PEOPLE'S BELIEFS ABOUT CAUSATION OF DISEASE AND IMPLICATIONS FOR CHOICE OF HEALTH CARE IN LUSAKA

BY

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DECLARATION

I, Violet Makala Nanchengwa, solemnly declare that this dissertation has not previously been submitted for a degree in this or any other University.

Signed ..Nanchengwa.....

Date ...24th July, 1984.....

APPROVAL

THIS DISSERTATION OF VIOLET MAKALA NANCHENGWA IS APPROVED AS FULFILLING PART OF THE REQUIREMENTS FOR THE AWARD OF MASTER OF ARTS IN SOCIOLOGY.

EXAMINERS

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ABSTRACT

The prime concern of this paper is threefold; to investigate people's beliefs about causation of disease and illness; to examine the extent to which beliefs about causation are affected by socio-demographic characteristics such as age, educational status and occupational status of respondents; and the extent to which beliefs about causation affect utilisation of health care services.

This study found that people distinguish three main causes of disease - natural, supernatural and both natural and supernatural causes. The study also found that beliefs about causation are affected by the respondent's age, educational status and occupational status.

Finally, the study found that beliefs about causation do not affect where people go for health care. People irrespective of beliefs about causation use modern health services.

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CHAPTER I

1. INTRODUCTION

The prime concern of this paper was to find out people's beliefs about causation of disease and illness in Lusaka urban and the extent to which beliefs about disease and illness causation affect the type of medical service sought for treatment.

In this paper the concepts of disease and illness are used interchangeably. Sociologically however, the concepts of disease and illness have different, but interrelated meanings. Coe (1978) and Tuckett (1976) say that disease is usually seen as an objective phenomenon characterised by altered functioning (in the form of signs and symptoms) of the body as a biological organism. Illness on the other hand is a subjective phenomenon in which individuals perceive themselves as not feeling well and therefore tend to modify their normal behaviour. In this study, illness and disease notions mean any behaviour, subjective or objective, that leads a person to seek medical care.

1.1 Theoretical Background

The general theoretical framework of this study is that of the modernisation approach. According to Wilbert Moore (1963), the concept of modernisation denotes:-

> "a total transformation of a traditional or pre-modern society into types of technology and associated social organisations that characterises the advanced economically prosperous and relatively stable nations of the Western world."

In this study, modernisation refers to change from traditional values and beliefs to those associated with a modern society. This study uses the modernisation approach to see how modernisation factors such as education have changed people's traditional beliefs about causation of disease and how this has affected the type of medical services that are used.

Before colonialism there was only one medical institution - the traditional one. Traditional medicine held monopoly in health care and health delivery. With the coming of colonialism, traditional medicine was challenged and held by forces of social change. Modern medicine or what is now called cosmopolitan or biomedical system of health care was introduced. In addition to the introduction of modern health services, a campaign was instituted by colonial administrators to discredit the work of traditional healers. They were called many names such as witch-doctors, fetish priests/priestesses, healers and so on. Their proper name, ng'angas, translated to mean doctors, was not used during the colonial period. Kaplan (1979) says that because of the colonial experience, most healers went underground, that is, to rural and outlying areas of the country to practice their medicine.

Though there was no definite legislative instrument which made the practice of traditional medicine illegal during the colonial period, a

stigma was attached to traditional medicine as a result of the campaign. Christians, school-goers, the literate population and urban dwellers were placed in an ambiguous situation. It was required of them to patronise modern medicine. Workers in the mines and other modern employment were required to produce medical certificates whenever they reported for work after sick leave. It was required of them to use facilities of modern medicine.

Inspite of this unfavourable campaign, the introduction of modern medicine has not succeeded to eradicate traditional medicine. In contemporary Zambia, like in most African societies, the two medical systems - traditional and modern - exist side by side. This aspect is supported by Janzen (1978) who says that all medical systems in the world today, with the exception of a few small and very isolated societies, are pluralistic. In other words at any given time there is the existence of more than one medical system. Zambia, like many Third World countries, is not able to offer adequate modern health services to all its people especially those in very remote rural areas. People in these areas have no choice, but to use the available medical services; that offered by traditional healers. The question of adequacy of modern health services also applies to urban areas. For example in Lusaka where there is a wide range of modern health facilities such as a large national teaching hospital, a system of citywide government sponsored clinics and a relatively large number of private physicians, there is a proliferation of traditional healers. This implies that even though there is a wide range of modern health facilities, these are not

able to adequately cater for the ever increasing population of Lusaka.

Some people in their attempt to cope with their health problems seek the services of traditional healers, others seek the services of modern doctors and yet others commute between the two medical systems. The choice of which service to use at a given time may not be random because all human behaviour has a cause. A recurring question which confronts health administrators in this regard is, what determines the differential use of existing health services?

1.2 Specification of the Problem and Rationale

The question of what determines the differential use of health care services is very pertinent in developing countries. Health planners in developing countries may encounter numerous problems in their attempt to implement health programmes because of people's unwillingness to accept the new programme. This may be due to people's beliefs about causation of disease. According to a folk dichotomy, the belief system separates natural from supernatural aetiology. The use of traditional or modern health care services therefore may depend on whether disease is considered to be of natural origin or of supernatural origin or of both causes.

The main incentive in undertaking this study is based on the fact that in contemporary Zambia the two medical systems - traditional and modern - exist side by side. The choice of which medical system to use at a given

time may not be random. Therefore there is need to know what determines the choice of health care. This study may assist us to understand the reason for the existence of the two systems of medical care in developing countries.

This study is important because from a theoretical viewpoint the meaning of a people's behaviour in medical matters can only be understood in the context of their total thought structure. It is also hoped that this study will help health planners understand the existing relationship between modern medicine and traditional medicine. Once this is done, planners will be able to design appropriate programmes to communicate needed educational information either to reinforce favourable attitudes or to modify unhealthy practices. In the long run this will help all workers in the health care delivery system. Hospitals, clinics, doctors, nurses and welfare officers do not carry on their work in a vacuum. They have to rely to an extent upon a background of knowledge of people's conceptions about disease and its causation. This is because practitioners of medicine, be it modern practice or traditional, find it helpful when the patient shares enough of his/her beliefs and attitudes to make a logical explanation of disease. Likewise, they find it frustrating when a patient cannot understand or accept their explanations or orders because they are found to be inconsistent with his/her beliefs or attitudes. This will be the practical contribution of this study.

It is also hoped that this study will help in the attempt to integrate traditional healers and modern doctors or to bring about collaboration between the two systems. The way this study can help in collaboration

of the two systems is by determining which cases should be referred to whom depending on the patient's beliefs about causation of disease.

Many studies of this nature have been carried out in different parts of the world. However, most of them have been carried out in rural areas. This study was conducted in an urban area and the main reason for this was to find out if social change (modernisation) has had any effect on the traditional thought patterns of people. Since such a study has not been done from a sociological viewpoint in urban Zambia, this study will contribute to theoretical knowledge on the subject.

The question that arises from the problem is how far people's beliefs about disease and illness causation affect patterns of health care utilisation.

1.3 Review of Literature

As said earlier, most studies on beliefs about causation of disease and implications for choice of health care have been undertaken in rural areas. These studies, such as those done by Twumasi (1977), Nukunya, Twumasi and Addo (1976), have found that there is a folk dichotomy in African belief system. These and other studies by Erasmus (1959), Colson (1971), Maclean (1979), Frankenberg and Leeson (1976), have observed that illnesses thought to be due to natural agents tend to be presented for treatment to practitioners of modern medicine whereas illnesses thought to be due to supernatural agents tend to be dealt with

by traditional healers.

Other early studies such as those by Evans-Pritchard (1937) did not recognise the natural/supernatural dichotomy. The studies of Evans-Pritchard observed that the Azande attribute sickness whatever its nature to witchcraft and sorcery. Following the lead by Evans-Pritchard, Field (1960) also pointed out that according to African dogma sickness and health are ultimately of supernatural origin. However, recent studies in Africa like those by Warren (1974), Twumasi (1972), Nukunya (1975) and Maclean (1966) have found that these assertions by Evans-Pritchard are too sweeping because they do not consider the fine distinctions that the people make between different diseases. These studies have shown that Africans do not believe that all sickness is supernaturally caused. For example Gillies (1971) in his study of the Ogori of Nigeria found that among the Ogori, certain diseases such as malaria are accepted as normal order. The Ogori also perceive some events as supernaturally caused such as the death of a young adult. They also regard some diseases as serious and mysterious in origin but curable. Each of these evokes different illness behaviour.

In another study, Fabrega (1971) found that the Zinacanteco Indians of Mexico see some diseases as serious whereas others are said to be of minor consequences. Some affect adults only, others children as well; some have a known remedy, others do not; some illnesses are believed to be cured by traditional healers whereas others do not require his services and may require visiting other types of practitioners.

Gould (1960) in his study of rural India saw a relationship between the type of illness and the type of medical referral. He argued that the type of illness determined the choice between modern and traditional medicine. He came to this conclusion after noting that traditional medicine was employed whenever the person's complaints were classifiable as chronic non-incapacitating dysfunctions while modern doctors were sought for complaints classifiable as critical incapacitating dysfuctions. According to Gould, chronic non-incapacitating dysfunctions are:-

> "conditions manifesting drawn out periods of suffering, sometimes cyclical in character, usually not fatal (or fatal to some degree), and partially debilitating (enabling the sufferer to maintain a semblance of his daily routine). An example of this is arthritis."

Critical incapacitating dysfunctions on the other hand are:-

> "ailments having the opposite symptoms; that is, maladies involving sudden and often violent onset, and complete debilitation with reference to some aspects of the individual's routine. A good example is acute appendicitis."

