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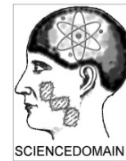

Understanding Illness Diagnoses, Prognoses and Treatments in Rural Households: A Case Study of Gomoa Manso in the Gomoa East District of Central Region, Ghana

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Authors' contributions

This work was carried out in collaboration between all authors. Author JAN designed the study in collaboration with authors KOD and BO. Authors BO and JAN collected the data. Author KOD analyzed and interpreted the data. Author JAN wrote the first manuscript. All authors read and approved the final manuscript.

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ABSTRACT

Introduction: Healthcare decision making is a complex and intertwined behavioural phenomenon in households. The sick and the caregivers bring to bear their knowledge and experiences in such decision making process together with other proximate social network players.
Aims: This study sought to unravel the social processes of prognosis, diagnosis and treatment of illness in rural households with particular attention to social networking in diagnosis and treatment of illness.
Study Area: Gomoa Manso, a rural community in the Gomoa East District of Central Region of ghana was selected for the study.
Methods: Qualitative research methods were employed, making use of in-depth group interviews

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with 25 purposively sampled households. Audio recorded interviews were transcribed and the transcripts were thematically analyzed with the aid of NVivo 20 qualitative analyses software.

Results and Discussion: The study revealed that distance and financial constraints were the most pressing determinants of household self-diagnosis and treatment. There was intergenerational knowledge transfer especially with diagnosis and treatment of diseases. The network of household members, community members and known health professionals was ascertained as the households listened and applied treatment from this network at the same time during diagnosis. Individuals who recover do not sometimes know the exact treatment that worked for them.

Conclusion and Recommendations: Households do not rule out professional medical practice but consults only when their treatments fail. Based on these findings, making community health services accessible and affordable is recommended.

Keywords: Households; rural community; social network; prognosis; diagnosis; treatment.

1. INTRODUCTION

Household is considered as a person or a group of persons living together in the same compound and sharing the same housekeeping arrangements [1]. They are units considered as a domestic group or family. These domestic groups cannot be devoid of illness [2]. Diagnosing to find the cause of such illness and the possible cure (treatment) is an issue of investigation in homes.

Some households make their own diagnosis of illness and suggest treatments that may work or not work. These households are therefore seen as hybrid centers of medical and therapeutic (tending to cure or restore to health) practices [2]. By hybrid centers of medical and therapeutic practices, Dew et al. [2] assert that it is where a plethora and mix of available folk and professional medication practices are assimilated and different forms of knowledge and expertise are made sense of. In case of illness, households' first line of approach is nonetheless non-medical [3], as negotiations for good health starts from within one's social network. This is very characteristic of rural communities which are considered an outside of town [4], low population density and small settlement areas [5]. Deliberations are made concerning any particular illness in these households regarding the kind of illness and what might be the best remedy drawing information from different people in a social network. Here, the social network theory is at work, with the household showing the importance of relying on network actors for information and other resources for members' wellbeing. The actors (family members and friends) are considered as having a reservoir of knowledge with the likelihood of helping diagnose and treat illness. There is almost always a hybrid [6] or mixture of diagnosis and treatment of illnesses in the households. These hybridized practices are always in the quest to maintain or restore the health of an individual member.

In the 17th Century, homes in England had medical kits in their kitchens, usually home brewed and some bought from the shop [7]. Before the advent of scientific medicine some households in Ghana always had some boiled leaves of some special trees for members to take for good health. It is not uncommon even now to find in rural Ghanaian households pots of brewed leaves and bark of trees for a myriad of illnesses. The Ethno Medical approach to health is ubiquitous in Ghanaian rural households [8] where there is emphasis on cultural elements and belief systems together with knowledge on physical causation of diseases. However, these are considered outside of orthodox medical practice. In rural Ghanaian communities, due to sameness and kinship ties [1], the individual is not an island from the rest of the community. Since this individual is in a network of social relationships, how is that individual's health negotiated in such a setting? Research has concentrated on compliance to medical prescription, referrals and community health workers [9,10,11] with little attention to the individual in a social network in relation to illness diagnosis, prognosis and treatment.

