to depression</td>
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<tr>
<td>Health</td>
<td>Chronic illness</td>
<td>Inductive</td>
<td>Any chronic illness other than epilepsy or HIV/AIDS</td>
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<tr>
<td></td>
<td>Epilepsy</td>
<td>Inductive</td>
<td>Mention of epilepsy</td>
</tr>
<tr>
<td></td>
<td>HIV/AIDS</td>
<td>Inductive</td>
<td>Mention of HIV/AIDS</td>
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<td></td>
<td>Illness episode</td>
<td>Inductive</td>
<td>Description of acute illness</td>
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<td>“Madness”</td>
<td>Inductive</td>
<td>Mention of “madness” (neko)</td>
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<tr>
<td></td>
<td>Mental illness</td>
<td>Inductive</td>
<td>Mention of mental illness, not madness</td>
</tr>
<tr>
<td></td>
<td>Stress</td>
<td>Inductive</td>
<td>Any mention of stress</td>
</tr>
<tr>
<td></td>
<td>Symptoms</td>
<td>Inductive</td>
<td>Description of symptoms and diagnosis for any illness – physical or mental</td>
</tr>
<tr>
<td>Health-seeking behavior</td>
<td>Access</td>
<td>Deductive</td>
<td>Access to health care – acceptability, accessibility, affordability, availability</td>
</tr>
<tr>
<td></td>
<td>Allopathic medicine</td>
<td>Deductive</td>
<td>Description of availing oneself of allopathic medicine</td>
</tr>
<tr>
<td></td>
<td>Confidentiality</td>
<td>Deductive</td>
<td>Mention of confidentiality, including concerns</td>
</tr>
<tr>
<td></td>
<td>Credibility</td>
<td>Deductive</td>
<td>Reference to credibility of healer or institution</td>
</tr>
<tr>
<td></td>
<td>Effectiveness</td>
<td>Deductive</td>
<td>Mention of effectiveness of any health action</td>
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<tr>
<td></td>
<td>Etiology</td>
<td>Deductive</td>
<td>Description of etiology of any illness – physical or mental</td>
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<td>Other models</td>
<td>Deductive</td>
<td>Health-seeking behavior explained by</td>
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<tr>
<td>Code</td>
<td>Type</td>
<td>Reference</td>
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<td>------------------------------------------</td>
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<tr>
<td>Indigenous medicine</td>
<td>Deductive</td>
<td>Description of availing oneself of indigenous medicine</td>
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</tr>
<tr>
<td>Order</td>
<td>Deductive</td>
<td>Reference to order in which multiple health actions are undertaken</td>
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<tr>
<td>Quality</td>
<td>Deductive</td>
<td>Mention of quality of institution or medicine</td>
<td></td>
</tr>
<tr>
<td>Religious medicine</td>
<td>Deductive</td>
<td>Description of availing oneself of religious medicine</td>
<td></td>
</tr>
<tr>
<td>Marriage</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Co-wife</td>
<td>Inductive</td>
<td>Mention of co-wife or sister-in-law</td>
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</tr>
<tr>
<td>Brideprice</td>
<td>Inductive</td>
<td>Mention of brideprice</td>
<td></td>
</tr>
<tr>
<td>Husband</td>
<td>Inductive</td>
<td>Description of relationship with husband, any incidents involving husband</td>
<td></td>
</tr>
<tr>
<td>Infidelity</td>
<td>Inductive</td>
<td>Mention of infidelity</td>
<td></td>
</tr>
<tr>
<td>Marriage</td>
<td>Inductive</td>
<td>Description of marriage (general)</td>
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<tr>
<td>Mother-in-law</td>
<td>Inductive</td>
<td>Mention of mother-in-law</td>
<td></td>
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<tr>
<td>Widow</td>
<td>Inductive</td>
<td>Mention of widowhood (not inheritance)</td>
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<td>Miscellaneous</td>
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<tr>
<td>Gender</td>
<td>Inductive</td>
<td>Reference to gender issues</td>
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<tr>
<td>God’s will</td>
<td>Inductive</td>