Explanations of why people select the therapists they do in areas where modern medicine is available but traditional medicine is still heavily utilised constitutes an important part of the literature of medical anthropology. The major reasons that scholars such as Clark (1959), Simmons (1955), Foster (1958) and Goodenough (1963) have cited for the dependency on traditional healers for treatment of certain illnesses in such situations are traditional beliefs concerning the nature, aetiologies and appropriate treatment of diseases. These studies have been complemented by other studies. For example, Marriot McKim (1955) in his study of a North Indian village asserted that the patronage of traditional

medicine surpasses that of modern medicine. Similarly, Oscar Lewis (1965) struck the same note when he observed the concept of disease and cure in an Indian village near Delhi. He made a general conclusion that these people prefer to use indigenous remedies. Fonaroff and Fonaroff (1966) also pointed out that even where modern health facilities are available, people do not always use them due to persistent cultural beliefs about disease causation and treatment. Neumann and associates (1971) on the basis of the Johns Hopkins Rural Health Research Functional Analysis study pointed out that the government health services in India are utilised by only 10 to 20 percent of the rural people. Other studies such as that by Simmons (1966) have complemented Neumann and associates' study and have attributed the acceptance of modern medicine to its therapeutic achievements. These studies have noted that modern medicine is utilised on the basis of its perceived accomplishments even if people still retain their traditional beliefs concerning the cause of disease.

Although the literature cited above is of studies that have been carried out in rural areas, there are a few that have been carried out in urban areas. One such study was carried out by Madan (1969) in an urban setting in India. He found that the expectancy of cure rather than the system of medicine seems implicit in the expressed preferences of health care. For example when patients want quick cure in the acute stages of their sickness, they seek the services of modern medicine. On the other hand patients turn to traditional medicine when cure of their illness is slow such as in chronic diseases. Therefore in some cases the same illness

is referred at differnt stages and sometimes simultaneously to several types of practitioners such as modern doctors in hospitals, clinics and private doctor's surgeries and others to traditional healers, that is diviners, diviner therapeutists and therapeutists otherwise known as herbalists. This aspect of illness behaviour has been examined by several scholars. Chavunduka (1978) in his study of traditional healers and the Shona patient in Zimbabwe struck the same note. Similarly, Frankenberg and Leeson (1976) in their study of the practice of traditional healers in Lusaka found a polarisation in the usage of modern and traditional doctors (ng'angas). They found that people sought the services of modern doctors for acute illnesses with physiological aetiologies whereas ng'angas were sought for misfortunes with social aetiologies. Survivors also consulted ng'angas for chronic illnesses. Many other scholars, for example Erasmus (1959), McKim (1955), Simmons (1959), Gould (1957), Straus (1961), Gonzalez (1966) and Maclean (1966) agree that it is rare in many societies to find an individual who relies entirely on modern medicine alone particularly in times of serious illness inspite of the respect with which medical science is held.

Although these examples about causation of disease and implications for choice of health care are by no means exhaustive, they show convincingly that beliefs about causation of disease differ between one traditional society and another. Beliefs may also differ within one traditional society. This indicates that each system must be studied in detail if health planners are to benefit from such endevours. In-depth studies will enable us to avoid making such sweeping statements that were

characteristic of some early studies. This study is an effort towards this direction.

The difference of this study from other studies of a similar nature is that it will try to see what leads to differences in beliefs about causation of diseases within one society. While several studies, some of which have been reviewed above have amply documented cross-cultural variations in beliefs about causation of disease, much less is known about such differences in a single society. Even though knowledge about disease can be said to be generally shared within a society, it is possible that if careful attention is paid to the way people look at diseases, differences will be found within the society. In this regard an attempt will be made to relate socio-demographic characteristics of respondents to beliefs about causation of disease. To this end three socio-demographic categories, namely, age, educational status and occupation will be examined in terms of their influences on perceptions of disease causation.

1.4 Objectives and Hypotheses

The objectives of this study were:-

i) To find out people's beliefs about causation of illness and disease in Lusaka urban.

ii) To determine the reasons for choice of health care in Lusaka urban.

iii) To find out if beliefs about disease and illness are affected

by socio-demographic factors such as age, educational status and occupation.

In order to obtain information in relation to these objectives, the following hypotheses were formulated for testing:-

a) People's beliefs about causation of disease and illness are influenced by their age.

   i) Young people have a more scientific attitude towards illness than older people which leads them to believe that illnesses are naturally caused.

   ii) Older people believe that illnesses and diseases are supernaturally caused.

b) People's beliefs about causation of disease and illness are affected by their educational status.

   i) The higher the education the more the inclination towards scientific beliefs.

   ii) The lower the educational status the more the inclination to seek traditional medicine.

c) People's beliefs about causation of illness and disease and utilisation are influenced by their occupation.

   i) People in skilled jobs believe that diseases are naturally caused.

   ii) Those in unskilled jobs such as labourers believe that diseases are supernaturally caused.

d) People refer diseases which they believe to be naturally caused to modern doctors and those they believe to be supernaturally caused

to traditional healers.

1.5 Definition of Concepts

Social change is defined as a significant alteration of the social structure in terms of affecting views, beliefs and normative behaviour of people. The factors of change relevant in this study are education and occupation.

Modernisation refers to change from traditional values, beliefs and behaviour patterns to those associated with a modern or 'advanced' society.

Natural diseases are diseases which are deemed to be caused by natural, empirically based, biological or mechanical agents.

Supernatural diseases are diseases deemed to be caused by spiritual agencies, spirits, ancestor or as a result of disordered social living.

Educational status means the highest level of formal education completed.

Occupation is the job that one does in a formal establishment such as skilled or unskilled work.

Skilled employee is one who has a certificate in a job.

Unskilled employee refers to manual workers or labourers with no formal certificate in their job.

1.6 Methodology

This was a survey research design aimed at finding out people's beliefs about causation of disease and the implications it has for choice of

health care in Lusaka. The data was obtained by structured questionnaires (see appendix) and formal interviews. Other information such as background literature was obtained from library research.

1.6.1 The Field Setting

The data used in this study were collected from a sample population of three Lusaka based organisations, namely, Small Scale Industries Development Organisation, Ministry of Commerce and Industry, and the University of Zambia. Since the investigator was interested in finding out if modernisation factors such as education and occupation affect people's conception of disease and illness, it was felt that the chosen working places should have different categories of employees. In this regard, the places of work were chosen on the basis of having people with different levels of education and different occupational categories such as skilled and unskilled workers. Also, the investigator knew some people at the places of work where the data were collected who introduced her to the relevant authorities. The authorities in turn introduced the researcher to the employees. Formal introduction made respondents more cooperative with the researcher.

The social structure of the three companies will be briefly described in order to provide a background from which to view some of the social characteristics of the respondents and the setting within which people's perceptions of disease and where they go for health care can be understood.

The three organisations are all based in Lusaka which is the capital city of Zambia with a population of 538,469 (Census data, 1981). Two of the organisations, the Small Scale Industries Development Organisation and the Ministry of Commerce, are situated along Cairo Road, the main road in the city. Most shops in the city are situated along this road. The University of Zambia is situated a few kilometres east of the town centre.

The Small Scale Industries Development Organisation, as the name implies, is an organisation which encourages the development of small scale industries in Zambia. This organisation has only been in existence for a few years and employs a little less than fifty people. About two thirds of the employees are University graduates. The rest of the employees consist of secretaries, typists, clerks, office orderlies and cleaners. The Ministry of Commerce also employs a good number of graduates. However most of the employees have at least secondary school education and are scattered in a wide range of jobs such as typists, secretaries, clerks, office orderlies and cleaners. The University of Zambia, apart from being the highest institution of learning, employs a large number of people with various occupations and educational standards. These include academic staff (who are not included in this study), those in administrative jobs, typists, secretaries, clerks, cleaners, cooks and general workers.

All the respondents in this study have had some form of formal education and all of them live in the city where they have been introduced to new ideas and institutions such as formal education, new economic, religious,

medical and other institutional arrangements. The extent to which these have affected people's traditional beliefs about disease will be examined in this paper.

1.6.2 Sampling Procedure

To get a representative sample of all the workers in the companies, a weighted stratified random sample was drawn. The sample from each company was influenced by the number of employees in each company. Information such as the strength of labour force in each occupational group and other background information of respondents was obtained from management.

Respondents were grouped in occupational categories such as unskilled workers and skilled workers. Variation in educational status was achieved by grouping employees in different occupational categories because, usually, one's occupation is determined by the educational status. The different occupational categories were further sub-divided into age-groups, namely, 20 years or under, 21 to 30 years, 31 to 40 years, 41 to 50 years and over 51 years. Dividing respondents according to their age-group was necessary so that variation in age could be achieved. This was important for testing of the hypothesis that a person's beliefs about causation of disease is influenced by age. Finally, employees in the different categories were grouped according to their sex. The sample was proportionate to the number in each category. After the proportions of each category were determined, any

person from each category was chosen until the required number of people in that category was achieved. For example, if two unskilled female respondents between the age of 21 and 30 years were required, any two females in that age-group were chosen to fill in the questionnaire.

1.6.3 Data Analysis

Responses to all questions were coded and fed into the computer for analysis. In the analysis, frequency tables and cross-tabulations were used. To find the relationship between beliefs about causation of disease and choice of health care in Lusaka, a chi-square test was used to see whether or not the relationship was significant. The relevant variables in the analysis were the social characteristics of respondents, namely, age, education and occupation.

1.7 Problems Encountered in Obtaining Data

During the collection of data there were a few problems encountered. One of the major problems encountered was the poor response from respondents. Most respondents complained that they were too busy to answer the questionnaire. The researcher gave them a few days in which to fill it in and the names of people to whom the questionnaire was given were noted so that each questionnaire would be traced. When the researcher returned to collect the questionnaires after the agreed number of days, it was found that about one quarter of the respondents had misplaced them. This happened in all the three companies. Some of

those who still had them had not completed them and it was difficult to persuade them to do so. To deal with this problem the researcher had to ask someone in the management to distribute and collect the questionnaires. In this way respondents felt that it was part of their work and therefore had no choice but to complete it.

