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PERCEIVED ILLNESS CAUSES AMONG MAASAI AND HEALTH PROFESSIONALS IN KAJIADO COUNTY, KENYA

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Abstract

This paper presents the results of an investigation of the perceived causes of illnesses among the Maasai people and health care providers in Kajiado County, Kenya. Little or no research has been conducted on the perceived causes of illnesses among the Maasai and health care providers creating a gap that demands specific studies to be undertaken to fill it. This study draws from the personalistic and naturalistic theories of illness causation. A qualitative research design was used because the study focused on uncovering experiences and gaining insights from informants regarding their perceptions towards causes of illnesses. A purposive sampling technique was used to select one-on-one interviewees and Focus Group Discussions (FGD) participants. The main data collection tools were one-on-one interviews and FGDs. The findings of this study revealed that the Maasai have different perceptions towards illnesses from those of medical healthcare providers. The Maasai perceive three main causes of illnesses; natural, witchcraft and curses. Further, curses were divided into two, curses of commission and omission. Medical health care providers, however, perceive illnesses to be as a result of abnormalities in the body. Different worldviews concerning illnesses are, therefore, likely to bring about misdiagnosis and miscommunication between patients and health care providers.

Keywords: Perceived illness causes, Maasai, healthcare providers

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1. Introduction

Health issues are of major concern to every human being throughout their lives. It can be said that one of the greatest fears of humans is illness and their worst experience is falling ill, suffering, dying and disappearing into the unknown. Gordon (1993) asserts that obsession with physical suffering and the mystery of what lies on the other side after death has propelled man to search for meanings to illnesses which has given birth to magic, mysticisms, religions and theorization of the contexts surrounding what causes illnesses.

The medical practice in the field of intercultural health communication has been debating over issues related to the biomedical and biopsychosocial perspectives of health (Mjomba, 2006). According to Rao et al. (2000), the biomedical model presumes that illness is always due to abnormalities in the workings of the body. This means that the biomedical model takes the simplest possible cause of the illness. According to Kar, Alcalay and Shana (2001) the medical culture relies on science as the principal authority over the patient's illness with regard to determining the illness.

Contrary to the biomedical perspective, de Pre, (2000, as cited in Mjomba, 2006) notes that the biopsychosocial perspective, views patients as thinking, feeling individuals who have a need to feel healthy at the biological, psychological and social levels rather than being perceived in purely in biological terms. Illness in this perspective is viewed in terms of a dynamic combination of biological, psychological and social factors rather than purely depending on discrete examinable infections and/or malfunction of organs (McLaren, 2002).

Apart from these differing medical perspectives on health, Witte and Morrison (1995) also note that health care providers and patients are separately entrenched in their own worlds. The medical health provider is entrenched in his western training while the patient may be encapsulated in his or her socio-cultural paradigms where health and illness are perceived in relation to personal beliefs, social, cultural, spiritual, and environmental characteristics. The majority of the public, however, have been noted to rely on entirely cultural perceptions towards illnesses or on both culture and science (Kar, Alcalay & Shana, 2001).

2. Literature Review

2.1. Intersection of culture and health

Before healers or physicians can effectively embark on the healing process, they must first understand what is wrong with the complainants, both subjectively and objectively. In order to understand effectively what is impeding health and leading to illness, they must commit to discovering the patient's perception of the causes of the illness (Witte & Morrison, 1995). Patients, in some cases, attribute their problems related to their health and illness to their socio-cultural background.

The concept of cultural illness etiologies includes cross-cultural differences in the beliefs and meanings related to life and death, causes of diseases, definitions and significance of illnesses and meanings of various symptoms and remedies. The preferred modality of treatment and prevention is usually consistent with the culturally defined etiology of illness and health-related beliefs. As perception and understanding cultural social phenomena is crucial to the patient, it also plays major part in planning and implementation of health care services in a community. Le Beau (2002) ascertained that the most important variables in

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health seeking behavior are cultural beliefs, perceptions of the cause of illness, and the patients' interpretation of symptoms and manifestations of illnesses.

The spread of knowledge about the variety of African cultures has all tended to leave largely untouched the prevailing misapprehensions regarding the role of traditional concepts of health and illness, which for a long time, have shaped the healing practices and therapeutic choice of communities like the Maasai people.

