

**INFLUENCE OF SOCIAL NETWORKS ON MEDICATION SHARING
AMONG SOMALI WOMEN IN ELDORET MUNICIPALITY**

BY

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DECLARATION

Declaration by candidate

This thesis is my original work and has not been presented at any institution for any purpose. No part of this thesis may be produced without prior permission of the author and or Moi University.

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DEDICATION

I dedicate this thesis to my mother WanjikuKhamasi and sister NjeriKhamasi for their support and understanding during the research and writing process.

ABSTRACT

Background: Prescription of medicine is one of the most common interventions in health care. For proper illness management, optimal use of appropriately prescribed medication is important. Medication sharing is a public health concern because it often results in treatment of symptoms and not the underlying disease. The ties in a social network are important because people are interconnected and so is their health. The health intervention given to one influential person can have an unintended effect on the rest of the network

Objective: The objectives of this study were to: Describe the Somali women's perception of medication sharing, Identify forms of social networks evident among Somali women living in Eldoret, and Examine how the social networks influence medication sharing behaviour.

Methods: This was a phenomenological study, which was concerned with the lived experiences of the participants and was conducted using the qualitative method. The study sought multiple perspectives on these lived experiences using both in-depth interviews and observations. The study population consisted of 30 Somali women living in Eldoret recruited from six areas namely Huruma, West Indies, Mwanzo, MailiNne, Kapsoya and the Central Business District. Using Purposive sampling, an initial 7 participants were recruited and a further 23 participants were recruited using snowballing sampling procedure. Data collected was transcribed and analysed and a composite was constructed to an overall description of the phenomena as people usually experience them. Data was also presented using tables, pie charts and diagrams.

Results: 21 of the participants practised medication sharing. The participants shared both prescription and over the counter medication. Their social networks which include family, friends, neighbours, those with similar health conditions, friends of friends, houseguests and health care professionals, influenced their medication sharing practice. These social networks influenced if and when medication should be shared and the type of medication to be shared. The familial social network had the most influence on the practice of medication sharing.

Conclusions: Medication sharing is practised by the Somali women living in Eldoret and within their social networks. Their social network has a direct influence on the types of medication shared.

Recommendations: Somali women need education on the effects of medication sharing from members of their social networks to promote safer medication taking practices.

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DEFINITION OF TERMS

Self-medication: Management of minor ailments using a pharmaceutical product that is available without a prescription

Medication sharing: giving medications to someone else or taking someone else's medication.

Social network: refers to a set of individuals and the ties among them.

Phenomenological study: A phenomenological study focuses on the lived experiences of individuals, their perceptions, perspectives and understanding of particular situations

ACRONYMS

NBS: National Bureau of Statistics

NCAPD: National Coordinating Agency for Population and Development

NCCSDO: National Coordinating centre for National Health Service Delivery and Organisation

UK: United Kingdom

OTC: Over-the-counter medicines

CHAPTER ONE

INTRODUCTION

Background

Prescription of medicine is one of the most common interventions in health care in the world (UK, 2004). According to the Kenya Pharmaceutical country profile 2010, in 2006, 63% of total health expenditure in Kenya was spent on pharmaceuticals. In addition, 91% of the total pharmaceutical expenditure was spent by the private sector with the Government of Kenya accounting for only 9% (NBS, 2010). Besides that, it is estimated 70% of Kenyans use traditional medicine (NCAPD, 2005).

Boon and Davidson state that the purpose of drug therapy is to cure or alleviate symptoms (2006). In addition, all drugs have adverse side effects and the potential good is weighed against the potential harm before a prescription is given (benefit to risk ratio) (Boon and Davidson, 2006). Furthermore, Boon and Davidson write that dosage regimen is dictated by factors which include: adverse side effects, drug interactions, and drugs with low therapeutic index (Boon and Davidson, 2006). In addition, practitioners also consider the timing and frequency of drug administration (Boon and Davidson, 2006). For proper illness management, optimal use of appropriately prescribed medication is important, however non-adherence to medication threaten this (UK, 2004). However people do not always go to a health facility (Watsierah, Jura, Oyugi, Abong'o&Ouma, 2010).

We self-medicate for both real and perceived health problems (Sloand&Vessey, 2001). According to Hughes, self-medicating for minor ailments is an option which could not

only help decongest hospitals, but it could also encourage people to be more involved in their health (2003). Ideally, self-medication is the “management of a minor ailment using a pharmaceutical product that is available without a prescription” (Hughes, 2003,p.1).

These products are classified as non-prescription medication or over-the-counter (OTC) medicines (Hughes, 2003). Like all medicines, OTCs are also subject to medical misuse and nonmedical abuse. Hughes defines misuse as “use of drugs for medical purpose but in an incorrect manner” while abuse is defined as “use of drugs for non-medical purposes” (2003, p.1). Self-medication using OTC can lead to delay in treatment of serious health conditions, masking of symptoms of a serious health condition, increased polypharmacy, an increase in the risk of interaction with regular medication (Hughes, 2001) as well as gastrointestinal problems and liver failure (Hanoch,Katsikopoulos, Gummerum& Brass, 2007, p. 802) . In addition it could also lead to an increase risk of prescribing cascade which is an adverse drug event caused by misinterpretation of an adverse drug event as a new symptom, leading to prescription of new meds which in turn could lead to additional adverse effects (Hughes, 2001, p.3).

Self-medication is however not limited to OTCs, people also self-medicate using prescription medicines (Chuma, Gilson &Molyneux, 2010; Watsierah et al., 2010; Goldsworthy, Shwartz&Mayhorne, 2008; Sloand&Vessey, 2001; Simoni-Wastila, 2000). In addition to misuse and abuse, self-medicationof prescription medication just like OTC’s can increase the chances of an adverse drug event (Hughes, 2003), which is

estimated to be the sixth leading cause of death worldwide (Hacker, 2008). Furthermore, self-medication will not be documented in one's medical record and this could lead to "miscommunication and inappropriate follow up" with fatal consequences (Goldsworthy et al., 2008, p.1116). For example, in Malaria endemic areas, 50-80% of the people self-medicate which has led to patterns of "overuse, underuse and inappropriate use" of anti-malarial drugs (Watsierah et al., 2010, p.2).

Medication sharing, which is defined as "giving medications to someone else or taking someone else's medication" by Goldsworthy et al.,(2008, p.1115) is a public health concern because it often results in treatment of symptoms and not the underlying disease (Goldsworthy et al., 2008; Simoni-Wastila, 2000). In addition, it results in reduced or delayed care seeking (Hughes, 2003), increased perceptions of ineffective treatment, increased antibiotic resistance, increased risk of side effects (Goldsworthy et al.,2008; Daniel,Honein&Moore, 2003) and drug abuse (Goldsworthy, et al., 2008; Simoni-Wastila, 2000). There is also the possibility of loss of warning and instructions concerning the medication being shared (Goldsworthy, et al., 2008). In women, the effect in addition to those mentioned above also includes possible teratogenic concerns, that is, medication sharing could raise the incidence of congenital malformations (Danielet al., 2003; Simoni- Wastila, 2000).

Statement of the problem

Medication sharing can lead to serious health consequences. Studies have demonstrated that women are more likely than men to share medication (Petersen, Rasmussen, Daniel,

Yazdy&Honein, 2008; Daniel et al., 2003). Furthermore, studies have shown the influence of social connections on health(Chumaet al., 2010; Watsierah et al., 2010; Goldsworthy et al., 2008; Sloand&Vessey, 2001; Simoni-Wastila, 2000).Goldsworthy, Shwartz and Mayhorne study showed that a social connection, be it familial or friendship connection, was a deciding factor in medication sharing for 1 out of every 4 participant.It is not clear why women are more likely than men to share medication.

These studies demonstrated the patterns of medication sharing across general populations and not in tight knit socially connected groups.There is therefore a need to examine the medication sharing in a tight knit socially connected group. There is a further need to examine why women are more likely to participate in medication sharing and the influence their social networks have on this behaviour. Therefore the purpose of this study wasto explore how social network influences medication sharing among Kenyan Somali women which is a tightknit socially connected group.

Justification of the study

In a social network, a health intervention given to one influential person can have an unintended effect on the rest of the network (Rossetti-Ferreira, Amorim& da Silva, 1999). I have over the years observed that the Somali have a strong local and global social network. These were evident among schoolmates, at weddings and even funerals. In addition I have observed how families interact during public holidays such as Idd Mubarak among others. I have observed the practice of medication sharing taking placeduring my interaction with the Somali women.

The study intended to explore how these social networks influenced medication sharing among the Somali women. The findings of this study will hopefully provide useful information from the Somali women's perspective on the extent to which their social networks influence the practice of medication sharing amongst them. At the practical level, the study may inform health related policies including use of medicines, education on medication sharing and control and/or prevention of infections and drug resistance.

Research question

1. How do social networks influence medication sharing among Somali women living in Eldoret town?
2. What are the characteristics of the social network ties with the most influence on medication sharing behaviour?

Objectives

Broad objective: To describe the influence of social networks on medication sharing among Kenyan Somali women living in Eldoret.

Specific objectives

1. Describe the Somali women's perception of medication sharing.
2. Identify forms of social networks evident among Kenya Somali women living in Eldoret town.
3. Examine how the social networks influence medication sharing behaviour.

