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CHAPTER 1

Orientation to the study

1.1 INTRODUCTION

All countries have their own cultures and in Angola there is a diversity of customs according to ethnic group and region. Customs often clash with science, and even reach the point where they threaten the psychological and/or physical well being of an individual, a family or a community. It is generally accepted that not all aspects of traditional culture are harmful and that not all modern practices are always and universally completely beneficial. In other words, each culture has both positive and negative aspects, and the challenge is to make appropriate use of the positive and reject the negative ones.

The researcher observed that certain sectors of the Angolan population preferred to consult traditional healers (witchdoctors), fortune-tellers (psychics), or religious sects rather than medical health professionals. These traditional healers and religious sects claimed to cure all ailments and diseases and that they were caused by the patients' family members, friends or neighbours. In many cases, this led to interpersonal conflict in homes and on occasion endangered human lives. Moreover, prompt medical assistance could sometimes have saved a patient's life.

These observations motivated the researcher to undertake this study to examine the reasons for making use of such alternative methods instead of modern health care. Accordingly, then, this study aimed to establish the cultural influences that prohibit some members of the Angolan community from seeking the assistance of scientific health care.

1.2 CONTEXT AND BACKGROUND

Angola is an African country situated in Southern Africa bordered on the north by the Democratic Republic of Congo and the Republic of Congo; on the south, by the Republic of Namibia; on the east by the Republic of Zambia and on the west by the

Atlantic Ocean (see figure 1.1). With a territorial area of 1 246 700 square kilometres, the Angolan population is estimated at 13 million inhabitants (Altunaga 2003:50).

Figure 1.1 Map of Angola

(Altunaga 2003:51)

With regard to the influence of culture on health care, in Angola, there is still a lack of knowledge and a systematic opposition to scientific progress. Many individuals still do not believe disease is caused by pathogenic microorganisms, but by the evil eye, a witchdoctor or a spirit from another world. When these people are ill, instead of making use of professional health services, they prefer to go to *quimbandeiros* (witchdoctors) or to *curandeiros* (herbal doctors), or join certain religious sects; often not only to seek treatment but also to find out who caused the harm. Generally, the *quimbandeiros* identify one of the patient's family members, neighbours, or close friends as the cause; they never identify unknown people. Young children have even been accused. The accused is then punished and could even lose his/her life.

Some families still refuse to take their children for vaccination, alleging that the vaccines release (cause) the very diseases they are supposed to prevent. Local newspapers frequently carry articles or reports on problems caused between people's beliefs and scientific knowledge. For example, Cabila (2005a:4) reported that the provincial governor of Uíge La province in Angola convened a meeting of local traditional leaders to establish the cause of death of Marburg virus patients. The meeting concluded that a

potion caused the deaths. After the findings were announced, the suspected perpetrators were physically punished. Moreover, some traditional healers in Uíge risked treating Marburg patients and also died, because the disease is highly contagious. A witchdoctor was also detained for having killed sixty-four people with witchcraft in the village of Nacandombe, including one who was forced to drink "*mbulungo*" after being accused of having killed a family member (Cabila 2005b:15). Belief in witchcraft resulted in the death of eight people accused of being witches in Kuando Kubango (Cabila 2005c:9).

An alarming problem, which has been exacerbated by cultural taboos and practices, is that of Acquired Immune Deficiency Syndrome (AIDS). According to Mayenda (2005:2), cultural taboos against discussing sexual practices constitute an obstacle to preventing and combating HIV/AIDS. Through its maternal health programme, the Ministry of Health in Angola, trains traditional midwives, who, when adequately guided, make a valuable contribution to the community.

Another problem related to traditional healing is the lack of research on the effects of the products used in the treatment. Although people appear to be cured, nothing has been written or reported on the short- or long-term harmful effects of the products used. The *quimbandeiros* (witchdoctors) not only treat, but also try to "diagnose" the etiological agent for the disease, by accusing a family member, friend, or neighbour of causing the disease through witchcraft.

From the foregoing, it is clear that strong cultural beliefs and customs influence communities' behaviour when seeking assistance for illness and other problems.

1.3 PROBLEM STATEMENT

The researcher found that cultural beliefs and customs still had a strong influence on the assistance people sought for health and/or relational problems. Some preferred to make use of the services of a traditional healer (witchdoctor) or religious sect, despite the detrimental effects of their treatment on the patients and their relatives and neighbours.

The problem identified for this study centred on the effect of cultural influences on people's choice of assistance for health and sickness-related issues. It was not clear whether individuals had a choice to access scientific health care if they so wished.

The study therefore wished to investigate and answer the following question:

> What cultural factors prevent Angolan people from accessing scientific health care services when they are unwell or ill?

1.4 OBJECTIVES OF THE STUDY

The objectives of the study were to

- identify the cultural beliefs and practices that discouraged or prevented Angolans from accessing scientific health care
- develop an educational programme to better inform the public about the advantages of modern scientific health care

1.5 ASSUMPTION

LoBiondo-Wood and Haber (2001:321) define an assumption as "a basic principle assumed to be true without the need for scientific proof". This study was guided by the assumption that traditional cultural beliefs and practices strongly influenced the way individuals behaved within the group with regard to health, food and interpersonal relations.

1.6 SIGNIFICANCE OF THE STUDY

In contrast to the effectiveness of research-based scientific medical practices, erroneous treatment by traditional healers jeopardizes many people's well being. The study therefore wished to highlight the dilemma of strong cultural practices versus the benefits of scientific medicine. Without due attention, this issue could become a threat to both individual and public health.

The researcher acknowledges that governmental authorities already fulfil a vital role in raising people's awareness of to what point they can resort to herbal doctors (*curandeiros*). The Marburg disease, which constituted a threat in Angola in 2005, is under control, thanks to public awareness campaigns on the importance of following the preventative measures initiated by the Ministry of Health authorities (MINSA) and local authorities. In the maternal health programme, MINSA works with traditional midwives to equip and enable them to provide safe and efficient assistance during childbirth. The intention is not to put an end to traditional healers, but rather to work together towards the well being of the population.

1.7 LIMITATION OF THE STUDY FIELD

The study was conducted in the province of Luanda, in an area encompassing people from various parts of the country, with significant cultural diversity. The respondents consisted of members of the general public.

1.8 RESEARCH DESIGN AND METHODOLOGY

Research methodology describes the procedures and methods applied to achieve the objectives of the study. It is important to take into account the logical coherence of the procedures adopted and their relevance to the objectives (LoBiondo-Wood & Haber 2001:188).

To decide on the methodology to be applied it is necessary to ask the following questions: What new information is required? What instruments are necessary to collect the information? Where can one collect the information? How many individuals must be included in the study and how to select them? How will data be collected? What to do with the data collected? How to verify if the methods for data collection are correct before initiating the study? (Varkevisser, Pathmanathan & Brownlee 1988:88). Polit, Beck and Hungler (2004:436) describe research methodology as the procedures and strategy to collect and analyse the data in research.

1.8.1 Research design

A research design or outline “is the general plan to obtain the answers to the research questions. Usually the design specifies which of the various research approaches will be adopted and how the researcher will implement the controls to enable the interpretation of the results” (Polit et al 2004:432). In this study, a quantitative approach, with an exploratory and descriptive design, was used because the main aim was not only to describe and observe the phenomenon, but also to try and investigate its complex nature as well as other factors with which it is related, including the prevalence, incidence, extent and measurable attributes (Polit et al 2004:348). According to Polit et al (2004:348-437),

- *Quantitative research* studies phenomena that enable measuring and quantification, often involving a strict and controlled delimitation.
- *Exploratory research* does not only describe and observe the phenomenon, but also tries to investigate its complex nature as well as other factors with which it is related.
- *Descriptive research* has as its main objective the precise portrayal of the characteristics of the individuals, situations or groups as well as the frequency with which certain phenomena occur.

1.8.2 Population

A population (also known as the universe) is “a well-defined set that has certain specific characteristics. A population can consist of people, animals, objects or events” (LoBiondo-Wood & Haber 2001:141). For this study, the people residing in the suburb of Capalanga, Municipality of Viana, in the Province of Luanda, were the target group. The subjects were people who visited a specific market.

1.8.3 Sample

Sampling is a process by which a researcher selects a portion of the designated population to represent the whole population. A *sample* is a set of elements (LoBiondo-Wood & Haber 2001:142).

Probability sampling is a random sampling technique in which every member of the population has a probability higher than zero of being selected for the sample (Burns & Grove 2005:447). The researcher planned to approach 100 people who worked and visited a specific marketplace as respondents, in order to include people from different social strata. Every person at the marketplace would thus have an equal chance of being included in the sample.

1.8.4 Data-collection instrument

In this study, the researcher used a *questionnaire* (also called self-controlled questionnaire) as the data-collection instrument (Varkevisser et al1988:129). According to Polit et al (2004:256), the questionnaire has several advantages and disadvantages:

1.8.4.1 Advantages

The questionnaire has the following advantages:

- It is less costly and requires less time and effort to manage.
- It offers the possibility of total anonymity.
- The absence of an interviewer ensures no bias in terms of how the respondent would react to the interviewer.

1.8.4.2 Disadvantages

The questionnaire has the following disadvantages:

- Although questionnaires can be distributed or posted to a target group, not all may be returned.
- Respondents can ignore a questionnaire that is posted. The low rate of replies could lead to partiality, because the respondents rarely constitute a random subset of those the researcher intended to include in the study.
- Many people cannot complete a questionnaire, for example, small children, visually impaired and the elderly.

The researcher developed a questionnaire consisting of sections on biographical information, the meaning of culture, and health care.

1.8.5 Validity

Validity is the degree to which the instrument measures what it is supposed to measure (Polit et al 2004:291). The questionnaire developed for this study was subjected to face and content validity.

Face validity refers to whether the instrument appears to measure what it is supposed to be measuring, while content validity refers to the extent to which it includes all the major elements of the construct being measured (Burns & Grove 2005:214; Polit et al 2004:292-294).

1.8.6 Reliability

LoBiondo-Wood and Haber (2001:192) define reliability as the level to which the instrument produces the same results over repeated measurements. Attributes such as stability, homogeneity and equivalence are important in establishing an instrument's reliability.

1.9 DEFINITION OF TERMS

For the purposes of this study, the following terms are used as defined below:

- **Belief**. A belief is "an opinion, conviction; trust or confidence, as in a person or a person's abilities" (*Concise Oxford Dictionary* 1964:108).
- **Culture**. People's culture refers to "the total of the inherited ideas, beliefs, values and knowledge, which constitute the shared bases of social action; the total range of activities and ideas of a group of people with shared traditions, which are transmitted and reinforced by members of the group (*Collins English Dictionary* 1991:387).
- **Herbal healer (*curandeiro*)**. A herbal healer is a person with no professional or medical qualifications, who grows, collects and uses herbs, especially medicinal

herbs, to cure or treat conditions or ailments and does not accuse anyone of being the cause of the illness.

- **Wizard/witch**. A wizard or witch is a person who practises or professes to practise magic or sorcery.
- **Phytotherapist**. A phytotherapist is a person who uses plants to heal or cure.
- **Phytotherapy**. Phytotherapy is the use of medicinal plants and herbs.
- ***Mbulungo***. *Mbulungo* is one of the traditional products that witchdoctors (*quimbandeiros*) use to test whether a particular person is a witch or not.
- ***Quimbandeiro*** (*quimbanda*). A *quimbandeiro/quimbanda* is a fortune teller doctor or magician traditional doctor who treats patients but accuses people of being the agents who cause the illnesses of the patients in question.
- ***Soba***. A *soba* is a chief of an African tribe.

