FEVER AND EVERYDAY LIFE IN RURAL UGANDA

Understanding children’s perceptions, experiences and health-seeking behaviour within the household.

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Dedication

To Vera
Acknowledgements

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Abstract

Fever/malaria is a serious public health problem in Uganda. It accounts for 46% of all childhood illness and 15% of inpatient deaths. In 2001, Uganda adopted the concept of home-based management of fever to off-set structural constraints of access to, and to improve timelines of treatment for children with fever. However, little is known about children's perspectives of fever in Uganda. This study explored how, and to what extent children's perceptions and experiences of fever influence health-seeking behaviour within the household. For this study, I assumed and argued that the social backgrounds of children, influenced by the specific cultural contexts determine their perceptions, experiences, and actions upon fever. I also argued that children's actions upon fever depend on the gender dynamics and power relations in the household.

The fieldwork was conducted was based on a small-scale exploratory-ethnographic study in a rural village community in Busia district, eastern Uganda. I used five different qualitative data collection techniques namely: ethnographic conversations, participant observation, focus group discussions, in-depth interviews and document review. My informants were children (6-13 years old), parents/caregivers and health care providers.

I found out that children had similar coping strategies for acting upon fever(s). These were in the form of self-diagnosis, decision-making, communication, negotiation of decisions of adults, and active care-seeking/self-care. These were pragmatic steps that enabled children together with adults to act upon fever within the household or to seek-help from existing health providers at local community level. However, I established that children's ability to effectively act upon fever was influenced by their gender i.e. social position in relation to particularly male adult members of the household. Consequently, boys had relatively better opportunities for self-care than girls.

In conclusion, the existence of mutual adult-child relations was critical for constructing and sustaining children's coping strategies to act upon fever in the household. Therefore, there is need to address the socio-cultural obstacles e.g. unequal gender and power relations that constrain adult-child relations leading to delays in care-seeking for children with fever in the household.
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### Acronyms and abbreviations

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<tbody>
<tr>
<td>ARI</td>
<td>Acute Respiratory Infections</td>
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<tr>
<td>BDLG</td>
<td>Busia District Local Government</td>
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<td>DHS</td>
<td>Directorate of Health Services</td>
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<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>HBMF</td>
<td>Home-Based Management of Fever</td>
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<tr>
<td>HC</td>
<td>Health Centre</td>
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<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome</td>
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<td>HSD</td>
<td>Health Sub-District</td>
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<td>JMS</td>
<td>Joint Medical Stores</td>
</tr>
<tr>
<td>LC</td>
<td>Local Council</td>
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<tr>
<td>MFPED</td>
<td>Ministry Finance Planning and Economic Development</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>NGO</td>
<td>Non-Government Organisation</td>
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<td>NMS</td>
<td>National Medical Stores</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>SSA</td>
<td>Sub-Saharan Africa</td>
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<td>UBOS</td>
<td>Uganda Bureau of Statistics</td>
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<tr>
<td>UNICEF</td>
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<td>WHO</td>
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Chapter 1: General introduction

1.1 Introduction

This thesis titled, "Fever and everyday life in rural Uganda: understanding children’s perceptions, experiences and health-seeking behaviour within the household," is presented in partial fulfillment of the requirements for the award of the "Amsterdam Master’s in Medical Anthropology," (AMMA). The thesis is a product of fieldwork conducted for an exploratory study in a rural village of Busia district, Eastern Uganda. The aim of the study was to contribute to a more cultural and children sensitive home-based management of fever approach in Uganda.

Some eight months before the study, I got interested in, and participated in the AMMA thematic module, "Children, Health and Well-being: A Cultural Perspective". During the module, I was introduced to a broad range of exciting ideas about the Medical Anthropology of Children. Some specific topics covered issues such as ‘children’s perspectives and role as active and creative social actors in society’. Secondly, I also had opportunity to gain skills of how to work with ‘a specific child-perspective on health and illness’.

During interactions with the Chair of the module, Ria Reis, I was struck by her magnanimity in sharing with us the knowledge and wealth of experience she had acquired over the years in Medical Anthropology, and its sub-field, the Medical Anthropology of children. In the course of the two weeks of the module, my minds traveled back and forth on a long journey into childhood trying to capture elusive experiences of growing up in a small rural village in Uganda. In my reflections I questioned how certain socio-cultural situations influence children’s lives nowadays in the rural countryside, over three decades later. From this point I started to think of different ideas that would enable me to work with children for my thesis. I decided to study fever/malaria, given its importance in Uganda. In a discussion with Ria about my research idea, her remark was more than inspiring to me. She said, “indeed, a lot of changes have taken place in Africa, but no one seems to exactly know what takes place in children’s lives at the level of the family…” As it turned, here lay the firm foundation for my project, hence this thesis.

In sum, I hope that by undertaking this study, I have made a contribution to that understanding, on one hand. On the other, I also hope that the thesis adds to the body of existing knowledge in the Medical Anthropology of Children.
1.2 Background and statement of the problem

In most developing countries, children die from avoidable and preventable causes for which there are known and effective public health interventions. Of the 10.5 million child deaths reported worldwide in 2004, 50% occurred in Sub-Saharan Africa (SSA), where only 20% of the world's young children live (United Nations 2006: 10). Currently, nine child deaths are reported every minute, which means a total of 4.8 million lives lost each year (UNICEF 2006: 1). Although child deaths may result from different causes, the majority in SSA are attributed to fever due to malaria. In general, of the 1.2 million deaths in children below 14 years, 90% are caused by fever or malaria in SSA. In addition, it accounts for 20% of mortality, and 10% of morbidity in adults. In total, 500 million cases of acute fever or malaria are reported each year in SSA alone (WHO 2002: 1-2; Malimbo et al. 2006: 1-2; Helman 2000). Given these scenarios, all children with fever should be treated for malaria in biomedicine (WHO 2004).

Studies in specific countries of SSA describe similar epidemiological patterns as above (McKaig 1995; Hill et al. 2003; Karamagi et al. 2004). These studies point out that affected people use both traditional and biomedical treatments in a hierarchy of resorts. That is, their actions range from self medication to consultations with others such that if one treatment fails, they turn to other locally available remedies (Helman 2000: 15). In addition, the studies outline limited access to adequate treatment, weak health systems, poor provider attitudes, drug shortage, and misuse, and lack of money as some of the critical factors that influence health-seeking behaviours. These factors constitute structural constraints that delay appropriate care-seeking by local communities. As a result, the majority (82%) of fever cases are treated at the community and household levels outside of the formal health sector (WHO 2002). In response, WHO recommends that many deaths among children can be avoided if interventions are delivered at community level linked to, and supported by a well functioning health system (WHO 2005: 5).

In 2002, Uganda adopted and implemented the concept of home-based management of fever (HBMF). This is a World Health Organization strategy aimed at addressing problems of access and timelines of treatment through improved

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1 Malaria is a collective name for different diseases that may result from infection by any of the genus Plasmodium. Its main symptom is fever, periodic bouts of which tend to alternate with days of less or no fever (see Najera et al. 1993: 281-283).
recognition, management, and treatment of fever in children under five years at community levels (WHO 2004; MoH, WHO & UNICEF 2001). The components involve: sensitization of community members and leaders; selection of community volunteers and mobilizers; community capacity building; provision of IEC materials; provision of antimalarial drugs; and monitoring and evaluation (Fapohunda et al. 2004).

Studies so far show that even when caregivers have better access to treatment, their health-seeking behaviours are still inappropriate for HBMF (Nsabagasani et al. 2007; Nsungwa-Sabiiti et al. 2005). This is because possible inherent weaknesses within the HBMF strategy. For example, HMBF seem to treat all fevers as malaria, contrary to lay conceptions that refer to different experiences of fever requiring separate treatments. In other words, people's local understanding of fever is different from the etiology of malaria. Hence the mismatch between lay understanding of fever and the biomedical notion of malaria contributes to differences and possible delays in caregivers' health seeking behaviours (Nsabagasani et al. 2007). This implies that HBMF might not be sensitive to the important role local cultural values and beliefs play in people's understanding of fever (Amuge et al. 2004). Briefly, cultural factors influence how people interpret the significance of fever, and whether or not they relate its symbolic meanings to malaria (Helman 2000: 255).

The present study focused on fever, a phenomenon that people “directly experience” (Crotty 1998: 79) through changes in the body conditions. From the children's point of view, studying fever as subjective and everyday experiences of their bodies helped me to stay as close as possible to the meaning of what they understand by fever in everyday terms (Crotty 1998: 83).

In Uganda, considering all children are vulnerable to fever, then HBMF's silence about those above five years seems to create social boundaries not consistent with local cultural values. For example, given that 44.4% of children below five years, and 41.6% above five years are susceptible to fever (cf. MoH 2001a; MoH 2001b: 1-2), then HBMF might be a less adequate approach to fever management. The presence of untreated and infected children does not only perpetuate fever transmission but also constrains the household members' capacities to seek care (Miguel et al. 1999).
Structurally, HBMF seems not to allow “space” to all social actors to participate in fever management. Adults e.g. mothers/caregivers are the target group of its implementation at household level. This excludes children and their perspectives yet they suffer the direct experience of fever (cf. Fapohunda et al. 2004). In the context of this study, such exclusion is contrary to the growing anthropological awareness of children as social actors in health issues (Christensen 2004; Christensen & Prout 2002; Christensen 1999; Van der Geest 1996; Onyango-Ouma et al. 2004; Akello-Ayebare 2003). These studies have demonstrated children’s abilities to deal with their own health and the health care of others in communities. For example, Akello-Ayebare’s study done in Uganda revealed that, as social actors children were able to express their own ideas of health and deal with illness in the context of medical pluralism (Akello-Ayebare 2003). In other words, they were able to self diagnose, self treat, buy medicines and take care of others (cf. Christensen 1999).

However, it was unclear to what extent HBMF pays attention to the children’s perspectives regarding fever management. Therefore, in this study I explored children’s perceptions and experiences of fever, and health-seeking behaviour within the household. Understanding perspectives of children might contribute new insights for improvement of public health and fever management at household level. Thus, the aim of the study is to contribute to a more cultural and children sensitive home-based management of fever approach in Uganda.

My main question is: How, and to what extent do children’s perceptions and experiences of fever influence health-seeking behaviour within the household?

In order to answer this question, I developed sub-questions following a 3-step model: children’s ideas of fever, the decisions and actions they took to treat and prevent fever, and whether or not children’s ideas of fever coupled with the decisions to act upon it relate to those of adults. Thus, I addressed the following sub-questions:
• How do children perceive fever?
• What does it mean to have fever from children’s point of view?
• How do children distinguish between fevers with regard to causes and transmission?
• How do children get information about the causes of fever, its transmission, treatment and prevention?
• What decisions, if any, do children take in households, and how does this influence their ability to act upon fever?
• What is children’s position(s) in the household and how does this influence their experiences of fever?
• In what ways are children’s gender roles related to their actions with regard to fever treatment or prevention at household?
• How do children’s ideas and actions upon fever relate to those of adults, and why?

1.3 Theoretical approach and literature review

1.3.1 Theoretical approach

For this study, I adopted an interpretive medical anthropological approach to explore children’s perceptions, experiences and health-seeking behaviour within the household context in rural Uganda. The approach analyses what Michael Crotty describes as, “culturally derived and historically situated interpretations of the social life-world” (Crotty 1998: 67). It is from such a standpoint, that I sought to interpret and understand how the social, cultural, economic, and political-historical contexts influenced the meanings of fever, actions and purposes of dealing with fever in specific ways from the point of view of the children themselves. More explicitly, I refer to such views as children’s explanatory models of fever in the context of everyday life (cf. Kleinman & Becker 2000; Helman 2000: 85-86).

In the context of the present study, everyday life refers to the specific social activities, events and processes that children told me they were involved in as members of their households. Therefore, to fully understand the influence of contextual factors on children’s experiences of fever and health seeking in households, I made the following assumptions. Firstly, the social backgrounds of children, influenced by the specific cultural contexts they live in determine their
perceptions, experiences, and actions to treat and prevent fever. Secondly, children's actions to treat and prevent fever depend on the dynamics of their position(s) in the household, whether or not they are allowed "space" to participate in decision making and engage in self-care. Thirdly, understanding both adult and child perspectives of fever would provide important insights towards realising a more cultural and child-sensitive concept of home-based management of fever in Uganda. A summary of these issues is presented in the problem analysis diagram (see annex 1).

In order to document evidence to verify and support these assumptions, I worked with the following theoretical concepts as anthropological tools of analysis: explanatory models of fever, fever classifications and health seeking behaviour, children's agency, household dynamics of decision-making, gender and power relations.

1.3.2 Literature review

1.3.2.1 A historical overview of malaria management in Uganda

In Uganda, fever/malaria is the lead cause of illness in the population. It accounts for 46% of all childhood illness, 40% of outpatient visits, 25% of hospital admissions, and 15% of inpatient deaths. The age specific morbidity stands at 44.4% among children below 5 years and 41.6% in children above 5 years. On the other hand, child mortality associated with fever/malaria is 42.9% in children below 5 years and 25.1% among children above 5 years of age (MoH 2001a; MoH 2001b: 1-2).

For this study, I studied children between 6-12 years because they constitute a large proportion (22%) of the population in Uganda. Secondly, these children are of school going age (MFPED 2002). In addition, over recent years, civil strife, poverty and HIV/AIDS have weakened the functioning of the family. As a result, in some parts of Uganda many children live on their own without adult care. For example, HIV/AIDS alone has left about 2.3 million children orphaned in Uganda. Thus, many children assume a lot of responsibilities to take of their own needs as well as those of adults at an early age (UBOS 2006; Kakuru 2006; Amuge et al. 2004).

The history of fever/malaria management in Uganda is typical of similar efforts elsewhere in SSA. Upon the collapse of the WHO campaigns to eradicate fever/malaria in the 1950s, eradication efforts subsided by the 1970s. By the early 1980s eradication programmes had virtually ceased due to the economic decline and political turmoil that characterised the country over this period. It is not until 1997
that fever/malaria management regained importance on Uganda’s national agenda and was included in the essential health care package. Also in many years, for the first time a national health policy was developed to provide the framework for fever/malaria control in Uganda (MoH 1999; MoH 2001a).