<td>Mention of God’s will, expressions of fatalism</td>
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<tr>
<td>Punishment</td>
<td>Inductive</td>
<td>Description of punishment, feelings of being punished</td>
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<tr>
<td>Rebellion</td>
<td>Inductive</td>
<td>Description of rebellious thoughts or behaviors</td>
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<tr>
<td>Negative</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Abuse</td>
<td>Inductive</td>
<td>Description of verbal or physical abuse, intimate partner violence</td>
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<tr>
<td>Accident</td>
<td>Inductive</td>
<td>Mention of any accident – road or otherwise</td>
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<tr>
<td>Alcohol/drugs</td>
<td>Inductive</td>
<td>Mention of drugs/alcohol</td>
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<tr>
<td>Childbirth outside of marriage</td>
<td>Inductive</td>
<td>Mention of childbirth outside of marriage</td>
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</tr>
<tr>
<td>Conflict</td>
<td>Inductive</td>
<td>Any disagreement or conflict</td>
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</tr>
<tr>
<td>Death of child</td>
<td>Inductive</td>
<td>Mention of death of child – young or adult</td>
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<tr>
<td>Infertility</td>
<td>Inductive</td>
<td>Mention of infertility or difficulty conceiving</td>
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<tr>
<td>Jealousy</td>
<td>Inductive</td>
<td>Mention of jealousy</td>
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<td>Negative past experiences</td>
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<td>Catch-all category for negative past experiences not encompassed by other codes</td>
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<tr>
<td>Positive</td>
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</tr>
<tr>
<td>Forgiveness</td>
<td>Inductive</td>
<td>Reference to forgiveness</td>
<td></td>
</tr>
<tr>
<td>Hope</td>
<td>Inductive</td>
<td>Reference to hope</td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AIC</td>
<td>Deductive</td>
<td>Mention of AIC</td>
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</tr>
<tr>
<td>Competition between churches</td>
<td>Inductive</td>
<td>Reference to competition or conflict between churches</td>
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</tr>
<tr>
<td>Conversion</td>
<td>Inductive</td>
<td>Description of conversion including reasons</td>
<td></td>
</tr>
<tr>
<td>Differences between churches</td>
<td>Inductive</td>
<td>Expression of differences between churches</td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----------</td>
<td>---------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Exclusion by church</td>
<td>Inductive</td>
<td>Reference to feeling excluded by church</td>
<td></td>
</tr>
<tr>
<td>Mainline church</td>
<td>Deductive</td>
<td>Mention of mainline church</td>
<td></td>
</tr>
<tr>
<td>Pentecostal church</td>
<td>Deductive</td>
<td>Mention of Pentecostal church</td>
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</tr>
<tr>
<td>Reasons for religiosity</td>
<td>Inductive</td>
<td>Reasons for engaging with religion – attending church, praying, reading bible, etc.</td>
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</tr>
<tr>
<td>Religiosity</td>
<td>Inductive</td>
<td>Expressions of religiosity</td>
<td></td>
</tr>
<tr>
<td>Religious concordance</td>
<td>Inductive</td>
<td>Mention of relationship in which both people belong to same religion</td>
<td></td>
</tr>
<tr>
<td>Religious discordance</td>
<td>Inductive</td>
<td>Mention of relationship in which people belong to different religions</td>
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</tr>
<tr>
<td>Salvation</td>
<td>Inductive</td>
<td>Mention of salvation</td>
<td></td>
</tr>
<tr>
<td>Self-criticalness rooted in religion</td>
<td>Inductive</td>
<td>Expressions of self-criticalness based on religious principles</td>
<td></td>
</tr>
</tbody>
</table>