1.1 Theoretical Framework (Social Network Theory)

This paper argues through the lens of Social Network Theory to investigate the mixed approach to negotiating wellness practices in rural households. Myriad of actors and their knowledge in wellness practices in diagnosing and treating illness is considered. According to Borgatti, Everette and Johnson [12] Social Network Analysis is a theory, a method and an

analytical technique. This means that it provides a framework within which a study could be conducted in entirety. Social network analysis is defined as a distinctive set of methods used for mapping, measuring and analysing the social relationships between people, groups and organizations [13,14]. Social network theory applies to different levels of analysis from small groups such as this study's concentration through to global levels. A network is a relationship (tie) between at least two actors (nodes) [15,16,17]. When applied to illness and therapeutic practices in the household, this theory can be drawn on to describe and analyze in-depth the individual's social relationships and its implications for health negotiation. The network of family members, the community and friends are active in the whole process of disease diagnosis and treatment. These ties are inclusive of trust and knowledge transmission [16]. These networks are sources of wellness practice hybridized by households [6]. Wellness practice is networked and mixed with orthodox medical practitioners feeding into this network but by no means dictating them. An individual with an ill health will draw from the knowledge of a network actor such as a relative or a friend who might recommend a particular medication or home brewed medication for treating the illness. In this dyadic network, the individual relative draws from the symptoms before prescribing any medication.

2. LITERATURE REVIEW

The part played by communities and households and the understanding of medical and therapeutic practices has been captured by Vassilev et al. [10] and Brooks et al. [9] as concerned with how social network actors are substantially involved in the health negotiation of household members. The understanding and acceptance of the influence of social network players in the homes cannot be dismissed as various studies are coming out with findings on the increasing influence of these network players [18]. Cohen, Dupas and Schaner [19] observe that the typical first response of households to manifestations of malaria is to self-diagnose and buy over-the-counter medication per recommendation from his/her social network (a friend or relative) or from past experience with such symptoms of malaria, bypassing the formal health care system altogether. This diagnostic process takes the form of discussing symptoms with actors in the social network where the actors bring to fore their knowledge and experiences concerning the illness and then prescribing a drug for the illness. Cohen et al. [19] argue further that a substantial number of those who self-diagnose through their social networks are not infected by the said illness. However, this argument does not object that self-diagnosis through one's social networks are sometimes done right.

Drawing on Latour's [6] notion of hybrids, households churn up these medical and therapeutic practices in the home based on what is already known, experimentations and what is recommended from outside the home. As Dew et al. [2] point out, households engage in their own "truth production" regarding what works and what does not in dealing with illness through research and observation. The issue of pure medical practice is not found in households as the households always churn up folk knowledge together with knowledge from the "pure" medical practice.

The issue of power which resides in the hands of the orthodox medical practice is decentralised in the households as their members engage in their own analysis and draw conclusions about medications from the mainstream orthodox practice in the homes where they are appropriated and individualised [20]. This challenges the argument by William and Popay [21] that household medical practices are outside the realm of science and disorganized, posing little threat to the power wielded by medical profession. However, Dew et al. [2] also argue that "lay beliefs and practices are inherently a challenge to the power of medicine, in particular because they are not readily visible and therefore not readily disciplined" (p.29). There is power of the powerless [22]. This has been looked at by the orthodox medical practice as households' non-compliance and more recently denoted as non-adherence to medical advice with devastating consequence for society [23,3,24]. This threat to the influence of orthodox medical practice is even more pronounced as individuals have access to internet and health magazines to consult when making wellness decision bringing into light new "medical cosmology" [25].

A study by Uzochukwu, Obinna and Onwujekwe [26] on socio-economic differences and health seeking behaviour for the diagnosis and treatment of malaria in South-East Nigeria showed that the use of traditional healers in one's social network and self-diagnosis were practiced more by the poorer households while the least poor used the patent medicine dealers

and community health workers less often for diagnosis of malaria and preferred going to the hospital. This brings into the picture an important social network player in local communities in Africa; the traditional healers. Twumasi [8] comments on such traditional healers:

> "…the service is performed through the utilization of magico-religious acts and concepts. This is not to say that the practitioners of traditional medicine have no notion of physical cures and treatment. They have a stock of remedies with which to treat ills and some may have scientific validity." (p. 9)

This shows the mix (hybrid) of magico-religious acts and science in diagnosing and treating illness. The stock of remedies together with magico-religious acts are sourced from a known network actor in the community who is considered an expert in issues of the unseen world [8]. In such instances multiple wellness practices are engaged in concurrently based on recommendations from different actors in the network.

The role of social networks has become very important in recent times with the advent of information and communication technologies making the hospitals no longer peculiar places of health care [27]. Nettleton [28] posits that people use the internet to access health information and practices. The internet can be used to access health advice from sources deemed "authentic" and reliable. Based on varied information found on the internet about illness, concerns about the internet source are not dismissed by householders [25]. This is because there is the analysis and sieving of information from the internet source before people adapt them [28]. Financial constraint has been argued as one risk factor for households to self-diagnose and treat illness [29,30] drawing on their social network.