2.2. Perception towards illness: A global perspective

In most traditional societies in the world, the etiology of illness is divided into three categories namely: natural causes, extraordinary powers, and religious sources. For example, among the Native Americans, a medicine man uses meditation and sometimes a crystal ball to perceive the causes of the illness (Jacobs, 1995; White & Maccabe, 1996, as cited in Lecca et al., 1998).

Similar perceptions of illness as those of the Native Americans can be seen in African-Americans. According to Jacobs (1995) among the African-Americans, health beliefs vary from community to community and from family to family reflecting their ancestral knowledge from Africa. The etiology of illness is divided into three categories namely: natural causes originating from sinful behaviour, extraordinary powers from evil persons seeking revenge, and finally from spiritual sources.

A study by Waldron (2002) revealed that many African Canadian women believed that mental illness is caused by three main factors namely evil or punitive spirits, biological which is genetic or physiological malfunctioning, and lastly, breakdown that results from the inability to cope with severe stress.

According to Katalanos (1994), irrespective of the modern medicine, the Chinese generally perceive three classes of illness etiologies; physical which are the illnesses caused by accidents like broken bones, cuts, eating spoiled food, ingesting poison and infectious disease such as tuberculosis, malaria and cholera; and metaphysical which are illness caused by bad wind, hot or cold energy imbalances, incorrect diet and excessive emotion and supernatural whose cause is soul loss.

Southeast Asians also have similar beliefs to the Chinese. This is because they have shared beliefs in animism and Buddhism. A major perception of the cause of illness to the Lao, who are the tribal inhabitants of Southeast Asia, is "soul" loss, which causes supernatural illnesses. The Afghans and Puerto Ricans believe in personalistic and naturalistic causes of illnesses. They explain that the naturalistic illness results from hormonal imbalance and are grouped into hot and cold classes (Harwood & Kleinman, 1981). In the personalistic perspective, illnesses can be caused simply by the malevolent look of an extremely envious person. The Nazar, or evil eye, among the Afghans can be avoided by expressing admiration or love to another person by adding a preventive phase, such as "God bless". This group of people believe that the most susceptible people to nazar are children, beautiful women, people with great fortunes and those in influential positions (Lipson & Omidian, 1992).

When a person is publicly identified as being good looking or being more fortunate than others, there is a fear of the manifestation of the evil eye whose symptoms are associated with psychological and physical illness as well as failures in life and personality problems. Many Somali mothers cringe with fear of the evil eye when they are told that their babies are big, fat or cute as they worry that something bad will befall their offspring (Kabir et al., 2004). It is culturally believed that a person can give someone else an

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"evil eye" either purposefully or inadvertently by directing comments of praise or curse at the person. The person responds by becoming ill.

2.3. Perceptions to illness: An African perspective

In African cultures, ailments are believed to be misfortunes in the relationship between the patient and the social, natural, and the spiritual environments (Chukwuneke et al., 2012). Any misfortune is interpreted as an attempt by the spirits to contact the living, which they do by a threat, a warning, or a blessing. "Ancestors annoyed at the neglect of their descendants, may send special diseases such as insomnia and epilepsy" (Mekoa, 2019, p. 103). African traditions communicate those illnesses do not simply happen by chance, but are events instigated by forces in the spirit world. A healer may claim that a dead ancestor is unhappy about something, or spirit mediums may suggest that someone has placed a curse on the victim by means of witchcraft resulting in sickness.

Jegede (2002) when conducting a study among Yoruba mothers in Nigeria, gave considerable attention on their cultural perception of health and illness. Out of the fifty mothers interviewed, 96.5% of the respondents indicated three etiological perspectives on causes of illness; those caused by enemies (ota), which include witchcraft (aje), socery (oso), gods (orisa) or ancestors (ebora); those caused by nature (aare); and those caused by heredity (aisan idile). In some cases, certain childhood diseases were attributed to the anger of the gods, especially when the taboos had been broken. Some diseases were attributed to the evil machinations of certain persons who seemed to bear certain grudges against the sufferer or the family. Respondents stated that the aje (witch) and oso (sorcerer) could inflict diseases on people through their mystical power.