However, to-date fever/malaria continues to pose a serious challenge to the health of the population. Fever/malaria management activities seem to be less focused on context specific needs of the local people. For example, in a study that assessed public health performance in Uganda, Ann Mckaig, found that of the six priority areas identified for primary health care (PHC) reorientation, communicable disease control, fever/malaria was rated as least adequate compared to immunization and tuberculosis control (Mckaig 1995: 222). Similarly, the more recently adopted concept of HBMF appears to be faced with challenges such as lack of comprehensiveness, cultural sensitivity and appropriateness (Nsabagasani et al. 2007; Nsungwa-Sabiiti et al. 2005).

In sum, despite attempts made to integrate interventions in the PHC system, public health aspects remain weak with the shift in focus from eradication to control of specific diseases e.g. malaria (MoH 2001b; Dunn 2005: 1). Thus, PHC interventions seem not to address what Helman calls “local realities”, i.e. social, cultural and economic aspects that determine the health needs and desires of local communities (Helman 2000: 254).

1.3.2.2 Local classifications of fever and health-seeking behaviours

A few studies have looked at the influence of people’s perceptions on local classifications of fevers and treatment among children in Uganda. In a study done in Kasese, Uganda, Nsungwa-Sabiiti and colleagues (2004) found fever to be a common illness in children that mothers/caregivers easily recognised by feeling the hotness of the body. The study also found that omutsutsa was the widely used emic concept or local term for fever. However, the term was used to describe different illnesses in children, which shared symptom overlaps such as fever combined with cough, diarrhoea, vomiting, abnormal cry, fast breathing and loss of appetite (Nsungwa-Sabiiti et al. 2004: 1193). Following this interpretation, six fevers were classified

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2 Body hotness is a major manifestation of fever, which if it presents in combination with one or more symptoms such as convulsions, vomiting, diarrhoea, loss of appetite among others suggests an infection of malaria (see MoH 2001a).
according to seasons, the perceived nature of symptoms and how they presented, and the response to initial treatment i.e. success or failure. These were: omutsutsa owe miibu (fever of the mosquito), ekyikenyera (chest problem), ekibale (stomach stone), ebironda ebyo muanda (stomach wounds), ekirwere (the disease) and ekikangararo (jerks) (ibid: 1194). The study concluded that local interpretation and classification of fevers were beyond the biomedical concept of malaria.

In terms of health seeking behaviours, people’s perceptions of fevers determined treatment decisions such that separate treatments, including traditional medicines were used. While this study may not be generalised, it points to critical gaps in biomedical interventions e.g. HBMF, that need to be addressed using cultural knowledge to improve public health and fever management (Williams & Jones 2004).

As Gramiccia (1981) argues, malaria is just one element in part of a socio-cultural and economic complex (Gramiccia 1981; cited in Dunn 2005: 3) that influences local understanding of fever.

Elsewhere in SSA, studies of childhood febrile illness have revealed similar interpretations and classifications of fever. A study in Tanzania found that mothers’ perceptions of fever influenced treatment decisions, with no immediate action taken, if ‘it was only ordinary fever’ (Kamat 2006: 2948). Fevers were classified depending on severity as ordinary fever (homa kawaida), strong fever (homa kali), malaria (homa ya malaria), and life threatening childhood convulsive fever (degdege). The study points out that while seeking biomedical help was delayed for all fevers; traditional treatment was used especially for degdege. In short, people’s local knowledge of fever relied on a complexity of contextual factors that in turn influenced their treatment decisions.

A study in Ghana also showed how care-seeking was a complex process that was strongly influenced by local health beliefs (Hill et al. 2003). The study found out that caregivers’ care-seeking actions for children with fever were sequentially decided guided by perceived severity of illness symptoms. Thus, there were differences in the patterns of resort between traditional and biomedical options. Despite the fact that caregivers did not interpret hot body as a danger sign of fever, its local classifications followed biomedical and traditional dichotomies. In this way, some fevers were

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3 Degdege is commonly believed to be caused by a coastal spirit in the form of a bird that casts its shadow on vulnerable children on moon lit nights. Children who come under the bird’s shadow become ill, subsequently develop convulsions, and in many cases, succumb to illness and die.
perceived to be traditional without biomedical equivalents and as such not-for-
hospital. Ascram was a kind of fever caused by personalistic agents. It was believed
that children got ascram if their mother passed behind a house containing herbs
during pregnancy and her breasts or a bad person saw her stomach. Ananosono, was
another fever caused by naturalistic means such as worms, giving maize-based foods
or dirty milk to children. And then, there was esoro illness ascribed to both
personalistic and naturalistic causes such as the shadow of a bird passing over the
child or it had dirt or phlegm (Hill et al. 2003: 670).

In sum, Hill et al. argued that local concepts of childhood fever classifications
and treatments were multifaceted. They represented more complex views that needed
to be explored as part of any care-seeking intervention. No doubt, exploring local
concepts is useful for understanding cultural and social dimensions of illness. As Pool
notes, there is need to be sensitive to indigenous interpretations in order to understand
the metaphoric and symbolic meanings of illness (Pool 2003: 262). Equally, local
concepts constitute what Kleinman & Becker describe as people's explanatory models
of illness (Kleinman & Becker 2000: 470-471). Therefore, health practitioners need to
pay attention to local explanatory models because they provide critical entry points
for delving further into a patient's socio-cultural background. Likewise, practitioners
are able to appreciate a variety of meanings illness may take on within personal and
cultural contexts (ibid: 472). In addition, it is possible to develop effective
interventions because knowledge of context helps to understand factors that influence
health behaviours and actions (Williams & Jones 2004).

In the context of the present study, while these studies may provide useful
emic views of illness, the accounts represent adult perspectives of fever in their
capacities as caregivers. The children's perspectives are consistently missing in spite
of the fact that they, more than anybody else, frequently suffer from fever and related
health effects.

1.3.2.3 Children's agency

In anthropology, the study of children as social actors is a relatively recent
development (Hardman 2001). It was not until 1973 that Charlotte Hardman set the
pace in developing anthropological understanding of society and culture from
children's viewpoint. In her work, "Can there be an Anthropology of Children?"
(1973), Hardman shows that children can, and should be studied as people in their
own right, and not just as receptacles of adult teaching. This is because in childhood there is a self-regulating and autonomous world (Hardman 2001:504). She argues that children have agency as they consciously act upon the world and other people. For example, studying their ideas and actions in the context of illness can reveal an important part of society's stock of beliefs, values and social interactions (Hardman 2001:516).

Thus, understanding children's perspectives and the meanings of their actions is useful in getting new insights of society. Briefly, Hardman's contribution to anthropology leads to a paradigm shift in the study of children. That is a change from representations of children as vulnerable and passive recipients of adult care to active agents or social persons that construct their own views and act meaningfully in the social and cultural world (Christensen 2000; Hardman 2001).

Child agency has since become one of the most central and popular topics especially in medical anthropological studies of society, health, and illness (see Hardman 2001; Christensen 1999; Christensen 2004; Christensen & Prout 2002; Van der Geest 1996; Akello-Ayebare 2003). Using the concept of child agency, Christensen (1999) explains the frequent problem that adults encounter in trying to understand children’ illness from their etic or “outsiders’ perspective”. Adults tend to manipulate the child’s body as an object, which often leads to misinterpretation of health and illness in everyday life. Such creates a communication gap around everyday illness that should not arise if children’s perspectives and practices were carefully looked at and contrasted with those of adults (Christensen 1999: 50).

In a related study that explored the concept of child agency, Christensen & James (2000) further caution that to fully understand children’s social experiences and relative competencies as social actors, these should be contextualised as processes of their physiological and psychological changes (Christensen & James 2000: 176). As a study done in Kenya demonstrates institutions have a lot of influence regarding children’s ability to act in particular ways (Onyango-Ouma et al. 2004). This study revealed how children in a primary school acquired conceptual changes about health and illness following a health education intervention. For example, through their participation in health actions at school, children’s concepts of health and illness were re-organised and transformed over the intervention period (Onyango-Ouma et al. 2004).
However, there are few recent studies of children's agency in the context of health and illness done in the developing countries (Onyango-Ouma et al. 2004; Akello-Ayebare 2003). In addition, these studies were done in formal institutional settings, in this case primary schools. The rest of the studies cited above represent children as social actors in the arena of health and illness largely from the context of developed countries. Therefore, the extent to which children as social actors exercise competence to act upon ill health, in particular fever within a household setting in Uganda is still largely unknown. It is also not clearly known how household dynamics e.g. gender and power relationships, (non-) participation in decision-making influence children's competence to act upon fever in Uganda. In this context, I do present a description of children’s competence to act upon fever at household level (see chapter 3).

1.3.2.4 Household dynamics, gender and power relations

The term ‘household’ is problematic to define because its meaning rather overlaps with that of other concepts like “the family” and “the domestic sphere”. However, a “household” is a term often used to refer to “the basic unit of society involved in production, reproduction, consumption, and socialisation” (Moore 1988: 54; cited in Kakuru 2006: 28). Under this conceptualisation, a household therefore shares a residence and meals, makes co-ordinated decisions, resource allocation and income pooling. In contrast, the family is a social unit based on kinship, marriage, and parenthood (Ellis 2000; cited in Kakuru 2006: 28). In view of the fluid nature of the family in Uganda as earlier on described, I adopted the concept of the household as my unit of analysis because it accommodates all persons whether kin or not who may share residence (Kakuru 2006).

In Uganda, livelihood in the majority of households is derived from subsistence farming i.e. cultivation of crops and rearing of animals mainly for own consumption. The main assets of these households are land, water, livestock, people’s own labour, their knowledge and ownership of productive tools (UBOS 2006; Kakuru 2006). Generally, the poor households involved in subsistence agriculture live below the poverty line because they earn very low incomes and are food insecure.

Gender plays a major role in determining which activities men and women undertake in agriculture and these vary with culture. Men tend to concentrate on cash crop and livestock production while women grow food crops and rear animals mainly
for household consumption. Despite their significant contribution to agriculture, women have less power in deciding about the use of incomes. Men have more power in decision making because they own land and control other production resources (Karuhanga-Beraho 2002). Furthermore, gender inequality at household level is made worse by the fact that women are less literate than men (MFPED 2002). Thus, in addition to the inability to control incomes, women’s low literacy affects their bargaining power by denying them health benefits of better education.

It is against this background of gender inequality and differential power relations that I intended to find out how children’s participation in the different tasks was influenced by their gender and position at household level, on one hand. On the other hand, I wanted to explore how adult perceptions of children with regard to gender and position influenced their ability to engage in self-care and act in a situation of fever. Doris Kakuru’s study in Luwero, central Uganda had useful insights about children’s involvement in household livelihood activities in the context of HIV/AIDS in Uganda (Kakuru 2006). She argued that one of the things poor people did was to increase children’s participation in agricultural tasks and homecare provision. This varied by gender e.g. like adults, children occupied unequal positions with girls socialised to do more tasks than boys. Secondly, while boys were free to work and earn money, girls were confined to household domestic and productive tasks (ibid: 173). This had implications for children’s health since gender; social position and participation in household decision making are important determinants of health seeking behaviour (Williams & Jones 2004). For example, Akello-Ayebare’s study found that children exhibited gender differentiated values in disease management, with boys inclined to masculine values of power and control while girls had feminine attributes of vulnerability, weakness and need of care (Akello-Ayebare 2003: 97). Therefore, in this study, I explored how gender and power relationships at household level influenced the ways in which children experienced and acted upon fever.

1.3.2.5 Children and health seeking behaviour

In Uganda, literature on health seeking behaviour among children is still very scanty. The available studies of health seeking behaviour cited in this review targeted adults i.e. mothers as caregivers of children. A few studies that attempted to study health-seeking behaviour among children in the household focused on orphans in
child-headed households. Even then, the objective was to understand how child-headed household, recognised malaria if it was suspected, and sought care compared to adult-headed households. Amuge and colleagues (2004) did such a study among child and adult-headed households in Rakai, Uganda. The study found that orphaned children in child-headed households had less knowledge on signs and symptoms of malaria compared to adult heads of households.

Although, the study pointed out factors such as distance to source of care, cost of treatment availability of drugs and nature of service delivery as the main determinants of health seeking behaviour, this was based on quantitative assessments of children's knowledge of symptoms of malaria (Amuge et al. 2004: 120). Also, while any child who was present in child-headed households was interviewed, in adult-headed households, the head or spouse was interviewed. In addition, the authors acknowledged that since the study catered for only those children, who were registered by non-government organisations (NGOs) in Rakai, there was a possible selection bias (ibid: 124). Besides, the context of orphaned child-headed households was likely to differently impact on children's health seeking behaviour from other contexts.

In conclusion, as the literature review shows in this chapter, most existing studies on fever/malaria in SSA, Uganda inclusive have tended to address structural issues and constraints that delay appropriate care-seeking by local communities. The chapter has also shown that some studies have but to a small extent, examined people’s beliefs and attitudes about health service providers; albeit from mainly adult perspectives. In addition, it has revealed that a few studies, which have attempted to study health-seeking behaviour within households from a child perspective, have focused on orphans in child-headed households. Yet, they have sought quantitative assessments of children's knowledge of symptoms of fever/malaria. Given those disparities, the research I present in this thesis explored children's health seeking behaviour in relatively “normal” households in rural Uganda. In Chapter two, I present the study methodology and data collection techniques. I also describe rural livelihood strategies, ethical considerations, the limitations of the study and personal reflections.
Chapter 2: Methodology: fieldwork and data collection techniques

2.1 Study type and design

The fieldwork was conducted in a rural village community in Busia district, eastern Uganda over a period of four weeks starting from June 4th to July 4th 2007. Given resource and time constraints, I carried out a small-scale study based on an exploratory-ethnographic design (see Hardon et al. 2001). For technical reasons, I could not begin conducting fieldwork straightway from the time I arrived back home in late May 2007. I had to adjust my study plans following certain administrative changes in the district. Some of the key technical personnel in district local governments had been transferred\(^4\). Meanwhile, I decided to use that time to do participant observation and a review of official documents for secondary data. The secondary data sources I reviewed included: the district local government three-year development plan, annual health workplans and reports, the district state of environment report, and HBMF activity implementation reports. I did a thematic content analysis of these sources of secondary data in order to understand how the wider socio-cultural, economic, and political-historical contexts impact on the health of local communities in general and fever management at the household level, in particular.

During the field data collection exercises, I used a combination of five different qualitative study techniques namely: ethnographic conversations (informal interviews), participant observation, ethnographic focus group discussions (FGDs) and in-depth interviews. These techniques enabled me to ask questions, listen, watch and interpret the different accounts of particularly children’s experiences of fever in everyday life. As I shall show later, the triangulation of these different techniques of data collection enhanced the validation of the study (Green & Thorogood 2004: 147).