Apart from complaining that they were too busy, some respondents expressed the sentiment that they were fed up with answering questionnaires whose results they never saw. Most people in Lusaka, being the capital city, have been exposed to many researches in which they have been respondents and some can not stand the sight of a questionnaire. Some respondents wanted to know how the study would contribute to their welfare. Many people seemed to resent investigators who collect data strictly for theoretical purposes without an intrinsic practical interest in either the culture or the welfare of the people. The researcher had to patiently explain to them what the study hoped to achieve. The researcher tried to gain their confidence by making every effort to show them that she was genuinely interested in their health problems. The researcher respected the views of the informants and tried to be as helpful as possible and was always careful to observe Zambian social protocol.

Another problem which the researcher encountered was with respondents who could not read or understand English well. Such respondents had to be interviewed in a language they could understand and their answers to questions filled in by the investigator. The problem was that the researcher can only speak two of the major Zambian languages - Tonga and

Nyanja. Fortunately, most people in Lusaka can understand Nyanja and so the researcher was able to interpret the questions. However, there were respondents who claimed that they did not understand either of the two languages. When this was the case, the researcher had to find somebody who spoke the respondent's language to interpret. Sometimes, an interpreter could not be found and when this was the case an alternative respondent who spoke at least one of these two languages - Nyanja or Tonga - in the same category was selected.

Finally, some respondents were not willing to answer some questions such as what they were suffering from when they last sought medical care. Some respondents felt that this was too personal and that the researcher would know who had filled in the questionnaire. The researcher tried to convince respondents that she was going to have between 100 and 150 questionnaires and since names were not indicated it was almost impossible for her to know who had filled in which questionnaire. After this explanation respondents seemed convinced that the questionnaires were anonymous, but it is possible that some people did not believe and this may have affected their response.

Apart from the above mentioned problems, others were minor such as not finding the respondents in the offices when going to collect the questionnaires. However, the researcher had to be patient and kept on checking until she finally found them. By this painstaking method a total of 136 completed questionnaires were retrieved. The responses were transferred onto data cards and eventually fed into the computer for analysis.

CHAPTER II

2. SOCIAL CHARACTERISTICS OF RESPONDENTS

Before dealing with people's beliefs about disease causation in detail, questions relating to socio-demographic characteristics of respondents were analysed. It was felt that socio-demographic characteristics were important because they may lead to different beliefs about disease. For example, it is likely that people brought up in rural areas will have different beliefs from those brought up in urban areas. Similarly, the young may have different beliefs from the old, and so on. To this end, seven socio-demographic characteristics, namely, sex, age, educational status, marital status, religion, occupation and environments within which respondents were brought up were analysed.

2.1 Sex

The first socio-demographic characteristic to be analysed was the sex of respondents. Table 2.1 below shows the absolute frequencies and the percentage of males to the total sample population.

Table 2.1 Sex of the Sample Population

	Absolutes	%
Males	79	58.1
Females	57	41.9
Total	136	100.0

Table 2.1 above shows that the majority of respondents in the sample population were males. They constituted 58.1 percent of the total sample population while females constituted 41.9 percent. This finding is more or less a reflection of the employment statistics in Zambia. According to the International Labour Organisation, South African Team for Employment Promotion (Sunday Times of Zambia, March 11 1984), there are slightly more males than females in wage employment.

2.2 Age

The second socio-demographic characteristic that was analysed was the age of respondents. A pre-test showed that most respondents were very secretive about their age. It was therefore felt that in the actual study age-groups should be used so that respondents did not have to indicate their actual age, but just circle or tick the code corresponding to their age-group. Table 2.2 below shows the distribution of the respondent's age-groups.

Table 2.2 Age-groups of the Sample Population

	Absolutes	%
20 years or under	6	4.4
21 - 30 years	52	38.2
31 - 40 years	57	41.9
41 - 50 years	19	14.0
Over 51	2	1.5
Total	136	100.0

The above Table shows that the majority of respondents were between 31 and 40 years old and constituted 41.9 percent of all the respondents. These were followed by those between 21 and 30 years who constituted 38.2 percent of the sample population. The next group in the hierarchy were the 41 to 50 year olds followed by the 20 year olds or under. The group with the least people was the over 51 years. One can safely say that this sample is representative because one expects the majority of people in wage employment to be between the ages of 21 and 50 years. One does not expect many 20 year olds or younger to be in wage employment because this is the age when most of them are pursuing their education. Those who have dropped out of school are very unlikely to be employed because the job market does not favour them. This finding concurs with the findings of the President's Citizenship College in a recent labour survey (Sunday Times of Zambia, March 11 1984). This

survey found that the age-group between 15 and 24 while accounting for 30 percent of labour force suffered 62 percent of the total unemployment. According to this survey, the higher the level of education attained by an individual the lower the incidence of unemployment and the shorter the duration of unemployment.

The President's Citizenship College's study also showed that failure to complete one's studies is seriously punished on the job market. The bulk of the unemployed were young persons with incomplete primary education followed by those with incomplete secondary education and those who have completed primary school in that order.

Similarly, one does not expect to find many people who are over 51 still working because this is the age when most people retire.

2.3 Education

Educational status of respondents was the third socio-demographic characteristic to be analysed. The educational status was divided into five categories, namely, illiterates, those with primary, secondary, University and College education. Though respondents were required to state the highest level completed, most of them did not and only indicated the group in which their educational level was. Table 2.3 below shows the educational status of respondents.

Table 2.3 Educational Status of the Sample Population

	Absolutes	%
Illiterates	0	0.0
Primary	18	13.2
Secondary	67	49.3
University	26	19.1
College	25	18.4
Total	136	100.0

The above Table shows that almost one-half of the people in the sample (49.3 percent) had secondary school education. The reason why most people in this study had at least secondary school education may be because most jobs offered in the organisations where the study was undertaken are white collar jobs and require at least form 5 level of education. Those with primary education were employed as manual workers, office orderlies or claners. Table 2.3 also shows that there were no illiterates in the sample population. The obvious reason for this is because the study was carried out at working places and almost all the jobs require some form of formal education. It is for this reason that one is unlikely to find illiterates in wage employment, even among manual workers.

2.4 Marital Status

The marital status of respondents was also examined. This was divided into five categories, namely, single, married, separated, divorced or widowed. Table 2.4 below shows the absolute frequencies and percentages of the categories to the whole sample population.

Table 2.4 Marital Status of Sample Population

	Absolutes	%
Single	39	28.7
Married	91	66.9
Separated	1	0.7
Divorced	4	2.9
Widowed	1	0.7
Total	136	100.0

The above table shows that the majority of respondents were married (66.9 percent). Twenty-eight per cent of the respondents were single while only 2.9 percent were divorced. The separated and widowed categories had one person each. The reason why the majority of respondents were married may be due to the fact that in Zambian culture everybody is expected to get married at one time or the other. If one has never been married, the society looks down on one.

2.5 Religion

The fifth socio-demographic characteristic to be considered was the religious affiliation of respondents. Only four religious groups, namely, Catholic, Anglican, Methodist and Baptist were put as possible choices. The reason for giving just four choices was due to the fact that there are too many religious groups in Zambia and therefore it was not possible to put all of them as possible choices. However, respondents whose religious groups were not among the four choices were given a chance to specify their religious groups under the 'others' category. Table 2.5 below shows the distribution of religious groups of respondents.

Table 2.5 Religious Affiliation of Respondents

	Absolutes	%
Catholic	48	35.3
Anglican	8	5.9
Methodist	7	5.1
Baptist	5	3.7
Others	57	41.9
None	11	8.1
Total	136	100.0

Table 2.5 shows that most of the respondents belonged to the 'others' category. This category however had a total of 12 religious groups which means that the 57 respondents were distributed among these.

The majority of respondents in the'others' category belonged to the Reformed Church of Zambia and the United Church of Zambia which both had 13 respondents each. These were followed by the Seventh Day Adventist which had 12 people. The rest were distributed among Pentecostal, Watchtower, Salvation Army, Apostolic Faith, Brethren in Christ, Hindu, Presbyterian and Church of Christ.

Table 2.5 also shows that many of the respondents belonged to the Catholic church which had 48 respondents. Again, the sample can be said to be representative of the whole population because the Catholic church is one of the oldest religious groups in Zambia and enjoys a very large following. Eleven people in the sample population said they did not belong to any church because they did not believe in Christianity.

2.6 Occupation

The sixth socio-demographic characteristic to be considered was the occupational status of respondents. Table 2.6 below shows the distribution of occupational statusses of respondents.

Table 2.6 Occupational Characteristics of Respondents

	Absolutes	%
Unskilled	41	30.1
Skilled	86	63.2
Managerial	8	5.9
Others	1	0.7
Total	136	100.0

Table 2.6 shows that the majority of the respondents were skilled workers. They constituted 63.2 percent of the sample population. The definition of a skilled worker in this study was one who has a certificate in his or her job. The second largest category of workers were the unskilled workers (30.1 percent). These included manual workers, cleaners and clerks who had no formal certificate in their job. Eight people were in managerial positions and only one person was in the 'others' category. This respondent said he was a professional and according to our operational definition, he fell in the category of a skilled worker.

2.7 Residential Pattern

The last socio-demographic characteristic of respondents that was examined was environments within which they were brought up. Table 2.7 below shows this.

Table 2.7 Residential Patterns of Respondents

	Absolutes	%
Rural area	78	57.4
Urban area	58	42.6
Total	136	100.0

The above table shows that the majority of respondents were brought up in rural areas. Again, this finding concurs with the general population statistics in Zambia which show that the majority of people live in rural areas. According to the 1980 Census Statistics, 43 percent of Zambia's population live in urban areas while 57 percent live in rural areas. The number of people living in urban areas is increasing at a very rapid pace because people from rural areas are coming into towns to seek greener pastures.

2.8 Summary

To sum up this chapter, one can say that information on social characteristics of respondents was important because it would provide a setting within which beliefs about causation of disease and choice of health care would be understood and interpreted.

CHAPTER III

3. BELIEFS ABOUT CAUSATION OF DISEASE AND CHOICE OF HEALTH CARE

After examining the socio-demographic characteristics of respondents specific questions about their conception of illness and disease, their beliefs about causation and choice of health care were analysed. Respondents were given a choice of answers for each question. Since there was a possibility of more than one answer for each question, respondents were required to say 'yes' to all the answers they agreed with and say 'no' to those they disagreed with.

