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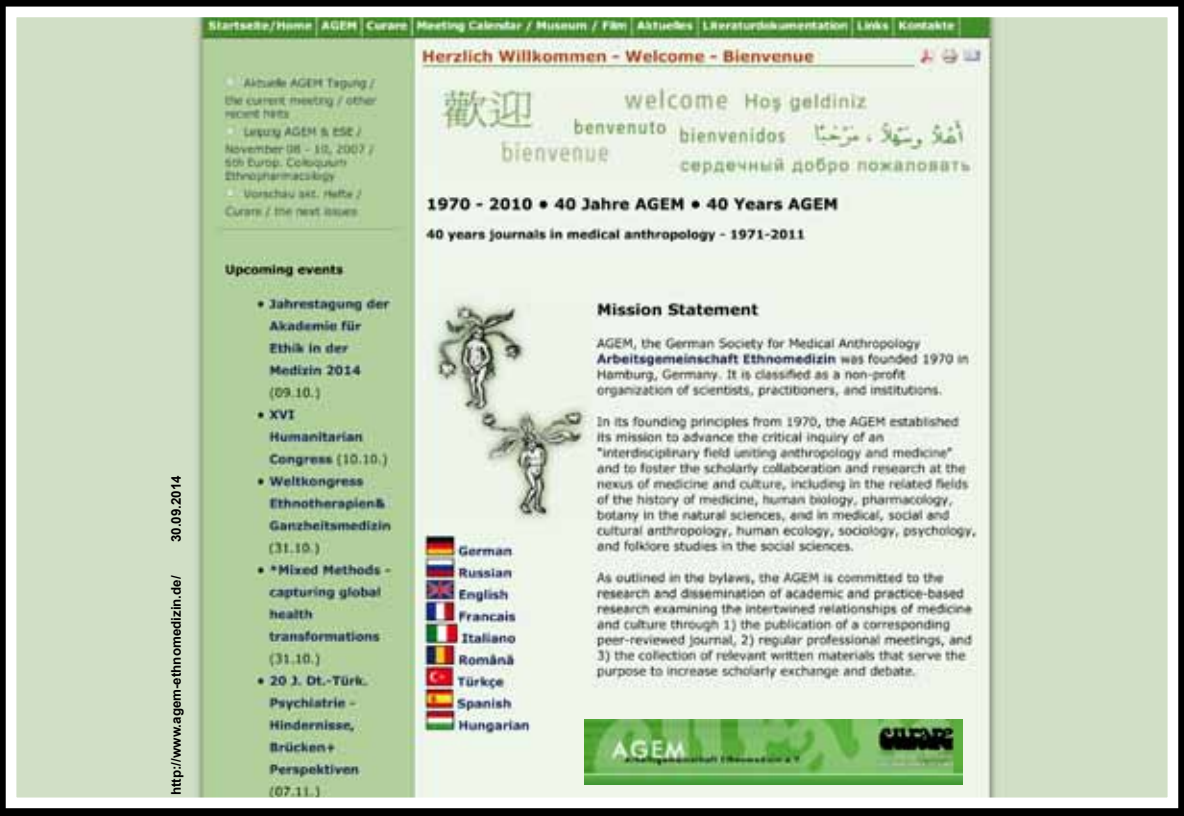

Medizinethnologische Perspektiven und Public Health

Perspectives of Medical Anthropology on Public Health

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S. 2: In der Liste der Autorinnen und Autoren auf Seite 2 sind korrekt zu lesen:
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S. 4 und 8f: Korrekter Vorname des zitierten Autors: Tobie Nathan.
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Reaction to Illness and the Process of Decision Making: Hospital Ethnography in Cameroon

Georg Winterberger

Abstract This paper explores which actions people in Cameroon take when they fall ill. It demonstrates the complete process: from noticing the symptoms, to the interpretation of these symptoms, to the decision making, and to the final reaction to illness. Data was collected by doing hospital ethnography by means of participant observation, informal conversations with hospital staff, in-depth conversations with traditional healers, and interviews with former patients of the hospital and farmers living in the area. The reaction to illness has four steps in maximum. First, people wait for the illness to disappear; second, a health center nearby or a community traditional healer will be consulted; third, people turn to a hospital; and fourth, they make use of a regionally well-known traditional healer. These reactions to illness can be explained by the three needs people have. First, they want to get back the (healthy) condition as soon as possible; second, it should cost as little as possible; and third, they want to go to their health care provider of confidence. The findings of the reaction to illness suggest a shift in the differentiation of health care providers. Therefore, affordable and less time-consuming health care providers should be distinguished from more expensive ones, and not the health care providers of the folk sector (e.g. traditional healer) from the ones of the professional sector (e. g. health centers and hospitals) as commonly done in literature. In a theoretical framework, the suggested differentiation is important, if one approaches it with an emic view.