Assumptions of the study

This study will be based on the lived experiences of the Somali women. It is assumed that these lived experiences will shed light on the influence of their social networks on their health decisions particularly on medication sharing behaviour.

CHAPTER TWO

LITERATURE REVIEW

Introduction

The Kenyan healthcare system is gradually shifting towards a community health strategy which aims to make communities responsible for their healthcare (Kenya, 2007). The role individuals and the community as a system play in health are becoming increasingly important. Patients are now empowered health care users and are proactive in the choice of health care and health information source (Chuma et al., 2010, Watsierah et al., 2010). The choices they make may appear to be unhealthy from the health care providers' point of view, but to them, they may appear logical (UK, 2010). For example, Chuma et al. examined treatment seeking behaviour along the Kenyan coast in both urban and rural populations (2010). One of the outcomes from the study in regard to treatment seeking options was that the participants reported a single action or type of provider (Chuma et al., 2010). Self-medication was often the first intervention undertaken and it involved either sharing somebody else's leftover medication, going to a pharmacy and getting over-the-counter medication or using drugs from shops which because people were waiting "to see" if the symptoms would disappear (Chuma et al., 2010, p.676).

Studying social systems and their influence on health is significant especially since social norms embedded in social networks might influence health behaviour (Rostila, 2010). Furthermore, studies show that a health facility is not the first choice when seeking health related interventions (Chuma et al., 2010; Special Programmes for Research and Training in Tropical Diseases; Watsierah et al., 2010). Case in point is a study carried out by Watsierah et al. on the factors determining anti-malarial drug use in Kisumu reported that most participants reported visiting the health facility only when their other health information sources did not lead to a cure (2010). In addition, they also noted that the household head influenced patterns of drug use with female headed households reporting higher incorrect medicine use. Other than pharmacies, private clinics and government hospitals, friends, relatives, neighbours and left over medicines were reported as sources of anti-malarial medication. Finally, only 51% of the participants in the study reported using the anti-malarial drugs correctly (Watsierah et al., 2010).

Goldworthy et al. define medication sharing as, “giving medications to someone else or taking someone else’s medication” (2008, p.1115). The literature suggests that women are more likely than men to practice medication sharing (Ellis & Mulan, 2010; Goldworthy et al., 2008; Daniel et al., 2003; Simoni-Wastila 2000). This is in part influenced by “gender differences in coping with and expressing anxiety and distress, willingness to seek medical care and perceptions of illness” (Simoni- Wastila, 2000). Some reasons given by women for sharing medication include: common practice, sharing with friends and family, medication costs, helping others, and already having a

prescription for the same medication (Daniel, et al, 2003). For example, a study conducted by Daniel, et al on prescription medication sharing among teenage girls, reported that medication sharing was “relatively common in adolescents” with 20.1 % of the girls reporting medication sharing compared to 13.4% of the boys (2003). In this study, 40.2% of the adolescent girls indicated that they would share medication if they had a prescription for the same medication, 33.4% indicated they would share medication with family members and 29% indicated that having the same medical condition was also a possible reason to share medication (Daniel, et al, 2003). This evidence is supported by a study conducted by Goldsworthy et al.on the frequency, circumstances and consequences of prescription medication sharing, where 39.4% of the participants indicated that they would be willing to share prescription medication with a family member and 38.6% were willing to share prescription medication with someone with a similar condition (2008). In addition, 23% of the informants reported loaning their prescription medication to someone else and 27% reported borrowing prescription medication from others (Goldsworthy et al., 2008). 1 out of 4 participants in the Goldsworthy et al.study indicated that they would share their medication if they thought it “could help a friend” and 1 out of 5 indicated they would share medication if they had “left over medication that would be wasted” (2008, p. 1118).

2.2 Social networks

Smith and Christakis define a social network as the contacts an individual has and the nature of the ties that connect them (Smith & Christakis, 2008, p. 407) and this includes

family, friends and co-workers (Young, 2004). They emphasized that the interrelationship between the ties is an important characteristic of a social network (Smith & Christakis, 2008) because people are interconnected, so is their health (Smith & Christakis, 2008; Cohen & Lemay, 2006). This is supported by Rostila (2010) who wrote that social networks can have either a positive or negative health consequences as they reinforce norms and attitudes.

People tend to form networks with similar others, a tendency known as homophily (Rostila, 2010; Smith & Christakis, 2008). The similarities might be based on gender, ethnicity, religion, education, race, age and occupation with ethnicity and race creating the strongest social divide in our personal surroundings (Degand, 2015; Rostila, 2010). Because human action and cognition are social, the composition of our social network is important in interpreting our health related decisions (Raudsepp, 2005). Social networks and health can influence each other in two ways: (a) the effect of health on the network structure and (b) the effect of the network structure on health (Smith & Christakis, 2008). Social networks limit individuals' social environment and this in turn influences the "information they receive, attitudes they form and interactions they experience" with either a positive or negative effect on the health of the network members (Rostila, 2010).

Rossetti-Ferreira et al. wrote that social networks can either be dyadic (made up of pairs of individuals) or supradyadic (multiple persons or groups) (1999). Technology and globalisation has made membership to both types of networks almost equally accessible and influential (Smith & Christakis, 2008; Raudsepp, 2005). They affect health through

various mechanisms, including (a) social support, (b) social influence (c) social engagement, and (d) person to person contact (Smith & Christakis, 2008). Consequently, a health intervention given to one central network member can have an unintended effect on the whole network (Smith & Christakis, 2008).

Social networks can consequently be a source for health information and a potential source of influence on patient medication taking behaviour both as an alternative treatment source and as a referral system (Latkin et al, 2009; Rossetti-Ferreira et al., 1999; Young, 2004). It is important to understand the patients' beliefs about their illness and treatment from the patients' perspective as an approach to minimise unsafe medication practices (Kenya, 2011; Watsierah et al., 2010; Smith & Christakis, 2008). It is also important to identify how patients, particularly women identify sources for health information and how these sources influence their medication taking behaviour (Cohen & Lemay, 2006; Kenya, 2011; Simoni-Wastila, 2000; Uzochukwu&Onwujekwe, 2004) because "even when alone, a person's behaviour presupposes a partner" (Rossetti-Ferreira et al., 1999, p. 338) and "women make 70% of the decisions to seek care for their social units" (Young, 2004,p.12).

2.3 Illness and Health Seeking behaviour

Young wrote that "illness is a social as well as biological and cultural event" (Young, 2004, p.9). "Perception of illness", Young added, "is the first step to behaviour" (Young, 2004, p.9). Young further added that we are socialised to view illness in a specific way which includes our coping behaviour, "choice of care giver, success of

interaction between the patient and ...doctor, degree of compliance with the prescribed regimen and the degree of recover/cure” (2004, p.9). Illness, argued Young, is socially constructed, while disease and sickness are biologically constructed. Young’s argument can be used to explain the different courses of action we undertake when we perceive ourselves to be ill. The action we undertake when we perceive ourselves to be ill is our health seeking behaviour (Lambert & Carmen, 2007; Uzochukwu&Onwujekwe, 2004).

2.4 The Somali

The Somali are members of the Eastern Cushites who occupy North Eastern region of Kenya. In addition the Somalis also reside in major towns and cities within Kenya. Eldoret town has a large number of the Somali community. The first group of Somali settlers in Eldoret inhabited what is currently referred to as Kambi Somali in the early 1900s. This was possible because Colonial settlers offered job opportunities to the Somali people. With time and by 2013, the Somali community in Eldoret has grown in numbers and can be found in different parts of Eldoret Town and in different occupations and or sectors of the economy. However most men are entrepreneurs and majority of Somali women stay at home and look after their children (Mama Asha, personal communication, May 2013).

2.4.1 Religion

The predominant religion practiced by the Somali is Islam. Both religion and culture shape their way of life. Most practice polygamy as under Islamic law where a man is allowed to marry up to four wives. The Somali are made up of a group of clans. The

Somali clans found in Kenya are the Isxaaq, DaroodOgaadeen, DaroodHarti and Hawiye. The Isxaaq and Darood are the largest clans. The Isxaaq and DaroodHarti clans are predominantly found in major towns in Kenya, while the DaroodOgaadeen clan resides in Wajir and Garissa regions. The Hawiye clan is divided into two subgroups, the Murale who reside in Mandera, and the Ajuuraan who inhabit Wajir, Marsabit and Isiolo regions (Jenkins, 2006).

The family and in extension the clan is an important institution among the Somali. Clan membership is determined by paternal lineage. In addition, upon marriage a woman joins her husband's clan although she retains a connection with her family and clan. Moreover, they rely on their clansmen for social, emotional and sometimes financial support. Word of mouth is a major method of communication because they are an oral people and express themselves through songs and poems. The Isxaaq and Darood traditionally practiced pastoralism and some still do, while the Hawiye, traditionally were farmers. They trace their lineage through clan and sub clan membership. Clan families dictate the nature of relationships amongst themselves (Ali, 2007).

2.5 Conceptual framework

This particular study was influenced by aspects of the social network structure in the social network theory as postulated by Sih, Hanser & McHugh (2009) and Berkman & Glass's (2000) interpretation of the behavioural influence of social networks on health status. As illustrated in the diagram and discussion below, social networks are made up of interconnecting individual ties. Social networks operate by either providing access to

or restricting access to health related opportunities (Berkman, Glass, Brissete&Seeman, 2000). These opportunities can include medication sharing.