3.1 Concept of Disease and Illness

Before dealing with respondent's beliefs about causation of disease, their definition of illness was analysed. To delineate between good health and illness, respondents' notions of good health were analysed.

On the definition of illness and disease, over 65 percent of the respondents defined it in terms of the presence of specific symptoms of physical pain. Another 80 percent defined illness and disease as generally feeling weak and unwell. Table 3.1 below shows the distribution of answers on the definition of illness and disease.

Table 3.1 Concept of Illness and Disease

What is your definition of illness/disease?

		Responses			
		No Response	Yes	No	Total
Specific symptoms of physical pain	Abs.	4	90	42	136
	%	2.9	66.2	30.9	100.0
Bad physical Condition	Abs.	4	89	43	136
	%	2.9	65.4	31.6	100.0
General weakness	Abs.	4	110	22	136
	%	2.9	80.9	16.2	100.0
Presence of a condition that kills	Abs.	8	89	39	136
	%	5.9	65.4	28.7	100.0

Table 3.1 shows that respondents in this study defined disease and illness both in objective and subjective terms.

On the notion of good health most respondents (85.3 percent) said that good health is when one is free from illness. Seventy six percent attributed good health to being physically fit. Table 3.2 below shows the distribution of answers on the notion of good health.

It will also be seen from Table 3.2 that 50.7 percent respondents said that good health obtains when one is able to perform normal duties while 39.0 percent said that good health exists when one is able to work. In both cases over 50 percent people disagreed with these notions of good health. The reason they gave for disagreeing was that one can work, or for that matter perform normal duties even when one is not feeling well.

Table 3.2 Notions of Good Health

What is your notion of good health?

		Responses			
		No Response	Yes	No	Total
Free from illness	Abs.	4	116	16	136
	%	2.9	85.3	11.8	100.0
Able to work	Abs.	2	53	81	136
	%	1.5	39.0	59.6	100.0
Able to perform normal duties	Abs.	3	69	64	136
	%	2.2	50.7	47.1	100.0
Free from worries	Abs.	3	59	74	136
	%	2.2	43.4	54.4	100.0
Feeling physically fit	Abs.	2	103	31	136
	%	1.5	75.7	22.8	100.0

Table 3.2 also shows that only 43.4 percent respondents saw good health in terms of being free from worries. The reason given by those who disagreed was that one can be free from worries but still be physically unwell. It is therefore wrong to say that when one is free from worries, one is in good health.

Only one person gave another notion of good health and he said that good health is a condition of both the body and mind. These notions of good health show that people see it in terms of both physical and mental well-being.

3.2 Cause of Illness and Disease

To find out people's beliefs about causation of disease, respondents were asked what in their opinion they thought was the cause of disease and illness. Most answers to this question were in terms of natural or empirical causation and entailed situations over which the individual had some control such as eating bad food (72.1 percent), lack of cleanliness (75.0 percent) and lack of nourishing food (75.7 percent). Other answers to this question were weak blood (44.9 percent), witchcraft (40.4 percent) and the will of God (37.5 percent). On the basis of these answers one can conclude that people in Lusaka distinguish between three main causes of disease - natural, supernatural and both natural and supernatural.

The fact that people in Lusaka distinguish between different causes of disease was re-established when respondents were asked if all diseases had the same cause. Only three people (2.2 percent) attributed all illnesses to one cause. Two of these people said that all illnesses are caused by germs while one of them said that the one cause is bad spirits. On the other hand 87.5 percent of the respondents said that there were many causes of disease and illness. Most of the causes given were in naturalistic terms such as those given in question 9 (see appendix) choices one to four, namely, eating bad food, lack of cleanliness, lack of nourishing food and weak blood. Other causes given were infections (in the form of germs, bacteria, viruses and fungi), eating contaminated food, lack of exercise, eating unbalanced food, ignorance, psychological factors such as unhappiness and poverty, accidents and promiscuous way of life. The

supernatural causes given were the same as choices 5 and 6 in question 9, (see appendix) which were witchcraft and the will of God.

In order to test the research hypotheses an attempt was made to relate socio-demographic characteristics of respondents to beliefs about disease causation. To make this possible, all answers relating to natural or empirical causation, that is, eating bad food, lack of cleanliness, lack of nourishing food and weak blood were classified as naturalistic causes of disease and illness. If respondents gave one or more of these as causes of disease they were classified as seeing the cause of disease in naturalistic terms. The grouping of these different categories was necessary if the research hypotheses were to be tested using the Statistical Package for Social Sciences.

3.2.1 Age-groups of Respondents and Beliefs about Causation

In order to test the first hypothesis, namely, people's beliefs about causation are influenced by age, the age-group of respondents was related to naturalistic beliefs about disease causation. When this was done it was found that 100 percent respondents who were 20 years old or younger believed in naturalistic causes of disease as compared to 88 percent of those who were between 21 and 50 years old. Only 50 percent of those above fifty years old believed in naturalistic causes. Table 3.3 below shows the relational analysis of the age-groups of respondents with naturalistic beliefs about disease causation.

Table 3.3 *Age-group of Respondents by Naturalistic Beliefs about Disease Causation*

What in your opinion is the cause of illness?

	Age-group (years)					
Natural causes	20 or under	21-30	31-40	41-50	Over 50	Total
No Response	0.0	0.0	1.8	0.0	50.0	1.5
Yes	100.0	88.5	89.5	89.5	50.0	89.0
No	0.0	11.5	42.1	10.5	0.0	9.6
Total %	100.0	100.0	100.0	100.0	100.0	100.0
Number	6	52	67	19	2	136
% of total responses	4.4	38.2	41.9	14.0	1.5	100.0

Chi-square = 34.65 with 8df significance = 0.0000

The above Table shows that the younger the individuals are, the more likely they are to have a scientific attitude towards illness. When the relationship between age-group and naturalistic beliefs was tested using a chi-square test, it was found to be statistically significant at .01 level of significance. This means that there is a strong relationship between the age of respondents and naturalistic beliefs about disease causation.

When the age-group of respondents was related to supernatural beliefs about disease causation the relationship was found to be statistically significant at .05 level of significance. Most people who believed that witchcraft can cause disease were between the ages of 41 and 50 years.

Table 3.4 below shows the cross-tabulation between age-group of respondents and **supernatural beliefs about causation.**

Table 3.4 Age-group of Respondents by Supernatural Beliefs about Disease Causation

Supernatural Causes	Age-group (years)					
	20 or under	21-30	31-40	41-50	Over 50	Total
No response	0.0	3.8	3.5	0.0	50.0	3.7
Yes	50.0	26.9	42.1	73.7	0.0	40.4
NO	50.0	69.2	54.4	26.3	50.0	55.9
Total %	100.0	100.0	100.0	100.0	100.0	100.0
Number	6	52	57	19	2	136
% of total responses	4.4	38.2	41.9	14.0	1.5	100.0

Chi-square = 25.83 with 8 degrees of freedom significance = 0.001

What the above results mean for our first hypothesis is that it is not rejected. A person's beliefs about causation of disease is influenced by age. Younger people have a more scientific attitude towards illness which leads them to believe that illness is naturally caused while older people believe that illness is supernaturally caused.

3.2.2 Educational Status of Respondents and Beliefs about Causation

When the educational status of respondents was related to naturalistic

beliefs about causation of disease, it was found that the relationship was not statistically significant at the .05 level of significance. Table 3.5 below shows this.

Table 3.5 Educational Status of Respondents and Beliefs about Causation

	Educational Status				
Natural Causes	Primary	Secondary	College	University	Total
No response	0.0	1.5	0.0	3.8	1.5
Yes	83.3	89.6	92.0	88.5	89.0
No	*16.7*	*9.0*	*8.0*	*7.7*	*9.6*
Total %	100.0	100.0	100.0	100.0	100.0
Number	18	67	25	26	136
% of total responses	13.2	49.3	19.1	18.4	100.0

Chi-square = 2.86 with 6 degrees of freedom significance = 0.83

The above results show that most respondents irrespective of their educational status believed in naturalistic causes of disease. Even though most respondents with different educational levels believed in naturalistic causes of disease, when belief in witchcraft was related to respondents' level of education, it was found that it was mostly people with primary school education who believed that witchcraft can cause disease (see Table 3.6 below).

Table 3.6 Educational Status by Beliefs in Supernatural Causes

Supernatural Causes	Educational Status				
	Primary	Secondary	University	College	Total
No response	0.0	4.5	3.8	4.0	3.7
Yes	83.3	35.8	26.9	36.0	40.4
No	16.7	59.7	69.2	60.0	55.9
Total %	100.0	100.0	100.0	100.0	100.0
Number	18	67	26	25	136
% of total responses	13.2	49.3	19.1	18.4	100.0

Chi-square = 16.66 with 6 degrees of freedom significance = 0.01

It will be seen from the above Table that 83.3 percent of respondents with primary education believed that witchcraft can cause disease. The percentage of those with secondary, university and college levels of education who believed that witchcraft can cause disease and illness was relatively small (35.8 percent, 26.9 percent and 36.0 percent respectively). Chi-square was 16.66 and with 6 degrees of freedom and at the .05 level of significance, this relationship was statistically significant. This result means that our hypothesis that people's beliefs about disease causation are affected by educational status is not rejected. Beliefs about causation are affected by educational status. Whereas those with post-secondary school education believed only in natural causes of disease, those with primary school education believed in both natural and supernatural causes.

3.2.3 Occupational Status of Respondents and Beliefs about Causation

To test the third hypothesis that beliefs about disease causation are influenced by occupational status, occupational status of respondents was related to natural beliefs about causation of disease and illness (see Table 3.7 below).