The literature reveals that households do experiment with wellness practice through their social network, but how these practices are carried out is not always readily apparent [2]. This study set out to explore the health negotiation practices in rural households in Gomoa Manso in the Gomoa East District of Central Region of Ghana with particular attention to social networking in diagnosis and treatment of illness. Specifically this study sought to investigate how households practice illness diagnosis and treatment and how they hybridize these practices for members' well-being even in the face of professional medical practice. Understanding the importance of social networks in the home and the community and the knowledge capital in this network in informing health decision making was the pursuit of this study.

3. METHODS

3.1 Research Design

This study made use of qualitative case study design. This was to help focus attention on the households and the therapeutic practices that they engage in to fully understand the individual in a network of social relationships.

3.2 Research Setting

Gomoa Manso is a rural community in the Gomoa East District of the Central Region of Ghana. This is a typical rural community with few cement block buildings. A branch un-tarred road leads to and ends in this community. There is no health centre or clinic in the community with most of the residents in the community as farmers. It is about seven kilometres from a Community Health Planning and Service (CHPS) centre. According to the Gomoa East District Assembly, the Community has an estimate resident population of about 3,400 people.

3.3 Source of Data

This study made use of primary source of data in its quest to investigate household behaviours in medication practice. The primary data was collected from the members within the households through group interviews.

3.4 Population

The population for this study was all households in the study area. The households formed the study population because they were the main focus in this study from whom data was collected.

3.5 Sample Selection

This study used the purposive sampling technique. A total of 25 households were purposively selected. The selected households included 11 households with children less than five years of age and 14 households with

grandparent(s). This was purposively done to include households with different membership composition to enrich data collected.

3.6 Data Collection and Analysis

Data was collected through interviews with the households. The interviews were held with not less than five members of each selected household. The group interviews were conversational but guided on by an interview guide. The interview guide contained questions relating to the households' initial action to diagnosis and treatment when a member is ill and also who they consult in their social network and why. The interviews were audio recorded and notes were also taken by the researchers. Each household was treated as a unit through group interviews. The interviews were done in vernacular to allow free expression.

Data was qualitatively analysed which was informed by the type of data collected. The audio recordings were transcribed. The transcripts were imported into NVivo qualitative analysis software. Portions of the imported transcripts with similar contents were selected and coded into nodes. Nodes of common ideas were collected together as themes and analyzed.

3.7 Ethical Issues

Informed consent was observed by formally submitting a request to the community leaders and telling them about the research. This included telling them about the nature of the research and the timeline for the study. The community leaders upon review granted entry for the study. Participating households were told of the intent of the study and how voluntary their participation was. Pseudonyms are therefore used to preserve the identity anonymity of the members of the households. Ethical issues have been dealt with as no ethical committee was consulted before the study.

4. FINDINGS AND DISCUSSION

4.1 Diagnosis

Disease diagnosis has been known to be in the grasp of qualified group of people with special training [31]. Such people are vested with the authority and the technical know-how to examine and make clear what is wrong with an individual's health. Households are therefore considered untrained in the diagnosis of disease. However, findings from this study revealed that all the 25 sampled households undertake their own diagnosis at some point in time. This, they usually do with reference to the symptoms which is presented by the illness in question. This is considered by Jutel [32] as "premedical assessment". This pre-medical assessment is not done by a single individual but by other actors in the individual's social network. This is where the state of illness is considered unacceptable and so the need to ascertain the nature and cause of such state. Households are not passive in disease diagnosis as self-diagnosis was found everywhere present within the sampled households. People in the homes practised self-examination through observations with the help of their social network (other family members and the community members). This is normally done by the older people in the networks. They are considered experienced as they might have come across some symptoms before as they were growing from childhood into adulthood. In eight of the households, self-diagnosis done by the young was to be validated by experienced adults in the social network, usually a family member. It was therefore ascertained that network players who were old and experienced were mostly called upon to determine the nature and cause of illnesses. This is what a young lady had to say;

> "When I am not well, I usually guess the kind of sickness. However, either my mother or grandmother confirms or rejects that and decide what to do for me"

It was revealed that the adults in the households usually self-diagnose. This is very common with illness and symptoms that they have come across on multiple of occasions. The more frequent the individual is confronted with a particular illness, the more likely he/she will be able diagnose. Therefore familiarity with particular illness can be argued as a cause of self-diagnosis in the study area. Though there are other social network actors, the individual with the ill health does not consult the network but self-diagnose based on past experience with the illness. This is what Ama who was a member of a multi-generational household had to say;

> "I usually know what is wrong with me from the feeling I get early in the morning. For example if I am shivering and my body is hot after feeling with the back of my palm, I know for certain I am not well."