Keywords reaction to illness – concept of illness – decision making – hospital ethnography– health seeking behavior – Cameroon

Die Reaktion auf Krankheit und der Prozess der Entscheidungsfindung: Ethnographie eines Spitals in Kamerun

Zusammenfassung In diesem Artikel wird darauf eingegangen, wie die Menschen in Kamerun auf eine Krankheit reagieren und wie sie ihre Entscheidungen treffen. Beschrieben wird der ganze Prozess beginnend mit Krankheitssymptomen, die bemerkt werden, über die Interpretation dieser Symptome bis zur Entscheidungsfindung und zur Reaktion auf die Krankheit. Die Forschungsdaten wurden anhand einer Ethnographie des Spitals gesammelt. Es kamen folgende Methoden zum Tragen: teilnehmende Beobachtung, informelle Gespräche mit Angestellten des Spitals, detaillierte Interviews mit traditionellen Heilkundigen und Interviews mit früheren Patienten des Spitals und mit lokalen Bauern. Die Reaktion auf eine Krankheit hat mindestens vier Stufen: Erstens warten die Betroffenen darauf, dass die Krankheit selbst wieder verschwindet; zweitens wird ein Gesundheitszentrum oder ein lokaler traditioneller Heilkundiger aufgesucht; drittens wenden sich die Betroffenen an ein Spital; und viertens gehen sie zu einem regional sehr bekannten traditionellen Heilkundigen. Diese Reaktion auf eine Krankheit kann mit drei Bedürfnissen erklärt werden, die die Betroffenen haben: Erstens möchten sie so schnell wie möglich die Gesundheit wieder zurückerlangen; zweitens soll es so wenig wie möglich kosten; und drittens möchten sie zu einem Gesundheitsanbieter gehen, in den sie Vertrauen haben. Die Resultate dieser Forschung legen den Schluss nahe, die Unterscheidung von Gesundheitsanbietern zu verlagern. Erschwingliche und nicht zeitaufwendige Gesundheitsanbieter sollen unterschieden werden von den teureren, und nicht wie es üblicherweise in der Literatur geschieht, nämlich die Gesundheitsanbieter des Volkssektors (beispielsweise traditionelle Heilkundige) von denen im professionellen Sektor (z.B. Gesundheitszentren und Spitäler) zu unterscheiden. Diese Unterscheidung ist für einen theoretischen Rahmen wichtig, in dem die emische Sicht zentral ist.

Schlagwörter Reaktion auf Krankheit – Krankheitskonzept – Entscheidungsfindung – Krankenhausethnographie – Kamerun

Résumé in French, see p. 175

Introduction

In 1954 the Basel Mission founded a leprosy hospital in Manyemen in the Southwest Province of Cameroon. The village of Manyemen lies in the middle of a lush forest about 80 km north of the small town of Kumba and about 100 km south of the town of Mamfe. In the last six decades, the hospital grew substantially and is now known under the name of *Medical Institutions Manyemen* (MIM). In the eighties and nineties, this hospital was nationally famous. It had a good reputation and patients took on long and exhausting travels to reach Manyemen, although, up to the present, the main access roads from Kumba and Mamfe are in very bad conditions. During dry season it takes about two to three hours to reach Manyemen, in rainy season it can take two days.

In the last two decades, the public health system in Cameroon improved, not only regarding the numbers of hospitals and health centers in the country, but also regarding the quality of care one gets. People have now not only to rely on privately run hospitals like the MIM. Needless to say, that the attractivity of MIM suffered. But the fundamental decline of numbers of patients within the last years is not only explainable by the improvement of the public health system in Cameroon and the bad condition of the roads to Manyemen. To get closer to an answer to the decline of patient numbers, I did hospital ethnography in MIM (as characterized by LONG, HUNTER & VAN DER GEEST 2008). The focus of my empirical research was the user—patients respectively—perception of the quality of care in this hospital (the concept of quality of care as argued by CAMPBELL *et al*. 2000). Through this research, I expected to get an insight view of the people's health practices.