1.10 ETHICAL CONSIDERATIONS

Nursing is an ethical profession. In nursing research ethics are behavioural norms or standards that guide moral options related to how the research proceeds. Ethical considerations encompass the principles of respect for persons, beneficence, and justice relevant to the conduct of research (Burns & Grove 2005:83).

All precautions were taken to protect the respondents in the study and prevent physical or mental harm, and avoid coercion. Accordingly, the respondents' rights to self-determination, privacy and dignity, anonymity and confidentiality, fair treatment, and protection against coercion and harm were respected and upheld (LoBiondo-Wood & Haber 2001:161).

1.11 OUTLINE OF THE STUDY

Chapter 1 is an orientation to the study.

Chapter 2 discusses the literature review undertaken for the study.

Chapter 3 describes the research design and methodology.

Chapter 4 discusses the data analysis and interpretation.

Chapter 5 presents the conclusions drawn and makes recommendations for practice and further research.

1.12 CONCLUSION

This chapter discussed the background, context and objectives of the study, the problem statement, the objectives and research methodology were. The aim of the study was to identify the cultural influences and other reasons that prevent Angolan people from accessing scientific health care services.

Chapter 2 deals with the literature review conducted for the study.

CHAPTER 2

Literature review

2.1 INTRODUCTION

The researcher conducted a literature review on the influence of culture in health care to familiarise himself with what has been written on the topic. A literature review is a systematic organisation of scientific knowledge accumulated on a particular topic.

For this study, the literature review covered books, newspaper and journal articles, radio and television programmes and the Internet. The aim of the literature review was to provide a general perspective on the taboos, beliefs and practices based on cultural traditions and their impact within the communities, especially with regard to individuals' choices as far as health care services are concerned.

2.2 CULTURE

In order to discuss the effect of culture on health issues, the term first needs to be defined.

2.2.1 Definition

Culture is "the total of the inherited ideas, beliefs, values, and knowledge, which constitute the shared bases of social action; the total range of activities and ideas of a group of people with shared traditions, which are transmitted and reinforced by members of the group" (*Collins English Dictionary* 1991:387).

Culture includes the customs and traditions transmitted from generation to generation and therefore shapes people's identity, and affects their behaviour. People's social environment influences their world-view and behaviour as well. Culture can have a positive or negative influence on people and their behaviour. Positive effects include the preservation of their own identity. Negative effects include beliefs and practices, such as superstitions and witchcraft that can harm people.

Freud, Jung and other psychologists hold that individuals have beliefs that make them envision their personal and collective experience. These beliefs are related to the past, the future, what must be valued or what must be done. Some of these beliefs are subconscious (Guimarães & Tavares [Sa]). The phenomenon of hypnotic suggestion shows how changes in beliefs can change individuals' perceptions and feelings, even to the point of making them "see", "hear" and "feel" objects or people who are not present. Ultimately, people's way of "perceiving", "feeling" and "experiencing" reality is highly conditioned by their deep-rooted beliefs, mainly the collective paradigmatic beliefs. In turn, these beliefs are positively affected by the way in which they react in terms of reality, based on their points of reference, which reinforces the beliefs and the paradigm (Guimarães & Tavares [Sa]).

In Angola, superstition-related witchcraft continues to exist in some areas. It is still fairly common to find parents who believe that their children are involved in witchcraft or possessed by evil spirits or demons.

2.2.2 Impact of culture on death and dying in Angola

Every society has basic suppositions that form the collective way of thinking and constitute a set of theoretical references which generally determine who they are, the type of universe they live in and what is important or not important for them. Those suppositions are evident in the existing institutions and cultural customs, ways of thinking and value systems; are taught indirectly through the social context in which people live, and are hardly ever questioned (Guimarães & Travares [Sa]).

In Angola, the news of a person's death is passed on to all the family members, near and far. Then the family members begin mourning, crying, screaming and dancing incessantly, in a paced and monotonous rhythm. They grieve for the lost person, call his/her name, thank him/her for kindness, praise his/her virtues, curse the causer of the death and express their wishes of happiness for the deceased. Family and friends take part in all the actions with gestures, contortions and dancing. In this manner they demonstrate to their ancestors the kindness of the deceased, whom they try to please so he/she does not return laden with malign influences. Besides, the festivities entertain and give courage to the deceased while he/she waits for his/her transformation into an ancestor. The solemnity of the rites is in proportion to the social prestige and especially

to the vital influence of the deceased. Chiefs are awarded special, solemn honours, including the gathering of the whole community.

As far as burial is concerned, the grave is generally placed near the village or along a pathway so the living can pay the deceased homage every time they go past the grave, by bowing their heads, observing silence or placing an offering at the grave.

In Quibala, an area in the Province of Cuanza Sul, the ‘quibala’ people place the bodies of their chiefs over rocks and cover them with rocks placed in a specific way to form a rectangular sarcophagus. The corpses are submitted to a type of mummification. Using a funnel, they pour boiling palm oil through the mouth into the body. This operation continues until the bowels disintegrate and are expelled through the rectum.

Cemeteries and graves hold an important position in community life. The ancestors are there, and the mystic causality that strengthens or weakens comes from them; through them vertical solidarity is strengthened. These are also places that instil awe, and where fear and mystery remain. After the burial those who came into contact with the corpse, those who transported it, and the people who accompanied it, have to bathe or to wash their hands in a river “to take away the smell of the dead” (Kota [Sa]).

The wearing of mourning clothes starts after the burial. Women usually paint their faces with black stripes, cut their hair or leave their hair loose, or even shave off their hair. Mourning forces the spouse of the deceased to do away with all luxury clothing and to wear humble clothes. It is common for women to uncover their upper bodies, because if they wore a normal dress, the deceased could recognize them and torment them. Everything that is touched becomes impure and is in danger of being taboo. Their meals are limited as well as their activities. Usually they remain in their houses or in other houses built for that purpose where they receive visitors and their food. They are not allowed to cook and their sexual activities are strictly limited. The aim is to prevent the contamination of the deceased, as they have with them the “smell of the deceased” (Niboji [Sa]).

In certain groups, before marrying again, which can take between one and three years, the widow must cleanse her impurities by having sexual intercourse with a close family member of her deceased husband. In other groups, she has to seduce some unknown

man, who ignores all taboos, and carries with him the impurity of the woman. If this man finds out about the trap, a fortune-teller has to subject him to purification rites (Kota [Sa]).

They must speak little, show sadness and cry sometimes, until the strict mourning period ends with purifying rites in the form of a cleansing bath in the river. The women are given a new dress and instruments for work. Usually a fortune-teller takes part by sprinkling them (Kota [Sa]).

2.3 HEALTH CARE

The World Health Organization (WHO) defines health not only as the absence of illness, but as a state of perfect physical, mental and social well-being (WHO in Health - Wikipedia, the free encyclopedia).

2.3.1 Causes of disease

Disease is “a specific illness or disorder characterized by a recognizable set of signs and symptoms, attributable to heredity, infection, diet, or environment” (*Mosby’s Medical & Nursing Dictionary* 1986:355).

In the Angolan culture, there are diverse beliefs about the causes of disease. Some people are not interested in knowing the cause of the disease, their main concern is to rid themselves of it; others question what harm they have done to become ill; still others resort to the services of the *quimbandeiros* (witchdoctors) in order to diagnose the source of the illness, anticipating that the illness was caused by someone from the family and not by microbes. In time, however, people become aware that even if they eventually resort to a *curandeiro* (herbal doctor), it is still necessary to diagnose the disease in terms of modern medicine.

2.3.1.1 Scientific research

Medical science has shown that harmful organisms, such as bacteria, viruses and parasites, can cause some illnesses. Louis Pasteur formulated the “theory of single causality”, with the discovery of microbes (viruses and bacteria) and, therefore, of the

aetiological agent, that is, the one that causes the disease. Due to the inability and inadequacy to explain the occurrence of a series of other ailments that affect people's health, however, this theory is complemented by knowledge based on epidemiology, which demonstrates multi-causality as the determining factor of disease and not the exclusive presence of an agent (WHO in Health - Wikipedia, the free encyclopedia).

Social epidemiology better clarifies the specification and occurrence of disease in individual and collective terms. Health and disease are now considered as states within a same process, and constituted by biological, economic, cultural and social factors. In addition, advances have been made in the fields of genetic engineering and molecular biology with regard to occurrence and therapy. Thus, various models for explaining and understanding health and the health-disease process have emerged, such as the epidemiological model based on the three components of agent, host and environment, considered as causes. This model has evolved to more encompassing ones related to the health area, with the involvement of the environment (not only the physical environment), the way of life, human biology and health system-services with a permanent inter-relationship and inter-dependency.

This underlines the complexity of causal factors and agents in undermining health and well-being. Health and disease are not static, isolated and random states; people are not healthy or unhealthy by chance. According to Breilh and Granda (1985), "the health-disease process constitutes a specific expression of the general process of social life". Within the health-disease process, the concept of what it is to be ill or what it is to be healthy should also be taken into consideration.

In any population there are individuals subject to risk factors in terms of becoming ill with higher or lesser frequency and higher or lesser severity. Moreover, amongst them, there are differences in terms of the possibilities of "producing conditions to be healthy" and of having access to health care in the event of an illness. Therefore, the process of intervention by means of a health care system that attends to the individual and collective needs, requirements and aspirations, should be considered as a technical, scientific and political process (http://bases.bireme.br/bvs/sp/P/pdf/saudcid/vol1_04.pdf).

It is political in the sense that it refers to values, interests, aspirations and social relationships and involves the ability to identify individual and collective health needs, and includes the allocation and guarantee of use of the resources necessary for that intervention. It is technical and scientific in the sense that this knowing and doing related to health-disease of the population must not be empirical, but can and must be manipulated through scientific knowledge and technological development by means of the advancement and progress of science (http://bases.bireme.br/bvs/sp/P/pdf/saudcid/vol1_04.pdf).

2.3.1.2 Angolan cultural beliefs

Belief in witchcraft attributes certain actions, things or conditions to supernatural powers. Belief in witchcraft is an obstacle to development, because when the causes of death, diseases and other misfortunes are attributed to witchcraft, the real causes are not investigated, determined or eliminated. Unless the real cause is not dealt with, the effect will not end (http://www.crari.org/investigacao/ meninos_feiticeiros _angola.pdf).

For example, the Handa in the south of Angola define disease as ills that result from the harmful actions of friends, neighbours or the spirits (Melo [Sa]). Besides the belief in the spirits and their influence on the living, the Handa believe that specific social players, known as *onganga*, *ocimbanda* and *omunianeki*, have extraordinary powers. The first one is considered as a typical cause of evil. Not content with his powers, it is believed that he acts, negatively, against third parties (family members or others) through evil practices, and is therefore accused of “eating the others”, that is, of taking others’ lives. In effect, the victim can die from an illness, an accident, or in any other way due to the intervention of the *onganga*. In the case of an illness, the intervention can vary. Headaches, toothache, epilepsy, haemorrhaging or even oedema can be the result of the malicious intervention of the *onganga*. The spirits (including the ancestors’ spirits) can also intervene in the same manner, when the intention is to punish the living (http://www.crari.org/investigacao/ meninos_feiticeiros _angola.pdf).