Ahorlu et al. (2005) conducted a study on community concepts of malaria-related illness with or without convulsions in Southern Ghana. Findings of the study revealed that the most frequently perceived causes of malaria-related illnesses with convulsions were spirits, phlegm, worm infections and malaria. Most frequently reported perceived causes of malaria relates illness without convulsion were mosquito bites, eating too much oily food and heat from the sun. Similarly, a study on socio-cultural factors explaining timely and appropriate use of health facilities for degedege (convulsions in children) in south eastern Tanzania was carried out by Dillip et al. (2009). Using a cultural epidemiology approach, the study revealed that convulsions in children were the result of weak blood and an evil spirit that takes the form of a bird that casts its shadow on children making them ill, develop convulsions, and possibly die.

du Toit and Pretorius (2018) conducted a qualitative study to gain an understanding of traditional health practices and experiences in delivering seizure care in Namibia. Using semi-structured interviews to collect data, all traditional health practitioners who participated in the study believed that seizures were caused by evil spirits, witchcraft, and supernatural forces.

Kahissay et al. (2017) conducted a study on beliefs and perceptions of ill-health causation among five Tehuledere communities found in the Amhara Regional State of Ethiopia. Using the qualitative ethnographic method to collect data, the study revealed the causes of ill-health among Tehuledere communities were supernatural, natural elements or physical causes, and social elements such as mistrust, social support or family dynamics as well as violation of taboos and moral injunctions. Supernatural causes included Almighty God or Allah or Egziabher, nature spirits and human supernatural agents such as

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witches. Natural causes of ill-health comprised environmental sanitation, personal hygiene, poverty, lack of food and well as biological and psychological causes such as aging, genetics, aging and stress.

2.4. Perception to illnesses: A Kenyan perspective

The Duruma of Kenya make an important contribution on a wide range of disease causation. Amuyunzu (1998) identified a range of cultural beliefs among the Duruma women on causes of illness. Some diseases are said to occur naturally and are blamed on the Duruma deity Mulungu, and others from witchcraft or utsai. Varieties of spirits are also blamed for the occurrence of illnesses. These include disembodied spirits (mashetani), ancestral spirits (nkoma) and nature spirits (mizuka). Breaking anti-witchcraft and anti-theft oaths (virapho) and sexual contact are said to bring about various illnesses.

Maina-Ahlberg (1979) conducted an informative study on beliefs and practices related measles and acute diarrhea among the Kamba people in Kenya. The Kamba classify illnesses in two major categories, the illness caused by man and those caused by God. Man's illnesses are associated with witchcraft and sorcery while those caused by God are those whose origin may not be known, but which are believed not to result from sorcery or witchcraft. Measles is classified under God's illness because it attacks small children and in epidemics it is known as an illness caused by weather. Measles is also regarded as part of the normal development of a child.

Mwenesi et al. (1995) also conducted a study among the Mijikenda and Luo residing in Kilifi district in Kenya to find out whether two severe complications of childhood malaria, convulsions and anemia, were recognized as symptoms of childhood illnesses, if they perceived convulsions and anemia as life-threatening and to determine how the two conditions were managed. The Mijikenda attribute causes of convulsion to a figurative 'animal or bird' which gets into the child by frightening the victim thus inducing the fits. Here the implicated creature is thought to be an owl.

All organized religions, including Christians and Islam, can be considered as different "cultures" which view illness as the will of God and is thought to result from not adhering to the principles of the religion (Lipson & Omidian, 1992).

2.5. The Maasai

The Maasai, according to Finke (2003) are inhabitants of the southern-west parts of Kenya and across the same zone in Tanzania within the Great Rift Valley. They are a marginalized group of people because they are an indigenous African ethnic group who practice their traditional culture with passion and have kept it to this day. Their resistance to change has led to romanticizing their way of life as living at peace with nature (Phillip & Bhavnagri, 2002). Their heritage is in nature, that is, people and cattle. Their Supreme Being or their creator is known as Enkai, who serves as the guardian over health, rain, fertility, love and the sun. According to Maasai legend, it was Enkai who gave them cattle and land (Phillip & Bhavnagri, 2002). Maasai being pastoralists are among the most disadvantaged of the world's poor due to challenges of harsh climatic and ecological conditions (Harragin, 2008). Their geographical remoteness results in policy makers providing less and poorer health services to this group compared to those provided to the urban population (Phillips & Bhavnagri, 2002). Similarly, Duba et al. (2001) noted that pastoralists living in areas characterized with low population density and extensive geographical dispersion with long

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distances between health facilities have limited accessibility to health care services. This results in the Maasai's reliance on traditional healers for general health problems

3. Theoretical Review

Anthropologists often divide theories of illness causation into two broad categories: personalistic and naturalistic.