This paper does not, however, explore the quality of care of MIM, which is another topic of my thesis, but it explores peoples' reaction to illness. My findings show that the understanding of peoples' reaction to illness is crucial, if one wants to get an idea of peoples' perception of the quality of care of a health institution. In my research, I was interested in peoples' concept of illness, too. Hence, I use the term illness as it was postulated by KLEINMAN (1980): health is culturally constructed; therefore, it has to be distinguished between the emic view of illness and the etic view of disease.

The goal of the paper is to provide an understanding not only of peoples' practices in case of illness, but also of the whys and wherefores of these practices. I address three key questions in this paper: How do people make their decisions in case of illness? How do people react to illness and why do they act or decide like they do? And which kind of differentiation do people apply—from an emic point of view—, if they distinguish one group of health care providers to another?

Background

The majority of Cameroonians who live in remote areas like Manyemen hardly has access to, or can afford proper (bio)medical services. Health care is provided by the government, non-governmental organizations, mission hospitals—like the one in Manyemen—and the private sector. The provided health care levels firstly include the community level with the health stations and the health centers, second the regional level with bigger health centers and the smaller district hospitals, third the province level with province hospitals, and fourth the national level with the central hospitals (KONDJI KONDJI 2005: 157–174). From the point of view of a person who falls ill, the health institutions mentioned above are not the only places to turn to. Beside the hospitals and health centers, there are other places which provide health care such as traditional healers—both, well-known healers who operate on a regional or even provincial level, and nonprofessional healers who operate on a community level and whose regular occupation is not the treatment of ill people but who are farmers, for example. Other possibilities to get health care include drug stores or sellers of traditional medicine, and not to forget self-medication and help from a family member or another known person who is skilled in medical care.

However, the existence of and the access to health care institutions or providers are not the only factors in the process of decision making when a person gets ill. Also to consider are the severity of the illness, the expected costs of the treatment, the money which is available, the experience of former illnesses and former treatments, and the concept of illness (POOL 1994). And, not to forget, decisions are rarely the product of one person, who decides on a rational basis, but more of a collectively bargained

agreement between the ill person and the household or its reference group respectively (Berman *et al*. 1994: 206–210, Wolkowitz 2000: 167). The crucial external factors shall be presented here; while the emic factors will be described further down, like the concept of illness, for example.

Manyemen lies in a region which is densely wooded by a lush forest. The main cash crop of the area is cocoa, which is planted in small family farms inside the forest. The harvest season is from late July to October; therefore, people are in funds only from August and not later than December, when they have bought their last Christmas gifts. If a severe illness occurs during the other months, one has to ask many family members and friends for money. The attendance of going for medical care is often depending on the available money and time.

Methods

I conducted the fieldwork in 2008 (February to July). My role in the MIM was less one of a participant observer, but more one of a lay non-medical anthropologist, who was interested in the patients and who sincerely tried to participate. It did, however, happen that I was treated as a patient when I was taken sick by malaria. And in the role of a patient, the ethnographer may understand the patient best, as suggested by van der Geest (2007). My role outside the hospital was not easy. Over the last decades, the old mission hospital was regularly visited by doctors from Europe who worked there for a few years. Nowadays, people in Manyemen and its surroundings expect a doctor in every person coming from Europe. It was a challenge to convince my interview partners of the fact that I was an anthropologist on research. But I finally succeeded; the collection of data relies on roughly one hundred interviews, on informal conversations, and on "negotiated interactive observation." Wind (2008) proposed to name participant observation in hospital settings "negotiated interactive observation," since the participation of a researcher is limited in a highly specialized healthcare system.