Table 3.7 Occupational Status by Naturalistic Beliefs about Disease Causation

	Occupational Status				
Natural Causes	Unskilled	Skilled	Managerial	Others	Total
No response	0.0	2.3	0.0	0.0	1.5
Yes	90.2	87.2	100.0	100.0	89.0
No	9.8	10.5	0.0	0.0	9.6
Total %	100.0	100.0	100.0	100.0	100.0
Number	41	86	8	1	136
% of total responses	30.1	63.2	5.9	0.7	100.0

Chi-square = 2.26 with 6 degrees of freedom significance = 0.89

The Table above shows that there is very little difference between respondents in the different occupational groups and natural beliefs about disease causation. A chi-square test showed that the relationship between occupational status of respondents and natural beliefs is not statistically significant. Chi-square was 2.26 and this is not significant at .05 level with 6 degrees of freedom. When the occupational status

of respondents was related to supernatural beliefs about causation of disease, it was found that the percentage of unskilled workers who believed that witchcraft can cause disease was more than skilled and managerial workers who said the same. Sixty-one percent unskilled workers said witchcraft can cause disease and illness compared to only 30.2 percent and 50.0 percent skilled and managerial workers respectively. Table 3.8 below shows this.

Table 3.8 Occupational Status by Supernatural Beliefs about Disease Causation

	Occupational Status				
Supernatural Causes	Unskilled	Skilled	Managerial	Others	Total
No response	2.4	4.7	0.0	0.0	3.7
Yes	61.0	30.2	50.0	0.0	40.4
No	36.6	65.1	50.0	100.0	55.9
Total %	100.0	100.0	100.0	100.0	100.0
Number	41	86	8	1	136
% of total responses	30.1	63.2	5.9	0.7	100.0

Chi-square = 12.24 with 6 degrees of freedom significance = .05

A chi-square test showed that the relationship between occupational status and supernatural beliefs about causation of disease was statistically significant at the .05 level. These results mean that the third hypothesis was also not rejected. While most skilled workers believed only in natural

causes of disease and illness, unskilled workers believed in both natural and supernatural causes. Therefore people's beliefs about disease causation are influenced by their occupational status.

3.2.4 *Other Socio-demographic Characteristics and Beliefs about Causation*

When other socio-demographic characteristics such as sex, marital status and the place of respondents' upbringing were related to natural beliefs about causation of disease, it was found that the relationships in both cases were not statistically significant. Similarly, there was no significant relationship when witchcraft was related to the sex and marital status of respondents. However, there was a significant relationship between the area of respondents' upbringing and supernatural beliefs about disease causation. Fifty percent of the respondents who were brought up in a rural area said they believed in witchcraft as compared to only 27.6 percent respondents brought up in urban areas who believed the same. Chi-square was 9.15 and with 2 degrees of freedom this was significant at the .01 level.

3.3 Choice of Health Care

When respondents were asked where they go for health care, most of them said they take their illnesses to hospitals (89.0 percent), clinics (86.8 percent) and to private doctors (58.1 percent). Only 14.0 percent said they used the services of traditional healers and 40.4 percent said they used home remedies. Some respondents said they tried all systems of health care until they found one that is effective. The different types

of health care services were related to socio-demographic characteristics to see if the relationship was significant.

3.3.1 Sex and Choice of Health Care

When the sex of respondents was related to the usage of modern hospitals, clinics and private doctor's facilities, it was found that there was no significant relationship between the two sexes in their usage of these services. There was also no significant difference in the usage of the services of traditional healers between male and female respondents. This finding was also true when the sex was related to the use of home remedies. Even though the relationship between sex of respondents and the use of home remedies was not statistically significant, it was found that slightly more females (42.1 percent) than males (39.2 percent) used home remedies.

3.3.2 Age-groups of Respondents and Choice of Health Care

When the age-groups of respondents were related to the use of a modern hospital, clinic and private doctor's facilities, it was found that there was no significant relationship in their usage between the sexes. This was also true when the age-groups of respondents was related to the use of the services of a traditional healer. However, when the age-groups were related to the use of home remedies it was found that it was mostly those who were over 41 years old who used them. These constituted 78.9 percent of the respondents. Only 33.3 percent of those under 20 years

old, 32.7 percent of those between 21 and 30 years, and 35.1 percent of those between 31 and 40 years old said they used home remedies. This relationship was not statistically significant at the .05 level. Chi-square was 14.75 and with 8 degrees of freedom the significance was .06.

3.3.3 Educational Status of Respondents and Choice of Health Care

When the educational status of respondents was related to the use of a modern hospital and a clinic for health care, it was found that the majority of people with different levels of education used the services of a modern hospital. However, there were differences in the use of private doctor's facilities between respondents with different educational levels. It was found that only 22.2 percent of those with primary education and 53.7 percent with secondary school education used the services of a private doctor for health care as compared to 80.8 percent and 72.0 percent respondents with university and college education respectively. The chi-square was 23.29 and with 6 degrees of freedom, this relationship was significant at the .01 level. These results mean that the usage of a private doctor's services depends on the level of education. People with higher levels of education tend to use the services of private doctors more than those with lower education. There was however no significant difference between the different educational groups in their usage of home remedies. Similarly, there was no significant difference between the different educational groups in their use of the services of a traditional healer though slightly more people with primary education than those with at least secondary education used these services.

3.3.4 Occupational Status of Respondents and Choice of Health Care

When the occupation of respondents was related to the use of a modern hospital and clinics, the results were similar to those obtained when educational status was related to the same. It was found that most people used the services of both modern hospital and clinics. There was however differential use of the services of private doctors among the different occupational groups. Only 31.7 percent unskilled workers said they used the services of private doctors as compared to 67.4 percent skilled workers and 100 percent respondents in managerial positions. The relationship between occupation of respondents and the use of the services of a private doctor was very significant. Chi-square was 48.43 and at the .01 level of significance the relationship was statistically significant. There was however no significant relationship between the different occupational groups in their use of home remedies and the services of a traditional healer.

3.3.5 Areas Where Respondents were brought up and Choice of Health Care

Finally, the usage of modern hospital, clinics and private doctors were related to the area where respondents were brought up. Most respondents irrespective of area of upbringing used all three services. When the use of home remedies was related to the area of upbringing, the relational analysis

found that more respondents brought up in rural areas (44.9 percent) used home remedies as compared to those brought up in urban areas (34.5 percent). Similarly, more people brought up in rural areas (21.8 percent) than those brought up in urban areas (3.4 percent) said they used the services of a traditional healer. Again, these relationships were not statistically significant.

To test the last hypothesis that beliefs affect utilisation of health care services, the three types of modern health care, that is, modern hospital, clinic and private doctor's surgery were grouped into one. If a respondent said he or she used at least one of these services, he was classified as utilising modern health services.

To find out whether diseases believed to be naturally caused are taken to modern doctors, naturalistic beliefs were related to the use of modern health services. Similarly, to find out whether diseases thought to be supernaturally caused are taken to a traditional healer, supernatural beliefs were related to the use of traditional health services.

When naturalistic beliefs about disease causation were related to the use of modern health services, it was found that over 95 percent of those who said diseases are naturally caused used the services of modern medicine. Table 3.9 below shows this.

Table 3.9 Naturalistic Beliefs about Causation of Disease by the use of Modern Health Services

Modern Services	Natural beliefs about Causation			
	No response	Yes	No	Total
No response	0.0	0.8	0.0	0.7
Yes	100.0	95.9	100.0	96.3
No	0.0	3.3	0.0	2.9
Total %	100.0	100.0	100.0	100.0
% of total reponses	1.5	89.0	9.6	100.0

Chi-square = 0.64 with 4 degrees of freedom significance = 0.96

When chi-square test was used to see whether there was a significant relationship between natural beliefs and the use of modern health services, it was found that this relationship was not statistically significant.

When those who said that witchcraft can cause disease were related to the use of the services of a traditional healer, it was found that the relationship was statistically significant. Very few people who believed that illness and disease is caused by witchcraft used the services of a traditional healer. Table 3.10 below shows this.

Table 3.10 Witchcraft as a cause of disease by the use of traditional medicine

	Witchcraft			
Traditional medicine	No response	Yes	No	Total
No response	12.5	1.9	5.3	4.4
Yes	50.0	21.2	9.2	16.2
No	37.5	76.9	85.5	79.4
Total %	100.0	100.0	100.0	100.0
Number	8	52	76	136
% of total responses	5.9	38.2	55.9	100.0

Chi-square = 12.94 with 4 degrees of freedom significance = 0.01

The results in Table 3.10 show that only 21.2 percent of the respondents who believed that witchcraft can cause disease said they used the services of a traditional healer. It was interesting to note that when belief in witchcraft was related with the use of modern health services, 100.0 percent of respondents who believed that witchcraft can cause disease and illness said they use the services of modern medicine.

What the above results mean for the stated hypothesis is that it is rejected. Beliefs about causation of disease do not affect where people go for health care in Lusaka. Modern health services are used for both naturally and supernaturally caused diseases.

3.5 Specific Illnesses of Respondents and Medical Care Sought

The fact that people in Lusaka use modern health services was re-affirmed when respondents were asked when they last sought medical care, what they were suffering from and where they first went for medical care. Respondents were further asked if they went anywhere else for treatment and if so, where and why.

One hundred and fourteen respondents (83.9 percent) had sought medical care less than a year ago while 22 (16.2 percent) had last sought medical care more than a year ago. The illnesses they presented the medical practitioners with ranged from routine medical check-ups, heart palpitations, coughing, abdominal pains, mental problems, simple headache, low and high blood pressure, general body pain, vomiting, eye problems, gynaecological problems, tonsillitis, indigestion, food poisoning to injuries caused by accidents.

With regard to where they first went for treatment, 97.1 percent respondents said they had first sought medical care in hospitals, clinics and private doctors' services. Only one person had sought the help of a traditional healer first. Two respondents said they just bought medicine from a chemist.

On whether they went anywhere else for treatment, 86.8 percent said they did not while 12.5 percent said they had. The types of health care sought by those who went elsewhere were varied. Some people moved from

one modern hospital to another. For example some respondents went to a big hospital from a clinic because of the nature of the illness while others moved from one big hospital to another. Yet others moved from the University Teaching Hospital to use the services of a private doctor. One respondent first went to a traditional healer and later went to a modern hospital because the traditional healer told him that the disease was not caused by witchcraft. Three respondents first went to a modern doctor, but later went to a traditional healer. Reasons for moving from one type of health care to another will be discussed in the next chapter.

