PATIENTS' REASONS CONTRIBUTING TO DELAYED HEALTHCARE-SEEKING BEHAVIOR FOR NON-PREGNANCY-RELATED ABNORMAL VAGINAL BLEEDING IN BOMET COUNTY, KENYA

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A Thesis Report Submitted to the Institute of Post Graduate Studies of Kabarak University in Partial Fulfillment of the Requirement of the Award of Master of Medicine in Family Medicine

KABARAK UNIVERSITY

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DECLARATION

I declare that this research work is my own work and to the best of my knowledge has not been presented in any university or college.

Signed:_____ Date: _____

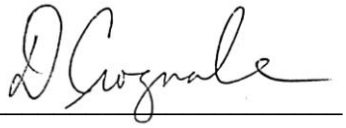
Elijah Terer

GMMF/M/1195/09/15

RECOMMENDATION

To the Institute of Postgraduate Studies:

The research entitled "***Patients' Reasons Contributing to Delayed Healthcare-Seeking Behavior for Non-Pregnancy-Related Abnormal Vaginal Bleeding in Bomet County, Kenya***" and written by Elijah Terer, REG NO. GMMF/M/1195/09/15 is presented to the Institute of Postgraduate Studies of Kabarak University. We have reviewed the research report and recommend it be accepted in partial fulfillment of the requirement for the award of the degree of Master of Medicine in Family Medicine of Kabarak University.

Signature  _____ Date_____

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DEDICATION

This research proposal is dedicated to my family for their unwavering support throughout the research study.

ABSTRACT

Globally, non-pregnancy related abnormal vaginal bleeding is common. A United States population-based survey of women ages 18 years and above reported an annual prevalence rate of 53 per 1000 women (Kjerulff, Erickson &Langenberg, 2016). The purpose of this study is to determine patients' reasons involved in delayed healthcare-seeking behavior for non-pregnancy-related abnormal vaginal bleeding in Bomet, Kenya. The objectives of this study are to describe how individual, health beliefs, and institutional reasons, contribute to delayed healthcare-seeking behavior. A qualitative phenomenological method has been employed with a target population including women aged 18 years and above who have experienced non-pregnancy related abnormal vaginal bleeding. The study used a convenience sampling method for the selection of 17 participants from the inpatient and outpatient departments of Long is a Hospital and Tenwek Hospital (9 participants from Tenwek Hospital and 8participants from Long is a Hospital). In order to determine and select the respondents, the researcher involved clinicians at these two hospitals. The clinicians notified the researcher upon presentation of a woman with a diagnosis of abnormal vaginal bleeding. Using the inclusion and exclusion criteria of the study, the researcher decided their suitability for the study. The principal investigator and research assistants collected primary data using in-depth interviews. Analysis of the data was completed using the Braun and Clarke framework for thematic analysis with the goal of reaching thematic saturation. NVivo coding was done where the participants' voices were assigned codes, categories, and themes. The guiding objectives of the study were found, in most areas, to agree with the findings. In addition, the impact of various demographic data has been explored. The following themes came out of this data; economic, fear, lack of knowledge and patients' perception on clinicians' competence (professionalism). This knowledge can be translated to the women in the community, women/village leaders as well as healthcare givers and also policymakers. Need for further research was also appreciated in this study.

Keywords: Abnormal Vaginal Bleeding, Non-Pregnancy, Healthcare-seeking behavior.

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ABBREVIATIONS AND ACRONYMS

AVB:	Abnormal Vaginal Bleeding
D&C:	Dilation and Curettage
FIGO MDC:	The International Federation of Gynecology and Obstetrics Menstrual Disorders Committee
HSB:	Healthcare-Seeking Behavior
PALM COEIN:	Polyp, adenomyosis, leiomyoma malignancy/hyperplasia, and coagulopathy, ovulatory dysfunction, endometrial, iatrogenic and not yet classified
UFE:	Uterine Fibroid Embolization

OPERATIONAL DEFINITION OF TERMS

Health Seeking Behavior presentation criteria: Refers to normal menstruation typically occurs every 28 days +/- 7 days (Williams Obstetrics, 2018). The average postovulatory bleeding lasts from 4 to 6 days.

Non-pregnancy related abnormal vaginal bleeding: Refers to Vaginal bleeding outside the period of gestation and 6 weeks post-partum, this bleeding is outside the established norms for quantity, duration or timing (Williams Obstetrics, 2018).

Delay in Presentation which refers patient delay is defined as the time taken from the first syndrome discovery until the first presentation at a primary healthcare facility of more than one (1) month.

Delay in diagnosis and treatment which refers to system delay is defined as the time taken from the first presentation at a primary care facility until a diagnosis resolution and initiation of appropriate treatment of more than 1 month.

CHAPTER ONE
INTRODUCTION

1.1 Introduction

This chapter covers the introduction to the study entitled the "***patients' reasons for delayed presentation with non-pregnancy-related abnormal vaginal bleeding in Bomet County***, ***Kenya***". In addition, the chapter covers background to the study, the purpose of the study, research objectives and research questions, significance, scope, limitations and the assumptions of the study.

1.2 Background to the Study

Non-pregnancy related abnormal vaginal bleeding refers to menstrual bleeding of abnormal quantity, duration, or schedule and any other cause of bleeding other than pregnancy related. This is a common gynecologic complaint, accounting for one-third of outpatient visits to gynecologists (Spencer and Whitehead, 2009). Globally, non-pregnancy related abnormal vaginal bleeding is also common. A United States population-based survey of women ages 18 years and above reported an annual prevalence rate of 53 per 1000 women (Kjerulff, Erickson &Langenberg, 2016).

Non-pregnancy related abnormal vaginal bleeding can be caused by a wide variety of local and systemic diseases and / or related to medications (Munro, Critchley, Broder, 2011). The International Federation of Gynecology and Obstetrics Menstrual Disorders Committee (FIGO MDC) identifies various causes of abnormal vaginal bleeding as resulting from various etiologies summarized by the acronym PALM COEIN: polyp, adenomyosis, leiomyoma, malignancy/hyperplasia, coagulopathy, ovulatory dysfunction, endometrial, iatrogenic and not yet classified (Fraser, Critchley, Broder& Munro, 2011).

The importance of non-pregnancy related abnormal vaginal bleeding relates to its major impact on women's quality of life, productivity, and utilization of healthcare services (Matteson, Boardman, Munro, and Clark, 2009). Empiral study has documented that non-pregnancy related abnormal vaginal bleeding may have a significant impact on the physical, social, emotional and material quality of life of women (National Institute for Healthcare Excellence, 2007).

In the United Kingdom, studies have documented that over 800,000 women seek help for abnormal uterine bleeding annually (NICE, 2007). In addition this study documented that along with the direct impact on the woman and her family, there are other significant costs to both the economy and health service. A study conducted in the United States reported financial losses of greater than $2,000 per patient annually due to work absence and home management costs (Frick, Clark & Steinwachs, 2009).

According to a study by Killewo, 69.3% of patients accepted that they delayed in making the decision to seek health care while 12.1% of these delays were attributed to the inability to access transport and an additional 24.6% pointed out that the delay was attributed to the health care provider's attitude. Furthermore, the delay has been well-described as consisting of three levels: delay in making the decision to seek care, delay in arrival at a health facility, and delay in receiving adequate treatment, which has been named first, second, and the third delay respectively (Thaddeus and Maine, 2014). In Africa, non-pregnancy related abnormal vaginal bleeding is a sensitive matter that is not divulged in public and one that is borne in silence for a long time before the patient decides to seek medical care (Jemal *et al,* 2011).

As noted previously, the major contributing factor to the development of health-related complications is attributed to the delay in accessing medical care. The broad range of possible diagnoses included in the PALM COEIN acronym diseases in which delayed presentation may lead to complications. For example, studies have documented in their publications that 85% of the new cervical cancer cases estimated worldwide came from developing countries (Ferla *et al,* 2010a; Jemal *et al,* 2011). In Kenya, abnormal vaginal bleeding is one of the most common presentations for cervical cancer which is considered to be the second most commonly diagnosed cancer in women according to Government of Kenya National cervical cancer prevention program (2012-2015).

Delay in seeking medical attention among women with abnormal vaginal bleeding is a major trend and is associated with late stage diagnosis which is associated with lower survival rates in cervical cancer (Waggoner, 2003). Additionally, delayed presentation leads to increased use of medical resources such as blood transfusions, contributing to the shortage of blood in Kenya (Kenya National Blood Transfusion Services 2001). Later diagnosis not only limits treatment options but also leads to

complications of the late-stage disease such as deaths from conditions such as anemia. This study consequently sought to describe patients' reasons for delayed healthcare-seeking for evaluation of abnormal vaginal bleeding. The study results can be applied to targeting interventions to encourage timely healthcare-seeking behavior.

1.3 Statement of the Problem

Abnormal vaginal bleeding is a significant clinical entity and common condition affecting 14–25% of women of reproductive age (Kimono, 2017). There is a high prevalence of women struggling with abnormal vaginal bleeding in Bomet County. For instance, during the month of April 2017 at Tenwek Hospital Obstetric and Gynecological Clinic, 23women were diagnosed with abnormal vaginal bleeding which could be extrapolated to 276 women annually. This number likely represents an underestimate since it excludes those patients coming at night or general inpatient and outpatient departments. The women presenting during this month often had bleeding for over one to three months prior to presenting for evaluation.

Abnormal vaginal bleeding, caused by a wide variety of conditions, includes diseases in which delayed presentation may lead to serious health consequences including increased utilization of healthcare resources, prolonged hospital stay with the increased cost of care and in some cases, significant morbidity and even mortality. For example, Ombati (2015) noted that 1/3 of the patients who delayed seeking for medical attention had complications from the condition even beyond the high demand for blood in Kenya for anemia requiring transfusion. Timely care prevents increased costs due to delays in seeking care (Healthcare Information Management Systems, 2013). However, the patients' reasons causing their delayed presentation remain unclear.

1.4 Purpose of the Study

The purpose of this study was to describe patients' reasons for delayed presentation in non-pregnancy-related abnormal vaginal bleeding in Bomet County, Kenya.

1.5 Objectives of the Study

The following research objectives guided this study:

i. To determine individual reasons contributing to women delaying evaluation for abnormal vaginal bleeding in Bomet County, Kenya.

ii. To describe health beliefs that influence healthcare-seeking behavior among women with abnormal vaginal bleeding in Bomet County, Kenya.
iii. To explore institutional reasons that influence women's ability to seek treatment for abnormal vaginal bleeding in Bomet County, Kenya.

1.6 Research Questions

The study aims at answering the following questions:

i. What are the individual reasons contributing to women delaying evaluation for abnormal vaginal bleeding in Bomet County, Kenya?
ii. What are the health beliefs affecting healthcare-seeking behavior among women with abnormal vaginal bleeding in Bomet County, Kenya?
iii. What are the institutional reasons that influence women's ability to seek treatment for abnormal vaginal bleeding in Bomet County, Kenya?

1.7 Justification for the study/ Significance of the Study

The knowledge gained from this study may allow multi-level translation to healthcare providers, policymakers, and future researchers who may have an objective of improving the health and long-term outcomes of women with abnormal vaginal bleeding. The findings may increase the level of understanding of the healthcare-seeking behavior of women and therefore health service providers may better assist women to receive timely interventions for their diagnosis. At a broader level, hospital administrators, even policymakers and other stakeholders in health may adopt the knowledge from this study to decrease the impact of the factors affecting delayed healthcare-seeking behavior. In addition, researchers may use the data generated from this study for relevant related future research work, elucidating novel solutions to impact women's healthcare.

1.8 Scope of the Study

This study aimed to describe patients' reasons for delayed presentation in non-pregnancy-related abnormal vaginal bleeding. The study focused on health beliefs, institutional reasons and individual reasons that contribute to delayed healthcare-seeking behavior for the evaluation of abnormal vaginal bleeding. The study was conducted in Bomet County, Kenya with a target population including females 18 years and above presenting with non-pregnancy-related vaginal bleeding at Long is a Hospital and Tenwek Hospital respectively.

1.9 Limitation of the Study

The limitation for this study was cultural. The sensitive issue of abnormal vaginal bleeding may have prevented some patients from participating and this was likely to lead to potential bias among the study participants. Of those women who were chosen to participate in the study, the delicate nature of the subject could have changed their responses. Additionally, the hospital setting may have likely caused some study participants not to freely share as opposed to if the study was conducted in their community, an environment they consider familiar. To minimize the effect of these limitations on the study, female research nurses were trained on how to conduct the interviews. In addition, a research study room was identified where clients who consented were enrolled and interviews conducted in an environment that provided comfort to the study participants.

1.10 Assumptions of the Study

In order to undertake this study, the following assumptions were made:

i. Women, who suffer from non-pregnancy-related abnormal vaginal bleeding in Bomet County, delay in seeking medical care from health facilities.
ii. The participants in the study would be willing to take part in the study, and would elaborate on their experiences.
iii. That those women who did not seek for care have related barriers making it difficult for them to reach a health facility.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter is a review of the scholarly literature pertaining to abnormal vaginal bleeding (AVB). Following a general overview of AVB and its clinical evaluation, the literature on healthcare access, patient decision-making and patients' perception of their disease with relation to delayed presentation for evaluation of AVB will be reviewed. After describing the theoretical framework involving the delayed model and healthcare-seeking model, the conceptual framework will be discussed. Health-seeking behaviour (HSB) is closely related with the health situation of a state and therefore its economic progress. Several studies have described HSB within the framework of various diseases. Nevertheless, understanding of HSB among populace sub-groups still remains scanty. This study's objective is to understand why women delay in seeking health care in Bomet County, Kenya.

According to Kasl and Cobb (1966) and highlighted by Olenja (2004), Healthcare seeking behaviour (HSB) has been demarcated as any action or inaction carried out by individuals who perceive themselves to have a health problem or to be sick for the purpose of seeking an appropriate remedy. Health Seeking Behaviour refers to what people do in order to maintain health and / or return to health, ranging from individual behaviour to collective behaviour. Several studies have been carried out on the health seeking behaviour of people in both the developing and developed countries.

Several studies that have made an effort to explain factors that considerably affect health seeking behaviour during illness experiences can largely be categorized into two groups. The first groupare studies which underscore the utilization of the formal system, or the health care seeking behaviour of persons. The studies that fall under this classification involve the development of models that describe the series of steps people take towards health care. These models are occasionally referred to as 'pathway models'. Whereas there are several differences of these models, the Health Belief Model and Andersen's Health Behaviour Model are time and again used as a beginning in discussions involving HSB.

The second group includes those studies which accentuate the process of illness response, or health seeking behaviour. These studies establish that the choice to engage with a particular medical channel is influenced by a range of factors such as socio-economic status, sex, age, the social status, the type of illness, access to services and perceived quality of the service. Many of the studies under this second classification emphasize on explicit types of determinants which lie between patients and services such as geographical, social, economic, cultural and organizational factors. For instance, access to health facilities, socio-economic status and perceived quality of service have been found to be significant influencers of health seeking decisions among different population segments.