The Messianic followers also do not go to hospital nor do they accept medical prescriptions. In the 1990s, the Messianic Church established its “headquarters” in the Maculusso suburb of Luanda, in a house which soon became too small for the number of people that started following this religion. The patient is given no medication as would

happen at a hospital. The treatment is done by administering “Jhorei”. Jhorei is a Japanese prayer that the followers have learned (Gomes & Miguel 2005).

In the municipality of Buengas, in the province of Uíge, three men accused of transforming themselves into lions and devouring a woman working in the fields, were handed over to the local police by the “*sobas*” and by the municipal administrator of Buengas in order to prevent retaliation by the people (Pâncio, Nelson. 2005. Televisão Pública de Angola [Public Television of Angola], 1 October 2005: 20h30).

2.3.2 Seeking medical assistance

When people are ill, their first concern is to be cured. They have a choice of modern medicine or traditional medicine. Their choice is also affected by the level of supply of health services, the costs, the distance and the information they have from others who have already been assisted by those services.

2.3.2.1 Curandeiros (herbal doctors)

Many consult *curandeiros* when modern medicine has failed; others have no other choice because it is cheaper. One of the advantages of traditional medicine is the fact that it is cheaper for the patient, as it makes use of plants available in that specific area. Furthermore, “calculations estimate that 80% of the world population is still dependant on traditional medicine in terms of health security. Many modern medications are made from natural sources, often impossible of being manufactured synthetically” (Hirt & Lindsey 2001:11).

Esporo (2006**)** refers to the potential of natural medicine in treating malaria. In Angola, many depend on traditional medicine, not only with regard to malaria but to meet their primary health needs. Approximately one third of the population does not have the resources to purchase medication and to pay for the costs related to modern medicine. Furthermore, *curandeiros* (herbal doctors) live among the people that they assist, which makes them more accessible to treat members of the community and to provide psychological support. They also have the advantage of understanding the people’s customs and beliefs.

Esporo (2006) emphasises that the main advantage of traditional medicine is that it is locally made at accessible cost, from plants available even in remote areas, and the communities either have witchdoctors or can easily be taught how to make effective formulas for the most common diseases.

2.3.2.2 The success of herbalists

With regard to the use of herbs for the treatment of illnesses, Esporo (2006) confirmed the safety and efficiency of various traditional procedures, especially as starting points for the development of future medication. However, traditional medicine has two main limitations, namely:

- Herbal doctors' diagnosis is not always clear or precise.
- There is no consensus, even amongst herbal doctors from the same region, on the most effective plants, mixture and dosages; and the concentration and stability of the active principals in the plants.

The Organisation for African Unity (OAU) declared 2001 to 2011 as the decade for the development of traditional African medicine, within the scope of which governments are invited to give high priority to the integration of mixtures made with medicinal plants, scientifically validated, in the national public health programmes, considered as being the most economic and at the same time most efficient way to disseminate solutions that are able to meet the serious problems in public health, even in the most remote areas, thus also creating conditions adequate for a more correct performance by herbal doctors in the communities they assist (Esporo 2006).

2.3.3 Advantages of scientific medicine

The advantage of scientific medicine is that it has means to identify the agent whether biological, physical, chemical or even psychological that causes the illness. Treatment is applied according to the type and seriousness of the illness. Furthermore, Fialho and Mirelle (2005) point out that conventional medical treatments are "not completely efficient, nor do they exclude collateral effects. The obvious advantage of those treatments is the more detailed knowledge of the way they work on the diseases, an efficiency tested in controlled studies on various patients and, when compared to other

standard treatments, having anticipated collateral effects. When opting for the conventional treatment, each patient can, upon starting it, have a clear idea of the advantages and disadvantages for their specific case.

2.4 CONCLUSION

The literature review indicated that culture and the environment play a significant role in treating illness. In addition, the belief in witchcraft is widespread and constitutes an obstacle to people's development and well-being.

Chapter 3 discusses the research methodology.

CHAPTER 3

Research design and methodology

3.1 INTRODUCTION

This chapter discusses the research design and methodology, including the population, sample, data-collection instrument, pilot study, permission to conduct the study, data collection and analysis, and ethical considerations.

3.2 RESEARCH OBJECTIVES

The objectives of this study were to

- identify the cultural beliefs and practices which discourage or prevent the Angolan population from accessing scientific health care
- develop an educational programme through which the public can be better informed about the advantages of modern scientific health care

3.3 RESEARCH DESIGN

The research design is “the general plan to obtain the answers for the research questions. Normally the design specifies which of the research approaches will be adopted and indicates how the researcher will implement the controls to enable the interpretation of the results” (Polit et al 2004:432). A quantitative approach with an exploratory and descriptive design was used for this study.

- **Quantitative research** aims at studying a phenomenon that can potentially be measured and quantified, often involving a strict and controlled and limited scope (Polit et al 2004:348).
- **Exploratory research** instead of simply describing and observing the phenomenon, also tries to investigate its complex nature and other factors with which it is related (Polit et al 2004:34).

- The main aim of **descriptive research** is the exact portrayal of the characteristics of the individuals, situations or groups and the frequency with which specific phenomena occur (Polit et al 2004:437).

3.4 RESEARCH METHODOLOGY

Methodology is the combination of research methods. Research is an investigation that makes use of methods that are scientifically organised to provide answers to questions or to resolve problems (Polit et al 2004:437). Research methods include stages, procedures and strategies for the collection and analysis of data.

The success of the study "depends on the quality of the methods for collection of data that are selected and applied as well as on the research methodology that evaluates and selects the tools available to measure variables of interest and of critical importance for the potential success of the study" (LoBiondo-Wood & Haber 2001:175-176).

3.5 ASSUMPTION

An *assumption* is "a basic principle that is supposed to be true without the need for scientific proof" (LoBiondo-Wood & Haber 2001:321).

This study was guided by the assumption that the beliefs and practices of traditional culture have strongly influenced the manner in which the individuals act in the group, with regard to health care, eating habits and interpersonal relations.

3.6 POPULATION

A population, also known as the universe, is "a well-defined set that has certain specific characteristics. A population can be constituted by people, animals, objects or events" (LoBiondo-Wood & Haber 2001:141). In this study, the target group was the population residing in Luanda, in the Municipality of Viana, in the suburb of Capalanga, emanating form various social strata. The researcher intended to use people who worked and visited a specific market as the respondents.

3.7 SAMPLE

Sampling is a process of "selecting a portion of the population designated to represent the whole population. A sample is a set of elements that constitute the population" (LoBiondo-Wood & Haber 2001:142).

Probability sampling is a random sampling technique in which every member of the population has a probability higher than zero of being selected for the sample (Burns & Grove 2005:40). From the indicated population, a random sample of 100 subjects was planned. People who worked and visited a specific marketplace were approached as respondents. However, the researcher found the targeted population reticent to become involved as they did not want to be away from their stalls for any period of time and the visitors were in a hurry to get their business done.

Convenience sampling was therefore applied to access sufficient respondents. In convenience sampling, subjects are included in the study because they happen to be in the right place at the right time, and available subjects are entered into the study until the desired sample size is reached (Burns & Grove 2005:40). The researcher approached people at their homes in the suburb where he lives until he had reached 100 respondents. Convenience sampling is considered a poor approach to sampling as it provides little opportunity to control biases (Burns & Grove 2005:40).

3.8 DATA-COLLECTION INSTRUMENT

The *instrument* is a technique that the researcher uses to collect data and can be a questionnaire, test, observation or interview. For this study, the researcher was of the opinion that the questionnaire would be the appropriate data-collection instrument.

The researcher developed the questionnaire based on the literature review and personal experience (see Annexure D). The questionnaire included open-ended and closed ended questions, and consisted of three sections, namely

- Section A: Biographical information
- Section B: The meaning of culture
- Section C: Health care

All research instruments should maintain certain standards of validity and reliability.

3.8.1 Validity

Validity is “the degree to which the instrument measures what it is supposed to measure” (Polit et al 2004:291). Face and content validity was considered appropriate for this study. Face validity is related to whether the instrument appears to measure what it is supposed to be measuring, while content validity examines the extent to which the method of measurement includes all the major elements relevant to the construct being measured, and is usually supported by the literature review (Burns & Grove 2005:214; Polit et al 2004:292-294). Face validity was achieved by submitting the questionnaire to academics and a statistician at the University of South Africa for comment and content validity was ensured by means of the literature review.

3.8.2 Reliability

The reliability of a research instrument refers to “the measure in which the instrument produces the same results over repeated measurements. The three attributes of reliability are stability, homogeneity and equivalence” (LoBiondo-Wood & Haber 2001:192). Reliability was tested by pre-testing the questionnaire.

3.9 PRE-TESTING THE DATA COLLECTION INSTRUMENT

A pre-test is done to ensure that the questionnaire as the data collection instrument is clear and relevant (Polit et al 2004:435). The pre-test was conducted in the suburb of Capalanga, municipality of Viana, Luanda with five respondents older than 18 years of age, of both sexes, who were not included in the main study. A number of adjustments had to be made in order to ensure that the desired information would be collected from the respondents.

3.10 PERMISSION TO CONDUCT THE STUDY

A written request for permission to conduct the study was submitted to the Municipal Coordinator (Annexure A), of the suburb where the research took place, together with a copy of the research proposal and the questionnaire (Annexure D). Written permission

was granted by Mr Artur, coordinator of the residents' committee for the Capalanga suburb (Annexure B).

3.11 DATA COLLECTION

The collection of data consists of collecting information that contributes to achieving research objectives. In a quantitative study, data collection is done according to a pre-determined plan, which in this case did not happen as planned. Due to the unwillingness of people at the marketplace to participate, the researcher was obliged to approach people at their homes, this was done in a suburb of Luanda. The researcher went from home to home and assisted those people willing to participate, in completing the questionnaire.

3.12 DATA ANALYSIS

According to LoBiondo-Wood and Haber (2001:223), the "analysis of data from an investigation consists of presenting the purpose and the content of the final sections of that investigation where the data is presented, interpreted, discussed and generalized". Descriptive analysis was done because it enabled the summarising of data in controllable portions and allowed the description of various characteristics of the referred data being studied.

A statistician analysed the data by means of descriptive analysis, which calculated the frequencies and percentages, using the Statistical Package for Social Sciences (SPSS) program. Once the data was processed, the results were organised in the form of tables, graphs and diagrams.

3.13 ETHICAL CONSIDERATIONS

Ethics are behavioural norms or patterns that guide the moral options on research behaviour. Ethical considerations encompass the ethical principles of respect for persons, beneficence, and justice relevant to the conduct of research (Burns & Grove 2005:83).

All precautions were taken to protect the respondents so as to prevent physical or mental damage and to remove constraints. The researcher adhered to the principles of the protection of human rights (LoBiondo-Wood & Haber 2001:161):

- Right to self-determination
- Right to privacy and dignity
- Right to anonymity and confidentiality
- Right to fair treatment
- Right to protection against coercion and damage

In this study *anonymity* and *confidentiality* were emphasised. Based on "the principle of respect, anonymity exists when the identity of the subject of research is not linked, not even by the researcher to his/her individual reactions. Confidentiality means that the individual identities of the research subjects cannot be linked to the information provided by them and will not be disclosed publicly" (LoBiondo-Wood & Haber 2001:163). The anonymity of the respondents was protected, as they were not required to indicate their names on the questionnaires.