To re-establish their beliefs about causation of disease, respondents were asked what in their opinion they thought was the cause of the illness which they had presented the different medical practitioners. Thirty-six respondents (26.5 percent) said that the illnesses started on their own, thirty-one (22.8 percent) said they did not know the cause, thirty (22.1 percent) said the illness was caused by mosquito bites, five (3.7 percent) said they were infected by someone, four (2.9 percent) said it was caused by hard work, thre said it was caused by excessive beer drinking and three others (2.2 percent) attributed it to walking in the rain. Only two respondents attributed the illness to witchcraft and eighteen did not respond. Other causes of illness cited were eating bad food and worries.

Furthermore, respondents were asked what the medical practitioner they consulted said was the cause of the illness. Ninety-one (66.9 percent) said the medical practitioner did not tell them the cause and six (4.4 percent) could not remember. Five were told that the cause of the illness was hard

work. Another five (3.7 percent) were told that they were infected by someone. Only one person (0.7 percent), presumably the one who consulted a traditional healer first, was told that his illness was caused by witchcraf Other causes given by the medical practitioners were mosquito bites, wrong lens in spectacles and eating bad food.

Respondents were also asked general questions about why people take their illnesses to traditional healers and to modern doctors. The majority of respondents (77.9 percent) said that people take their illnesses to traditional healers because the illness cannot be cured by modern medicine. The reasons given by most respondents on why people take their illnesses to a modern hospital was attributed to the successes of modern medicine.

The last question that respondents were asked was if their definition of disease and illness affects where they go for health care. If their answer was yes, they were asked to specify the type of illness and the healing agency sought for treatment. Most respondents (62.5 percent) said their definition of illness did not affect where they went for medical care. Thirteen respondents (37.5 percent) said that their definition affected where they went for care. Others did not respond.

Those who said their definition affected where they went for care said that they would take chronic illnesses or illnesses that cannot be cured by modern medicine, supernaturally caused diseases (for example diseases caused by witchcraft), mashabe (spirit possession), mental illnesses, fits and epilepsy to a traditional healer. Diseases that would be taken to a

modern hospital included acute illnesses, mental problems and diseases such as malaria, headache, cholera, yellow fever and small-pox. Barrenness and impotence would be taken to both medical systems.

3.6 Summary of Discussion

On beliefs about causation of disease and choice of health care, this study found that most people in Lusaka believe in natural causation of disease. The study also found that beliefs about causation are affected by some socio-demographic characteristics such as age, educational status and occupational status. Finally, this study found that beliefs about causation do not affect where people go for health care. Most people irrespective of beliefs use the services of modern medicine.

CHAPTER IV

4. INTERPRETATIONS OF FINDINGS AND DISCUSSIONS

In the previous chapter, it was found that beliefs about causation of disease are influenced by socio-demographic characteristics of respondents such as age, occupational status and educational status of respondents. The findings also showed that beliefs about causation do not affect where people in wage employment in Lusaka go for health care. The aim of this chapter is to suggest possible reasons for these findings.

4.1 Age

As shown in the previous chapter, age had an influence on people's beliefs about causation of disease. Young people had a more scientific attitude towards illness. There are a number of possible explanations for the association of age with beliefs about causation. Young people are more exposed to modernisation factors like formal education than older people. The instruction of formal education theoretically opposes traditional beliefs and traditional way of living. This leads to alienation of people from traditional values. Therefore, the more young people become educated, the more traditional structures will break down.

Young people are also more likely to come into contact with modernising influences of the outside world. This is because young people are more

likely to come into contact with people of other cultures and this kind of contact leads to adoption of other people's culture.

More older people than the young attributed the cause of illness to supernatural factors. The opposite of why young people have a scientific attitude towards illness and disease may be true for older people. Old people are likely to be less educated than the young people. Fewer opportunities existed in the past for old people to achieve high levels of education as compared to the present young generation. Also older people were born during colonialism when modern health facilities for Africans were limited. The only viable institution was the traditional one. Now modern medical facilities are available, especially in urban areas. Nevertheless, older people may still retain some traditional beliefs. They are slower in adopting new values than the young. Older people are what Rodgers (1967) would term laggards. According to him laggards are traditionalists and are more resistant to change than everyone else.

4.2 Education

Education like age also affected people's beliefes about causation of disease More respondents with primary education than those with post-secondary education believed that witchcraft can cause disease. There are several reasons that may contribute to such differences in beliefs about causation according to educational status. Education, like age, is associated with changes in attitude. The more educated a person is, the more he is likely to show a scientific attitude toward disease and illness. Education in

Zambia is free and all the people in Zambia are making use of these facilities. As mentioned earlier, formal education leads to the breakdown of traditional cosmology. As most scientists have emphasised, education is a transmitter of modern ideas. In Zambia, as elsewhere in Africa, the educational system and most of the literature is based on values of former colonial masters. Thus what is taught in schools is based on the values of other people. This has led to the alienation of youths from traditional society. As Busia (1964) indicated , youths may hardly understand traditional society after leaving school, and they may become, as it were, strangers in their own society. The educated tend to look down on those who have not received formal education.

Formal education therefore, even of primary level becomes a major force in breaking down reliance upon the traditional world view. This explains why in this study even respondents with only primary education had a scientific attitude towards disease and illness. However, fewer people with secondary and post-secondary education than with primary education believed that witchcraft can cause disease because the longer a person goes through formal education, the further he or she may be removed from traditional culture and world view. Fosu (1978) sums up this change by saying that the longer a person goes through the system, the more he gains the necessary mental attitude (mental mobility) which enables him to view the world through the scientific process of enquiry. The cause of disease in the scientific system, for example are sought in the laboratory and in the field under controlled conditions since it requires scientific proof for substantiation.

Formal education also leads one to be more exposed to western cultural influences such as mass-communication through radio, television and newspapers. In urban areas of Zambia, all these are available. This exposure to mass media is likely to influence people to use modern health services.

4.3 Occupation

Occupation is another factor that influenced people's beliefs about causation. Skilled workers had a more scientific attitude towards disease causation than unskilled workers. The possible explanations for this difference may be the same as those offered for education. Occupation is usually associated with educational status. People with more education are more likely to be skilled in their work than the less educated. Therefore, the difference in beliefs between skilled and unskilled workers can be attributed to the differences in the educational standard of respondents.

4.4 Other Socio-demographic factors

When other socio-demographic factors were examined, it was found that they did not influence beliefs about causation. For example, when sex was related to beliefs about causation, it was found that both sexes had a scientific attitude towards disease and illness. This contradicts Leeson and Frankenberg's findings (1978) in their study of the social aspects of a healer in Lusaka suburb. Frankenberg and Leeson found that women are more likely to be found at the traditional healer's place of healing than men and children. The reason for this contradiction in findings

may be due to differences in the target group of Frankenberg and Leeson's study and that of this study. Frankenberg and Leeson carried out their study at the traditional healer's place of healing which means that the people they found there were the uneducated none working women . These women belong to a different population from those dealt with in this study - the working women. Naturally, differences are expected between thes groups. The working more educated women are more likely to have a scientifi attitude towards illness and disease than the none working less educated women.

There may be several other reasons why there were no differences in the beliefs of the two sexes. One reason may be due to the fact that the educational statusses of the two sexes in this study were not very varied. Women nowadays have an equal chance of being educated as men. They are also equally exposed to modernising factors. Another reason may be because while playing their traditional sex role, especially the wife-mother role, women are expected to be more frequently in contact with hospitals. When a child in the home is sick, it is usually the woman who takes it to the hospital. This may lead to change in attitude of women towards diseases.

This study also found that slightly more females than males use home remedies. Again, this may be attributed to the sex role. It is generally women who deal with illnesses in the home. Therefore women tend to be more exposed and have more knowledge about health from family and friends. Women are generally found to be more experimental than men. If a friend told a woman of some home remedy that she uses or knows, the woman would

most likely try it. Women are more flexible in their outlook and they would like to experiment with new things.

Similarly, the marital status of respondents and the area of their upbringing did not affect beliefs about causation. This may again be due to the educational status of respondents not being very varied. None differential attitude toward disease and illness between those brought up in urban areas and rural areas may be attributed to the length of time that those brought up in rural areas have lived in urban areas. They may have lived in urban areas for a long period of time which means that they have been exposed to modernising factors for a long time. Thus their attitude towards disease and illness become the same as those brought up in urban areas.

4.5 Choice of Health Care

In terms of choice of health care, this study found that most people first took their illnesses to modern hospitals. This finding has been complemented by similar studies done in an urban setting. For example, Bhardwaj and Madan (1969) found that in urban India people preferred modern health services. The opposite has been found in studies done in rural areas. Scholars such as McKim (1955), Lewis (1965), Fonaroff and Fonaroff (1965) and Neumann and associates (1971) found that in rural Indian villages traditional medicine was preferred.

Preference of one medical system does not mean shunning the other completely. For example, in this study it was found that though people preferred modern

health services, they said they would use traditional medicine for illnesses that can not be cured by modern medicine. These results indicate that people use the services of both traditional and modern medicine in time of need. This finding has been complemented by many other studies. Erasmus (1952), McKim (1955), Simmons (1959), Barker (1959), Gould (1960), Straus (1961), Gonzalez (1966), Maclean (1966) and Chavunduka (1978) have argued that inspite of the great successes of modern medicine, it is rare in many societies to find an individual who relies entirely on modern medicine alone, particularly in times of serious illness. On the basis of this, one can say that people usually view the two medical systems - modern and traditional - as complementary rather than as antagonistic and are prepared to move from one to another and back as they search for relief and cure.