An observation by Mwabu (1984) Igun (1981) and Nyamwaya (1982) indicated that in a given period of sickness, patient or the next of kin make health care decisions in stages. At the awareness of illness, decisions have to be made as to whether amongst the existing therapeutic alternatives proceeds. A visit to a health care facility is assumed to be the result of a patient health care decision making process.

A patient, having visited a health care facility continues to observe the effects of the administered treatment regimen. In the light of these effects, the patient further chooses whether or not to seek further treatment and evaluation. Should the patient choose to seek further treatment, the patient has to decide between the choices once again. It is expected that not all patients come back to this stage, as some feel well and drop out of the sick role category. Others though sick may stop seeking further assistance for reasons such as lack of resources. Therefore, underlying the observed visits [or lack of them] in the event of an illness to a health facility is an iterative and sequential decision making process which patients often repeat. The introduction of Western style health care facilities by missionaries and colonialists triggered a wide range of therapeutic opportunities to Kenyans.

These choices were put on top of the indigenous medical system often referred to as traditional medicine (Sofowora 1982; Nyamwaya 1982). Sofowora (1982) looks at the indigenous medical system as the total combination of knowledge and practices, whether understandable or not used in diagnosing, inhibiting or eliminating a physical, mental or social disease. Such a system may rely entirely on past understandings and observation handed down from one generation to another orally or in writing for Africa. Sofowora

(1982) notes that such a system integrates people's original concept of nature. This takes account of the material world, the sociological environment whether living or dead and the hypothetical forces of the world.

The important features of the indigenous health practices is that they were ordinarily evolved by the communities themselves in response to the health problems encountered by them (Banerji 1981). Medical workforces in this system can be described as people who are accepted by the community in which they live as experts to provide health care (Sofowora, 1982). Elling (1981) nevertheless notes that this medicine tends to be built upon accumulated understandings and is more generally known to everyone with less concentration on the hands of specialists.

The Western style medicine traces its birth to Western Europe in the late 18th century. Foucault (1973, cited in Cockerham 1992:4) noted the emergence at this time of medicine of the species and medicine of the social spaces. Medicine of the species concentrated upon classifying diseases, diagnosing and treating patients and finding cures. The human body became an object of study and observation in order that physiological processes could be demystified and brought under medical control (Cockerham 1992).

The medicine of social spaces was concerned with preventing diseases. Falola and Ityavyar (1992) observe that western medicine had benefited from the innovation of the germ theory before its introduction to Africa. The success of Robert Koch, Louis Pasteur and others in bacteriological research led to the conceptualization of the germ theory of disease (Cockerham 1992).This went along with tremendous progress in the development of internal medicine, anesthesiology, pathology, immunology and surgical techniques (Cockerham 1992, Falola & Ityavyar 1992). Physicians therefore focused entirely upon a clinical medicine grounded in scientific laboratory procedures.

The practice of medicine thus rested upon a premise that every disease had a specific pathogenic cause whose treatment could best be accomplished by removing or controlling the cause within a bio-medical framework. Dubos (1959, cited in Cockerham 1992:6) has pointed out that modern medical thinking has been dominated by a search for drugs as magic bullets that can be shot in the body to control or kill the health disorders. Both the manner of introduction and the heritage of western medicine brought

new features and distortions to Africa (Falola&Ityavyar,1992). This involved emphasis on curative care which stressed the building of hospitals and medical schools, an expensive curative approach for patients involving their travelling to hospitals paying hefty bills and acquiring drugs, a reduced role for the community and difficult access to health care.

Although there were cases of improvement in some aspects (UNICEF 1981), there were at the same time problems generated by the penetration of western capitalism. The entrenchment of the western medical system was a direct attempt to suppress traditional systems of health care (Mburu 1992). Missionaries and colonialists were extremely ethnocentric and assumed the superiority of their own civilization over nonwestern societies was obvious. Western medical personnel have been, if anything, even more ethnocentric about the superiority of western medicine (Foster and Anderson 1978).They find it difficult, despite evidence to the contrary, that given the opportunity, all peoples will not accept a new medical system in its totality. Research has conversely established that the introduction of another medical system to a people whose health problems previously have been met by an indigenous system opens up an amazing array of alternatives.

In Lusaka for instance Frankenberg and Leason (1976, cited in Foster and Anderson 1978:249) found the choices open to the sick to be of confusing complication. They include dyadic consultation with kin, with White Indian, and with fellow African employer, with neighbours and with friends, with western style doctors operating privately, or through government hospitals, all in addition to traditional healers. Lasker (1981) in Ivory Coast lists therapeutic choices as herbal medicine, diviners, religious rites, prophets, self-treatment and western medical services.

Studies by Young (1980), Osero (1990), Mwabu (1984), Van Luijk (1981) and Nyamwaya (1982) have established a wide range of therapeutic choices. They include: - a) Self-treatment uses herbs, b) Self-treatment using patent drugs from pharmacies or retail shops, c) Indigenous medicine requiring a visit to a traditional healer, d) Modem medical treatment requiring a visit to a facility employing western medicine procedures and equipment, e) Faith healing, f) No treatment at all i.e. expecting illnesses to go away on their own. These choices can be resorted to for different illnesses or at different stages for the same illness.

Research conducted on the stages in health seeking has adopted a wide range of methods and approaches. In most of these approaches, however, a number of insufficiencies can be observed. According to Igun (1981) the most important inadequacy is the limiting nature of the popular method of correlating selected factors with reported utilization behaviour. This does a lot of damage through unnecessary fragmentation to a phenomenon which is largely an unfolding process. Igun (1981) notes that such methods make it difficult to explore in depth the influence of the relevant factors in empirical ongoing health seeking situations. Freidson (1960), Frankenberg (1968), Suchman (1965) and Fabrega (1973) have attempted to provide models that might be useful in explaining health seeking behaviour. Igun (1981) highlights several limitations inherent in these models. A look at two of these models discloses some of the weaknesses. Suchman (1965) model for example assumes a single system of medicine and healthcare.

Accordingly, this makes its value rather limited when it comes to explaining health seeking in people where there are two or more well defined health care systems from which patients select a source of care. Fabrega (1973) model includes alternative sources of treatment. But, as Igun (1981) observes, the model is needlessly mathematical and ends up confusing what it sought to explain. Because of the above limitations, Igun (1981) advocates the building of an eclectic model from those available. His model, therefore, is a combination of the processes listed in the earlier models.

Stages are made up of sequences of events which represent major transition points involving new decisions about future medical care. The stages, however, should be seen mainly as logical possibilities since not all incidences of sicknesses may go through the stages. These stages vary in duration and may be concurrent or so closely combined as to be only critically discernable. The first stage health seeking is the symptoms experience stage. Igun (1981) analytically differentiates four aspects of this stage.

First is the physical experience which represents the actual physical pain, discomfort or debility. The cue process is second and represents a series of events that lead to the awareness that something could be wrong with someone's health. Third is the cognitive aspect which refers to the interpretation and derived meaning which a person gives to the chain of indicative events. The emotional response is the final aspect

representing the fear and anxiety that accompanies the above three stages. In Igun (1981) model the second stage is self-treatment.

On the other hand Mwabu (1984) observes that there are situations where a patient(s) may opt not to initiate any treatment for a variety of reasons. Mwabu claims that the first decision concerns whether or not to seek treatment. It should therefore be anticipated that there is a no treatment stage which antecedes the self-treatment one. The self-treatment stage depends on two major factors (Igun 1981).These are: - a) that a patient believes he understands and can attach a label to the symptoms and b) that a patient perceives the symptoms as not serious and capable of being removed by self-treatment.

Young (1980) adds another important thought to the above two. This is the knowledge of a home medication which represents a very significant constraint to self-treatment. Consequently, a person will move from this stage to the next when four factors obtain. These are: one that the patient does not understand the symptoms and is unable to attach a label; two that the patient sees the symptoms as grave and not capable of being removed by self-treatment; three, that he/she has no knowledge of a home remedy; and four, that self-treatment has failed to remove the symptoms.

His self-treatment is followed by the communication to significant others (Igun, 1981), and this may be voluntary or involuntary. For instance, a person with a persistent headache will intentionally inform members of his immediate family. Equally a close kin or a friend may notice the constant staying in bed, loss of appetite or the failure to participate in daily activities and draw the attention of the members of his immediate family to it. This stage may lead to or proceed at the same time with the assessment of the symptoms stage (Igun 1981). These two are determined at the assessment of symptoms (Igun 1981).These are whether a person should rightfully assume the sick role and the statement of an uncertain diagnosis.

At the end of this stage a person may justifiably be an obligatory of the sick role (Igun 1981). At the assumption of the sick role, the person is socially recognized for the first time as a legitimate incumbent of the sick role. His/her sick role has become socially legitimate and he becomes entitled to the privileges as well as the duties of a sick person (Frankenberg 1968, Igun 1981).The expression of concern stage by kin, close friend and

even neighbours follows the notion of the sick role (Igun 1981).This expression of concern offers expressive and instrumental support. Of major concern in decision making is the instrumental support. This is because close friends and kin offer diagnosis and/or recommend treatment.

The above stage may lead to or proceed at once with the statement about an assessment of the probable efficacy or appropriateness of sources of treatment (Igun 1981).Every society has a taxonomy or language of illness which is made up of illness categories and labels (Young, 1980).These labels also contain ideas and recommendations about appropriate source of treatment or actions for various diseases (Igun 1981). For example, Young (1980) acknowledged disease types that are widely regarded as only treated with traditional curing methods.

The selection of treatment follows the assessment of probable efficacy. The former is the stage when particular sources of treatment or treatment action are opted for (Mwabu, 1984: Igun, 1981). At this point, the selected treatment plan is executed. Mwabu (1984) notes that at any one given time, each of these choices is separate in the sense that a patient either chooses to seek health care from a particular clinic, and not from any others.

This stage may lead on to death and so terminate the process, or lead to the next stage where the effect of treatment on the symptoms is assessed. This often goes on with treatment. As the treatment proceeds, the patient, his relatives, close friends and the practitioner whose services are being utilized constantly monitor the progress being made (Igun 1981; Mwabu 1984).

This is to see whether or not the treatment is producing the desired effects on the symptoms. If so, the stages of recovery and rehabilitation commence. If it is not, the case then returns to the stage of assessment of symptoms with the aim of following the subsequent stages once more (Igun 1981). It must be emphasized that these stages are not necessarily present in every case of illness but they will often be found even in a condensed form. It is however necessary to examine the entire length of health seeking stages so as to analyze all cases and directions of decision making.

According to Foster and Anderson (1978) a continuing problem in the doctor-patient and health educator-client relationship in the developing world is the assumption

that patients or potential patients make decisions about what kind of healthcare help to seek. Lasker (1981) makes the same comment. In her research, MC Kinlays' cites findings in the United States and Great Britain that social networks is a useful concept undulating explored (Lasker 1981:164).The notion of social networks is similar to what Freidson (1960) referred to as the "lay referral system". It consists of non-professionals, family members, relatives, friends or neighbours who assist individuals in indorsing a course of action (Cockerham 1992). Freidson (1960) described the process of health seeking as involving a group of potential consultants which begin in the nuclear family and extending outward to more select influential lay individuals until the professional practitioner is reached.

The role of social networks commences at the point where a sickness assumes both personal and social significance (Igun 1981). According to Frankenberg (1968) the idea of disease is a social concept. The society is concerned about the illness of individual members because the illness of an individual member may disrupt stability in social relations. Societal members therefore act to restore the previous equilibrium or to achieve a new one (Frankenberg 1968). Members of the Society through instrumental responses help to diagnose and recommend initial and subsequent treatment options. The role of social networks should be examined within the society in which they operate. In all cases men may be multicultural or locally oriented (Frankenberg 1968). Freidson (1960; cited in Cockerham 1992; 99) suggests that when cultural classifications of sickness contradict professional ones, the referral process will often not lead to the professional practitioner.

The highest degree of resistance to using medical services in a lay referral structure lies in low class neighborhoods. These are characterized by strong ethnic identification and extended family relationships (Freidson I960). Cosmopolitan action by contrast is to be found in communities with low ethnic exclusivity, less limited friendship and fewer authoritarian family relationships. These are more likely than authoritarian groups to know something about the disease and to trust health professionals. Studies by Freidson (1960), Frankenberg (1968) and studies of low income blacks and Mexican Americans by Cockerham (1992) propose that under certain conditions close and ethnically exclusive social relations tend to channel health seeking behaviour initially to the group.

This is as opposed to professional health care deliveries. On the other hand, Geertson et al (1975; cited in Cockerham 1992:104) establish an opposite inclination. They observed that the Momon community in Salt Lake City had a strong value of good health, education and an emphasis upon family authority and tradition. Their investigation established that group closeness and exclusivity can increase rather than decrease the likelihood of an individual responding to professional health services. They concluded that people who belong to close and exclusive groups, especially tradition and authority oriented families, will seek professional care if it is consistent with their beliefs and cultural practices.

They will, however, decline to seek professional care if their beliefs support skepticism and distrust of professionals. Similar processes were observed by Salloway (1973; cited in Cockerham 1992: 105) in the Gypsy community. Although semi-literate, poor and ethnically distinct, Gypsies operated an extensive communication network in the community. They informed each other on a regular basis about who was sick, where they were being treated and how pleased or displeased the patients and other interested parties were with the treatment. Salloway (1973 in Cockerham 1992: 107) points to the existence of an accumulation of data among family members and friends concerning past diagnostic treating agencies, the prescription, prognosis for specific disorders and differences in the quality of service, including specialties offered in specific facilities. These enabled them to extensively utilize the available health care providers. In view of such differing research findings, this study endeavors to establish the role played by social networks in health care choice for Khwisero.

In the case of health care choice, social networks and their specific values, opinions and attitudes act to suggest advice or coerce an individual into particular courses of action. The roles of social networks in meeting the costs of health care in the event of financial difficulties were examined. The significance of socio-cultural factors in differential choice and consequent utility of healthcare options has been highlighted in a number of studies. This is because, as Kleinmann (1980) observed, health, sickness and health care related aspects are expressed as constituent parts of cultural systems. Such parts are, like other parts for example kinship and religion, symbolic parts, built out of meanings, values and behavioral norms. The health care system articulates sickness as a cultural expression. This further links to the beliefs about disease causation, the

experience of symptoms, specific patterns of illness behaviour, decisions concerning treatment alternatives, actual therapeutic alternatives and evaluation of therapeutic outcomes. Health, sickness and health care are therefore part of a cultural system and need to be understood in relation to one another.