For the interviews, I conducted two Focus Group Discussions (FGDs) with children within the age range of between six and twelve years. One group comprised of thirteen children while the other had up to seventeen child participants. Contrary to my earlier plans to hold smaller and separate discussions for boys and girls, the groups were bigger and mixed. I could neither separate the groups nor restrict the

\(^4\) Following an amendment of parliament, the authority to appoint and transfer district chief executives: Chief Administrative Officers (CAOs) that had hitherto been the responsibility of district local governments reverted back to central government. Hence, the countrywide transfers.
number of participants since the venue was open to many children i.e. a school playground with a hand pump borehole nearby. Thus, it was easy to have both boys and girls participate in the discussions.

In addition, I held one FGD with parents/caretakers to give them feedback concerning children’s views about fever. The parents/caretakers’ reactions and issues raised were used to support my analysis, interpretation and discussion of findings. All discussions were conducted using topic guides, taped and transcribed.

After the group discussions, I conducted ethnographic conversations for in-depth interviews with six purposively selected children (3 boys and 3 girls). I selected these children on the basis of their active participation in the group discussions. In order to gain a deeper understanding of certain topics or issues that came up during FGDs and individual interviews, I followed these children at different points in time, and in a couple of settings. The purpose of varying the settings with individual children was to compare the reliability of the answers given to me. The settings included at households, playground, school and health unit. The interviews with children were kept short, lasting about fifteen minutes on average per child. Additionally, I had discussions with parents of some of the children during home visits to do observations. On two occasions, I visited the referral health unit at Masafu Health Sub-District (HSD) to conduct observational exercises as well. Further still, I held in-depth interviews with the following categories of informants: a Community Drug Distributor (CDD), Public Health officer, Clinical Officer, member of the Local Council one executive/local leader and an opinion leader/elder. All interview informants were assured of their confidentiality and their identities kept anonymous.

2.2 Study site and setting

The fieldwork site for this study was a small rural village community called Buduli. I purposely selected this village for different considerations. My most immediate consideration was the limited time I had to carry out the fieldwork. Other important considerations had to do common socio-cultural aspects that I shared with the study community. With specific reference to the later issue, I would therefore say that I was no complete stranger to the local people. The reason is because I have lived and grown up in this village as a child and for a greater my youthful life. Among the
most important socio-cultural aspects I considered very critical for my study was the ability to speak the language.

Although the exact meaning of the word Buduli remains elusive to many people I talked to, one of my informants, an elder and opinion leader, probably in his late 80s, said the name was coined from another word, Obudu-nduli. From his description, Obudu-nduli is a metonym referring to charming things [people]. According to him, Badu-nduli [people] later shortened to read Buduli by colonial authorities, was home to charming and nice people. He explained that:

The people were healthy, of good physical build, living in clean homes and had good morals. We were known to be peaceful, full of hospitality and to exercise a strong communal spirit of helping one another. These days, you don’t see that anymore; people are living in poor health, the homes are dirty, they are selfish and don’t respect each other.

Whereas, I find it difficult to generalise the above observation due to differences in circumstances of individual households, there were some common aspects that reflected that reality, and in support of the views expressed by my informant. During participant observation I noticed that there were a number of households that had characteristics of inadequate hygiene and environmental sanitation. Generally, such households or homes were dirty. Some lacked “basic” hygiene and sanitation facilities like pit latrines, and garbage pits necessary for ensuring environmental cleanliness.

Another challenge to keeping environmental cleanliness arose from the fact that people carried out farming activities around their homes. I found gardens of cereals: maize, millet and sorghum growing next to houses (See annex 2). A few other homes had water trapped in pits or containers for making bricks. The parents told me that the proximity of gardens next to their homes was intended to keep off vermins from destroying crops, monkeys in particular. The other reasons were lack of access to bigger acreage due to shortage of land; to scare off thieves from stealing crops e.g. maize and to increase household incomes. Certainly, all these reasons are very rational in the context of everyday life situations. For example, for many households, those are the only viable strategies for ensuring food security as well as improving incomes for economic well being (see section 2.3 for a detailed discussion of rural livelihoods).
However, such activities create additional breeding and hiding places for mosquitoes, resulting into easy transmission of malaria. In short, it is important to appreciate some of the harsh realities of everyday life struggles poor people go through in the rural country side in order to eke a living. Such was the case in the study community, no matter whether the local people were left with little choice to engage into health promoting practices. As Heggenhougen et al (2003: 149-150) argue:

Smaller-scale activities by poor people place them at increased risk when they try, in various ways, to improve their economic situation. The precarious circumstances make it difficult for them to prioritise health, or prevention of malaria, if this is seen to jeopardise income (and food for the family) or be costly in time or money.

Buduli is located some 215-km to the South East of Kampala, the present capital city of Uganda in Eastern Africa. It is one of the twenty village councils (LC1) in Butangasi parish. Butangasi parish is part of the three administrative areas that constitute the lower local government of Masaba sub-county in Busia district. The other two are Masaba and Mbehenyi parishes. In addition to the reasons earlier given, for this study, I was interested in studying children in a rural setting where fever is highly prevalent (cf. MoH 2001a). I also chose to live at my home within the community in order to minimise living and travel costs that I would have incurred had I done my fieldwork elsewhere in Uganda. More important, was that I was familiar with most of the local people living within the village community. Therefore, gaining access through the various gatekeepers (local political and religious leaders, teachers, parents and caretakers) as well as securing children’s willingness to participate in the study was not a big problem. Moreover, while it is always difficult for an adult to work with children, I enjoyed the advantage of being at home. Being indigenous and fluent in the local language (lusamia-lugwe) was a huge asset, which I tactfully exploited to minimise communication difficulties with my informants.

For some children, much as I was an ‘insider,’ I remained an ‘outsider’ in certain respects. For example, to them, I was an adult, an elite living and working in the capital city, besides being in school abroad. However, speaking to them in lusamia-lugwe and engaging in role taking such as fetching water and particularly

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5 The LC1 is the smallest political-administrative unit of local governance in the rural areas under the present system of decentralization in Uganda. Its equivalent in the urban context is called a cell. A number of these cells depending on the population form the lower local government called a parish.
doing ‘homework’ together made it possible to minimise the social distance between us. In short, we enjoyed mutual trust and had meaningful interactions through ethnographic conversations or dialogue. As Crotty (1998: 75) writes, “only through dialogue can one become aware of the perceptions, feelings and attitudes of others and interpret their meanings and intent”. Therefore, I used dialogue as a tool to contextualise and interpret children’s perspective of fever.

One important infrastructure in the village is the grade seven primary school. The primary school is located ideally in the centre of the village community. Because it is a symbol of extension of social services to this community by the government, the school is known by the name of village: Buduli P.7 Primary School. As part of fieldwork preparations, I visited this school a couple of times to do participant observation. I also made visits with the hope of establishing contact with some of the children for group discussions. These initial efforts still paid off in some ways although I could still not hold group discussions with children. The school provided the only recreation facility for children in the village i.e. the playground. Secondly, it had the only source of safe drinking water for the households; a hand pump borehole sunk right in front yard of the classroom blocks. During observations, I noted that while both boys and girls fetched water from this borehole, a role traditionally known to be for females; the children used different styles to carry water containers (i.e. plastic jerrycans). While the girls carried the jerrycans on their heads, most boys used bicycles to ferry water.

Except for some of its incomplete structures i.e. classroom blocks, I learnt from a parent that the school accommodates well over five hundred pupils. However, I established quite an interesting dimension about the use of one of the classrooms. On Sundays, a classroom labelled ‘P.4 B’ would be turned into a hall for church service. A visiting Assistant to the parish priest [catechist] came to conduct prayers for the predominantly catholic village community of Buduli. A few years ago, the only structure that stood on the present school compound was a dilapidated grass thatched mud and wattle building in form of a church. Catholics (myself included) used to attend Sunday service in it. But this time I found it was no more. A fellow Christian, a young man who lived nearby the school said the church had collapsed during the heavy rains earlier in the year. ‘Since then, the school authorities allowed us to use one of the rooms,’ he said.
The village is served by a poorly maintained community access road, which joins the trunk road at Mairo Munane, a rural township to the south in Butangasi. Mairo Munane, which is the local translation for eight miles, refers to the trading centre located eight miles from Busia town along the Busia-Majanji trunk road. The community access road also rejoins the trunk road to the east at Masafu county headquarters. To the west it links the village to another trunk road in Makunda village, the home of the administrative headquarters of Masaba sub-county, from where it continues westward into Bugiri district.

Masaba sub-county is one of the nine sub-counties of Busia district. The others include Buhehe, Bulumbi, Buteba, Dabani, Lumino, Luyo, Masafu, and Busia Town council. Busia district was originally part of Tororo district, then known as Samia Bugwe County. The county was first elevated to full district status in 1976, only to be lowered to a Sub-district status after the fall of Idi Amin in 1979. However, it regained district status in July 1997. One negative effect of this seemingly unpredictable political-historical context was failure by the interim administrations to plan and develop social services infrastructure. In particular, the ever-shifting political decisions negatively impacted the health sector (see a detailed account in chapter 3).

Busia district is located in the south-eastern part of the Republic of Uganda. The district borders the Lake Victoria to the south and the Republic of Kenya to the west. Other borders include Tororo district to the north and Bugiri to the west. The district lies approximately between longitudes 33° 5' East; 34° 1' East and latitudes 0° 10 North; 0° 35' North, and extends further south into Lake Victoria. The present boundaries cover a total area of 743 sq. km (BDLG 2007). Busia town is a major exist and entry point for both human and commercial traffic between Uganda and the republic of Kenya (see Annex: 3 for maps 1 and 2 showing the location of Busia in Uganda and Masaba sub-county respectively).

In 2002, the district had a total population of 255,008 composed of 107,799 males (47.9 percent) and 117,209 females (52.09 percent) with an annual growth rate of 2.7 percent and a total fertility rate of 7.1 births per woman. The major ethnic groups are the Samia, Bagwe, Iteso, Basoga, Bagisu and Karimojong (MFPED 2002). However, as of December 2006, the total population of the village community of Buduli was one thousand thirteen (1013) people. Of these, fifty-two (5.1 percent) were children under five years of age. Three hundred thirty-two (32.8 percent) were
children aged between five and thirteen years, while two hundred twenty-six (22.3 percent) were children aged between thirteen and seventeen years. The rest; four hundred three (39.8 percent) were adults. Altogether, this population lived in about two hundred and fifteen households (Source: Buduli LC 1).

2.3 Rural livelihood strategies

For the majority of the population (85%) living in rural Busia, subsistence agriculture is their source of livelihood. That is to say, it is the main source of both household food and income. A few households combine subsistence farming with other livelihood strategies involving off-farm activities: fishing, petty trading, brick making, stone quarrying sand mining, charcoal burning, sell of firewood and casual labour (BDLG 2007). The main crops grown are sorghum, millet, maize, cotton, cassava, sweet potatoes, and beans. Because the subsistence cultivators use hand implements namely the hand-hole and panga coupled with the fact that the farming is rain fed, the yields are generally very low. From the consultations carried out with key informants in the district, I established that on average annual household incomes earned in two farming seasons ranged between 50,000 and 80,000 Uganda shillings [50 US dollars]. Some of the informants said that despite interventions by the central government to increase population access to social services e.g. primary education and health, the local government had not been steadfast in addressing the issue of household incomes. Consequently, the poverty situation in the local communities had been worsening due to lack of livestock and valuable and stable cash crops.

Yet, another interesting gender dimension, which ironically gave me deeper understanding of the rural livelihoods’ strategies in rural Busia is that it was mostly women and children that did the farming activities. These were combined with different household chores such as preparing food, fetching water, looking for firewood and tending young children. For a good number of men, other than working on household farms (mainly during the early hours of the day), they spend much of the daytime looking for, and doing casual work to earn money or remained unemployed altogether (BDLG 2002). Unfortunately, women have a high illiteracy rate (58.9%)-thus they can not adequately adopt better and improved technologies, particularly for farming resulting into a vicious cycle of poverty.

However, this phenomenon is not unique to Busia district alone. It is an important characteristic of rural livelihoods for most local communities in different
parts of the country (UBOS 2006). Ironically, it is the men that traditionally own and control productive resources i.e. land and livestock. While women often have access to productive resources i.e. land, on the contrary, they hardly own the yield, and neither do they control incomes from such outputs (cf. Karuhanga-Beraho 2002; MFPED 2002). In general, some of the main factors that affect rural household incomes in Busia district are:

- Low production and productivity
- Low farm input by especially the youth and men
- A high dependence ratio because of a large household size (e.g. 7 persons).

Although the pattern of rural livelihoods as described above affects different categories of people differently in the district, it was interesting to understand how such an unfavourable socio-economic context affected health issues in the household from the children’s perspective (see chapter 3 for a detailed description).

2.4 Getting started

It is Sunday June 4th; I wake up to the sounds of the church bell, calling Christians for the nine o’clock mass. The morning is cool and dry despite the previous day’s afternoon downpour. I quickly prepare and stroll to the school, half a kilometre away through a bushy community access road now turned-footpath. There is no one else in the way up to school, indicating that I am rather late. Nevertheless, I find people just settling in, in one of the classrooms. ‘We are happy to see you,’ says the catechist. This is my first visit to the “church” in ten months after a long absence from the village.

The ‘church’ setting was quite revealing in its representation of some of what I describe as the persistent social values and cultural practices of the people in this village community. I will pick one striking example that I observed. That is the sitting style in the ‘church’. On the right side, the boys and men took seats on wooden benches. Although there were some empty benches, the girls and women sat down to left either on mats or pieces of cloth for wrappers, that they had carried along with them from their homes. Amidst lots of small discussions that were going on, I exchanged glances and smiles with the people that I knew. Without interruption, I took a seat on the bench right next to me to right. Moments later, the congregation went silent as mass got underway. I later found out that it was not culturally appropriate for women to take raised seats above the ground. However, I also found it to be something symbolic of the social
position of males in this (my) community. Social relations between males and females have traditionally been regulated by patriarchal ideologies, such that men enjoy superior social positions than women. Thus, the sitting style is a reflection of cultural ideals that perpetuate patriarchy even up to the present times. Patriarchy, among other things tilts gender-power relations in the favour of men as figures of authority and in their roles as husbands and elders of the community. As for the boys, they are socialised to internalise the gender imbalance of power in favour of their future roles as husbands, albeit even in domains outside the household (cf. Kilbride & Kilbride 1990).