The basic premise of the social network theory is that social structure matters and that a social structure is made of four characteristics (Sih et al., 2009). First, individuals differ in their social experiences. Secondly, indirect connections matter. Thirdly, individuals differ in importance in the social network. Lastly, social network traits often carry over across contexts (Sih et al., 2009).

Berkman and Glass argue that social networks influence health behaviour in four ways. Firstly, network ties influence health by providing different kinds of social support. These include emotional, instrumental, appraisal and informational support. Secondly, network ties provide a basis for attitude comparison through social influence. Thirdly, network ties provide opportunities for meaningful participation through social engagement and attachment. Lastly network ties provide access to resources and material goods (Berkman et al., 2000, p. 846). These factors can influence a person's health behaviour, including medication sharing, either positively or negatively depending on the individual's social network structure.

The diagram below (figure 1) is a visual representation of the behavioural influences a social network can have on its individuals.

Figure 1.1 A visual representation of the effect of social networks on its individuals, adapted from Sih, Hanser & McHugh's Social Network Theory (2009) and Berkman & Glass's (2000) interpretation of the behavioural influence of social networks on health status.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter describes the study setting, study and target population, study design, sampling procedure and sample size, selection of participants, data collection tools and procedure. As well as, data entry, analysis and presentation, reliability and validity in research and ethical issues of the study.

3.2 Study Site

The study was carried out in Eldoret Town within Uasin Gishu County. Eldoret is a town within Eldoret Municipality which covers about 147 square kilometres and is elevated between 2100 meters above sea level to 2700 meters. This area is a busy business hub and is home to agricultural, horticultural, textiles, food processing and timber industries. Also, it is administratively made up of 14 wards namely: Kamukunji, Kapyemit, Kidiwa, Stadium, Market, Hospital, Kapsoya, Kimumu, Kipkenyo, Langas, Pioneer and Racecourse. Finally, according to the 2009 population census, it had a population of approximately 289,380 people (Kenya, 2010).

3.3 Study Population

Because of the nature of a phenomenological study where the “phenomena dictates the type of participant” (Degand, 2015; Groenewald, 2004), the participants, Somali Women above the age of 18, were chosen from within Eldoret town particularly from areas with a

high concentration of Somalis. The first group of Somali settlers in Eldoret inhabited what is currently referred to as Kambi Somali in the early 1900s (Mama Asha personal communication, May 2013).

3.4 Target Population

This study targeted Somali women above the age of 18 residing in Eldoret town.

3.5 Study Design

This was a Phenomenological study. A phenomenological study focuses on the lived experiences of individuals, their perceptions, perspectives and understanding of particular situations (Degand, 2015; Newberry, 2011; Groenewald, 2004; LeVasseur, 2003; Caelli, 2001; Leedy & Ormrod, 2001). The focus of this phenomenological study was to gain insight into the lived experiences of the phenomenon medication sharing behaviour among Somali Women through multiple perspectives of the same situation. This was done using semi-structured in-depth interviews and observations to.

3.6. Sampling Procedure and Sample Size

The nature of a phenomenological study dictates both the method and type of participant chosen (Degand, 2015; Groenewald, 2004). Purposive sampling, as recommended for phenomenological studies, (Degan, 2015; Leedy & Ormrod, 2001) was used to identify a key informant to the Somali community in Eldoret. The key informant then identified informants looking for those who could recruit more informants using snowball

sampling. Snowballing, is a technique in which each successive informant or group is named by a preceding group or individual (Le Compte & Preissle, 1993). “Snowballing”, is further defined by Groenewald as “a method of expanding the sample by asking one informant or participant to recommend others for interviewing” (Groenewald, 2004).

Leedy and Ormrod regard 5-25 individuals as a sufficient sample in a phenomenological study (Leedy & Ormrod, 2001, p.157). A total of 30 women took part in the in-depth interviews.

Having identified a key informant to the Somali community in Eldoret and explaining the nature of my study, I requested help in identifying informants to take part in the study. Using purposive sampling, my key informant introduced me to 8 women. 3 from the Central Business District, 2 from Kapsoya, 2 from West Indies and 1 from MailiNne. My key informant then requested these women to introduce me to other informants.

This is how my study informants were recruited using both purposive and snowballing techniques. Through these two techniques I was introduced to 33 women, of whom 30 agreed to take part in the study.

Fig 3.1 purposive and snowballing sampling chart

3.7 Eligibility Criteria

The inclusion criterion was one had to be Somali woman above the age of 18 and residing within Eldoretown at the time of the study.

3.8 Data Collection Tools and Procedure

I employed a multi-dimensional approach in my data collection using, semi-structured in-depth interviews and observations, as recommended for phenomenology studies (Degan, 2015; Bowen, 2005; Leedy&Ormrod, 2001). First, I conducted semi-structured in depth phenomenological interviews with the respondents. According to Groenewald, a phenomenological interview is a discussion between two people about “a theme of mutual interest” in which the researcher’s intent is to “understand the phenomena as experienced by the informant in their own terms” (2004, p.47). For the informants, these experiences are what their realities are based upon (Degand, 2015). Interview questions were directed towards the informantsexperiences, beliefs and convictions about the themes in question. The interviews lasted between twenty minutes to one hour in length. Only five women agreed to have the interviews audio taped.

These five audio-taped interview sessions were assigned a code, correlating to the question in the semi structured guide and later transcribed. During the non-audio taped interviews, the researcher wrote down the informants responses. These non-audiotaped interviews were typed and assigned codes similar to the ones in the audio-taped interviews. The interviews were conducted in homes and places of business at a time

convenient to the informants. During the interviews there were occasional interruptions, such as the informant taking care of a child, answering the door or serving a customer. The interruptions at the place of business were helpful in that I was able to recruit two more participants into the study as well as gather more information about the Somali women's social network and how it influences medication sharing. These insights were included in the observation field notes and they enriched the analysis of the data.

The interviews were carried out in English, Kiswahili and two informants requested a friend to translate from English to Somali. But after the demographic questions, they no longer required the translation services and they answered the questions without waiting for a translation.

I also used observations as a data collection tool. I recorded what I heard, saw, experienced and thought in the course of collection and reflected on the process. The observations were dated to enable correlation with the data at a later stage. The two women who had asked for a translator approached me after the interviews were conducted and I included our discussions under observations. This was because these discussions took place after the interview, but were related to the phenomena of medication sharing.

3.9 Data Entry, Analysis and Presentation

The semi-structured in-depth interviews were first transcribed. After transcribing the semi-structured in-depth interviews, I took the following steps as recommended by Groenewold, 2004 and Leedy and Ormrod, 2001:

1. I *identified statements that related to the topic*. I did this by separating relevant from irrelevant information in the interview and then explicated (“investigation of the constituents of the phenomenon while keeping the context of the whole” (Groenewald, 2004)) the relevant information into small segments such as phrases and sentences that each reflect a single, specific thought.
2. I then *grouped statements into “meaning units”*. I grouped the segments into categories that reflected the various aspect/meanings of the phenomena as they were experienced.
3. I then *sought divergent perspectives*. I looked at and considered the various ways in which different people experience the phenomena. This included the literal way the phenomena were described, as well as the number of times it was mentioned.
4. I then *grouped the units of meanings to form themes*. The various units of meanings were grouped together into clusters that described the phenomena.
5. Finally I *constructed a composite*. I used the various clusters identified to develop an overall description of the phenomena as people usually experienced them (Groenewold 2004; Leedy and Ormrod, 2001).

3.10 Reliability and Validity in Qualitative Research

In keeping with the tests for rigour, I adopted the following approaches as recommended by Groenewald, (2004); Conroy, (2003);Golafshani,2003; Patton, (1999):

1. Dependability was ensured by providing an audit trail or documentation which included field note accounts, audio recordings and transcriptions.
2. Confirmability of the data were demonstrated by “comparing and cross checking the consistency of information derived at different times and by different means using qualitative methods” (Patton, 1999, p.1192). This was done by collecting data using two different data collection techniques that is semi-structured in-depth interviews and observations.

Ethical Issues of The Study

The aim of the study was explained in detail before gaining informed consent from informants. Also, by an informant agreeing to take part in the interview was taken as implied consent. All the information from informants is treated with confidentiality and the stored data are in a password protected laptop. Respect and dignity was upheld while collecting data. If an informant did not want to be probed deeply I respected that Identifiers were erased and any information that would lead to one identifying informant was erased. An approval from the Institutional Research and Ethics Committee (IREC) of Moi University was obtained prior to the commencement of the research.

CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter focuses on the findings of the study and it is organized as follows; the first section describes the socio demographic characteristics of the informants and the second section concentrates on the themes generated from the study and data that address the research objectives.