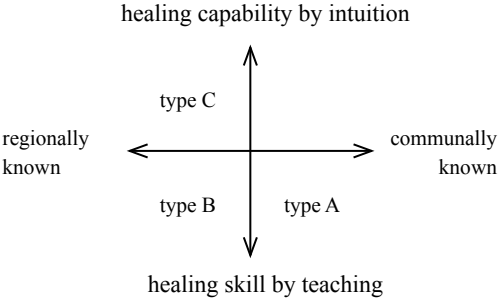
I interviewed about fifty users and former patients of MIM. I decided to select only former patients and not current patients, since the latter may have their own agenda by answering to a person, which they believe belongs to the hospital that they are enrolled in. I conducted about twenty in-depth conversations with doctors, nurses, caretakers, and traditional healers and I interviewed all households of two villages in the surroundings of Manyemen to find out where people go in case of illness—one village situated on the main road and one in the forest. I selected my interview partners at random by choosing a random sample out of all the patients who visited the hospital during the former year, in-patients as well as out-patients, from the register books of the hospital. Fortunately, the register books contain the place of residence, too, beside name, age, disease, and date of treatment. Additionally, I checked my sample to represent the totality of patient in the ratio of age, gender, rural areas and so on. It was important to conduct the interviews not in the hospital but in the villages where the users lived. Firstly, it was easier to remove myself from their assumption that I am a doctor, and, secondly, the users were impartial about their assessment of the hospital treatment. The other side of the coin was the challenging trips I had to undertake. To meet one patient, for example, I had to make a journey of more than 200 km, and another was living in the deep forest, which cost me a full day motorbike ride at walking pace and half a day trekking into the jungle. In fact, these were exceptions, but still the interviews were laborious. Together with the location of the interviews, the language was important, too. I talked with the users and their relatives in the language of the province: English or Pidgin-English—the latter especially with elderly people. Unfortunately, it was not possible to learn all the uncountable local languages. But since they use Pidgin-English themselves as the main form of communication between the villages, my interview partners were used to it.

I couldn't conduct interviews with every person on my random list; I conducted about fifty interviews out of eighty on the list. There are four categories of reasons: first, six persons were deceased in the meantime—remember, I chose former patients; second, the details in the register book were incorrect (ten persons); third, eight persons could not be traced back—this happened when the persons lived in big cities; and fourth, six persons were constantly absent—usually I tried to find a person two to three times. The first category of deceased persons was still important to be included into my analysis, although I could only conduct one interview with the family members. But the cut out of the six deceased persons would have been falsifying my analysis

since there would be information missing about the quality of care of the hospital from patients with very severe disease. The second category I had to delete out of my analysis. Though, the third category was important to take into account, since the persons from big cities had totally other reasons to take the long journey to Manyemen than somebody from a near forest village, for whom MIM is the nearest hospital. The problematic issue was the unavailable interviews and data. I conducted two interviews with persons from cities; that makes about four percent of the total number of interviews I conducted. Thus, the random sample gave me fourteen percent of persons from cities. The fourth category could be neglected in turn, since it was about persons from villages; I had enough data from this category.

The in-depth conversations with health care providers were easier to conduct in terms of accessibility. The difficulties were to convince my conversation partners to give me an insight view into their work—at least some of the traditional healers. The following table gives an overview of types of traditional healers I met:

Table 1

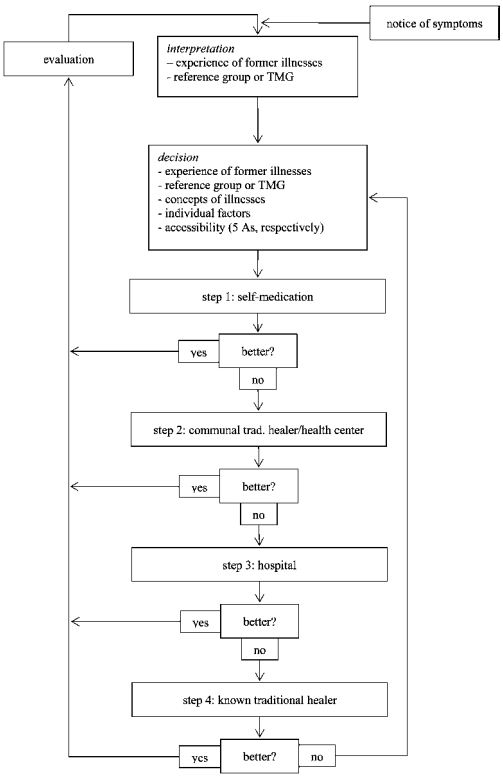


Type A can be found in nearly every village; it is mainly a farmer (the main profession in the villages) whose father or grandfather taught him how to find the necessary herbs in the forest and how to use them. Hence, in case of type A, the ability to heal is a learnable skill; such healers are communally known. They would not have much time to heal many patients, since they have to work on their farms. The healers of type B learned the skill to heal from a family member as well. The difference to type A is their success and popularity; they are consulted on a regular basis by people of the whole region – not only from the community, as it is the case with type A. There was one traditional healer of type B in the surroundings of Manyemen who was able to cure open and closed bone fractures. He told me that he was very successful and his patients never got a wound infection. Healers of type C are another category. They did not learn any skill to heal, but they got the capability to heal by intuition. While type A and B were imbedded in a family tradition, type C wasn't; the intuition could happen even late in such a person's life. While healers of type A and B mostly were men, healers of type C were of both sexes. Usually, they were regionally or even provincially known. In the surroundings of Manyemen I didn't meet any healer of type C who was only communally known (should actually be type D in table 1). I conducted in-depth conversations with all healers in the surroundings of Manyemen who were known regionally (type B and C). I paid attention only to healers of type A, who lived in Manyemen itself, or in one of the neighboring villages, because healers of type A, from villages far from Manyemen, cannot be seen as competitors to the hospital.