As Kleinmann (1980) accurately submits, to examine one in isolation, distorts our knowledge of the nature of each and how they function in the context of specific cross cultural systems. Foster and Anderson (1978) state that non-western people; in their values and belief systems, exhibit forms that sometimes inhibit their acceptance of Western medicine. All people are ethnocentric. They are attached to their traditional ways and beliefs and they assume that these ways are equal to if not superior to the ways of others. The health and sickness views of every people are part of their innermost being (Kleinmann 1980) and cannot be cast aside lightly. Anthropologists have made use of the "adversary model" (Foster and Anderson 1978) which articulates the conflict between "primitive and folk medical systems" on the one hand and scientific medicine on the other. This model indicates that when western medicine is availed to peoples whose previous experience has been with traditional systems, therapeutic practices that are interpreted to be in direct conflict with traditional etiologic beliefs will encounter most resistance (Foster and Anderson 1978). Young and Garro (1981) have illustrated on the work of Freidson (1960) concerning the effect of adherence to folk sickness beliefs in rural third world health care choices.

Freidson (1960; cited in Young et al 1981: 1453) proposes that the degree of similarity between lay conceptions of sickness and symptoms and those of modem medicine is a primary determinant of whether or not people believing themselves to be ill will consult a physician. He asserts that the primary reason as to why people in non-western cultures are less likely to resort to physicians than people in western culture is because they believe that certain sicknesses cannot be treated by western health care treatments.

In cross-cultural literature explanations on the use and non-use of physicians' services and support for this conceptual incompatibility, hypotheses are variable. Research in Latin America, for instance, has recounted the operation of folk cognitive contradictions in the choice of treatment (Young 1980). Indigenous folk etiological beliefs led to the grouping of some illness types as incurable by physicians. In India,

Gould (1957 in Foster and Anderson 1978: 134) establish that critical weakening dysfunctions tend to be treated by the physician, while chronic non-incapacitating dysfunctions tended to be treated in the village. Benyousef and Wessen (1974) account on the role of traditional healer attitudes as an important barrier to overcome in bringing about improvement in health care services of rural Tunisia. In Kenya, Nyamwaya (1982) asserts that children with measles among the Pokot may sometimes be kept away from the hospital. This is because it is feared that an injection might kill them. In the same culture, mental illness, sterility, impotence, fractures and constipation are usually treated by indigenous healers (Nyamwaya 1982).

Other cases in Kenya include tuberculosis, among the Akamba (Ndeti 1972) leprosy and functional disorders among the Luo (Whissen 1964, Van Luijk 1971).In the current study, patients were interviewed at the health care facilities from where they are seeking treatment. Using data collected from the patients at two health care facilities – Tenwek Hospital and Longisa Referral Hospital in Bomet County of Kenya we determine the individualities of patients that influence their choice of health care facility types. The major findings of the study include: facility type choice is influenced by the patient's age, gender, marital status, and highest education level. Younger patients are more likely to seek treatment from dispensaries and health centres while older ones are more likely to seek treatment from hospitals and clinics; female patients are more likely to seek medical treatment from hospitals and clinics while their male counterparts are more likely to seek treatment from dispensaries and health centres; currently married patients are more likely to seek treatment from health centres while not-currently-married ones are more likely to seek treatment from hospitals; and, highly educated individuals are more likely to seek treatment from hospitals and clinics while less highly educated ones are more likely to seek treatment from health centres.

Health-seeking behaviors are largely dependent on the individual’s identification and interpretation of their symptoms. The stigma surrounding vaginal bleeding is still very real and it's putting our health at risk. According to a study published in the BMJ Journal (2017), the belief for us to discreetly manage any vaginal bleeding issues, namely in low and middle-income countries, is contributing to health issues for women. The study doesn't just focus on menstruation; it also discusses other causes, such as

bleeding after childbirth or during miscarriage, or bleeding due to any medical issues such as endometriosis.

To steer these experiences, researchers said, women need accurate information to be able to differentiate between healthy spotting and abnormal bleeding. Not getting that information can result in a "marked silence" that leads to greater health risks. The researchers looked at women and girls in what they deemed low to middle-income countries (Nigeria, Senegal, and Mali) and found that there were significant numbers of women who experience vaginal bleeding related to reproductive health conditions. However, having to manage such issues in the face of stigma as well as in situations where women have low resources for care has proven to be detrimental to women's health.

In higher income countries, the researchers said, the stigma still exists, but women in general have better access to healthcare resources and support if they're not sure what their bleeding means, not to mention, women in higher income countries are also likely have access to safe, clean bathrooms to manage their symptoms. Generally, the investigators give emphasis to the need for support for those experiencing vaginal bleeding in low and middle-income countries as well as the need for adequate access to resources and supplies to help them manage.

"The first step is breaking the silence around the topic of vaginal bleeding, from the global to the local level, so that girls and women are able to seek out the healthcare and management required with confidence and support," the study read.

In a research conducted in Mukono and Buikwe in Uganda to determine factors influencing compliance and health seeking behaviour for hypertension and published by the International Journal of Hypertension (2018), patients sought various channels of care for their hypertension. Self-medication and access to antihypertensive drugs with or without prescription were common as well as use of herbal remedies. Regular monitoring of blood pressure was not a common practice. Factors influencing HSB were related to health systems and the patient socioeconomic and structural environment. The main system issues were related to availability and attitudes of staff and shortage of supplies and medicines. The patient factors were related to awareness, perceived severity, perceived effectiveness of therapy, adverse effects, and perceived fears of lifelong

dependence on medicines. The patient socioeconomic status played a role as did the marketing of traditional medicine.

The group of people that an individual chooses to talk to about their symptoms is informed by pre-existing beliefs about the implications of the symptoms and the access to relevant sources of help. Researchers explain disclosing vaginal bleeding as a difficult situation for many women due to many of them being afraid of people's reaction towards it (Chapple, 2001; Kostick et al., 2010). Majority of women visit health care providers alone to get treatment for vaginal discharge compared to being accompanied by someone (Ishaq Bhatti et al., 2002).Similarly disclosing symptoms associated with reproductive health matters is a stigma for most cultures. With regard to symptoms of reproductive tract infection, many studies point out that women communicate in a different way even with their spouse (Rizvi et al., 2004; Prusty et al., 2013; O'dowd et al., 1996; Sabarwal et al., 2012).Some researchers explicate that if women experience physical or sexual violence at the hands of their husband, they are reluctant to talk about vaginal bleeding (Sabarwal et al., 2012).

Most of the time women disclose their symptoms to a doctor without discussing with anyone else and few others discussed with another family member or a friend (O'dowd et al., 1996). But in some studies have found that women normally discussed their signs and symptoms with husbands or mothers in-law (IshaqBhatti et al., 2002). While in others, it has been found that women's first level of help-seeking advice comes from friends and neighbours while they work (Binh et al., 2002). Reporting reproductive issues is still stigmatized in many communities and this has to be changed with necessary education. Women's knowledge concerning causes for vaginal bleeding and their complications is poor (Rabiu et al., 2010). Further, women term vaginal bleeding as a disease which is common but different from STIs (Rizvi et al., 2004). Socio-economic factors have been identified by various studies as income, education and/or occupation. Cockerham (1992) explains that the higher or lower one's income education, and / or prestige are the higher or lower will be their socio-economic class position. The socio-economic class provides or constrains accessibility to various health care options both at national and household levels.

It has already been observed that at national levels, many developing countries cannot afford to provide all the Western health care services required by their

populations (Nyamwaya 1982).This can be attributed to lack of resources. Pearce (1992) writes that in Africa, there is a deepening crisis and that global recession is felt more intensely than in other regions of the world. Most people in Africa are still farmers. But, there have been crop declines, an exodus of people from abandoned rural areas and an increased importation of food items. As there are growing inequalities in health between western and non-western countries, there also exists inequalities within Africa (Pearce 1992).

Western style health care in Kenya primarily provided by the state is almost exclusively in major urban areas, having been inherited largely without modification from former colonial powers (Mburu 1992). The inequalities between the urban and the rural areas are in the differential allocation of such facilities as water, industries and health care (Pearce 1992). A bigger population in Kenya lives in the rural areas. Fatefully, this is where dispensaries and clinics are very few. If and where such facilities exist, they are poorly equipped and understaffed (G.O.K 1997).Another major problem that rural residents face is that they must often travel great distances to reach a health clinic (Mburu 1992; Osero 1990; Mwabu 1984). Travel expenses, lack of transportation due to poor road networks in rural areas and delays are major impediments to the utilization of certain health care options. They consequently constitute decision making criteria. The above conditions prompted Lasker (1981) to conclude that choice of western medicine is inhibited not by "unscientific" attitudes but rather by political and economic factors. These factors, apart from limiting the usefulness of these services, increase the attractiveness of available alternatives.

Accessibility of health services is the key factor in what are essentially rational decisions by rural inhabitants (Lasker 1981). Availability of resources at household level is a factor that affects accessibility to various health care alternatives. According to Lasker (1981), the notion of accessibility includes such factors as the actual location of facilities, cost of facilities, communication breakdown and time delay. These are relevant, especially as they relate to household characteristics. According to the Kenya Poverty Assessment Report (KPAR 1995) the pattern of response to the occurrence of sickness in the household depends on several factors. Among these are the household characteristics which include the location of the household and its income. Yet, facility use also depends critically on the characteristics of the facilities themselves (KPAR

1995).These are the characteristics which affect the price of the services provided and those that affect the quality of the service itself.

The availability of resources at the household level is a crucial factor as most forms of healing options involve some payment. Young (1980) noted that in Mexico, the cost of treatment ranged from very little to investments of quite substantial proportions of household resources for a physician's treatment. Households from lower economic classes may be constrained from utilizing options that involve huge amounts of money. It is commonly believed that people from lower socio-economic classes tend to under-utilize health services because of the financial cost and/or the culture of poverty (Cockerham 1992).The culture of poverty is an occurrence in which poverty over time influences the adoption and development of certain socio-psychological traits among those trapped in it. These behavioral traits which include dependence, fatalism and a lower value placed on health tend to strengthen an individual's disadvantaged position. The culture of poverty affects individual's perception of illnesses that warrant healthcare attention and those that do not (Cockerham 1992).

The perceived gravity of a sickness is a factor that determines the choice of health care. Igun (1981) notes that the seriousness of an illness is one of the two conditions that may make a patient start, or omit the self-treatment. Mwabu's (1984) study found that as the severity of an illness increases patients seek treatment from high quality government hospitals, private and mission health facilities. Young (1980) identifies three levels of the gravity of an illness that may affect the choice of health care. At the first level is the non-serious category. This refers to an illness incidence that allows normal activities, or that does not involve an interruption in the daily routines for more than a day or two. At this level, patients are known to either ignore the problem or to start on a self-treatment treatment. Lasker (1981) found that self-treatment was used for fever and for less serious complaints. Mwabu (1984) found that dispensing chemist's or drug stores were important sources of treatment at the early stages of a sickness. Nevertheless, as an illness period prolongs their significance as sources of treatment declines rapidly.

The second level of severity is the moderately serious category (Young 1980). It is this stage of illnesses that pose substantial interruption of daily activities by requiring one to remain in bed. The disease usually lasts longer than two days and resists

initial treatment. Leavitt (1979) notes that an individual's belief about the severity of his own sickness, defined in terms of physical harm or interference with his own social functioning is a cue to action to seek health care service. At such a level specialized forms of diagnosis and treatment may require consultations with a healer or a visit to a hospital. Sicknesses at this level are not regarded as posing a threat to life although they may become such a threat if left unattended to (Young 1980).At the final level of gravity are ailments that constitute potential threats to life. They may involve extreme pain or discomfort as well as considerable functional impairment. Such ailment may be described as grave, dangerous or heavy (Young 1980). Seriousness assessments take into consideration the interaction between the severity of a sickness and the resistance of the victim. The very old, young children and especially infants are regarded in most societies as lacking in resistance. Their ailments, consequently, almost always evoke considerable concern. Cockerham (1992) discerns that one of the reasons as to why older people reportedly utilized the services of physicians more frequently is because they were most likely to be disabled. Certain constitutional factors are thought to be related to resistance.

Young (1980) found that in Mexico, some people are said to have damaged blood which lowers their resistance, or to have blood that easily carries sicknesses. Therefore, what is objectively the same sickness may be judged as representing different levels of gravity in two different individuals. Cockerham (1992) also notes that some people will recognize common physical symptoms and seek out a physician for treatment. While others with similar symptoms may attempt self-medication or dismiss the symptoms as not needing attention. The gravity of a sickness does not only affect the initial choice of health care but consequent patterns also. In the event that a particular therapeutic option is initially tried and a cure is not obtained, the seriousness of the "new" condition determines the choice of the new provider.

2.2. Abnormal Vaginal Bleeding

All women have normal vaginal bleeding as a part of the reproductive cycle which occurs every 21 – 35 days with duration of 4 to 6 days (Williams Obstetrics, 2018). Bleeding occurring outside of this defined period is referred to as abnormal vaginal bleeding (Wentz, 2016). The differential diagnosis for abnormal vaginal bleeding remains broad, involving etiologies summarized by the acronym PALM COEIN: Polyp, Adenomyosis, Leiomyoma, Malignancy/hyperplasia, Coagulopathy, Ovulatory

dysfunction, endometrial dysfunction, Iatrogenic and Not yet classified (Fraser, Critchley, Broder and Munro, 2011).

Vaginal bleeding affects women from adolescence through adulthood. Ideal healthcare involves routine gynecological examinations per current recommendations combined with prompt diagnosis and treatment. A thorough examination including bimanual evaluation is provided for the adult women and sexually active adolescent (Hof, 2007). Abnormal findings on bimanual evaluation may be further evaluated with ultrasound to rule out structural disease as it may contribute to AVB. Trans-vaginal ultrasound, hysteroscopy, and MRI rarely play a role in the adolescent investigation. Following diagnosis, medical treatment is tailored to the etiology requiring medical, surgical or a combined approach to treatment (Goldfarb, 2008).

2.3. Healthcare Access

Evaluation, diagnosis and appropriate treatment of AVB require adequate access to healthcare. Various modes of treatment are required to manage AVB depending on its etiology and how the disease has advanced. Although medication may be sufficient for the management of some conditions, such as hormone-releasing intrauterine devices in the case of ovulatory dysfunction, surgical treatment such as uterine fibroid embolization, endometrial ablation, myomectomy, dilation and curettage,and even hysterectomy may be required (Gray,2007). These surgeries require a hospital setting with experts in the field of obstetrics and gynecology who can accurately diagnose the condition and provide the appropriate surgical treatment. These are delicate procedures which expose the patient to risk if not properly managed (Hof, 2007).

In Kenya, most doctors, particularly specialists such as obstetrics and gynecology, practice in urban areas leaving rural counties with a limited number of clinical practitioners. This state of healthcare practitioner distribution places many women at a disadvantage. Healthcare is less accessible in rural areas, which is concerning since the majority of Kenya's population resides in rural areas. Additionally, the treatments used are expensive and sometimes even unaffordable for women suffering from vaginal bleeding further impeding access to healthcare and contributing to delayed presentation for evaluation of AVB. Leckie (2006) conducted a study of major hospitals and noted that women who seek medical attention on issues such as bleeding were of a higher socioeconomic demographic. It was indicated that most women were supported

by their families or spouses financially since the procedures and services required for the treatment of some conditions associated with AVB are expensive.