4.2 Socio-demographic characteristics of the informants

Table 4.1: Background characteristics of informants

| Characteristic | Number Of Informants |
|--------------------------|-----------------------------|
| Age | N=30 |
| 18-27 | 3 |
| 28-37 | 9 |
| 38-47 | 9 |
| 48-57 | 3 |
| 58-67 | 2 |
| 68-77 | 1 |
| 78-87 | 1 |
| Did not disclose | 2 |
| Marital Status | N=30 |
| Single | 1 |
| Married | 23 |
| Separated/divorced | 2 |
| Widowed | 4 |
| Educational Level | N=30 |
| No formal education | 9 |
| Primary incomplete | 8 |

| | |
|---------------------------|-------------|
| Primary complete | 4 |
| Secondary complete | 4 |
| Secondary + | 5 |
| Occupation | N=30 |
| Casual labourer | 21 |
| House wife | 7 |
| Business owner | 1 |
| Formal employment | 1 |
| Number of children | N=30 |
| None | 2 |
| Pregnant | 1 |
| Two | 1 |
| Three | 3 |
| Four | 10 |
| Five | 7 |
| Six | 2 |
| Seven | 2 |
| Did not disclose | 2 |
| Site | N=30 |
| Central Business District | 5 |
| Huruma | 1 |
| Kapsoya | 5 |
| MaliNne | 7 |
| Mwanzo | 1 |
| West Indies | 11 |

4.3 Findings

4.3.1 Introduction

The term “medication sharing” includes both medications loaning which is giving someone your medicine and medication borrowing which is asking someone for medicine (Goldsworthy,2008, p.1115). A small group of informants, 3 indicated that they did not share medication and they had neither encountered nor heard of anyone who

had. 6 of the informants indicated that although they did not share medication, they had come across people who did. Twenty one of the informants reported various degrees of sharing medication behaviour.

4.3.2 Drugs shared

The informants shared a variety of drugs, and in some cases the informants themselves were not sure what exact drug they had been given. The drugs shared ranged from over-the-counter drugs like Paracetamol and Aspirin to antibiotics.

Antibiotics and painkillers were the most common drugs shared across the board. However women with young children mentioned that they commonly shared cough medicine and pyretics. The older women shared antibiotics, and in addition depending on the chronic condition of the individual hypertension medication, diabetic medication and painkillers. The list below shows the drugs the informants mentioned having shared.

Table 4.2: List of drugs mentioned by informants

| | Drugs | No. of informants who reported using drug |
|-----------|---|--|
| 1 | Antibiotics- Amoxicillin | 11 |
| 2 | Hypertension medication | 3 |
| 3 | Prescription painkillers e.g Aspirin, Paracetamol, Piriton, Ibuprofen, diclofenac | 20 |
| 4 | Vitamins | 1 |
| 5 | Herbal medicine | 4 |
| 6 | Diabetic medication | 1 |
| 7 | Cough syrup e.g coldcap | 7 |
| 8 | Ulcer medication | 3 |
| 9 | Fertility drugs | 1 |
| 10 | Antipyretics | 2 |
| 11 | Antiemetics | 4 |
| 12 | Antimalarials | 2 |

4.3.3 Themes and sub-themes

As noted in the methodology chapter, following the steps recommended by Groenewold (2004) and Leedy and Ormond (2001), I first identified statements that related to the topic. The relevant information was explicated into phrases and sentences that reflected a specific thought. I then grouped the statements into themes that reflected the various

aspects influencing the phenomena as they were experienced. I then sought divergent perspectives of the phenomena and finally I developed an overall description of the phenomena as experienced by the informants.

Table 4.3: Themes and Subthemes

| THEMES | SUB-THEMES |
|----------------------------------|--|
| Approach to health | <ul style="list-style-type: none"> ▪ Nature of illness ▪ Seriousness of the illness ▪ Time of onset of illness ▪ Availability of resources |
| Denial | |
| The Amoxicillin Phenomena | |
| Addiction | |
| Harm | |

Approach to health

The informants' approaches to health were varied and dependent on various factors. Decisions were based on nature of illness, seriousness of illness, and time of illness and availability of resources. For example two informantsailing from Arthritis reported a routine with how they dealt with early morning stiffness. CBD 01 and KAP 02 had this to say:

If I am not feeling well, the first thing I do is to take water and clean myself for prayers, brush my teeth then I pray after praying I take my tasbii and pray. Then I

leave for the shop to work. I don't feel well but I have to go to work. After praying like that I feel better (KAP 02).

a) Nature of illness

The nature of the illness determined the participants approach to health. Some health complaints were not deemed serious enough to seek medical attention from a health facility. From the participants' description, ulcers were one of the health complaints that were least likely to warrant a trip to a health facility. One participant said she goes to hospital for all other complaints other than ulcers. In the first quote below, the informant describes her sharing behaviour with a neighbour:

The neighbour usually borrows but there was one time the ulcers were severe so the neighbour went to the hospital. I give two-three tablets. The neighbour has money but you know it is a neighbour so I give out (InformantMWA 01).

She describes her neighbour as having money, to differentiate this neighbour from her other neighbours who may borrow medicine because of lack of resources. For other participants, particularly those with chronic illnesses, they described a routine that they go through as shown below:

In the morning I usually feel that my body is not right, my leg, my back, all ache. I sit for a while then I take a hot bath. When I take a hot bath I feel a little relief. Then I come to work, sometimes I take a painkiller sometimes I don't. If I get worse I go to hospital (InformantCBD 05).

For others with chronic illnesses, their approach to health appeared to be slightly different. Informants described how people would come to them and demand a specific drug for a specific condition. One of the informants shared how a neighbour would come to their house and demand hypertension medicine. This neighbour was aware that

Informant KAP 01's mother had hypertension and was receiving treatment for the same. Furthermore she believed that Informant KAP 01's mother's medicine was of better quality than hers. The following quote illustrates Informant KAP 01's recollection of one such incident: There was one woman who used to live here. That grandmother would come and say 'I have pressure give me your medicine for pressure'(Informant KAP 01). Informant CBD 02 gave a reason why she believes this is so as follows: "They believe your medicine is better than theirs".

Informant CBD 05 described a similar incident as follows:

Women who have aching legs they will say to you, 'you had a leg that was aching recently, what drug did you take?' 'There is this drug which is very good let me show you', you give you two tablets they go and buy (Informant CBD 05).

Other informants described scenarios where the participant in the medication sharing was more proactive. For some, instead of waiting for people to borrow medicine, they take initiative to give it away. This is especially the case when they are dealing with someone who has similar symptoms to theirs. This is illustrated in the following quote:

But we usually tell them, 'there is this drug that has helped me, let me show you'(Informant CBD 05).

Depending on the nature of the illness and age of participants, the quantity of medicine the informants described sharing was. Most of the participants described giving one to four tablets at most. The elderly, however, were identified as a group that specifically asked for half of one's dosage as Informant KAP 01 describes in the following quote:

“Particularly these old people, particularly the old people. They are the ones with this problem. They hear someone is sick, what helped you, these medicine, give me half, you are given half” (KAP 01).

b) Seriousness of illness

The seriousness of the illness, as described by the informants, also informed their approach to health. In the first quote below, the informant describes what illness she feels is serious enough to necessitate her going to the hospital:

I only go to hospital if i have diarrhoea or fever, any other illness, no. I don't like going to the hospital (Participant KAP 05)

Another participant explained that for her to visit a health facility, she must be very ill, she preferred going to her neighbours for medicine. For others, a serious illness meant a trip to the chemist. Those participants who preferred to go the chemist when they were very ill said they were afraid of going to the hospital. This may be because a chemist is less likely to ask intrusive questions or they may have had a bad experience.

Medical emergencies were also identified as situations when medicine was shared. These emergency situations included being in pain and not having immediate access to a health facility, and it being too late to go to a health facility. In the quote below, the informant explains why she borrowed medicine:

Sometimes your child is sick, you can't wait to go to hospital, you just ask your neighbour or friend for medicine (Informant WIN 05).

Informants also reported that they were not consistent with taking their prescribed medicine especially after they started feeling better. They gave several reasons for this including changing doctors often, not being expected to finish a dose and stopping

medication ones they felt they were better. They only took medicine as long as they felt they were seriously ill regardless of the type of medication they are on. This explains why they always have extra hypertensive medicine, extra antibiotics and extra painkillers.

Informant WIN 01 shared her experience as follows:

“You know most people when they take medication when they start feeling better, they stop the medication, me included. They don’t finish so... like when you start feeling better, you stop and just keep them, when the doctor prescribes again, if they are not expired you just take them”.

c) Time of onset of illness

In some cases going to hospital or seeking a professional medical opinion was seen as a hindrance rather than a solution to receiving treatment due to time it would take to get to the health facility, the waiting time at the health facility and the time the illness struck. One of the informants, described how in the 15 years she had been married, her husband had been to hospital twice. Her husband has medical cover but does not have time in his busy schedule to visit a health facility, preferring to go to a chemist where he gets medicine which he does not finish. Another informant, as shown below, describes a similar scenario:

You know when someone feels unwell at that time, they borrow. They feel that the hospital is far and they feel that they don’t have time to go, they want instant pain relief (Informant WIN 03)

Other informants gave similar accounts. They feel that going to a neighbour, to the chemist or to a friend for medicine are faster than going to a health facility and in some cases the pain relief will be faster.

d) Availability of resources

Availability of resources was one of the factors that informants considered when thinking of their approach to health. The resources considered included availability of any drugs, availability of a particular drug and lack of money. Some informants explained that having drugs available and the inability to deny a friend's request for drugs as one of the reasons they shared medication.

If somebody asks you for medicine, you can't say no (Informant WIN 05).

There are those informants who shared that they borrowed whatever drugs a friend or neighbour had available. However one of the informants further explained that, there were those who borrowed a specific drug. The quote below illustrates this point:

Many people share Amoxicillin because when you go to buy it, its like its expensive, the original one, it is a lot of money compared to the fake one and they prefer the original one, so instead of buying it, you just ask someone if they have it. The doctor prescribes it for you, you ask somebody else, so they don't take a full dose (WIN 01).