3.1. Personalistic theory of illness causation

In the personalistic system of beliefs, illness is believed to be caused by the intervention of supernatural beings, a human being with special powers, or a nonhuman entity. A supernatural being may be a deity or a dead ancestor. A human being with special powers might be a witch or a sorcerer while a non-human entity may be a ghost, an ancestor or an evil spirit. Evil forces cause illness in retaliation for moral and spiritual retaliation. If someone has violated a social norm and/or breeched a religious taboo, the person may invoke a wrath of a deity and their illness is explained as form of divine punishment. Similarly, illness is seen in many cultures as punishment for failing to carry out the proper rituals of respect for the dead. Evil spirits possess the living to revenge the dead. Finally, illness in many cultures is accepted as simply bad karma or bad luck (Carteret, 2011; Henninger-Rener, 2017).

3.2. Naturalistic theory of illness causation

"In naturalistic ethno-etiologies, illness is believed to be as a result of natural causes such as cold, heat, wind, dampness and above all an upset in the balance the basic body elements" (Foster, 1976, p. 775). The naturalistic explanation assumes that illness is solely due to impersonal, mechanistic causes in nature that can be potentially understood. Causes of illness according to the naturalistic medical systems include organic breakdown or deterioration (e.g., tooth ache, heart failure) obstruction (e.g., kidney stones, arterial blockage), injury (broken bones, wounds), imbalance (e.g., too much or too little of hormones), malnutrition (e.g., too much or too little food) and parasites (e.g., bacteria, virus, worms).

Modern healthcare providers are trained in biomedicine and they rely on the naturalistic explanation of illness (O'Neil, 2006). However, "biomedical institutions and policies often do not recognize the important role that indigenous ill-health beliefs and medical knowledge plays in rural health care, especially in developing countries" (WHO, 2000, p. 1) because health care providers and patients operate in their own worlds. The health provider is entrenched in western training while the patient is capsulated in culture (Witte & Morrison, 1995).

4. Purpose of the Study

In light of these differing perspectives and beliefs, this study, therefore, sought to find out health care providers' perceptions towards causes of illness and if these perceptions were different from those of the Maasai in Kajiado county, Kenya

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5. Research Questions

Based on the purpose of the study the following research questions emerged:

i) What are the Maasai's perceptions towards causes of illness in Kajiado county, Kenya?
ii) What are the medical care providers' perceptions towards causes of illness in Kajiado county, Kenya?
iii) Are there differences in these two groups' perceptions of the causes of illness?

6. Methodology

6.1. Research design

In this research study, the researcher used qualitative methods in data collection and analysis. According to Mugenda and Mugenda (2003), qualitative research methods are techniques and measures that produce data in the form of words that are collated to produce themes rather than numbers. Ngechu (2004) argues that the qualitative method of study encourages interaction between the researcher and the target community members thus, allowing for more in depth, holistic information, attitudes, values, and knowledge to emerge.

6.2. Research site

The study was conducted in communities and healthcare facilities in Kitengela ward in Kajiado East sub-county and Olekimunke in Central Keekonyokie ward, Kajiado North sub-county in Kajiado County, Kenya. These locations were chosen because they were areas with pockets of permanent settlements of Maasai community. There was also the fact that Kajiado county was the area of convergence as the Maasai moved on their southerly migratory route from Northern Kenya to Tanzania in search of pasture. The choice of this site was envisaged to prompt a richer cultural exchange with the Maasai.

6.3. Target population

In this study, the target population was composed of the Maasai community and healthcare providers living in Kitengela ward and Olekimunke in Central Keekonyokie ward.

6.4. Sample size and sampling technique

Research assistants assisted in identifying four focus groups of eight persons and eight one-on-one interviewees (two focus groups and four one-on–one interviewees in each location). The interviewees comprised one healer, two community leaders (a male and a female) and one health care provider in a health facility from each of the selected locations. Senior clinical nurses who participated in one-on-one interviews were selected by the chief administrators in healthcare facilities visited by the researcher. The eight Focus Group Discussions (FGD) participants were selected with due consideration of their knowledge and the information they had in respect to illnesses.