2.4. Patient's Decision to Present for Evaluation of AVB

There are various factors that influence a woman's choice to seek medical attention when she is having abnormal vaginal bleeding. In India, Calvello (2015) noted that women between the ages of 18 to 24 years were dependent on their families. Therefore, when they had abnormal vaginal bleeding, they feared to report the case to their parents/guardians. It was believed that excessive vaginal bleeding was related to women who had irresponsible sexual behaviors. They feared to present their case because of fear of being ill-treated by their own family members.

Another factor influencing women's decision to present for evaluation of abnormal vaginal bleeding is the failure to recognize the potentially serious nature of the bleeding. For example, AVB can be a presenting sign of cervical cancer. However, it can be only cured and treated at its early stages. Many women do not recognize that AVB may be a sign of a serious disease such as cervical or endometrial cancer, perceiving it as a normal occurrence which will eventually stop. A survey conducted in developing countries indicated that 80% of women seek medical care after they have developed signs and symptoms (Albers, 2004). In the case of cervical cancer, one of the most important prognostic factors is the stage of disease at diagnosis. Delay in presentation and in diagnosis continues to be a serious challenge in the treatment of cervical cancer.

2.5 Patient Perception of Disease

Hof (2007) demonstrated that women who had experienced abnormal bleeding and had had a history of milder gynecological symptoms such as vaginal discharge in the past were reluctant to seek medical attention probably because they are not aware of the seriousness of the symptoms. Therefore, these women considered AVB to be normal until their disease became advanced and demonstrated more serious signs and symptoms. Of the many etiologies causing AVB referred to in the PALM COEIN acronym, cervical cancer is a good example of how a patient's knowledge and perception of its signs and symptoms may contribute to the delayed presentation. The delayed presentation may be contributed by failing to appreciate or recognize atypical or nonobvious symptoms and patients may label all vaginal bleeding as normal. Wilson (2000) found that patients with

very limited knowledge about cervical cancer were at risk for delayed evaluation of early symptoms of the disease.

Shorter delay in patients with gynecological cancers was attributed to regular visits to health-care providers, including attendance for routine screening (Lambert & Loiselle, 2007). Furthermore, positive encouragement to seek care affects women's decision to be evaluated for AVB. This statement has been supported by medical practitioners in Zambia who have created platforms to reach out to many women (Mackian, 2013). For example, the provision of free services and treatment has helped to reduce the numbers of deaths from AVB.

2.6 Theoretical Framework

2.6.1 Three Delayed Model

Thaddeus and Maine (1994) outlined three common delays in accessing quality health care. The first involves the patient's decision making in seeking medication. Next is the delay in accessing the health facility and finally the delay involved with receiving adequate health care. Albers (2004) applied the three delayed model to audit data on AVB in Morocco and found that the patient's decision-making to pursue healthcare was the predominant factor in patients with delayed presentation. Bradley &Geiye (2016) revealed that the leading cause for delayed presentation for evaluation of AVB in Zambia was in the patient's ability to reach an appropriate facility to receive adequate healthcare. The three delays are interlinked- several of the contributing factors and potential interventions are applicable to more than one delay.

2.6.2 Health Seeking Behavior (HSB) Model

Godfrey Hochbaum, Stephen Kegels and Irwin Rosenstock developed the HSB Model. It is a systematic method that explains and forecasts various health behaviors (Wentz, 2016). The model focuses on aspects of health behaviors, relationship practices and utilization of health services. The HSB may be applied to all types of health behavior in different kinds of study. It indicates that an individual's behavior to seek care is categorized into three components including their individual perceptions, modifying behaviors and the likelihood of action. Individual perceptions are factors that affect the perception of illness. Modifying factors include demographic variables, perceived threat, and cues to action. The likelihood of action is the probability of appropriate health behavior.

The HSB states that the perception of a personal health behavior threat is influenced by general health values (interest and concern about health), particular health beliefs about vulnerability to a particular health threat and beliefs about consequences of a health problem (Wilson, 2000). Once an individual perceives a threat to their health and is simultaneously cued to action, and his/her perceived benefits outweighs their perceived threats, then that individual is most likely to undertake the recommended preventive health action. Each individual has his/her own perception of the likelihood of experiencing a condition that would adversely affect one's health. Individuals vary widely in their perception of susceptibility to a disease or condition. Effects can be considered from the point of view of the difficulties that a disease would create such as pain and discomfort, loss of work time, financial burdens, difficulties with family, relationships, and susceptibility to future conditions (Creats as, 2013). It is important to include these emotional and financial burdens when considering the seriousness of a disease or condition. Taking action toward the prevention of disease or toward dealing with an illness is the next step to expect after an individual has accepted the susceptibility of disease and recognized it as a serious condition. The direction of action that a person chooses will be influenced by the beliefs regarding the result of the action.

However, the action may not be taken, even though an individual may believe that the perceived benefit of a particular action may outweigh the perceived threat. This may be due to barriers that relate to the characteristics of treatment or preventive measure. The individual views it in regard to its inconvenience, expense and/or unpleasant, painful or upsetting nature. These characteristics may lead a person to avoid the desired action. The HSB model is applied in health education, to incentivize an individual to take a clear course of action and to enhance a feeling of competency in one’s ability to take the desired action.

2.7 Conceptual Framework

This conceptual framework outlines the relationship between socio-demographic, institutional, health belief and individual factors affecting healthcare-seeking behavior.

Healthcare Utilization among Urban and Rural Households in Esera District: Comparative Cross-sectional Study.

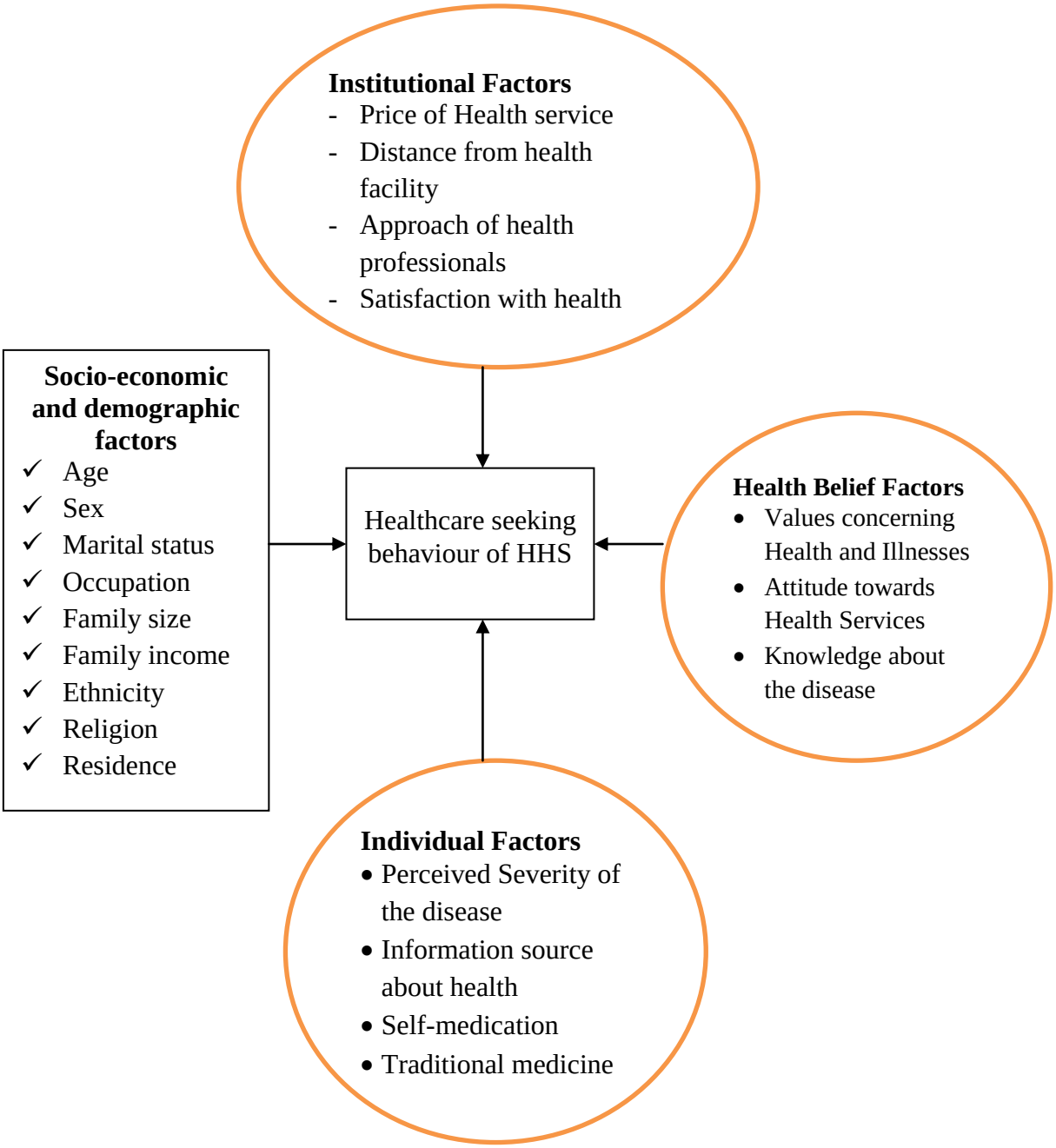

Figure 1: Conceptual framework of healthcare seeking behavior

CHAPTER THREE
RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

This chapter covered the methodology of the study which included: the Research Design, Location of the Study, Population of the Study, Sampling Procedures and Sample Size, instrumentations which covers Pilot Study, Validity of the Instruments and Reliability. In additions, Chapter three covers Data Collection Procedure, Data Analysis and Ethical Considerations for the study.

3.2 Research Design

This was a qualitative study which utilized phenomenological study design. Phenomenology is a research method and it is a way of returning to experiencing and exploring the reality of life and living. This study aimed to understand the women's experience of AVB and described their reasons leading to delayed healthcare-seeking for evaluation. This study method was selected to elucidate the contextual reasons that influence these women to delay evaluation despite bleeding that affects multiple aspects of their daily lives and may potentially complicate management of their condition secondary to blood loss.

3.3 Location of the Study

The study was conducted in Bomet County whose economy is largely dependent on agriculture. Two hospitals were selected for the study, namely Tenwek and Longisa. The hospitals are situated in Tenwek and Longisa Sub Counties which have a combined population of 724,186 residents (KDHS, 2009). The choice the health facilities were mainly because they are considered to be referral Hospitals. Longisa Hospital and Tenwek Hospital are the two institutions that were selected for the study. Longisa Hospital is a government county referral institution with a bed capacity of 144. Tenwek Hospital is a private/faith-based, non-profit institution with a bed capacity of 310 serving as a tertiary referral hospital. The hospitals are located 20 kilometers apart allowing patients in the region to select either for their care. The two hospitals were selected for the study since one is private/faith-based and the other is a public hospital. This provided the opportunity to obtain information from respondents with different socio-demographic backgrounds who attend either hospital.

3.4 Population of the Study

The target population for this study was women aged 18 years and above who presented with non-pregnancy-related abnormal vaginal bleeding to either Tenwek Mission Hospital or Longisa County Referral Hospital. An upper age limit in this study was not placed on participants since AVB may affect women from 18 years anytime during their adolescence and throughout the stages of adulthood and therefore this broadened the respondent pool. A total of Seventeen women from these hospitals; nine (9) women from Tenwek hospital and eight (8) women from Longisa hospital with a diagnosis of AVB were enrolled and interviewed in this study.

3.4.1 Inclusion and Exclusion Criteria

The study included consenting females aged 18 years and older who are oriented to person, place and time and are presented to either the inpatient and outpatient departments in Longisa Hospital or Tenwek Hospital with a diagnosis of AVB. These participants were able to understand and speak English, Kiswahili or Kipsigis (local language). The study excluded women who were diagnosed with AVB who did consent or too sick to be participate in the study.

3.5 Sampling Procedure and Sample Size

3.5.1 Sampling Procedure

The study employed a convenience sampling method for the participant selection as only specific women with the condition were targeted. The researcher requested the clinicians at both Longisa Hospital and Tenwek Hospital to inform the researcher upon the diagnosis of a patient with abnormal bleeding. The researcher applied the inclusion and exclusion criteria for the selection of study participants. Participants from each hospital were to be selected with provision to continue until saturation of themes was attained. Guest et al (2006), suggests a sample size of six in-depth interviews may be appropriate in establishing themes for useful interpretation; however, in this study, interviews went beyond six and it was expected that that thematic saturation would be reached by the 12^{th} interview.

3.5.2 Sample Size

Cochran's posteriori formula was used in this study to calculate the sample size for the study, when pop. <50.000 is: n1 = 246/ (1+246/17) = 16and where the population

size was =17 n0 = required return sample size according to Cochran's formula= 246 Where n1 = required return sample size because sample > 5% of population.

3.6 Instrumentation

An in-depth interview schedule tool translated into Kiswahili and Kipsigis was used to collect primary data. The interview questionnaire was prepared employing the principles of the Health Belief Model (HBM) and three delays model to assist in describing patients' reasons for delayed presentation for evaluation of AVB.

3.6.1 Pilot Study

Prior to conducting data collections for this study, a pre testing of the questionnaire was done at Litein Mission Hospital and Kericho District Hospital respectively. The choice of the two health facilities, a mission and govern health facilities was because it had similar socio demographic and health characteristics with the study site chosen for this research.

3.6.2 Validity of the instruments

The questionnaires were translated to Kiswahili and Kipsigis respectively. A team of University lecturers participated in translation to ensure that the language and meaning were retained even during the translation process. Additionally, there were validated questionnaires from a previous study.

3.6.3. Reliability of the instruments

Reliability was assessed using a test-retest method and, the interview questionnaire was administered twice to the same participants at an interval of two (2) days. A correlation co-efficient (at 95% CI) of 0.87 (0.81-0.93) was achieved, and this was considered adequate.

3.7 Data Collection Procedure

The research proposal was approved prior to data collection by the institute of post graduate studies of Kabarak University. Ethical approval of the study was sought from Kabarak University ethical review board. Research Authorization and permit was obtained from National Council of Science and Technology (NACOSTI). Additional ethical approval for research was sought from the ethical review committees at Longisa, and Tenwek Hospitals. . Once approval was granted, the researcher liaised with the

clinicians and nurses and planned a one-day training on data collections tools. The clinical team were trained on enrollment procedures, AVB diagnosis and referral mechanism.

The researcher then selected the participants using the criteria for the study. In this study, data collection was done using an in-depth interview with the provision of an interview guide. The participants were interviewed by the research team; their responses were recorded using an audio recorder. The research team also took notes during the interview sessions. A total of Seventeen women were enrolled and interviewed. The recorded audios were transcribed verbatim using a translator to English.

Once a prospective respondent had been identified, the researchers provided full disclosure of the study and ask her if she was willing to consent to participate in the study. Following patient consent, the participant was referred to as a room set aside to maintain confidentiality. The interview sessions were digitally recorded. Four female nurse research assistants (who were employed staff, two from each of the hospital) were trained by principal investigator on the interview process and operation of the audio recorder to ensure data was accurately collected.