Other informants described how they shared medicine just because they were in a setting where the medicine was available at that particular time. This is especially the case when they make a social call as illustrated below:

Friends, they come to see you when they hear you are unwell, they ask, 'where does it hurt?' If you say your head, they ask you if the medicine works, if you say yes, then they say 'my head also hurts, give me some of your medicine' because it works better than theirs. If they are not ill, they will take whatever medicine you have, it doesn't matter which ones (Informant CBD 02).

Some of the participants shared scenarios where people borrowed medicine just because they saw another person take it. They did not take it because they were sick, but because they saw someone else taking medicine. They were also not choosy about the medicine in question, as long as it was medicine; they were willing to take it as described by Informant CBD 04: *"it doesn't matter what it is for. If they see you taking medication they will ask you, 'what is it for? Does it work? Even i am suffering from... and could you give me some?'. "*

Sometimes the availability of the drug leads others to take it without the knowledge or consent of the owner of the drugs as described by Informant KAP 04 below:

I don't borrow but my friend who is currently staying with me always does. She just takes medicine that is around without asking. She is not literate, she just takes what she finds. She assumes that all medicines are painkillers. One day she took antibiotics from the medicine cabinet (KAP 04).

However, some informants described how sometimes they simply lacked the resources to buy medicine or visit a health facility. One of the informants explained that the reason her children shared medicine was because she could not afford to buy medicine for each of her 7 children: "You know there is not enough money for each child. If a child gets sick, you give the child another ones medicine. If there is one who is coughing, you give them cough medicine" (WIN 11).

Denial

There were two examples of divergent information. The first example was between what the informants reported and what others reported about them. For example, informant KAP 02 reported “*no one has borrowed my medicine*”. However her daughter, another informant (KAP 01), reported that one of the neighbours used to come often to borrow medicine from her mother: “*There was one woman who used to live here. That grandmother would come and say ‘I have pressure give me your medicine for pressure’*” (KAP 01).

As the interview progressed, KAP 02 mentioned that she shared antibiotics with those in need. Later on she admonished her granddaughter for having refused to take antibiotics and instead insisting on going to hospital.

Another informant, WIN 01 also shared something similar. She reported that her mother not only borrowed her prescription medicine but shared medicine between two of her brothers. She expressed it as follows:

My mother once brought my baby brother medicine for cough medicine, Coldcap then my younger brother got sick again so she gave it to him... Yeah, the diclofenac, me included I share it sometimes with my mum with my siblings (WIN 01).

However during interview when WIN 03, WIN 01’s mother, was asked if she knows anyone who shares medicine, her response was “*Yes there are those who can, but it is not right. If you have a prescription it is yours...*” (WIN 03).

The second example was in what the informants themselves revealed during the interview process and during interaction with the researcher. For the second category of denial, MAL 01 denied sharing any medicine but admitted to borrowing the painkiller

Paracetamol, and observing others doing the same: *“I have not heard of anyone who borrows. All I have heard about is Panadol. Only Panadol, the painkiller no other medicine do I take from people. Panadol is the only medicine I see people share, I have seen no other medicine” (MAL 01).*

When asked if anyone had ever borrowed medicine from her, HUR 01 at first admitted to sharing medicine with a friend: *“Yes a friend. [borrowed from me] cough syrup for her child. But she later retracted her statement and said “No. I only take what the doctor prescribes. I finish my dose and I don’t give out my medicine” (HUR 01).*

In another example of denial, one of the informants CBD 01, said she did not know anyone who borrowed medicine yet during the interview, she admitted to sharing vitamins with her friend. Her daughter also passed by and tried to get her mother to share some of her herbal mixture which she had borrowed from somebody.

The Amoxicillinphenomena

One of the more shared drugs amongst the informants was Antibiotics, especially the Amoxicillin. It was described as a painkiller, a cure for anything and all that ails a person and a first aid option.

Even informant KAP 02 who said she does not share any of her prescription medicine mentioned that Amoxyl was one of the drugs she had no problems sharing with others *“now that one I use and I can share with someone” (KAP 02).* She gives reasons for this: *“Antibiotics are like Panadol; you can take Amoxyl, and give to someone. That*

cannot harm them because it is something you buy in the shops just like aspirin, we buy that, it causes no harm” (InformantKAP 02).

This view of how harmless Amoxylis, can be seen when the informants describe how they share it. The informants described taking it as one would an over the counter painkiller. Because of its popularity informant’s shared no more than 2 capsules per individual, however for pain relief, one tablet was described as adequate. In the following quote, informant MAL 05 describes how many Amoxyl capsules she shares and for what condition: *“Antibiotics, Amoxyl for chest pain... the antibiotics I give one capsule” (MAL 03).*

Furthermore, Amoxyl was identified by the informants as one of the most commonly shared drugs. It was also described as something that was good to take as illustrated by the following quote by Informant WIN 07: *“Amoxyl Yes I have heard, it is good to take, I have heard”.*

Addiction

One of the informants, WIN 04 identified addiction as one of the causes of the behaviour of borrowing medication. She specifically mentioned addiction to killers: *“There are also those who are addicts especially to painkillers and they also borrow medication. These are both men and women... Pain medication especially because of addiction” (WIN 04).*

KAP 04, another informant, described the behaviour of an addict although she did not label her friend whom she was describing as an addict: *“I also know this man. If he*

finds any medicine lying around even if it is in the street, he will take it. If you are not around he will take without asking. If you are, then he will borrow”(KAP 04).

CBD 04: “It doesn’t matter what it is for. If they see you taking medication they will ask you, ‘what is it for? Does it work? Even I am suffering from --- and could you give me some’.”

Harm

When asked whether anyone experienced side effects from the borrowed medicine, some one of the informants gave an affirmative response as follows: “Mostly allergies, the women will say, *‘That medicine made me ill’ Informant CBD 04”*.”

Most of the women who said they did not share medicine, or who qualified the type of medicine they shared, had either witnessed someone experience an adverse side effect as a result of sharing medicine or had heard something tragic happen to someone or knew someone who had something tragic happen to them after sharing medication. Interestingly, adverse effects happening to them did not appear to affect them as much as the adverse effects happening to someone else.

Informant KAP 02 described a medicine sharing scenario that led to death and because of the experience she said she does not share pressure medication or borrow hypertension medication. The reason she gave for not sharing hypertension medication was that even if two people have hypertension, they may not require the same dosage so one must go to a doctor to get the correct dosage. This was after she witnessed the following scene at a social gathering:

“Now there was one woman I heard who died, something like that. She used to live behind here, I heard she used to say ‘are you sick?’ yes, ‘what?’ pressure, ‘eh I was the one who was given pressure medication ... here take this pressure medication...’ now that woman took out her medicine and gave this other lady and blood came out from her nose and she died (InformantKAP 02)”.

For other participants, being advised against sharing medication by someone whose advice they respected was enough to not participate in medication sharing as illustrated in the following quote: *“I have arthritis so I go to the doctor. It is not right to share medication because people do not suffer from the same disease. My niece, who is a doctor told me it is wrong” (InformantCBD 02)*.

For other participants, it was a question of trusting the person prescribing the medicine as shown in the following response from Informant WIN 08:

I have never borrowed medication because I cannot trust them, the women, because some of them are not educated. How can I trust them? I only trust the doctor. Sometimes I go to the chemist even though am not very sure about what they are giving me but I go. If I sometimes have a cough or cold I go (WIN 08).

CHAPTER FIVE

DISCUSSION

5.1 Somali women's perception of medication sharing

The phenomenon of medication sharing is practiced by the Somali women living in Eldoret. The findings suggest that it was perceived as being one of the ways they help each other take care of their health. In addition, the women only took medicine or shared medicine that “worked”. These medicines could have worked for them before or for somebody else they know. These findings are consistent with studies by Petersen et al., Boyd, McCabe, Cranford and Young (2008, 2006) which found that medication sharing is common risk behaviour particularly amongst women.

5.2 Forms of social networks evident among Somali women in Eldoret

Family: The family, both extended and nuclear, emerged as one of the more influential social networks in both supporting and discouraging the practice of medication sharing. This is supported by studies by Ford and Lacerenza, Goldworthy et al., Petersen et al., Boyd, McCabe, Cranford and Young and Daniel et al. (2011, 2008, 2008, 2006, 2003).

In this study, with the exception of one woman who cited her husband who was a healthcare professional as the keystone individual in her family, women emerged as the

key individuals in health matters. This is supported by a study by Petersen et al. which found that women acted as family doctors (2008).

The family is also where drug taking behaviour is cultured. This study found that families did not disapprove not finishing a prescription and the use of left over medication by household members. This finding is similar to previous studies focussing on adolescents and self-medication showed that the practice of self-diagnosis and self-medication is approved or disapproved by parents (Sloand&Vessey, 2001). In the Sloan and Vessey study, the adolescents reported that they had access to medicine in the house and they either took or asked for the last medicine they had taken (2001). This is further supported by other studies that have shown that the family can act as a drug cache where the family's left over medication is pooled for later use (Goldsworthy et al., 2008; Boyd et al, 2006).