The researcher undertook not to disclose or make accessible any information the respondents provided. The respondents were required to give informed consent, by signing a document that explained the nature, purpose, duration, and potential risks and benefits of the study, as well as that participation was voluntary, refer to Annexure C for an example of the consent form.

3.14 CONCLUSION

This chapter described the research design and methodology for the study, including the target population, sample, data-collection instrument, data analysis and ethical considerations. The researcher adopted a quantitative approach, using an exploratory and descriptive design.

Chapter 4 covers the data analysis and interpretation.

CHAPTER 4

Data analysis and interpretation

4.1 INTRODUCTION

The overall purpose of this study was to determine to what extent cultural beliefs and practices discouraged or prevented the Angolan population from accessing scientific health care and thereafter to develop an educational programme through which the public could be better informed about the advantages of modern scientific health care. Data was collected from the respondents by means of a questionnaire. One hundred questionnaires were distributed and all were returned, giving a 100% response rate.

The completed questionnaires were submitted to a statistician at UNISA for data processing and analysis. The questionnaire consisted of three sections, namely biographical information, the meaning of culture, and health care.

4.2 DATA ANALYSIS

The Statistical Programme for Social Sciences (SPSS) version 13 was used for data analysis. The questions in the questionnaire consisted of categorical responses, which led to categorical variables.

The statistician provided frequencies for the responses to the individual questions; that is, counts of how many respondents selected a particular response. These frequencies were illustrated by means of pie charts or bar charts. Bar charts are particularly useful in questions that offer a number of alternatives and where respondents are allowed to mark more than one choice because the bar chart compares the frequencies of the different choices. The pie chart is used in cases where the respondents are allowed to choose only one alternative, and the pie chart then illustrates the share of the total respondents opting for each choice.

4.3 DATA PRESENTATION

The information was presented in tables, pie graphs and bar charts. As the frequency of the 100 respondents equalled 100%, the results are discussed mainly in percentages. The percentages in the tables were calculated on the number of respondents who answered the particular question and therefore do not always correspond with the total frequency of 100.

4.3.1 Section A: Biographical information

This section dealt with aspects such as age, gender, academic education, and province of origin.

4.3.1.1 Age

The respondents were required to indicate their age according to the intervals given (see figure 4.1).

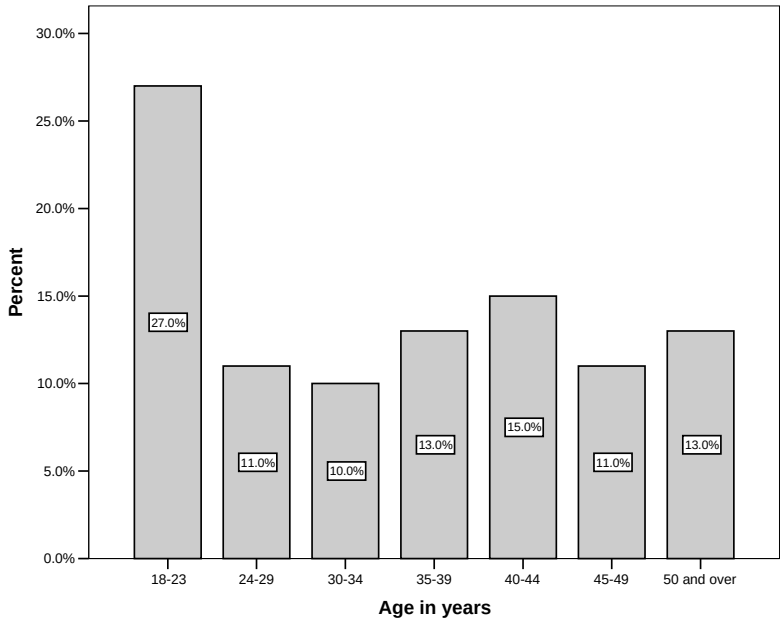

Figure 4.1

Respondents' age distribution (n=100)

Of the respondents, the majority (27%) represented the 18-23 age category with a fairly even spread throughout the other categories.

4.3.1.2 Gender

The respondents were required to indicate their gender to determine the profile of the sample (see figure 4.2).

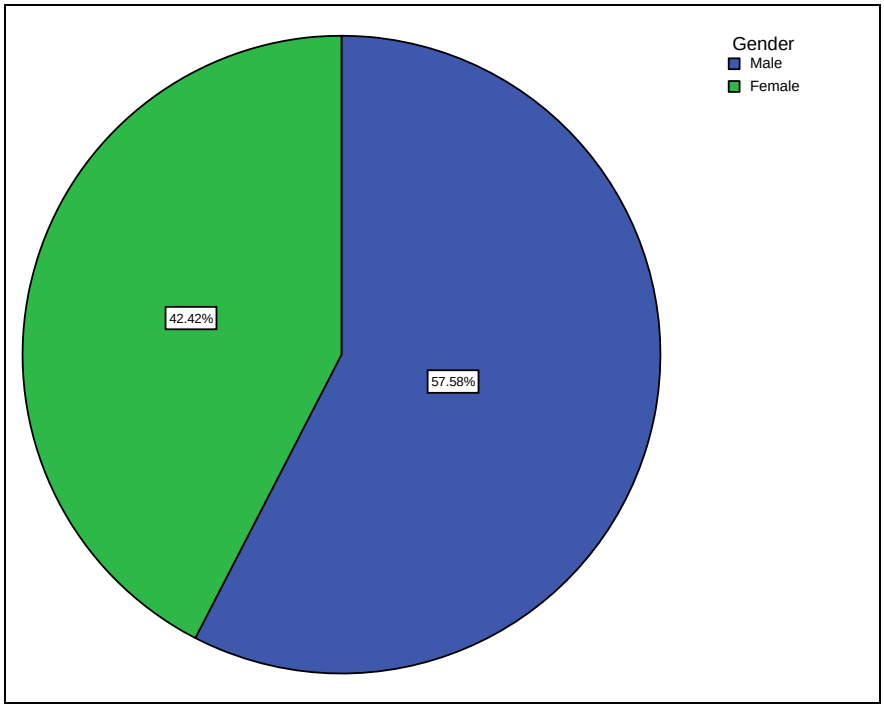

Figure 4.2
Respondents' gender distribution (n=100)

Figure 4.2 indicates that there were more males (58%) than females (42%) in the sample.

4.3.1.3 Educational level

The respondents were asked to indicate their level of education, as this could provide an indication of how they viewed specific aspects of culture (see figure 4.3).

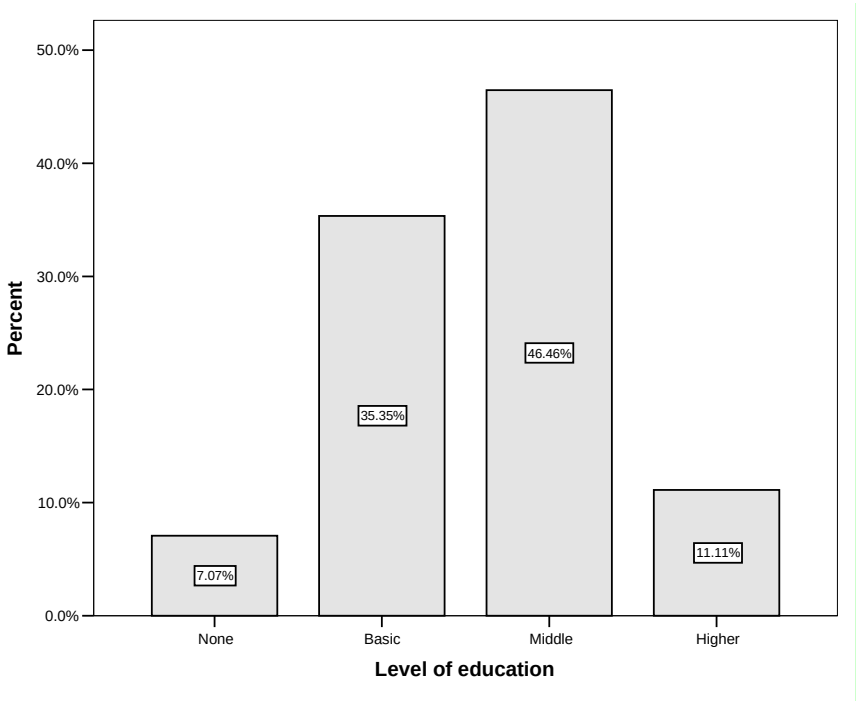

Figure 4.3

Respondents' level of education (n=100)

Figure 4.3 illustrates that the majority of the respondents had a basic (35%) or middle (46%) level education.

4.3.1.4 Province of origin

The researcher considered it relevant to determine the different regions from which the respondents came as this could possibly have an influence on their cultural beliefs. The respondents were required to select the province from a given list where they were born (see figure 4.4).

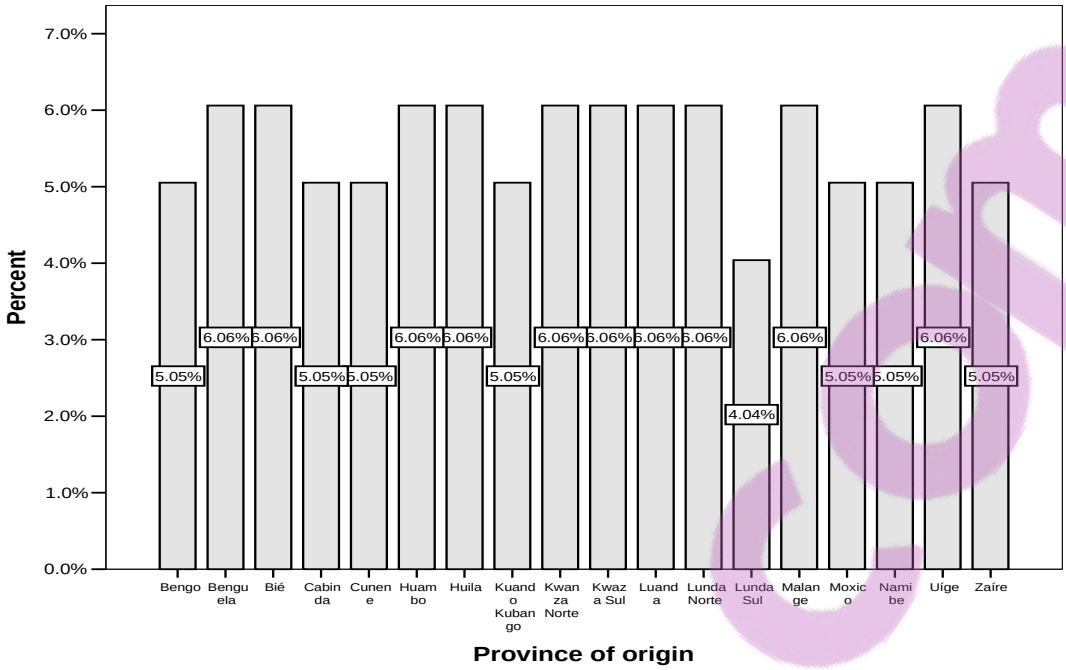

Figure 4.4

Respondents' province of origin (n=100)

According to figure 4.4, the respondents were fairly evenly spread throughout the provinces.