3.8 Data Analysis

Analysis of the data was performed using the framework for thematic analysis as described by Braunand Clarke (2006). In vivo coding where participants' voices were assigned codes, categories, and themes. The audio-recorded data were transcribed to English via a translator and the translation cross-checked by 3 researchers. The patterned responses were extracted, thematic analysis applied to identify the themes relevant to the research question. Three researchers independently analyzed the transcriptions for emerging themes using deductive thematic content analysis.

The principal investigator and the research assistants first read the transcripts to identify the codes, categories, and themes. They then re-read the transcripts to enable the data to be categorized into meaningful sections or units (themes). The sections/units (themes) identified as having a similar focus or content were integrated. Free imaginative variations were applied to the integrated and coded themes followed by elaboration on their findings. This included descriptions of the essential meanings discovered. The original texts were reviewed to confirm the interpretations of both the general structure

and essential meanings. The researcher then finalized the name of each theme, wrote its description and illustrated it with several quotations from the original text to help communicate its meaning to the reader.

Analysis of the data was via thematic analysis. Thematic analysis is one of the most common forms of analysis in qualitative research. It emphasizes pinpointing, examining, and recording patterns (or "themes") within data. Themes are patterns across data sets that are important to the description of a phenomenon and are associated with a specific research question. Deductive reasoning works from the more general to the more specific. Sometimes this is informally called a "top-down" approach.

Thematic coding was done by three individuals who identified texts from the respondents and using in vivo coding. Texts were coded, put into categories which yielded themes. Thematic coding is a form of qualitative analysis which involves recording or identifying passages of text or images that are linked by a common theme or idea allowing you to index the text into categories and therefore establish a "framework of thematic ideas about it" (Gibbs, 2007). Each study researcher independently identified codes, categories, and themes. They later sat together to go through the respective thematic codes and came up with themes which were then subjected to peer review to increase trustworthiness.

3.9 Ethical Consideration

Approval from the institute of post graduate studies was sought prior to data collection. Ethical approval was sought from the institutional Research and Ethics Committee, Kabarak University. Additional ethical approval was obtained from Tenwek Mission Hospital and Longisa County referral Hospital. Research authorization and permit was obtained from the National Commission for Science and Innovation (NACOSTI).Written Informed consent was obtained from all the study participants. The researcher ensured that participants have a clear understanding of the nature of the study and plans for the application of its results. The researcher also confirmed that the participants took part in the study of their own volition without any pretense or coercion.

Confidentiality and anonymity were maintained at each stage in the study from data collection to the dissemination of results. The audio recorder was locked with the key kept by the principal investigator and no unauthorized persons were allowed to

access the recorder. In the event the participants decided, for any reasons, to withdraw at any point from the study, they would have been given that right to withdraw. Their private information would have been permanently deleted. This would not have affected their care. The principal investigator arranged for the provision of counseling services for any participant who felt they have experienced psychological injury as a result of the questions asked in this study relating to AVB. The qualitative data gathered remains confidential following the conclusion of the study.

CHAPTER FOUR
DATA ANALYSIS PRESENTATION AND DISCUSSIONS

4.1 Introduction

This chapter describes the data analysis and the discussion of the research findings. The following research objectives guided the study:

i. To determine individual reasons contributing to women delaying evaluation for abnormal vaginal bleeding in Bomet County, Kenya.
ii. To describe health beliefs that influence healthcare-seeking behavior among women with abnormal vaginal bleeding in Bomet County, Kenya.
iii. To explore institutional reasons that influence women's' ability to seek treatment for abnormal vaginal bleeding in Bomet County, Kenya.

Analysis of the data was performed using the framework for thematic analysis as described by Braun and Clarke (2006) through NVivo software coding where participants' voices were assigned codes, categories, and themes.

4.2 General and Demographic Information

4.2.1 General Information

4.3 Demographics Data of the participants

A total of 17 participants (nine from Tenwek hospital and eight from Longisa Hospital) were interviewed. The largest group was aged 35-54 years, while the smallest group were aged 18-24 years.

Table 1: Demographic Charecteristics

Age	No. of Respondents (n)	Percentage (%)
18-24	2	11.8
24-35	4	23.5
35-54	7	41.2
Above 54	4	23.5

The target population for this study was women aged 18 years and above and presenting with non-pregnancy-related abnormal vaginal bleeding. No upper age limit was placed on participants in this study since AVB may affect women from anytime during their adolescence and throughout the stages of adulthood and this broadened the

respondent pool. The highest range in the study was the age between 35 and 54 which represents 41.2% of the entire population. This is a group of the populations who have given birth or are in their early menopause. This population group is still experiencing episodes of menstruation periods or has stopped having their periods. In this study, the age group between 18 and 24 contributed the least number of participants contributing to 11.8% of the entire population.

The highest number of respondents had attained secondary education (Table 2) constituting 34.5% of the study population. This is a group which would be expected to be able to seek healthcare service without delay. This is also the case with college graduates who constituted12.9 % of the study population. Respondents who had attained the primary level of education contributed 30.1% of the population, while unschooled participants constituted 21.5%.

Table 2: Respondent's Education Levels

Education Level	No. of Respondents (n)	Percentage (%)
College graduates	2	12.9%
Secondary	6	34.5%
Primary	5	30.1%
Unschooled	4	21.5%

4.3.2 Abnormal bleeding period before seeking healthcare

From this study, 68.8% of the population delayed seeking healthcare for between a month and four months after their first experience of abnormal vaginal bleeding. One participant representing 4.3% of the population had delayed for more than 1 year before seeking healthcare service.

Table 3: Length of Delay (Months)

Length of delay (Month)	No. of Respondents (n)	Percentage (%)
1-4	11	68.8%
5-8	3	17.2%
9-12	2	8.6%
Above 12	1	4.3%

4.3.3 Individual reasons contributing to women delaying evaluation for abnormal vaginal bleeding in Bomet County, Kenya

The following table (Table 4) shows the codes identified by the researchers and grouped into categories leading to the identification of two themes; economic and participants' knowledge deficits were agreed as the individual reasons contributing to women delaying evaluation for abnormal vaginal bleeding in Bomet County, Kenya.

Table 4: Individual Reasons Contributing to Women Delaying in Seeking Healthcare

Codes	Category	Theme
1. The high cost of health services 2. Lack of Medical cover	Economic	Economic
3. Painless bleeding 4. Traditional Medicine 5. Self-medication	Knowledge deficit	Participant's lack of knowledge

Individual reasons play a role in health outcomes; these are a range of personal, social, economic and environmental factors that influence health status. During this research, several individual reasons were identified and coded by three individual researchers. These codes were then grouped into categories and later yielded into themes which were also subjected to peer's review as part of increasing trustworthiness measures of data seeking healthcare.

Eleven participants alluded the cost of healthcare services is high. These costs include facility fees and transport cost to the facility. One participant aged 32 reported that she could only afford to meet the cost of food from her farming,

"*We only get little money through farming only for food"*.

Another participant aged 60 reported that traveling from her rural home to hospital in town was expensive and could only afford to get treatment from a private facility within her village: -

"*Travelling from my home is Kshs. 150 then back (total Kshs. 300) I cannot afford this, yet I have to pay to see the doctor, it is better to go to a private clinic which is cheap.*"

Lack of Medical cover was another economical reason that led to delay in health-seeking among women. Ten of the participants did not have medical cover, one of the participant said,

"*I don't have NHIF and the cost of paying cash is high, I cannot afford it.*"

The National Health Insurance Fund in Kenya covers for both inpatients and outpatient services, however, in outpatient the insurances cover limited service and one should be registered to a particular hospital.

"*I was told that NHIF card does not apply in outpatient and I called my husband who told me to go to a nearby small private health facility*," A 37-year-old participant said.

Five participants indicated that the condition was painless and hence did not know the seriousness of AVB,

"There was no pain, therefore, I did not see a reason to seek treatment." A42-year-old participant said.

One participant stated that they preferred using traditional medicine than seeking healthcare in a hospital,

*"I have been using traditional herbs when I am sick and they work well. I was also told by other women in our village that the herbs will stop the bleeding,"*34-year-old participant.

This delayed their presentation to receive proper diagnosis and relevant treatment by a qualified clinician.

4.3.4 Health beliefs that influence healthcare-seeking behavior among women with abnormal vaginal bleeding in Bomet County, Kenya

The table 5 below shows the codes identified by the researchers and grouped into categories leading to the identification of two themes; participants' lack of knowledge and fear as health beliefs that influence healthcare-seeking behavior among women with abnormal vaginal bleeding in Bomet County, Kenya.

Table 5: Health beliefs that Influence Healthcare-Seeking Behavior among Women

Codes	Category	Theme
Fear of the diagnosis	Fear, knowledge deficit	
Fear of examination procedure		Participant's lack of
Common Problem for women.	Knowledge deficit	knowledge
Traditional Medicine		
Self-medication		
Shame	Shame	Fear
Feeling shy to talk about AVB	Shyness	

Health beliefs are values concerning health and illness by individuals or society. Health belief is the attitude towards health services and knowledge about a disease. Health Seeking Behavior Model states that the perception of a personal health behavior threat is influenced by general health values (interest and concern about health), particular health beliefs about vulnerability to a particular health threat and beliefs about consequences of a health problem (Wilson, 2000).

Five participants feared the outcome of the diagnosis. They perceived AVB leads to more complicated diagnosis if they seek healthcare; for example, a participant said that she feared going to the hospital as the result may be cancer.

"*I preferred not to seek care. I thought it may be cancer and I thought it was better not known.*"

Another participant, 34-year-old mother of tenreported that if screening was done, it may turn out to be cancer and her belief was touching it would lead to its spreading faster,

"*You see I was told that if it is touched it will spread faster which will lead to death. Many people have died because it was touched.*"

Three participants said that they feared the examination procedure; they thought that the procedure is very painful. Thirteen participants believed that it was a common problem among women and would resolve with time.

Seven participants did not talk about their conditions early as they felt that it was shameful to talk about it. For instance, one participant aged 48 reported:

"*I did not tell anyone because of shame. Even when I went to a health facility in my home, I did not tell anyone until I came to Tenwek Hospital very sick*"

Another participant 18-year-old said,

"*I feared to say because I was shy. I gave a different complain whenever I came to a health facility. I thought I will be isolated when people get to know my condition.*"

4.3.5 Institutional reasons that influence women's ability to seek treatment for abnormal vaginal bleeding in Bomet County, Kenya

The following table shows the codes identified by the study researchers and grouped into categories leading to the identification of two themes; economic and patients' perspective on clinician competence (professionalism). These were agreed 100% by the three study researchers as the institutional reasons that influence women's ability to seek treatment for AVB in Bomet County Kenya.

Table 6: Institutional Reasons that Influence Healthcare-Seeking Behavior among Women

Codes	Category	Theme
1. Cost of health services		
2. Distance to the higher health facility	Economic	Economic
3. Inappropriate diagnosis		
4. Lack of examination before prescription.	Examination (physical/diagnostic)	
5. Treatment without diagnosis	No diagnosis	Patients' perception on Clinicians competence (professionalism)
6. Lack of healthcare provider-initiated talk on AVB	Communication	
7. Lack of referral	No referral	

The third objective in this study was to identify institutional reasons that influence women's ability to seek treatment for AVB in Bomet County Kenya. These factors included services provided at a health facility, health workforce, and equipment within institution and drugs availability. According to Conceptual framework of healthcare seeking behavior by Bayu and Thomas (2016) institutional factors influencing

healthcare seeking behavior includes the price of health services, distance from a health facility, the approach of health professions and satisfaction with health services. The study reported issues related to inaccessibility to healthcare. Health care service is less accessible in rural areas, which is concerning since the majority of Kenya's population resides in rural areas.

From this research one of the institutional factors influencing women's ability to seek treatment for AVB in Bomet County, Kenya was the distance to a health facility. Six of the participants had to travel a long distance to access healthcare in either Tenwek or Longisa referral hospital.

> "*I have walked from Sogoo (Narok-South) to Tenwek hospital to access these services*" one research participant aged 37, a mother of seven said.

Another participant aged 54 added,

> "*It is hard to get better healthcare services in clinics in our location hence I have to walk for a long distance to get proper examination and treatment.*"

Eight participants reported that they had been given a prescription of drugs without any physical examination in their first consultation at the rural health facility.

> "*There was no test that was carried out on me. The clinician just told me to go and buy medicine from the chemist*" a 35-year-old participant mother of 7 said.

Eleven participants also indicated that they received treatment without a clear diagnosis. A 31year-old high school leaver participant reported,

> "*I went to a public health facility in my area and I was told that it was a hormonal imbalance and I was given an injection to stop the bleeding,*" said the participant.

From the study thirteen respondents representing 76% of the study population indicated that they were not asked by their first contact healthcare providers to seek further treatment in a higher health facility.

> "*The clinician in the clinic I first visited when I noticed the bleeding gave me some drugs and told me to come back to the facility if the bleeding did not stop. When I went back, they gave me a different set of drugs that did not heal me.*

Every time I went, they gave me different drugs and never referred me to a better hospital," a single mother aged 39 said.

Four participants said that they preferred the clinician to initiate talks on vaginal bleeding.

"*If the healthcare provider had initiated the talk, I would have been comfortable to discuss",* "explained a participant aged 42.

4.4 Discussion

The chapter covers the method of data analysis, study results and findings' discussion. The findings from the study did not vary with the study objectives. Also, various demographic data were discussed. The following themes came out of this data: Economic, Fear, Participants' lack of knowledge and Patients' perception of clinicians' competence (professionalism).

4.4.1 Economic reasons

In this study, it was found that women delayed in seeking healthcare because of their economic status. Healthcare is less accessible in rural areas not only because of distance but also economic reasons as eluded by a number of participants, which is concerning since the majority of women resides in rural areas. Additionally, investigation, examination, and treatment used are expensive and sometimes even unaffordable for women suffering from abnormal vaginal bleeding further impeding access to healthcare and contributing to delayed presentation for evaluation of AVB. Several other studies in the literature have agreed with the finding that women delay in seeking healthcare because of their low socioeconomic status. Leckie (2006) conducted a study of major hospitals and noted that women who seek medical attention on issues such as bleeding were of a higher socioeconomic demographic. It was indicated that most women were supported by their families or spouses financially since the procedures and services required for treatment of some conditions associated with AVB are expensive. In India, Calvello (2015) noted that women between the ages of 18 to 24 years were dependent on their families. In this study, this age group represented 12.9% of the study population.

Institution reason influencing women's ability to seek treatment for AVB in Bomet County Kenya is the distance to a health facility. Six of the participants had to incur high travel cost because of the long distance to access healthcare in either Tenwek or Longisa referral hospital. Lack of Medical cover was another economical reason that led to delay in health-seeking among women. Ten of the participants did not have medical cover. The National Health Insurance Fund in Kenya covers for both inpatients and outpatient services. However, in outpatient the insurances cover limited services and one should be registered to a particular hospital.