Friendships: Friends were also a great influence in the practice of medication sharing as supported by studies by Ford and Lacerenza, Goldsworthy et al., Petersen et al., Boyd et al. and Daniel et al., (2011,2008,2008,2006,2003). Only two informants identified friends as allies encouraging them not to share medicine by sharing both informational and social support. Friends were identified in influencing medication sharing in several ways. Firstly, friends could not refuse to give you medicine and they visit each other when they are unwell which gives them the opportunity to distribute whatever medication they are taking amongst themselves whether one is ill or not. These friends also occasionally provide a place to “shop” for any medicine one cannot afford instead

of going to a pharmacy with one's prescription or ones' child's prescription. Finally, for you to actually have medicine to share with your friends, you and your family cannot finish your prescribed medicine because if you do, you will have nothing to share.

Neighbours: Neighbours like friends also influenced the medication sharing practice in similar ways as they too are a part of an individual's social support system as postulated by Bernadi and Klarner (2014). One informant described how she always had to buy a double dose of medicine because she had a neighbour who always insists on borrowing her medicine whenever the informant went to hospital. Informants also cited neighbours as a source of medicine for visiting family members, especially their visiting elderly family members.

Just like with friends, there are those neighbours who "always" have medicine. One informant identified her medicine source as a neighbour who was never short of medicine because the neighbour's husband worked at a local health facility therefore always had medicine in the house. Just like with friends, informants expressed the need to always have medicine available so that you have something to give out to those neighbours who come to you for medicine.

Similar Health Conditions: There were those informants who described sharing medicine with people who had similar illnesses. This is similar to what other studies found (Goldsworthy et al., 2008; Petersen et al, 2008; Daniel et al., 2003). These were illnesses such as diabetes, hypertension and arthritis and ulcers and other illnesses requiring an antibiotic. With the exception of those who took antibiotics, this social

network was made up of people who 1) had similar diagnosis from a health care practitioner, 2) had a prescription, 3) had a long term condition which required more than one follow up hospital visit.

Self-Diagnosis: In these illness based social networks, there was an element of self-diagnosis just like in the other aforementioned social networks. A study by Boyd et al, (2006) also found that self-diagnosis was one of the initial steps taken by the study participants before medication sharing. The reasons these network members shared medicine included the belief that another's medicine was better than theirs, they thought that their network member required another type of medicine that their doctor did not prescribe, and cutting down costs by sharing medicine with someone with a similar condition.

Friends of Friends: The informants described situations where friends of friends shared medicine. This illustrates one of the aspects of the social network structure, that of indirect connections. Indirect connections can be as important as direct connections (Sih et al., 2009). For example one informant described two women who had never met before sharing fertility drugs. Others shared whatever one saw others taking. In the first case, the strangers shared medicine because they “worked” and in the second case it was so as not to be left out of an activity. Here we see what Bernadi and Klarner (2014) describes as building of a social support network by introducing people who have something to contribute to the social network, in this case information and drugs.

Houseguests: Another type of social network that influenced medication sharing was houseguests. These houseguests were not necessarily family members but friends and sometimes clan members. Somalis house each other, even relative strangers who are clan members, distant relatives or friends of friends. These houseguests can stay overnight or for months at a time. The informants mentioned that their houseguest borrowed mostly painkillers. However one informant shared that her houseguest who is a long term houseguest, takes medicine from the medicine cabinet. This medicine cabinet had mostly prescription medicine for her children. The houseguest took antibiotics which she thought were painkillers. In this particular household the host and her children inadvertently participated in medication sharing.

Health Care Professionals: Health care professionals also formed part of the informants' social network. However, they were rarely considered Keystone individuals in health related matters. For 10 of the informants, the hospital or doctor was the first step when seeking treatment. However, only 7 informants said that they followed their doctor's advice to the letter, and 5 were of the opinion that other than Paracetamol any other medicine taken must be prescribed by a doctor. For three of these five informants, that decision was influenced by having a family member in the health profession.

For the three women mentioned above, the family member in the health profession though younger than them, seemed to be a keystone individual to them in health related matters. For the two remaining women out of the afore mentioned five, the social network structure aspect of indirect connections exerting influence over health related

decisions was in effect. For these women, they listened to the doctor and followed the doctor's advice because a friend advised them that this was the best course of action.

5.3 Influence of social networks on medication sharing behaviour

No informant who took part in this study belonged to a social network that exclusively supported or disapproved of medication sharing. This was because they came together during celebrations and community events and they interacted during these events.

However when it came to health related issues, there was a distinction about whose advice and company they sought. This finding has been supported by studies on social networks that have shown that because a social network is made up of on-going social relations and the social structure does not fully determine an individual's actions (Bernadi&Klarner, 2014; Smith &Christakis, 2008).

The informants who did not support the behaviour of medication sharing sought the company of people with the following characteristics when seeking health related advice:

- a) A person who sought medical intervention from a medical practitioner when unwell,
- b) A person who finished their prescribed medicine,
- c) A person who only consulted individuals who did not support medication sharing when discussing health related issues and

d) A person who had made a conscious decision to not share medicine.

These social networks also provided both informational and emotional support that did not encourage medication sharing. The effect of this network on the informants' health behaviour led them to seek informational and emotional support from what their social networks viewed as highly credible sources, and this in turn enabled them to negate pressure from other sources encouraging medication sharing. The informational support provided included being given referrals to doctors and information on different medicines and how they work. The credible sources in these cases included medical professionals related to the informants, friends with the same beliefs and role models with a high social standing within the community.

Many of the informants belonged to social networks whose members mostly supported the practice of medication sharing. The members of these social networks appeared to be highly generous with their personal health information. This is especially important because a person's health information is important when deciding where to go for medicine especially when you are looking for a specific type of medicine. The members of these types of social networks also:

- a) Encouraged the practice of not completing dosages so as to have left over medicine,
- b) Played on the members' sense of guilt where members felt they had to share medication,
- c) Felt susceptible to illness.

In addition to these, the members of these social networks also provided emotional, active and material support. Just like in the Daniel et al. 2003 study, the members of this network were more likely to be a family member, those with similar health problems, someone with a medical emergency and someone who could not afford the medicine.

5.4 Conceptual framework, social network and medication sharing practice

This particular study was influenced by aspects of the social network structure in the social network theory as highlighted by Sih et al. (2009) and Berkman and Glass's (2000) interpretation of the behavioural influence of social networks on health status. The basic premise of the social network theory is that social structure matters and that a social structure is made of four characteristics (Sih et al., 2009). First, individuals differ in their social experiences. Secondly, indirect connections matter. Thirdly, individuals differ in importance in the social network. Lastly, social network traits often carry over across contexts (Sih et al., 2009). These factors can influence a person's health behaviour, including medication sharing, either positively or negatively depending on the individual's social network structure.

Berkman and Glass argue that social networks influence health behaviour in four ways (2000). Firstly, network ties influence health by providing different kinds of social support, providing a basis for attitude comparison through social influence, providing opportunities for meaningful participation through social engagement and attachment and lastly network ties provide access to resources and material goods. These four aspects can independently influence social networks.

Using the above factors as thematic headings, the results of this study shows the following patterns:

#1. Social support

The social support provided by a social network can be emotional, active, informational or judgemental. This could be through a physical meeting or through other forms of communication such as through phone calls. They have a phone tree system, where A calls B, who calls C who calls D and so on, and at the end of the day, they will have passed on whatever message, be it reporting a death, an illness or a wedding. In this way, you see social network traits carrying over across contexts (Sih et al., 2009). By using informational social support, they are able to pass on messages. The informants used a phone tree to pass on information.

The informants reported that they visited each other when they were ill, when they needed medicine, and to help out during functions. These visits provide a venue to share information, actively share medicine, make monetary donations and influence decision making as well as provide emotional support.

#2. Social influence

Social networks provide social influence by providing the opportunity for attitude comparison and health care utilisation (Petersen et al., 2008). However social influence

does not require physical contact. Social influence can be exerted by comparing your attitudes with those of similar others you have interacted with. The social influence exerted by the informants' social networks took several forms. The first type of social influence was through reinforcement of information about certain medicines, for example, even those who did not share medication voiced that they had heard about the wide range healing qualities of amoxicillin. In addition, the informants noted the use of words and phrases such as “good” and “it was prescribed by a doctor”, “strong”, “expensive” and “original” to encourage the sharing of particular drugs. Secondly, the social influence can be more direct where even those who do not want to share medication do so at social events so as to fit in with others.

#3. Social engagement and attachment

Social engagement and attachment gives one a chance to meaningfully participate in social network activities (Degand, 2015). This can be by both getting in touch with friends and meeting new people physically or by using other means of communication such as mobile phones and social media. This widens ones network because you meet new people, gather information and in some cases gain access to medicines. Social engagement and attachment also reinforces current social network ties.

#4. Access to resources and materials

Social networks can either restrict or provide access to resources and materials. The informants reported that the people who could provide access to resources and materials were known within the social network. These people included neighbours, friends and

family members. This is similar to the findings in a study by Ford & Lacerenza (2011). Access to resources and materials was not hindered by geographical location because one could send money and medicine across local and international borders. One's current health status also influenced the access to resources and materials.

If one had been recently ill then that person could conceivably be a resource person because there was a high likelihood of them having recently purchased medicine and therefore have some to share

#5. Perception

Some informants only took medicine or shared medicine that "worked". These medicines could have worked for them before or for somebody else they know. This is similar to findings in studies by Petersen et al., (2008) and Boyd et al. (2006).