4.3.2 Section B: The meaning of culture

This section contains data on the respondents' understanding of what culture entails and its effect on them as individuals.

4.3.2.1 What is *culture*?

The respondents were given a number of alternatives in terms of what culture could be (see figure 4.5).

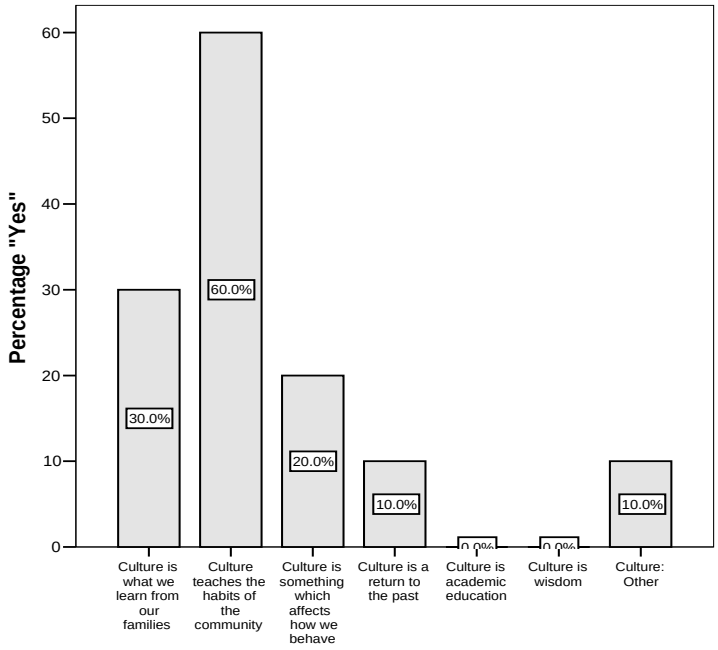

Figure 4.5

Respondents' view on what culture is (n=100)

The respondents viewed culture as a facet that teaches the habits of the community (60%), is learnt form their families (30%), and affects the way people behave (20%).

4.3.2.2 Effect of culture on one's life

The respondents were asked to indicate what effect culture had on their lives (see figure 4.6).

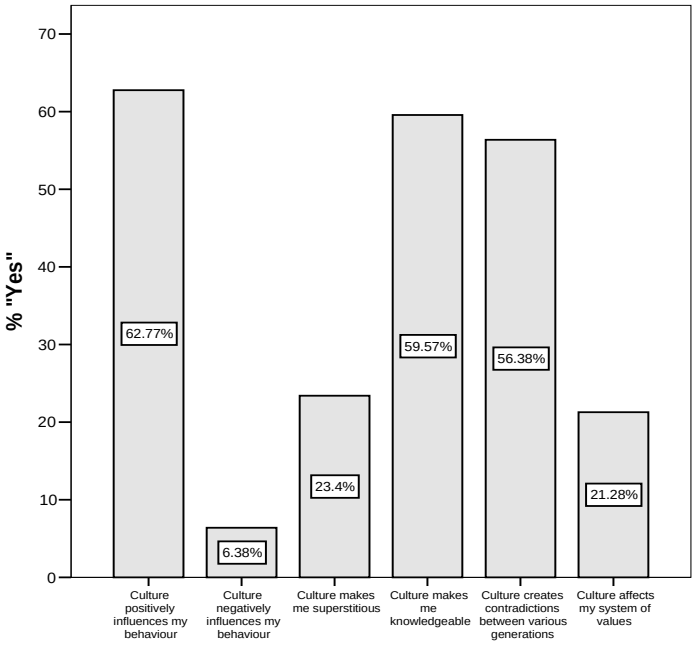

Figure 4.6

The effect of culture on the respondents' lives (n=100)

Of the respondents, 63% indicated that culture positively influenced their behaviour; 60% indicated that culture made them knowledgeable; 56% indicated that culture also created contradictions between various generations, and 6% thought that culture negatively influenced their behaviour.

4.3.2.3 Traditionalism versus modernism

The respondents were asked whether traditions were more important than modern developments (see figure 4.7).

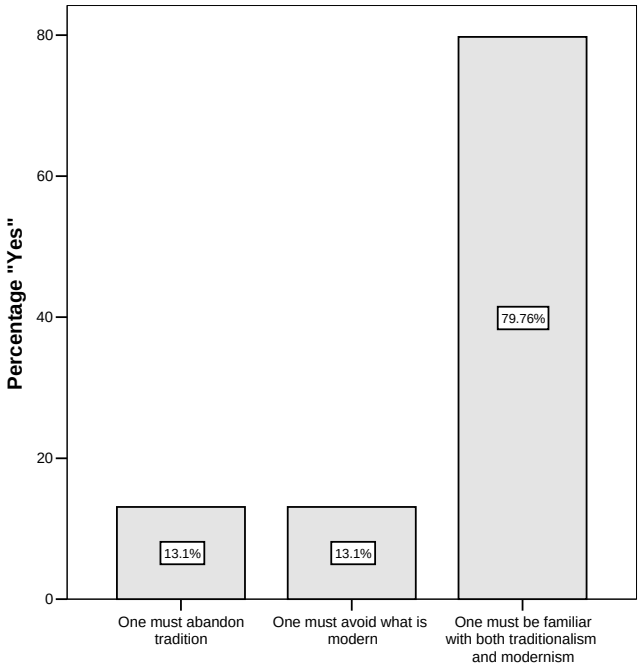

Figure 4.7

Respondents' views on traditionalism vs modernism (n=100)

Of the respondents, 80% held the balanced view that one must be familiar with both traditionalism and modernism.

4.3.3 Section C: Health care

In this section, the respondents were asked to give their views on disease, determinants of illness and health care.

4.3.3.1 Causes of disease

As African culture still has many strong beliefs about witch doctors and the effects of being cursed, the respondents were required to provide their views on the possible causes of disease (see figure 4.8).

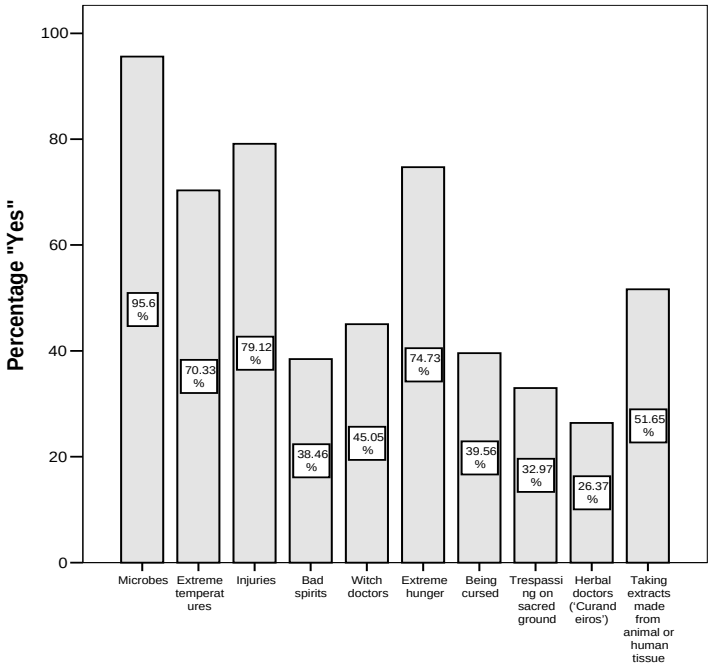

Figure 4.8

Respondents' views on the causes of disease (n=100)

Of the respondents, 95% accepted microbes as the cause of disease; 79% also blamed injuries; 74% blamed extreme hunger; 70% indicated extreme temperatures, and 52% blamed taking extracts made from animal or human tissue. This indicates that the majority of the respondents have a good indication of what modern medicine accepts as some of the causes of ill health.

However, it should be noted that of the respondents, 45% ascribed diseases to witch doctors; 38% to bad spirits, and 32% to trespassing on sacred ground, which is indicative of strong cultural influences and adherence to traditional beliefs.

4.3.3.2 Existence of pathogenic agents (microbes/germs)

The respondents were asked whether they believed that pathogenic agents existed as causes of disease (see figure 4.9).

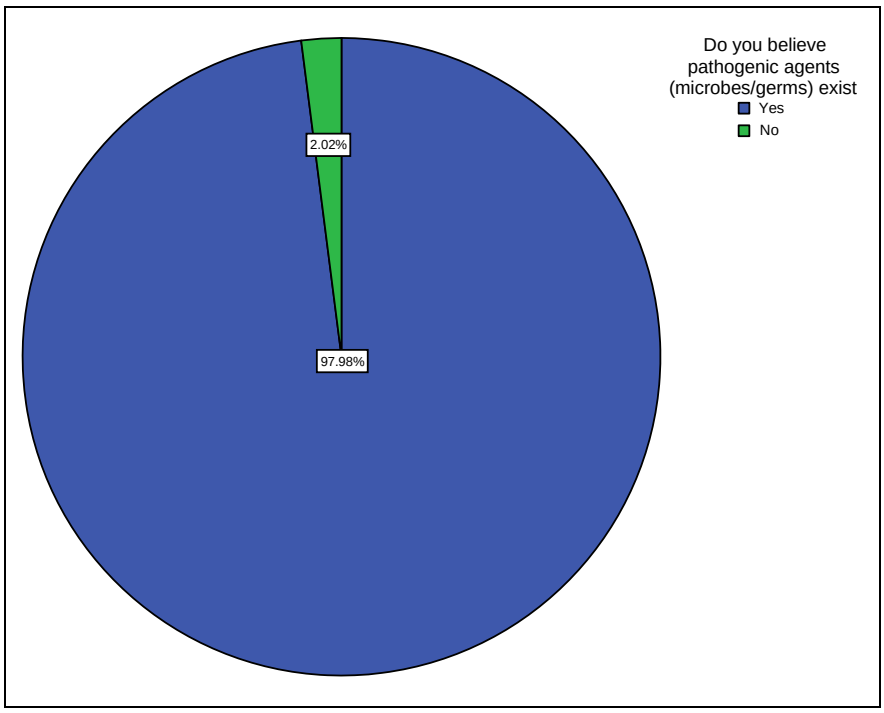

Figure 4.9

Respondents' views on the existence of pathogenic agents (n=100)

The respondents strongly indicated (98%) that pathogenic agents exist, which supported the findings in figure 4.8 that diseases are caused by microbes. It was thus evident that the respondents were enlightened about the fact that germs are mostly responsible for diseases.

4.3.3.3 Witch doctors as the cause of disease

The respondents were asked to indicate whether they believed that witch doctors could cause disease (see figure 4.10).