Overall, the mass went well with only occasional noises from crying babies and murmuring of one father and his son who happened to share the same bench with me. I tried making sense out of their talk but the voices were so soft for me to comprehend. Towards, the end of mass, the catechist thanked everyone for coming, adding that, "as we come close to the end of the service, I want to make some announcements". He sent a reminder to the representatives of the church council to encourage Christians to fulfil their pledges towards construction of a new church. He then expressed happiness to see one of his sons [myself], inviting me to greet the Christians and share any good news. I obliged, came forward, and shook hands with him, then with a few other Christians. As I started to recount my story about school in a foreign country, one boy exclaimed, "How can big [old] people like you go to school"! I replied, 'yes, it is true, I have been to school to learn new things to serve people better'. Although anxious, I realised then, that that was the moment I needed to make meaningful contact with the children. So, immediately I thought of a plan, and told about the thirty children gathered in the congregation that my teachers had infact given me 'homework' (i.e. take home assignment) for which I needed their help in a meeting. The children looked at each and smiled, which signalled willingness to help.

A couple of minutes later, the catechist wished us well and left. Thereafter, the parents also started to walk away in small groups. Some of parents asked the children to listen so that they would later get the full story from them while back at home. I asked those children who wanted to go home to leave. The young children and some girls left, saying they had work to do at home. In the end, there were thirteen children (eight boys and five girls) left for our meeting. Because it was becoming hot, we chose to sit under the tree shade near the playground. Ideally, I had been granted 'informed' consent by the parents but I told the children that should anybody want to leave anytime, they were free
to go because participation was voluntary. However, I was so pleasantly surprised that all the thirteen stayed. Before I could introduce the topic of the ‘homework,’ they demanded that we start. Careful not to lose their focus, I immediately introduced the objective of the ‘homework’ and requested for volunteers to facilitate the discussions. I explained I was going to take notes, meaning I needed time listen attentively and write as well. Two boys, Waf and Didi (not real names) came up. I briefed them about the topic list and the discussions kicked off. Meantime, I stayed in the background from where I assumed another of steering the discussion without giving personal judgements. After discussing the last topic, almost an hour since we had started, the children said the ‘homework’ was tough but they enjoyed it. They promised me they would tell their parents and friends about the homework. I thanked all of them for their patience and kind offer to assist me the ‘homework,’ I said, ‘I am so grateful for your beautiful answers’. Because I needed another group discussion later that same Sunday afternoon, I asked the children how best I could reach their friends whom I did not meet during church service. Again, I was quite happy to see the two facilitators volunteer to mobilise others for the next discussion. We agreed to meet in the same venue. But before they could leave, I gave each of them a token of a piece of washing soap that I bought at one of the homes in the school neighbourhood. As we dispersed, I walked home in the company of two children (boy and girl) who took the same direction with me. We continued our conversations following up on the issues from the group discussion until they branched off to their homes.

Much later in the afternoon, at about 4 O’clock, my friend Didi came running to my house saying another group of children had already assembled at our meeting place. I gave him a lift on my father’s bike to the school. This time they were nineteen children (eleven boys and eight girls), including my two mobilizers. After introducing the discussion and ourselves, I asked my good friends Didi and Waf to stay or leave whatever they felt like doing. But to my pleasant surprise, they chose to stay. I was happy with them because their presence made the rest participate in the discussions more confidently. Like with the first group, we had quite smooth but informative discussions, this time lasting longer, one and half-hours. The children in this group too received a

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6 I got to know the assistant to the parish priest some years back when he worked as my religious instructor (catechist) for baptism preparatory teachings.

7 Schools had just resumed for the second term in the year. I had to be sensitive not to interrupt children’s schooling activities hence the reason I decided to conduct group discussions with children on the same day, Sunday.
piece of washing soap, although Waf and Didi got an additional piece in appreciation of
their role as mobilizers who put together the second group.

I decided to conduct discussions of mixed sex because the children knew one
another so well. They were acquaintances either from school, the village borehole or
simply as playmates—thus, they easily interacted even in the mixed group situation.
Specifically, they answered the questions put to them without difficulty; including asking
me certain issues about health they did not know. I was particularly amazed by the fact
that children told me they would want to know the result of the ‘homework’. This
particular demand by the children awakened my experience to the reality that:

There are methodological and epistemological advances to be gained from
adopting a perspective in which children are regarded as competent social
actors who can inform the research process of their own views (Christensen &

In response to their call, I promised the children that I would definitely inform
them about the result when I return home after school later in the year. In fact I am
looking forward to meeting them during the September school holidays to share the
outcome of the joint ‘homework’. In general, I found the group discussions very useful
in exploring children’s ideas and concepts of fever, its meanings, their feelings about it,
including its perceived causes, transmission, treatment and prevention. The idea of doing
‘homework’ together helped so much in the rapport building process with the children. I
was able to establish relationships based on mutual trust with the children because of
they took the ‘homework’ as a joint project. In this way, I had no difficulty taking notes
neither using a tape recorder with them. From this experience I learnt that as a
researcher, to collect meaningful data you need to be honest with your informants no
matter whether you are an insider or outsider. I also learnt that children can and in fact
do sympathise with adults if they are treated with respect. As Christensen (1998: 190)
observer:

In everyday interactions both children and adults observe situations and
contexts where adults exhibit incompetence and children act competently
and skilfully. This again leaves scope for interactions and negotiations which
may obliterate or demarcate the accepted categorical positions.
2.5 Data management and analysis

At the end of each day, I manually edited all data collected to ensure completeness and clarity. During the process of conducting focus groups discussions and interviews with key informants, the discussions were recorded verbatim, transcribed and continuously analysed, on one hand. On the other hand, the discussions were concurrently summarised and analysed while field notes were analysed and interpreted respectively. Thereafter, all data were coded for relevant themes and sub-themes developed in relation to the study questions. Lastly, I identified, analysed and interpreted the general trends and patterns across all the texts as presented in this thesis.

2.6 Ethical considerations

In order to safeguard the informants against possible harm, I had to meet some basic requirements. Before the fieldwork started, I obtained permission from the district local government administration and from the directorate of health services (DHS) Busia. I also obtained permission from the political leaders in village community i.e. the chairperson of the village council (LC 1). Thereafter, I sought the informed (verbal) consent of parents/caretakers as the heads of households and from the children themselves. In addition, I assured all my informants of keeping their confidentiality as well as anonymity at all times. I ensured that each of the informants, particularly children were free to voluntarily participate in the study. I respected their choices not to answer any questions, in case they felt uncomfortable about them for one reason or another.

2.7 Limitations of the study and reflections

The data collection exercises for this exploratory ethnographic took 4 weeks. This was relatively very short period considering the huge research task at hand. In fact, I realised in due course that my research question was quite ambitious. I found it particularly very demanding to use a child-focused research methodology within such a short time. However, I overcame some of the difficulties through the use of a combination of different data collection techniques. Focus group discussions and conversations with individual children were so helpful to exploring and understanding their experiences of fever. Although the social world of children is complicated to understand from an adult perspective, these techniques proved to be so useful for
sharing in the children’s stories. Through such stories, I got deeper insights into understanding children’s experiences and perceptions of fever, on one hand. On the other hand, it was possible draw close to what was at stake for them. That is, understanding their physical and social (and emotional) feelings of fever both at personal and socio-cultural levels of everyday life (Kleinman & Becker 2000: 472).

Gaining access to the children was equally challenging to me due the different social layers that surround children’s everyday life. For example, much as I had met many children in various places within the village community and taken on roles e.g. fetching water; my activities of gathering data remained limited to participant observation. It was not until after the Sunday mass and upon the invitation of the priest that I had the opportunity to present myself to the local community. It is here that I also obtained the ‘informed’ verbal consent of the parents and secured the willingness of children to participate in the study. Even then, real contact in terms of discussions and conversations only happened when I used the innovative idea doing joint ‘homework’ with the assistance of the children that I was able to talk to them. Despite the difficulty involved in unequal power relations between adults and children, I was tried to minimise that through exchange of roles with the children. For example, I became the learner and they were the facilitators, thereby handing over some control to them. Another challenge arose from the fact while I was in ‘insider,’ in reality I remained an ‘outsider’ in some ways. For example, I could not distance myself from the fact that I am adult, who is elite, employed in the city and then turned student. It was difficult to totally escape from this reality on my part as well as for the children to completely internalise it. However, I constantly reflected on my position and roles all through my interactions with the children.

Last but not least, due to time constraints, it was very challenging to do complete participant observation in order to fully understand the influence different social realities had on children’s ideas of fever. Participant observation requires considerable time to live with the community in order to understand how their social reality is influenced by the social structure, and socio-cultural beliefs and values (Green & Thorogood 2004: 135). However, I tried to overcome the time constraint by following and talking to the children in varying social contexts e.g at household, school and health centre, so as to establish how these shaped their perspectives of fever. Therefore, through varying the contexts of study about children’s perspectives, I was able to validate my study findings.
2.8 Layout of the thesis

The thesis is comprised of five chapters. Chapter one presents the general introduction to (and motivation of) the study, background and statement of the problem, theoretical approach and literature review. Chapter two is the methodology: fieldwork, data collection and management techniques. It also describes rural livelihood strategies, ethical considerations, limitations of the study and reflections. Chapter three, I describe the concept of children’s perspectives of fever: life and tasks in a day: a child’s view, the meaning of fever, children’s perceptions about causes and transmission of fever. I also describe the sources of information about fever and children’s actions upon fever. In chapter four, I describe fever management in the district in relation to service delivery for children with fever. I also describe the concept of home-based management of fever, the challenges and lessons learnt in its implementation. Chapter five presents summaries and conclusions of the study.
Chapter 3: Children’s perspectives of fever

3.1 Life and tasks in a day: a child’s view

In order to assess and understand the influence of gender and power relations on children’s position(s) in the household, I asked children to describe life in terms of the different tasks they performed on a typical day. In this context, together with the children, we decided on a Saturday to represent a typical day in their life. The reason was because they didn’t have to attend school on that day, it was taken that they spend most of their time in the household. In general, both boys and girls mentioned the various tasks and things they did at household level on a Saturday. These include: washing of utensils, preparation and cooking of food, fetching water and collecting firewood; sweeping the house and yard, and caring for young siblings. Children also mentioned other task they did as tethering of livestock, running errands, playing and selling of food stuffs.

However, in order to analyse and understand the gender division of labour between boys and girls within the household, I purposively selected two children: a boy and a girl. They were 10 and 9 years old respectively. Although the children were from slightly different social background, their situations were fairly comparable in two major aspects. First, each child came from a household lived s/he lives with other siblings. Secondly, regarding the main means of livelihood, both household were engaged in subsistence cultivation. Therefore, detailed data about life and tasks in a day from a child’s view were collected from Getu and Tom⁵ (not real names) in the form of typical story narratives.

Getu’s story:

At home on a Saturday, after waking up and washing my face, the first thing I do is to go to dig. From digging, I sweep the house and sometimes the yard. I then have to fetch water, and pick firewood in case there isn’t any left from the previous evening’s cooking. I will also grind the millet if there is no flour in the house. I then wash plates. When everything is finished, I assist my mother with cooking food and then we have lunch. After lunch, I have to keep the baby because my mother has to go to the market every Saturday. So I will play with the baby until she returns in the evening and we prepare dinner together. My big sister (Nina) used to

⁵ All names used here are pseudonyms for purposes of ensuring confidentiality and guaranteeing anonymity of the informants.
do the same things before she went to stay with our grandmother. Our grandmother is ill, so Nina takes care of her. But my brother I come after lives at home. Like me he goes to dig in the morning but after lunch he does nothing. So he goes to play with his friends for the rest of the day.

**Tom’s story:**
For me, usually on Saturday, I go to dig in the morning. When I come from garden I tether our one cow and two goats. I also like seeing clean things, so sometimes I sweep the yard. But when I want to help my sisters, say to wash plates, my mother stops me. She says, ‘it is not good for the boy child to do that’. A lot of times, she has also stopped me from fetching water and picking firewood. My work then is to see that the cow and goats graze well. So I check on them and wait for the lunch meal. After lunch, I am free to go and play. I only return in the evening to bring the animals back home and eat dinner. That is how the day ends.

The analysis of these two stories revealed that there were gender differences in the allocation of tasks by sex to the children within the households. When I asked the children who decided on which tasks they should do. They said, their mothers took the decisions as well as allocated the tasks to them. On the other hand, they said their fathers didn’t stay at home most of the time, especially on Saturdays. It was established that although the children didn’t know what their fathers exactly did, they were said to spend most of the day in the market, just like Getu’s mother did. On the whole, it was noted that children had different social experiences of life. For example, the girl child performed more tasks than the boy child did. She also had little social space to decide on what tasks to do, including time to play and interact with other children outside the household. Getu’s story also highlights the fact that the girl child didn’t only contribute to the performance of tasks in the parental household, but would aslo be involved in households of close kin if need arose. For example, her sister Nina was staying and looking after their sick grandmother. This finding is consistent with conclusions made by other studies about the functioning of the family as a social structure in some parts of Uganda (UBOS 2006; Kakuru 2006; Amuge et al. 2004). These studies have shown that many children assume alot of responsibilities to take care of their own needs as well as those of adults at an early age due to weak social structures.

Because the boy child did fewer tasks and was also allowed the social space to decide on some of the things to do, he had time to himself and could engage into other
social activities away from household e.g. playing. However, it can be argued that this was possible because the mother’s act of stopping the boy child from doing certain tasks perceived not to be culturally appropriate for him to do. Therefore, by so doing, it can be noted that the mother (un-)consciously contributed to the perpetuation of gender inequalities among in the household. As earlier hinted, the gendered division of labour in the household in favour of the boy child constituted an example of socio-cultural practices that have persisted over time (cf. Kilbride & Kilbride 1990). For example, in this regard Kakuru (2006) has argued that the gendered nature of household division of labour in patriarchial settings like Uganda is not new. In her study of gender inequality in education in Luwero, Uganda, she also found out that girls did a multiplicity of domestic chores. However, she concluded that the roles didn’t only subject girls to tardiness but also to their absenteeism from school more than boys (Kakuru 2006: 68).

In sum, the children’s stories about life and tasks in a day depict a village community organised around cultural ideals of a patriarchial and patrilineal system. In this system boys are socialised to internalise gender and power imbalances in their favour as future husbands and figures of authority in society (Kakuru 2006; Kilbride & Kilbride 1990). In the context of the present study, gender and power imbalances were not only seen in the things children did i.e. household tasks but were also found to have a significant impact on children’s health seeking behaviour in the household (as I shall show later). In the next section, I present children’s ideas about the meaning of fever.