Some women reported that they did not support or take part in medication sharing practice of medicines other than painkillers. They believed the consequences of sharing some types of medication were too high. Some of the barriers they perceived to sharing medicine were allergic reactions and death. This was likely because of the following previous experience:

5.5 Lessons Learnt in the field

1. The Somali community is very insular and without my key informant I would not have been able to recruit the thirty informants I required for the study.
2. Had my study been conducted any later, that is, after the West gate bombing I would have been unable to conduct it.

3. The Somali communication network is vast and information travels incredibly fast. After my second interview, a lot of the people had heard about me and while I was at Central Business District, people kept dropping in just to see who this person asking questions was.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

This study examined the influence of social networks on the practice of medication sharing among Somali Women living in Eldoretown.

Medication sharing is practised by the Somali women living in Eldoretand within their social networks. Their social network which is made up of both people of Somali and non-Somali origin has a direct influence on both the practice of medication sharing and the types of medication shared. The forms of social network ties identified were family, friendships, neighbours, those with similar health conditions, friends of friends, houseguests and health care professionals. Health care professionals emerged as one of the least influential of the social network ties while family, neighbours and friends being some of the more influential forms of social networks. The Somali women seemed to put more significance into their personal experiences and the experiences of members of their social networks than on the professional opinions of healthcare professionals in matters relating to medicines, illnesses and drug interactions.

Medicines, particularly those that are described as “strong”, “expensive” and “original” are more popular than those that are not described that way. In the same vein, medicines brought from overseas are considered better than the ones bought in Kenya. These characteristics were important when these medicines are being shared.

The Somali women’s described the members of their social network who lived close to them as neighbours, when they were of non-Somali origin and as friends when they were of Somali origin. They willingly shared medicine with their neighbours regardless of the ethnic persuasion. Friends and neighbours were a good resource during emergencies, when lacked money to visit a health facility or purchase medication, and also a good place to find out what new medication is available and to try it out for future reference.

The few Somali women who did not support the practice of medication sharing had their opinion changed by an adverse drug event while others changed their view after being educated on the dangers of medication sharing by someone, mostly family member, whom they held in high regard.

6.2 Recommendation

6.2.1 The community

1.

The Kenyan Somali women demonstrated some knowledge on drugs and what they treat. However, efforts are required to raise their knowledge on why correct

T

dosage is crucial and to encourage proper utilisation of the health care system and proper medicine use through existing local Kenyan Somali women's groups.

2.

S

ince mothers are usually the first responders to their children's medical emergencies, significant attention is needed to be directed to mothers to dissuade them from the practice of medication sharing. This will help in breaking the chain when it comes to learning the practice of medication sharing.

3.

E

ducation is needed to make the Kenyan Somali women aware of the interrelationship between the direct and indirect effects of medication sharing on them and their social network members.

6.2.2 The local government

Medication sharing is a practice that could hinder not only regular medical interventions but also medical interventions during outbreaks. Local governments should carry out qualitative studies on the practice of medication sharing to get a perspective on the reasons why it is taking place to counteract the practice.

6.2.3 Ministries of health and health agencies

The effects of medication sharing such as antibiotic drug resistance, do not only affect one community but the whole country. There is a need for better, consistent and centralised monitoring of drugs being sold particularly drugs that require a prescription

such as antibiotics. There should also be better enforcement of existing laws governing dispensing of drugs.

6.2.4 Implications for Future Research

The findings of this study identified the following key research areas which could be explored:

1. Future research is needed to determine if sharing of medication amongst members of a social network could lead to developing drug abuse problems particularly to painkillers, allergy medication and cough medicine.
2. Future research on medical practitioners experiences on medication non-adherence amongst their patients.

REFERENCES

- Ali, A.H. (2007)*Infidel: My life*. New York: Pocket Books.
- Berkman, L.F., Glass, T., Brissette, I. & Seeman T.E. (2000). From social integration to health: Durkheim in the new millennium. *Social Science & Medicine*, 51, 843-857.
- Bernadi, L. & Klärner, A. (2014). Social networks and fertility. *Demographic Research*, 30(22), 641-670. doi:10.4054/DemRes.2014.30.22.
- Boon, N. A. & Stanley, D. (2006). *Davidson's Principles and Practices of Medicine* (20th ed.). Edinburgh; New York: Elsevier/Churchill Livingstone.
- Bowen, G.A. (2005). Preparing a qualitative research-based dissertation: lessons learned. *The Qualitative Report*, 10(2), 208-222.
Retrieved from <http://nsuworks.nova.edu/tqr/vol10/iss2/2>.
- Boyd, C.J., McCabe S.E., Cranford J.A. & Young, A. (2006) Adolescents' motivation to abuse prescription medications. *Pediatrics*, 118, 2472. doi: 10.1542/peds.2006-1644.
- Caelli, C. (2001). Engaging with phenomenology: Is it more of a challenge than it needs to be? *Qualitative Health Research*, 11, 273.
doi: 10.1177/104973201129118993.
- Chuma, J., Gilson, L., & Molyneux, C. (2007). Treatment-seeking behaviour, cost burdens and coping strategies among rural and urban households in coastal Kenya: an equity analysis. *Tropical Medicine and International Health*, 12(5), 673-686. doi:10.1111/j.1365-3156.2007.01825.x.
- Cohen, S. & Edward, P. L. (2006). Why would social networks be linked to affect and health practices? *Health Psychology*, 26(4), 410-417.
doi: 10.1037/0278-6133.26.4.410.
- Conroy, S.A. (2003). A pathway for interpretive phenomenology. *International Journal of Qualitative Methods*, 2(3).

- Daniel, K. L., Honein, M. A., & Moore, C.A. (2003). Sharing prescription medication among teenage girls: potential danger to unplanned/undiagnosed pregnancies. *Pediatrics*, 111, 1167. Retrieved from http://pediatrics.aappublications.org/content/111/Supplement_1/1167.full.html.
- Degand, D. (2015). A phenomenological multi-case study about social success skills, aspirations, and related media experiences. *The Qualitative Report*, 20(6), 872-900. Retrieved from <http://nsuworks.nova.edu/tqr/vol20/iss6/13>.
- Ellis, J. & Mullan, J. (2009). Prescription medication borrowing and sharing: risk factors and management. Retrieved from <http://ro.uow.edu.au/medpapers/3>.
- Ford, J.A & Lacerenza, C. (2011). The relationship between source of diversion and prescription drug misuse, abuse, and dependence. *Substance Use & Misuse*, 46, 819–827. doi: 10.3109/10826084.2010.538461.
- Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The Qualitative Report*, 8(4), 597-606. Retrieved from <http://nsuworks.nova.edu/tqr/vol8/iss4/6>.
- Goldsworthy, R. C., Schwartz, N.C. & Mayhorn, C.B. (2008). Beyond abuse and exposure: Framing the impact of prescription-medication sharing. *American Journal of Public Health*, 98, 1115–1121. doi:10.2105/AJPH.2007.123257.
- Groenewald, T. (2004). A Phenomenological research design illustrated. *International Journal of Qualitative Methods*, 3(1).
- Hacker, M. (2008). Adverse drug reactions. In *Pharmacology Principles and Practice*. Ed. Miles, Hacker, William Messer and Kenneth Bachman. London: Elsevier Inc.
- Hanoch, Y., Katsikopoulos, K.V., Gummerum, M. & Brass, E.P. (2007). American and German students' knowledge, perceptions, and behaviors with respect to over-the-counter pain relievers. *Health Psychology*, 26(6), 802–806. doi: 10.1037/0278-6133.26.6.802.
- Hughes, C.M. (2003). Monitoring self-medication. Editorial. *Expert Opinion. Drug*.

Safety, 2(1),1-5.

- Jenkins, O.B. The Somali of Kenya.Strategyleader.org/profiles/somalikenya.html
- Kenya, Kenya National Bureau of Statistics.(2010).*2009 Kenya Population and Housing Census Volume 1 A, Population Distribution by Administrative Units*. Nairobi: Government of Kenya.
- Kenya, Ministry of Medical Services (2010). *Kenya pharmaceutical country profile 2010*. Nairobi: Government of Kenya.
- Kenya, Ministry of Health.(2007).*Linkingcommunities with the health system: The Kenya Essential Package for Health at level 1. A manual for training community health workers*. Nairobi: Government of Kenya.
- Kenya, NCPAD. (2005). *The national draft policy on traditional medicine and medicinalplants*. Nairobi: Government of Kenya.
- Krause, J., Croft, D.P.& James, R.(2007). Social network theory in the behavioural sciences: potential applications.*Behavioural Ecology and Sociobiology Review*, 62,15-27.doi:10.1007/s00265-007-0445-8.
- Lambert, S.D.& Carmen, L. G. (2007). Health information-seeking behaviour. *Qualitative Health Research*,17, 1006.doi: 10.1177/1049732307305199.
- Latkin, C., Donnell, D., Celentano, D.D., Aramrattna, A., Liu, T., Vongchak,T.,... Metzger, D. (2009). Relationships between social norms, social network characteristics, and HIV risk behaviours in Thailand and the United States. *Health Psychology*, 28(3), 323-329.doi: 10.1037/a0014707.
- LeCompte, M. D. &Preissle, J.(1993).*Ethnography and Qualitative Design in Educational Research*.(2nded.). San Diego:Academic Press Inc.
- LeVasseur, J.J. (2003). The Problem of Bracketing in Phenomenology. *QualitativeHealth Research*,13,408.doi: 10.1177/1049732302250337m.
- Leedy, P. D.&Ormrod E.J. (2001).*Practical Research Planning and Design*(7th Ed). Ohio: Merill Prentice Hall.
- Mama Asha (2013), Personal communication. Eldoret, Kenya.