Here, Ama is not passive but actively involved in diagnosing herself of high temperature, possibly fever. In households, the "normal" is always established over time [2] and with the frequency with which an illness occurs. This is an impetus for individuals to self-diagnose within their social network. For Ama, it is a normal occurrence for fever to be accompanied by symptoms of rise in temperature and shivering. Overtime, households come to identify with some symptoms as peculiar to particular illness. This makes households match particular symptoms to particular illnesses. However, it is worthy of note that this self-diagnosis is not done in isolation from other members of the network. There are inputs from other members in the household network to confirm or reject the diagnosis made by the household member. This is what Kwaku, a 23 year old farmer in a multi-generational household said;

> "... why go to the hospital for them to tell me what I already know is wrong with me? Normally, my grandmother will tell me what is wrong with me after telling her how I am feeling... this is especially true of malaria"

This is a young man who asserts that he already knows what his illness is and does not need the professional practitioner to reiterate what he already knows and confirmed by his grandmother. There is thus the inter-generational knowledge transfer. To such a person, it is redundant to go to the practitioner for any confirmation. This network of relationship between the person who is ill and the grandmother cannot be dismissed as it has implications for the wellness practices of the person. This shows that common illnesses in the home are usually diagnosed by the members in the home as they have come across such illness more than they can recall. Common household illnesses such as cold and flu are easily and quickly diagnosed [33]. Self-diagnosis was seen in the light of the frequency with which such illnesses occur in the households. This was however not true of illness which were not very common in occurrence in the homes. Prior [31] opines that diagnosis in the households can be wrong. This is because not all symptoms point to the illness they seem to point to. According to him, underlying cause may be different but the manifesting symptoms may be the same. So diagnosing based on the physical manifesting symptoms is likely to be wrong. This is also supported by Cohen et al. [19], who say people might not be even infected by the said disease they self-diagnose in the households. Based on the study's location and distance (7 km) from CHPS centre, it can be asserted that distance to the nearest health centre might likely be a cause of self-diagnosis in most of the households interviewed. The lack of professional health workers in the community leads households to rely on their social network to diagnose and treat illnesses.

In some instances, people who are not qualified practitioners from outside the households feed into the diagnosis of illness in the households [2]. Households sometimes rely on folk knowledge from outside the home in determining the nature or cause of an illness. It was found that 11 of the households where there were no elderly people contacted networked actors who are outside of their homes regarding symptoms that they consider "strange" or "rare". It was realised that in such instances many network actors are consulted concurrently resulting in a plethora of diagnosis which has implications for treatment. Esi had this to say regarding network actors who are outside the home;

> "When my son got ill, we didn't know what it was since the signs were not normal. He was shaking, he was hot and had bloody stool. We called Auntie (a known traditional healer in the community) who came in and diagnosed him of malaria."

Another man had this to say;

> "I remember talking to the old man just behind our house about a "man's" problem that I had some time ago. I didn't know what it was and I was worried and very confused as to what it might be. You know I can't talk to just anyone about it so I went to him and he did help me out."

To Esi, though she may be familiar with feverishness as one common symptoms of malaria, she found the bloody stool of the son to be rare and thus strange. This required an external actor in the network to help with diagnosis. This will then be added to household's list of symptoms for malaria. It can be realized that network actors are very important.

Past experiences with some illnesses provide clues to identifying the nature and aetiology of current illnesses. For example, a mother of an under five year old son had this to say about when the son was seriously ill.

"When my son was not feeling well the other time, I realized it was an illness I had encounter before since my elder child showed that same symptoms when she was young and was sick. My son had difficulty breathing and had noise in his breathing with hot body when felt with my hand just like I had observed before."

This mother diagnosed based on past experience with previous child's illness. To her since the elder child showed same symptoms of probably pneumonia, the current child is likely suffering from pneumonia if he shows that same symptoms as the elder child did when under five years. It was realized that mothers of higher parity almost always do self-diagnosis of their children's illness and find their own remedies for it. This is not surprising as they have had children before and so are very familiar with the issues of health and illness of their wards. This however does not mean that they are always right as asserted by Jutel and Banister [3]. This is reiterated by Olsen and Abeysinghe [34] that uncertainty permeates the area of diagnosis, especially if scientific tests are not performed together with observations.