The purposive sampling technique was used to select one-on-one interviewees and FGD participants. During the selection of Maasai participants in FGDs, homogeneous samples were preferred because mixed age or gender groups usually inhibited women from expressing their views and sharing wide

knowledge on the Maasai culture. A preliminary observation by the researcher with some Maasai communities indicated that same age and sexual composition of the group facilitate free discussion.

6.5. Instruments

The study made use of in-depth interviews that focused on one-on-one (OOO) interview format. The researcher generated in-depth interviews whose questions were based the six open-ended questions that were in line with the research questions.

In addition, the researcher developed an observation checklist that was used to observe the respondents' non-verbal communication in form of facial expressions, gestures and body movements to facilitate interpretation of their attitude towards the information they were volunteering in the group.

6.6. Data collection

The study employed one-on-one (OOO) interviews, FGDs and participant observation. In-depth interviews focused on one-on-one (OOO) interview format. Research assistants, on behalf of the researcher, helped to identify community healers and leaders, and arranged a meeting at the most convenient time and place as was agreed between the respondent, the research assistants and the researcher.

One-on-one interviews with healthcare providers were conducted during working hours of the health facility. Each respondent was interviewed individually. The format was flexible to allow capturing of responses, in form of narratives, in as much detail as possible. Data collected from the interviewees was audio recorded to make sure that no detail was lost and was done with respondent's permission.

In this study, prior arrangements were made to constitute the focus group discussions. The research assistants assisted in identifying two focus groups of eight persons in each location. The researcher relied on research assistants for the selection of Maasai participants in FGDs. Research assistants were carefully selected so as to closely resemble the participants in their characteristics in terms of gender and age bracket.

During the data collection process, the researcher also observed the respondents' non-verbal communication in form of facial expressions, gestures and body movements to facilitate interpretation of their attitude towards the information they were volunteering in the group.

6.7. Data processing and analysis

After each focus group session, the researcher documented the discussion as explicitly as possible, using the participants' own words. The key statements, ideas, and attitudes expressed for each topic of discussion were listed. After the transcript of the discussion was prepared, the researcher wrote comments on the statements being the first round of interpretation of the data.

7. Findings

7.1. Demographics

Respondents in the study comprised one male healer (Olaabani) from Olekimunke and a female healer in Kitengela, two clinicians, one in Kajiado District town hospital and another one in Tinga clinic at

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Olekimunge, a female community leader and a male community leader in each location. There were also two groups each totaling eight female and eight male FGDs in each location.

7.2. Maasai's perceived causes of illnesses

In both FGDs and OOO discussions, there was a consensus that illnesses among the Maasai focus on three categories namely curses, witchcraft and natural causes.

7.2.1. Curses (oldeket)

When asked what a curse is, a Maasai traditional healer said that a curse usually arise as a result of a member of the community breaking a taboo or when the primary web of interaction of family members is interrupted through misconduct with or without prior knowledge of the offender. A body of oral law covers many aspects of behaviour and wrongdoing, which are identified as the cause of a specific or a number of curses that bring about illnesses. The Maasai respondents collaborated by saying that a curse involves supernatural forces. It was stressed, however, that strangers cannot curse other strangers because they are not bound by the taboo of strangers.

Curses were further subdivided into two categories namely curses of commission and curses of omission.

Illnesses from Curses of Commission- A female community leader respondent during OOO interview said, "Curses of commission originate from premeditated bad behavior, disrespect and actions directed to members of the family especially the elders. The offender and the offended have full knowledge that the offense has been committed." With regard to the person whom the curse befalls, one woman healer said, "People usually know that a curse will be upon them if their actions are hurting to their family or the community." Asked to give instances that result in curses of commission, one of the respondents in a FGD said, "If someone refuses to help an elderly person who is a close relative, the person gets a curse spell." Another respondent in the same FGD elaborated that help sought by elderly persons included fetching firewood, food, water and attendance to daily needs, which they are unable to perform. In addition, a female respondent in the same FGD said, "Children sometimes will die in incomprehensible circumstances and the curse will remain within that family until a blessing is sought from the offended old person." Most of the respondents in the FGD pointed out that a curse could extend to animals owned by the offender causing them to cease producing milk and even die.

Another example of curses of commission discussed was protection of breastfeeding babies and their mothers. Most of the respondents in the two locations affirmed that Maasai elders advise young men against beating breast-feeding mothers for it causes a serious illness known as nagidaa (polio-like disease). A woman healer stated that beating a breast-feeding mother annoys the guardian spirits enshrined in happy marriages and protection of vulnerable infants. Respondents further agreed that epilepsy is brought about by a curse from the in-laws caused by a poor relationship between a son and the in-laws. When the relationship between the two starts becoming sour, the daughter becomes disturbed, and the husband becomes epileptic.