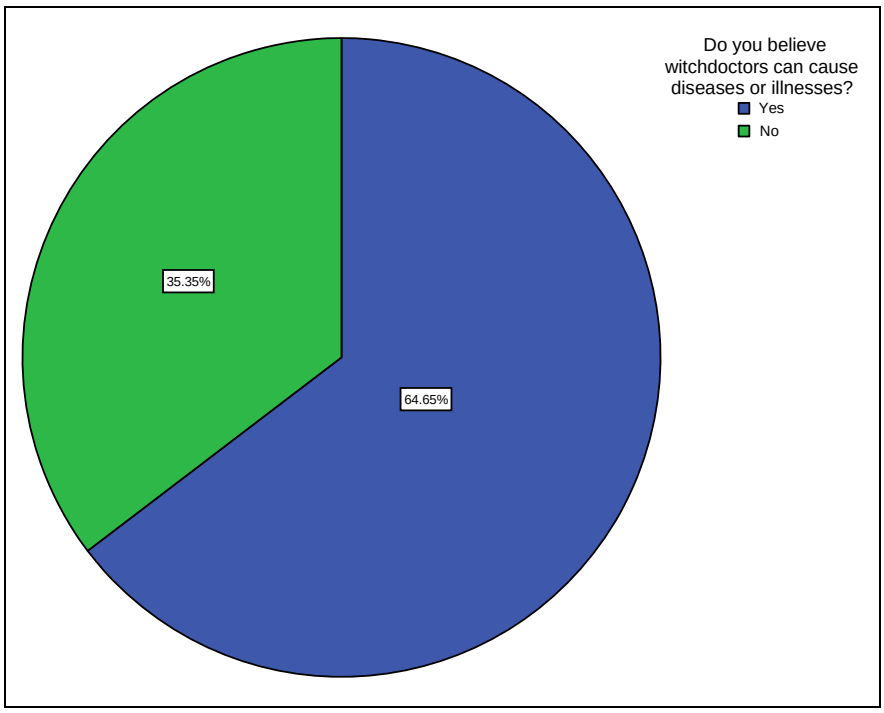

Figure 4.10

Respondents' views on whether witch doctors can cause disease (n=100)

Of the respondents, 64% indicated that they believed that witch doctors could cause disease. This appeared to contradict the responses in figure 4.8, where 54% of the respondents indicated that witch doctors "may" not cause illness and disease, whereas here (figure 4.10) 64% indicated that witchdoctors "can" cause illness and disease. It is not clear whether the discrepancy was due to the difference between "can" and "may", or whether the data were unreliable.

4.3.3.4 Witch doctors as the cause of social and family problems

The respondents were asked whether they believed that witch doctors could cause social or family problems (see figure 4.11).

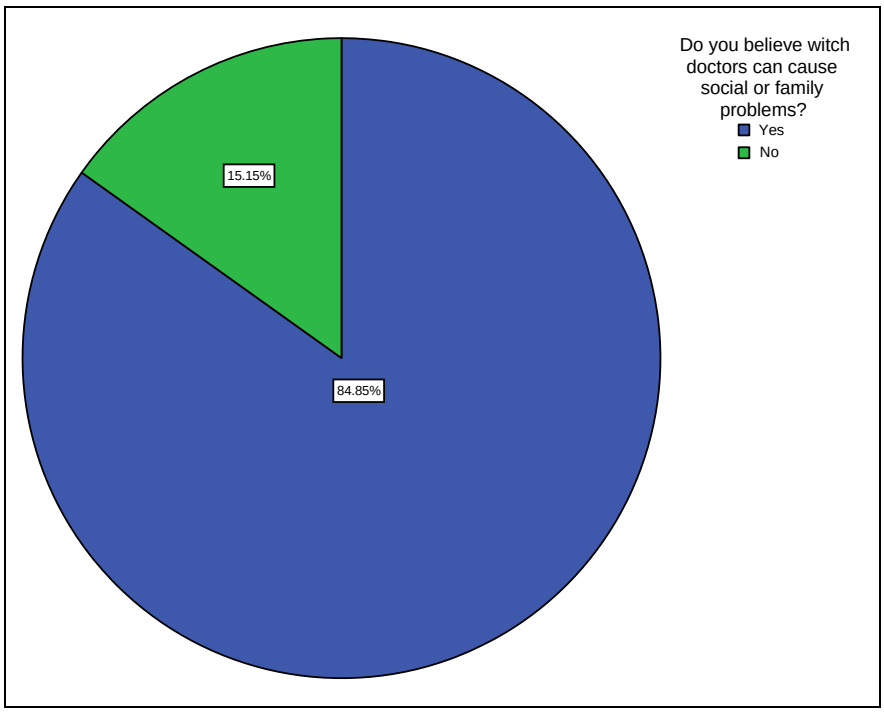

Figure 4.11

Respondents' views on witch doctors as causing social and family problems (n=100)

There appeared to be near-consensus (84%) that witch doctors could cause social or family problems, thus supporting the view that witch doctors still had a strong influence on the community at large.

4.3.3.5 Advantages in using witch doctors

The respondents were asked whether there were any advantages in using witch doctors (see figure 4.12).

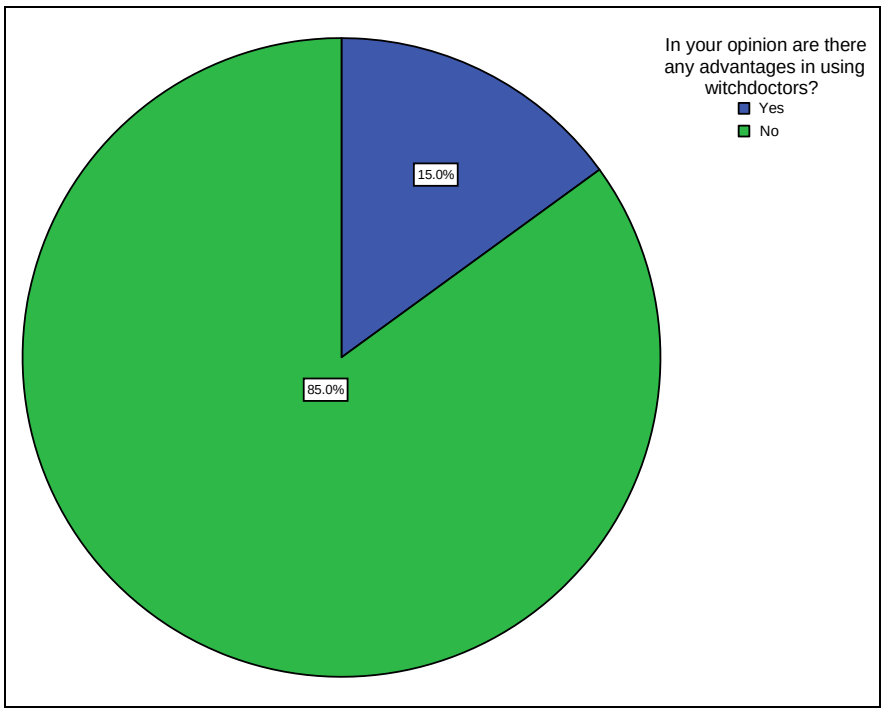

Figure 4.12

Respondents' views on the advantages of using a witch doctor (n=100)

Of the respondents, only 15% believed there were advantages, whereas 85% denied that there were any advantages in making use of the services of a witch doctor.

4.3.3.6 Seeking health assistance

From a given list of providers, the respondents were asked to indicate their preference if they required health assistance (see table 4.1).

Table 4.1 Respondents' preference for health care provider (n=100)

SERVICE	WILL NEVER USE	ONLY IF NOTHING ELSE AVAILABLE	WILLING TO USE	PREFER TO USE
18.1 Private clinic	9	12	52	25
18.2 Government Hospital	8	7	47	36
18.3 Herbal doctor (*Curandeiro*)	44	33	17	5
18.4 Witch doctor (*Quimbandeiro*)	78	11	6	5
18.5 Headman (*Soba*)	50	29	13	7
18.6 Mobile clinic	6	16	57	19
18.7 Visiting health care worker	2	12	56	28

If the response alternatives *willing to use* and *prefer to use* are grouped together as a set of positive responses and *will never use* and *only if nothing else is available* as a set

of negative responses, then the following is evident from table 4.1. Of the respondents, 84% would consult a visiting health care worker; 83% would visit a government hospital; 77% would visit a private clinic, and 76% would use a mobile clinic. In support of these findings, the negative responses substantiated the preference for modern scientific medical treatment as 89% of the respondents indicated that they would not make use of a witch doctor, 79% would not consult the headman, and 77% would not consult a herbal doctor.

4.3.3.7 Freedom to decide on health care provider

The respondents were asked whether they were able to freely decide which type of health care they would like to use when they or their family members were ill (see figure 4.13).

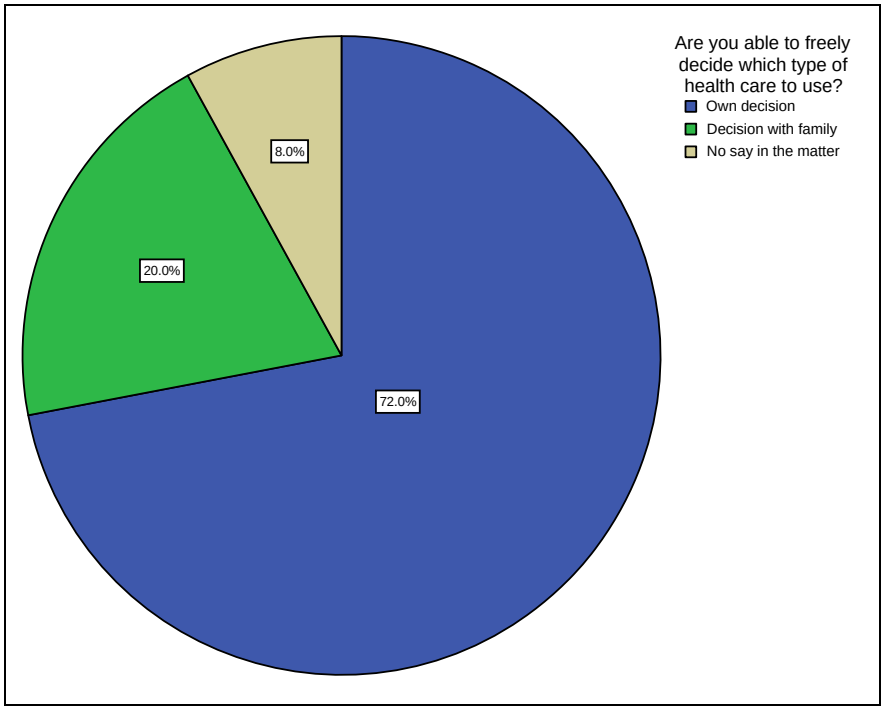

Figure 4.13

Freedom to select health care provider of choice (n=100)

Of the respondents, 72% indicated that the type of health care used was entirely their own decision; 20% decided in consultation with their family, while only 8% had no say in the matter.

4.3.3.8 Cost of obtaining health care from different providers

Health care is becoming increasingly expensive worldwide. The respondents were asked what payment the different providers would require as a consultation fee (see table 4.2).