The in-depth conversations were conducted with health care providers of biomedicine as well, such as street sellers of drugs, small drug stores, private health stations, governmental and mission health centers, and five mission hospitals.

To get answers to the question of which health care provider(s) people choose in the case of illness, I chose two villages not far from Manyemen. Both villages were at the same distance from a hospital, a health center and a regionally known traditional healer. I conducted interviews with all households in the village to find out where people go in case of illness. Throughout my research I questioned the patients about the reaction to past events of illness and not possible events in the future, because for future events I get answers about the intended reaction to illness and not the actual reaction. The example which follows shows how important this approach is: Paul was a friendly young man I met in Manyemen. He worked on his own cocoa farm. He was a passionate catholic—he even tried to convert me to Catholicism. When I asked him what he was usually doing when he got sick, his answer was praying. He was of the opinion that it was the only accurate and true reaction to illness. A month later I found him with a swollen hand—he got an infection due to a

Table 2



small wound incurred during farm work. The first thing he did was to go to the hospital.

Results

My fieldwork presents two steps of the decision process: After a person noticed an illness, it firstly had to be interpreted and, secondly, the person had to come to a decision about the further steps of action. These further steps are usually a maximum of four in number. The first step implies waiting for the illness to disappear and self-medication. If the illness is still there, the person, in a second step, consults a health center or a community traditional healer nearby. In a third step the person usually turns to a hospital, or, in rare cases, to a regionally known traditional healer. If the treatment of step three still doesn't help, the person makes use of a regionally or even provincially well-known traditional healer or, in rare cases, of a provincial or central hospital. Table 2 shows this process which will further be described in detail.

Interpretation of the illness

The interpretation of an illness is itself a complex process. Within this social process the ill person goes through a number of stages—e. g. notice of symptoms, trying to categorize and explain the symptoms, realizing the role of a sick person and behave like one, establishing a strategy of behavior, making a decision of action, and so on (Slikkerveer 1990: 39). Within this process, the ill person is not alone, but will be accompanied by the household (Berman *et al*. 1994, Hampshire *et al*. 2011). Janzen (1987: 68, 73–76) refers to it as the Therapy Management Group (TMG). The group implies a number of persons—usually relatives—who are planning the therapy and make decisions on behalf of the sick person. It makes more sense to speak of a Therapy Management Group in the context of this research. My fieldwork in fact showed that most interviewees had been assisted either by the person in the household who pays the bills, or by the person in the household who is most experienced with health care, when it came to the interpretation of the illness. However, not only the household members assisted them, but also persons from the neighborhoods and even strangers they spoke with during a bus drive or on the market.

The interpretation of an illness finally happens together with the Therapy Management Group and is based on the severity of the illness, experiences of former illnesses, the personal attitude towards this illness, and some other factors, like socio-demographic and psychosocial characteristics. Based on this interpretation, a decision will be taken.

Decision making

It depends on the status of the sick person within the household and the severity of the illness, by whom it is finally decided what to do. The decision is not only highly influenced by the interpretations of the specific illness that occurred, but also by general concepts of illnesses (Pool 1994). Kleinman (1980: 104–118) and Helman (2007: 128–130) refer to it as Explanatory Models (EM). These EMs are dependent on cultural factors and on the context in which the person lives. The Explanatory Models vary from

case to case and they are responsible for the fact that the selection of the medical system also varies depending on the illness or the interpretation of the symptoms—as VAN EEUWIJK illustrated (1999: 82). The data from the fieldwork doesn't allow a generalization of the decision process depending on the kind of illness since I could not find a correlation between a kind of illness and one reaction to this kind of illness. The region of research was quite heterogenic. Nevertheless, I found regularity: if an illness shows symptoms like impotence, then people explain this illness with transcendental reasons. They will mainly consult the traditional healer for such kind of illnesses. The traditional healer will also be consulted when the patient goes for prevention.