4.6 The Effects of Beliefs on Choice of Health Care

On whether beliefs affected the choice by respondents of specific types of health care, this study found that it did not. Almost all repondents, even those who believed that witchcraft can cause disease used modern health services. Several reasons may be suggested for the non-differential use of health care. One reason may be that people are ashamed of showing their association with traditional medicine. As earlier said, most educated people look down on traditional beliefs. This may lead them to think that acknowledging that they use traditional medicine is a sign of ignorance or backwardness.

Another reason for the non-differential use of medical services in Lusaka may be because Lusaka has a wide range of government run medical services in the form of clinics and a hospital. These services are free for everyone whereas one has to pay for the services of a traditional healer, especially when cure has been obtained. In these days of economic hardships no one would opt to use expensive services when free medical services are available. People therefore use modern free health services first, but when treatment is not achieved they resort to the services of a traditional healer as a last alternative.

People in Lusaka may also prefer to use the services of modern medicine because these services are centrally located and within easy reach. Clinics are found in most residential areas and people go there first and are only referred to the hospital if the illness is of a serious nature. There is also an efficient transport system from town to the hospital. Although there may be many traditional healers in Lusaka, scattered all over the townships, good reputable ones may not be within easy reach. This means that patients may have to travel long distances in order to see them. Not only is this inconvinient, but it is also expensive.

Another reason why people use the services of modern medicine may be due to the fact that all respondents in this study were working people. At places of work employers need a sick note from a modern hospital when one is absent from work because of ill-health. It is unlikely that employers would accept a note from a traditional healer. In Zambia there is yet no legislation that gives traditional healers as much power

as their counterparts in modern medicine.

Although most people used modern health services, there were differences in the use of the hospital and clinics on one hand and the use of the services of private doctors on the other hand. More people in skilled and managerial jobs than in unskilled jobs used the services of private doctors. This may be due to the obvious reason that people in managerial and skilled jobs earn more money than unskilled workers and therefore can afford to pay for the services of a private doctor which are very expensive. At a private doctor, apart from paying a consultation fee, one also has to pay for the medicine. Inspite of this, some people may still prefer to use the services of private doctors to escape from the inconviniences of going to the hospital. At the hospital, queues are very long and the doctor may not spend a lot of time with a patient, let alone tell them what is wrong with them because he has to attend to the next patient. Patients are thus left to guess what is wrong with them.

This poor communication between doctors and patients has been commented on by a number of people. Various reasons have been suggested for this poor communication. Coe (1970) attributed this poor communication to the fact that the doctor may be uncertain about the diagnosis and therefore becomes deliberately vague in relating information to the patient. Straus (1961) suggested two reasons for this poor communication. Firstly, doctors find it hard to explain to a patient who they believe will not understand. Secondly, patients because of lack of familiarity with medical terms and partly because they do not want to seem as though they are questioning the

doctor's expert judgement are often reluctant to press the doctor for definite answers. Because of this attitude on the part of the patient, the doctor may in turn feel that the patient does not really want to know. Foster (1957), Simmons (1959) and Brown (1963) suggested that communication is impossible between doctors and patients because of the social distance between them. Chavunduka (1978) suggested that poor communication between doctors and patients in the case of the Shona may be due to three factors, namely, the language barrier, the difficulty of expressing some scientific terms in Shona and the problem of conceptual transfer. Many doctors in Zimbabwe do not speak Shona and have to rely largely on the ability of their interpreters. Chavunduka compared the problem of conceptual transfer in Zimbabwe with what McDermott and associates (1960) discovered among the Navaho.

> "The problem of physician-patient communication among the Navaho is a formidable one, not so much because there are wide differences between the Navaho and the English language as because there are wide differnces between the two cultures with respect to concepts of bodily disease. If both cultures had essentially the same concepts of disease and treatment, any person reasonably fluent in both languages could serve as a satisfactory 'bridge' between the patient and his physician. As it stands, however, with the differences in medical concepts that exist, an interpreter may be completely bilingual in discussing the ordinary affairs of life yet wholly unreliable in discussing medical matters unless he is quite generally familiar with the medical concepts of both cultures. To be sure, this same principle applies in some degree to technologies other than medicine. But in most other technologies - for example animal husbandry or agriculture - the two people involved in the attempts at communication are both usually concerned with the invisible world around them and not with inner feelings of one of the persons."

Chavunduka concluded that most patients are left to make the evaluation of their illness primarily in terms of their own understanding of disease.

In the case of the Lusaka patient, the poor communication may be due to one other factor - the number of patients the doctor has to attend to. The number of doctors at the University Teaching Hospital is very small compared to the population they have to cater for. According to the Ministry of Health (1978) there were only 244 doctors in Lusaka province and these had to cater for a population of 693,878 people. This means that there was one doctor for approximately 2,844 people. In order to attend to all the patients, doctors can only spend a short time with each patient. Thus doctors may not have time to explain to the patients what is wrong with the Doctors just prescribe medicine for the patients. One can hardly read the doctor's hand writing on the prescription and therefore people are left to decide what is wrong with them according to their own understanding of disease.

4.7 Reasons for Moving from one type of Health Care to Another

In this study it was found that some patients moved from one type of medical care to another. There may be several reasons for this. For example, some people moved to a bigger hospital from a clinic because of the nature of the illness. Clinics only deal with minor complaints and are usually run by medical assistants and nurses. This means that when one's illness is of a serious nature, they have to be referred to a hospital. People may also move from one big hospital to another in search of drugs. In Zambia, medicines are sometimes in short supply because of lack of foreign exchange. Patients have no choice, but to move from one hospital to another in search of medicine.

Some people first went to the University Teaching Hospital but later sought treatment from private doctors. One reason may be because the nature of the disease required maximum privacy. Maximum privacy is not possible at the University Teaching Hospital because doctors treat their patients in the presence of student nurses and student doctors. This can be very embarassing on the part of the patient if the disease is one which the patient is ashamed of.

Another reason for moving from the hospital to a private doctor's surgery may be the one that was cited earlier - the University Teaching Hospital is the only big hospital in Lusaka and caters for a very large population while doctors are few. This may lead some people to think that treatment at a private doctor's surgery is better because a private doctor spends more time with his patients than a doctor at the University Teaching Hospital.

A respondent who first went to a traditional healer later went to a modern hospital because he was told that his illness was not caused by witchcraft. Chavunduka (1978) suggested that people change from traditional healers to a modern one because they undergo a process of re-definition of their illness. He suggested five reasons why this process takes place.

> "People seem to redefine their illnesses when traditional medicines fail to cure the disease; when the suspicions held by the patient and his social group regarding the cause of the disease is not confirmed by the traditional practitioner; when the patient and his social group are unable to accept the traditional practitioner's diagnosis; when the patient and his social group are uncertain about the diagnosis or prognosis of the illness and when additional unusual symptoms disappear."

The reasons Chavunduka gave for the change from a traditional healer to a modern one may also hold true for this study.

Other respondents first went to a modern hospital and later went to a traditional healer. This change was attributed to the illness not being cured by modern medicine. Traditionally, people believe that an illness that can not be cured by modern medicine must be caused by supernatural powers and therefore belongs to the domain of traditional medicine. Chavunduka in his study of the Shona also found that this was the main reason why people re-assessed their illness and changed from traditional to modern medicine.

Another reason given by one respondent for the change from traditional to modern was because she was forced by relatives who suspected that the disease was caused by witchcraft. The fact that this respondent was forced to go and seek the help of a traditional healer shows that sometimes, the wider kin-group plays a very important role in the decision-making process of the individual during an illness. Adair (1963) and Chavunduka discovered this behaviour in their studies. Both of them found that kinsmen both educated and uneducated jointly take decisions throughout the illness of an individual.

4.8 Summary of Discussion

The above discussion shows that modernisation factors such as education have played a very important role in changing people's attitudes towards

disease. Modernisation has caused people to prefer modern health services This discussion also showed that even though people prefer to use modern health services, they do not hesitate to seek the help of traditional healers when their illness cannot be cured by modern medicine.

CHAPTER V

5. SUMMARY AND CONCLUSIONS

The prime concern of this study was twofold: to investigate people's beliefs about disease causation; and to examine the extent to which beliefs about causation affect the choice of health care.

Previous research on the topic has mostly been conducted in rural areas. On beliefs about causation, early studies observed that Africans attribute all illnesses to supernatural powers. Recent studies have however observed that there is a folk dichotomy in African belief system which separates natural from supernatural aetiology. On the choice of health care, early studies have shown that people prefer to use traditional medicine due to their concept of disease causation. Recent studies have however observed that illnesses thought to be due to natural agents tend to be presented for treatment to practitioners of modern medicine whereas illnesses thought to be due to supernatural agents tend to be dealt with by traditional healers.

Studies that have been conducted in urban areas have shown that people use the services of the various types of practitioners such as modern doctors and traditional healers in their search for cure. The general conclusion that has been reached by those urban studies is that it is the expectancy of cure which seems implicit in the expectancy of cure which

seems implicit in the expressed preferences of health care.

The difference of this study with other studies of a similar nature is that it focused on people in wage employment. The reason for focusing on this group was to see if modernisation has changed traditional beliefs about disease. This study constituted of a stratified random sample of three Lusaka based establishments.

5.1 Summary of Findings

This study found that beliefs about causation were affected by socio-demographic characteristics of respondents. From the available data, the following conclusions were arrived at.

1. A person's beliefs about causation of disease is influenced by age. Younger people have a more scientific attitude towards disease and illness than older people.

2. People's beliefs about disease and illness are affected by educational status. The higher the education attained, the more scientific attitudes towards illness will be.

3. People's beliefs about disease causation are influenced by their occupational status. Skilled workers believe mostly in natural causes of disease and illness while unskilled workers believe in both natural and supernatural aetiologies.

4. People's beliefs about causation do not affect where they go for health care. People use modern health services irrespective of the perceived cause of disease.

5.2 Implications of Findings and Discussions

From these findings, one can easily jump to the conclusion that people in wage employment in Lusaka have completely moved away from traditional values to modern ones in that they see the cause of disease in naturalistic terms and prefer modern medicine to traditional medicine. However, the truth of the matter may not be as simple as that. There is a proliferation of traditional healers in Lusaka. The exact number is not known, but they appear to outnumber modern doctors. A question that arises from this is, why does traditional medicine still persist even where modern medicine is offered?