4.4.2 Fear

Health beliefs are values concerning health and illness by individuals or society. It is the attitude towards health services and knowledge about a disease. Health Seeking Behavior Model states that the perception of a personal health behavior threat is influenced by general health values (interest and concern about health), particular health beliefs about vulnerability to a particular health threat and beliefs about consequences of a health problem (Wilson, 2000).Once an individual perceives a threat to their health and is simultaneously cued to action, and his/her perceived benefits outweigh their perceived threats, then that individual is most likely to undertake the recommended preventive health action. In a study conducted by Herlitz, *et al.*(2010), on factors of importance for patients' decision time in acute coronary syndrome found out that fear of the consequences can significantly shorten the patients' decision time.

However, in this study, it was noted that women delayed because of fear of the outcome of the diagnosis. Fear could be a factor because it is likely that women with abnormal vaginal bleeding are not comfortable exposing their condition for fear of stigmatization. In a qualitative study conducted by Khisa and Nyamongo (2011) on factors contributing to obstetric fistula formation in rural Kenya, the researcher reported that social forces such as fear of hospital health care providers performing different procedures, which are contrary to the local traditions, keep many women from visiting the health institutions. This was also the case in this study where some participants delayed seeking health care because they were ashamed to talk about their conditions, while others delayed seeking health care services because they feared examination procedure in relation to AVB. Healthcare providers not limited to only public health

officials should be able to educate the public and do individual counseling to reduce social reasons such as the fear that contribute to delay in healthcare seeking behavior.

4.4.3 Participants' lack of knowledge

According to U.S. Department of Health and Human Science (2010), Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. In addition to basic literacy skills, health literacy requires knowledge of health topics. People with limited health literacy often lack knowledge or have misinformation about the body as well as the nature and causes of disease. Without this knowledge, they may not understand various health outcomes. Health information can overwhelm even persons with advanced literacy skills. Medical science progresses rapidly. Culture affects how people communicate, understand, and respond to health information.

Culture and traditions play a major role in the lower utilization of health services. Two studies by Kijugu (2009) and Melkamu (2008) where the later study was investigating the problem of health-seeking behavior and utilization of health care services, was carried out both in rural and urban areas of four major regions of Ethiopia where it investigated the association of culture and tradition and modern health-seeking behavior. This research found that women prefer home-based care because they were able to maintain the tradition that they have been accustomed to for generations. A similarly finding in the study by Kijugu (2009) revealed the low status of women in the society, culture,and beliefs are factors contributing to women failing to access health services. This was the case in this study where some women preferred to use traditional herbs to seeking health care in the hospital.

In this study, it was noted that a number of respondents delayed seeking health care services since they did not experience any pain with the bleeding. It is therefore, possible that lack of perceived seriousness of symptoms and signs and lack of perceived possible cure of the cause of abnormal vaginal bleeding contributed to the delay in healthcare seeking behavior. Patient's perceptions that they were able to cope with or control symptoms contributed to their delay in seeking healthcare service in Nurs Res, 19 (2010).Individual interpretations of symptoms are both drivers of and barriers to help in healthcare seeking behavior. Interpretations are informed by symptom onset, sources of information and coping mechanisms.

4.4.4Patients' Perception of clinicians' competence (professionalism)

One of the most important factors that contribute to a successful healthcare career is professional etiquette. Many personal interactions with a variety of people are seen in healthcare. It is not enough to have just good manners; it is about establishing respectable relationships with everyone including patients, colleagues, and supervisors. In a medical setting, healthcare professionals must set the tone for the interaction with patients and visitors. They are constantly in contact with people who will assess them based on the way they communicate, body language, and appearance.

Various studies identified as the direct or underlying problem a cycle of repeated consultations with multiple healthcare providers without a correct diagnosis. In these studies, patients visit health facilities at the same level or had multiple visits to the same health care provider and there was minimal activity in seeking a higher level facility. In Burkina Faso for a patient seeking a health post or a private practitioner, the progression towards specialized services was poor. Patients had repeated consultations at the same level, such that more than 94% of patients underwent repeated courses of nonspecific antibiotics (Storla *et al*; 2008). Lack of proper diagnosis is often connected to inadequate training. AVB may be as a result of a chronic condition just like other chronic condition like TB and its diagnosis require a high index of suspicion by health personnel. For instance, in Ghana, the health personnel at government health posts have poor training in diagnosing TB (Storla *et al*; 2008). In a study in Malaysia, only 11% of patients received their diagnosis after the first consultation, and 45% received their first diagnosis after the third consultation (Storla *et al*; 2008).

In this study, respondents reported having been seen by various providers in primary-level government health posts and small private facilities, who have limited diagnostic facilities and inadequately obtain history and examination of abnormal vaginal bleeding. This led to their delay in seeking health care in higher facilities with proper diagnostic facilities and competent staff. Lack of adequate history and physical examination of a patient by health care providers by primary-level government health and small private facilities before prescription was noted in this study which further delayed proper diagnosis and potential treatment of abnormal vaginal bleeding or referral to higher health centers.

CHAPTER FIVE

5.1 Introduction

This chapter will discuss the summary of the findings, conclusion, and recommendations of the research study.

5.2 Summary

The objectives of this study were to investigate individual reasons contributing to women delaying evaluation for abnormal vaginal bleeding, describe health beliefs that influence healthcare-seeking behavior among women with abnormal vaginal bleeding and explore institutional reasons that influence women's ability to seek treatment for abnormal vaginal bleeding in Bomet County, Kenya. From this study, it's notable that the findings were in agreement with the study objectives and that the impacts of various demographic data were explored. The following themes came out of this data: economic reasons, fear, and participants' lack of knowledge and Patients' perception of clinicians' competence (professionalism).

5.3 Conclusions

Data collected showed women are suffering in silence because of economic reasons due to cost not only of health services but transport as well. The clinicians' strategy to arrive at diagnosis was wanting in most primary-level and small private health facilities. Healthcare utilization was limited by fear where women felt shy and ashamed to talk about their condition. Others were scared by examination procedures and a number had little understanding of the seriousness and treatment options for this condition. The experience of women in Bomet County seems to reflect experiences seen elsewhere. This study revealed that women with vaginal fistula suffered in silence because of multiple social issues to include stigma.

The cost of healthcare services can be seen in this study. This study was conducted in two major hospitals in Bomet County and noted that women who seek medical attention on issues such as bleeding were of a higher socioeconomic demographic. This study also reflects unique perspective in several areas such as perceived seriousness of symptoms and signs of Acute Myocardial infarction. The study showed that when it is the heart, there is a lower delay in healthcare-seeking behavior which i was not the case in this study dealing with abnormal vaginal bleeding. The

responses of these women give us insight into misunderstandings and obstacles to them seeking care for this problem.

Specifically, we identified that there are economic reasons, fear, participants' lack of knowledge and clinicians' competence (professionalism). Performance in healthcare is highly scrutinized. It is important for the medical practitioner to focus on providing positive experiences for patients and caregivers that begin as soon as they enter the door. This helps patients to be comfortable in presenting their illnesses.

5.4 Recommendations

In order to ensure that women seek healthcare services for abnormal vaginal bleeding early, the following recommendations are pointed out.

i. Aim at empowering the society to play an active role in improving their own health, successfully engage the community to be responsible for their health action, and push governments to meet their responsibilities in addressing health-relate dissues. One of the reliable ways to achieve this is improving the health literacy of the people.
ii. Women should be encouraged through healthcare givers to seek specialized healthcare service so as to decrease diagnostic and treatment delay. This is possible by raising awareness among women about abnormal vaginal bleeding and its treatment options.
iii. The health sector should look into improving the primary-level government health posts which have limited diagnostic facilities and inadequately trained healthcare givers.
iv. The government should ensure to put checks on private practitioners, unqualified vendors and traditional practitioners with low awareness of the serious cause of none pregnancy-related abnormal vaginal bleeding. The clinicians should be aware that there are many potential sources of abnormal vaginal bleeding in women and the actual site must be determined. This calls for proper history and physical examination.
v. Targeted public health interventions are required to inform symptom interpretation and reduce delays.

5.4.1 Policy Recommendations

The following are recommendations based on the research findings:

i. There is a need to raise awareness among women about vaginal bleeding and its treatment options through relevant stakeholders in the health sector. This could be done through the campaign on special health needs among women in the county government.

ii. There is a need to find out the topics covered by health care providers under continuous medical education in primary-level and small private health facilities. Do such sensitive topics like abnormal vaginal bleeding get covered and to what extent and by whom? It therefore, calls for relevant continuous medical education in all levels of health care providers.

5.4.2 Recommendations for Further Research

The following are recommendations for further research:

i. Effect of health insurance cover in reducing delayed healthcare seeking behavior
ii. The role of healthcare providers in achieving universal health care in Kenya
iii. Challenges faced by the devolved government to adequately implement universal health care among women
iv. Impact of health campaign messages on early healthcare seeking behavior on women's sensitive health issues.

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AAPENDICES

Appendix I: Cover Letter

To:

Chairperson,

Institutional Research and Ethics Committee

Kabarak University

Private Bag, Kabarak

RE: IRB RESEARCH PROPOSAL SUBMISSION FOR ELIJAH KIPKIRUI TERER, REG NO. GMMF/M/1195/09/15

Greetings in Jesus' Name.

I am a student at Kabarak University, School of Medicine and Health Sciences, pursuing masters in Family medicine.

My details are as follows:

Name Elijah KipkiruiTerer.

Registration No.: GMMF/M/1195/09/15

Course: Masters in Family Medicine.

As a requirement of the university, I am expected to accomplish a research project by end of this year 2018. This letter, therefore, is to tender my research proposal to your esteemed committee for ethical scrutiny and approval.

The details of the proposed research are summarized in the following abstract. Further, I have attached a separate document containing the proposal in full for your perusal.

ABSTRACT

The purpose of this study is to determine patients' reasons involved in delayed healthcare-seeking behavior for non-pregnancy-related abnormal vaginal bleeding in Bomet, Kenya. The objectives of this study are to describe how health beliefs, institutional reasons, and individual reasons contribute to delayed healthcare-seeking behavior. A qualitative phenomenological method will be employed with a target population including women aged 18 years and above who have experienced non-pregnancy related abnormal vaginal bleeding. The study will use a convenience sampling method for the selection of 20 participants from the inpatient and outpatient departments

of Longisa Hospital and Tenwek Hospital (10 participants from each hospital). In order to determine and select the respondents, the researcher will involve clinicians at these two hospitals. The clinicians will notify the researcher upon the presentation of a woman with a diagnosis of abnormal vaginal bleeding. Using the inclusion and exclusion criteria of the study, the researcher will decide their suitability for the study. The researcher and research assistants will collect primary data using in-depth interviews. Analysis of the data will be completed using the Braun and Clarke framework for thematic analysis with the goal of reaching thematic saturation. The goal of the study is to improve understanding of patients' factors contributing to the delayed presentation with abnormal vaginal bleeding and to help target interventions which will encourage timely healthcare-seeking behavior. This knowledge can be translated to the woman in the community, women/village leaders as well as healthcare policymakers.

Methods:

Objectives

The following are the research objectives:

i) To describe health beliefs that influence healthcare-seeking behavior among women with abnormal vaginal bleeding in Bomet County, Kenya.
ii) To explore institutional reasons that influence women's ability to seek treatment for abnormal vaginal bleeding in Bomet County, Kenya.
iii) To investigate individual reasons contributing to women delaying evaluation for abnormal vaginal bleeding in Bomet County, Kenya.

Design:

This is a qualitative study that will utilize a phenomenological study design. This study will examine the women's experience of abnormal vaginal bleeding and why there is a delay inhealthcare-seeking behavior among women in Bomet County.

Sampling:

The study will employ a convenient sampling method for the participant selection as only specific women with the condition will be targeted. The researcher will request for the clinicians at both Longisa Hospital and Tenwek Hospital to inform the researcher when they have a diagnosis of abnormal vaginal bleeding. The researcher will apply the inclusion and exclusion criteria for the selection of study participants. Ten participants

from each hospital will be selected with provision to continue until saturation of themes is attained. Guest et al (2006), suggests a sample size of six in-depth interviews may be appropriate in establishing themes for useful interpretation; however, it is most likely that thematic saturation will occur within the first 12 interviews.

Ethical issues

Permission to perform this study will be requested from all the relevant authorities including the independent research boards of Kabarak University, Longisa Hospital, and Tenwek Hospital.

Written Informed consent will be obtained from all the study participants. The researcher will ensure that participants have a clear understanding of the nature of the study and plans for the application of its results. The researcher will also confirm that the participants take part in the study of their own volition without any pretense or coercion. Confidentiality and anonymity will be maintained at each stage in the study from data collection to the dissemination of results. The tape recorders will be locked with a key kept by the researcher and no unauthorized persons will be allowed to access the recorders. In the event the participants have decided, for any reasons, to withdraw at any point from the study, they will have that right to withdraw. Their private information will be permanently deleted. This will not affect their care.

The researcher will arrange for the provision of counseling services for any participant who feels they have experienced psychological injury as a result of the questions asked in this study relating to AVB. The qualitative data gathered will remain confidential following the conclusion of the study.

Anticipated benefits

The goal of the study is to improve understanding of healthcare-seeking behavior of women with bleeding and help to inform the required interventions. This is possible with knowledge obtained from the community involved and will influence health policy makers as well.

Budget/Funding

The budget of the study amounts to Ksh.78, 865.00 with the funding coming from Micro-Research international. Micro-Research is a Canadian Non-Profit organization

that helps capacity building in research with special interest in underdeveloped countries. Approval from the organization has already been obtained.

I hope that our proposal meets the satisfaction of your committee.
I am looking forward to obtaining your approval and further input towards this project.

Appendix III: Written Informed Consent (In English)

Study Title: Patients' reasons contributing to delayed healthcare-seeking behavior for non-pregnancy-related abnormal vaginal bleeding in Bomet County, Kenya.

This informed consent is for women with abnormal bleeding from the birth canal that is non-pregnancy related.

Dr. Elijah Terer, Principle Investigator
Kabarak University
Tenwek Hospital

The Consent Form has two parts:

- To share information about the study with you, an information sheet will be given.
- For signature, if you choose to participate, there is a certificate to sign.

Part I: Information Sheet

Introduction

I am Elijah Terer, a student at Kabarak University and a doctor at Tenwek Hospital. I am doing research on issues that involve abnormal bleeding from the birth canal in women. You will be invited to be part of this research after you have received the information.

If you do not understand some words in the consent, I welcome you to please ask me to stop so as to give you more clarification in areas that you do not understand. Feel free to ask me any question any time.

The research's purpose

The goal of the study is to improve understanding of seeking for the care of women with abnormal bleeding from the birth canal and help to inform the formulation of interventions. This is possible with knowledge obtained from the community involved and will influence health policy makers as well.