The fieldwork shows that the very first need in case of illness is to get back to a healthy condition—not remarkable. The second crucial need is to get this condition back by spending as less money and effort as possible. That's why the concept of accessibility is important: PENCHANSKYS' and THOMAS' definition of the five As is (1981: 128–129):

> *Availability*, the relationship of the volume and type of existing services (and resources) to the clients' volume and types of needs. It refers to the adequacy of the supply of physicians, dentists and other providers; of facilities such as clinics and hospitals; and of specialized programs and services such as mental health and emergency care.
>
> *Accessibility*, the relationship between the location of supply and the location of clients, taking account of client transportation resources and travel time, distance and cost.
>
> *Accommodation*, the relationship between the manner in which the supply resources are organized to accept clients (including appointment systems, hours of operation, walk-in facilities, telephone services) and the clients' ability to accommodate to these factors and the clients' perception of their appropriateness.
>
> *Affordability*, the relationship of prices of services and providers' insurance or deposit requirements to the clients' income, ability to pay, and existing health insurance. Client perception of worth relative to total cost is a concern here, as is clients' knowledge of prices, total cost and possible credit arrangements.
>
> *Acceptability*, the relationship of clients' attitudes about personal and practice characteristics of providers to the actual characteristics of existing providers, as well as to provider attitudes about acceptable personal characteristics of clients. In the literature, the term appears to be used most often to refer to specific consumer reaction to such provider attributes as age, sex, ethnicity, type of facility, neighborhood of facility, or religious affiliation of facility or provider. In turn, providers have attitudes about the preferred attributes of clients or their financing mechanisms. Providers either may be unwilling to serve certain types of clients (e. g. welfare patients) or, through accommodation, make themselves more or less available.

CHOPARD extends the concept by two more *As* (2008: 41): The dimension of *Accountability* "[…] corresponds to the effectiveness, quality of care, or responsibility of health care providers to restore the health of their patients. It is the appropriateness, quality and reliability of diagnosis, treatments and therapies." And with the concept of *Adaptability*, Chopard thinks of the capacity of a health system to integrate elements of another system, e. g. the willingness of traditional healer to attend an education in biomedicine.

The concept of accessibility plays a crucial part in my thesis. A detailed description of this concept's application in the situation of people surrounding Manyemen will be found there. In this paper, I will argue only for the affordability of the health care providers, since this concept is crucial (CLEARY *et al*. 2013). Let's compare the prices of traditional healers to that of health care providers of biomedicine. Traditional healers of type A (table 1) ask CFA 5.000 to 10.000 (CFA 1.000 is equivalent to US$ 2) for a treatment. The regionally known healers of type C ask CFA 10.000 to 20.000 for a treatment and the healer of type B even asks CFA 30.000. The latter is more expensive, because he only treats bone fractures which need many consultations. The hospitals ask CFA 20.000 to 30.000 for treatment in the child or medical ward, but CFA 50.000 for a treatment in the surgical ward. An ambulant treatment in a government health center can cost up to CFA 10.000. It can be concluded that traditional healers are not cheaper by any means; especially the well-known healers are expensive, too. But the traditional healers are cheaper if providers are compared

in the same category (e. g. communal health centers with communally known healers and hospitals with regionally known healers). The indirect costs (for example the lost working time on the farm) play a role as well. Communal traditional healers have the advantage to be nearby. This has to be taken into account when analyzing the reaction to illness.

Reaction to illness

The common reaction to illness is the first step in table 2: waiting for the illness to disappear and self-medication (Nyamongo 2002, van der Geest 1987). Exemptions are the severe and very acute illnesses and fractures, of course. The reaction of waiting is practiced either because of the expectation to save money, or because there is no money for a treatment at the moment—the latter applies mainly during non-harvest season of cocoa, which is the common cash crops. Self-medication includes buying medicine from small pharmacies or street sellers. These pharmacies are often owned and managed by former hospital nurses. They usually sell good quality medicine and do small consultations for free. The street sellers are more of a problem. They often sell medicine and tablets which are produced in neighboring Nigeria and which contain not the right dosage of active ingredients. Self-medication by traditional medicine (e. g. herbs) is a declining practice. It implies that people have less knowledge of herbs, e. g. how to find them in the forest and how to use them. One of my interview partners articulated this decline by saying: "Currently, we don't believe in native treatment any more, the science destroyed it! The knowledge [about traditional healing] is lost, and the next generation doesn't know any more about it."