Interestingly, qualified medical practitioners also feed into household diagnosis indirectly. Here, the qualified practitioner's diagnosis is put to work without his/her presence as long as the same symptoms which he/she diagnosed are observed in the home. There is usually some form of confidence with such diagnosis because of previous confirmation by a qualified practitioner. There is therefore patient empowerment through health education by qualified medical practitioners. Kobina, an 18 year old youth had this to say about diagnosing Acid Reflux Disease (ARD);

"I have had burning sensations in my chest area before. The Doctor told me what was wrong after describing the symptoms to him. I have forgotten the name of the sickness he told me. He gave me some prescriptions and advised on what and how to eat and what not to do immediately after eating. … so I always know what to do when I get those sensations in my chest."

From the experience of Kobina he is now able to diagnose if he has ARD or not. Though not professionally appropriate, he draws from the external network actor – the qualified medical doctor.

Most of the elderly populations in the sampled households almost always self-diagnose and make their own prescription of some traditional concoction to be made for them. Self-diagnosis, diagnosis by other network actors in and outside the household and the non-dictating diagnosis of qualified practitioners are all brought to light in the household. The study revealed that in some instances where the household members are not very sure of the nature and cause of an illness, the nearest Community Health Planning and Services compound becomes the next resort for them to attend for the diagnosis to be done professionally.

In the study area, the spiritual is sometime seen at work regarding illness. This is the narrations of Kojo who was ill for close to six months;

"...they can also make you ill. The witches and wizards and those who hate you can make you ill in order to kill you. I was ill for a long time and no treatment seemed to work. I had tried the hospitals, herbal clinics and home remedies but they all didn't work. A nurse even asked me to seek spiritual help. No one could tell me what was wrong with me. The hospital just told me I had low blood level and that I would be fine. But I was getting weaker and weaker in body, until my mother contacted a traditional healer in another town who said the illness was spiritual and that some sacrifices had to be made and some concoction prepared for me to drink. I started getting better and now I am healthy."

The spiritual in most cases is not dissociated from the physical as the belief that the spiritual affects the physical Twumasi [8], is still at play in rural Ghana. From the narration of Kojo, it can be realized that the aetiology of the illness was not considered physical in nature but rather with a spiritual root cause. Such diagnosis usually requires the confirmation of traditional healers or someone who is known to be very knowledgeable in the things of the spiritual. It is common to find people at prayer camps seeking spiritual help for various sicknesses.

Diagnoses in the households are thus done by almost anyone who has experienced an illness at one time or the other. Drawing on past experience and other network actors, households are able to diagnose what is wrong with its members and in some cases use the conventional medical route.

4.2 Prognosis

It was found that prognoses in the households were almost always positive. This is what Adjoa had to say;

> "The last time I had a serious headache, my husband told me I will be fine in the next two or three hours and that I only had to take in much water and relax. The headache did calm down after some hours and was totally gone the next day."

Experiences of individual members in the households are used in the prognosis of illness. This was not surprising as the households did not have scientific means of ascertaining the trajectory of an illness except drawing on their plethora of past experiences and that of others in their networks. However, this does not always work out as expected. This was affirmed with a statement by Kwame;

> "The last time I had backache, I just knew it would go by itself so I did not bother. The same thing happened to my elder sister and she recovered without any medication. However, mine got serious and I had to use hot ointment to relieve me."

Though the prognosis of Kwame was based on past experience of a sister, it did not happen so with him. This brings out the weakness in the folk ways of illness prognosis. Because of these uncertainties, implications for treatment and health negotiations are complex. Prognoses have implication for seeking treatment for any particular illness in the household. In instances where one anticipates getting well he or she will not make much effort to seek medication which might worsen an otherwise mild illness. Some households consider particular illness as a normal household illness and that anyone suffering from such illness will get better even without medication. To them it is no news for a member to report of such illness. This is what a household head had to say;

> "In this house, headaches are normal. If you have headache, it just goes by itself. I guess it is a family thing"

4.3 Treatment

> "We have a box of leftover drugs from our visits to the hospitals. We make use of them when anyone is not feeling well" (Male household head)

The quotation above is a statement from a father of three children with one child less than five years of age. Dew et al. [2] found in their studies that some households in urban centres in New Zealand have leftover drugs from their previous visits to the hospital. It is not uncommon to find individuals stopping medication or deviating as soon as they "feel" they are well. These households make use of it in times of need especially if they envisage a disease closely linked to the reason why those leftover drugs were given. The households did not have designated first aid kit in the houses for early treatment before referrals to the clinic or hospital. This was not surprising as folk medicine was a common place in the study area. Everyone knew one or two remedies for some illness in the community.