### Roles

<table>
<thead>
<tr>
<th>Role</th>
<th>Inductive</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caretaker</td>
<td></td>
<td>Mention role as caretaker (not mother)</td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td>Mention role as mother</td>
</tr>
<tr>
<td>Youth</td>
<td></td>
<td>Mention of youth, including own children</td>
</tr>
</tbody>
</table>

### Social capital

<table>
<thead>
<tr>
<th>Capital</th>
<th>Deductive</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bonding</td>
<td></td>
<td>Mention of bonding relationship – including rationale for classification</td>
</tr>
<tr>
<td>Bridging</td>
<td></td>
<td>Mention of bridging relationship – including rationale for classification</td>
</tr>
<tr>
<td>Emotional support</td>
<td></td>
<td>Reference to emotional support - not faith-based</td>
</tr>
<tr>
<td>Faith network</td>
<td>Deductive</td>
<td>Faith-based relationship</td>
</tr>
<tr>
<td>Faith support</td>
<td>Deductive</td>
<td>Faith-based support (emotional, informational, instrumental)</td>
</tr>
<tr>
<td>Faith trust</td>
<td>Deductive</td>
<td>Faith-based trust – trust in religious institutions and faith-based relations</td>
</tr>
<tr>
<td>Group</td>
<td>Deductive</td>
<td>Mention of group – secular or religious</td>
</tr>
<tr>
<td>Informational support</td>
<td>Deductive</td>
<td>Reference to informational support (advice, information) – not faith-based</td>
</tr>
<tr>
<td>Instrumental support</td>
<td>Deductive</td>
<td>Reference to instrumental support – not faith-based</td>
</tr>
<tr>
<td>Leadership</td>
<td>Deductive</td>
<td>Mention of leadership role in group or church</td>
</tr>
<tr>
<td>Linking</td>
<td>Deductive</td>
<td>Mention of linking relationship – including rationale for classification</td>
</tr>
<tr>
<td>Negative effects of social capital</td>
<td>Deductive</td>
<td>Catch-all category for negative effects of social capital not listed here</td>
</tr>
<tr>
<td>Reciprocity</td>
<td>Deductive</td>
<td>Mention of reciprocity – includes payback</td>
</tr>
<tr>
<td>Sharing</td>
<td>Inductive</td>
<td>Mention of sharing secrets or discussing personal topics</td>
</tr>
<tr>
<td>Category</td>
<td>Type</td>
<td>Reference</td>
</tr>
<tr>
<td>------------</td>
<td>----------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Size of network</td>
<td>Inductive</td>
<td>Reference to the size of one’s network</td>
</tr>
<tr>
<td>Strong bond</td>
<td>Inductive</td>
<td>Reference to strength of bond</td>
</tr>
<tr>
<td>Institutional trust</td>
<td>Deductive</td>
<td>Reference to trust in institution (church, health facility or healer)</td>
</tr>
<tr>
<td>Interpersonal trust</td>
<td>Deductive</td>
<td>Reference to trust (interpersonal and general)</td>
</tr>
<tr>
<td>Visitation</td>
<td>Inductive</td>
<td>Mention of visitation – visiting or receiving visitors</td>
</tr>
<tr>
<td>Wealth</td>
<td>Business</td>
<td>Mention of small business – actual or envisioned</td>
</tr>
<tr>
<td></td>
<td>Education</td>
<td>Mention of education – participant’s or other’s – including school fees</td>
</tr>
<tr>
<td></td>
<td>Land</td>
<td>Mention of land (as an asset or the source of conflict)</td>
</tr>
<tr>
<td></td>
<td>Laziness</td>
<td>Mention of laziness (vs. working hard)</td>
</tr>
<tr>
<td></td>
<td>Microfinance</td>
<td>Mention of any microfinance arrangement</td>
</tr>
<tr>
<td></td>
<td>Poverty</td>
<td>Description of poverty</td>
</tr>
<tr>
<td></td>
<td>Wealth</td>
<td>Description of wealth</td>
</tr>
</tbody>
</table>
Appendix O. Diary summary example

<table>
<thead>
<tr>
<th>Contacts, color-coded for in-person/by phone and</th>
<th>Communication with person who lives away</th>
<th>One column per diary</th>
<th>Help/support received</th>
<th>Health actions during day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of times symptom</td>
<td>Self-reported health and reason for</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-reported happiness and reason for</td>
<td>Daily record of depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of symptoms reported</td>
<td>Information about people mentioned</td>
<td></td>
<td></td>
<td>Grey used to denote day when participant could not be reached</td>
</tr>
<tr>
<td>Color key</td>
<td>Comments used to clarify data</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: it is not necessary to read the data, only my notes explaining the type of data presented
### Appendix P. List of indigenous healers in the study area