Type of Research Intervention

This research will involve your participation in an interview where we gently discuss some questions about what you want to happen in the future.

Participant Selection

You are invited to take part in this research since we feel that your contribution can enrich much of our understanding and knowledge locally.

Voluntary Participation

In this research, it is wholly voluntary. Participating or not in this research has got nothing to do with the services you receive from us. You can also withdraw at any point with or without a reason.

Procedures

A nurse or a clinician will help identify you if you have this condition as the reason for your hospital visit. The nurse or clinician will receive you, seek your condition, ask if you are willing to participate in the study and direct you to the researcher or research assistants. All interviews will be conducted in a room set aside for the study and English, Kiswahili or Kipsigis language will be used depending on your ability to understand. You will be made comfortable during the interview; you can, therefore, choose to be seated on a chair or on a bed/coach.

Duration

The interview will last for about one hour.

Risks

We understand that we are asking you to share with us some very personal and confidential information; this may make you not to be at ease. It is fine not to take part in the interview if you don't wish to do so. Do not feel that you have to give us any reason for not responding to any question, or for refusing to take part in the interview.

Benefits

From the study, there may be no direct benefit to you, but your participation is likely to help us find out how to attend to the needs of our patients with abnormal bleeding through the birth canal in the near future.

Reimbursements

No enticement to take part in the research.

Confidentiality

The research is being done in a room set aside in the hospital. Your information will not be shared with anyone outside of the research team. The information that we collect from this research project will be kept private. Only the authorized people will access the information and we will lock that information up with a lock and key.

Results Sharing

All the information that you share with us, won't be shared with anyone outside the research team, and no attribution to your name. We will share the findings with the two health facilities and the university administration. Hopefully, the results will be published so that other interested people may learn from the research and this includes the policymakers, women in the community and village leaders.

Right to Refuse or Withdraw

To take part in this research is wholly voluntary, and choosing to participate or not participate will not affect the services you receive from us. Therefore, you can also withdraw at any point of the study.

Who to Contact

You are welcome to ask questions now or later. If have any question to ask later, you may contact the following: Principal investigator, Dr. Elijah Terer 0718-856844 or Kabarak University IREC secretary Tel. 0724-887431.

Part II: Certificate of Consent

I have been invited to participate in research about reasons for delayed healthcare-seeking behavior in non-pregnancy related bleeding from the birth canal.

I have read the preceding information, or it has been read to me. I have been given the opportunity to ask questions about it and Iam satisfied with the answers given. I, therefore, consent voluntarily to be a participant in this study

Participant‘s number _____

Participant’s signature _____

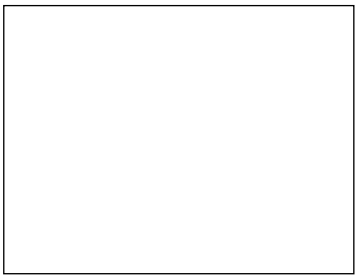
Date _____

If illiterate

Having witnessed the accurate reading of the consent form to the potential participant, and the opportunity given to her to ask questions, I confirm that the individual has given consent freely.

Participant’s number _____

Participant’s signature/Thumb print



Witness’s signature _____

Date _____

Statement by the researcher/person taking consent

To the best of my ability I have made sure that the participant understands that the following will be done:

1. An interview will be done.
2. Notes will be taken and the interview will be audio-recorded.
3. Confidentiality of the shared information

It is true that the participant was given a chance to ask questions about the study, and all the questions asked by the participant have been answered correctly. I confirm that the individual has not been coerced into giving consent, and the consent has been given without stinting and voluntarily.

Participant has been given a copy of the form.

Name of Researcher/person administering the consent_____

Signature of Researcher /person administering the consent_____

Date _____

Appendix IV: Hati Ya Ridha (Consent in Kiswahili)

Idhini hii ni ya wanawake wanao vuja damu kutoka kwa njia ya uzazi isiotokana na uja uzito.

Dr. Elijah Terer, MtafitiMkuu
Kabarak University
Tenwek Hospital
Fomu hii ya Idhinii na sehemu mbili

- Kurasa ya habari (inatoa habari kuhusu utafiti)
- Hati yaridha (yakutia sahihi ukichagua kushiriki)

Utapewa nakala ya fomu hii ya Idhini

Sehemu ya Kwanza: Kurasa ya habari

Mwanzo

Mimi Elijah Terer, Mwanafunzi katika chuo Kikuu Cha Kabarak na pia daktari Hospitali ya Tenwek.

Ninafanya utafiti wa suala linalohusisha kuvuja damu isiyo ya kawaida kutoka kwenye njia ya uzazi kwa wanawake. Nitakupa habari na kukualika ushiriki kwenye utafiti huu.

Fomu ya idhini ina maneno ambayo huyaelewi. Tafadhali nisimamishe tunapoendelea kupitia habari na nitachukua muda wakufafanua. Ukiwana swali baadaye, unaweza kuniuliza au unaweza kuuliza mtafiti mwingine.

Sababu yaUtafiti

Lengo la utafiti ni kuboresha ufahamu wa tabia ya kutafuta afya ya wanawake walio na damu isiyo ya kawaida kutoka kwenye njia ya uzazi na kusaidia uundaji wa njia za kuzuhia. Hii inawezekana kwa ujuzi uliopatikana kutoka kwa jamii unaohusishwa na utaathiri wa tunga sera zaa fya pia.

Aina ya Uingizaji wa Utafiti

Utafiti Huu utahusisha ushiriki wako katika mahojiano ambapo tunazungumzia kwa upole baadhi ya maswali kuhusu kile unata kakutokea baadaye.

Uchaguziwa washiriki

Unakaribishwa kushiriki katika utafiti huu kwa sababu tunaona kuwa pembe jeo yako inaweza kuchangia sana kwenye ufahamu wetu na ujuzi wamapendekezo yamitaa.

Kushiriki kwa hiari

Ushiriki wako katika utafiti huu ni kikamilifu kwa hiari. Ni uchaguzi wako kama kushiriki au la. Ikiwa unachagua kutoshiriki Huduma zote unazopokea kutoka kwetu zitaendelea na hakuna chochote kitabadilika. Unaweza pia kuondoka wakati wowote na bila sababu.

Taratibu

Muuguziwa kupima au daktari atasaidia kutambua kama unadalili hii kama sababu ya ziara yako ya hospitali. Muuguzi au daktari atakupokea, tafutahali yako, uulize kama ungependa kushiriki katika utafiti na kukuelezea ambapo wasaidizi wautafiti watasubiri. Mahojiano yote yatafanyika katika chumba cha faragha kwa lugha ya Kiingereza, Kiswahili au Kipsigis kulingana na uwezo wako wakuelewa. Utafanywa vizuri wakati wamahojiano; basi unaweza kuchagua kuketi kiti au juu ya kitanda / kochi.

Muda

Mahojiano itachukuwa saa moja.

Hatari

Tunakuomba utupe maelezo ya kibinafsi na yasiri, na unaweza kujisikia wasi wasi kuzungumza juu ya baadhi ya mada. Sio Lazima kujibu swali au kushiriki katika mahojiano ikiwa hutaki kufanya hivyo, na hiyo pia ni sawa. Sio Lazima utupe sababu yoyote ya kutojibu swali lolote, au kwa kukataa kushiriki katika mahojiano.

Faida

Labda hakutakuwa na faida ya moja kwa moja kwako, lakini ushiriki wa kouna wezekana kutusaidia kujua jinsi ya kuudumia mahitaji ya wagonjwa wetu wenye damu isiyo ya kawaida kwa njia ya uzazi siku za usoni.

Malipo

Hutapewa malipo yoyote ya kushiriki katika utafiti. Hata hivyo, tutakupa shawl / kanga kwa muda uliochukua kuzungumza nasi.

Usiri

Utafiti huu unafanyika katika chumba cha faragha katika hospitali. Hatutatoa habari kukuhusu kwa mtu yeyote nje ya timu ya utafiti. Taarifa ambayo tunakusanya kutoka kwa mradi huu wa utafiti itahifadhi wa binafsi. Watafiti tuwatao na habari na tutaifunga habari hiyo. Haitatolewa au kupewa mtuy yote.

Kutoamatokeo

Hakuna kitu ambacho unatuambia leo kitakachotolewa kwa mtu yeyote nje ya timu ya utafiti, na hakuna kitu kitakachoonyesha jina lako. Tutatoa matokeo ya utafiti kwa vituo viwili vya afya na utawala wa shule. Tunatarajia kuchapisha matokeo ili watu wengine wanaopendezwa waweze kujifunza kutokana na utafiti na hii inajumuisha watengeneza sera, wanawake katika uongozi wa jamii na vijiji.

Hakiya Kukataa au Kutoa

Si Lazima kushiriki katika utafiti huu kama unataka kufanya hivyo, na kuchagua kushiriki au kutoshiriki hakutaathiri Huduma utakayopokea kutoka kwetu. Unaweza pia kuondoka wakati wowote wa utafiti.

Nani wa Kuwasiliana

Ikiwa unamaswali yoyote, unaweza kuuliza sasa au baadaye. Ikiwa unataka kuuliza maswali baadaye, unaweza kuwasiliana nasi ukitumia anuan izifuatayo:

Mtafiti mkuu, Dr. Elijah Terer 0718-856844 auKarani Chuo Kikuu Cha Kabarak IREC Tel. 0724-887431.

Sehemu ya Pili: Hatiya Ridha

Nimealikwa kushiriki katika utafiti kuhusu sababu zilizojulikana za kuvuja damu kutoka njia ya uzazi na kuchelewa kuonekana.

Nimesoma taarifa iliyotangulia, au imesomezwa. Nimekuwa na fursa yakuuliza maswali kuhusu hilo na maswali yoyote niliyo yaomba yamejibiwa kwa kuridhika kwangu. Ninakubalikwa hiari kuwa mshiriki katika utafiti huu

Andika Nambari ya Mshiriki _____

Sahihiya Mshiriki _____

Tarehe_____

Kama hajasoma

Nimeshuhudia kusomewa sahihi wa fomu ya idhini na kukubalia inakwa mshirikiwa tarajiwa, na mtu binafsi amekuwa na nafasi ya kuuliza maswali. Ninathibitisha kwamba mtu huyo ametoaridhaakwauhuru.

AndikanambariyaMshiriki _____

Kidole cha GumbayaMshiriki/ Sahihi

SahihiyaShahidi _____

Tarehe_____

Taarifa ya Mtafiti / mtu kuchukua idhini Nimesoma kwa usahihi karatasi ya habari kwa mshiriki mtarajiwa, na kwa uwezo wangu wote kuhakikisha kuwa mshiriki anaelewa kuwa mambo zifuatazo zitafanywa:

1. Mahojiano itafanywa
2. Mahojiano yatanakiliwa na kunaswanachombo cha sauti
3. Habari zote zitawekwa siri

Ninadhibitisha kwamba mshiriki amepewa nafasi ya kutosha kuuliza maswali kuhusu utafiti huu, nani mejibu maswali yake yote kwa kadiri ya uwezo wangu. Nadhibitisha mshiriki amepeana idhini kwa ihari yake mwenyewe.

Mshiriki amepewa nakala ya fomu hii.

Andika jinaya Mtafiti/Yule anayepeana idhini_____

Sahihi ya Mtafiti/Yule anayepeana idhini_____

Tarehe _____

Appendix V: Kaanjinet nekagigonennaet (Consent in Kipsigis)

Kartasinikinyitenebochamjinetkotinyekwondonemondoikorotikenoretabsigisio ago mandaanatokomatingengekiiakmanagetanankosigeetablakwet.

Daktari Elijah Terer

kochigilindetneinendetkobunusugulitabbarakneboKabarakakkorakonyoiseensipitalitapTenwek.

Kartasinikinyitenebochameetkotinyekebeberwekaeng

. Negonulogoiyon (ne arorunagobochigilani)

. Ne iboruchametenchito ne kagoyan(negindoisiiyet yon kagoyan chi kowoltebutik)

Kigoninkartasitnekergeineiborukolekagoyan chi kowoltebutik

Kebeberta ne tai: Karstasit ne aroru

Taunet

Kigurenon Elijah ArapTerer, ago eninguniasomaniensugulitapbaraknebo Kabarak, akanyoiseiensipitalitabTenwek.Ayaechigilisietagobomandaetabkorotikenoretabsigisioen oret nemoboatgaitugulenchebioso. Amachea goninlogoiyonakatachiniegukebebertapchigilani.

Kartasinibosomeetiegunewolutebutikabereitinyengalekchesait age komeguiye,asomin ale kaigaiitelelsion yon kitesetaikibagengeagoninlogoiyweksikobitaibkasartaaarorunkomie.Indabitutebutietkasar age itebenananankochigilindet age.

Tokyinetabgenebochigilisiet

Imonguchigilisionikoarorenoret ne kiguitosagoboatebtonebochebiosone change tililindo yon tinyeikaimutietabmandaetabkorotikenoretabsigisioakkotoretkoboroor ne gimuchiketoretenchito ne miani.Imugakseinitoyekinyorkaguiyetkobunbikabbororchekatinykaimutioniakkotoret korabikchechabeingatutikabtililindo.

Ortinywekcheiboruchigilisietkeleimuchikotoretis

Chigilisionikotinnyeienoret ne kitepseen yon kingalalkibagengekobuntebutikenkerengungenoleiimaktoikoyaiyakenbetusiekchebwanei.

Olekichendoibikchewolutebutik

Kitochiiniegukebebertaenchigilisioniamunkigasekele kit ne igonukotoreti missing koguiyenyoonaknaenyoon ago boolemaktoibikeninganaset.

Konunetabge ne makiskyiin chi

Kebebertangungenchigilisionienkebebertatugulkokonunengungboge.Ileweniiegukebebertaanan koacha.Yon megonugeketesetaiiegukebebertabchigilisioniitesetaiinyorutoretetyomamiwalet.Imuchikoraistegeenkebeberta age tugulnebochigilisionikomiananingomamiamune.

Olekisiptoitetutik

Chepkerichot ne bimonikorokkotomkogerindaktarikotoretinkoborunkoleitinyekaimutionikaimutuninyonsipitali.Tochininendetakkochigilmiando ne itinyeakkotebenenngotiyoniiegukebebertanebochigilisieteitiokoboruntoretindetabchigilindet neigenisiei.Ngalalettugulkeboisienkutitabkingeresa, kiswailianankokipsigiskouyeimuchiiguiyeinyendet.Kigoninkasartanemieenngalalettugul, ago imuchiitebotenngecheretananiruenkitandet.

Kasarta ne tarei

Ngalaletkotareinegitsaitagenge.

Ngoiyonditnemi

Kisominipcheiyweechlogoiwekchetinyin ago boungateninye, ago kasar age ililanjiningalalutikalak. Mewolutebutikananingalalen kit nememocheinyenndet, ago maetatnotokkora.Makilenlasimaimwowechamuneesikomewolutebutik, anansimeigukebebertabingalalani.