> "My grandmother almost always has a remedy for any illness that comes up in the house. She advises on what to brew and how to brew it for treatment. She is usually of the view that their time was a time of herbs and that all herbs have medicinal purposes." (Abena)

This is clear on how the older generations fuse into the younger generations with their knowledge capital on disease treatment. Traditional belief systems cannot be dismissed in disease treatment in rural Ghana as trust in herbal medicine still persists even in the advent of scientific medicine.

It was revealed that those who have the power to make health seeking decisions were mostly the one with the most economic power. Though household heads were envisaged to be the men, especially in households where the man was around, issues of treatment of illness was not necessarily made by the man. The first point of action in terms of treatment as found by the study was not scientific medicine. There was experimentation with treatments from members of the households and other members of the community. There was thus a multiplicity of treatment practices in the households for any particular illness. This is what a 32 year old woman said;

> "...sometime you do not know what may work, so you try different treatments at the same time with the hope that one or two will

> work. I remember my mother telling me how to treat malaria in the house instead of going to the hospital since it will be costly going to the hospital. My son also had leftover drugs for his malaria treatment of which I was taking at the same time."

Another man said;

> "Normally I ask my colleagues in town what might be the appropriate treatment for an illness after telling them the symptoms. Sometimes I am told to try different treatments so that the illness will go very quickly."

This means that individuals draw from the network in which they find themselves to look for treatment. People even get well without knowing which treatment worked. Kofi said;

> "I normally go straight to the chemical shop and tell the man how I am feeling and he gives me medicine to take. I usually combine it with treatment advice given by my grandfather. It usually works. I am only interested in getting well"

It can be asserted that households try out treatments and if it does not work, they visit the clinics. This is because eight particular households had the practice of treating illnesses at home and waiting a day or two for improvement. If there is no improvement, they then visit the clinic or hospital. They usually refer to the Community Health Planning and Services compound as the clinic.

> "We like to try and treat in our own way. If it works then fine, but if it doesn't work, we take the person to the clinic for treatment."

It was realised that distance and financial constraints were the most pressing determinants of household self-diagnosis and treatment. For fear of financial expenses, these households engage in their own treatment experiments and find alternative means of negotiating their health through their social network. It is worthy of note that illness which households diagnose as having spiritual aetiology was usually referred to traditional healers for treatment or a Pastor to pray for the sick person in their network. In some instances prayers were considered treatments in themselves and at other times too prayers were said together with the drug or concoction for treatment. Kweku had this to say;

> "When I was not able to give birth, I was told it was my mother's sister who was a witch and making it impossible for me to procreate. I was given some oil by the Pastor to smear at..., while I also prayed"

The study showed that households do not totally leave out the orthodox medicine in their negotiation for wellness. However, they are hybridized with the folk medicine for wellness of the individual. According to McClean and Shaw [35], they are adopted, critiqued and added to the folk medicine for wellness practice. The orthodox medicine is usually considered as the last resort in the network as most of the individuals in households had Health Insurance. It was realised that despite household members' enrolment on National Health Insurance, many of the wellness practices were within the social network of relationships in the households and the community in which they lived.

5. CONCLUSION

Households, especially rural households are bent on self-diagnosis and treatment of illnesses in the household, especially if distance to health facility is far. An undeniable fact is that these households try out their own remedies in wellness practice and blend with the orthodox medicine. In diagnoses of illness, households draw on past experiences and actors in the network to inform their diagnosis. Financial constraint and distance from the nearest health care centre is a cause of self-diagnosis. It is however, worthy of note that myriad of diagnoses are done concurrently as with treatment. Prognoses of illness are usually in the positive affirmative direction within households. In treatments, households draw on different sources in the network to treat illnesses and are sometimes not sure which treatment worked and which didn't work. It is interesting that these three phases of wellness practices (Diagnosis, Prognosis and Treatment) sometimes take place concurrently. Based on these findings, it is recommended that community health services are made easily available and accessible. Also, medical expenses should be subsidised for rural folks such as those of this study's concentration through the Health Insurance Schemes.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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