Table 4.2 Cost for using different health care providers (n=100)

HEALTH SERVICE	FREE	CHEAP	EXPENSIVE	NOT AFFORDABLE
21.1 Private clinic	2	3	56	39
21.2 Government Hospital	37	60	2	1
21.3 Herbal doctor (*Curandeiro*)	5	43	24	28
21.4 Witch doctor (*Quimbandeiro*)	3	20	16	60
21.5 Headman (*Soba*)	70	12	4	12
21.6 Mobile clinic	7	63	21	9
21.7 Visiting health care worker	2	8	37	52
21.8 Other	0	0	1	0

In an effort to make a division between the less expensive and unaffordable health care providers, the *free* and *cheap* responses were grouped as a positive set, and *expensive* plus *not affordable* were grouped as a negative set. From table 4.2 it is clear that 97% of the respondents noted that government hospitals are less expensive, that the headman (82%) is affordable (except that it was evident from table 4.1 that the respondents were not keen to consult the headman), that the mobile clinic was either free or cheap to visit and 48% indicated that the herbal doctor was also affordable.

Private clinics (95%) were expensive or unaffordable, and so were the visiting health care worker (89%), the witch doctor (76%) and the herbal doctor (52%).

4.3.3.9 Seeking treatment for specific complaints

The respondents were asked to indicate which provider they would consult for specific ailments (see table 4.3).

Table 4.3 Respondents' preference of health care provider for specific ailments (n=100)

COMPLAINT	GOVERNMENT HOSPITAL	PRIVATE CLINIC	WITCH DOCTOR	HERBAL DOCTOR	SELF-MEDICATION
22.1 Headache	35	6	0	1	58
22.2 Malaria	77	13	0	2	7
22.3 Diarrhoea	63	9	0	3	22
22.4 Tuberculosis	86	10	0	2	2
22.5 Influenza	41	9	0	1	48
22.6 HIV	87	9	0	0	3
22.7 Stomach ache	55	10	0	4	29
22.8 Nightmares	29	7	17	27	12

The respondents preferred to self-medicate in the case of headaches (58%) and influenza (48%); were willing to seek the help of witchdoctors (17%) and herbal doctors (27%) for nightmares, and preferred to go to the government hospital for malaria (77%), diarrhoea (63%), tuberculosis (86%), HIV (87%) and stomach ache (55%). It was thus evident that most of the respondents would for most ailments prefer to seek assistance from the public hospitals in their vicinities.

4.4 CONCLUSION

This chapter discussed the data analysis of the responses to the questionnaire. It was found that even though traditional beliefs were still relevant for some respondents, a large segment of the respondents had knowledge of and favoured accessing modern scientific medicine.

Chapter 5 presents the findings and makes recommendations for practice and further research.

CHAPTER 5

Findings, conclusions and recommendations

5.1 INTRODUCTION

A quantitative, exploratory and descriptive research design was applied in this study with the aim of investigating the influence of culture on accessing modern scientific medicine, and to make recommendations.

Based on the data analysis and interpretation, this chapter discusses the objectives, results, conclusions, limitations and recommendations of the study.

5.2 OBJECTIVES

The objectives of this study were to

- identify the cultural beliefs and practices which discourage or prevent the Angolan population from accessing scientific health care
- develop an educational programme through which the public can be better informed about the advantages of modern scientific health care

5.3 RESULTS

For this study, the self-developed questionnaire comprised three sections and the results will be discussed in line with the sections.

5.3.1 Section A: Biographical information

One hundred respondents participated in the study. The respondents were people who lived in a suburb of Luanda. Of the respondents, 58% were males and 42% were females; 27% fell within the age group 18 to 23 years, with an even spread between the other age categories which varied from 24 to 50 and more years.

Of the respondents, 46% had a middle level education, 35% had a basic level and 11% had some form of higher education. The respondents' origin (place of birth) was fairly evenly spread between the 18 provinces of Angola.

5.3.2 Section B: The meaning of culture

Of the respondents, 60% stated that culture teaches the habits of the community; 30% indicated that culture was what people learnt from their families, and 20% noted that culture was something that affected how people behaved.

With regard to the effect of culture on their lives, 63% of the respondents indicated that culture positively influenced individuals' behaviour; 60% believed culture made people knowledgeable; 56% indicated that culture created contradictions between generations and 6% thought that culture negatively influenced their behaviour

Regarding traditionalism and modernism, 79% were of the opinion that one must be familiar with both traditionalism and modernism; 76% indicated that one should not abandon tradition, and 73% indicated that one should not avoid what is modern.

5.3.3 Section C: Health care

In determining what factors cause disease, the respondents indicated the following: microbes/germs (95%); injuries (79%); extreme hunger (74%); extreme temperatures (70%), and taking extracts made from animal or human tissue (51%). Of the respondents, 97% believed that pathogenic agents (microbes/germs) existed. It should be noted, however, that the following causes of disease were also given: witch doctors (44%); being cursed (39%); trespassing on sacred ground (32%), and herbal doctors (24%).

Of the respondents, 64% indicated that they believed witch doctors could cause diseases, while 84% were of the opinion that witch doctors could cause social or family problems. Regarding any possible advantages in using witch doctors, 85% responded negatively, while 15% felt it could be advantageous.

When requiring health assistance, 84% of the respondents preferred to use visiting health care workers; 83% indicated government hospitals; 77% preferred private clinics, and 76% preferred mobile clinics. With regard to what providers that might be associated with cultural beliefs they would never use or would use only if no other services were available, the responses indicated the following: the witch doctor (89%), headman (79%), and the herbal doctor (77%).

In determining the preferences of respondents to access a health care provider of their choice, 72% indicated that it was entirely their own decision; 20% consulted with their family members, and 8% indicated that they had no choice in the matter at all.

With regard to the costs involved in accessing the different health care providers, the respondents indicated that the following were either expensive or not affordable: private clinics (95%); visiting health care worker (89%); witch doctors (76%), and the herbal doctor (52%). Those that were free or cheap were government hospitals (97%), headmen (82%) and mobile clinics (70%).

When asked where would they go for treatment in view of specific ailments, the respondents selected the following: the government hospital for HIV (87%), tuberculosis (86%), malaria (77%), diarrhoea (63%) and stomach ache (55%). For nightmares, 27% would visit the herbal doctor and 17% would consult a witch doctor.

5.4 CONCLUSIONS

The conclusions are drawn from the findings.

5.4.1 Biographical information

The respondents came from all the provinces of Angola, and had mostly completed basic or middle level education.

5.4.2 The meaning of culture

- The respondents had a good knowledge of what culture entails in that they noted it is what one learns from one's family, it teaches the habits of the community, and it affects the way individuals behave.

- The effect culture has on the respondents varied from influencing their behaviour and providing them with knowledge, to creating conflict between generations.

- The respondents were of the opinion that one must not abandon tradition, or avoid what is modern, and must be familiar with both traditionalism and modernism.

5.4.3 Health care

- The respondents were well informed about the factors which may cause diseases or illness, the majority noted that microbes existed (97%) and that they, plus injuries, extreme hunger, extreme temperatures and taking extracts made from animal or human tissue, were responsible for causing disease and illness. There were however between a third and a half of the respondents who indicated that witch doctors, bad spirits, being cursed and trespassing on sacred ground could make one ill.

- Two thirds of the respondents indicated that witch doctors could cause disease or illness, and more than 80% indicated that witch doctors could cause social or family problems, while 85% noted that there were no advantages in consulting witch doctors.

- In seeking health assistance the majority of respondents preferred the services of government hospitals, visiting health care workers, private clinics and mobile clinics. Most of the respondents also acknowledged that they would never use the following services, or only do so if no other service was available: witch doctor (89%), headman (79%) or herbal doctor (77%).

- In making a decision on what type of health care service the respondents wanted to use, 72% were able to make their own decisions, 20% consulted with their family members and 8% had no say in the matter.

- With regard to the cost of the different health care services, the private clinic, visiting health care worker, witch doctor and herbal doctor were the most expensive, whereas, government hospitals, the headman and mobile clinics were more affordable.

- In seeking treatment for specific ailments the greater majority noted they would go to the government hospital for assistance in view of HIV, tuberculosis, malaria, diarrhoea, stomach ache, and influenza. More than half indicated that they would self-medicate for headache, influenza and stomach ache.

The overall conclusion is that most respondents are well aware of what causes disease and illness, and prefer to make use of services which are labelled as 'modern scientific' health care services. However, there is still a strong belief in witch doctors' powers and that they can be relied upon for health matters, but could also have a negative impact on individuals' physical and psychological well being.

5.5 LIMITATIONS OF THE STUDY

Three limitations affected the outcomes of this study.

First, the study was done by means of distance tuition and not campus-based tuition; the supervisors travelled from South Africa to Angola and were not fluent in the Portuguese language. Communication had to be done through the services of an interpreter.

Secondly, it was difficult to get a sufficient number of respondents to participate in the study. People appeared cautious to become involved. This led to a convenience sampling technique where no guidelines to reduce biases were applied.

Thirdly, the phrasing of a few questions may have led to confusion; especially where the terms "may" and "can" were used.

5.6 RECOMMENDATIONS

Based on the findings of the study, the researcher makes the following recommendations for practice and for further research.

5.6.1 Practice and education

The following recommendations focus on better distributing information and knowledge about the value of modern scientific medicine and its affordability:

- Develop health education posters and leaflets, emphasising the value of modern tested scientific medicine, and post them in conspicuous places in villages (e.g., the church, shops, post offices, clinics and transport waiting areas).

- Encourage health care workers, such as clinic staff or visiting health care workers, to hold information and health education sessions at community gathering places, such as at churches, markets, transport waiting areas and government offices.

- Conduct role-play sessions and plays at schools during which the advantages of modern medicine and success stories (of people who recovered from ailments due to scientific medicine) are emphasised.

- Convey the message that government health care services, in the form of hospitals and clinics, are usually less costly for individuals to use than the witch doctor, by means of posters, leaflets and role-plays.

- The authorities should be approached and encouraged to expand the infrastructure of roads and communication means to rural areas, as well as the provision of decentralised primary health care facilities, so that people in rural areas can more easily access scientific treatment instead of resorting to witch doctors because there is no alternative.

5.6.2 Further research

Further research should be conducted on the following topics to contribute to the community receiving better health care service:

- The cultural influences on health care in specific ethnic groups, and/or regions.
- The possibility of registering witch doctors and herbal doctors with the aim of ensuring some standard of acceptable health care provision.

5.7 CONCLUSION

This study examined Angolan culture as an influence to accessing modern scientific health care with the aim to develop health information brochures to inform the population of the advantages of scientific medicine. The quantitative approach with an exploratory and descriptive design was applied in this study, using a questionnaire to collect data from 100 respondents by means of a convenience sample.

The findings indicated that most of the respondents were aware of what caused disease and illness in terms of modern knowledge, preferred to access government hospitals and also that government health care services were more affordable than some of the other alternatives. However, the study also found that a small section of the respondents believed in the powers and advantages of witch doctors, thus confirming that certain cultural issues still influenced the selection of assistance when health care and treatment is required. Recommendations were made through which health education could be distributed.

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Authorized on 14/11/2006 Signed) Illegible and stamped by the President of the Committee (illegible) of the Capalanga Suburb in Viana.

REPUBLIC OF ANGOLA

From Manuel Licas Nunes
Resident in Viana:
Z.C., Q25, R1, House no. 3
Capalanga Suburb

The Coordinator of the
Capalanga suburb
Viana
- LUANDA-

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

It is herewith requested that you grant permission to conduct research at this suburb of Capalanga, which falls under your jurisdiction, for purposes of a dissertation on the topic *Cultural Influences in Accessing Scientific Health Care in Angola.*

I am presently registered at the University of South Africa (UNISA) where I am completing the Master's degree on Health Sciences. The research project is part of the requirements to complete the referred Master's degree.