3.2 The meaning of fever

_The violent wind_

As earlier stated, the main objective of this study was to understand how children’s perceptions and experiences of fever influenced health-seeking behaviour within the household. In order to achieve this objective, I asked children during group discussions and individual level interviews, how they described fever using local names and terms. For a start, in the group discussion, the children had little debates among themselves until one girl stated that the local name for fever was, ‘omuyaaka’. However, one of the boys gave another name, calling fever, ‘omusujja’. But the rest
of the children said that the word ‘omusujja’ was from another language i.e. Luganda\(^9\), and not their local dialect i.e. Lusamia-lugwe-thus it had a different meaning. The children clarified that even though some people within the local community used the word ‘omusujja’, it had different meanings and purposes of usage. That is to say, the use of the word ‘omusujja’ depended on context and particularly what the users intended to communicate. Otherwise, the common name for fever was that stated by the girl i.e. ‘omuyaaka.’ Therefore, they clarified that the word ‘omusujja’ was sometimes used as a name of a certain type of fever, which caused shaking or shivering of the body in an uncontrollable manner. The children further clarified that such an experience was locally termed as okhwesuchasucha, obulwaye bya’magitta oba amadendeme (i.e. one’s body rapidly trembled with fingers folding in-and-out, and shoulders shaking involuntarily).

Furthermore, the children stated that people in the local community ironically often used the same word, ‘omusujja’ in the form of abuse. For example, the word was used to describe unexpected behaviour such as a person appearing confused and doing silly things. Indeed, during one of the group discussions a child described the other as having ‘omusujja’. The girl said, ‘bona owomussujaa wuno’ (i.e. look at this confused person). Although the friend protested, she insisted by saying, ‘tussekho omusujja kwawo’ (take away your silly behaviour from me). The rest of the children laughed. Because I seemed puzzled, the children explained to me that the girl had meant to ridicule the friend because he disturbing her and causing distraction during the ‘homework’. Clearly, from the children’s explanations, I was alerted to an experience of differences in the socio-cultural backgrounds of the children. Specifically, I was alerted to how such differences influenced the meanings of certain words and names that people use in everyday life. For example, during a conversation with one of the boys, I established that one of the parents of the boy who had called fever ‘omusujja’ was from the Ganda ethnic group. The point I would like to emphasise here is that through dialogue with the children, it was possible to establish how socio-cultural differences influenced the children’s meaning(s) of fever. I also established that fever as a concept was very complex to analyse. Therefore, to understand its use I had to pay critical attention to the specific contexts in which its indigenous conceptions and interpretations were made. As Pool notes, such

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\(^9\) Luganda is the local dialect of the Bantu ethnic group called Baganda from central Uganda.
conceptions and interpretations often attract much wider metaphoric and symbolic meanings than could be noticed while studying them from the etic perspective of an ‘outsider’ (see Pool 2003: 262). Thus, I had to be more careful not to take the children’s use of names and terms for granted. Instead, I had to cross check the meanings and interpretations of fever as described by the children within their specific socio-cultural context. Further, as Winch et al (1996) cautions, ‘local illness’ terms are in constant flux, so that [cultural] ‘rules’ that make sense now might be entirely inappropriate later (Winch et al. 1996: 1065; cited in Heggenhougen et al. 2003: 39).

From such a perspective, we went on to discuss the different meaning(s) and interpretations of the local term, omuyaaka. According to the children, the term literally translated for a “violent wind”. When I asked in what ways the violent wind was related to fever, the children explained that, both often resulted into experiences of trouble for people. It was also revealed that just like the violent wind destroys people’s things [property], fever diminishes a person’s energy to work and do things i.e. the ability to carry out social roles and to participate in social activities and interactions. For example, the children explained that because fever was a common illness they often suffered from, it was possible to tell a child with it. It was then stated that if a child had fever, then s/he felt weak, liked sleeping most of the time, failed to play, didn’t like bathing, lost appetite and skipped school. In addition, the child didn’t perform normal household tasks such as cooking, fetching water, gathering firewood, washing plates, tethering cows and goats, and cleaning the house or yard et cetera. However, I noticed that there were implied gender differences in the things the children said that they were unable to do due to experiences of having fever. The girls’ concerns were about things that were more closely related to the performance of traditionally prescribed feminine roles e.g. cooking, fetching water, and cleaning the house. To the contrary, the boys were more concerned about those things that reflected masculine roles. These include tethering cows and goats, failing to play, and skipping school. Thus, it can be noted the children’s ideas about the failure to perform social roles due to fever mirrored the different ways, in which boys and girls were socialized in the study community (see Kakuru 2006).

Furthermore, the children gave another comparison between wind and fever by stating that both made the body to become dry and pale. These features, i.e. dry and pale were described by the children as unpleasant feelings. One boy specifically
observed that, ‘if you have fever, the body feels very hot and weak as though it has been boiling in hot sun or fire’ (i.e. noba no ’muyaaka, omubiiri khuyu kakaaka handi khunafuwa ngo ’khutula mumubasu khwakakaaka oba mumuliro). Based on these descriptions, it can be noted that children used the wind as a metaphor of illness (see Helman 2000: 88-90). From children’s’ own emic descriptions, fever was vividly portrayed as a common illness, which they were often confronted with in everyday life. In short, I found out that as an illness, fever was a frequent experience for which children had vital skills to enable them self diagnose. That is to say, they were able to detect fever through immediate experiences of changes in body states such as pain or discomfort (cf. Crotty 1998). However, given the various emic descriptions and interpretations of fever by the children, there was need to understand its wider meanings.

**Wider meanings**

Within such a context of the meaning(s) and interpretation of fever, I asked the children in what ways the word *omuyaaka* was used as a local term for fever in everyday life. From the descriptions that children gave, the word was used in a variety of ways to refer to different feelings of pain or discomfort. The analysis of the descriptions also revealed that the word *omuyaaka* was used in a much broader sense to describe various types of fever(s)-emiyaaka (plural form). More importantly, the children identified and classified fever(s) through the use of specific idioms of distress (see Kleinman & Becker 2000). Kleinman & Becker define the concept of idioms of distress to mean the use of specific symptoms to express emotional and somatic (i.e. body) experiences of illness. They also note that since symptoms are culturally mediated as specific responses to illness, then individuals are socialized to attend to and interpret experience in locally meaningful ways (*ibid*: 465). Following this conception, the terms children used to express social and personal experiences of fever were summarized and analysed. The findings are presented in the in the matrix below:
The synthesis of the above findings revealed that there was no single definition but several definitions of fever. In other words, there were varied types of fever presenting with various symptoms. Secondly, however, there were symptom overlaps among the fevers. As one boy explained, “usually, when I have stomach-aches, I get diarrhoea as well. I also get a cold and cough, many things at a time”. As this example clearly shows, quite often children suffered from the different fevers concurrently. This particular observation prompted me to ask how the children perceived the ‘fever of mosquito’ since they seemed unaware of any distinct symptoms. From their own viewpoint, children expressed little understanding about the fever. For instance, hardly any child could clearly recall having specific experiences with this particular fever. However, the few children that mentioned the fever, and hence had some ideas said that they had only learnt about it from school.

<table>
<thead>
<tr>
<th>Local idiom of distress</th>
<th>Translation</th>
<th>Interpretation/descriptive characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Omuyaaka khwo’khunyalala aba ohwedaba</td>
<td>Fever of diarrhoea</td>
<td>Frequent passing of watery stools, feelings of anxiety, loss of appetite</td>
</tr>
<tr>
<td>Omuyaaka khwo’munda</td>
<td>Fever of stomach</td>
<td>Feelings of sharp stomach-aches, nausea &amp; dizziness</td>
</tr>
<tr>
<td>Omuyaaka khwo’mutwe</td>
<td>Fever of the head</td>
<td>Feelings of headaches, hot forehead, dizziness</td>
</tr>
<tr>
<td>Omuyaaka khwo’musirifu</td>
<td>Fever of chest pain</td>
<td>Feelings of hotness and heaviness in the chest</td>
</tr>
<tr>
<td>Omuyaaka khwo’khuyendezera musirifu no’khuholola</td>
<td>Fever of chest congestion</td>
<td>Feeling heaviness in chest with difficult breathing &amp; disgusting persistent cough</td>
</tr>
<tr>
<td>Omuyaaka khwo’kwengusa</td>
<td>Fever of flu/cold</td>
<td>Running nose/mucus and dizziness</td>
</tr>
<tr>
<td>Omuyaaka khwe’kaaka</td>
<td>Yellow fever [jaundice]</td>
<td>Yellow skin, eyes &amp; urine plus diarrhoea</td>
</tr>
<tr>
<td>Omuyaaka khwo’khuwereketo/ okumbe</td>
<td>fever of skin rash [measles]</td>
<td>Rough itchy rash all over the skin like a toad; gets worse with eating meat &amp; bathing</td>
</tr>
<tr>
<td>Omuyaaka khwo’kwesuchasucha/ magifita{omusujja}</td>
<td>fever of trembling with shivers &amp; chills- [jerks &amp; convulsions]</td>
<td>A state of deluded minds, silly or funny behaviour</td>
</tr>
<tr>
<td>Omuyaaka khwe’ sunna</td>
<td>fever of mosquito</td>
<td>Not sure; just told by parents &amp; health workers</td>
</tr>
</tbody>
</table>
Some others said that they had occasionally heard about it during communications between their parents and health workers. For example, a girl (Getu) child, who had herself been recently treated at a health centre following repeated episodes of fever imitated a nurse as she narrated the encounter:

‘...omwana abere nende omuyaaka khwesunna omubitirifu.’ (...the child had a lot of fever of mosquito). But I didn’t know what she meant by those words because I had headache and chest pain. So when I reached home, I told my mother what the nurse had said, ‘...omwana abere nende omuyaaka khwesunna omubitirifu...’ Then my mother said the nurse meant that I had a lot of fever of mosquito’.

For those children who had heard about the fever of mosquito from school, they said it was a teacher who told them that mosquitoes bring fever to human beings. However, neither were they sure of its exact name nor the symptoms. As I hinted, given the overlaps in the local meanings and interpretations of fever(s) it was difficult from the children’s perspective to clearly link any fever, including fever of mosquito to the biomedical concept of malaria. Like the different idioms of distress mentioned by the children showed, local understanding of fever was a complicated process. It required a clear understanding of children’s experiences of fever and further analysis of skills of self-diagnosis. Such a task was slightly beyond the scope of the present study given the time constraints. Nonetheless, this finding is consistent with what Nsungwa-Sabiiti et al (2004) found about adult perspectives of fever in Kasese district in Uganda. The authors noted that local interpretation and classification of childhood fevers were beyond its biomedical concept of malaria (ibid: 1194).

Perceived severity

In terms of perceived seriousness, the children shared a strong view that all fevers regardless of their nature could be cured. They observed that whereas fevers occurred with differing experiences of body pain or discomfort e.g. stomach-aches, diarrhoea, and chest congestion et cetera; such illnesses healed upon receiving treatment. Yet, they also observed that sometimes some fevers ‘just stopped’ by themselves [i.e. were self-limiting]. In this respect, the children identified chest congestion, diarrhoea, and in particular flu or cold. In fact, it was interesting to note
that from the children’s perspective, as a fever, flu or cold didn’t require specific treatment. Instead, it was perceived flu or cold become serious if one suffering from it was not active i.e. didn’t do work or exercise to gain body heat lost due to cold. For that matter, flu or cold as the children put it was also locally known as, “the illness of lazy individuals,” (okhulwala ‘bakaata). In general, children’s perceptions of fever mainly revolved around inability to do things i.e. work. Secondly, children also perceived medicines as useful remedies for most fevers. This particular finding about the children’s responses to the perceived severity of fever slightly contrasts with what Van der Geest (1996) noted about European children’s accounts of illness. According to Van der Geest, children saw illness in social terms i.e. a time to enjoy special attention and care from other people as more important aspects than the use of medicines (Van der Geest 1996; cited in Helman 2000: 99). In sum, in the context of this study, children perceived severity of fever in terms of inability to do things, on one hand. On the other hand, they saw medicines as remedies used to restore the ability to do things.

Building on the children’s optimistic views that all fevers were curable, I further explored their emotions and feelings when confronted with fever. The purpose was to get deeper insights about the influence of fever on children’s social relations and interactions in everyday life. In describing their general emotions and feelings about fever, children used both physical and social expressions that demonstrated quite interesting experiences. The experiences were graphically illustrated through the performance and acting out of symptoms of distress (see Good 1998: 60-61). Specifically, some children left their mouths and eyes wide open to show how fever could make a sufferer become ‘insensitive’ to things in one’s immediate environment. Others scratched themselves ‘white’ to illustrate a ‘dry and pale’ body; ‘folded arms’ around their ‘necks’ to show ‘sadness’ and ‘worries’ due to fever. In addition, a few continuously ‘shook’ their hands and legs to show experiences of fever that caused the body to ‘shiver’ or ‘tremble’ as if one had ‘fits’. Consequently, while the children’s illustrations were difficult to explicitly verbalise (i.e. were related to non-verbal behaviour) I attempted to find accounts that gave more visual and graphic impressions of their performances and views. Among these include: getting disoriented (okhuwubaala no ‘khudangaala); the body feeling heavy and lazy.
(omubiiri khusidoya no'khukataayala); the body looks pale (omubiiri o'khusamuhiiirira) and shivering (okhutengereha).

By comparison, the emotions expressed include disgust (okhusinye), sadness and worries (Okhwewunamira no'khwelalihirira) and getting bad dreams and nightmares (okhufuna ebiloto biibi handi ebitiisa). Consequently, the children perceived such situations as disturbing and very undesirable. The reason was because those situations sometimes involved developing a sense of confinement, helplessness and despair. I will give two examples of children’s stories that were narrated to show a personal sense of internal feelings of dislike and helplessness when confronted with fever. The story of 11 year old Pat.

One day, I woke up feeling weak and dizzy. By good chance it was a Saturday so there was no schooling. I tried to get ready to go to dig but it was not possible. Instead, I felt nausea and started vomiting after washing the face. It was too early to take tablets. My parents told me to stay at home as I watched the condition. Shortly, I became so weak. I decided to lie on a papyrus mat next to our kitchen house. I couldn’t to sleep because my belly was hurting so much. It is during this time that I saw the neighbour’s dog grab one my rabbits and it ran away. I was so bitter with myself because I couldn’t do anything to save the rabbit. I tried shouting but it was all useless.