A few answers to this question may be suggested. The conclusion that people in Lusaka do not use the services of traditional healers may have been arrived at because of the target group of this study. This study only dealt with one sector of the population in Lusaka and therefore the results should only be generalised for this group of people. Lusaka consist of other groups of people such as illiterates, unemployed, the self employed and so on. It is possible that if all these categories were included in the study, the results would have been different and this may have helped explain why there is still persistence of traditional healers in Lusaka.

Another reason may be that traditional medicine serves a certain need of the people, especially in illnesses that cannot be cured by modern medicine. People do realise the great successes of modern medicine as it continues to discover new sophisticated cures for illnesses. However, as long as modern medicine does not offer complete cures for some illnesses, traditional healing will persist. Dubos (1961) observed that while modern medicine can boast of so many startling achievements in the health fields, its role has not been so complete as is commonly claimed. Traditional medicine can boast of successes, especially in the area of chronic or psychosomatic ills where modern medicine has failed to produce equally good results. Barker (1959) also came to this conclusion and observed:

> "Where we failed, in the hopeless cancers, or in chronic ailments, the spirit world would again be invoked, but often only in despair which prompted fond relatives to leave no avenue unexplored which might lead to a last minute restoration of their sufferer's health. When this happened, European know-alls were ready to point a finger: 'You see doc? They are a primitive lot at heart and given half a chance always go back to their old ways. You will never change them.' Yet I fancy that the return to the magician owed more to love than to fear; more to desire to help in an extremity than to persistence of superstition. All varieties of quacks and herbal cranks flourish in our own society on the edges of the well-tilled fields of medicine. To some extent their existence, like that of the tribal medicine-man must be laid at our door who do not know enough and whose medical philosophy is too small to embrace, in addition to the body's ills, the need for the sick soul."

Whereas modern medicine deals mainly with physiological factors in the disease situation, traditional medicine deals mostly with social aetiologies such as breach of taboo, kinship morality, witchcraft and so on. In any illness, both should be dealt with if the individual is going to be treated completely.

People may therefore use the two types of medical care in their search for good health.

5.3 Recommendations

As long as traditional medicine serves a particular need of the people, its existence will persist. Traditional medicine still plays a very important important role and therefore should not be ignored. Traditional healers should be encouraged to help people, especially in illnesses where modern medicine has failed to find cure. There could be cooperation between modern doctors and traditional medicine in the form of a referral system. Modern doctors can refer some illnesses such as those chronic in nature to traditional healers and traditional healers can do the same for acute illnesses. Modern doctors have often complained that many patients whose illnesses might be cured by them move from one traditional healer to another and eventually come to the hospital when it is too late to help them. This behaviour can be changed by the help of traditional healers in the form of referral, but first and foremost, modern doctors should demonstrate the effectiveness of their medicine in curing many diseases. This will change the attitude of traditional healers and they will in turn change the behaviour of the people.

Traditional medicine should also be encouraged because it can play a very important role in the provision of medicine, especially nowadays when the country is experiencing a shortage of drugs in hospitals due to lack of

foreign exchange. Traditional medicine, whether involving the supernatural or not, depends very much on the use of plants which are locally available and this can be a very cheap source of ensuring health for the people.

Modern health facilities require financial and manpower resources and most Third World countries including Zambia do not have these resources. Harrison (1974-75) suggests that traditional healers can fill a vacuum in health care created by the shortage of health manpower and the cost of training modern health workers.

5.4 Suggestions for Further Studies

The results of this study are a reflection of only a small category of the population in Lusaka. Other categories of the population such as the illiterates and the self-employed were not included. Hence if further studies were to be carried out, they should include all the constituents of the population. Further studies could also be done on a comparative basis between rural and urban areas to see how much modernisation has affected beliefs in the two areas.

5.5 Conclusion

The main objective of this study was to find out if people's beliefs about causation affect choice of health care in Lusaka. Although this study found that people in Lusaka utilise mostly modern health services, it also

identified the important role that traditional medicine plays. It can therefore be concluded that inspite of the great successes of modern medicine, traditional medicine still has an important role to play in non-Western cultures. The integration of certain elements of traditional medicine with modern medicine in Africa is desirable if health for all by the year 2,000 is to be achieved.

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APPENDIX

QUESTIONNAIRE

Instructions: Please place the number opposite your answer in the box.

e.g. Which ethnic or cultural group do you belong to?

Lozi - 1
Chewa - 2
Mambwe - 3
Lunda - 4

[3]

This indicates that you are Mambwe. Thank You.

A. Background Characteristics of Respondents

Sex

1. Sex

Male - 1
Female - 2

[ ]

2. Age

Under 20 or 20 years - 1
21 - 30 years - 2
31 - 40 years - 3
41 - 50 years - 4
51 years or over - 5

[ ]

3. Education

Illiterate - 1
Primary - 2
Secondary - 3
University - 4
College - 5

[ ]

What is the highest level completed? _____

4. Marital Status

Single - 1
Married - 2
Separated - 3
Divorced - 4
Widowed - 5
Other (specify) _____

[ ]

5. Religion

Catholic - 1
Anglican - 2
Methodist - 3
Baptist - 4
Other (Specify) _____ ☐

6. Occupation

Unskilled - 1
Skilled - 2
Managerial - 3
Other (Specify) _____ ☐

B. Concept of Disease and Illness

7. What is your definition of Disease and Illness?

When specific symptoms of physical pain are present Yes -1 No -2 ☐

When as a result of bad physical condition you are unable to perform normal duties Yes - 1 No - 2 ☐

Generally feeling weak and unwell Yes - 1 No - 2 ☐

When a condition that kills is present Yes - 1 No - 2 ☐

Other (specify) _____ ☐

8. What is your notion of good health?

Free from illness Yes - 1 No - 2 ☐
Able to work Yes - 1 No - 2 ☐
Able to perform normal duties ☐
Free from worries Yes - 1 No - 2 ☐
Feeling physically fit Yes - 1 No - 2 ☐

Other (Specify) _____

C. Causes of Disease and Illness

9. What in your opinion is the cause of illness?

Eating bad food	Yes - 1	No - 2	☐
Lack of cleanliness	Yes - 1	No - 2	☐
Lack of nourishing food	Yes - 1	No - 2	☐
Weak blood	Yes - 1	No - 2	☐
Witchcraft	Yes - 1	No - 2	☐
Will of God	Yes - 1	No - 2	☐

Other (specify) _____

10. Do all illnesses have the same cause?

Yes - 1
No - 2
I do not know - 3
I am not sure - 4

☐

11. If yes, what is the cause of illness?

_____

12. If no, what are the different causes of illness?

_____

_____

_____

D. Choice of Health Care

13. Where do you go for health care?

Traditional Healer	Yes - 1	No - 2	☐
Modern Hospital	Yes - 1	No - 2	☐
Clinic	Yes - 1	No - 2	☐

Private doctor Yes - 1 No - 2 ____
Use home remedy Yes - 1 No - 2 ____
Other (specify) _____ ____

_____

14. Which diseases would you take to a modern hospital?

Diseases that are naturally caused Yes - 1 No - 2 ____
Diseases that are acute (i.e. can cause death fast) Yes - 1 No - 2 ____
All diseases Yes - 1 No - 2 ____

Other (specify) _____ ____

15. Which diseases would you take to a traditional healer?

Diseases that are caused by witchcraft Yes - 1 No - 2 ____
Mental diseases (e.g. Madness) Yes - 1 No - 2 ____
Diseases that cannot be cured by modern medicine Yes - 1 No - 2 ____
Other (specify) _____ ____

16. When did you last seek for medical care?

Less than a month ago - 1
2 to 6 months ago - 2
6 to 12 months ago - 3
More than a year ago - 4

____

17. What were you suffering from?

_____

18. Where did you first go for treatment?

Modern Hospital - 1
Clinic - 2
Private doctor"s surgery-3
Traditional Healer - 4
Other (specify)_____ ____ _____

____

19. Did you go anywhere else for treatment? Yes - 1 No - 2 ____

20. If yes, where and why? _____ ____

_____

21. What in your opinion was the cause of the illness?

Started on its own	-1	
Dirty drinking water	- 2	
Excessive beer drinking	- 3	
Infected by someone	- 4	
Mosquitoes	- 5	____
Walking in the rain	- 7	
Accident	- 8	____
Spirits	- 9	
Witchcraft	- 10	
Taboo	- 11	
Do not know	- 12	
other (specify)		_____

22. What did the medical practitioner say was the cause of the illness?

Dirty drinking water	- 1	
Hard work	- 2	
Excessive beer drinking	- 3	____
Infected by someone	- 4	
Witchcraft	- 5	____
Spirits	- 6	
He/She did not say	- 7	
I cannot remember	- 8	
Other (specify)		_____

23. Why do people take their illnesses to traditional healers?

Because he tells what is wrong with the patients Yes - 1 No - 2 ____

Because there is personal contact with his patients Yes - 1 No - 2 ____

Because of availability of traditional healers Yes - 1 No - 2 ____

Because the disease cannot be cured by modern medicine Yes - 1 No - 2 ____

Because the queues at a traditional healer are shorter than at a modern hospital Yes - 1 No - 2 ____

Other (specify) _____

_____

24. Why do people take their illnesses to a modern hospital? ____

Because of availability Yes - 1 No - 2 ____
Because it is cheap Yes - 1 No - 2 ____

Because of its successes Yes - 1 No - 2 ____

Because of the nature and type of disease Yes - 1 No - 2 ____

Because at work they are required to produce a sick note from a modern hospital Yes - 1 No - 2 ____

Because of religious beliefs Yes - 1 No - 2 ____

Other (specify) _____

25. Does your definition of disease affect where you go for treatment?

Yes - 1 ____
No - 2 ____

If yes, specify the type of illness and medical care sought.

Illness	Healing Agency Sought