Curses of omission - The Maasai respondents perceived curses of omission as unmeditated actions committed with no awareness of their repercussions or intentions to hurt the feelings or interfere with the normal activities of the members of the family. In this case, one respondent said, "It is only the offended

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that has knowledge that the offense has been committed". Although curses of omissions are considered unacceptable; sometimes, they are excusable. An example given was failure to recognize some family members by giving them gifts during ceremonial occasions such as marriages and other important functions.

7.2.2. Witchcraft

The Maasai recognize two types of witchcrafts. The first is when a bad omen happens to a person by verbal pronouncement (verbal witchcraft) and the second is when a calamity happens to a person using an object. Most of the respondents in the study believed that witchcraft can produce effects beyond the natural powers of a normal person. An Olaabani respondent said the following regarding verbal witchcraft, "Sometimes there is a call up to the dead to bring calamity or impotence upon enemies, rivals, fancied oppressors and many more that represent the principal purposes that witchcraft has been called up to serve." One of the respondents in OOO interviews stated that witchcraft is bad and it is conducted by evil people.

Respondents in one FGD collaborated by saying that evil eye also falls under witchcraft. An Olaabani respondent said, "This is a look or stare that causes injury or bad luck on the person to whom it is directed for reasons of envy or dislike." Most of the respondents in both FGD and OOO interviews concurred with the Olaabani and said that evil eye is caused by someone who is envious, jealous or covetous and it can sicken both human and animals, especially cattle, goats and sheep. An OOO respondent also said, "Some people can bestow injury on victims by the malevolent gaze of their magical eye."

7.2.3. Natural Causes

Respondents in both FGDs and OOO interviews perceived natural causes of illnesses as resulting from injuries, accidents, and lack of food and hygiene. When the respondents were asked to name some of the natural illnesses, they mentioned malaria, ringworms, measles, anthrax, trachoma, colds and HIV and AIDS representatively. The majority of the Maasai respondents in both FGD and OOO said that malaria is perceived to be caused by mosquito bites and drinking dirty water especially during rainy seasons.

Several agents were perceived to cause ringworms. They include houseflies that land on the skin causing contamination, sharing of hair shaving tools, especially razors, with an infected person and witchcraft through the evil eye. Measles was perceived to be as a result of a child sharing a bed with someone infected with the illness. In some cases, witches are blamed as perpetrators of measles. Anthrax is believed to be contracted by eating or coming into contact with a contaminated hide or animal skin. Trachoma was perceived to be caused by the Bazaar fly (Musca Sorbens). Colds were perceived to be caused by drinking cold dirty rainwater and dust during dry seasons. HIV and AIDS is perceived among the Maasai people to be contracted from prostitutes.

7.2.4. Health Care Providers' Perceived causes of illnesses

All the healthcare providers perceived illnesses to be caused by abnormalities in the functioning of the individual's body. All the healthcare providers who were interviewed said that germs, bacteria and viruses in the body caused illnesses. One health care provider said, "We discourage the beliefs that diseases

are caused by curses and evil eye, witchcraft or any other cause that is not related to what we know. We never compromise on this notion."

8. Conclusion

To answer research question 3, it is clear that the Maasai have very different perceptions towards illnesses from those of medical healthcare providers. In answering research question 1, it has been established that the Maasai perceive three main causes of illnesses; natural, witchcraft and curses. Further, curses were divided into two, curses of commission and omission. In answering research question 2, it has been established that medical health care providers, however, perceive illnesses to be as a result of abnormalities in the body.

The implications of these findings are critical for the effective deployment of healthcare services as different worldviews concerning illnesses are likely to bring about miscommunication, misunderstanding and consequently, misdiagnosis between patients and health care providers. The lack of understanding shown by the healthcare providers with their stance of "never compromise(ing) on this notion" will certainly drive away the Maasai from accessing what little healthcare is available for them, causing them to lose out on much needed medications for themselves and their children. The findings of this study reveal that an overhaul as to how healthcare providers are trained is greatly needed in order to gently draw the Maasai into the modern healthcare system without disrespecting or disregarding their cultural beliefs as superstitious nonsense

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