On her part, 8 year old Joy expressed bitterness with her mother for refusing her to hold a baby because she had a cough. She narrated that:

That day, I had cough and a little pain in the throat. It was not so bad. I wanted to play with friends but my mother couldn’t allow me to leave home. Because I was bored, I tried to carry our baby. My mother shouted at me, ordering that I sit in a distance from the baby. I felt angry but couldn’t do anything.

As the two examples reveal, the social worlds of children are constructed around inter-relational properties i.e. they see themselves as being part of things they act upon and the people they interact with both in times of health and illness. For example, while Pat thought felt irresponsible for failing to protect his rabbit from the dog, on one hand. On the other hand, Joy felt angry about being stopped from caring for the baby. As Vaskilampi et al (1996) point out; children’s view of health is a holistic, multidimensional one, incorporating physical, psychological and social elements in it. Thus, they tend to see illness in functional terms: as not being able to do things. In short, it can be argued that children’s experiences of fever forced them into assuming passive roles rather than being active participants in social interactions.
and activities of their every day life (see Christensen 1998). In the next section, I describe children’s ideas about the causes and transmission of fever(s).

3.3 Children’s perceptions about causes and transmission of fever

In order to establish other relevant aspects of children’s Explanatory Models-EMs (Kleinman & Becker 2000) of fever, I examined ideas and beliefs of children regarding its causes and transmission. At both the group and individual levels, children ideas about causes of fever were related to actions of contamination with bad things. They argued one caught fever(s) if s/he ate bad food, drank dirty water, played in rain, dust and sunshine, and in the cold. In other words, children perceived some of their own actions as bringing them into contact with the different causes of fever. For example, Buda explained how he got fever as follows:

Last time I got sick it had rained too much. I was sent to buy paraffin from the shops and on my way back it started raining. I tried to wait [take shelter] but it was getting dark. So I decided to run through the rain up to home. It was raining too much that by the time I reached home I was completely wet and shivering with cold. I had no extra cloth to change so I decided to sit by the fire. Although, I later got dry, I didn’t feel good until I went to sleep. The next day, I had joint pains and headache. I was sick for two days until the third day when I swallowed tablets and started feeling better again. From that time I hate to move in the rain.

[FGD with children]

On his part, Sam stated that:

Fever is terrible. It started like I was just tired. You know we had been playing football that whole afternoon under the hot sun. So I thought I got tired from all the running I had done in the pitch. But later at night I could not breathe well. I had no sleep, my body was hot, the legs shaking and feeling weak. In the morning I was very sick. My father gave me tablets, which I took for sometime time and got fine again.

[Conversation with Sam]

By contrast, Tisa said she got fever through sharing a bed with a sick cousin. She narrated her experience as given below:

I went to visit my aunt. At night we shared a bed with my sister [cousin]. She had complained of not feeling well during the day. Three days after I had returned home, I became sick myself. I started having headache, and then I felt cold and later vomited yellow things. My mother said it was
fever. I couldn’t eat so she took me to the clinic. I was given two
injections, one in the morning and another in the evening. I feared that my
sister might become sick because we sleep together [share bedding]. It
didn’t stop there; I was also dreaming bad things that I had made my
sister sick.

[Conversation with Tisa]

These narrative descriptions show that the children internalized catching fever
in terms of things that caused to realise an experience of interruption of the body and
their connections to the social and material world (Christensen 2000: 47). For
example, Buda believed that he got fever because he had been beaten by rain. Like
Buda put it, ‘...I hate to move in the rain’. However, Tisa’s viewpoint was
exceptional in some way. It provided yet another perspective of children’s thoughts
about the causes and transmission of fever(s). In Tisa’s thinking, she believed in
person to person transmission of fever e.g. sharing bedding with a sick cousin.
Although conversations with other children didn’t show that they believed in person
to person transmission of fever, it was established that they too shared bedding with
their siblings, regardless of whether they were ill or not. It can be noted that through
sharing bedding it was possible for a child with fever to transmit it to others within the
same household. Therefore, much as the different etiological explanations of fevers
could have been partly influenced by children’s individual experiences of fever, they
are also instructive of the relatively similar socio-cultural and economic contexts of
the children. For example, their views reflect household contexts that were
characterized by low-level hygiene, sanitation and environmental cleanliness. These
can be seen as health demoting aspects, adding to the social complexities of dealing
with fever(s) in the households.

In addition to person to person transmission, children believed that vectors like
bedbugs and fleas also transmitted fever(s). Furthermore, it was also established that
certain fevers were got through non-naturalistic means such as getting into contact
with ‘bad winds’ while fetching water or firewood at night. As noted earlier, such
perception might have been related to the symbolic meanings of fever. On the whole,
children’s beliefs about the causes and transmission of fever point to its local
understanding as a complex reality, combining different notions of contagion and cold
and hot explanations (see Helman 2000). The children’s perceptions about causes and
transmission of fever(s) were analysed and summarised as presented in the matrix below:

<table>
<thead>
<tr>
<th>Fever of-</th>
<th>Cause(s)</th>
<th>Transmission</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stomach</td>
<td>- Not sure</td>
<td>- 'Bad winds' Fetching water/firewood at night</td>
<td></td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>- Bad food</td>
<td>- Eating bad food - Ate bad food</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Dirty water</td>
<td>- Drinking dirty water - Drank dirty water</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Cold food/leftovers</td>
<td>- Eating cold food - Ate cold food/leftovers</td>
<td></td>
</tr>
<tr>
<td>Chest pain</td>
<td>- Too much work</td>
<td>- Carrying heavy things - Fetched a lot of water - Carried heavy loads of foodstuffs</td>
<td></td>
</tr>
<tr>
<td>Chest congestion &amp; cough</td>
<td>- Dust</td>
<td>- Playing in dust - Playing in dust - Played in the dust - Shared bedding</td>
<td></td>
</tr>
<tr>
<td>Flu/cold</td>
<td>- Coldness</td>
<td>- Not clothing well - Stayed in the cold naked - Played in dust - Didn't cover with blanket</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Dust</td>
<td>- Playing in dust - Playing in dust - Shared bedding</td>
<td></td>
</tr>
<tr>
<td>Jaundice/yellow fever</td>
<td>- Don't know</td>
<td>- Playing together with the sick - Played with sick child - Shared bedding with sick sibling</td>
<td></td>
</tr>
<tr>
<td>Skin rash/measles</td>
<td>- Not sure</td>
<td>- Playing together with the sick - Played with sick child - Shared bedding with sick sibling</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Bedbugs &amp; fleas</td>
<td>- Sleeping with the sick - Had bedbugs &amp; fleas at home - Shared home utensils</td>
<td></td>
</tr>
<tr>
<td>Shaking i.e. jerks &amp; convulsions</td>
<td>- Don't know</td>
<td>- Don't know - Don't know, just happened</td>
<td></td>
</tr>
<tr>
<td>Mosquito</td>
<td>- Don't know</td>
<td>- mosquito bites - Didn't cover self at night</td>
<td></td>
</tr>
</tbody>
</table>

Given the diversity of children’s perceptions about causes and transmission of fever(s), the study sought to understand how children accessed information i.e. the sources of information about fever in their village community.
3.4 Sources of information

As a way to further examine the influence of socio-cultural and economic contexts on children’s perceptions of fever, I asked them how they got information about the causes of fever and its transmission. As already hinted above, among the sources of information were the teachers that gave science lessons to children while at school. The second source comprised of the information children shared with their parents/caretakers. This included ideas, which parents themselves had received from health providers at the health units. However, as we have already seen above, these sources of information seemed limited to only a few children. For many children, their ideas about causes and transmission of fever(s) were formed from information received through a variety of other sources. These include local operators of private clinics and drug shops, peers and siblings, churches and radio. Unfortunately, as I noticed from some of the children’s views, many of the sources sometimes gave conflicting and contradicting ideas about factors responsible for the transmission of fever. The data about other important sources of information that children identified were summarised and is presented as shown in the matrix below:

<table>
<thead>
<tr>
<th>Source</th>
<th>Medium</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>School/Teachers</td>
<td>-Science lessons</td>
<td>-mosquitoes, cockroaches, houseflies carry germs, which make people sick</td>
</tr>
<tr>
<td></td>
<td>-Drawings &amp; posters</td>
<td></td>
</tr>
<tr>
<td>Parents/caretakers</td>
<td>-conversations</td>
<td>-playing in the hot sun, dust and rain brings fever</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-eating bad food &amp; drinking dirty water causes diarrhoea</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-wash hands before eating, bathe &amp; wash clothes to keep clean</td>
</tr>
<tr>
<td>Health providers at health units/private clinics/drug shops</td>
<td>-communication to parents/caregivers</td>
<td>-talk about fever of mosquito</td>
</tr>
<tr>
<td></td>
<td>-posters</td>
<td>-houseflies carry germs from faeces to food</td>
</tr>
<tr>
<td>Peers and siblings</td>
<td>-conversation, plays &amp; games</td>
<td>-playing in the hot sun, dust and rain brings fever</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-eating bad food &amp; drinking dirty water causes diarrhoea</td>
</tr>
<tr>
<td>Church</td>
<td>-religious teacher</td>
<td>-warning about cholera, people should keep clean</td>
</tr>
<tr>
<td>Rock Mambo (local FM radio station)</td>
<td>-announcements</td>
<td>-keep clean to avoid cholera</td>
</tr>
</tbody>
</table>
Despite the multiplicity of sources as described in the matrix above, the children said they were not aware of the link between mosquitoes and fever (i.e. biomedical malaria). For example, I had anticipated that those children who were then attending school would be aware of such a relationship, but they had no such knowledge. However, during the couple of times I visited the school to do observations; I established that the lower grade pupils seemed to have been not exposed to that understanding yet. My study of the diagrams drawn on classroom walls showed only two particular insects namely cockroaches and houseflies as disease carrying vectors (see annex 4). I also found out from those children who had interacted with health workers at the time of care-seeking that they had no chance to learn about mosquitoes and malaria. The children said that the health workers talked to their parents/caregivers about how to use prescribed medicines. One boy said that:

I have often gone to Masafu [Health Centre IV] for treatment by myself when I have a bad fever. The health workers I find there only ask me how I am feeling and they treat me. Sometimes they ask me, "who did you come with?" I tell them nobody. Then you hear them saying that some parents don't know their responsibility. They have no time to tell you other things apart from the number of times you should swallow the tablets a day, if they give them to you.

[Conversation with Pat]

Pat’s account depicts the kind of relationships children find themselves in when they interact with health workers on their own with (-out) other adults e.g. parents. For example, children find themselves in situations where they have no opportunity to express and share their views and needs with adults. Secondly, there is no mutual relationship between them and adults to enable children learn about aspects that influence their health well being such as the causes of fever(s). According to Christensen (1998) the reason is because encounters as described above involve complex relationships between children and the formal and informal hierarchies that influence their lives. In such relationships, children’s positions are constrained and dependent because their status is constituted as inferior to adults in general and health professionals in particular (Christensen 1998: 187).

In addition, I also found out that children faced other indirect constraints to access health information because Information, Communication and Education (IEC) were hardly made available to local communities. In one specific incidence, I
observed at a Health Centre that IEC materials on how to treat bed nets were being used to wrap medicines for patients.

In view of such contradictory realities as observed at school and the health centre, I asked the children, which of the mentioned sources of information about fever they preferred, including the reasons for their preferences. The children stated their preferred sources of information that include: peers and siblings, the church and operators of private clinics and drug shops in that order of priority. For the reasons, the children explained that, usually as peers and siblings they challenged each other to learn many things; including health issues by asking, and answering questions in the form of riddles. In case one got the answer wrong, the others would simply tease the person but still help them to understand the expected issues. One child gave an example of a riddle as, “an adventurous child is cleverer than the mother,” (i.e. Namwanna wo ‘genda ahira ngina amakesi). The child explained that this riddle was used to give children inspiration to learn new things from different contexts. These include schools, churches, neighbours and distant relatives. As for the owners of private clinics and drug shops, children said these never shouted at them. Instead, as one child elaborated,

...many times I have forgotten the correct name of the tablets I am sent to buy. The drug seller keeps giving me different clues. He mentions names of tablets in relation to body parts until when I remember. With my father, he just says I am good for nothing and I feel ashamed.

For the religious teacher, children said that he was very passionate person who treated them with respect and kindness. Because of this the children it was possible to learn and internalize the things he told them. On the contrary, the children’s narratives about the way some of the teachers and parents treated were surprising and revealing. The narratives were full of insights that were critical for understanding power and gender relations within individual households as well as the entire local community. Below are citations off the children’s narratives.

In the first narrative, a girl stated thus:

One Friday, the teacher told us to find out the names of insects that bring diseases to people. I tried to ask my father the following day, he didn’t even listen. He just walked away. As for my mother, she didn’t know. I was so scared of the teacher. He, shouts at girls and even spanks us for giving wrong answers in class. But he doesn’t do the same to the boys. It
seems he doesn’t like girls. Before we entered class on Monday, I asked my friend Lona. She reminded of the diagram of a fly on the wall of P.5. That is how I survived that day.

In the second narrative, a boy said:

I don’t know what is wrong with my uncle. He doesn’t allow anyone to touch his radio. Last Sunday we were in church, the religious teacher said people should listen to the radio, cholera is around. It had killed people in some parts another district. He repeated it many times. At home, I asked my uncle to put on Rock Mambo [local FM radio station], he refused. He just told me to go and play.

Clearly, these stories revealed that regardless of their needs, some adults didn’t listen to, and respect the views of children. More importantly, the stories suggest some of the realities, which children were faced with, within their local social structure. That is to say, children experienced unequal power and gender relations, which made it difficult for them to have easy access to information about health issues in general and fever in particular. For example, when I asked children whether in their village community, local political leaders talked about health issues, and fever in particular, they said, “we have never heard local council leaders talk about fever”. This was ironical since in Uganda there is provision for a position of the Secretary for information. The roles of such a local leader include among others dissemination of information about health issues. However, it was not clear how children’s access to available information enabled to transform their ideas into actions to deal with experiences of fever. Therefore, the next section describes children’s actions upon experiences of fever(s).

3.5 Children’s actions upon fever

One vital sub-question for this research was: What decisions, if any did children take within the households, and how did that influence their actions to act upon fever? In order to address this question I had conversations with three children, two of whom were boys, and one was a girl. I knew all the three children from our previous meetings; first at the church, and thereafter as participants during group discussions with them. During individual conversations with each of them, the three children told me their experiences of fever(s) and the specific actions they took to
overcome feelings of pain or discomfort. The following are the detailed descriptions of the case stories given by the children: Pat, Sam and Tisa.