- Newberry, A.M. (2011). Interpretative Phenomenological Analysis: Theory, Method and Research [Review of the book *Interpretative Phenomenological Analysis: Theory, Method and Research*]. *Qualitative Health Research*, 21, 1298.
- Patton, M.Q. (1999). Enhancing the quality and credibility of qualitative analysis. *Health Services Research* 34(5).
- Perry-Smith, J.E. & Shalley, C. E. (2003). The social side of creativity: A static and dynamic social network perspective. *The Academy of Management Review*, 28(1), 89-106. Retrieved from <http://www.jstor.org/stable/30040691>.
- Petersen, E.E., Rasmussen, S.A., Daniel, Yazdy, K.L. & Honein, M.M. (2008). Prescription medication borrowing and sharing among women of reproductive age. *Journal of Women's Health*, 17(7). doi: 10.1089/jwh.2007.0769.
- Raudsepp, M. (2005). Why is it so difficult to understand the theory of social representations? *Culture and Psychology*, 11(4), 455-468. doi: 10.1177/1354067X05058587.
- Rossetti-Ferreira, M. C., Amorim, K.S & Soares da Silva, A.P. (1999). The network of meaning which structure and canalizes interactions, interpretations and comments. *Culture and Psychology*, 5(3), 337-349. doi: 10.1177/1354067X9953005.
- Rostila, M. (2010). Birds of a feather flock together- and fall ill? Migrant homophily and health in Sweden. *Sociology of Health and Illness*, 32(3), 382-399. doi: 10.1111/j.1467-9566.2009.01196.x.
- Sih, A., Hanser, S.F. & McHugh, C.A. (2009). Social network theory: new insights and issues for behavioural ecologist [Review in *Social networks: new perspectives*]. *Behavioural Ecology and Sociobiology Review* 63:975. doi: 10.1007/s/00265-009-0725-6.
- Simoni-Wastila, L. (2000). The use of abusable prescription drugs: the role of gender. *Journal of Women's Health and Gender-Based Medicine* 9(3).
- Sloand, E. D. & Vessey, J.A. (2001). Self-medication with common

household medicines by young adolescents. *Issues In Comprehensive Pediatric Nursing*, 24, 57-67.

Smith, K.P. & Nicholas, A. C. (2008). Social networks and health. *Annual Review of Sociology*, 34, 405-429. doi:10.1146/annurev.soc.34.040507.134601.

Special programmes for Research and Training in Tropical Diseases

(TDR) (2008). *Gender and tuberculosis: Cross-site analysis and implications of a multi-country study in Bangladesh, India, Malawi and Colombia. Social, Economic and Behavioural Research*. Report series no. 3. TDR/SDR/SEB/RP/06.1. World Health Organisation.

UK, National Co-ordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO). (2004). *Concordance, adherence and compliance in medicine taking*. United Kingdom: NCCSDO:

Uzochukwu, B.S.C. & Onwujekwe, O.E. (2004). Socio-economic differences and health seeking behaviour for the diagnosis and treatment of malaria: a case study of four local government areas operating the Bamako initiative programme in south-east Nigeria. *International Journal for Equity in Health*, 3(6). doi:10.1186/1475-9276-3-6.

Watsierah, C.A., Jura, W. G.Z.O., Oyugi, H., Abong'o, B. & Ouma, C. (2010). Factors determining anti-malarial drug use in a peri-urban population from malaria holoendemic region of western Kenya. *Malaria Journal*, 9(295). Retrieved from <http://www.malariajournal.com/content/9/1/295>.

Young, J. T. (2004). Illness behaviour: a selective review and synthesis. *Sociology of Health and Illness*, 26(1), 1-31.

APPENDIX B-I**INTERVIEW GUIDE****INTRODUCTION**

This interview guide is divided into two parts:

- Part A: Demographic information
- Part B: Interview

Part A: Demographic Information

Respondent's name: _____

Location: _____

Age: _____

Marital status: _____

Date: _____

Household size: _____

Education level: _____

Location: _____

Part B: Interview**Section One**

- a) It is normal for people to feel unwell. What do you normally do when you wake up for example feeling unwell?
- b) I am aware that some people when unwell borrow medicine from neighbours, friends and family members.(follow up with questions)

Section Two

- a) Do you know anyone who has ever borrowed medication from someone else?
- b) Whom did they borrow it from?
- c) Do you remember what type of medicine it was/ for what ailment?
- d) Did they suffer any side effects from taking someone else's medication?
- e) Did the person they borrowed from replace the missing medicine?
- f) Do you know why they borrowed the medicine instead of going to the hospital?

Section Three

- a) Have you ever heard of anyone who shares their medication?
- b) How did they share it?
- c) Do you remember what kind of medication it was?
- d) Why do you think they shared their medication?

Section four

- a) Do you remember anyone sharing their medication with you?
- b) What kind of medication do you think people share/borrow the most?
- c) Whom do they share/borrow from the most?

KIAMBATISHO B-II**KIONGOZI YA MAHOJIANO****UTANGULIZI**

Jinalanguni Khadiala Khamasinamiminimwanafunzikatika Chuo Kikuu cha Moi. Mimi nimwanafunziwa Afyaya Ummanamimininaniayakujifunzajinsi wanawakewa Jamii ya Somalia huchukua hudumaya afyazao. Kama unamuda, ningependakutumia dakika 30 kuzungumzanawewe juu ya jambo hili. Data yeyote binafsi itabakisiri. Unahakikiyaku kata kuhojiwa.

SEHEMU A: TAARIFA YA DEMOGRAPHIA

Jina la Mhojiwa: _____

Mahali: _____

Umri: _____

Hadhiyandoa: _____

Ukubwawa kaya: _____

Ngaziyaelimu: _____

SEHEMU B: MAHOJIANO**Sehemu Ya Kwanza**

- a) Ni jambo la kawaidakwawatu kujisikiavi bayamarakwamarawanapoamka. Ningependa unielezewewe ukiamkanahujisiki vizuri wewe hufanyanini?
- b) Ninatambu kuwaba adhi yawatu wakiwawagonjwawa ohukopada wakutokakwam ajirani, marafiki na familia (kufuatili kwamaswali).

Sehemu Ya Pili

- a. Unamfahamu tu yeyote ambaye amewahukopada wakutokakwam tumwinge?
- b. Wahusika waliomba dawahizi kutokakwanani?
- b. Unakumbukani aina gani yadawailiyokopwa / zilikuwazakutibuugonjwaipi?
- c. Je, waliokopawa lipatamadharayoyote kutokananahizidawa?
- d. Je, mwenyekupeanadawa alinunua dawazingine iliarudishezilealizopeana?
- e. Unajuakwanini watu haowaliko padawabadalaya kwenda hospitali?

Sehemu Ya Tatu

- a. Je, umewahikusikiajuuyamtuyeyoteambayealipeanadawazake?
- b. Unajuakipimoalichotumiakupeanadawahizi?
- c. Unakumbukazilikuwadawazaainagani?
- d. Unajuasababuganialipeanadawahizi?

Sehemu Ya Nne

- a. Unakumbukamtuyeyoteakikugawiadawazake?
- b. Unajuani dawaainagani ambavyo huombwa au hupeanwazaidi?
- c. Tabia hii huonekana sanakwanaa kinanani?

APPENDIX C-I**CONSENT FORM**

My name is KhadialaKhamasi a Moi University student. As part of the requirements for a Masters degree in Public Health at Moi University, i am conducting a research in Eldoret Municipality. The purpose of my research is to a) Find out what is the Kenyan Somali women's perception of medication sharing, b) Identify how the Kenyan Somali women's' social networks influence medication sharing behaviour. In order to do this, i need your assistance.

In accepting to be involved in this research project, your participation will allow me to conduct personal in-depth interviews. All personal data will be confidential and pseudonyms will be used in the report writing. You have the right to refuse to be interviewed.

Signature: _____ Date: _____

I hereby consent to participate in the research project.

Signature: _____

Date: _____

KIAMBATISHO C-II**FOMU YA IDHINI**

Jinalanguni Khadiala Khamasinamiminimwanafunzika Chuo Kikuu cha Moi. Kama sehemuyamahitaji yakupata shahada yauzamilika Afrika ya Ummatika Chuo Kikuu cha Moi, ninafanyautafiti katika Manispaaya Eldoret. Madhumuni yautafiti wangu ni a) Kujuanimtizamowawanawakewajamii ya Kisomali kuhusukugawanadawa, b) Kutambua jinsimitanda oya kijamii yawanawakewajamii ya Kisomali unaushahishita biayaku gawanadawa. Ili kufanyahivyo, ninaomba saadawako.

Kwakukubalikushirikika tikamradi huwautafiti, ushiriki wakoutaniruhusukufanyauhojiano yabinafsi. Data zote zakibinafsi yatakuwanisira jinabandiazitatumika katika kuandikaripoti. Unahakikiyukataakuhojiwa.

Sahihi: _____ Tarehe: _____

Hilini ridha ya kushirikika tikamradi wautafiti.

Sahihi: _____

Tarehe: _____