If self-medication didn't work, the second step is consulting a health center nearby or a community traditional healer in the vicinity. While the focal point of step one is to get healthy again by spending (almost) no money, the focal point of step two is to find professional help in the proximate neighborhood. And this can be a traditional healer, a health center, or even a hospital, depending on the place of living. Step two can be characterized by its out-patient treatment. It includes a consultation and a treatment, which is the case with both, the traditional healer and the health center, but also with the hospital out-patient sector. The treatment of step two is quite expensive for the ordinary farmers, but still affordable, at least in a (governmental) health center and with a communally known tradition healer.

If the ill person is very unlucky, the illness still stays. It may be like this due to an incorrect treatment, or because of taking the wrong dosage of medicine, or for some other reasons. Anyhow, the sickness is already delayed on this stage. This acuteness of the illness normally brings patients to the hospital—the third step. Now, a successful treatment is difficult, and if possible it is very expensive and takes a long time. The patients in this stage already spent their small money in the small pharmacies or to the street sellers (step one), and in the health center or to the traditional healer (step two), that makes them broke, not able to pay for a treatment in the hospital. Though, it has to be said, that this strategy works in many cases. Often the illness effectively disappears in step two or even in step one. Unfortunately, the delayed sickness is difficult to cure. The money often suffices only for the consultation fee and the most important medicines, but not for the full dosage of medicine. And that's again a reason why ill persons continue suffering, up to the point the sickness is not curable any more.

In a fourth step, people turn again to a traditional healer. But first, they have to raise funds money from members of their extended family or from friends, since a treatment with a regionally known traditional healer can be very expensive. And the transport cost also has to be taken into account, due to the fact that the regionally known traditional healers are often living in the cities. When I interviewed people who were in step four, they told me about the length of the treatment. So actually, we could label it as chronic disease.

Although, the steps I presented here are consecutive, they are not distinct. The course of action is a mix of strategies described above, and the four steps converge, since decision making is a dynamic process characterized by uncertainty, experimentation, debate, and shifting interpretations (Colvin *et al*. 2013). The health care seeking process may also vary depending on the setting (Wiseman *et al*. 2008). In table 2 you find the closing action after a successful treatment. Every person who was ill—and its reference group or TMG—evaluates the course of action and the course of disease. This evaluation will help with the next illness on the stage of interpretation and decision.

The case of Pamelia

The example of Pamelia may illustrate the reaction to illness in the surroundings of Manyemen:

Pamelia lives with her family in a rather large village with 3673 inhabitants seven kilometers off the main road to the city of Kumba. The village has a traditional healer, a pharmacy which is operated by a former nurse, and two village shops where medical pills can be bought. There is a governmental health center on the main road and a hospital 21 kilometers further down the paved main road. Pamelia is 33 years old and lives together with her husband, four children, and her mother. They live from subsistence farming.

A few months ago, Pamelia suddenly got pain in the chest area. First, she went to the traditional healer in the village and soon for a second consultation. The two consultations produced costs of CFA 8.000 in total. But the pains were still there. So, she went to the pharmacy to buy medicine for CFA 25.000. But the problem persisted. Finally, Pamelia went to the hospital in Manyemen—three weeks after the emergence of the pains. There, she was medicated for malaria as an out-patient. The pains disappeared after the second treatment. She had to pay a total of CFA 21.000 for the two hospital treatments. Pamelia said, they had chosen the hospital in Manyemen because they knew—like all people—that it was a modern healthcare provider.

A month ago, the chest pain returned. But now, they had no money for a treatment. They had to wait for the next cocoa harvest until going to the hospital again.