**Case story one: Tisa**

Tisa was a small girl, 9 years old and in grade 3 at the village primary school. Together with her mother and younger sister, they lived in a mud and wattle, grass-thatched house. Tisa's home was located at the southern end of the village community. Both her parents were subsistence cultivators. Because the father was married to a second wife in another village far away from there, he occasionally stayed with Tisa's mother. One Saturday afternoon I met Tisa at the borehole. Like her, I had gone to fetch water. I asked Tisa if I could talk to her for a few minutes about fever. She smiled and obliged. When I asked, what she did the last time she had fever, Tisa's story was as follows:

I told my sister I wanted to stay in bed a bit longer because I had headache and my body was feeling weak. I talked to her first because we share the same bed. I then told my mother as she greeted us in the morning. My mother felt sorry but couldn't do anything. She had no money in the house. She had to wait for our father. He was expected to come home that same day. I started vomiting yellow things as my mother was telling me to wait and see if the pain would reduce. I told her I was feeling bad and wanted to go the clinic. Although there was no money, my mother allowed, and we went to the clinic together. The good thing is that the nurse knew us. This was not the first time to see her. We had been to her clinic many times before. The nurse touched my forehead. She asked how I was feeling. I told her it was headache and I had vomited yellow things in the morning. She then asked whether it was true I had vomited yellow things and mother replied that I had said the truth. She decided to give me two injections. It was two times that day; one in the morning and the second one in the evening. I was also given some tablets, after which we returned home. "Tablets...?" I asked. She said, "Yes, it was panadol and another type, I didn't know". I swallowed the tablets as the nurse had instructed until they were finished. By the time my father came home, it was after three days but I was already healed. When my mother told him that I had been sick, he just said, 'sorry,' and then asked my mother what happened. She then explained to him. However, he only stayed for a while and left after having lunch without saying anything. I didn't see him again until after another three days.
Case story two: Sam

Like Tisa, Sam’s family lives in a mud and wattle house. The family lives by cultivating land. But Sam’s father makes and sells bricks as well. He was known on the village to have been working in the brick making project for some years. In spite of that, he had not built a brick house for himself and the family. Perhaps, he not made enough money yet. Sam was only 10 years old but looked so big for his age. He was in grade 4 at the same village school like Tisa. The two children actually knew each other very well. Sam told me that Tisa’s parents and his mother were goods friends for they often visited each other’s families. Sam and I became close friends right from the first meeting at the church. As a matter of fact, he was the boy who asked me, how a big person like me could go to school. One Monday morning, a week after we had had the group discussions, Sam came to my house to ask if I had any piece of washing soap left, so that I could give it him. He explained that he could not go to school that morning because the previous day soap got finished before he could wash his school uniform. I told him that he was unlucky because there was hardly any soap left. He seemed not convinced and decided to stay. It seemed he hoped that I was only joking but would probably give him the soap after wards. Meantime, Sam asked me whether we would have ‘homework’ again. I said I was not sure, but I had a few questions to ask him in case he didn’t mind. He said he didn’t. So I began by asking Sam what made his father to give him tablets the last time he caught a fever. Sam told me:

My dad talks to me every morning before he leaves the house to go to garden. So that day, I told my dad that I am not going to school today. I said I am very sick. My joints are very painful and I have a bad headache. He asked me to stay home. When he came back from garden the sun was high up in the sky but I was still in bed. He asked me if I had taken any tablets, I said no. You know before that I had had a fever, but when I told him he just laughed it off and said, ‘it seems you don’t want to go school’. Since he didn’t believe me, I waited for him to go to garden. I then checked in the basket under his bed and picked ‘Homapak’ tablets and swallowed. Yes, I took two tablets. I had seen him put them there sometime back. When I told him that I had swallowed the tablets from the container under his bed; this time he laughed again but told me to be careful. He said, ‘it is bad to just take any tablets you find’. But I told dad that a lot of times when I had headache, I would buy ‘panadols’ from the shops and take. Anyway, my dad gave tablets ‘panadols and chloroquine,’ which I took two days and the headache stopped completely. After narrating that, I asked Sam, ‘how did you know that panadols were used
to treat headaches? He replied that he had heard it from his dad’s radio that panadols cure headaches’.

Case story three: Pat

Pat was 11 years old. He was in grade 5 at another primary school called Butangasi. His school was located about 4 km from the village school of Buduli P.7 primary school where Sam and Tisa went to attend classes. He has two older siblings, both of them girls and attending the same school with him. Similar to the cases of Sam and Tisa, Pat’s parents are subsistence cultivators. Secondly, their houses were also built in mud and wattle. However, Pat’s family lived to the western end of the village. They were neighbours to the last village in the parish. But we met first time at the village church where his family usually came to attend church service on Sundays. Besides subsistence cultivation, Pat’s father was also a cyclist, dealing in local transportation (i.e. Bodaboda). This was an off-farm income generating activity that occupied him for the rest of the time during the day. He gave people lifts on his bicycle for a fee to different places of their destination within the area. Pat told me that together with his two sisters, they slept in a separate house from their parent’s main house. At the time of our conversation, I had gone to the shops in the trading around Pat’s school to fix my bicycle tube. I then met him on my way as he was also walking home after school. I gave him a lift, and that is how we had time and another opportunity to talk for a longer time. When I asked him about what he does when he had a fever. Pat explained to me that:

I have known for a long time that when you get omuyaaka (fever) you need to treat it. There is usually that bad type that comes with headache, dizziness, diarrhoea and sometimes vomiting. Many times I get a headache, I have taken tablets myself. The good thing is that I know how to ride. If I have sold my rabbits I keep some money. If fever gets me when I have the money, I will go to the shops myself to buy tablets. But if dad happens to be around and has money, then I will tell him to help me. I will then buy tablets, take and keep the reminder to wait for next. Sometimes, fever comes when there is no money at home. If that happen then I will boil herbs (Halulu) and take. You know that herb is Halulu is also good. It is very bitter like that medicine called…I have forgotten the name. Two weeks ago, I was attacked by fever; you remember the story I told you about the neighbour’s dog eating my rabbit…that time the fever couldn’t go. On my own I decided to walk to Masafu [Health Centre IV] for treatment. I told the health worker how I was feeling then he decided to inject me. I cried because the injection was so painful but the man told
me, ‘boy; stop crying, men don’t cry. It is women, who cry over small things like a needle’.

Despite some slight differences in the approaches and coping strategies that the three children took to deal with experiences of fever, their narratives share some common themes. This is with respect to the kind of decisions they were able to make themselves. Consequently, the narratives also show similarities in children’s pragmatic actions towards managing fever(s). Based on these stories I present and discuss the common themes as well as highlight some of the differences in children’s health-seeking behaviours within households. These issues concern the children’s abilities to:

a) self-diagnose fever

b) decide and communicate to parents and siblings i.e. next of kin

c) negotiate with adults (i.e. parents)

d) seek treatment (i.e. buying and taking medicines and going to health facilities)

**Self-diagnosis**

As the case stories suggest, one of the key things that children did to demonstrate the ability to act upon fever was to engage into a process of self-diagnosis. As we can see from their stories, the children were able to notice bodily changes that seemed to first interrupt their normal social functioning e.g. waking up early. Secondly, self-diagnosis occurred in the form of perceived interruption of normal activities the children had to undertake in the course of the day. For example, for both Tina and Sam, the first thing was to recognise feelings of pain or discomfort that inhibited the socially expected behaviour from them by other people in the household. Tina told the sister she wanted to stay in bed longer because as she put it, “I had a headache and my body was feeling weak”. On the other hand, Sam felt he couldn’t go to school and described his experience as, “I am very sick. My joints are paining and I have a bad headache”. It can be noted that the expressions were based
on the children’s own assessments of their subjective states of being in relation to having fever(s). The children then use the assessments as useful cues to enable them to determine the next courses of actions to take. That is to say, how to share their feelings with their next of kin within the households. More importantly, it can be noted that the children’s responses to unusual feelings help other people who might not share subjective feelings to understand how children react to bodily sensations that affect their physical and emotional well-being. For this study, the relevance of such knowledge regarding the children’s ability to self-diagnose can not be underestimated. As Christensen (1999), observes, “...the process through which children engage with illness as a distinctive social and bodily event can better be understood when children’s own perspectives are taken into account”. Thus, it can be argued that through self-diagnosis, children were able to initiate the process of health-seeking within their households. In short, the process of health-seeking effectively started when children took the decisions to share their feelings with others i.e. through communicating their experiences with their kin in the household.

**Decision-making and communication**

In order to draw the attention and concern of their kin (i.e. siblings and parents) in the household, the children took decisions to let them know that they were unable to take part in specific social activities and events expected of them in everyday life. As already noted, Tisa’s decision to tell the sibling that she wanted to ‘stay in bed’ could be interpreted that she meant that she would not be able to perform normal activities e.g. going to dig. By comparison, Sam even put his decision more explicit terms. Hence, he told his father, ‘I am not going to school today’. However, in both cases the children were able to communicate their decisions about things they couldn’t do because of fever.

It can be noted that following the children’s decisions to communicate with their kin, they succeeded in engaging particularly the adult kin into into discussions about their experiences of fever. Among other things the discussions helped children and their adult kin to assess the severity of symptoms of fever(s). The discussions were also used as the means to determine whether or not it was necessary to treat the fever at home to seek help from competent health care providers outside the
household. Despite some contradictions in child-adult interpretations of symptoms of fever, the adults respected the children’s decisions not to participate in everyday life routines (i.e., social activities and events). Secondly, and perhaps more important, the adults respected the children’s decisions to seek help. For illustration, we see that Tisa’s mother never challenged her decision to seek help at the clinic. Similarly, Sam’s father didn’t insist on him going to school. Instead, he asked him to stay home. However, the interesting point to stress is that neither of the parents immediately perceived the children’s views and experiences of fevers as severe enough to require immediate treatment. Of course, in the case of Tisa, the mother’s actions were constrained by lack of money. But in Sam’s case the father didn’t entirely believe him. It can be noted that the parents’ perceptions were constructed from an outsider’s perspective that views children as objects to be manipulated using symbolic marker e.g., using time to determine duration of symptoms and ascertain experiences of illness (see Christensen 1998). However, as Christensen further points out, this tendency arises out of the fact that adults try to understand children’s illness from their etic perspective. Thus, without critically understanding children’s perspectives, adults misinterpret children’s health and illness in everyday life (Christensen 1999: 50). Therefore, it can be argued that failure by adults to understand children’s perspectives of fever(s) significantly contributes to delays in health-care seeking at household level.

Nonetheless, the study found that children’s ability to communicate about experiences of fever largely depended on the nature and quality of access children had to their parents. While the girl (Tisa) easily turned to her mother as the caring person in the household, she had no access to her father. The father was less available and as such offered little help during the times Tisa had fever and needed his care. By comparison, the boy (Sam) had both the direct access to, and enjoyed better communication with his father. Given the two different scenarios of adult-child relations, it is clear the children’s gender was a critical factor in influencing their agency to act upon fever. That is to say, children’s abilities to act upon fever depended on their social position (i.e., gender) in the household. From such a perspective, it can be argued that differences in children’s access to their parents, is a typical example of the social obstacles that children, especially girls were faced in seeking effective care for fever(s) at the level of the household. This finding is closely
related to observations made by earlier studies that explored the concept of child agency in situations of illness (see Christensen & James 2000; Onyango-Ouma et al. 2004). For example, Onyango-Ouma et al's (2004: 337) study in Kenya revealed how children’s actions and active participation in social structures influence their abilities to understand health and illness.

Therefore, the above finding contrasts studies that have argued that appropriate health-seeking for fever(s) by local communities is delayed due to limited access to, and negative social relations within formal structures (McKaig 1995; Hill et al. 2003; Karamagi et al. 2004; WHO 2002). This study has shown that delays in appropriate health-seeking for fever(s) is primarily influenced by social factors e.g. gender of the child coupled with power relations within the household level.

**Negotiation of decisions**

This study also found out that children made their communications about the need to act upon fever more effective through the negotiation of adults’ (parents’) decisions. I will draw on Tisa’s narrative to illustrate children’s ability to negotiate adult decisions. From her account, we a clear example of adult attempts to make children suppress feelings of pain and discomfort even in the presence of severe symptoms of severe fever. For instance, despite the fact that Tisa was ‘vomiting yellow things,’ the mother told her to ‘wait and see if the pain would reduce’. However, Tisa managed to act in a more pragmatic way by convincing her mother that she was feeling bad and therefore they had to immediately go to the clinic. Based on her narrative, it can also be noted that she has learnt how to negotiate adults’ decisions out of repeated confrontations with experiences of fever. As Tisa clearly explained, even without money they went to see the nurse. The nurse knew them because they had been to her clinic many times, indicating that Tisa had been treated for frequent fever at her clinic.

Beyond this, the study also found out that both children and adults were constantly engaged in what has been described as the cultural construction of illness i.e. fevers (see Helman 2000). In the context of this study, this means that through sharing ideas i.e. engaging in communication and the negotiation of decisions, adults
admitted the children’s experience of fever as a reality. Secondly, they developed coping strategies to manage it i.e. allow children to practice self-medication or seek help from outside the household. Apart from that, it is important to note that in case of failed negotiation, children had their own coping strategies for acting upon fever. For example, Sam explained that, ‘since he didn’t believe me, I waited for him to go to garden’. After which, Sam decided to look for medicines that he had seem the father keep in the house and treat himself. For this study, Sam’s action demonstrated the fact that in the context of ill health children are not passive recipients of adult decisions but active participants in the continued search for health (cf. Christensen 1998; Van der Geest 1996). A detailed discussion of children’s active participation in the form of devising coping strategies to deal with fever is described in the next sub-section.

**Ability to seek treatment**

In describing how children’s ability to seek treatment influenced health-seeking in the household, I will now draw on all the three case studies. To begin with the stories of Pat and Sam are quite revealing in many aspects of the coping strategies that children had to deal with fever in everyday life, on one hand. On the other hand, they reveal the dynamics of the different factors that impacted on children’s health-seeking behaviour within the households. For example, in his story, Pat explains how children perceived ‘bad fever’ (i.e. severe fever). According to Pat, severe fever was understood by the children through engaging into a process of clustering different symptoms together (see Christensen 1999: 42). It can be seen that on the onset of fever, children constantly studied how the different symptoms manifested. Once more than one symptom presented then this resulted into household decisions to seek care from formal health providers. These include: private operators of clinics and drug shops (see Tisa’s story), and professional providers at public health facilities e.g. Masafu HC IV (see Pat’s story). In Pat's own view, bad fever presented with multiple symptoms e.g. headache, dizziness, diarrhoea and vomiting, which had to be treated.