Kelchinoik

Mamikelchinoikcheisicheinyenndet, ago yon keigukebebertabchigilisioniitoretechkenaiolekitoretitoibikchemiandoskomondoikorotikenoretabsigisietenbetusiekchebwonei.

Wegunetabtugukchekeboiisien

Momikiy ne isicheenchigilisioni, kobatenkigoninsiolitanankokitambaetab kanga amunenkasartangung ne gegonech.

Ungeetabngalek

Kiyaechigilisionien got neungatensipitali.
Makimwaitoingalekenbikchemobotochigilani.Ngalekchebitunenchigilisionikeunyekobu njichichok.Kereichigilindetinegenlogoiywekchemiakkounyenoleungaatkokagiker.
Makimwachin chi anankigochi chi age.

Pcheeptabwolunoik

Kit ne kemwaawechkomakimwachinchitonemobotochigilisioni, amakimwaekainengungkelekemwa.Wolunoikkegochinsipitalisiekaengakkandoinatetabs ugulitagenge.Kisirewolunoiksibikchemochekonetegeichigilisionikomuchkonyorkoboto bikchetinyegeiakngatetabngatutik, chebiosokenkokwotinwekakkandoik.

Kamuget ne imuchichitokoesioanankoistogei

Memuchiiegukebebertaenchigilisioningotkomemoche, imuchiileweniegueagengeenchewolutebutikananiyesiei ago matinyeinotontoretenyonnekigonin.Imuchikoraistegeenkebeberta age tugulnebochigilisiet.

Ngo' neiwolchini

Ngotitinyetebut age tugul, imuchiiteebenkasartaage.Ingotimocheiteebkiyimuchiinyoruchigilindet neo notonkoDaktari Elijah Tererennambachebosimoit 0718856844 anako SirindetabIRECeng Kabarak University Simoit.0724-887431.

Kebebertaneboaeng: Kartasitnebokayanjinet

Kigitachanaiegkebebertabchigilisietnetinyegeak ole ibwotitoibiikkoleamuneisiekcheyaebikkomasibkoborkoimutietabmadaetabkorotikenoreta bsigisio.
Karasomankebebertanebotainebologoiywek, anankagesomannwon.Kiasichkasartaateebtebutikagobonotonaktebutagetugul ne kiateebkokigiwolwoonkoyaman.Kaachamaiegkebebertanebochigilisiooni.

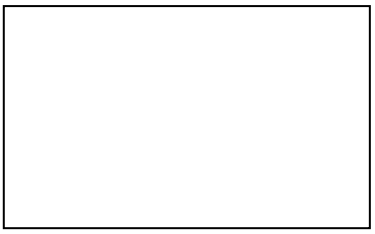
Sir nambanebochichoto _____

Indesiiyetnebochichoto _____

Sir tarigit _____

Ngo moimuchikosoman

Korogerbaornatetnenotoensomanetabkartasitnebokayonjinetaiegkebebertabchigilisiet, ago kagoteebtebutikchichoto.Agonubaornatet ale kagoyaanchichotonkomakisimji.
Sir nambanebowolunindenoton _____



Ingochilaksiiyet neo/ seiinebowolunindetnoton

Seiinnebobaoriat _____

Tarigit_____

Ngolyioonkobunchigilindet/ chito ne kaiyankogonge

Kaasomankomiekartasitabkaarorortoetagobo chi ne imuchkoiegkebebertabwolunikchebotebutik, akennaenyuntugulkomatinyetamjinagobokaguiyetnekanyorinendet ago yaiyakseituguchu:

1. **Biitungalaletnebochigilet**
2. **Kisireisirutikakketangalalet**
3. **Logoiwektugulkomakimandoi**

Kaagimitnaeyun ale kagigochichito ne kaiyankoiegwolunindetkasartakoteebtebutikagobochigilisioni, aktebutiktugulchekateebwolunindetkokagiwoljikomiekou ole kaimugaksei.Abaoriani ale magisikyiinendetkoiegwolunindetabtebutikasikoyan, ago kaiyankoineegenenchamet.

Kartasit ne gergeiaknitokogagochichito ne kaiyankoiegwolunindetabtebutik.

Sir kainetabchigilindet/ chitonekaarorukaanjinet_____

Seiinebochigilindet/chitonekaarorukaanjinoni_____

Tarigit _____

Appendix VI: Introduction Letter from Institute of Postgraduate Studies in Kabarak

INSTITUTE OF POST GRADUATE STUDIES

Private Bag - 20157
KABARAK, KENYA
E-mail: directorpostgraduate@kabarak.ac.ke

Tel: 0203511275
Fax: 254-51-343012
www.kabarak.ac.ke

21st Jan, 2018

The Director General
National Commission for Science, Technology & Innovation (NACOSTI)
P.O. Box 30623 – 00100
NAIROBI

Dear Sir/Madam,

RE: RESEARCH BY TERER ELIJAH - REG. NO. GMMF/M/1195/9/15

The above named is a Master of Medicine in Family Medicine student at Kabarak University in the School Medicine and Health Sciences. He is carrying out research entitled **"Patients reasons contributing to delayed health-care - seeking behaviour for non - pregnancy-related abnormal vaginal bleeding in Bomet County, Kenya".** He has defended his proposal and has been authorized to proceed with field research.

The information obtained in the course of this research will be used for academic purposes only and will be treated with utmost confidentiality.

Please assist him to obtain a research permit.

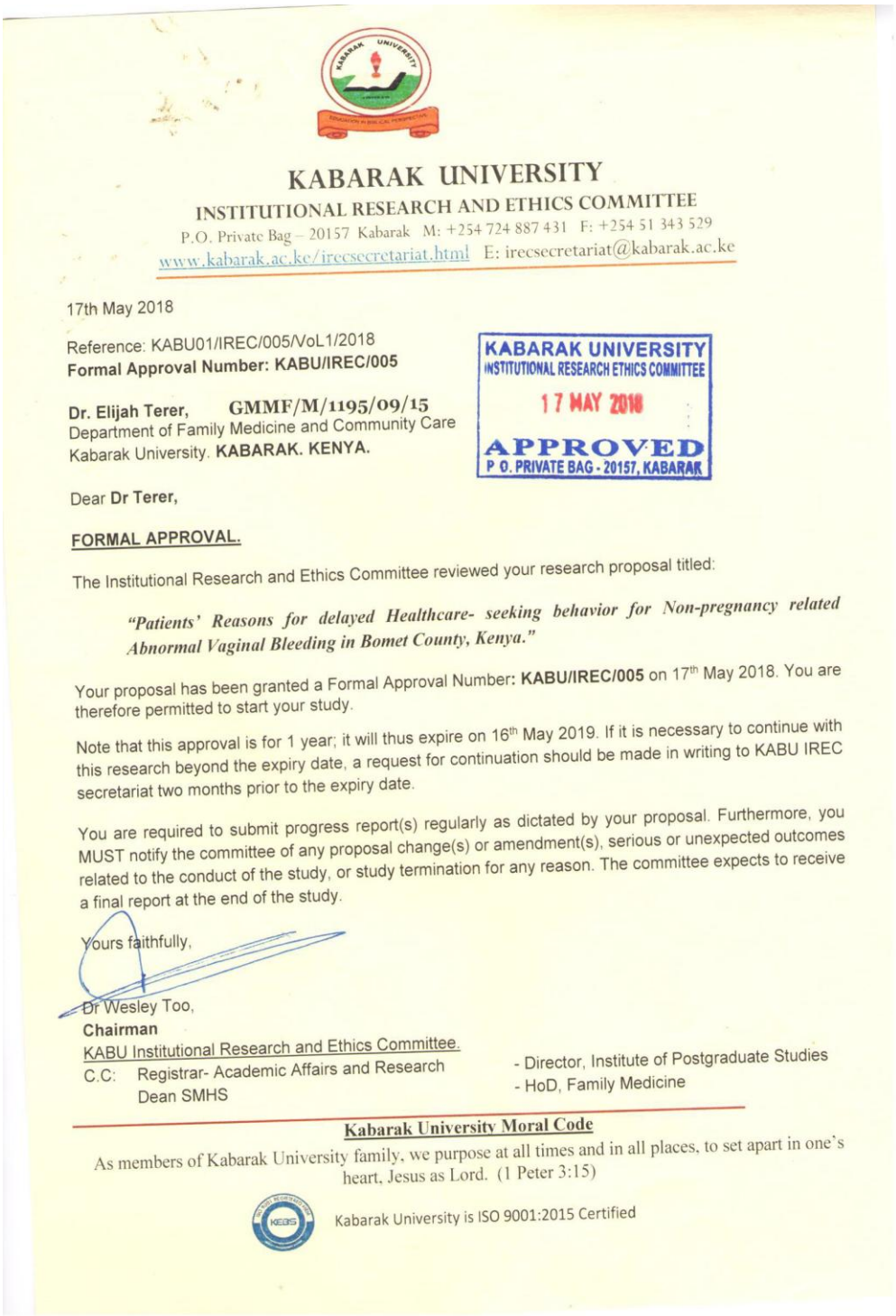
Thank you.

Yours faithfully,

KABARAK UNIVERSITY DIRECTOR POSTGRADUATE STUDIES 27 JAN 2018 PRIVATE BAG - 20157, KABARAK

Dr. Betty Tikoko
DIRECTOR - (POST-GRADUATE STUDIES)

Appendix VII: Formal Approval from Kabarak Institutional Research and Ethical Committee



KABARAK UNIVERSITY

INSTITUTIONAL RESEARCH AND ETHICS COMMITTEE

P.O. Private Bag – 20157 Kabarak M: +254 724 887 431 F: +254 51 343 529

www.kabarak.ac.ke/irecsecretariat.html E: irecsecretariat@kabarak.ac.ke

17th May 2018

Reference: KABU01/IREC/005/VoL1/2018
Formal Approval Number: KABU/IREC/005

KABARAK UNIVERSITY
INSTITUTIONAL RESEARCH ETHICS COMMITTEE
17 MAY 2018
APPROVED
P O. PRIVATE BAG - 20157, KABARAK

Dr. Elijah Terer, **GMMF/M/1195/09/15**
Department of Family Medicine and Community Care
Kabarak University. **KABARAK. KENYA.**

Dear **Dr Terer,**

FORMAL APPROVAL.

The Institutional Research and Ethics Committee reviewed your research proposal titled:

"Patients' Reasons for delayed Healthcare- seeking behavior for Non-pregnancy related Abnormal Vaginal Bleeding in Bomet County, Kenya."

Your proposal has been granted a Formal Approval Number**: KABU/IREC/005** on 17th May 2018. You are therefore permitted to start your study.

Note that this approval is for 1 year; it will thus expire on 16th May 2019. If it is necessary to continue with this research beyond the expiry date, a request for continuation should be made in writing to KABU IREC secretariat two months prior to the expiry date.

You are required to submit progress report(s) regularly as dictated by your proposal. Furthermore, you MUST notify the committee of any proposal change(s) or amendment(s), serious or unexpected outcomes related to the conduct of the study, or study termination for any reason. The committee expects to receive a final report at the end of the study.

Yours faithfully,

Dr Wesley Too,
Chairman
KABU Institutional Research and Ethics Committee.

C.C: Registrar- Academic Affairs and Research
Dean SMHS
- Director, Institute of Postgraduate Studies
- HoD, Family Medicine

Kabarak University Moral Code

As members of Kabarak University family, we purpose at all times and in all places, to set apart in one's heart, Jesus as Lord. (1 Peter 3:15)

Kabarak University is ISO 9001:2015 Certified

Appendix VIII: NACOSTI Authorization Letter

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone:+254-20-2213471,
2241349,3310571,2219420
Fax:+254-20-318245,318249
Email: dg@nacosti.go.ke
Website : www.nacosti.go.ke
When replying please quote

NACOSTI, Upper Kabete
Off Waiyaki Way
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No. **NACOSTI/P/19/18555/27895**

Date: **20th February, 2019**

Dr. Elijah Kipkirui Terer
Kabarak University
Private Bag - 20157
KABARAK.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Patients' reasons contributing to delayed healthcare – seeking behavior for non-pregnancy related abnormal vaginal bleeding in Bomet County, Kenya"*** I am pleased to inform you that you have been authorized to undertake research in **Bomet County** for the period ending **20th February, 2020.**

You are advised to report to **the County Commissioner, the County Director of Education and the County Director of Health Services, Bomet County** before embarking on the research project.

Kindly note that, as an applicant who has been licensed under the Science, Technology and Innovation Act, 2013 to conduct research in Kenya, you shall deposit **a copy** of the final research report to the Commission within **one year** of completion. The soft copy of the same should be submitted through the Online Research Information System.

GODFREY P. KALERWA MSc., MBA, MKIM
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
Bomet County.

The County Director of Education
Bomet County.

Appendix IX: NACOSTI Research Permit

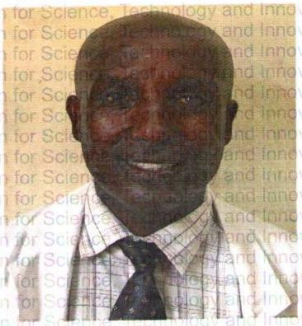
THIS IS TO CERTIFY THAT:
DR. ELIJAH KIPKIRUI TERER
of KABARAK UNIVERSITY, 0-20400
Bomet,has been permitted to conduct
research in *Bomet County*

on the topic: *PATIENTS' REASONS CONTRIBUTING TO DELAYED HEALTHCARE-SEEKING BEHAVIOR FOR NON-PREGNANCY-RELATED ABNORMAL VAGINAL BLEEDING IN BOMET COUNTY, KENYA.*

for the period ending:
20th February,2020

.....
Applicant's Signature

Permit No : NACOSTI/P/19/18555/27895
Date Of Issue : 20th February,2019
Fee Recieved :Ksh 1000



.....
Director General
National Commission for Science, Technology & Innovation

THE SCIENCE, TECHNOLOGY AND INNOVATION ACT, 2013

The Grant of Research Licenses is guided by the Science, Technology and Innovation (Research Licensing) Regulations, 2014.

CONDITIONS

1. The License is valid for the proposed research, location and specified period.
2. The License and any rights thereunder are non-transferable.
3. The Licensee shall inform the County Governor before commencement of the research.
4. Excavation, filming and collection of specimens are subject to further necessary clearance from relevant Government Agencies.
5. The License does not give authority to transfer research materials.
6. NACOSTI may monitor and evaluate the licensed research project.
7. The Licensee shall submit one hard copy and upload a soft copy of their final report within one year of completion of the research.
8. NACOSTI reserves the right to modify the conditions of the License including cancellation without prior notice.

National Commission for Science, Technology and innovation
P.O. Box 30623 - 00100, Nairobi, Kenya
TEL: 020 400 7000, 0713 788787, 0735 404245
Email: dg@nacosti.go.ke, registry@nacosti.go.ke
Website: www.nacosti.go.ke

REPUBLIC OF KENYA

NACOSTI

National Commission for Science, Technology and Innovation

RESEARCH LICENSE

Serial No.A 23213

CONDITIONS: see back page