Table 23. Indigenous healers operating in the study area

<table>
<thead>
<tr>
<th>Type</th>
<th>Functions</th>
<th>Examples</th>
</tr>
</thead>
</table>
| **Ajuoga (also called jahoso or jobilo)** | **Witch doctor (good and bad)**<br>**If someone hangs himself or dies in the bush and you are the first person to see, must call jahoso – otherwise bad things can happen (can go mad, bad spirits can come to you and haunt you/your children) – give herbs**<br>**Give love potion, kill, give madness, blindness**<br>**People visit secretly**<br>**Traditional healer; may invoke spirits, may use tools for divining (like stones), herbs; people visit for many things, including when they want wealth or if something is stolen; can have negative connotation** | **Samson Odongi** - “Samson Odongi is not a medicine man, he is a killer. Someone goes to him for a particular death of another person”; treats juogi – “or if a child cries so much and she/he wants to be named after someone, he can help.”<br>**Ogana**<br>**Philemon Oduor** - prays to cure chira, sihoho, tako<br>**Samson Orembe** - restores manhood<br>**R**: He can also bring back a lost person.<br>**M6**: No, he just restores manhood only.<br>**Salgo** - “He doesn’t hoso. When he does the kingo, nobody can hoso it.”<br>“You see he sheds tears, that means he has killed.”<br>“Mwanda [Salgo’s father] used to kill people although he would ask several times if you really want the person killed because once he put his charms no one can undo them.”<br>“There is a woman who went to him to kill someone for her. Salgo told her not to do that because it was right in her house. She had lost Ksh. 900 and she didn’t know who stole it. It was unfortunate she realized when her husband’s stomach was fully swollen. She went back to Salgo for hoso but he told her that he had warned her – there was nothing he could do about it.”<br>**Dimo Kouna**<br>**Odero** - uses herbs<br>**Wilfrida Dola**<br>**Ochoyo** – the old man - and all his sons<br>“They wash – if someone ‘dirtifies’ you then they wash you with water. You go with your own water, then it’s boiled in a pot. And if it’s your leg, for instance, that’s paining you, then they wash it inside the water, then you
put the used water in a bottle, then you take to them. He has another pot which he mixes the water and another medicine which I don’t know. Then inside the mixture will be what someone put for you. That means that you will be cured then.”

**Chege Odongi** - love potion

“Even if you don’t like someone and you want to divorce him, he can also help that.”

| Jamanyasi | Treat chira (use herbs) | MO (Interviewer): And those who give manyasi?
All: They have combined all these together
A: This is because they are nowadays looking for money and this increases their chances of getting cash |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sometimes people visit secretly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Herbalist; use manyasi (mixture of herbs for treating Luo diseases, like chira)</td>
<td></td>
</tr>
</tbody>
</table>

**Nyakachunga** (deceased)

**Ochieng**

**Yembe Rakuju**

**Okitat Ngili** - “This is also jamanyasi who can hosio from snake’s venom if you are bitten by a snake, you just touch his clothes and you be healed.”

**Jayadh nyaluo**

**Herbalist, medicine man**

**Oduor Odongi** - most clients come from far, advertises on the radio - treats epilepsy, ‘makes a home’: “He adds man’s strength on his manhood (all laughing)”, treats barrenness.

“So there are some sicknesses they can treat and some that they don’t (all nodding in agreement). There some which the hospital cannot treat but are treated by ajuoga.”

“All the time you go to them to treat you also mention God’s name. They recognize that God is superior than them.”

**Ochogo and sons** - “The name of their father is Ochogo and all his sons have inherited the talent.”

**Masella Majiwa** - treats children

**Daughter of Amolo** - treats every disease

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| Regina Awuor Atito            | treats herpes with herbal medicine, treats both children and adults |
| Salome                       | treats women with infertility problems and cramps |
| Rawour Kokumu                | uses herbs to protect homes and also for manyasi |
| Edwin Oyieyo                 | |
| Wang’ Bel (also ajuoga who treats juogi - “He is good at that. If you have juogi then he can treat it.”) “He only hoso when he did the kingo.” |
| Nyarkagaria – “We don’t know her name that’s why we call her Nyarkagaria”; treats stomachache (orianyacha) |
| Orungi Dubia                 | “Lady from Ng’iya” |
| Obul                         | treats livestock with herbs |
| Oluoch                       | |
| Jachomo                      | Bonesetter |
| Ouma Odima                   | “There is also another young man from Odima’s family, grandson of Odinga” |
| Jangad lim                   | Cut uvula, put herbs Surgeon |
|                                | “There was one who used to do that in Nyang’oma Dispensary, but he died.” |
| Janak                        | Dentist (incl removing lower 6) |
|                                | “They are very rare nowadays, although the Legio members are done for in their church by their own members” |
| Jatako/jahoso                | Sihoho/juok wang – jatako treats this using herbs or suck it out – spirits tell them where thing is Mostly children get sihoho Some people don’t have control – do it to their own children on purpose – to protect other children |
| Peli                         | |
| Philemon Ouma                | “Gungla who comes from Ralak” |
| Mother Domtilla              | |
| Born with ability to give sihoho (inheritable), can’t get rid of it unless you pray and really believe |
| Specializes in making incision into stomach to suck out undigested food resulting from constipation or evil eye |
| Treats sihoho (evil eye) |

Source: Group discussions
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