In addition, like Sam, Pat took decisions to initiate health-seeking in the household in two ways. First, the children took self-medication i.e. used available medicines within the household that were kept as the balances of previous treatments. Secondly, the children were involved in the buying of medicines from the drug sellers
available within their communities. It is interesting to note that some children (i.e. Sam) knew where their parents kept the medicines. Thus, they had easy access to medicines and would treat themselves upon realising that they had fever. On the other hand, a few children like Pat kept their own medicines and treated themselves whenever they were in need. Clearly, Pat’s account demonstrates that children, who were already confronted with fever, tended to internalise the experience and took pragmatic steps in dealing with subsequent experiences of fever. For example, they were able to buy drugs and practice self-medication without necessarily consulting with adults.

Furthermore, it can be argued that unlike the girls, the boys’ abilities to act upon fever were enhanced by the fact that they enjoyed special social relationships with their fathers. Like Pat put it, ‘if dad happens to be around and has money, then I will tell him to help me’. Similarly, Sam’s father seemed not bothered by the fact that alot of times he had bought and taken panadols to treat headaches. By making no comment, it can be suggested that Sam’s father gave him the money as well as the go a head for him to engage into actions of self-care.

Pat’s ability for self-care was further enhanced by the fact that not only did he earn his own money but he also had knowlegde of local herbal remedies (i.e Halulu). Therefore, it can be argued that he had better skills of self-care compared to either Sam or Tisa. As Hardon et al (2001: 43) point out; self-care constitutes self-diagnosis and treatment using home remedies, herbal medicines or modern pharmaceuticals. Thus, Pat’s story is a typical example of children’s health-seeking behaviour informed by knowlegde of alternative treatments or available remedies for fever in the household (Helman 2000: 15). In conclusion, it can be noted that the existence of mutual adult-child relations was an important factor in building and sustaining children’s coping strategies and actions upon the management of fever within the household.

This chapter has described children’s perceptions of fever: gender and power relations; the meaning of fever; children’s perceptions about causes and transmission of fever; sources of information and children’s actions upon fever. In the next chapter, I briefly describe how I found health care services delivered to children with fever in the district.
Chapter 4: Fever management in Busia

4.1 Health care services for children with fever

The aim of this study was to contribute to a more cultural and children sensitive home-based management of fever approach in Uganda and Busia district in particular. In an attempt to reach this aim, I assessed the status of health care delivery for children with fever in the district. A study and analysis of official documents regarding health care delivery in the district was done. I also had discussions with technical staff from the Directorate of health services (DHS). The analyses of data from these two sources revealed that service delivery for children with fever remains sub-optimal.

The study established that the morbidity burden due to fever(s) was high despite the existence of interventions for its management. For example, the top annual diagnoses of common diseases for all ages as at 2005/2006 were presented according to magnitude (percent) of reported occurrence. These were malaria (41.5), acute respiratory infections (ARI- 26.6), intestinal worms (8.5), diarrhoea (5.6), trauma (5.5), sexually transmitted infections (STIs- 4.7), anaemia (2.1), skin diseases (9.2) and eye infection (1.4). In addition, was HIV/AIDS, sero-status estimated at 15 percent, which is more than double the national average of 6.4 percent and protein energy malnutrition (DHS 2007).

It is important to note that the statistics described above represent only the number of patients reporting to formal health services in the district. These exclude (non-) reporting patients. In the context of this study, these are children who might not access formal health facilities for different reasons. For example, 33.3 percent of Ugandans are known not to attend government health service because the facilities are too far. On the other hand, high cost of treatment accounts for 15 percent non-attendance (MoH 2004). Given such scenarios, the actual burdens of morbidity (and mortality) suffered by the local communities due to the different illnesses reported to be prevalent in the district remained unknown.

Nevertheless, the study concluded that fever/malaria contributed most significantly to morbidity (and mortality) of particularly children in the district, as elsewhere in the country. I drew this conclusion based on the fact that the number of fever cases among children above five years had substantially increased over time (see annex 5). It was noted the main contributing factor to the high prevalence of
fever was because the DHS mainly focused on tackling structural barriers i.e. improving access to, and making services affordable to local people. As I have so argued, such an approach does not address itself to the socio-cultural complexities that children face in the management of fever at the household and local community levels (see chapter 3). In the following section, I present a brief account of the failed concept of home-based management of fever for children at the household and local community levels.

4.2 The concept of home-based management of fever (HBMF)

The home-based management of fever (HBMF) was introduced and implemented in the district in 2005 with the aim of addressing problems of access and timelines of treatment of children with fever. This was to be realised through improved recognition, management and treatment of fever in the household. However, it was established that the concept had failed to improve fever management because it had a limited focus in meeting the health needs of children with fever. For example, presumptive fever treatment was made available only for children below five years without any provision for the rest of the children. Even then, treatment for children below five years was often affected by intermittent stock-outs. Altogether, it was established that none of the components of HBMF sought to understand children's perspectives of fever and how these influence health-seeking behaviours in the household.

On the contrary, the concept used an adult-centred approach to fever management in the household. As earlier noted, adult-child relations even at the level of informal social structures like the household are characterised by hierarchies in which children's positions tend to be inferior to adults (Christensen 1998). Such unequal social relations constrain children's abilities to effectively act upon fever. Thus, by building on the existing unequal social relations, HBMF contributed to the process of undermining the children's roles as social actors in the management of fever in the household. For illustration, I will highlight some of its major components:
Mobilising communities particularly mothers to seek care early and give appropriate home treatment.

Teaching both mothers and drug distributors to recognise and refer children with severe illness in time (MoH 2002: 25; WHO 2004; WHO & UNICEF 2001).

As seen above, the concept placed the entire responsibility of health-seeking for children with fever in the hands of adults e.g. mothers. However, due to unequal gender and power relations within the household, it was noted that not only did mothers find it difficult to meet treatment needs for all children but also experienced delays in health-seeking. For example, I found out that some mothers perceived that once one child got fever in the Household then the rest of the children would do. This kind of perceptions led to the sharing of medicines among children. In this regard, a key informant stated thus:

Usually, when a child gets fever, treatment actions will be based on first experiences of symptoms noticed by the mother. And because it is difficult to understand the behaviours of children, if one child falls sick then it is expected that others will also get sick. Because of this mothers tend to rationalise the practice of children sharing drugs for fever.

Furthermore, HBMF exclusively focused on malaria, yet as the findings revealed the local meanings and interpretations of fever(s) were diverse, complex and without a clear link to this biomedical concept (i.e. malaria).

From a policy perspective, it can be argued in general that HBMF failed to address itself to the socio-cultural contexts that inform people's local understanding and interpretation of fever(s). Therefore, despite being a community-based programme, HBMF was conceived and developed based on the conventional biomedical perspective of disease (see Helman 2000). That is to say, adults were the key instruments for making decisions to treat children with fever. In short, the concept of HBMF was faced with two critical gaps in fever management. These are the failure to pay attention the experiences of children with fever and the assumption fever had the same meaning for all people regardless of their socio-cultural context.
4.3 Challenges and lessons learnt

In general, the analysis of the different informants’ perspectives revealed many challenges and constraints that rendered HBMF a less effective approach in the delivery of care to children with fever. Among others, these include:

- Lack of awareness by adults e.g. drug distributors and mothers about children's emic views of fever, which often resulted into inadequate skills to manage fever (s) at household and local community levels.
- The HBMF approach remained incomprehensive i.e. it could provide for the health needs of all children with fever.
- HBMF lacked sensitivity to socio-cultural values of people in the local community.
- Delays in the timelines of treatment of children with fever continue due to intermittent stock outs.
- Delayed care-seeking for children with severe fever because local people were not aware that the available medicines were meant for presumptive treatment.

In view of the above, I argue that there have been no significant improvements in health care delivery for children with fever in the study community even the concept of HBMF was introduced. Therefore, a more holistic approach is required for better management of fever in the household. Specifically, health care professionals need to work in concert with all stakeholders, including children as social actors in health care practice. This will help to understand children’s perspectives of fever(s) so as to realise appropriate health-seeking behaviours for fever at the household and local community levels.
Chapter 5: Summaries and conclusions

The main question for this study was: How, and to what extent do children’s perceptions and experiences of fever influence health-seeking behaviour within the Household? However, in order to explore the issues raised in this question, I assumed and argued that; the social backgrounds of children, influenced by the specific cultural contexts they lived in determined their perceptions, experiences, and actions upon fever. Secondly, I argued that children’s actions upon fever depended on the dynamics of gender and power relations in the household. And, thirdly, I argued that understanding children’s perspectives of fever would provide critical insights for realising a more cultural and child-sensitive concept of home-based management of fever in Uganda.

I found out that gender differences existed in the tasks performed by boys and girls in the households. Children had different social experiences of life with the boy child having more social space to decide which tasks to do than the girl child. As a result, the unequal gender and power relations in the household did not only influence children’s social life but also had a significant impact on their ability to act upon fever.

The children’s meanings and interpretations of fever revealed that it was a complex concept. Children used the concept of fever to describe different body experiences of pain or discomfort. However, I noted that the local names and terms children used to describe fever reflected their socio-cultural backgrounds. Because of the diverse meanings of fever, none of the local names and terms that children used to describe it had a clear link to its biomedical concept of malaria.

In terms of perceived severity of fever, children related experiences of fever with their inability to do things. In this regard, children saw medicines as remedies to be used to restore their ability to do things. Similarly, children’s ideas about the causes and transmission of fever were based on different etiological explanations. These combined notions of contagion with hot and cold theories, including person-to-person transmission. In short, children’s understanding of causes of fever was instructive of the socio-cultural and economic contexts of their everyday life.
Regarding sources of information, I established that although children learnt about fever through multiple sources, they preferred peers/siblings, the church and operators of private clinics and drug shops to both their parents and teachers. Children based the choice of their preferences on the relatively mutual relationships they had with the preferred sources, hence guaranteeing them better access to information.

The findings about children’s actions upon fever revealed that they had similar coping strategies. These ranged from the ability to self-diagnose to taking pragmatic choices of care-seeking. Children were able to self-diagnose fever through perceived interruptions of normal body functioning e.g. waking up early and going to school. More importantly, children ably communicated their experiences of fever to their kin in the households. Thus, I concluded that based on their decisions to communicate to their kin about their experiences of fever, children initiated the process of health-seeking in the household.

Equally, important was the fact children engaged adults in meaningful discussions, which often resulted in determining the course of health-seeking. However, I established that children’s ability to discuss their experiences of fever with adults was largely influenced by the nature and quality adult-child relations in the household. Specifically, the girl child had less access to the male parent. He was less available and as such offered little help. By contrast, the boy child enjoyed relatively better access to, and discussed his experiences of with the father. In sum, the child’s gender was found to be a critical social obstacle in limiting children’s agency i.e. ability to act upon fever. Therefore, I concluded that delays in appropriate health-seeking for fever(s) were primarily influenced by social factors e.g. gender of the child coupled with power relations within the household.

In addition, I found out that children were to express the need to act upon fever more effectively through the negotiation of decisions of adults. As result, adults acknowledged the child’s experience of fever as a reality. This was followed by developing strategies to deal with fever. These include allowing children to practice self-medication and to seek help from outside the household. On the other hand, children still had own coping strategies in case of failed negotiation with adults.

At a very practical level, children took pragmatic steps to influence health-seeking in the household. First, they took self-medication i.e. used available
medicines within the household. Such medicines were kept by themselves or adults as the balances of previous treatments, or were bought altogether. Secondly, through clustering different symptoms children assessed the severity of fever, which became the basis for care-seeking outside the household.

However, the boy child’s ability to act upon fever was enhanced by his relatively higher social position in the household. In particular, he had better access to care because of money given to him by the father or earned by himself. Moreover, he also had knowledge of local herbal remedies (i.e. Halulu), hence better self-care skills.

In conclusion, I established that the existence of mutual adult-child relations was a crucial factor in building and sustaining children’s coping strategies and actions upon fever in the household. Therefore, there is need to address socio-cultural obstacles that negatively impact and constrain adult-child relations leading inappropriate health-seeking behaviour for children with fever in the household.

An assessment of health care delivery for children with fever showed that services were sub-optimal. I established that the morbidity burden in children due to fever(s) was high. The main contributing factor to the high prevalence of fever was the failure by existing interventions to address the socio-cultural complexities that children with fever faced in health-seeking, especially at the household and local community levels.

Although, the concept of home-based management of fever (HBMF) had been in place for sometime, it had failed to improve fever management at local levels. This is because adults were the key instruments for making decisions to treat children with fever. In short, the concept did not pay attention the experiences of children with fever among other issues.

In conclusion, I argue that there were no significant improvements in health care delivery for children with fever in the study community after the concept of HBMF was introduced. Therefore, I advocate for a more holistic concept of fever management in the household. In particular, there is for health care practitioners to work in concert with all stakeholders, more so children. Because, if they are brought on board as social actors in health care practice, then it is possible to understand their perspectives of fever(s) and how these influence health-seeking at the household and local community levels.
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Annex 1: Problem analysis diagram

**National policy level**

- Health centers
  - Home-based management of fever strategy

**Community level**

- Alternative informal sources of care: drug shops, private clinics, traditional healers, herbal medicine.
  - Child death & disability
  - Delay to seek care
  - Lack of access to health care

**Household level**

- High prevalence of fever/malaria
  - Infected/untreated children
  - Inadequate knowledge about children’s perspectives of fever
    - Influence of socialisation agents e.g. media, school, church and peers.

**Individual level**

- Child's age, sex, education, position/participation in household tasks
  - No information about children’s experiences of fever.
  - No information about children’s competence to act upon fever.

**CONTEXTUAL FACTORS:**
- Size, economic status, education, socio-cultural beliefs, gender roles, power relations, decision-making, hygiene, sanitation, health-seeking behaviour & social support
Annex 2: Maize garden around the housing unit
Annex 2: Containers for trapping rain water for making bricks
Map 1 showing location of Busia district in Uganda

Map 2 showing location of Masaba Sub-county in Busia district

Key:
- District boundary
- County boundary
- Subcounty boundary
- Tarmac road
- Muram road
- Railway line
- District Headquarters
- Trading centre
Annex 4: A sample of diagrams showing disease carrying vectors found drawn on the P. 5 classroom block at Buduli P.7 Primary school
Annex 5: Graph showing the prevalence of malaria cases in children attending Masafu Health Sub-district

Source: Records office: Masafu Health Sub-district