My research proposal has already been approved by the Department of Health Studies of the University of South Africa.

The aim of the research project is to *identify the cultural beliefs and practices which discourage or prevent the Angolan population from searching for or having access to scientific health care.* For that purpose it is necessary to complete a questionnaire, so as to enable the researcher to collect the necessary data for the research. I therefore request your permission to distribute the above mentioned questionnaire to potential participants in the research.

The researcher undertakes to rigorously adhere to all ethical considerations and measures in conducting the research so as to prevent any potential damage and in order to protect the confidentiality of participants.

Annexed please find a copy of the research proposal as well as a copy of the questionnaire that will be used for the research.

I would be most grateful if you would cooperate in this regard, by granting me permission to conduct the research *Cultural Influences in Accessing Scientific Health Care in Angola.*

Yours truly,

Signed) *Manuel Licas Nunes*

The DEAN
(Signed)
Maria da Conceição Martins
/MA/

Confirming Signature
Illegible
2/05/06

Consent to Partake in Research

I, the undersigned, ……..……..……..……..
herewith agree to:

- Partake in the research on the (topic)

  Cultural Influences in accessing scientific health care in Angola

- Fill in the relevant questionnaire

- Authorize the researcher, to use, at his discretion, the data that I have provided in the questionnaire, for purposes of writing the researcher's report on the research that was carried out.

Furthermore I also state that it is my understanding that

- I may, at any time, discontinue my involvement in this research or withdraw my consent to partake in this research;

- the information that I have provided until such time as I withdraw my participation in this research can, however, still be used by the researcher;

- the researcher will, at all times, maintain strict confidentiality and that the identity of the participant will never be linked to the information provided;

- I will not receive any financial reward or payment for the information herewith provided or for my involvement in this project;

- I have the option to refuse to answer any question(s) should I feel that this/these question(s) constitute a violation of my own privacy;

- when signing this consent form to partake in the research I undertake to answer in an honest manner to all reasonable questions and not to provide any false information or in any other way purposely mislead the researcher

- I will be provided with a signed original copy of this consent form

I herewith declare that the researcher

- has explained to me the objective of this research
- has informed and explained to me the content of this consent to partake in the research
- has elucidated me on the implications of signing this consent to partake in the research

By co-signing this consent to partake in the research, the researcher undertakes to

- maintain confidential and private the identity of the participant and the information provided in the research
- organized, beforehand, an appropriate venue and time for me to partake in this project
- to keep in a safe place the duplicate of this consent to partake in the research

Signed in ....., on .... 2006.

.....	.....
PARTICIPANT'S Signature	RESEARCHER'S Signature

1	2	3

QUESTIONNAIRE FOR ASSESSING THE CULTURAL INFLUENCES IN ACCESSING MODERN HEALTH CARE IN ANGOLA

1. THE OBJECTIVE IS

To identify the cultural influences which prevent people from accessing modern health care.

2. UNDERTAKING

All information provided will be treated in confidence. You are not required to provide your name on the questionnaire.

3. INSTRUCTIONS

3.1 Please answer all the questions.
3.2 Complete questions by providing an x in the appropriate box or by providing the information requested.
3.3 Please complete the questions as honestly, frankly and objectively as possible.
3.4 Please answer the questions as they apply to your personally.
3.5 Please return the questionnaire by ……(Mr Nunes insert the date according to your plans and then delete this comment)

SECTION A: BIOGRAPHICAL INFORMATION

Please answer the questions by placing an x in the appropriate answer box.

1. Please indicate the age group to which you belong.

For office use

AGE IN YEARS		ANSWER
1.1	18 - 23	1
1.2	24 - 29	2
1.3	30 - 34	3
1.4	35 - 39	4
1.5	40 - 44	5
1.6	45 - 49	6
1.7	50 years or older	7

	4

2. Indicate your gender

GENDER		ANSWER
2.1	Male	1
2.2	Female	2

	5

3. Indicate the level of academic education you are currently busy with or have successfully completed.

LEVEL OF EDUCATION		ANSWER
3.1	None	1
3.2	Basic	2
3.3	Middle	3
3.4	Higher	4

	6

4. Please indicate your province of origin, in other words where you were born.

PROVINCE OF ORIGIN		ANSWER
4.1	Bengo	1
4.2	Benguela	2
4.3	Bié	3
4.4	Cabinda	4
4.5	Cunene	5
4.6	Huambo	6
4.7	Huila	7
4.8	Kuando Kubango	8
4.9	Kwanza Norte	9
4.10	Kwaza Sul	10
4.11	Luanda	11
4.12	Lunda Norte	12
4.13	Lunda Sul	13
4.14	Malange	14

4.15	Moxico	15		
4.16	Namibe	16		
4.17	Uíge	17		
4.18	Zaíre	18		7

SECTION B: THE MEANING OF CULTURE

Indicate with an **x** the statements you feel are relevant

5. What is *culture*?

MEANING OF CULTURE	Yes	No		
5.1 Culture is what we learn from our families	1	2		8
5.2 Culture teaches the habits of the community	1	2		9
5.3 Culture is something which affects how we behave	1	2		10
5.4 Culture is a return to the past	1	2		11
5.5 Culture is academic education	1	2		12
5.6 Culture is wisdom	1	2		13
5.7 Other; please specify …………………………………………......…………...... ……………………………………………………………….. ………………………………………………………………..	1	2		14

6. What *effect* does culture have in your life?

EFFECT OF CULTURE	Yes	No		
6.1 Culture positively influences my behaviour	1	2		15
6.2 Culture negatively influences my behaviour	1	2		16
6.3 Culture makes me superstitious	1	2		17
6.4 Culture makes me knowledgeable	1	2		18
6.5 Culture creates contradictions between various generations	1	2		19
6.6 Culture affects my system of values	1	2		20
6.7 Other; please specify …………………………………………......…………...... …………………………………………......…………...... …………………………………………......…………......	1	2		21

7. What is your view regarding traditionalism versus modernism?

TRADITIONALISM VERSUS MODERNISM?		Yes	No		
7.1	One must abandon tradition	1	2		22
7.2	One must avoid what is modern	1	2		23
7.3	One must be familiar with both traditionalism and modernism	1	2		24

8. Justify your answer provided in question 7:

_____
_____
_____
_____

SECTION C: HEALTH CARE

9. According to your view, please indicate which of the following factors/persons may cause diseases or illness:

CAUSE OF DISEASES		Yes	No		
9.1	Microbes (germs)	1	2		25
9.2	Extreme temperatures	1	2		26
9.3	Injuries	1	2		27
9.4	Bad spirits	1	2		28
9.5	Witch doctors (‘Quimbandeiros’)	1	2		29
9.6	Extreme hunger	1	2		30
9.7	Being cursed	1	2		31
9.8	Trespassing on sacred ground	1	2		32
9.9	Herbal doctors (‘Curandeiros’)	1	2		33
9.10	Taking extracts made from animal or human tissue	1	2		34
9.11	Other; please specify …….....……..... …….....……..... …….....…….....	1	2		35

10. Do you believe pathogenic agents (microbes/germs) exist?

PATHOGENIC AGENTS (GERMS) EXIST?		ANSWER		
10.1	Yes	1		
10.2	No	2		36

11. If your answer was YES in question 10, then please list five diseases which you believe are caused by pathogenic agents

_____
_____
_____
_____
_____

12. Do you believe witch doctors can cause diseases or illnesses?

WITCH DOCTORS CAUSE ILLNESSES ?	**ANSWER**		
12.1 Yes	**1**		
12.2 No	**2**		37

13. If your answer was YES in question 12 then please list five diseases/illnesses which you believe can be caused by witch doctors.

_____
_____
_____
_____
_____

14. Do you believe witch doctors can cause social or family problems?

WITCH DOCTORS CAUSE SOCIAL OR FAMILY PROBLEMS ?	**ANSWER**		
14.1 Yes	**1**		
14.2 No	**2**		38

15. If your answer was YES in question 14 then please list five diseases/illnesses which you believe can be caused by witch doctors.

_____
_____
_____
_____
_____

16. In your opinion are there any advantages in using witchdoctors?

ADVANTAGES IN USING WITCHDOCTORS ?	**ANSWER**		
16.1 Yes	1		
16.2 No	2		39

17. If your answer was YES in question 16 then please list five advantages in using witch doctors.

_____
_____
_____
_____
_____

18. If you require health assistance, what would your preference be with regard to the following services. Please select from the following scale, an option for <u>each</u> of the services.

1 = Will never use
2 = Will use only if nothing else is available
3 = Willing to use
4 = Prefer to use

TYPE OF HEALTH CARE	**ANSWER**					
	1	**2**	**3**	**4**		
18.1 Private clinic	1	2	3	4		40
18.2 Government Hospital	1	2	3	4		41
18.3 Herbal doctor ('Curandeiro')	1	2	3	4		42
18.4 Witch doctor ('Quimbandeiro')	1	2	3	4		43
18.5 Headman ('Soba')	1	2	3	4		44
18.6 Mobile clinic	1	2	3	4		45
18.7 Visiting health care worker	1	2	3	4		46
18.8 Other; please specify …..…… …..…… …..…… ….…….	1	2	3	4		47

19. Are you able to freely decide which type of health care you would like to use when you or your family members are unwell?

FREE CHOICE TO ACCESS HEALTH CARE OF YOUR CHOICE?	**ANSWER**		
19.1 Yes, it is entirely my own decision	1		
19.2 Yes, in consultation with other family members	2		
19.3 No, I have no say in the matter	3		48

20. If your answer to question 19 was NO, could you please explain why it's not possible

_____
_____
_____
_____

21. What will it cost you to obtain treatment at the following health services? Please select one of the following options for <u>each</u> service:

1 = Free
2 = Cheap
3 = Expensive
4 = Not affordable

TYPE OF HEALTH CARE	ANSWER					
	1	**2**	**3**	**4**		
21.1 Private clinic	1	2	3	4		49
21.2 Government Hospital	1	2	3	4		50
21.3 Herbal doctor ('Curandeiro')	1	2	3	4		51
21.4 Witch doctor ('Quimbandeiro')	1	2	3	4		52
21.5 Headman ('Soba')	1	2	3	4		53
21.6 Mobile clinic	1	2	3	4		54
21.7 Visiting health care worker	1	2	3	4		55
21.8 Other; please specify ..…… …..…… …..…… ….…….	1	2	3	4		56

22. Where would you go for treatment of the following complaints? Please select an option from the following scale for <u>each</u> of the complaints:

1 = Government Hospital
2 = Private Clinic
3 = Witch doctor ('Quimbandeiro')
4 = Herbal Doctor ('Curandeiro')
5 = Self medication

TYPE OF HEALTH CARE	ANSWER						
	1	**2**	**3**	**4**	**5**		
22.1 Headache	1	2	3	4	5		57
22.2 Malaria	1	2	3	4	5		58
22.3 Diarrhoea	1	2	3	4	5		59

22.4	Tuberculosis	1	2	3	4	5			60
22.5	Influenza	1	2	3	4	5			61
22.6	HIV	1	2	3	4	5			62
227	Stomach ache	1	2	3	4	5			63
22.8	Nightmares	1	2	3	4	5			64

Thank you very much for your time and effort in answering this questionnaire.