Discussion

The results of this study suggest that people in Cameroon do not distinguish between the different health sectors (see the model of three health sectors: the popular sector, the folk sector, and the professional sector, KLEINMAN 1980: 49–60). That means they do not care as much about the kind of health care provider than about the accessibility of it. Therefore, it is not too important whether they have a traditional healer (folk sector) or a health center (professional sector) in the village, it's important that there is a health care provider in the village at all, as LEACH *et al*. pointed out that the health-seeking behavior relates to other categories than biomedical versus traditional (2008). So, people distinguish between the more available health care providers—since they are numerous—and the less affordable health care providers, e. g. hospitals. This finding shows that the distinction between traditional healers and biomedical health care providers, which is often found in literature, is not as important as assumed in an emic view. The study claims to distinguish between four groups of health care. The first group includes the health care in the popular sector, e. g. self-medication by traditional herbs and biomedical pills, and the small pharmacies and street sellers. The second group includes the numerous communally known traditional healers and (governmental) health centers. The district hospitals and regionally known traditional healer can be summed up in the third group. And the fourth group includes the provincially known traditional healers and the provincial or central hospitals. These suggested groups suit the levels of health care as described by KONDJI KONDJI (2005: 157–174), except of group one which is missing, since Kondji Kondji didn't take self-medication health care into account. He distinguished the community level (health stations and health centers), the regional level (bigger health centers and smaller district hospitals), the province level (province hospitals), and the national level (central hospitals). The groups I suggested also almost suit the types of traditional healers I distinguished in table 1. Traditional healers of type A are regionally known and have learned the knowledge of healing by a teacher (mostly a family member). Traditional healers of type B have also learned from a teacher, but their healing skills are very good, what makes them regionally known. And traditional healers of type C got their healing capability by intuition, they are regionally or even provincially known. To complete the traditional or folk sector, the family members have to be mentioned, who are skilled in medical care. Table three shows the comparison:

Table 3

group/ step	biomedical health care	traditional healer	need
1	self-medication	skilled family member	need 1 and 2
2	community level	type A	need 1 and 2
3	regional level	type B	need 3
4	province and national level	type C	need 3

When I asked the interviewees what their needs were in case of illness, I mostly got a three step answer: 1) Get back the (healthy) condition which they had before the illness appeared—as soon as possible. 2) The treatment—or the process of getting healthy again—should cost as little as possible. 3) They want to go to the health care provider whom they feel comfortable with. They want to trust the chosen health care provider—be it because they have an experience themselves, or because this health care provider was recommended.

Now we can combine these three needs with the groups of table 3. That leads us to the answer of why people behave the way they do as presented in the chapter about the reaction to illness (see table 2 as well). When a person notices symptoms of an illness and the interpretation of these symptoms is done, a decision has to be made. The person will firstly address him or herself to the health care of group one (table 3)—that is self-medication, and this corresponds with step one in table 2. This reaction fulfills the first need and the second need. The first need includes not only to get healthy again, but also to get it as soon as possible. Self-medication allows the person to stay at home and to save the trip to a health care provider, and self-medication is very cheap (need two). In a second step, the person addresses him- or herself to a health care provider of group two in the proximate neighborhood – that is a health center nearby or a community traditional healer close-by. This step fulfills need one and two as well—the health care providers of group two are near (need one) and quite cheap (need two). If the illness doesn't disappear up to now, the person, in a third step, will visit a district hospital or a regionally known traditional healer (these are health care providers of group three). In the meantime, the person realized that the fulfillment of need one and mostly of need two is not given anymore. In this third step, need three will be important—to go to a health care provider of confidence. Therefore, the person will address him- or herself to a hospital with a good reputation or one which was recommended. The same applies to step four. If the treatment from step three still doesn't help, the person makes use of a regionally or even provincially well-known traditional healer or of a provincial or central hospital (that are health care providers of group four). In this step, it's crucial for the ill person to go to a health care provider of confidence (need three).

Limitations of this study

This study has a number of limitations that should be considered. First, the interviewees were asked about events in their past and not about possible events in the future. This approach allowed drawing conclusions on the effective behavior of people, and not on the desired behavior. At the same time, it limits the study to take only past events into account which, of course, do not imply all possible kinds of events.

The hospital in Manyemen was in an uncommon situation during the time of fieldwork. There was no doctor from Europe there, which is very unusual. The hospital was not operating as it was under the management of doctors from Europe. The reason is not that the Europeans can do it better, but because it was expected from both caretakers and patients, that Europeans should be in Manyemen to manage the hospital. This situation could have influenced the answers on the hospital in the interviews.

Since this study was conducted only in the surroundings of Manyemen, the results cannot be generalized for the entire Cameroonian population. Even the regions in the English speaking western part of Cameroon are quite different. The results may be applicable to the whole region of the forest land, which coincides with the Southwest Province, but they may not applicable to the grasslands of the Northwest Province, for example.

Despite its limitations, this study still provides valuable insight into the process of decision making and the reaction to illness in Cameroon. It suggests a shift in the differentiation of health care providers. Therefore, the affordable and less time-consuming health care providers should be distinguished from the more expensive ones and not the health care providers of the folk sector (e.g. traditional healer) from the ones of the professional sector (e. g. health centers and hospitals). The suggested differentiation is important, if we want to approach the topic with an emic view (Winterberger 2014).

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